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Teacher management in a context of HIV and AIDS

Botswana report

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Education in the context of HIV & AIDS

This report is one of a series of case studies and forms part of a project entitled 'Teacher Management in a Context of HIV and AIDS'.

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Background to the research

Introduction

This study aims to describe and analyse the results of a qualitative research study on teacher management policies, tools and practices in Botswana, a country where HIV and AIDS is highly prevalent. The research aims to discover whether teacher management policies, tools and practices have evolved in high prevalence settings as a response to the HIV epidemic.

The current report is part of a series of monographs commissioned in 2008–2009 by the International Institute for Educational Planning (IIEP) at the United Nations Educational, Scientific and Cultural Organization (UNESCO) and will contribute to a multi-country synthesis of similar studies. The eight countries included in the study have some of the highest HIV prevalence rates in southern Africa: Botswana, Kenya, Lesotho, Malawi, Swaziland, Tanzania, Zambia and Zimbabwe. It is expected that analysing the situation in countries most affected by HIV and AIDS will shed light on innovative approaches undertaken in terms of teacher management.

Overview

The push for Education for All (EFA) has greatly increased primary school completion rates and demand for secondary education. In order to sustain the rapid expansion of education in developing countries, a large number of teachers will have to be recruited over the next decade. The UNESCO Institute for Statistics (UIS) estimates that 18 million primary school teachers will be needed over the same period to achieve Universal Primary Education (UPE) (UIS/UNESCO, 2006). However, while teacher demand is increasing, the epidemic is having a negative impact on teacher supply. Many countries are already facing teacher shortages, and the AIDS epidemic has created additional obstacles in responding to demand and in meeting the objectives of quality education.

In sub-Saharan Africa alone, the region most affected by the epidemic, 1.6 million additional primary teachers will be required by 2015 (UIS/UNESCO, 2006). In the hardest hit countries, where overall mortality rates have increased as a result of the epidemic, teachers have been dying in greater numbers than in the past. However, it is impossible to say with any precision what proportion of these deaths is related to AIDS. In Malawi, nearly 40 per cent of all teacher losses are due to terminal illnesses, most of which are presumed to be AIDS-related illnesses (World Bank, 2007).

Attrition remains high among teachers, estimated between 6.5 per cent and 10 per cent in southern African countries (UIS/UNESCO, 2006). How much of this loss is due to AIDS-related stress and illnesses is not known. The number of teachers who die every year is fortunately lower than predicted in earlier studies using AIDS-adjusted demographic projections (Bennell, 2005). Precise rates of HIV infection among teachers remain unknown in most countries, but recent research shows that HIV prevalence rates among teachers tend to be similar to those found in the general population. A comprehensive study of South African public schools, for example, found that 12.7 per cent of teachers were HIV-positive – a very high figure, but not significantly different from the rate among the general population (Shisana et al., 2004).

Absenteeism is problematic in many countries,[1] regardless of HIV and AIDS. However, the epidemic has transformed absenteeism into a very serious issue in highly impacted settings. In Zambia it is estimated that 60 per cent of teacher absences are due to illness or having to care for family members or attend funerals (UNAIDS/WHO, 2006). In Namibia, sick leave and attendance at funerals are the largest causes of absences in the northern provinces (Castro et al., 2007). Absenteeism has major implications for the quality of education; classes are often not taught and it creates heavier workloads for the remaining teachers and increases reliance on less qualified teachers (see Caillods et al., 2008). The effects on teacher morale also have an impact on job commitment and performance.

[1] It is very difficult to obtain reliable data on the extent of teacher absenteeism, but it is generally understood to be quite high for a number of reasons such as illness, low salaries, collecting payments, etc.

This has major implications in terms of costs. The financial impact of teacher absenteeism due to AIDS-related illness for Mozambique and Zambia in 2005 was estimated at US$3.3 million and US$1.7 million respectively (plus an additional US$0.3 million and US$0.7 million respectively in increased teacher training costs). According to projection data, it appears that absenteeism generates significantly higher costs (24 per cent to 89 per cent of overall HIV and AIDS costs) than the cost of hiring and training new employees to replace those lost to AIDS (17 per cent to 24 per cent). This differential may be slightly lower for teachers, given the length of their training (see Desai and Jukes, cited in UNESCO, 2005, p. 89).

Little information is available on how teacher policies and management practices have been affected by and adapted in response to the HIV epidemic. In a context where HIV is prevalent, teacher management issues such as workplace policies, access to treatment, retention, early retirement, redeployment of teachers needing care, training and replacement of missing or absent teachers are all issues that need to be addressed.

While the role of education in HIV prevention efforts has been recognized as a key factor in tackling the HIV epidemic, less attention has been paid to mitigating the impact on the education sector itself. Implications for the management of teachers, who in most developing countries represent the largest segment of the public workforce, need to be explored. The present research intends to fill this gap and will seek to review current teacher management practices in some of the most highly affected countries.

Scope and key research questions

This study, and all eight country studies, are concerned with describing and reviewing current teacher policies and management practices in primary and secondary formal education. Issues relating to teacher management and support in tertiary institutions are not addressed, as well as issues of pre-service training, curriculum, practices at school level or the distinction between different types of schools. The visits to schools provide insights into the awareness of policies by the head teacher and teachers themselves, as well as possible difficulties in the implementation of these policies.

The main objectives of the research for this study, and for all eight country studies, are as follows:

- to enhance knowledge on the extent of the impact of HIV on teachers
- to highlight teacher management strategies that can be replicated and/or adapted by policymakers
- to provide practical suggestions and policy directions for improving teacher management in a context of HIV and AIDS.

The current study specifically addresses the following questions:

- What is the degree and monitoring of teacher absenteeism and attrition in Tanzania and what are the measures adopted to address those problems, including replacing teachers?
- To what extent have HIV and AIDS affected teacher management practices, and to what extent are the effects of HIV taken into account to plan teacher supply and demand?
- Has the role of stakeholders in teacher management evolved as a result of HIV or indirectly through new legal and social measures affecting the teacher policy framework?
- What measures, if any, have been adopted to protect the rights of HIV-positive teachers?

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ACHAP	African Comprehensive HIV/AIDS Partnerships
AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
BAIS	Botswana AIDS Impact Survey
BGCSE	Botswana General Certificate in Secondary Education
BOSETU	Botswana Secondary Education Teachers' Union
BONELA	Botswana Network on Ethics, Law and HIV/AIDS
BPOMAS	Botswana Public Officers Medical Aid Scheme
BTU	Botswana Teachers' Union
CBO	Community based organization
CSO	Central Statistics Office
CCE	Concurrent Certificate in Education
CHBC	Community home-based care
COSC	Cambridge Overseas School Certificate
DMSAC	District Multisectoral AIDS Committee
DPSM	Directorate of Public Service Management
DSS	Department of Social Services
ECCE	Early Childhood Care and Education
EFA	Education for All
EMIS	Education Management Information System
FBO	Faith-based organization
GDP	Gross Domestic Product
GER	Gross Enrolment Ratio
HAART	Highly Active Antiretroviral Therapy
HBC	Home-based care
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
IGCSE	International General Certificate in Secondary Education
MoESD	Ministry of Education and Skills Development
MTP	Medium-term Plan
NAC	National AIDS Council
NACA	National AIDS Coordinating Agency
NER	Net Enrolment Ratio
NGO	Non-governmental organization
NSF	National Strategic Framework
PEO	Principal Education Officer
PGDE	Post Graduate Diploma in Education
PLHIV	People living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PSLE	Primary School Leaving Examination
PTA	Parent-Teacher Association
PTR	Pupil to Teacher Ratio
RNPE	Revised National Policy on Education
STI	Sexually transmitted infection
TB	Tuberculosis
TCB	Teacher Capacity Building Project
TMIS	Teacher Management Information System
TR	Transition rate
TSM	Teaching Service Management
TT&D	Teacher Training & Development
UB	University of Botswana
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNGASS	United Nations General Assembly Special Session

UPE	Universal Primary Education
UTS	Unified Teaching Service
VCT	Voluntary counselling and testing

Executive summary

Introduction

This study aims to describe and analyse the results of a qualitative research study on teacher management policies, tools and practices in Botswana, a country where HIV and AIDS is highly prevalent. It looks at whether these policies, tools and practices have evolved in response to the HIV epidemic.

Study design and data collection

The research was conducted by Gaelebale Nnunu Tsheko, Senior Lecturer, Faculty of Education, University of Botswana,with the assistance of Research Assistant Doreen Mooketsi between April and May 2009.

Data were collected through a combination of document reviews, semi-structured interviews and focus group discussions. Documentation was obtained from relevant offices at the Ministry of Education and Skills Development (MoESD), government printers and the internet.

The study was qualitative and was based on a total of 21 in-depth interviews at the central level with a limited number of senior and middle-level officers at the MoESD headquarters in Gaborone and school visits in Gaborone – an urban area – and Kanye, a semi-urban area. This was supplemented by a focus group discussion for primary school teachers.

Botswana is reported have one of the highest HIV prevalence rates in southern Africa. Sentinel data estimates the national prevalence rate of around 27.0% for adults aged 15–49 years.

Key findings

1. Attrition

Through HIV-related illnesses, the education sector has experienced loss of productivity as a result of death or because staff are forced to leave service prematurely to care for ill family members. Though this picture has improved as a result of the availability of antiretroviral (ARV) treatment, the sector is still experiencing staff shortages. During interviews with teachers, school heads, education officers and teachers' union members, issues of secrecy, denial and stigma were reported to influence teacher attitudes and perceptions regarding HIV and AIDS. Unfortunately, this is still high. The quality of education stands to suffer as a result of the HIV epidemic.

As well as illness, reasons for teachers leaving their posts include retirement, resignation, dismissal, death, further studies and secondments. Retirement from public service is compulsory at the age of 65, but after 25 years of service, teachers can take early retirement. The contributory pension scheme comes with increased benefits at time of retirement and therefore the early retirement option is not popular. In 2006, 163 teachers were reported to have retired.

Resignation rates are not high given the limited employment opportunities elsewhere, especially for primary school teachers. Every year about 20 teachers are dismissed for misconduct.

In an earlier study, Bennell et al. (2001) had projected that the teacher mortality rate would rise in Botswana, based on the HIV prevalence rates at the time. However, mortality rates have declined over the years, especially with the availability of ARVs, which are offered at no cost to those who need them (Bennell et al., 2008).

Most teachers are on medical aid schemes and this takes care of health needs, including provision of HIV treatment where needed, thus reducing death rates. Seventy-five teachers are reported to have died in 2006. However, since death due to HIV is not reported separately in education sector records, this makes it difficult to assess the overall impact of HIV in the education sector.

2. Absenteeism and leave

Teacher absenteeism was reported by many of the participants as a major problem in Botswana's schools. The primary reason for teacher absence is ill health, but unfortunately there is often a lack of detail about the nature of these illnesses. There are other reasons for teacher absenteeism, such as lack of commitment to work, especially among new teachers There is also a growing concern regarding the abuse of alcohol and drugs by both teachers and students.

In the case of absenteeism due to illness, there is the suspicion that in most cases the ill health is HIV related. However, this cannot be ascertained, as disclosure of one's HIV status is voluntary.

A teacher who is not able to attend their duties due to illness must report to their supervisors as soon as possible. Absence from leave for 48 hours should be accompanied by a medical report stating the nature of the illness and a recommended period for sick leave. The medical certificate must be signed by a government or private medical officer. If a teacher is considered to be incapable of carrying out their duties because of physical or mental illness, they may undergo a medical examination conducted by either a medical practitioner or a medical board nominated by the director. The teacher can also request such an examination on their own. Results of the examination will be used with other information from the teacher to decide whether the teacher should be retired on medical grounds.

There is a need to replace teachers who are lost to the teaching service due to various attrition routes. There is a general feeling among teachers that replacement of teachers takes a long time. When a teacher is absent, other teachers take on their workload. The common practice is for the other teachers to divide the class of the absent teacher amongst themselves. Teachers are replaced only when they have been granted leave such as long-term sick leave, further studies, maternity leave or retirement.

3. Deployment and transfer

There is a great deal of movement of teachers, although detailed analysis is unavailable. Many teachers are applying for transfers at any given time. For example, in the South region, to which Kanye belongs, at the time of this study over 500 teachers had submitted applications for transfers. Reasons for requesting transfers are many, but ill health is often cited by the majority. Other reasons include transfers to other schools and requests to be near a study institution.

Many teachers who are ill request to be transferred closer to medical institutions in semi-urban areas, town and cities. This has an impact on the quality of teachers left in the remote or rural areas.

However, given that disclosure of HIV status is not required, some teachers do give false reasons to apply for transfers, such as to be near sick family members, and this cannot be verified.

Stigma still plays a significant role in schools. As a result, there are instances where school heads recommend teachers for transfer when they are suspected to be HIV-positive. Stigma is sometimes also shown by parents. When they hear a teacher is HIV-positive, they come to the school and either remove their children or ask that their children be moved from the teacher's class.

4. Teacher management tools

The MoESD has made tremendous improvements in developing and computerizing the management of information on teachers. The Educational Management Information System (EMIS) together with the TSM Infinium Human Resource Database system are making it possible for teacher data such as teacher movement to be available at the click of a button. Though the database has been decentralized to the five educational regions, at the regional level it has not yet been fully implemented. This means that some data are not captured in a timely manner, thus rendering the system ineffective. These systems are not capturing all the necessary data in teacher management, for example, absenteeism. HIV and AIDS are not singled out as an illness or cause of death, and therefore assessment of teacher management in the context of HIV and AIDS is a challenge.

There is a Teacher Management Information System (TMIS). This database mainly captures information on the recruitment and movement of teachers, as well as their salaries. Information on the supply and demand for teachers is therefore kept on this database.

5. Policies

The Government of Botswana has declared HIV and AIDS a national emergency and is committed to an aggressive, comprehensive and expanded multisectoral and multilevel response to fight the epidemic and to curb its impact on society.

The education sector's response to HIV and AIDS was developed in 1998 as part of the national response to the epidemic. An HIV and AIDS Unit has been developed in the Ministry of Education and Skills Development (MoESD) and ministerial policy documents, such as an HIV and AIDS policy, have been developed. With these structures in place, it would be expected that the HIV and AIDS agenda is mainstreamed into all levels of the sector. However, lack of capacity at the ministry level is impeding the implementation of programmes.

In some divisions and departments of the MoESD, the HIV focal persons are given this role in addition to their regular office work. As a result, they are unable to perform duties related to the HIV and AIDS agenda. They see this as a duty to be carried out when all other duties are complete and this hampers progress in pushing the HIV and AIDS agenda in the ministry. This lack of capacity impacts on the lower levels such as at institutional levels.

The MoESD does not have a workplace policy document on HIV and AIDS, possibly also as a result of inadequate staffing. This in turn is responsible for the lack of workplace policy in schools.

6. Structures

There are no sectoral support structures for HIV-positive teachers. Teachers are treated the same as other Batswana and therefore have to use the same structures that are available to everyone. At the national level, when somebody tests HIV-positive, they are counselled and referred for HIV evaluation and treatment. Teachers receive exactly the same treatment as everyone else. The MoESD does not have a separate referral system for those infected or affected by HIV.

Teachers' unions are playing a significant role in advocating for teachers living with HIV. They sometimes run workshops and invite experts to educate teachers on HIV, as well as inviting HIV-positive teachers to share their experiences. One teachers' union is working on developing a support group for teachers living with HIV. Unions are also arguing for teachers with HIV to be offered preferential treatment, in comparison to other public servants.

Teachers' unions are also playing a significant role in defending the rights of teachers living with HIV. Most teachers are members of a teachers' unions and these offer many services for their members, such as funeral services, a legal aid scheme and credit/loan schemes. The funeral service offered by the union is reported to respond much more quickly in times than the regular funeral services offered by private providers. The fees towards funeral services are comparable to those offered by other providers, but the speed at which one is assisted at the time of need is said to be the attractive part that is now drawing more teachers to join unions. Union members have to contribute towards the legal aid scheme and this scheme is meant to cater for social and private problems of teachers, as the work-related problems are covered through the union membership.

7. Treatment

Like all other Batswana, teachers access HIV treatment free of charge at designated places throughout the country. There is no differential treatment for teachers. Like all other public employees, teachers apply for leave to access treatment at designated centres. These places are mainly with private doctors, for those on medical aid schemes, or at public facilities such as hospitals and clinics.

The Government of Botswana launched the treatment programme Masa (New Dawn) in 2002 to provide free antiretroviral (ARV) therapy. Botswana was the first country in Africa to provide free ARV treatment to all citizens who need it. This was accompanied by a nationwide information, education and communication (IEC) programme to provide Batswana with the necessary information on HIV and AIDS and ARV therapy. This treatment package is available throughout the country and the team working on this is involved in various activities, including community mobilization.

Although this programme is one of Botswana's success stories, it has not been without its challenges. The programme started in one site (Gaborone) and within the same year had expanded to three more sites (Francistown, Serowe and Maun) to ensure that there was a site in all four corners of the country for access by rural and urban dwellers. Given the size of Botswana, this meant that some people

travelled long distances and queued to access treatment. the number of sites has NOW increased and the situation has been alleviated.

A further challenge with treatment is the low adherence to treatment by patients, as reported often by health practitioners. However, this is expected to be under control once planned intervention strategies are fully implemented.

8. Training

According to the MoESD HIV policy, in-service training on HIV and AIDS has to be provided for teachers. However, due to lack of capacity, this is not fulfilled. In general, only designated guidance and counselling teachers receive the training. Guidance and counselling is offered as an enrichment subject to all students in primary and secondary schools. The curriculum for this subject covers many topics including health and HIV and AIDS. HIV and AIDS has been integrated in some subjects and teachers are to integrate it into all the other subjects. It is apparent that integration is difficult for teachers as most have not had any training on HIV and AIDS. The adequacy of teaching HIV in the schools cannot therefore be ascertained.

There are initiatives such as the Teacher Capacity Building Project (TCB), Botswana's success story in the education sector. This programme is a partnership between African Comprehensive HIV/AIDS Partnerships (ACHAP), MoESD, Botswana Television and the United Nations Development Programme (UNDP). The curriculum for the programme has been prepared and produced by the Department of Teacher Training & Development (TT&D) with technical support provided from UNDP. The curriculum includes topics on basic HIV and AIDS knowledge, prevention, care and support, HIV testing, culture, attitudes and the role of the community. However, it has not been without its challenges. Some schools do not have electricity and therefore are not able to participate in the programme, while in some schools facilities are not always functional. The timing for the programme is Tuesday at noon and sometimes schools are not able to stop regular teaching and view the programme at this time. Teachers have to call in to access the service and telephone reception is reported to be a challenge in some areas.

There are other programmes that have been put in place such as the TalkBack programme, an interactive television teacher education programme. This targets Botswana teachers with information about HIV and AIDS in an effort to build teacher capacity to effectively address HIV and AIDS issues in the classroom.

Major challenges

Teacher management is experiencing many challenges in Botswana, particularly in the era of HIV and AIDS. The MoESD in Botswana is working both within its own structures and collaborating with other partners to fully address teacher welfare at this crucial time. However, it is clear that there is inadequate capacity to handle Botswana's HIV agenda. The structures are in place but often the extent of their work is limited by not having personnel to carry out the many activities necessitated by plans. There is lack of clear personnel designated specifically for HIV in the various ministry departments and units as often those who are appointed to serve in HIV committees have other core business to attend to. This in itself sets a tone that HIV is not as important as other business. Many of the policies and documents used in the sector to address the epidemic are also woefully outdated.

There is a lack of data regarding the impact of HIV and AIDS on the education sector, which makes it difficult to plan to mitigate the impact of the epidemic. For example, currently the monitoring of teacher absenteeism is left to individual school heads with no standardized tools. As absenteeism is such a major problem in schools, close monitoring of the problem is needed, as teacher absences could threaten to compromise the quality of education.

Stigma around HIV and AIDS is also a major challenge dating back to the beginning of the HIV pandemic, though major progress has been made to address this. Unfortunately education is the best strategy to address stigma and this takes time. There is also often a lack of openness around the issue of sexual abuse and sexual harassment, as sexual issues are regarded as taboo in Botswana. Given the often lower levels of education of parents in rural and remote areas, rigorous steps need to be taken to expedite this. More efforts will be needed if change is to be realized.

Policy and programmatic recommendations

- Many documents used are out of date and need to be updated. The ministry needs to keep abreast of the numerous changes in the sector and new knowledge in this era of HIV and AIDS and thus review their policies as often as necessary.
- Welfare of teachers should be assessed separately from that of other public servants given the nature of their work.
- Capacity building at all levels of education should be intensified so that all are empowered in dealing with HIV and AIDS issues. A series of workshops, seminars and short training courses should be mounted by MoESD.
- HIV and AIDS focal points in the ministry should be regularized into HIV officers with a mandate to fully take up HIV and AIDS work.
- The release of policy documents such as Code of Ethics for Teachers should be expedited, as this would help to address issues such as sexual harassment in the context of teachers.
- Absenteeism of teachers should be monitored by developing daily data capturing tools in the schools.
- To curb the number of teachers requesting transfers to urban areas to be closer to medical facilities, it would be ideal to provide full health facilities and service across the country.

1. Study design and data collection

Introduction

This chapter will outline the research methodology adopted for the study. It includes an overview of the study research design and approach, selection of the study areas and samples and techniques for data collection and data analysis.

The research was conducted by Gaelebale Nnunu Tsheko, Senior Lecturer, Faculty of Education, University of Botswana, with the assistance of Research Assistant Doreen Mooketsi between April and May 2009.

Data were collected through a combination of document reviews, semi-structured interviews and focus group discussions.

Documentation was obtained from relevant offices at the Ministry of Education and Skills Development (MoESD), government printers and the internet.

Data collection techniques

The study was qualitative and was based on in-depth interviews at the central level with a limited number of senior and middle-level officers at the MoESD headquarters in Gaborone and school visits in Gaborone and Kanye. This was supplemented by a focus group discussion for primary school teachers.

Permission was sought from the Research Unit in the MoESD and a supporting letter from the UNESCO office in the same ministry. Interview appointments were made by phone or office visits.

The instruments for the study were structured interview guides and focus group discussion guides for the respective officers and teachers. The guides included questions on teacher absenteeism, attrition, HIV policies and teacher management tools.

Table 1.1 Sample of participants by category, type and number interviewed

Level	Category	Person Interviewed	Total Interviews
Central	Senior managers (MoESD)	Director, Secondary Chief Education Officers Assistant Director, Teaching Service Management (TSM)	5
	HIV /AIDS Office	HIV/AIDS Coordinator	1
	EMIS Office	EMIS Head	1
	Planning Office	Head of Planning	1
District	Senior managers and staff	Secondary and Primary Department, Principal Education Officers	4
School	School leadership	School Heads, Primary and Secondary	3
	Other staff	Teachers	4
Other stakeholders	Teachers' union	Senior managers	2
Total			**21**

Documentary analysis

The researchers reviewed relevant documents such as the Revised National Policy on Education (1994), Teaching Service Act (1999), Education Act (1976), Code of Regulations for Teachers (1976), National HIV Policy (1998) and Ministry of Education HIV Policy (1998). Since the data collected were

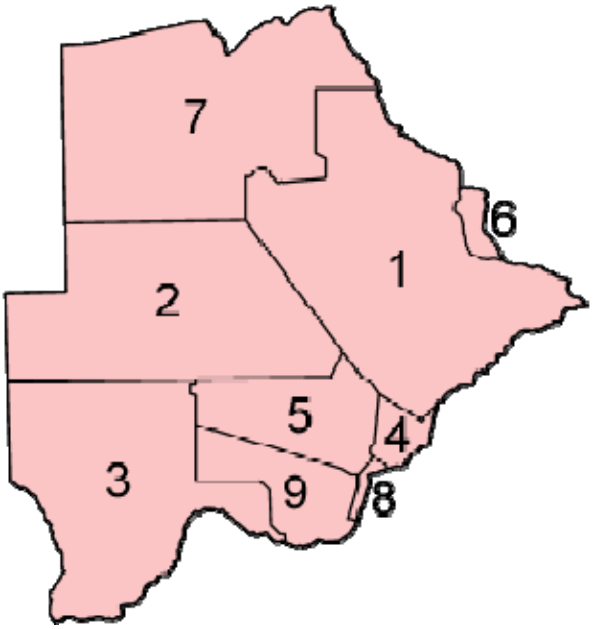
qualitative, the analysis was mainly related to content analysis. Themes were created using the respective question areas from the interview guides and further coding was carried out based on the responses.

Selection of study districts and samples

For the purposes of the study, Gaborone was selected as an urban region and Kanye was selected as a semi-urban region. It was not possible to visit a rural area given the time limitations of the study.

Senior and middle-level management officers at the MoESD headquarters in Gaborone were interviewed, including: Heads of Pre-Primary, Primary and Secondary Departments; Teaching Service Management (TSM) officers; HIV and AIDS Coordinator; Head of Education Management Information System (EMIS); Head of Planning and Teacher Training and Development (TT&D) officers. In addition to ministry personnel, teachers and school heads in primary and secondary schools in Gaborone and Kanye were included in the sample. One teacher from primary and one from secondary were sampled in each region. Teachers' union officers were also sampled. A total of 21 interviews were conducted and one focus group discussion for primary school teachers took place in Gaborone.

Figure 1.1 Administrative map of Botswana



1. Central District
2. Ghanzi District
3. Kgalagadi District
4. Kgatleng District
5. Kweneng District
6. North-East District
7. North-West District
8. South-East District
9. Southern District

Study sites: Gaborone in District 8 and Kanye in District 9.

Source: http://en.wikipedia.org/wiki/Districts_of_Botswana retrieved on 23 September 2009.

Limitations

There were a number of limitations for this study. The biggest limitation was the time constraints. The proposed timeline for the study was 30 days, which was too short to conduct a full study. This time included all the study activities, including data collection and report writing. Data collection, especially the qualitative research, took more time than allocated. This is understandably so as it was dependent on when the potential study participants were available. The review of documents also took much longer than expected, as some documents were not readily accessible unless written permission was sought from relevant authorities. Statistical information was difficult to locate, as officers interviewed often did not have these numbers readily available.

Furthermore, getting appointments with government officials was quite a challenge. Often the relevant person to meet with was out of the office on official or personal business and those acting for them were not in a position to grant an appointment. In this case, the researchers often had to return to the same office several times to get an appointment. Getting an appointment was also no guarantee that

the interview would take place, as officers would again be out of the office in meetings and other activities that arose at short notice. When an interview finally took place, there would often be questions that officials were not able to answer and therefore the researchers were asked to go to yet another office. In some cases the officer would be newly appointed and therefore not yet able to locate the required information.

The researcher also had to balance her work schedule and study activities, especially the data collection. Sometimes an officer would give an appointment time that coincided with work engagements and this created problems, especially as the time for the study was so short.

2. Demographic and economic context

Geography

The Republic of Botswana is a landlocked country in Southern Africa, bordered on the west by Namibia, on the south and east by South Africa and on the north by Zimbabwe. Botswana covers an area of 582,000 square kilometres. The capital city is Gaborone. There are major semi-urban areas such as Molepolole, Kanye, Serowe, Maun and Mochudi. The population of Botswana is estimated to be 1.84 million, with an annual growth rate of 1.4 per cent.

Figure 2.1 Map of Botswana

Source: http://www.lib.utexas.edu/maps/cia08/botswana_sm_2008.gif.

Economy

The current nominal Gross Domestic Product (GDP) per capita is reported as U.S$7,343, with a real growth rate of 3.5 per cent. The main economic activities are mining (mainly diamonds, copper, nickel and coal), agriculture (sorghum, maize, millet, beans), raising livestock (cattle, sheep, goats) and other services including tourism and beef processing.

Population

The people of Botswana are called Batswana. Although there are a number of languages spoken in Botswana, the main language is Setswana. Dialects of Setswana are spoken by the so-called mainline subgroups: Bangwato, Batawana, Bakgatla, Bakwena, Bangwaketse, Barolong, Batlokwa and Babirwa. The other subgroups have to learn Setswana as a second language in school, as it is used as a medium of instruction in the first two years in primary school. The official language is English.

3. The HIV and AIDS epidemic, its evolution and impact

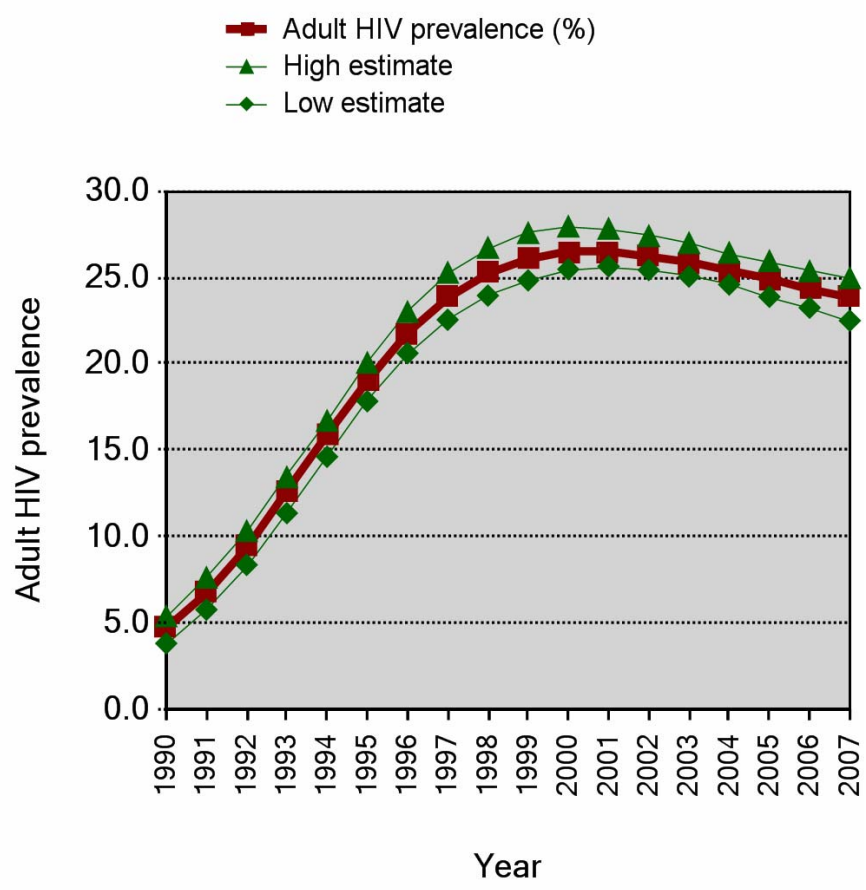
Epidemiology

Botswana's first AIDS case was reported in 1985. Since then HIV and AIDS has become a matter of grave concern. Botswana is reported to be one of the countries in southern Africa with the highest HIV prevalence rates, with about 300,000 Batswana out of a population of approximately 1.84 million estimated to be living with HIV.

Data from numerous sentinel surveys, research and consultancy reports, the Botswana AIDS Impact Survey (BAIS) II and voluntary counselling and testing (VCT) all demonstrate that HIV rates are extremely high in Botswana. For example, according to the Botswana Sentinel Survey (2005), HIV prevalence among women aged 15–49 years was 33.6 per cent. The highest prevalence of 46.5 per cent was recorded in Selebi-Phikwe, while the lowest was in Kgalagadi (17.8 per cent). In 12 of the 22 districts, HIV prevalence was over 30 per cent. HIV prevalence was over 20 per cent in nine out of the ten remaining districts. Only in Kgalagadi was the prevalence below 20 per cent. The Botswana last Sentinel Survey (2007) showed that HIV prevalence among women aged 15–49 still stood at 33.7 per cent showing not much of a change. The highest prevalence was still in Selebi-Phikwe (49.0 per cent) and the lowest in Jwaneng (21.4 per cent). In 16 districts, HIV prevalence was over 30 per cent and the remaining eight districts had prevalence rates between 20 per cent and 30 per cent. As with previous sentinel surveys, HIV prevalence rates in urban districts are higher than those in rural districts.

The highest age-specific prevalence of 50.3 per cent was observed among women aged 30–34 years. However, prevalence among young women aged 15–24 years has been declining over the years (from 24.7 per cent in 2001 to 17.2 per cent in 2007).

Figure 3.1 Estimated adult HIV prevalence in Botswana among 15–49 year olds (%), 1990–2007



Source: UNAIDS/WHO (2008).

Distribution of HIV

In a situation where one in every three adults is HIV-positive, the epidemic has inflicted untold damage on a large percentage of Botswana's population.

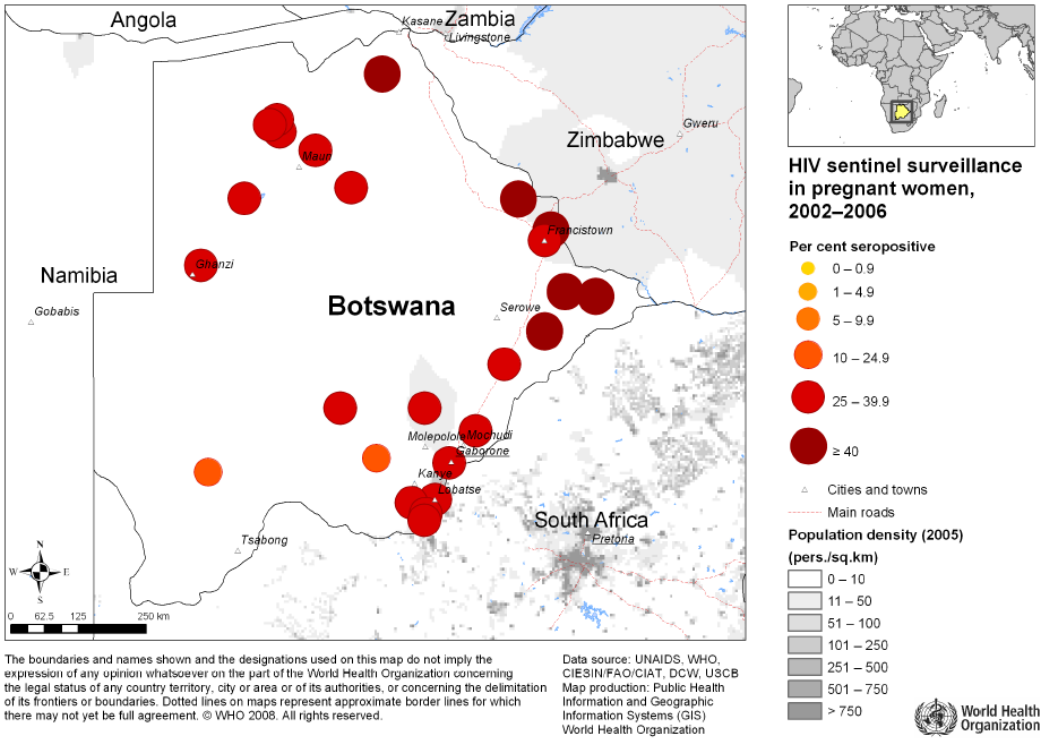
Prevalence rates from the BAIS population-based survey offer better estimates than the previously used sentinel surveys, which were based on data collected from pregnant women who present themselves for antenatal care. The recently released results of BAIS III (2008) show an increase in the national prevalence rate from 17.1 per cent to 17.6 per cent (20.4 per cent for females and 14.2 per cent for males). In general, females have the highest prevalence compared to their male counterparts. This was also true in BAIS II, which was conducted in 2005.

There are five districts with high prevalence rates: Selebi-Phikwe (26.5%), Sowa (25.4%), Francistown (23.1%), Chobe (23.0%) and North East (21.8%). The highest HIV prevalence is reported for Selebi-Phikwe (26.5%) and the lowest in Kweneng West (10.3%).

The age group with the highest prevalence rate is the 40–44 year olds at 40.6 per cent, followed by the 35–39 year olds at 40.5 per cent. Prevalence in urban areas (17.9 per cent) continues to be higher than for rural areas (17.6 per cent).

An urban setting is one where at least 75 per cent of inhabitants are engaged in non-agricultural activities and the area has a population of at least 5,000. This includes towns and cities. Though in some countries the difference between cities and towns is based on attributes such as population size, in Botswana the difference is mainly administrative. The country's two cities – Gaborone and Francistown – are the main administrative points in the country and the towns are sub-administrative points. The cities, however, tend to have largest populations.

Figure 3.2 HIV sentinel surveillance in pregnant women, 2002–2006



Source: UNAIDS/WHO (2008).

AIDS and women's vulnerability

A close analysis of the situation in Botswana shows that young women and girls are more vulnerable to HIV infection than their male counterparts. Trends show that girls aged 15–19 are 12 times more likely to be infected than boys in the same age category. Furthermore, young women aged 20–24 are 3.5 times more likely to be infected than their male counterparts. The following causes seem to be the major determining factors: biological and physiological factors, intergenerational sex, socio-cultural factors and gender inequality and discriminatory practices that put women at a social and economic disadvantage.

Impact

Today, the HIV epidemic continues to pose a grave threat to the country's population. One of the consequences of the epidemic in Botswana has been an increase in mortality. The Central Statistics Office (CSO) data shows that 18 per cent of all deaths are attributable to AIDS. AIDS-related mortality is one of the main influences of the current and projected decline in life expectancy at birth in Botswana. Life expectancy at birth has declined from 65.3 years in 1991 to an estimated 55.7 years in 2001. The increase in mortality and the consequent decline in life expectancy are thought to be associated with AIDS (Republic of Botswana Government, 2003). The report of the 2002 National Response to the United Nations General Assembly Special Session (UNGASS) Declaration of Commitment on HIV/AIDS estimates life expectancy at birth during 2002 at 36.3 years, showing continued decline. The negative impact comes not just from the loss of lives and the reversal of economic development efforts, but also, from the plight inflicted on families and the community at large. At the social level, the number of orphans continues to increase. Recent estimates from the Department of Social Services (DSS) put the number of orphans in Botswana at 52,000 (DSS Report, December 2005).[2]

[2] Orphans in Botswana are not classified by the cause of death of parent(s). Therefore there are no official statistics on the number of children orphaned by AIDS.

The devastating impact of HIV and AIDS is noticeable in the health sector. One of the health concerns associated with HIV has been an increase in opportunistic diseases, especially tuberculosis. HIV and AIDS-related conditions have put a strain on the national health system. Up to 80 per cent of patients in most hospital wards are suffering from HIV-related conditions.

Apart from its health and social impact, HIV and AIDS have a devastating economic impact. A study on the macro-economic impacts of the epidemic in Botswana anticipates several impacts by the year 2021. These include: an 8 per cent decline in national household income per capita; an increase of 5 per cent in the number of people living in poor households; a drop of 13 per cent in the per capita household income for the poorest quartile of households, as well as significantly higher dependency ratios for the poorest households. The average real economic growth is estimated to be declining by 1.5-2% a year over the period of 2001-2021 (Econsult, 2007). The impact of HIV and AIDS on the economy is noticeable as it results in reduced productivity and increased absenteeism. The impact of HIV and AIDS is particularly serious in the context of limited human resources and the high reliance on expatriate labour that prevails in Botswana.

It is clear from the above discussion that the HIV epidemic in Botswana has become a serious developmental and social problem impacting on all sectors of the economy. It continues to be a threat to the survival of individuals, families and communities at large. To this end, the former President, Festus Mogae, has described HIV and AIDS as a national emergency, and has declared this as a war that the government and people of Botswana are determined to win.

Government response to HIV and AIDS

The Government of Botswana has responded to the HIV epidemic by putting in place several policies and intervention programmes to prevent HIV transmission and to mitigate its impact. While the focus was initially on health aspects, a shift towards a multisectoral and coordinated response emerged in the 1990s. The response to HIV and AIDS in Botswana is guided by the National Strategic Framework (NSF) for HIV and AIDS, which aims to eliminate the incidence of the pandemic and to reduce its impact through collaborative partnerships between government ministries, districts, non-governmental organizations (NGOs) and the private sector and international development partners such as African Comprehensive HIV/AIDS Partnerships (ACHAP), (Republic of Botswana Government, 2003). Botswana is also benefitting from responses to HIV and AIDS in the Southern African Development Community (SADC) region, which are being implemented in the context of SADC HIV and AIDS Strategic Framework and Programme of Action for 2003−2007 (Southern African Development Community, 2003).

The key features of the responses include: the prevention of infection; treatment; testing (pre- and post-test services); people living with HIV (PLHIV) participation and community mobilization; support to individuals who are affected or infected; the provision of information to improve understanding of the pandemic and to reduce the stigma associated with it; as well as the mainstreaming of HIV and AIDS awareness in the activities of government, NGOs, faith-based organizations (FBOs), community based organizations (CBOs) and private institutions. These responses foster the sharing of experiences between the districts, as well as the development of common and coordinated approaches to addressing HIV and AIDS.

Currently there are many intervention programmes in Botswana to cover areas of prevention, treatment, care and support. These programmes need to be continually evaluated and monitored to map out their impact. Two of the programmes are described below.

The prevention of mother-to-child transmission (PMTCT) of HIV programme was rolled out nationally in 2000 and all public health facilities offer the programme. PMTCT services are integrated into routine sexual and reproductive health services in all public health facilities in Botswana. All women reporting at antenatal clinics (over 95 per cent) are offered services in this programme, including HIV pre- and post-counselling and testing and ARV treatment where necessary.

The Government of Botswana launched the treatment programme Masa (New Dawn) in 2002 to provide free antiretroviral (ARV) therapy. Botswana was the first country in Africa to provide free ARV treatment to all citizens who need it. This was accompanied by a nationwide information, education and communication (IEC) programme to provide Batswana with the necessary information on HIV and AIDS and ARV therapy. This treatment package is available throughout the country and the team working on this is involved in various activities, including community mobilization. Although this programme is one of Botswana's success stories, it has not been without its challenges. The programme started in one site (Gaborone) and within the same year had expanded to three more sites

(Francistown, Serowe and Maun) to ensure that there was a site in all four corners of the country for access by rural and urban dwellers. Given the size of Botswana, this meant that some people travelled long distances and queued to access treatment. With assistance from ACHAP, the number of sites has increased and the situation has been alleviated. A further challenge with treatment is the low adherence to treatment by patients, as reported often by health practitioners. However, this is expected to be under control once planned intervention strategies are fully implemented.

Establishment of National AIDS Council (NAC)

The HIV and AIDS epidemic came as a challenge to the scope of the Ministry of Health. It became necessary to implement a more comprehensive multisectoral approach to addressing issues related to HIV and AIDS.

The multisectoral approach mandated coordination between many different sectors, which led to the establishment of the National AIDS Council (NAC) in 1995. This was to be chaired by the Minister of Health, with representation from all other sectors. In 1999, when AIDS was declared a national emergency in Botswana, the President took over as Chair of the NAC. This council was mandated to monitor and coordinate the implementation of the national AIDS policy and programmes developed within its framework. Additionally it was to advocate for the active involvement of all ministries and sectors in HIV and AIDS prevention and care, ensuring the implementation of programmes in their own ministries and organizations.

Extending and intensifying efforts

The National AIDS Coordinating Agency was established under the NAC in 1999 and serves as the NAC secretariat. NACA guides the national response to HIV and AIDS through a National Strategic Framework for HIV/AIDS (Republic of Botswana Government, 2003b).

At the ministerial level, there are AIDS coordinators who facilitate the implementation of programmes within their respective ministries. At the district level, there is a District Multisectoral AIDS Committee (DMSAC) with technical support from the district AIDS coordinator and the AIDS Coordinating Unit of the Ministry of Local Government.

National policies and strategies

The Government of Botswana has declared HIV and AIDS a national emergency and is committed to an aggressive, comprehensive and expanded multisectoral and multilevel response to fight the epidemic and to curb its impact on society (Republic of Botswana Government, 2003b).

The first National Policy on HIV and AIDS was developed in 1992 and this was revised in 1998. The 1998 National Policy on HIV and AIDS was adopted by government through a presidential directive. This policy emphasises a multisectoral approach to the epidemic with an international human rights approach for addressing stigma and discrimination against PLHIV. The key elements of this national policy are: prevention of HIV, AIDS and sexually transmitted infection (STI) transmission; reduction of personal and psycho-social impact of HIV and AIDS and STIs; mobilization of all sectors and communities for HIV and AIDS prevention and care; provision of care and support for the infected and affected; and reduction of the soci-economic consequences of HIV, AIDS and STIs.

The policy advocates for the involvement of government ministries, private sector, parastatals, NGOs, CBOs, United Nations and other development partners as stakeholders in the HIV epidemic. The role to be played by all these stakeholders is outlined in the policy. Additionally the policy outlines ethical and legal implications of the epidemic, including those relating to confidentiality. The policy also outlines how the programmes and activities of all stakeholders will be coordinated by the NAC.

National Strategic Framework for HIV and AIDS

The Government of Botswana developed an emergency Short-term Plan (STP, 1987–1989), which focused mainly on increasing public awareness of HIV and AIDS, as well as clinical protocols for the management of infected people. This plan was followed by a Medium-term Plan I (MTP I, 1988–1993). This plan was oriented and driven by the health sector. As it became more apparent that HIV and AIDS were not only a health issue, a new multisectoral strategic plan was developed – the Medium-term Plan II (1994–1998). The key elements of this strategic plan included thematic areas of blood safety, care and support, prevention, as well as a programme for orphan and vulnerable children (OVC). The

area of care and support included clinical management, PMTCT, voluntary counselling and testing (VCT), ARV, home-based care (HBC), community home-based care (CHBC) and social and psychological support of PLHIV and their families. There are national guidelines for PMTCT, ARV, VCT, CHBC, orphan care and tuberculosis (TB) programmes, and all these are offered free to all citizens of Botswana.

MTP II was followed by the National Strategic Framework (NSF) of 1999–2003, which was revised and replaced by the 2003–2009 framework (also currently under review). In the NSF, gaps identified from the MTP II were addressed. The main objectives of the framework are to articulate, disseminate and educate Batswana on agreed national priorities and strategies within the scope of the Botswana Vision 2016[3] (Republic of Botswana Government, 1997). Secondly the framework is meant to provide clear guidance for ministries, districts, NGOs and the private sector to enable them to work in a collaborative manner to achieve the intended national goal of responding to HIV and AIDS: "*to eliminate the incidence of HIV and reduce the impact of AIDS in Botswana*". With prevention as the first priority of the Botswana National Response, the framework has five key goals including prevention, care and support, management of the national response and provision of a strengthened legal and ethical environment for those who are HIV-positive.

It is from the National Framework that the public sector, through its various ministries, has developed sectorial strategic frameworks. The Ministry of Education and Skills Development (MoESD) is guided by the Ministerial HIV and AIDS Strategic Response Framework, 2001–2003.

The Ministry of Education HIV and AIDS Policy

The HIV and AIDS Education Policy was developed in 1998 as part of the national response to the epidemic. The responsibility of the MoESD, as outlined under the national policy, is to reduce the spread of HIV infection by addressing HIV and AIDS in all its programmes. The major task for this ministry is to integrate and incorporate HIV and AIDS issues in the school curriculum and in the training of teachers.

[3] Botswana Vision 2016 is the country's translation of the Millennium Development Goals(MDGs) to suit local development priorities. This is presented in the form of seven pillars for the nation: an educated and informed nation; a prosperous, productive and innovative nation; a compassionate, just and caring nation; a safe and secure nation; an open, democratic and accountable nation and a proud and united nation.

4. Overview of the education system

Structure of the education system

The education system in Botswana currently involves seven years of primary school, three years of junior secondary and two years of senior secondary education. Pre-primary education was not considered part of the mandate for the government for a long time, despite the Revised National Policy on Education (RNPE) recommendation. The MoESD is currently working on how to incorporate this part of education into the main education system. The provision of pre-primary education was left in the hands of private practitioners and accessible to only a few who could afford the usually exorbitant fees.

The existing system has been in place since 1995 as part of the implementation of the recommendations of the 1993 National Education Commission. In Botswana education has always been free but not compulsory. School fees were abolished in primary and secondary schools in 1988 and re-introduced in 2006.[4] The education at primary and secondary levels is driven by the MoESD. The first ten years of schooling (seven years of primary and three years of junior secondary) is called Basic Education. These ten years were meant to be accessible to all children, but this has not been possible as some children still have to travel long distances between their homes and the nearest school. This problem is further compounded by the introduction of school fees.

Though access to senior secondary school has increased tremendously over the years, places are based on performance from national examinations at the end of junior secondary. The selection is more rigorous from secondary to tertiary education as places are limited. Scholarships for tertiary education are mainly obtained from the government. An undergraduate university degree takes four years. There is currently one public university and it is only now that another university is being built. There are, however, a number of private tertiary institutions that unfortunately also rely on government sponsorship for potential students.

Administration and management of education

The management of education is mainly through the MoESD. This ministry operates a central office in the capital Gaborone, but it has decentralised the running of education to five educational regions throughout the country.

The MoESD derives its mandate from the Education Act CAP 58:01 Section 3(1), which states that this ministry should "*promote primary, post-primary education, education research and the progressive development of school*". The core functions of the ministry include provision of policies, strategies and leadership, teaching manpower as well as education at various levels. The ministry is undergoing re-structuring and this comes with major changes in the management structure, including a more decentralised structure. As in the old structure, the ministry is headed by the Minister who has the overall responsibility for ministry activities. The Permanent Secretary reports to the minister and has direct responsibility for overall ministerial policies, strategies and leadership. There are four Deputy Permanent Secretaries for Basic Education, Regional Operations, Education Support Services and Corporate Services. Under the Deputy Secretary for Basic Education there are various departments, including the Department of Pre- and Primary Education and Secondary Education, each headed by a director. The Department of Teaching Service Personnel is under the Corporate Services Deputy Director and is also headed by a director.

Regional offices are headed by directors. Though at central level these offices are operational, this is yet to be operationalized at regional level. Regional directors will have managers of the different services reporting to them, such as the school supervision management (responsible for schools) and

[4] The introduction of school fees did not intend to leave any child of school-going age at home, as it was thought the fee was a small amount and those assessed as not able to pay were to be exempt from fees. However, there are parents and guardians who are not able to pay these fees and, given the delays in assessing families for exemption, some children do drop out of school because of non-payment of school fees.

regional management (responsible, among other things, for staff, including teacher recruitment, placement and welfare).

The current (old) inspectorate structure is compartmentalised under various departments such as pre-primary and secondary departments to provide inspection services on quality assurance for schools, supervision of school heads and generally providing support to schools. Under the new structure, this will be consolidated to provide comprehensive maintenance of quality education as opposed to the fragmented old system, which is proving to be difficult to evaluate.

Trends in education sector development

Financing education

The education sector gets a third of the national budget annually. In 2009, MoESD received P7.57 billion (29.4 per cent) of the national recurrent budget (P25.73 billion equivalent to U.S$3.6 billion) the highest among all sectors. The increase mainly went towards post-secondary bursaries. The ministry did not get any allocation from the developmental budget. The distribution of the budget across the various departments of the MoESD is determined using their respective annual submissions. Each department has a finance office that is responsible for drawing a recurrent budget annually, which is then submitted with those of other departments to the Ministry of Finance.

Access

Number of schools

The number of primary schools in Botswana was 782 in 2006. The total number of primary schools operating at the beginning of 2008 was 790. The majority of these are located in the South Central region, which includes Gaborone, Kweneng, Kgatleng and South East (see Table 4.1). Of the 790 schools, 731 belonged to local government (council) and 59 were privately owned. In 2006, there were 274 secondary schools, of which 27 were government senior secondary schools and 206 were government aided junior secondary schools. The rest (41) were private schools and these do not separate junior and senior secondary education. This information was not available by region.

Table 4.1 Number of primary schools by ownership and education regions, 2008

Region	Council schools	Private schools	Total
Central South	137	7	**144**
Central North	110	9	**119**
West	83	6	**89**
North	70	5	**75**
South	158	5	**163**
South Central	173	27	**200**
Total	**731**	**59**	**790**

Source: Republic of Botswana Government, 2008.

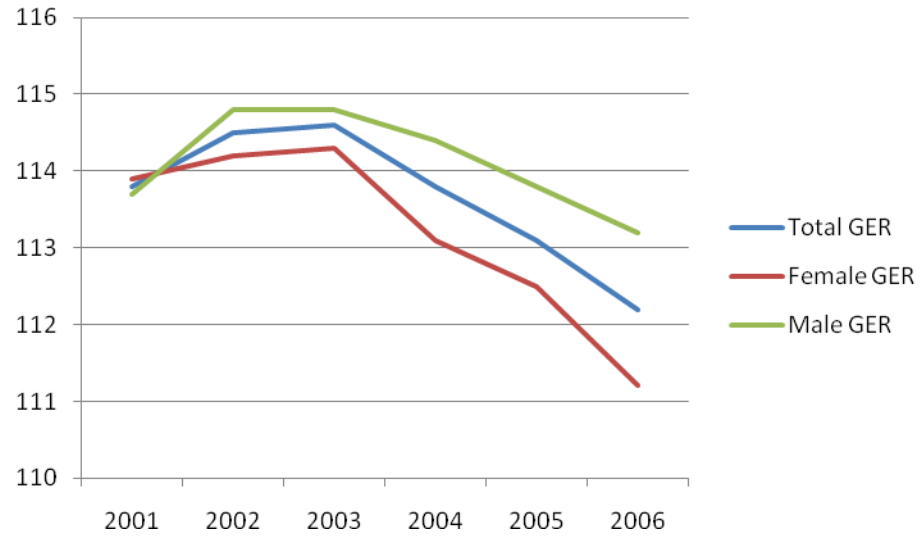
Enrolment

In 2006, the total enrolment recorded in all primary schools was 330,417, compared with 329,191 in 2005. This indicates a slight increase of 0.4 per cent between the two years. However, this had decreased to 329,125 at the beginning of 2008. The private school enrolment constitutes 5.3 per cent of the total enrolment.

The Gross Enrolment Ratio (GER) of the 6–12 year age group was 108 per cent in 2008, indicating that 8 per cent of children enrolled in primary schools are not of school-going age. These children are either under or over age. The official entry age for public primary schools is six years. In comparison,

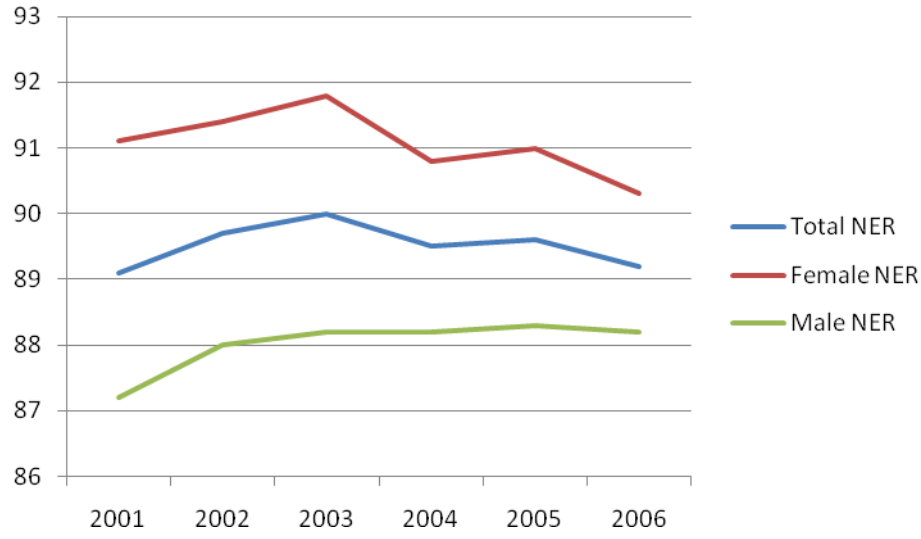
the GER was 112.2 per cent in 2006 showing a declining pattern of GER at age 6–12. This indicates a positive response to the RNPE recommendation on school entry age of six years at primary school, though the pattern shows that it is slow. There does not seem to be gender differences in the GER (see Figure 4.1). In order to achieve Universal Primary Education (UPE), the number of under-age and over-age pupils need to decline to free up places for pupils in the official primary school age group. The Net Enrolment Ratio (NER) for the 6–12 year old age group was 85.6 per cent in 2008, indicating that 14.4 per cent of children of primary school-going age are not in school. It is possible that this figure could be inflated by those children who finished primary school before the age of 12 or the six years olds who may still be at home because their parents feel they are not ready to start primary school. There are more boys who are not in primary school even though they are of primary school-going age (see Figure 4.2).

Figure 4.1 Primary Gross Enrolment Ratio (GER) by gender (6–12) (%), 2001–2006



Source: Ministry of Education and Skills Development. (2006). Education Report. Gaborone: MoESD.

Figure 4.2 Primary Net Enrolment Ratio (NER) by gender (6–12) (%), 2001–2006

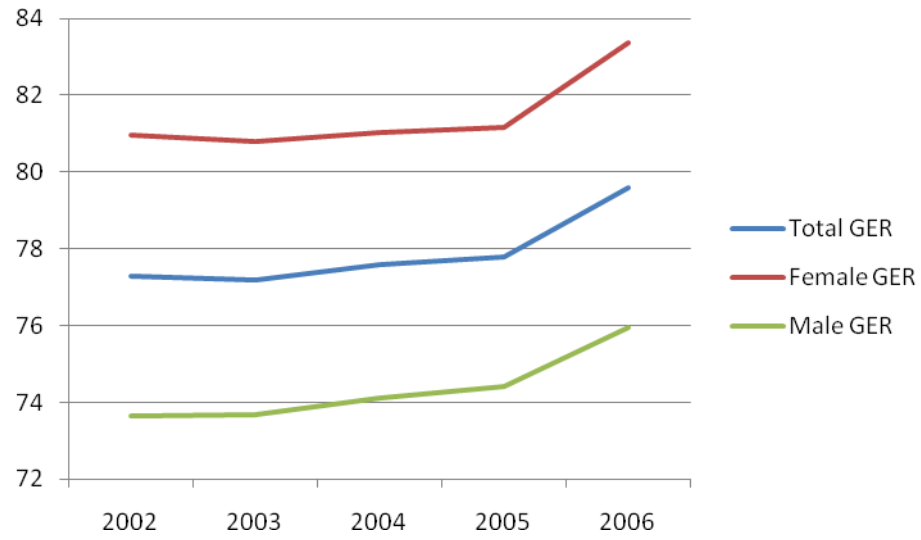


Source: Ministry of Education and Skills Development. (2006). Education Report. Gaborone: MoESD.

The GER by sex is widely used to show the general level of participation in secondary schools by sex. The GER indicates the capacity of the education system to enrol students of a particular age group. In our case, those age groups are 13–17 for pupils starting school at age six. The age range 14–18 (for those entering the system at age seven) is not shown here.

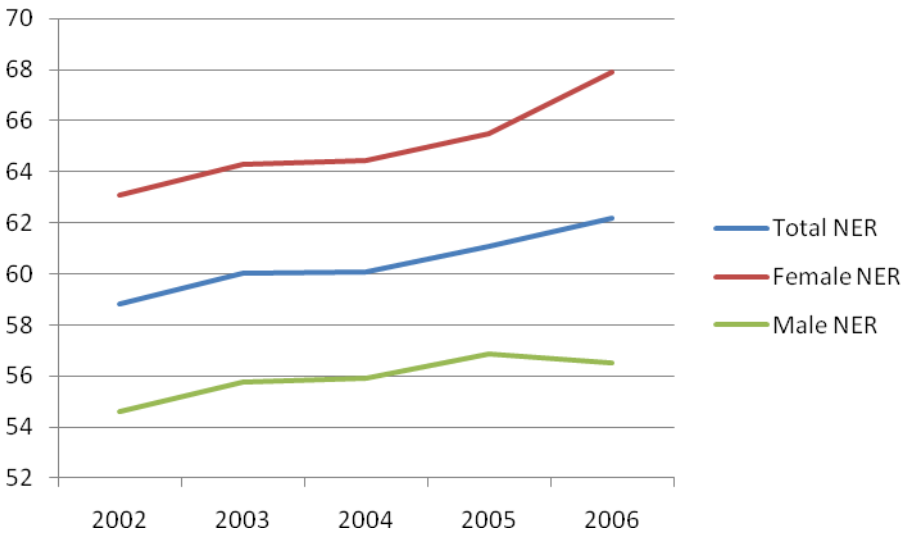
The NER 13–17 for both sexes has increased from 58.8 per cent to 62.2 per cent (Figure 4.3). The NER 13–17 for females increased from 63.1 per cent in 2002 to 67.9 per cent in 2006 (Figure 4.4) while that of males increased from 54.6 to 56.5 in the same period (Figure 4.4). This is an indication that females tend to start school earlier than males, or at the recommended age. Similarly for GER, the ratio for females is higher than that of males. The picture is similar for the 14–18 year olds.

Figure 4.3 Secondary Gross Enrolment Ratio (GER) by gender (13–17) (%), 2002–2006



Source: Ministry of Education and Skills Development. (2006). Education Report. Gaborone: MoESD.

Figure 4.4 Secondary Net Enrolment Ratio (NER) by gender (13–17) (%), 2002–2006



Source: Ministry of Education and Skills Development. (2006). Education Report. Gaborone: MoESD.

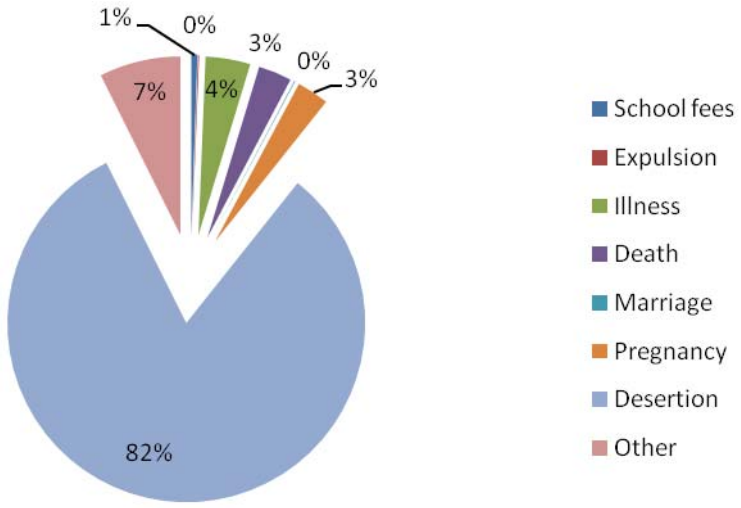
Efficiency

The high transition rate (TR) indicates a positive response from Batswana people on government policies with regard to the acquisition of basic education for all. The TR increased from 92.6 per cent in 1998 to 97.7 per cent in 2006. This general increasing trend shows that the gap between Standard 7 and Form 1(primary to secondary) enrolments is getting smaller as the years go by. Primary school levels are named Standards(1-7) while secondary levels are called Forms (1-5).This is due to the fact that every child is expected to proceed from Standard 7 to Form 1 regardless of the status of the Primary School Leaving Examination (PSLE) results. There has been a significant decrease of 14.8 per cent recorded in the number of pupils dropping out of school – from 4,626 in 2005 to 3,941 in 2006 (see Figure 4.5). There was a 22 per cent drop-out rate in Standard 1 in 2007 and this rate is higher for males (65 per cent) compared to females (35 per cent). It should be noted that drop-outs recorded in 2005 and 2006 are those that effected in 2004 and 2005 respectively. Generally, primary school pupils drop out of school due to desertion, which constitutes 81.9 per cent and has decreased by 3.1 per cent compared to the previous year. Illness constitutes 4.1 per cent of total dropouts from 196 in 2005 to 160 in 2006. Desertion here refers to prolonged (minimum of 20 days) absence from school. A decrease of 3 per cent was observed in the number of deaths in 2005 compared to 3.5 per cent recorded the previous year. The number of drop-outs due to pregnancy decreased by 3.4 per cent from 119 in 2005 to 115 in 2006. The dropping out of primary school pupils due to pregnancy may result in the spread of HIV and AIDS and other traumas associated with a girl child getting pregnant at an early age. Lack of school fees as a reason for dropping out of school contributed 0.5 per cent of all reasons; this has decreased by 0.4 per cent from 2005. Of all primary schoolchildren who dropped out of primary school in the previous years, 1,954 re-entered the system in 2006. Although a number of primary school pupils drop out of school because of desertion, a good number of them re-enter the school system.

Following a cohort of 51,420 pupils who started Standard 1 in 1995, more female students progress from Standard 1 to Form 5 than their male counterparts as shown by 46 per cent and 36 per cent progression for females and males, respectively.

Though students drop out for various reasons, girls dropping out due to pregnancy accounted for 31.7 per cent in 2006, a slight decrease of 0.4 percentage points from the 31.3 per cent recorded the previous year. The high drop-out rate due to pregnancy is an indication that many female students engage in unprotected sex, which is a threat to efforts to address the HIV epidemic. Drop-out due to illnesses and deaths as a percentage of total drop-outs were 3.5 per cent and 2.3 per cent respectively. Only 0.9 per cent of the drop-outs were due to expulsion.

Figure 4.5 Primary school drop-outs by reason (%), 2006



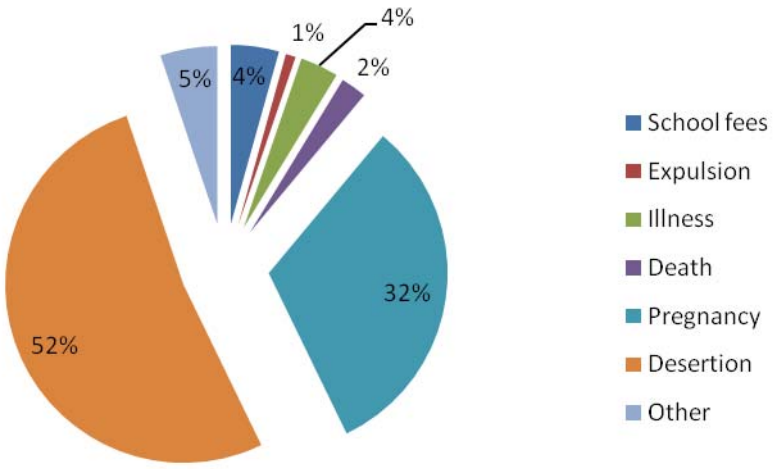
**Expulsion and marriage represent a negligible cause of school drop-outs (both at 0%)*

Source: Ministry of Education and Skills Development. (2006). Education Report. Gaborone: MoESD.

Although a number of secondary school students dropped out of school (mostly because of desertion and pregnancy), a significant number of them re-enter the school system. For example, in 2006, 71 per cent of the re-entrants were students who previously dropped out of school because of pregnancy.

Generally the drop-out rates have been declining well below 4 per cent for junior and senior secondary schools. Repetition rates in junior secondary schools have decreased from 3.25 per cent in 1996 to less than 1 per cent in 2006. The highest repetition rate in the senior secondary schools recorded between 1996 and 2006 was 2.23 per cent, observed in 2004.

Figure 4.6 Secondary school drop-outs by reason (%), 2006



Source: Ministry of Education and Skills Development. (2006). Education Report. Gaborone: MoESD.

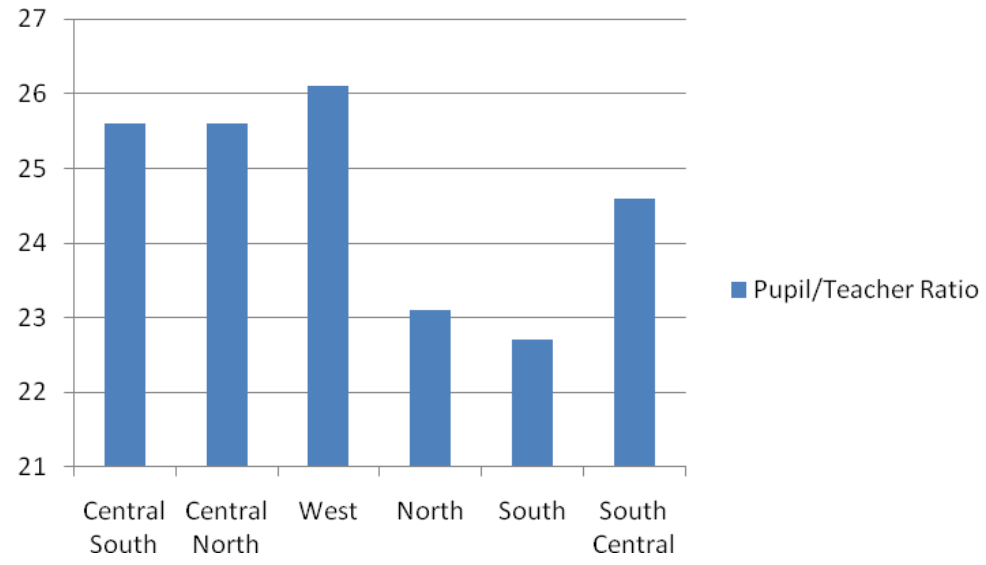
The total number of candidates who sat for the 2006 Junior Certificate Examination was 37,261. Of those candidates, 36,393 were registered through schools while 868 were privately registered. Of all the 37,261 candidates who met the requirements and sat for the examination 51.0 per cent were female and 48.9 per cent were male.

Quality

Pupil to Teacher Ratios

The Pupil to Teacher Ratio (PTR) throughout ranges from 22.7 in the South region to 26.1 in the West region, with a national PTR of 25.7 in 2005, 25.4 in 2006 and 24.6 in 2008. Though in some cases it seems to have gone up, the overall picture is that PTR is slowly going down, an indicator that the quality of education could be improving. There is not much difference in this ratio by location. A low PTR suggests that there are fewer students per teacher and therefore there is more individual attention paid to learners.

Figure 4.7 Pupil to Teacher Ratio for primary schools by region, 2008



Source: Republic of Botswana Government, 2008.

For secondary schools, the Student to Teacher Ratio is reported as 14.7 inclusive of untrained teachers (Republic of Botswana Government, 2008). This ratio for secondary is not informative as teachers specialise in subjects and a more meaningful ratio would be that of student classroom ratios, for which data was not available in the first term. The CSO Education report cited in this report was for the primary and secondary first term statistics.

5. Overview of teacher management

Teacher qualifications

The minimum qualification for primary school teaching used to be a teaching certificate but has been upgraded to a diploma. This has mandated a rigorous upgrading of primary school teachers' qualifications through in-service training. The MoESD in recent years has made this upgrading a priority and a significant increase has been made in upgrading teacher qualifications. There has been a 54.7 per cent increase in the number of teachers with diplomas. There are, however, still 42.1 per cent of primary school teachers with certificates and 0.6 per cent untrained teachers. It must be noted that the primary school teaching force is predominantly female (76 per cent).

The minimum qualification for secondary school teachers is a diploma and the 2008 CSO Education statistics indicate 48.5 per cent of secondary teachers have a diploma (22.8 per cent with Bachelors of Education and 21.9 per cent with BA plus Post Graduate Diploma in Education (PGDE) or Concurrent Certificate in Education (CCE). There is a small proportion of untrained teachers (0.5 per cent).

Qualified teachers

The total number of primary school teachers stood at 13,377 teachers in 2008 (CSO, 2008). There were 24.1 per cent males and75.9 per cent females. The proportion of trained teachers went up from 93.0 per cent to 99.3 per cent in 2008, which can indicate a possible improvement in the quality of education delivery. The number of untrained teachers has been decreasing significantly from 1,629 in 1998 to 80 in 2008. The proportion of untrained teachers declined from 14 per cent in 1996 to 0.6 per cent in 2008.

Table 5.1 Primary school teachers by sex and qualification

Training												
	M. Ed	B.Ed	Diploma	ETC	PTC	PTC +CERT	PH	PL	Untrained	Temporary	Other	Total
Male	16	314	1,937	2	715	42	4	18	10	132	27	3,217
Female	49	851	3,977	19	4,754	93	20	82	70	176	69	10,160
Total	65	1165	5,914	21	5,469	135	24	100	80	308	96	13,377
%	0.5	9.0	45.5	0.2	42.1	1.0	0.2	0.8	0.6	2.3	0.7	100.0

Source: Republic of Botswana Government, 2008.

The total number of secondary school teachers was 12,179 in 2008. There were 48.3 per cent males and 51.7 per cent females. The proportion of trained teachers stands at 94.9 per cent in 2008 which can indicate possible improvement in quality education delivery. The number of untrained teachers has been decreasing significantly stands at 0.5 per cent in 2008.

Table 5.2 Secondary school teachers by sex and qualification

	Training							
	M.Ed	B.Ed	Diploma	BA + CCE	BA + PGDE	Untrained	Other	Total
Male	138	1,405	2,817	108	1,043	33	333	5,877
Female	141	1,360	3,062	95	1,337	25	282	6,302
Total	279	2,765	5,879	203	2,380	58	615	12,179
%	2.3	22.8	48.5	1.7	19.6	0.5	5.1	100.0

Source: Republic of Botswana Government, 2008.

Teacher training

Teacher supply

The supply of teachers is mainly from the six colleges of education. There are four colleges that train mainly primary school teachers and two that train teachers geared for secondary (junior) teaching. The University of Botswana continues to train teachers (degree holders) geared mostly for senior secondary school teaching. Enrolment of pre-service teachers in the colleges is slightly lower than as was expected in the National Development Plan(NDP9) due to welfare matters such as the shortage of accommodation at the colleges. Graduates from these colleges hold teaching diplomas. Of these graduates, about 10 per cent are in-service teachers who had teaching certificates but have been upgraded. The university also produces degree holders for primary schools. The Teaching Service Management (TSM) reports indicate that all diploma teachers from the colleges are recruited by TSM. The market for the secondary school teachers, especially the degree holders, seems to be saturated as most are not employed after graduation.

There is no accurate information on the number and characteristics of teachers recruited to both primary and secondary schools (Bennell, 2008) due to lack of capacity and compounded by the use of the Infinium human resource management system (see Box 6.1), which requires proper management.

Teacher appointment and management

The Department of Teaching Service Management (TSM) is the teacher employment arm of the MoESD established in 1976 through an Act of Parliament, the Teaching Service Act, Cap 62:01 and is additionally powered by the following documents:

- Teaching Service Code of Regulations (COR 903(1))
- Teaching Service Management Directives
- Teaching Service Management Circulars and
- Revised National Policy on Education (1994).

The recruitment, deployment, promotions, conditions of service, welfare, training and development of teachers lies with the TSM in the MoESD. For primary teachers, this is done in collaboration with the Department of Pre- and Primary Education, while for secondary teachers it is done in collaboration with the Department of Secondary Education. It should be noted that pre-primary education is a new addition, despite the Revised National Policy on Education (RNPE) recommendation that it has to be part of formal education.

The Pre- and Primary Department is responsible for the supervision and inspection of all primary school teachers and schools. Likewise, the Secondary Department does the same for secondary school teachers and schools.

The core activities of TSM centre around:

- review of staffing needs of schools
- preparing job descriptions for new teaching posts
- appointment of new teachers
- appointment of teachers to senior management posts
- preparation of recurrent budgets and
- management of human resources information systems.

This department is able to do all this through its six divisions: Teaching Manpower Planning; Department Management; Procurement and Placement; Teaching Manpower Development; Manpower Administration and Salaries. The reviewing of staffing needs of schools is the responsibility of the manpower planning division. The recruitment, selection and placement of teachers into various government schools is undertaken by the procurement and placement division. This division is also responsible for administration of contracts and teacher transfers.

Box 5.1 Teacher recruitment

Recruitment of new teachers is done by Teaching Service Management (TSM) based on the needs of schools in all the education regions. Candidates apply using a Unified Teaching Service (UTS) form and appointment can be on either a permanent, contract or temporary basis. Once TSM has hired new teachers, the list is sent to respective regions and the regional office then posts the teachers based on the needs of schools in the region. For managerial posts (such as School Head, Deputy Head, Head of Department and Senior Teachers), vacant posts from the schools are reported monthly to TSM by regional office. These are then advertised so that those who qualify can apply. Those shortlisted are then subjected to further assessment using a psychometric test. The successful applicants are then posted to the vacant posts. There is also recruitment of temporary teachers who are hired against the posts of permanent and pensionable staff who are either on study leave, maternity leave or on leave due to ill health. Temporary teachers are hired at regional level. In 2006, temporary teachers accounted for 6.6 per cent of total primary school teachers and 3.9 per cent of secondary school teachers. Temporary teachers are entitled to a monthly salary at a scale determined by their qualification and experience. They are also entitled to leave days during school vacations.

A teacher appointed on permanent terms is required to serve on probation for two years or for such a period as may be prescribed. During probation the teacher is supervised and appraised by the school head who then reports the performance to TSM. Confirmation of the appointment is recommended if their performance is satisfactory at the end of the probation period. If performance is not satisfactory, termination of service or an extension on the probation may be recommended.

Teacher benefits

Teacher benefits include a monthly salary, annual leave, a pension and the opportunity to enrol in a contributory medical aid scheme. On their first appointment, teachers enter the salary scale appropriate to the post they are appointed to. Salary scales provide for increases in salary by annual increments of prescribed amounts until the maximum scale is reached. Additionally teachers are entitled to allowances such as responsibility and acting allowances, local allowance and training allowance. A responsibility allowance is paid to teachers who are appointed to posts of responsibility beyond their teaching duties, and acting allowances are paid to teachers who act in posts of responsibility continuously for no less than 28 calendar days. A local allowance is paid to teachers who teach in what are viewed as remote districts such as Kgalagadi, Gantsi, Ngami, Chobe districts and some parts of Central Kweneng and Ngwaketse districts. These allowances vary according to marital status. Those who are married are paid allowances that are double those of single teachers. Leave and medical aid benefits are discussed in the section below regarding teacher attrition.

Teacher attrition

Reasons for teachers leaving their posts include retirement, resignation, dismissal, death, further studies, secondments, among other reasons. Retirement from public service is compulsory at the age of 65, but after 25 years of service, teachers can take early retirement. Most teachers work until compulsory retirement age, as at that point benefits are better. Resignation rates are not high given the limited employment opportunities elsewhere, especially for primary school teachers. Every year about 20 teachers are dismissed for misconduct. Though acts of misconduct are not clearly stated in the Teaching Service Act, the Code of Regulations includes a list of duties and conduct issues that, if not done accordingly, can be an act of misconduct, e.g. disclosure of public information, political involvement, accepting presents related to performance of duty.

In an earlier study, Bennell et al. (2001) had projected that the teacher mortality rate would rise, based on the situation that prevailed at the time. However, mortality rates have declined over the years, especially with the availability of ARVs, which are offered at no cost to those who need them (Bennell et al., 2008). Teachers who are members of the Botswana Public Officers Medical Aid Scheme (BPOMAS) and those accessing the government programme Masa (New Dawn) receive treatment and thus are still in the workforce. BPOMAS is a contributory scheme established through a presidential directive in 1990 and covers public servants and their dependants. This scheme allows those covered to receive healthcare services within and outside the country. The standard coverage under this scheme includes emergency and medical evacuation and funeral cover for the principal members and their dependants. Additionally there is a managed care programme that focuses on chronic illnesses. Under this programme beneficiaries manage their chronic illnesses through a health provider of their choice. Member contribution depends on their salary and is deducted monthly from their salaries. Enrolment is voluntary. Masa, the national ARV therapy programme, is offered to HIV-positive people with a CD4 count of 200 or less, though this figure is changing. This is programme is described in more details elsewhere in Section 3 of this report.

A small number of teachers go on study leave on a full-time basis, but most would rather take part-time studies and therefore such teachers are still included in the teaching force. Secondment to other departments takes place on a small scale (see Table 5.3).

Table 5.3 Primary and secondary school teacher attrition 2004 and 2006

	2004	***2006***
	%(n)	*%(n)*
Primary		
Resignation	*-(6)*	*0(0)*
Retirement	*-(98)*	*1.25(162)*
Dismissal	*-(3)*	*0.1(13)*
Death	*-(95)*	*0.58(75)*
Secondment	*-(9)*	*0.13(18)*
Total	***-(211)***	***2.06(268)***
Secondary		
Resignation	*0.56(59)*	*0.49(57)*
Retirement	*0.10(11)*	*0.19(22)*
Dismissal	*0.07(7)*	*0.16(18)*
Death	*0.40(42)*	*0.38(44)*
Secondment	*0.19(20)*	*0.11(13)*
Total	***1.31(139)***	***1.33(154)***

Source: Bennell et al., 2008 and Republic of Ghana Government, 2006.

Note: - denotes that percentages could not be computed due to missing information.

6. Problems facing the management of teachers in an HIV context

Through HIV-related illnesses, the education sector has experienced loss of productivity as a result of death or because staff are forced to leave service prematurely to care for ill family members. Though this picture has improved as a result of the availability of ARV treatment, the sector is still experiencing staff shortages. During interviews with teachers, school heads, education officers and teachers' union members, issues of secrecy, denial and stigma were reported to influence teacher attitudes and perceptions regarding HIV and AIDS. Unfortunately, this is still high. The quality of education stands to suffer as a result of the epidemic.

Teacher supply and demand

There are many reasons contributing to the demand for teachers, such as having to replace teachers who have been lost to the many attrition routes (study leave, retirement, resignation, dismissal, localization and death). Localization of posts occurs when suitable Botswana citizens are recruited to take up such posts from expariates. Additionally, untrained teachers need to be replaced by qualified teachers, thus adding to the demand for teachers. There is no increased demand for relief teachers, as teachers force themselves to perform their duties even when they are in ill health to avoid loss of salary and to avoid being stigmatised (Bennell, 2008). This can compromise the quality of education, as an unhealthy teacher is bound not to carry out their duties fully. As already discussed above, early retirement comes with a lower pension, so teachers often opt to stay on to maximize their pension, especially since the new contributory pension scheme offers them a chance to increase their pension pay.

Teacher absenteeism

In the Code of Regulations (COR 903(1)) of 1976 governing the conditions of service of teachers, with the exception of illness, a teacher may not be absent from their duties unless they are given leave of absence by either the school head, a supervisory officer or the regional director. Applying for leave is not a guarantee that the leave will be granted and therefore a teacher needs to wait for approval before taking such leave. Even when leave has been approved, the supervisor has the right to recall a teacher from leave except when the leave is prior to retirement, resignation or dismissal.

A teacher who is not able to attend their duties due to illness must report to their supervisors as soon as possible. Absence from leave for 48 hours should be accompanied by a medical report stating the nature of the illness and a recommended period for sick leave. The medical certificate must be signed by a government or private medical officer. If a teacher is considered to be incapable of carrying out their duties because of physical or mental illness, they may undergo a medical examination conducted by either a medical practitioner or a medical board nominated by the director. The teacher can also request such an examination on their own. Results of the examination will be used with other information from the teacher to decide whether the teacher should be retired on medical grounds.

Discussions with teachers, education officers and senior ministry management revealed that one major concern in schools is teacher absenteeism. As a senior officer in the secondary school department said:

> *"School heads report that teachers are not coming to work. They are ever absent. This is one of the biggest problem we have in the schools."*

Teachers are said to not come to work for various reasons, but the major reason for failure to report for duty is ill health. At the school level, the supervisor is the school head and often when following up on teachers who fail to report for work, a doctor's report is required. The health details are not required to be disclosed to third parties and therefore the causes of ill health are never known.

Government officers and school managers are concerned about the impact of HIV on teachers. One of the officers interviewed at a regional office indicated how, in a recent survey of students, school heads and deputy heads of primary schools reported HIV and AIDS as the greatest challenge in implementing government policies and programmes. Though no specific policies or programmes were identified, the Government has new policies and programmes every year and these include schools for implementation. Though ill health is not necessarily related to HIV and AIDS, as disclosure is voluntary, the common practice in Botswana is for people to diagnose others given the nature of visible symptoms. There is, however, another common type of absenteeism that was reported mostly in secondary schools. This 'technical absenteeism', as they called it, is when teachers are present in school but do not go to class. This is reported at an alarming rate especially during lessons towards the end of the day, as teachers leave early. This form of absenteeism is common among newly qualified teachers, showing a lack of commitment to the job. When asked about this absenteeism, one teacher said:

> *"The major challenges facing teachers in my school [is] the lack of commitment to the job by the new teachers especially those with five years and below. There appears to be two sets of teachers operating in schools. The newly appointed teachers seem to have taken teaching as [a] last resort but not as a viable career option hence their lack of commitment and love for their profession."*

School heads are responsible for monitoring absent teachers at the school level. School heads monitor teachers in various ways to ensure that they comply with regulations. In some schools, school management teams have introduced special forms to keep track of teacher activities, especially ensuring that they have made necessary plans for their classes before they request being away on any given day. There does not seem to be any standard procedure for handling or monitoring absenteeism in schools. If a teacher is reported by a school head as having been absent without proper approval, the salary will be stopped and efforts made to locate the teacher. Such reports are not common. The teacher is not fired until proper communication with them has been carried out.

There is also a growing concern regarding the abuse of alcohol and drugs by both teachers and students. Many cases have been reported at the highest level (MoESD), which means that the cases have gone from the school through the regional office up to ministry headquarters. Observations made by some officers on the ill health of teachers indicate that some end up with illnesses that make it impossible for the teachers to carry out their duties. For example, many cases of teachers losing their sight have been reported. In some cases, teachers come back with medical reports recommending that such teachers should be given 'light duty' work. This is difficult as there is no such duty for a teacher. In such cases, supervisors have no choice but to recommend a Medical Board, which can then recommend that such a teacher retires on medical grounds as stated in the Code of Regulations for teachers. A teacher retiring on medical grounds still receives their pension accordingly. There is no special dispensation for HIV-positive teachers.

7. Policy and management responses

Leave

The different kinds of leave that teachers are entitled to are: leave without pay; study leave; secondment to other posts; special urgent and compassionate leave; maternity leave; and sick leave. These can be divided into short- and long-term leave.

Short-term leave includes compassionate leave, maternity leave and vacation leave. This is shown in Table 6.1. Teachers employed on a permanent basis are entitled to a minimum of 40 calendar days of vacation leave with pay in every year of employment. Leave must be taken during school vacations. Additional leave with salary may be granted for any period during the school holidays. Temporary teachers are only entitled to leave if they have continuous employment of 12 months but can be granted leave for any period of school vacation while in employment.

Long-term leave includes study leave, sick leave and leave without pay. In any period of three years, a teacher may, subject at any time to decisions taken on medical grounds, be granted up to 180 days of leave on full pay followed by up to180 days on half pay.

Table 6.1 Types of leave taken by teachers

Type of leave		
Short-term	**Condition**	**Length**
Maternity	A teacher approaching confinement must apply for maternityleave not less than three months before expected date of delivery	42 days prior to expected date of delivery and 42 days subsequent to expected date of confinement
Compassionate	A teacher compelled on urgent and compassionate grounds to apply for leave during school term with pay	5 days
Vacation	Teachers' entitlement every year of employment; leave may not be accumulated and must be taken during school vacation	40 calendar days/year with pay
Long-term		
Study leave	Where it is considered to be in the best interest of the service that a teacher should be nominated to attend a full-time course of study or training	Number of years vary (usually 2–4 years). Paid salary and allowances in accordance with provisions of government regulations
Sick leave	Taken if a teacher is not able to perform their duties due to ill health	Up to 180 days full pay, followed by 180 days half pay
Leave without pay	Not counted as a service, but teachers can apply for it to study privately or to attend to urgent private matters	Years vary

Early retirement

A teacher who has reached the age of 45 may, at the discretion of the appointing authority and in the interest of the service, be retired from the teaching service and this constitutes early retirement. Such a teacher is entitled to their pension benefit as at the point of retirement.

Retirement issues as stated in these regulations are outdated and since the document is under review, it is difficult to state what really happens in clear terms. For example, the regulations still make reference to a Provident Fund Act, which is no longer in use. Though this document is out of print, it was a pension scheme that was non-contributory and thus employee benefits at retirement were dependent on the employer. The government has since moved to a contributory pension fund for public employees.

Medical checks

Before a teacher is appointed to the teaching service on a contract or permanent basis, they undergo a medical examination carried out by a government medical officer or a private practitioner, approved by the Ministry of Health. Any teachers recruited from outside the country do their medical examinations in their own country before they can be appointed in Botswana. Teachers recruited on temporary terms will also undergo a medical examination, although this requirement is waived where appointments are for a short period of less than three months. Thereafter, the director of the teaching service may, if desirable, require a teacher to be examined by a medical officer at any time. There is no requirement that an HIV test be included.

Benefits for HIV infected and affected teachers

There are no special benefits for HIV infected or affected teachers. Teachers infected or affected by HIV are entitled to the same benefits as other teachers. In the event that a teacher is compelled on urgent and compassionate grounds (such as a death in the family or to nurse a sick family member), the teacher may apply for compassionate leave, which is granted based on the head teacher's discretion. This leave is for a period of no more than five days and is with pay. The head teacher's application for such leave is decided by their supervisors. If a longer period is needed, an extension of leave, again based on supervisor discretion, may be granted provided the total number of leave days does not exceed 30 days.

Death benefits

If a teacher dies while in service in Botswana, their school head or supervisory officer concerned will inform the director of the service. As quickly as possible, the director will then inform the teacher's next of kin, if this has not already been done. The director will then start the process for payment to the family of dues such as salary, gratuity or other awards for which the teacher is eligible. If a teacher dies in service, the spouse or next of kin will be paid, in addition to any salary due to the teacher at the time of death, a sum equivalent to one month's basic salary at the rate due to the teacher at the time of their death. Communication with the family on funeral arrangements will also be initiated. The family is entitled to transport and baggage allowance to carry the teacher's body to their place of permanent residence for burial. This allowance must be claimed and utilized within six months of the date of death, otherwise it will lapse.

Teacher replacement

There is a need to replace teachers who are lost to the teaching service due to various attrition routes. There is a general feeling among teachers that replacement of teachers takes a long time. When a teacher is absent, other teachers take on their workload. The common practice is for the other teachers to divide the class of the absent teacher amongst themselves. Teachers are replaced only when they have been granted leave such as long-term sick leave, further studies, maternity leave or retirement.

Covering teacher absenteeism

When a teacher is absent from work, the usual practice is for the school head to work out an internal arrangement with other teachers. This usually means that the other teachers either share the class that the absent teacher was to teach or take it in turns to teach the class. As one primary school teacher said:

> "*When a teacher is absent, their class is divided among those teachers who teach the same stream*."

Depending on the length of required sick leave, a temporary teacher may be engaged.

Procedures for filling vacancies

When a teaching post becomes vacant or is expected to become vacant, the supervisory officer at the regional level notifies the TSM Director by entering the information into the Infinium Database (see Box 6.1). The computerized system allows for a summary of vacancies to be filled in a region and reasons for it (e.g. has the teacher been transferred or promoted to create the vacant post). The supervisory officer may make a recommendation on filling the post, giving full information on the recommendation. Teacher movement is managed at the regional level but if it is a new post, the post will be advertised at national level and it is through this central office that new appointments are processed.

Transfers

There is a great deal of movement of teachers, although detailed analysis is unavailable. Transfers are facilitated by the various transfer boards that are in place, such as the regional transfer board, the inter-regional transfer board and the senior management transfer board. Many teachers are applying for transfers at any given time. For example, in the South region, to which Kanye belongs, at the time of this study over 500 teachers had submitted applications for transfers. Reasons for requesting transfers are many, but ill health is often cited by the majority. Other reasons include transfers to other schools and requests to be near a study institution. As one officer said:

> *"The major problem is that of teachers who want to transfer from where they are mainly on reasons of being 'sick'. There is no requirement that they disclose what the sickness is but there are instances where it can be assumed related to HIV and AIDS. For example, when a teacher wants to be transferred from place x in a remote area, to place y in a semi-urban or urban area citing lack of health facilities as reason for transfer, one is left to suspect it has something to do with access to special treatment such as ARVs."*

Though HIV treatment is available to most Batswana who need it, it is not yet available in some rural and remote areas. Treatment is often offered in semi-urban areas, towns and cities. Disclosure of status is voluntary. Teachers do disclose when they want to strengthen their transfer application. Sometimes reasons are given such as "*want to be closer to my family as that will reduce chances of being infected with HIV*", or "*My spouse is sick and needs my attention*". On compassionate grounds, depending on the availability of teachers, sometimes such transfers are granted.

It must be noted that this movement is mostly towards the cities, especially the capital city, Gaborone. This has earned the city the nickname 'Sick Bay'. This has an impact on the quality of teachers left in the remote or rural areas, as most qualified teachers move to urban areas, especially the cities.

As one officer said:

> *"Teachers want to move claiming it is for health reasons. And they all want to move to Gaborone. Remote areas do not have qualified teachers as everyone wants to move to Gaborone. Sick leave is very frequent. You can verify this for yourself with the regional office."*

There is no clear evidence that urban schools have surplus teachers, though with rural schools the compromised quality of teachers is evidenced by poor performance in primary and secondary school leaving examinations. Surplus teachers are reported to regional offices and are then transferred according to demands for the subjects they teach. To curb this, it would be ideal to provide full health facilities and service across the country, but this is currently an expensive exercise. The government is committed to this and benefits should be realized in the near future.

However, given that disclosure of HIV status is not required, some teachers do give false reasons to apply for transfers, such as to be near sick family members, and this cannot be verified. Principal Education Officers (PEOs) do make school visits and observations indicate an unhealthy workforce but since HIV status cannot be deduced from just looking at a person, it is difficult to relate the situation to HIV and AIDS.

Stigma still plays a significant role in schools. It has been observed that sometimes school management uses someone's HIV status to recommend them for transfer. There are instances where

school heads recommend teachers for transfer when they are suspected to be HIV-positive. Stigma is sometimes also shown by parents. When they hear a teacher is HIV-positive, they come to the school and either remove their children or ask that their children be moved from the teacher's class. As a member of a teachers' union who was interviewed for this study said, *"School heads often recommend the sick to be transferred. Even parents recommend that their children be removed from such teacher's classes."*

Issues of stigma date back to the beginning of the HIV pandemic, though major progress has been made to address these. Unfortunately education is the best strategy to address stigma and this takes time. Given the often lower levels of education of parents in rural and remote areas, rigorous steps need to be taken to expedite this. More efforts will be needed if change is to be realized.

Teacher management tools

There is a Teacher Management Information System (TMIS) for TSM. This database mainly captures information on the recruitment and movement of teachers, as well as their salaries. Information on the supply and demand for teachers is therefore kept on this database. Interviews with regional education officers revealed that TSM had decentralized the database and this kind of information can now be entered at regional level. Once entered at regional level, the system is updated and the information is then made available to all regions. There is an additional database that is kept by the Education Management Information System (EMIS) office and this database information is based on the annual forms that are sent to schools. This form captures information on students and teachers.

The interview with the Head of EMIS for this study showed that teachers are classified according to their status as permanent, temporary, relief or whether they are on study leave. Other information about teachers includes their citizenship, sex, qualification and the subjects they teach. Teacher movement by reason and teacher death by reason are also captured. However, the Head of EMIS indicated that the system was not fully operational and that information was still not consolidated.

Box 6.1 TSM Infinium Database

The Infinium HR (human resources) information system was introduced within TSM in 1999, with the intention of using it to administer teacher-related activities such as:

- Appointment of teachers, workforce planning for schools, salary adjustments, promotions and demotions, confirmation of teachers on probation, monitoring teachers on study leave, terminations related to resignation, retirements, etc.
- Managing teacher information and providing access to system facilities from all regional offices and devising appropriate structures, as well as revising procedures, to support effective implementation of the system.
- Capturing teacher transfers and other movements and allowing users to normalise staffing issues as data from the whole country is captured.

The system is operational in the five education regions in Botswana. It is accessed by education sector management at ministry headquarters and at regional level, such as PEOs.

8. The policy framework on HIV

National policy on HIV and AIDS for the education sector

The Government of Botswana has policies that address HIV and AIDS and these are applicable across the country. The expectation is that all Batswana will learn about these and use them. However, there are challenges associated with dissemination. These policies are often written in English and most people, especially in rural and remote areas, cannot read English. As one officer lamented, "*If only they could be translated into Setswana, maybe things could be better*". This situation also applies to schools especially in situations where some pupils are not yet conversant with English such as in primary schools.

The HIV policies are described below.

National policy on HIV and AIDS

The Botswana National Policy on HIV and AIDS (1998) is currently under review. This policy is framed around the realization that the high magnitude of the psycho-social impact of HIV and AIDS necessitates a multisectoral approach. The policy thus outlines the roles to be played by the different sectors, including that of the private sector and civil society.

The MoESD's role was to focus on:

- Integration of AIDS and STI education into all levels and institutions of education, starting at primary school level and extending to tertiary, teacher training and non-formal institutions.
- Involvement of parents, through Parent-Teacher Associations and other appropriate mechanisms, in discussion of school-based HIV and AIDS education.
- Ensuring that other services related to HIV and STI control and care are accessible to students and teachers in need.

The HIV and AIDS Education Policy was developed in 1998 as part of the national response to the epidemic. The responsibility of the MoESD, as outlined under the national policy, is to reduce the spread of HIV infection by addressing HIV and AIDS in all its programmes. The major task for this ministry is to integrate and incorporate HIV and AIDS issues in the school curriculum and in the training of teachers. It was intended that this would equip both learners and teachers with the skills, attitudes and practices to curb the spread of HIV and to manage it. The guidelines in this policy are to:

- make the integration HIV and AIDS into the curriculum at all levels of education compulsory
- adapt age-specific content, methodology and strategies in imparting HIV and AIDS education
- make it the responsibility of all education practitioners to participate in HIV and AIDS education
- develop in-service courses on HIV and AIDS education and strategies
- develop in-service curriculum and plan for implementation in consultation with Ministry of Health
- make counselling a component of training programmes for Guidance and Counselling teachers
- involve community through Parent-Teacher Associations (PTA) in AIDS education
- run HIV and AIDS awareness programmes for all ministry employees
- support learners, teachers and other education practitioners and guard them against discrimination.

This two-page policy has not yet been reviewed but it will be reviewed by the ministry once the reviewed national policy is publicised.

Ministry of Education HIV/AIDS Strategic Response Framework

Though outdated, the MoESD response to HIV and AIDS is guided by the ministry strategic framework of 2001–2003. This framework was developed using the National Strategic Framework (NSF) as a guide and thus uses the role of this ministry outlined in the NSF. This ministerial framework has not yet been revised. The ministry set out to use its trained staff as a resource in building capacity in others in the implementation of the framework. In the framework document, the ministry conducted a rapid analysis as a way of informing its strategic response.

The strategic response for this ministry focused on:

- mainstreaming HIV and AIDS into the education sector
- developing effective management structures
- developing functions and responsibilities at both central and regional levels
- developing reporting structures.

Workplace policy

The Public Service Code of Conduct on HIV and AIDS in the workplace was developed by the Directorate of Public Service Management (DPSM) and released in 2001. This document provides an overview of the rights and obligations of Public Service Management and employees with regards to HIV and AIDS. The document does not single out any group of employees. It serves as the focal point for all national policies and matters relating to public service. It is the responsibility of individual ministries to implement programmes relevant to their workplaces. Most sectors have produced their sectoral workplace policies such as some government ministries, parastatals and private sector. Government ministries are allocated funds to carry out HIV and AIDS activities through NACA. The MoESD does not have a workplace policy document on HIV and AIDS possibly as a result of inadequate staffing in the office of HIV and AIDS. This in turn is responsible for the lack of workplace policy in schools.

Teachers' code of regulations

Unified Teaching Service Code of Regulations (COR 903(1))

The Botswana Unified Teaching Service Code of Regulations (Republic of Botswana Government, 1976c) continues to be used as a major management tool in the teaching service. This document covers regulations on the duties and conduct of teachers, discipline, salaries, allowances, leave, housing, health and medical treatment, and retirement benefits. This is the reference document for the welfare of the teachers.

Code of ethics

Although no statistics are available, there are cases of sexual abuse of pupils by teachers. In some cases, there are pupil-teacher relationships but these are not always reported. It must be noted that discussions about sex in Botswana have been taboo for a long time. For that reasons, victims are often reluctant to come forward. It is even worse if victims are minors, as it means having to report such a matter to an adult (teachers or school head). Often the adults make it difficult for the minor to tell their story, as they do not create a conducive or friendly environment for them. The common response when a child reports such acts about an adult is not to believe them and to dismiss them as liars. This happens both at school and in the home. Although teachers do admit such acts happen, they are reluctant to give details as often they seem to protect other teachers, as they know they can lose their job. There is often little concern about the learner in such matters.

The Code of Regulations is out-dated and is silent on the issue of sexual harassment. A code of conduct for teachers is covered in the Code of Regulations and Teaching Service Act, but there is no separate document dealing with teacher conduct. There is no ministerial policy on sexual harassment either. However, there is a draft Code of Ethics for Teachers (draft dated 19 June 2009) that TSM has developed. In this document, sexual harassment issues are covered. Once released, this document should assist in handling the ethical issues around teachers. Currently these issues are handled at the

discretion of school, regional office or TSM supervisors. Offending teachers are either dismissed or transferred.

9. Teacher support and referral structures

Structures

The MoESD HIV and AIDS Coordination Committee includes all Heads of Departments with a technical committee that is made up of HIV/AIDS focal persons in all departments. The focal persons oversee the implementation of plans. The integration and incorporation of HIV and AIDS into the curriculum is a key area for the ministry, which is responsible for mainstreaming HIV and AIDS into service delivery for learners and teachers. In the schools, guidance and counselling teachers act as focal persons on HIV and AIDS matters. Guidance and counselling teachers are teachers designated to follow a special curriculum which focuses mainly on life skills, health and career issues. Each class at all levels has a lesson of this every week. The guidance and counselling teachers are not all trained in the area but those who are, get their training from the University of Botswana or other tertiary institutions outside the country. Those who are not trained in the area are put on waiting list for such training but continue to serve as guidance and counselling teachers. The training they receive is a Bachelors degree in counselling. Other teachers and school heads rely on them to carry the HIV and AIDS agenda forward.

There are no sectoral support structures for HIV-positive teachers. Teachers are treated the same as other Batswana and therefore have to use the same structures that are available to everyone. However, the view from a teachers' union as given by a respondent in this study is that the nature of the work teachers do should accord them preferential treatment. The argument is that teachers are posted to all corners of the country, even when they are in ill health. It is suggested there has to be a "*readily available consideration without discrimination*".

At the national level, when somebody tests HIV-positive, they are counselled and referred for HIV evaluation and treatment. Teachers receive exactly the same treatment as everyone else. The MoESD does not have a separate referral system for those infected or affected by HIV.

Access to treatment

Like all other Batswana, teachers access HIV treatment free of charge at designated places throughout the country. There is no differential treatment for teachers. Like all other public employees, teachers apply for leave to access treatment at designated centres. These places are mainly with private doctors, for those on medical aid schemes, or at public facilities such as hospitals and clinics. For any differential treatment or discrimination as a result of one's HIV status, anyone can access the Botswana Network on Ethics, Law and HIV/AIDS (BONELA), an NGO with a mission to create an enabling and just environment for those infected and affected by HIV. In 2008 alone, the BONELA's legal clinic has handled 50 court cases, of which 30 have been settled out of court and some are still in progress. The cases highlight human rights abuses such as unfair dismissal, stigma, discrimination, wrong diagnosis, denied access to tests and deportation in a specific case (Ganetsang, 2008). In 2007, BONELA represented an HIV-positive female teacher who experienced stigma and discrimination when her HIV status was revealed to other teachers and students at a general meeting at one school in the south of Botswana. As a BONELA representative said, "*HIV/AIDS stigma in the Botswana workplace is worsening and it manifests as discrimination. The workplace is made intolerable…*"

Although ARVs are free, there are sometimes delays in enrolling for treatment or in some cases, patients have to travel long distances to reach a service point. The involvement of ACHAP in the treatment programme has seen major progress in offering treatment, and Botswana is currently offering treatment to 90 per cent of those needing it. There have been no reports of shortages of ARV treatment drugs, although unavailability of other drugs for other treatments have been reported across the country.

Ministry of Education HIV/AIDS Unit

The HIV/AIDS Unit in the MoESD is headed by a coordinator. The main responsibilities of this unit are to:

- ensure that HIV is mainstreamed into all ministry departments
- mobilize resources, both financial and human, for HIV interventions
- implement the part of National Strategic Framework that is relevant to the ministry
- inform policy and programme development relating to HIV and AIDS.

This unit liaises with the departments of the ministry to develop appropriate programmes at ministerial level and these programmes are to be developed at an institutional level. At the institutional level, however, these programmes are non-existent. Implementation is hampered by lack of capacity and often efforts at that level primarily target learners. This unit does not deal directly with the welfare matters of teachers but works with other departments of the ministry such as TSM on such matters relating to teachers.

Teachers' unions

Teachers' unions play a significant role in advocating for teachers living with HIV. They sometimes run workshops and invite experts to educate teachers on HIV, as well as inviting HIV-positive teachers to share their experiences. There are two teachers' unions for primary and secondary teachers. The Botswana Teachers' Union (BTU) has members from both primary and secondary schools, while the Botswana Secondary Education Teachers' Union (BOSETU) is for secondary school teachers only. Although the exact proportion of members is not know, teachers nowadays appreciate the role of unions, as they find them offering an opportunity to raise welfare issues. One teachers' union is working on developing a support group for teachers living with HIV.

Teachers' unions are also playing a significant role in defending the rights of teachers living with HIV. Teachers Unions offer many services for their members, such as funeral services, a legal aid scheme and credit/loan schemes. The funeral service offered by the union is reported to respond much more quickly in times than the regular funeral services offered by private providers. The fees towards funeral services are comparable to those offered by other providers, but the speed at which one is assisted at the time of need is said to be the attractive part that is now drawing more teachers to join unions. Union members have to contribute towards the legal aid scheme and this scheme is meant to cater for social and private problems of teachers, as the work-related problems are covered through the union membership. The loan schemes include a loan service for those who might not qualify for loans from commercial banks.

Collaboration between MOE, agencies and associations

The MoESD interacts with many different agencies on HIV-related issues, including the Ministry of Health, NACA, the Ministry of Local Government, the Ministry of Culture and teachers' unions. The interaction is usually in the form of meetings, seminars, workshops initiated by the ministry, as well as the other partners. Although these meetings are not regular, since there are so many different partners, there is always something going on in terms of engaging the ministry on HIV issues across the country.

Associations of HIV-positive teachers

There is no association for HIV-positive teachers yet, although one of the teachers' unions, BTU, has started talking about forming a support group for HIV-positive teachers.

Professional

In-service training

As stated in the MoESD HIV policy, in-service training on HIV and AIDS has to be provided for teachers. However, due to lack of capacity, this is not fulfilled. Mostly guidance and counselling teachers receive the training, but the rest of the teachers do not get the opportunity. Guidance and counselling is offered as an enrichment subject to all students in primary and secondary schools. The curriculum for this subject covers many topics including health and HIV and AIDS. HIV and AIDS has been integrated in some subjects and teachers are to integrate it into all the other subjects. It is apparent that

integration is difficult for teachers as most have not had any training on HIV and AIDS. The adequacy of teaching HIV in the schools cannot therefore be ascertained. One respondent said of HIV policies, "*The strength of a policy should be seen at grassroots level. Can teachers pass message and not feel intimidated? Some teachers cannot address HIV, afraid to be stigmatised*."

HIV/AIDS education in schools

Efforts to deal with HIV and AIDS in the schools have been made through the HIV and AIDS unit of the MoESD. However, lack of capacity to handle HIV and AIDS is experienced at the school level due to lack of training. The guidance and counselling teachers get overburdened with HIV and AIDS issues when in some cases even these teachers are not trained. The guidance and counselling teacher post comes with a higher salary and some teachers get promoted to these posts with no training. Teachers interviewed for this study agree that those who are appointed to these posts just want the money and have no interest in the work that comes with the title. Although the guidance teacher should be able to handle HIV and AIDS issues, other teachers also need to be trained, as they also have to address such issues in their teaching. This initiative has not yet been successful.

Other than coverage of the topic in subjects like science and guidance and counselling, there are initiatives such as the Teacher Capacity Building Project (TCB), Botswana's success story in the education sector. This programme is a partnership between ACHAP, MoESD, Botswana Television and the United Nations Development Programme (UNDP). The curriculum for the programme has been prepared and produced by the Department of Teacher Training & Development (TT&D) with technical support provided by UNDP. The curriculum includes topics on basic HIV and AIDS knowledge, prevention, care and support, HIV testing, culture, attitudes and the role of the community. However, it has not been without its challenges. Some schools do not have electricity and therefore are not able to participate in the programme, while in some schools facilities are not always functional. The timing for the programme is Tuesday at noon and sometimes schools are not able to stop regular teaching and view the programme at this time. Teachers have to call in to access the service and telephone reception is reported to be a challenge in some areas.

There are other programmes that have been put in place such as the TalkBack programme, an interactive television teacher education programme. This targets Botswana teachers with information about HIV and AIDS in an effort to build teacher capacity to effectively address HIV and AIDS issues in the classroom (Ministry of Education, 2004). However, this has also faced challenges such as lack of electricity in some area thus making it difficult to watch television.

Beyond this, there have been other projects such as the Ringing the Bell project, which has not done so well. However, interviews for this study revealed that the project is being resuscitated. In this project, PLHIV were attached to schools to promote positive living.

There are yet more programmes, such as the Circles of Support project, in which basically all stakeholders are given information about general issues, including HIV. There are efforts to engage both teachers and students on HIV, AIDS and health issues, though these efforts are mostly isolated.

HIV and AIDS education in teacher education colleges

Teacher training does not formally include HIV and AIDS education, but the topic is covered in some subjects and integrated in others. Integration has proved to be difficult for most teachers, as it is often left to the discretion of individual teachers.

Discussion and recommendations

The following is a discussion on the main issues from the study followed by recommendations.

Teacher absenteeism and attrition: Teacher absenteeism was reported by many of the participants as posing a problem in Botswana's schools. The major reason for teacher absence is ill health, but unfortunately there is often a lack of detail about the nature of these illnesses. There are other reasons for teacher absenteeism, such as lack of commitment to work, especially among new teachers. In the case of absenteeism due to illness, there is the suspicion that in most cases the ill health is HIV related. However, this cannot be ascertained as disclosure of one's HIV status is voluntary. Close monitoring of the problem of absenteeism is needed, as this can compromise the quality of education. Currently the monitoring is left to individual school heads with no standardized tools. Closely related to absenteeism is the issue of attrition. With improved health and pension provision many teachers are not leaving the profession prematurely. Most teachers are on medical aid schemes and this takes care of health needs, including provision of HIV treatment where needed, thus reducing death rates. The contributory pension scheme comes with increased benefits at time of retirement and therefore early retirement option is not popular. However, since death due to HIV is not reported separately in education sector records, this makes it difficult to assess the overall impact of HIV in the education sector.

Teacher management tools: There are various policies in place in terms of teacher management, as shown in the main document. The views on the strengths and weaknesses of these policies were raised by respondents. In terms of strengths, participants reported that the policies were good as they did not distinguish teachers from other public sector employees. However, some constraints or weaknesses were cited:

- Most of the policies used are outdated (e.g. UTS Code of Regulations (1976), National HIV/AIDS policy (1998)).
- Although it was seen as a good thing not to separate teachers from other public sector employees, it also turned out to be a weakness. Some respondents found this to disadvantage teachers as it ignored the nature of their work. Teachers are posted to any corner of the country, regardless of their health status, while other public sector employees are allowed to negotiate where they can be posted.
- Policies do not cover all important issues. For example, sexual harassment is not addressed in all these outdated policy documents.

Teacher welfare: Teacher movement is now recorded on a computer database, although the systems used are not yet fully implemented in the regions. Through its various divisions, TSM handles teacher appointments, movement and salaries. However, this is not enough, as in most cases teacher welfare is not separated from the welfare of other public employees. This has seen teachers' unions echoing teacher welfare issues, as unions are now recognized by the MoESD as negotiating partners for teacher welfare. The argument is that teachers are not the same as all other public officers given the nature of their work.

Capacity: Through the MoESD, regional offices and schools, it is clear that there is inadequate capacity to handle Botswana's HIV agenda. The structures are in place but often the extent of their work is limited by not having personnel to carry out the many activities necessitated by plans. There is lack of clear personnel designated specifically for HIV in the various ministry departments and units as often those who are appointed to serve in HIV committees have other core business to attend to. This in itself sets a tone that HIV is not as important as other business.

Recommendations

Given the above discussion and based on the findings of this study, the following steps are recommended:

- As already stated, some of the documents used are outdated. The ministry needs to keep abreast of the numerous changes and new knowledge in this era of HIV and AIDS and thus review their policies as often as necessary.
- Welfare of teachers should be assessed separately from that of other public servants given the nature of their work.
- Capacity building at all levels of education should be intensified so that all are empowered in dealing with HIV and AIDS issues. A series of workshops, seminars and short training courses should be mounted by MoESD.
- HIV and AIDS focal points in the ministry should be regularized into HIV officers with a mandate to fully take up HIV and AIDS work.
- The release of policy documents such as Code of Ethics for Teachers should be expedited, as this would help to address issues such as sexual harassment in the context of teachers.
- Absenteeism of teachers should be monitored by developing daily data capturing tools in the schools.
- To curb the number of teachers requesting transfers to urban areas to be closer to medical facilities, it would be ideal to provide full health facilities and service across the country.

Conclusion

Teacher management is experiencing many challenges, especially in the era of HIV and AIDS. The MoESD in Botswana is working both within its own structures and collaborating with other partners to fully address teacher welfare at this crucial time. However, this cannot be achieved in isolation and requires the full participation of all stakeholders.

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