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Student Voices in the Implementation of Health and Life Skills Policy in Zimbabwe Teacher Training Colleges

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Abstract: *The study sought to assess the extent to which the Health and Lifeskills Policy is being implemented in Teacher Training Colleges in Zimbabwe to strengthen the sexual reproductive health rights of college students. The Policy was developed to protect the rights of students to access health services. The multiple case study conducted among 3rd year students from 7 Primary and 2 Secondary School Teacher Training Colleges from 2012 to 2014, revealed lack of compliance with policy provisions which undermined the rights of the students to provision of health services. Students' lack of awareness to the policy provisions enshrined in the Policy, like the right of students to access information on health services, voluntary confidential HIV counseling and testing, access to treatment, condom provision, antiretroviral therapy and family planning, made it difficult for students to have a voice to demand for their rights. Hence students' health was negatively affected resulting in unprotected sex, sexual abuse and acquiring sexually transmitted infections including HIV and AIDS. Effective Health and Lifeskills Policy implementation is essential to prevent negative social behavior.*

Keywords: Health and Lifeskills, Policy, Student voices, Sexual Reproductive Health Rights, Negative Social Behavior.

I. Introduction

The study is an analysisof the implementation of the Health and LifeskillsPolicy for students in Teacher Training Colleges in Zimbabwe from the student' perspective. The problems related to sexual and reproductive health of college students has increased over the past years and in the face of negative social behavior like prostitution, alcohol and drug abuse among others leading to HIV and AIDS and sexually transmitted diseases. Students are confronted with harsh realities of life at the colleges as most parents cannot provide the basics for their children due to the harsh economic climate; hence some of the students resort to risky activities to earn a living. The government, through the Ministry of Higher and Tertiary Education developed Health and Lifeskills Policy to protect the rights of college students within the Teacher Training Colleges and to address the threat of HIV and AIDS and other sexually transmitted diseases as well as equipping the students with survival skills to cope with college solitary life.

Musoko (2010)[1] states that Health and Lifeskills dates back to 1990 as the subject was taught as HIV&AIDS, but faced a lot of negative criticism from curriculum influencers like church organizations, parents and teachers. This is because in Zimbabwe culture, it is a taboo to discuss sexual matters in public. Religious organizations on the other hand opposed the idea of teaching and learning about HIV and AIDS related issues as they were seen as contradicting bible teachings about sex in marriage, hence teaching the use of condoms and other sexual activities outside wedlock

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was found to be immoral practice which was totally unacceptable. Teachers as curriculum implementers regarded teaching of HIV and AIDS alone as not enough for behavioural change towards reducing the spread of HIV in the Zimbabwean Society. Therefore the curriculum designers complied with the needs and expectations of the society to widen and change the subject to Health and Lifeskills. Rousseau(1712 – 1778), the pioneer of child education, advocates that children must learn from their immediate environment and should be aware of all community issues and learn how to solve community challenges through embarking on community projects. This led to the birth of Health and Lifeskills.

The study analyzed the effectiveness of the implementation of the Health and Lifeskills policy in colleges in relation to students' sexual and reproductive health, more than 6 years after it was developed. According to the Zimbabwe Demographic and Health Survey (2010 – 2011) [2], the age at first sexual intercourse can be used as a proxy to the beginning of exposure to the risk of pregnancy. The median age at first sexual intercourse for women aged 25 – 49 is 18.9 years while for men of the same age group is 20.6 years. By age of 20, about six in ten Zimbabwean women have had sexual intercourse while men exhibit a slightly older median age of 20.6years. This age range is the age group in which the college students fall into. Sexuality education activities are guided by the Sexual Reproductive Health (2010 - 2015)[3] which offers three approaches to addressing SRH issues of young people – health facility based approach; school based approach and community based approach. In Zimbabwean schools, health and Lifeskills education is compulsory in all primary and secondary schools and tertiary institutions, and HIV and AIDS is integrated into relevant subjects. The research questions guiding this study focused on the extent to which the Health and Lifeskills policy is being implemented in Teacher Training Colleges; what HIV/AIDS services are being provided to pre-service teachers; the constraints faced by the teacher training institutions to implement the Health and Lifeskills Policy and how these can be overcome to strengthen teacher training and better prepare teachers to deliver effective Health and Lifeskills education.

1. Methodology:

The multiple case study design was used for this study between 2012 and 2014. The study population was composed of 3rd year exit students from 7 Teacher Training Colleges which prepare students for teaching in both primary and secondary schools. The college intakes were different based on the size of the college, hence the samples of the students were also proportional to the size of the intake.

This group was selected realizing that they are at the point of exiting the colleges after exposure to all the education on health and Lifeskills. The student sample was selected using the convenient sampling method. Questionnaires were distributed to a total of 900 students and 16 focus group discussions were done (two per college - one with a group of women and the other with a group of men). This enabled the students to be as open as possible without the element of shame or fear of ridicule. The findings in this article include issues that were raised through the focus group discussions and the questionnaires.

II. THEORETICAL FRAMEWORK

The study was based on the constructivist theoretical framework which focuses on the shift from the teacher to the students. The concept of constructivism has roots in classical antiquity, going back to Socrates's dialogues with his followers, in which he asked directed questions that led his students to realize for themselves the weaknesses in their thinking. The Socratic dialogue is still an important tool in the way constructivist educators assess their students' learning and plan new learning experiences.

In the constructivist model, the students are urged to be actively involved in their own process of learning. The teacher functions more as a facilitator who coaches, mediates, prompts, and helps students develop and assess their understanding, and thereby their learning. One of the teacher's biggest jobs becomes asking good questions. Both teacher and students think of knowledge not as inert factoids to be memorized, but as a dynamic, ever-changing view of the world we live in and the ability to successfully stretch and explore that view. Curriculum emphasizes big concepts, beginning with the whole and expanding to include the parts.Pursuit of student questions and interests is valued. Materials include primary sources of material and manipulative materials. Teacher's role is interactive, rooted in negotiation. Assessment includes student works, observations, and points of view, as well as tests. Process is as important as product. Knowledge is seen as dynamic, ever changing with our experiences.

Students work primarily in groups. Constructivist teachers pose questions and problems, then guide students to help them find their own answers. They use many techniques in the teaching process. For example, they may:

- prompt students to formulate their own questions (inquiry)
- allow multiple interpretations and expressions of learning (multiple intelligences)
- encourage group work and the use of peers as resources (collaborative learning)

It is important to realize that the constructivist approach borrows from many other practices in the pursuit of its primary goal: helping students learn how to learn. Students are not blank slates upon which knowledge is etched. They come to learning situations with already formulated knowledge, ideas, and understandings. This previous knowledge is the raw material for the new knowledge they will create.The student is the person who creates new understanding for him/herself. The teacher coaches, moderates, suggests, but allows the students room to experiment, ask questions, try things that don't work. Learning activities require the students' full participation (like hands-on experiments). An important part of the learning process is that students reflect on, and talk about, their activities.

Students also help set their own goals and means of assessment. Examples: In Health and Lifeskills education, asking students to read and think about different versions of and perspectives on HIV and AIDS can lead to interesting discussions. Is HIV and AIDS as taught in textbooks accurate? Are there different versions of the same problem? Whose version of the origin of HIV is most accurate? How do we know? From there, students can make their own judgments, control their own learning process, and lead the way by reflecting on their experiences. This process makes them experts of their own learning. The teacher helps create situations where the students feel safe questioning and reflecting on their own processes, either privately or in group discussions. The teacher should also create activities that lead the student to reflect on his or her prior knowledge and experiences. Talking about what was learned and how it was learned is really important. College students will be expected to be creative when they leave college to teach pupils in the respective schools that they will be expected to go to.

Constructivism relies heavily on collaboration among students hence the importance of involving them in Health and Lifeskills Policy formulation and drafting implementation strategies. There are many reasons why collaboration contributes to learning. The main reason it is that students learn about learning not only from themselves, but also from their peers. When students review and reflect on their learning processes together, they can pick up strategies and methods from one another, hence introduction of peer education in Health and Lifeskills education. The main activity in a constructivist classroom is solving problems. Students use inquiry methods to ask questions, investigate a topic, and use a variety of resources to find solutions and answers. As students explore the topic, they draw conclusions, and, as exploration continues, they revisit those conclusions. Exploration of questions leads to more questions. Constructivist teaching takes into account students' current conceptions and builds from there. What happens when a student gets a new piece of information? The constructivist model says that the student compares the information to the knowledge and understanding he/she already has, and one of three things can occur:

- The new information matches up with his previous knowledge pretty well (it's **consonant** with the previous knowledge), so the student adds it to his understanding. It may take some work, but it's just a matter of finding the right fit, as with a puzzle piece.
- The information doesn't match previous knowledge (it's **dissonant**). The student has to change her previous understanding to find a fit for the information. This can be harder work.
- The information doesn't match previous knowledge, and it is **ignored**. Rejected bits of information may just not be absorbed by the student. Or they may float around, waiting for the day when the student's understanding has developed and permits a fit.

1. What are the benefits of constructivism?

- Children learn more, and enjoy learning more when they are actively involved, rather than passive listeners.
- Education works best when it concentrates on thinking and understanding, rather than on rote

memorization. Constructivism concentrates on learning how to think and understand.

- Constructivist learning is transferable. In constructivist classrooms, students create organizing principles that they can take with them to other learning settings.
- Constructivism gives students ownership of what they learn, since learning is based on students' questions and explorations, and often the students have a hand in designing the assessments as well. Constructivist assessment engages the students' initiatives and personal investments in their journals, research reports, physical models, and artistic representations. Engaging the creative instincts develops students' abilities to express knowledge through a variety of ways. The students are also more likely to retain and transfer the new knowledge to real life.
- By grounding learning activities in an authentic, real-world context, constructivism stimulates and engages students. Students in constructivist classrooms learn to question things and to apply their natural curiosity to the world.

  Constructivism promotes social and communication skills by creating a classroom environment that emphasizes collaboration and exchange of ideas. Students must learn how to articulate their ideas clearly as well as to collaborate on tasks effectively by sharing in group projects. Students must therefore exchange ideas and so must learn to "negotiate" with others and to evaluate their contributions in a socially acceptable manner. This is essential to success in the real world, since they will always be exposed to a variety of experiences in which they will have to cooperate and navigate among the ideas of others.

2. Findings:

Health and Lifeskills implementation utilizes the constructivist paradigm. Findings presented in this study were based on the analysis of findings from data collected from students in the 7 Teacher Training Colleges and the focus group discussions. The discussions focused on the voice of young people regarding Health and Lifeskills interventions which are offered at Teacher Training Colleges. Recommendations were made on the current status of sexual and reproductive health issues affecting college students. Implications for action and further research were discussed.

2.1 Health and Lifeskills Policy position:

The findings showed that the Government through the Ministry of Higher and Tertiary Education developed an Education Sector Wide Health and Lifeskills Policy to guide colleges in implementing the Health and Lifeskills Policy to protect the rights of students' sexual and reproductive health. Other colleges also developed their own college specific Health and Lifeskills Policies to respond to their college issues. In addition the Adolescent Reproductive Health Strategy (ASRH) 2010 – 2015 was developed to guide the MOHCC's efforts in providing quality, affordable and appropriate sexual and reproductive health services to young people in Zimbabwe. Policy development is a positive step in ensuring that there is a framework of implementing activities. In this study, the Health and Lifeskills was developed but not all students were aware of the existence of the policy which then ultimately affects utilization in the policy provisions. Literature indicates the importance of having an HIV and AIDS policy (Dyk, 2004; Sarua, 2006) Responses on knowledge of students on existence of the policy indicated that only 65% of the respondents were aware of the policy provisions. Of those students 45% confirmed lack of access to the policy documents since they were kept by the Health and Lifeskills Lecturers and not necessarily accessible to the students as and when they needed them. The only time the students got to know about the policy was through briefings by the Health and Lifeskills Lecturers during orientation meetings and at workshops. . This finding supports the Zimbabwe Open University baseline study (which found that students and Lecturers were not aware of the HIV and AIDS policy within the institution. The objectives of having an HIV and AIDS policy in institutions are given by literature as to reduce stigma and discrimination associated with HIV and AIDS, create supportive environment of compassion and understanding for students and Lecturer with HIV and related illnesses; ensure that all students and staff members are treated equally whenever they are infected or not by HIV; provide all students and staff with the information necessary to increase their awareness of the issues related to HIV infections and AIDS; ensure that institutions or organizations provide prevention, care and support services to staff and students, to reduce personal, family and organizational impact of HIV and AIDS and promote shared confidentiality among staff and students (University of Port Harcourt: 2007)

2.2 Status of Health and Lifeskills as a subject:

The students confirmed that Health and Lifeskills was an examinable subject in the syllabus (99.5%) and failure in this subject required students to rewrite the subject (92%). This fits in well with the constructivist theory. The subject weighting was not different from the other subjects. On adequacy of the time allotted to the subject, 56% of the students felt that the time was sufficient while 44% felt that the time was inadequate.

2.3 Sources of Information:

The students gave the following as their main sources of information on Health and Lifeskills were:

Sources of Information	**Percentage**
Health and Lifeskills Lecturers	54%
Mass media	21.3%
NGOs	10.4%
Library	6.8%
Other	6.7%

Despite the policy being in place the students stated that they were not aware of the policy provisions for sexual reproductive health. This in turn made it difficult for the students to demand accountability to the service providers.

2.4 Material resources

The findings revealed that though the subject of Health and Lifeskills was awarded the status of an examinable subject, the colleges did not have adequate resources such as text books and reference books in comparison to other subjects. Absence of the textbooks as well as reference materials negates the importance and weighting attached to the subject.

2.5 Competency of Health and Lifeskills Lecturers:

Policy implementation with regard to competency of lecturers, was positive based on comments received from students in colleges regarding competence and commitment of Lifeskills Lecturers and rated as good by 74% of the students. This was confirmed by the findings from the focus group discussions which confirmed that the Health and Lifeskills were well informed and capable of teaching the subject. Some students however felt they were not specialists and often fell short of detailed health information which students required. Health and Lifeskills training was seen as a niche of the Health and Lifeskills Lecturers only within colleges as the other Lecturers indicated lack of knowledge on what was involved in Health and Lifeskills. The attitude of "what is in it for me" was not supportive of effective policy implementation as some of the Health and Lifeskills Lecturers kept voicing the lack of incentives with donor withdrawal.

2.6 Accessibility of Health Services:

Health services were available but not always accessible for students eg. condom provision was discouraged in some colleges. In other colleges the condoms were made available but inaccessible for the students because they were kept in places that students would be unable to go and collect them without being noticed. In church based colleges, students felt the authorities considered the college a "holy place" where sexual relations were not practiced but in reality the truth was that the students stated that they would sneak into the bushes outside school premises to have sexual relations. This resulted in students practicing unprotected sex and the subsequent surge in sexually transmitted diseases as reported by the nurses at the respective Teacher Training Colleges.

2.8 Health problems faced by college students:

Table 2: Sexual and reproductive health problems that students face at college by age distribution

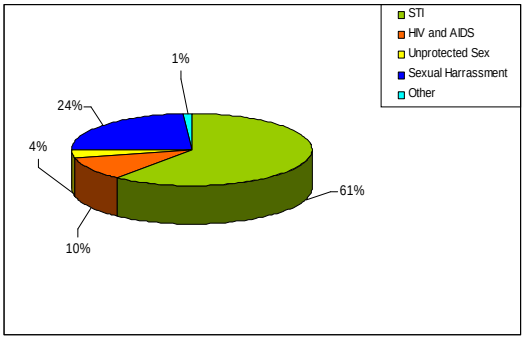
Response by Age	20 -24	25 - 29	30 - 34	35 - 39	40 +
STI	56.5	56.8	59.6	57.6	48.2
HIV and AIDS	12.2	11.6	17.4	9.9	11.1

Unprotected Sex	2.7	3.8	1	4	11.1
Sexual Harassment	25.5	25.8	21	27.2	29.6
Other	3.1	2	1	1.3	0
Grand Total	100	100	100	100	100

Table 2 above shows the health problems faced by students in teacher Training Colleges.

Each student stated what they considered the worst problem. Of major concern are the high numbers of STIs and the issue of sexual harassment. Focus group discussions revealed that female students find themselves in a difficult position because of Lecturers who make advances to them for sexual favours. If they deny them the sexual favours then they compromise their success in studies. Church related institutions were not spared either. Female students expressed frustration at having continuous harassment from teachers, the church leadership and also male students all demanding sexual favours from the same students. The most frustrating thing was that they could not report the violation of their rights for fear of victimization and also as there were no channels or forum for them to report the harassment.

Figure 1 Sexual and Reproductive Health problems / Diseases that students face at college



2.7 Health and Lifeskills service provision:

On the provision of services, inadequate information on rights of students' access to reproductive health services, like HIV and AIDS, voluntary testing and counseling, access to drugs for STIs and ARVs, family planning services were raised as a concern by students. The study found out that there were inadequate HIV and AIDS services, such as provision of Voluntary Counselling and Testing (VCT) which was often outsourced in most institutions. Drugs for STIs and ARVs were inadequate resulting in high cases of STIs, HIV and AIDS at the colleges. The family planning services offered were inadequate or in some cases non-existent.

2.9 Confidentiality:

A major concern for the students was the lack of confidentiality in the counselling offered by College Based Health Care Providers, to which the resultant underutilization of health services was attributed. Students preferred visiting Counsellors instead. However students raised concern about the irregular services which the visiting Counsellors provided.

2.10 Areas needing strengthening:

On areas that needed strengthening, students pointed out that for the majority of them there were no real strong role models at their colleges; they highlighted the need for learning materials (34%); participatory teaching methods (18.6%), improvement of attitudes by Lecturers and Health Service providers (18.3%) and provision of information on communicable diseases, provision of condoms and provision of food. Referrals to established health facilities was a cost that most students could not afford.

2.11 Student competency to teach the subject:

Being third year exit students, they would be deployed to schools and expected to impart the knowledge on Health and Lifeskills that they learnt at the Colleges, so they were asked to rate themselves regarding skills in teaching students about Health and Lifeskills. The majority (51.9%) stated that they had enough knowledge and experience to take up the task, while the others still needed more knowledge, skills and experience. All students get exposed to HIV and AIDS education during teaching practice. Approximately 89.9% of the students confirmed that they had the opportunity to teach about HIV and AIDS, Health and related Lifeskills activities during workshops, guidance and counseling sessions and awareness campaigns.

2.12 Monitoring of students on teaching practice:

Students expressed concern withinadequate monitoring and follow up of students on teaching practice by Health and Lifeskills Lecturers due to lack of transport and shortage of staff. Some students on teaching practice were not given the opportunity to teach health and life skills by their mentors in the schools where they did their teaching practice, even though the subject had time allotted on the syllabus.

2.13 NGO support to the colleges:

NGO support to the colleges was minimal or nonexistent in some colleges, as the NGOs had changed focus leaving the programme without adequate financial support and therefore marginalized. Lack of resources in the colleges forced some students to engage in negative social behavior like prostitution to get money for basic needs.

2.14 Forum for airing concerns:

Students bemoaned the lack of a voice and opportunity to discuss their concerns with college authorities for fear of victimization, e.g. regarding the private issue of interaction between boys and girls after school; this was not permitted especially in church related institutions. This led to students resorting to unorthodox means of fulfilling their sexual desires using unprotected means and the subsequent surge in sexually transmitted diseases. A testimony was given by a married student whose husband was also at the same college that they had no access of seeing each other until the school holidays because the college did not permit any such interaction. The students felt they lacked strong role models.

2.15Negative behavioural factors:

Negative behavioural factors by students were highlighted. These included promiscuity by some students for favours such as to pass examinations. Peer pressure led new students, who felt isolated, into smoking, drinking and taking drugs to have to have a sense of belonging. Pressure by female students in their last year of college, who were desperate to get married before they leave college, led them into having unprotected sex so that they fall pregnant as a way of security to get the responsible man to marry them. This led them into acquiring STIs, HIV and AIDS.

IV. DISCUSSION

Contrary to the constructivist perspective of involving learners to actively participate in the learning situation, students reported non participation in policy formulation and implementation of the policy provisions. The critical importance of involvement of the young people in Teacher Training Colleges in Health and Lifeskills hinges on the resultant two pronged benefit of attaining life skills information for their personal benefit as well as for their subsequent clientele (pupils in Primary and Secondary Schools and the community at large). Therefore importance of the preparation for this role cannot be overemphasized. It has to be comprehensive and of good quality ensuring accuracy in the information imparted. Good and appropriate communication skills are vital to the successful dissemination of the information to the pupils.

The competence level of the Life Skills Lecturers in managing the Health and Life skills programme in colleges is an important issue pointing to lack of awareness of the impact student involvement on the operationalization of the Health and Lifeskills policies and articulating the correct facts regarding the Health and Lifeskills programme. Congruency between the Health and Life Skills Lecturers and students' interests should be managed in all contexts and this could indeed be the initial phase in addressing Health and Lifeskills programme implementation challenges through student engagement to address the students' sexual reproductive health needs. Lifeskills Lecturers who fail to share the same vision with students result in management discord which results in the erosion of skills and talent through failure to invest in students' brilliant ideas for the benefit of the programme and students. In situations where the Health and Lifeskills Lecturers are passive, this charade can unfortunately continue until the students exit the colleges, without benefiting much on health and Lifeskills to go and impart the little they learnt, which may not be quality content, to students at Primary and Secondary School levels. Because of lack of confidence in the subject area the same attitude is then cascaded to lower levels, the school children. For some Health and Lifeskills Lecturers, the "what's in it for me?" attitude is prevalent and there is no evidence of intentions to control this negative attitude towards performance. The risk is that, if not controlled the contagion effect of this attitude will spread throughout the colleges at the students' expense and to the

detriment of the programme. This leaves Lifeskills Lecturers with no option but to pursue student engagement strategies in order to achieve superior performance results in addressing students' reproductive health concerns within the Health and Lifeskills programme.

V. Gaps identified

The following gaps were identified within teacher training colleges on preparing students for dissemination of correct information on sexual reproductive health:

V.4 Challenging policy environment – lack of access to policy guidelines for students within the colleges and undocumented practices implemented as policy in some Teacher Training Colleges.

V.5 Implementation by some colleges of policies that contradict provision of some aspects of reproductive health in TTC eg. lack of accessible condoms to students in colleges.

V.6 Policies that that are blind to reproductive health needs of students eg. sexual harassment, expulsion of students who are pregnant regardless of their marital status and gender based violence within the colleges.

V.7 Peer influence - drug and alcohol abuse, poverty leads to sexual intercourse for financial benefit. Students also engage in negative social behaviours to gain small favours eg. to pass, to get job opportunities and for recognition.

V.8 Inadequate information, education to equip students against the negative social behavior and attitudes on STI, HIV and AIDS

VI. Recommendations:

I.1 Role of the Government: Within the context of voice and accountability, Ministry of Higher and Tertiary Education and the Teacher Training Colleges to strengthen operationalization, implementation and monitoring of Health and Lifeskills Policies to ensure adequate and effective dissemination of the policy and guidelines among the college students. There is need for joint Ministry approach – Ministry of Health and Ministry of Higher and Tertiary Education and Ministry of Primary and Secondary Education approach to addressing Health and Lifeskills education issues affecting students in Teacher training colleges as this in turn cascades to their pupils in primary and secondary schools.

I.2 Voice for students:

There is need for a platform and safe spaces to strengthen the voice students to express their views and grievances without fear of victimization. This entails empowerment of students to demand for their sexual reproductive health rights and participating in positive initiatives that develop personal, social skills, promote well-being and reduce risky social behavior. There is need for the removal of barriers and improving direct access of students in fora that engage students with college decision makers to deliberate on issues affecting the rights of students. Students to be ultimately prepared for their future role as role models and advocates for behaviour change in the community.

I.3 Responsibilities of College Authorities: College authorities to design and ensure availability of the Health and Lifeskills Policy and training programmes, equip the students with skills to adequately protect themselves from diseases e.g. sexually transmitted infections and not only outsourcing this service to NGOs.

I.4 Role of the community: The community groups and Health promotion networks to incorporate young people from Institutions of Higher learning in their communities to participate on their boards in a bid to strengthen the voice of students. The community can strengthen the voice of the youth and duty bearers to be accountable for the health of young people. Ensuring provision and availability of good health is everyone's right and responsibility.

VII. Proposed areas for further research

I. How can students empowered to fight for their rights within their respective colleges without compromising their studies? Rights of young people are claims or entitlements that accrue by virtue of the fact that they are young people, there are human rights that are universal and cannot be taken away from anyone eg, right to health, safe and satisfying

sex and the right to equal treatment and right to bodily integrity.

II. What is the role of the community groups in the prevention of negative social behaviours among students, without undue interference to the smooth functioning of colleges, in view of the fact that colleges are autonomous.

VIII. CONCLUSION:

The study highlighted the gaps in the implementation of Health and Lifeskills Policy within the Teacher Training colleges. Dissemination of the Policy to students needs to be on a wider scale and operationalized to uphold the sexual and reproductive health rights of students in teacher training colleges and to spell out the responsibilities of College authorities so that students are aware of them. Students need smooth transition and protection by school authorities, from being cushioned in the comfort of home to the harsh realities of college life, by raising awareness of the negative influences that students are likely to meet and how to cope. Students also need to be responsible for their own health, their fellow students and the community's health. Colleges should provide safe places and privacy for students to interact. There is need for a platform and safe spaces for students to express their voices, views and grievances without fear of victimization.

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