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Draft Integrated Strategy
on HIV and AIDS
2012–2016



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LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
DBE	Department of Basic Education
DoE	Department of Education
DOH	Department of Health
DPSA	Department of Public Service and Administration
EAP	Employee Assistance Programme
EC	Eastern Cape
EFA	Education for All
ELRC	Education Labour Relations Council
FS	Free State
GET	General Education and Training
GP	Gauteng Province
HCT	HIV Counselling and Testing
HEDCOM	Heads of Education Departments Committee
HIV	Human Immunodeficiency Virus
HRC	Human Rights Commission
HSRC	Human Sciences Research Council
ILO	International Labour Organisation
KZN	KwaZulu-Natal
LO	Life Orientation
LP	Limpopo Province
MDG	Millennium Development Goals
M&E	Monitoring and Evaluation
MP	Mpumalanga Province
MRC	Medical Research Council
NACOSA	National AIDS Coordinating Committee of South Africa
NC	Northern Cape
NCS	National Curriculum Statement
NGOs	Non-Governmental Organisations
NSNP	National School Nutrition Programme
NSP	HIV and AIDS and STI National Strategic Plan 2007-2011
NW	North West
OVC	Orphans and Vulnerable Children
PLHIV	People Living with HIV
PMTCT	Prevention of mother to child transmission
SADC	Southern African Development Community
SANAC	South African National AIDS Council
SGBs	School Governing Bodies
STIs	Sexually Transmitted Infections
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
VCT	Voluntary HIV Counselling and Testing

NOTE ON TERMINOLOGY

There is often confusion regarding the terms HIV prevalence and HIV incidence. Both terms are central to understanding the HIV epidemic. As such, they are explained here as taken from the Joint United Nations Programme on HIV/AIDS (UNAIDS) publication, *Understanding HIV-1 incidence and prevalence in eastern and southern Africa*.¹

HIV prevalence

HIV prevalence is a measure of the proportion of people who are living with HIV in a given population at a particular point in time. Prevalence is typically measured in cross-sectional surveys. It is a useful measure for understanding the total burden of disease and for planning care and treatment needs.

HIV incidence

HIV incidence is the number of new HIV infections that occur in a given population over a given period of time. Incidence is usually expressed as a number or percentage of infections that occur in a given population over a given period of time. Knowing the current incidence of HIV in a population provides information on how fast the virus is spreading.

¹ UNAIDS. *Understanding HIV-1 incidence in eastern and southern Africa: a guidance note for policy makers, HIV programmers and HIV monitoring and evaluation practitioners*. Geneva: UNAIDS; 2009.

SECTION ONE
THE CONTEXT TO THE STRATEGY

1. PURPOSE OF THIS DOCUMENT

While there are some positive signs in South Africa's national response to HIV and AIDS, a turning point has not yet been reached where the country can safely say that it is rolling back the epidemic. Renewed commitments have been made by Government, civil society and the private sector to focus and intensify implementation of the *HIV and AIDS and STI National Strategic Plan (NSP) 2007-2011*.²

Within the Department of Basic Education (DBE) this integrated strategy is currently being developed in accordance with the NSP and with new thinking globally on rolling back HIV and AIDS. The strategy relies on the framework of the NSP with prevention, treatment, care and support and research/monitoring arms together with efforts to mainstream and strengthen a systemic response to HIV and AIDS. It will also define interventions beyond the Life Skills Programme to respond more comprehensively to the epidemic.

This substantially widened focus implies that this strategy, once adopted, will guide the national Department in consultation with provinces and constituencies, towards a new national policy. Policy, in turn, will be carefully thought through by provinces and implemented in such a manner as to integrate with other provincial priorities and plans.

Given this move towards new policy, the target audience for the final strategy will include senior management within the DBE, Heads of Education Departments Committee (HEDCOM) members, senior provincial managers, provincial HIV and AIDS coordinators, educator unions and student organisations, supporting Non-Governmental Organisations (NGOs), senior members at the South African National AIDS Council (SANAC), and selected experts from UNESCO and other international agencies.

The first draft of the DBE's thinking on a new strategy has been enhanced through consultation with senior management in the DBE, HEDCOM and provincial HIV and AIDS coordinators to produce the current version of the draft strategy (this document). It will be presented for wider consultation with relevant constituents in the sector. The final strategy will form the basis of a planning process involving provinces, districts and schools.

2. BACKGROUND

2.1 Introduction

South Africa's first official effort at responding to HIV and AIDS in the education sector was made in 1998 with the development of the *National Policy on HIV and AIDS for Learners and Educators in Public Schools and Students and Educators in Further Education and Training Institutions* and its gazetting in 1999. This was a mere four years after the transition to democracy and at the time this development was ground-breaking with South Africa being one of the first countries to adopt formal policy on HIV and AIDS in the education sector.

² South African National AIDS Council. HIV & AIDS and STI Strategic Plan for South Africa 2007 – 2011. Pretoria: South African National AIDS Council; 2007.

The primary intervention instituted by this policy has been the HIV and AIDS Life Skills Education Programme funded by National Treasury through a conditional grant. The focus of the Life Skills Programme has been on the prevention of HIV and AIDS among learners through knowledge and skills building, mainly through the Life Orientation (LO) Learning Area, and subsequently infused into other Learning Areas.

Ten years after this initial development, the nation is in a state of crisis regarding HIV and AIDS and in response government and SANAC have unveiled dramatic and far-reaching programmes. National accelerated action is sought from all sectors and the new DBE has embarked on a process to develop and adopt a comprehensive approach to realising the HIV and AIDS national strategic plan in schools, through the development of a new integrated strategy on HIV and AIDS.

2.2 Eight imperatives for a new HIV and AIDS strategy in basic education

There are eight key imperatives that underpin the need for a revised and integrated strategy within basic education:

- Imperative one : HIV and AIDS as a developmental challenge
- Imperative two : The impact of HIV on the education sector and educational outcomes
- Imperative three : Lessons from available evidence on effective responses
- Imperative four : Schooling as a protective factor – the role of prevention
- Imperative five : A duty of care in schooling
- Imperative six : Alignment with the NSP
- Imperative seven : Alignment with Government’s outcomes focus
- Imperative eight : A sustainable, integrated response

Imperative one: HIV and AIDS as a developmental challenge

Two of the key markers of the state of development in a country are life expectancy at birth and the under five mortality rate. In a period of rapid development post-apartheid, South Africa has regressed on these key indicators. In 1998 the life expectancy for men and women in South Africa was 59 years and 68 years respectively. By 2008 this had dropped to 52 and 55 years³ respectively. Similarly, in 1990 the under-five mortality rate was 56 deaths per 1000 live births.⁴ By 2000, the figure had risen to 73 deaths per 1000 live births. This was followed by a very slow decline to 67 deaths per 1000 live births in 2008. There is little dissent that HIV and AIDS has played a significant role in this regression in human development terms. In fact, more than 40

³ World Health Organisation. World health statistics. Geneva: World Health Organisation; 2010.

⁴ Kibel M, Lake L, Pendlebury S, Smith C (eds). South African child gauge 2009/2010. Executive summary. Cape Town: Children’s Institute, University of Cape Town; 2010.

countries with adult HIV prevalence above 4% have regressed on child mortality gains achieved in the 1980s.⁵

South Africa has signed up to and is a global supporter of the Millennium Development Goals (MDGs). There is now global recognition that the AIDS epidemic “continues to pose serious challenges, undermining broad progress in development and in poverty reduction, threatening basic human rights and seriously affecting the prospects of attaining the MDGs and the Education for All (EFA) goals.”⁶ Given the long duration of the epidemic and that individual-focused, biomedical interventions had limited impact on the epidemic, sustainable, population-level plans are required that involve every sector of society.

The United Nations General Assembly⁷ also recognises that interventions to address HIV, given its strong social and structural underpinning, are inextricably linked to the development agenda. For example, while interventions to address HIV will make a direct contribution to MDG 6, *To reduce the burden of HIV*, instituting a comprehensive package of HIV-related interventions will have positive impacts on many of the other goals. Conversely, failure to prevent and mitigate the impact of HIV and AIDS will compromise the ability of countries to achieve the MDGs.

The link between the achievement of the MDGs and HIV interventions are outlined below:⁸

- Goal 1 – to eradicate extreme poverty and hunger (addressing structural drivers of the HIV epidemic such as inequality, unemployment and poverty will reduce risk for HIV);
- Goal 2 – access to universal primary education (instituting care and support programmes for orphans and other children made vulnerable by HIV such as school feeding and no fee schools will improve enrolment and retention);
- Goal 3 – empowerment of women and promotion of gender equality (unequal gender power relations are considered one of the fundamental factors promoting the feminisation of the epidemic; hence changing social norms on gender equality and equity will lower the risk of infection amongst women);
- Goal 4 – reduction of child mortality (expansion of access to prevention of mother-to-child transmission and paediatric HIV treatment will have a positive impact on infant and child mortality rates); and
- Goal 8 – innovation and global partnerships (given the scale of the HIV epidemic, a number of sectors of the global community including governments, civil society and development partners have come together to mount a unified and large scale response to HIV).

⁵ UNICEF Innocenti Research Centre. AIDS, public policy and child well-being. Italy: UNICEF Innocenti Research Centre; 2007.

⁶ UNAIDS. A strategic approach: HIV & AIDS and education. Geneva: UNAIDS, May 2009.

⁷ United Nations. High-level meeting on the comprehensive review of the progress achieved in realising the declaration of commitment on HIV/AIDS and the political declaration on HIV/AIDS. New York: United Nations, General Assembly; June 2008.

⁸ *ibid.*

Education, as one of the fundamental and critical levers for overall development, must institute a comprehensive response to HIV and AIDS. Unless HIV is addressed in a fundamental way in planning and implementing an accelerated approach to achieving quality education, it has the potential to undermine all our efforts with significant consequences for schooling, and the country.

Imperative two: The impact of HIV on the education sector and educational outcomes

The DBE has recently crafted a new sector plan to improve basic education entitled *Schooling 2025*.⁹ The plan has two broad strategic areas: The improvement of learning outcomes and improved access to education. The plan recognises the centrality of teacher and learner well-being to the achievement of educational outcomes.

In the 1980s and the 1990s, gross enrolment rates in 22 of 41 sub-Saharan African countries for which data is available, either declined or stagnated.¹⁰ The greatest declines were observed in countries with high HIV prevalence rates. While at the aggregate level, the effect of HIV on education is hard to disentangle from other factors such as poverty, rising unemployment etc, at the individual level, the link between HIV and enrolment is much more distinct. Three examples cited below demonstrate the relationship between HIV and AIDS and educational outcomes:

- Many children in South Africa live in poverty, but the arrival of HIV and AIDS in the family creates an even greater financial burden. The financial burden of HIV and AIDS related illnesses or death on households is an estimated 30% greater than the burden created by deaths from other causes.¹¹ The increase in poverty makes the payment of school and related fees increasingly difficult and is a significant cause of lower enrolments and retention of children affected by HIV and AIDS.¹²
- Children affected by HIV and AIDS experience high levels of grief and trauma as a result of the (often multiple) illnesses and deaths in the family. The cumulative effect of loss, grief and trauma is expressed in declining school enrolments, delayed enrolments, erratic attendance, poor attention and performance, and higher drop-out rates.¹³
- Children infected with HIV and AIDS or children whose family members are infected experience discrimination and stigma which takes various forms, including emotional, verbal and physical abuse as well as social exclusion and isolation.¹⁴ *The National Policy on*

⁹ Department of Basic Education. Towards a Basic Education Sector Plan (working document). Pretoria: Department of Education; 2010.

¹⁰ UNICEF Innocenti Research Centre. AIDS, public policy and child well-being. Italy: UNICEF Innocenti Research Centre; 2007.

¹¹ Coombe C. Mitigating the impact of HIV/AIDS on education supply, demand and quality. In Cornia GA, editor. AIDS, public policy and child well-being. Italy: UNICEF; 2002.

¹² UNAIDS Inter Agency Task Team on Education. HIV and AIDS and education: the role of education in the protection, care and support of orphans and vulnerable children living in a world with HIV and AIDS. UNICEF.

¹³ Coombe C. HIV/AIDS, poverty and education: The circle of hope and despair. Pretoria: Faculty of Education, University of Pretoria; 2003.

¹⁴ Strode A, Barrett Grant K. The role of stigma and discrimination in increasing vulnerability of children and youth infected with and affected by HIV/AIDS- research report. Arcadia: Save the Children UK and South Africa; 2001.

*HIV and AIDS for Learners and Educators in Public Schools*¹⁵ recognises the harmful impact of this on enrolment, continued attendance and performance.

While the examples cited above demonstrate some of the immediate and short-term impacts of HIV and AIDS on educational outcomes, the true and full impact of HIV and AIDS on the education system may never be precisely measured and attributed, and will probably not be felt for many years to come. HIV and AIDS has a long-term impact in which the first wave of infection is followed over time by the second wave of death and third wave of impacts. For example, HIV infection peaked in Uganda in 1989, but the number of AIDS orphans peaked 14 years later in 2003.¹⁶ Similarly, in South Africa, where HIV infection may not have peaked, the number of orphans may well continue to rise until 2020. This will pose a new challenge to the education system, having to confront a whole generation of educationally disenfranchised children that the system has previously not been able to integrate optimally.¹⁷ So while dire predictions of national collapse, rising levels of crime and economic stagnation may not come to pass, the impact will be differentiated and borne most profoundly by the poorest and most vulnerable sectors of society.¹⁸

The sector and the Department shall not wait for these impacts before they act decisively, this being in line with Government's commitment to act now and to act forcefully to avoid negative futures. Ill health, absenteeism or any other increased stress or vulnerability on the part of school-age children and youth, educators, school support staff and officials constitutes a threat to the attainment of teaching and learning education outcomes, as defined by Government and the Minister of Basic Education.

Imperative three: Lessons from available evidence on effective responses

Globally and regionally we have learned a great deal about what works and what does not work in responding to HIV and AIDS. With regard to prevention, UNAIDS and its partners acknowledge that traditional prevention efforts placed the individual at the heart of the response and failed to acknowledge the societal factors that must be in place in order to facilitate individual behaviour change. In addition, there is widespread acknowledgement that knowledge by itself does not lead to behaviour change. This latter learning has enormous implications for school responses that have traditionally relied exclusively on knowledge of HIV and AIDS transmitted only via the curriculum as taught in the classrooms.

In fact a recent Lancet series advocates three important targets for HIV prevention:¹⁹

¹⁵ Department of Education. National policy on HIV/AIDs for learners and educators in public schools, and students and educators for further education and training institutions. Pretoria: Department of Education; 1999.

¹⁶ Whiteside A. HIV/AIDS. A very short introduction. Oxford: Oxford University Press; 2008.

¹⁷ UNICEF Innocenti Research Centre. AIDS, public policy and child well-being. Italy: UNICEF Innocenti Research Centre; 2007.

¹⁸ Whiteside A. HIV/AIDS. A very short introduction. Oxford: Oxford University Press; 2008.

¹⁹ Coates TJ, Richter L, Caceres C. Behavioural strategies to reduce HIV transmission: How to make them work better. The Lancet, 2008 Aug; 372(9639): 669-684.

(1) **Comprehensive prevention** - countries that have experienced downturns in HIV incidence have combined multiple risk reduction strategies with strong political leadership and active community engagement.

(2) **Combination prevention** - the strengths of biomedical interventions must be combined with access to treatment, behaviour change strategies and structural approaches to change social and economic conditions that predispose people to engage in unsafe behaviour.

(3) Countries with generalised epidemics like South Africa require **large-scale interventions** that can produce generational shifts in behaviour amongst new and emerging categories of risk groups.

In terms of **support**, increasing evidence from a range of sources²⁰ suggests that, as in prevention, structural factors have been under-emphasised. Societal norms and aspects of culture have exacerbated stigma and discrimination and programmes need to make significant inroads into addressing these issues.

Gender inequity and the substantially higher prevalence rates amongst girls and young women are now clearly documented in national surveys undertaken in the past years. Human Science Research Council (HSRC) surveys conducted in 2002,²¹ 2005,²² and 2008²³ indicate that females between 15 and 39 years of age continue to have a higher HIV prevalence than males. Several points are relevant to basic education. Firstly, amongst the age group representing in-school youth most likely to be sexually active (15 - 19 years old), girls and young women have almost three times the prevalence of boys and young men (of similar age). In the age group just out of school not only does prevalence increase overall, but for girls and young women it escalates to over 21%. This suggests among other possibilities that prevention programming is failing to provide sustainable resilience needed by these young people, especially young women, to cope with sexual decision-making after they leave school. Hence targeted interventions are required for young women.

Also of concern for basic education is the **high prevalence rates for adults aged 25 - 39** who make up the majority of the teaching cadre. Of these, the highest rates are for those aged 25 - 29 which would reflect young teachers just entering careers in teaching. The implications for human resource management and for mitigation and care in the Department are significant.

A lesson only slowly being acknowledged is the need for **focused use of resources** according to detailed knowledge of the epidemic. For the DBE, while programmes require universal

²⁰ Inter alia the Cape Area Panel Study managed by UCT; The carer-child wellbeing project of the Department of Social Development and partners; and the mid-term review of the NSP.

²¹ Shisana O, Simbayi L, editors. Nelson Mandela HSRC study of HIV/AIDS: full report. South African national HIV prevalence, behavioural risks and mass media. Household survey 2002. Pretoria: Human Sciences research Council, 2002.

²² Shisana O, Rehle T, Simbayi L, Parker W, Zuma K, Bhana A et al. South African national HIV prevalence, HIV incidence, behaviour and communication survey, 2005. Cape Town: Human Sciences Research Council, 2005.

²³ Shisana O, Rehle T, Simbayi LC, Zuma K, Jooste S, Pillay-van-Wyk V et al. South African national HIV prevalence, incidence, behaviour and communication survey, 2008: A turning tide among teenagers? Pretoria: Human Sciences Research Council; 2008.

implementation in the school setting, they will also need to adopt **targeted approaches** such as focusing on most at risk groups and particular geographic areas in which risk is concentrated.

Imperative four: Schooling as a protective factor – the role of prevention

Despite global progress in responding to HIV, such progress has been uneven and the expansion in the epidemic is far outstripping the pace at which services can be taken to scale. In 2007, it was estimated that for every new cohort of a million people receiving antiretroviral treatment, 2.5 million people were newly infected.²⁴ There is now consensus that countries will not be able to treat their way out of the epidemic. **Prevention represents the turn-around strategy for the HIV epidemic.** The Mid-Term Review of the NSP conducted in 2009 recommended the critical need for the country to strengthen prevention.

In this regard, young people account for 45% of all new HIV infections globally, with almost 90% of this number occurring in sub-Saharan Africa.²⁵ While youth are considered the drivers of the epidemic, they also represent the most viable opportunity to halt the spread of AIDS and to prevent new infections. Countries that have reported down-turns in the HIV epidemic have attributed this to behaviour change among young people. In fact, the first declines in HIV incidence in South Africa have been reported among young people aged 15 - 19 years.²⁶ Given the focus on young people, the education sector in South Africa has therefore been assigned a lead role on prevention in the NSP.

The past 10 years have increasingly made clear the centrality of education provision in combating the impact of HIV and AIDS. If schools are able to increase attendance by learners and to retain learners in the system, then, provided that the schools themselves are maintained as safe environments, **schools are protective against negative reproductive health outcomes** such as teenage pregnancy and HIV and AIDS.

UNAIDS in A Strategic Approach: HIV & AIDS and Education²⁷ lays this out as follows:

“We now have evidence of the important role that education plays in offering protection against HIV. School-going children and young people are less likely to become infected than those who do not attend school, even if HIV and AIDS are not included in the curriculum. Education reduces the vulnerability of girls, and each year of schooling offers greater protective benefits. Where offered, well-planned and well-implemented education on life skills or sex and HIV has increased knowledge, developed skills, generated positive attitudes and reduced or modified sexual behaviour. The first line of the response should therefore be to provide more and

²⁴ United Nations. High-level meeting on the comprehensive review of the progress achieved in realising the declaration of commitment on HIV/AIDS and the political declaration on HIV/AIDS. New York: United Nations, General Assembly; June 2008.

²⁵ UNAIDS. 2008 Report on the global AIDS epidemic. Geneva: UNAIDS; 2008.

²⁶ Shisana O, Rehle T, Simbayi LC, Zuma K, Jooste S, Pillay-van-Wyk V et al. South African national HIV prevalence, incidence, behaviour and communication survey, 2008: A turning tide among teenagers? Pretoria: Human Sciences Research Council; 2008.

²⁷ UNAIDS. A strategic approach: HIV & AIDS and education. Geneva: UNAIDS, May 2009.

better schooling. A second and complementary line of response can then be to introduce specifications tailored to the epidemic, such as providing HIV and sexuality education. In highly-affected settings, educating parents and learners about HIV treatment, care and support should also be prioritised.”

UNAIDS has recognised that education has the following impacts on HIV and AIDS:

- Access to quality education protects against HIV;
- Education can reach large numbers of children and young people;
- Education reduces the vulnerability of girls;
- Education can reach those who are not in school;
- HIV and AIDS education impacts on HIV-related knowledge, skills and behaviour;
- The higher the level of education, the greater the protection against HIV infection;
- Education can reduce stigma and discrimination; and
- Education provides a cost-effective means of HIV prevention.

The proviso made at the beginning of this section is that schools are only a protective factor with regard to HIV and AIDS if they are safe spaces for all youths and adults, who work and learn within them. But the scope of school safety must be expanded beyond infrastructure concerns such as fencing and gates to include psychological safety. So how might a safe school be defined?

“A safe school may be defined as one that is free of danger and where there is an absence of possible harm; a place in which non-educators, educators and learners may work, teach and learn without fear of ridicule, intimidation, harassment, humiliation, or violence. A safe school is therefore a healthy school in that it is physically and psychologically safe. Indicators of safe schools include the presence of certain physical features such as secure walls, fencing and gates; buildings that are in a good state of repair; and well-maintained school grounds. Safe schools are further characterised by good discipline, a culture conducive to teaching and learning, professional educator conduct, good governance and management practices, and an absence (or low level) of crime and violence.”²⁸

Imperative five: A duty of care in schooling

The entire country has a duty of care towards its children, and at a time of recognised crisis that duty becomes more focused. While the DBE has a primary responsibility for educating young minds, with a strong focus over the coming years on improving the quality and outcomes of that education, it also has a duty to protect children and youth in its system and to prepare them for their role as citizens of the future.

²⁸ Squelch J. Do school governing bodies have a duty to create safe schools? *Perspectives in Education*. 2001; 19:137-149

This duty of care, especially to orphans and vulnerable children (OVC), is well entrenched in a number of international and regional frameworks (such as the Convention on the Rights of the Child) to which South Africa is a signatory. These frameworks also stipulate that the duty of care must be fulfilled in a holistic manner through a comprehensive and integrated package of services, care and support.

Prevailing over all government action and policies is the Constitution of the Republic of South Africa and its Bill of Rights, which delineate a host of rights specifically for children, including the right to education - the guarantee of which is unhindered by any reference to 'progressive realisation'. But the right to education is dependent on the prior fulfilment of a number of other rights, the attainment of which is dependent on prevailing circumstances such as poverty, HIV and AIDS and other such factors. In terms of the role of the DBE in the realisation of these rights, there are a number of frameworks and policies that call for schools to become centres through which care and support is facilitated. The list of obligations imposed on DBE by its own and other government policies is extensive.

South Africa, in accordance with Southern African Development Community (SADC), has committed to providing care and support for teaching and learning. This commitment emanates from the strong policy mandate and the wide recognition that education systems have several comparative advantages over other services when it comes to the care and support of children. In addition, there are a number of factors that make schools a strategic place for children to access a range of services:²⁹

- Schools are relatively accessible and they often provide a physical infrastructure in communities where other crucial infrastructure is absent. The education system has an existing infrastructure of around 28 000 schools (25 850 public schools in 2010).³⁰ The space and grounds at schools have the potential for expanded use.
- Schools represent an existing network of many components, including school staff, learners, their caregivers, school governing bodies (SGBs) and the broader school community. Each component is a potentially valuable resource for care and support.
- The way schools are currently clustered creates opportunities for further collaboration and provides educators and middle management with more support.
- The school environment is an inclusive environment, which focuses on children and is committed to children's development. The education system reaches approximately 11 809 355 children (12 260 099 in all schools in 2010),³¹ including those most affected and most at risk of HIV infection. Children spend a large amount of their time at school over many years. It is also an environment where all kinds of vulnerabilities are exposed and it therefore has the potential to work against stigma associated with HIV and AIDS. If children feel supported within the school, they will come to school and they will remain within the school.

²⁹ Giese S, Meintjes H, Monson J. Schools as nodes of care and support for children affected by HIV, AIDS and poverty. Cape Town: Children's Institute, UCT; 2005.

³⁰ Department of Education. 2010 School realities report. Pretoria: Department of Education; 2010.

³¹ *ibid.*

- The school can also reach the younger and most vulnerable age group through school-going children and their families, for example, through child-to-child programmes.
- Educators see children every day for five days of the week and are therefore ideally placed to track their well-being, to recognise change in children's lives, and to identify vulnerable children.
- In communities with inadequate service provision, schools take on an ever-increasing burden of support.

Imperative six: Alignment with the NSP

The education sector response to HIV and AIDS has historically not been sufficiently aligned to the national framework on HIV and AIDS – namely, *The HIV and AIDS and STI National Strategic Plan for South Africa 2007-2011*.³² Despite the fact that the DBE is recognised as a lead Department on a number of interventions, non-alignment to the strategy has significantly hampered the Department from fulfilling this national mandate and being able to report to SANAC on key indicators.

The NSP highlights the increased vulnerability of certain groups in South Africa to HIV infection. Two of these groups that are at an increased risk of HIV infection are adolescents and young adults between the ages of 15 and 24 years and children between the ages of 0 and 14 years. The heightened vulnerability of these age groups to HIV infection underscores the important role of the education sector in the fight against HIV and AIDS.

In particular, the DoE has been identified as a lead agency in implementing a number of interventions crucial to the achievement of the goals of the NSP. The Department has a central role in helping achieve the goals associated with (1) HIV prevention, (2) treatment, care and support, and to some extent (3) human rights and access to justice. Many of the objectives and interventions outlined by the NSP for the Department of (Basic) Education to undertake are consistent with empirical evidence and literature regarding the individual and structural drivers of HIV infection in youth.

In terms of augmenting HIV prevention efforts, the NSP assigns responsibility to the DoE for developing and implementing strategies to address gender-based violence that can effectively address cultural norms and attitudes that promote gender-power stereotypes and condone coercive sexual practices. Furthermore, the NSP recommends the Department undertakes efforts that will reduce infection in young people with a special focus on young women that centres upon policies and legislation to keep youth in school, strengthening school-based life skills programmes and enhancing teacher training and ability to deliver quality life skills programmes to youth.

The NSP also assigns responsibility to the Department for developing and implementing targeted HIV prevention activities that will reach high risk out-of-school youth as well as

³² South African National AIDS Council. HIV & AIDS and STI Strategic Plan for South Africa 2007-2011. Pretoria: South African National AIDS Council; 2007.

developing guidelines for schools to become places of care and safety for children and young people. Other prevention efforts relevant to schools, according to the NSP guidelines, include encouraging pregnant teenagers to take HIV tests and establishing close referral links to facilitate access of HIV positive pregnant youth into Prevention of mother to child transmission (PMTCT) programmes.

The education system also plays a significant role in achieving the objectives within the second pillar of the NSP, *Treatment, Care and Support*. Accordingly, the education systems needs to increase care and support for OVC through strengthening the implementation of OVC policy and programmes. Not only will such efforts serve to augment the care and support OVC receive, but such efforts may also succeed in reducing their vulnerability to HIV infection.

In terms of priority area four of the NSP, *Human Rights and Access to Justice*, the DBE will ensure adherence to existing legislation and policy relating to HIV and AIDS in the education system. In order to achieve this, the Department is required to develop and distribute national guidelines on the rights of children in schools to access information, prevention, treatment, care and support. However, in order to facilitate access to useful HIV and AIDS information and services, the education system must attempt to forge effective referral networks and relationships that can assist youth in accessing prevention, treatment, care and support services.

Imperative seven: Alignment with Government's outcomes focus

South Africa is in the process of developing a 'South Africa Vision 2025' development plan and along with this a change in Government thinking from inputs and bureaucracy to outcomes for the nation. This is also articulated in the new sector plan for education, *Schooling 2025*.³³

This strategy aligns itself with this new Government emphasis by focusing on four key outcomes that will fundamentally alter the relationship between schooling in South Africa and the country's response to HIV and AIDS. These outcomes are closely aligned with best international thinking and emerging recommendations of global agencies. It then recommends key outputs that will achieve these outcomes.

Clearly, an outcomes focus requires that outcomes are measured. Thus monitoring and evaluating the strategy and the operational plans that will follow are key to ever-increasing success.

Imperative eight: A sustainable, integrated response

The HIV epidemic has run a long course of 25 years and it is likely to persist for several decades into the future. Until recently, the epidemic in most countries has been managed as an emergency.³⁴ Given its duration and that increasingly HIV and AIDS is being considered a chronic

³³ Department of Basic Education. Towards a Basic Education Sector Plan (working document). Pretoria: Department of Education; 2010.

³⁴ United Nations. High-level meeting on the comprehensive review of the progress achieved in realising the declaration of commitment on HIV/AIDS and the political declaration on HIV/AIDS. New York: United Nations, General Assembly; June 2008.

disease much like diabetes and cardiovascular disease, sustainable, long-term, population-level plans are required to curtail its spread as well as its intergenerational impact. This requires strong and durable leadership, planning, implementation, financing and human resources for HIV and AIDS.

To garner such a sustained response to HIV and AIDS within the education system, mainstreaming of an integrated and comprehensive response to the epidemic is required. First, this demands interventions for all role players within the education system – learners, educators, officials and support staff - who are both infected and affected by HIV and AIDS. Second, strategies must be developed at both prevention and at treatment, care and support levels, in line with the public health approach adopted by the NSP. And third, interventions must be mainstreamed across the education system. Although mainstreaming of HIV and AIDS is currently recognised as a goal, practical implementation at national and provincial levels has been very limited.

2.3 The development of the new Department of Basic Education HIV and AIDS integrated strategy

During 2009 the DoE took a strategic decision to move the HIV and AIDS Life Skills Education Programme from the General Education and Training Branch (GET Curriculum and Assessment Chief Directorate) to the Social and School Enrichment Branch (Health in Education Chief Directorate). The decision was based on the desire to strengthen the integration and alignment of the programme with the HIV and health-related programmes in the Department. This was in recognition of the fact that over the years the Life Skills Programme had increasingly shifted to incorporate activities beyond curriculum concerns, including care and support-related activities, partly in response to the realities on the ground in schools and in education districts.

The Department also began to align its work, including the life skills conditional grant framework, to the NSP. This facilitated improved focus and reporting against the NSP targets, enabling the Department to conform to one of the requirements set by SANAC. The pillars of this new integrated and comprehensive approach to HIV were presented to HEDCOM in December 2009 and accepted.

In 2009 the Chief Directorate, Health in Education, began to conduct background research and develop a well-reasoned proposal based on the new approach. They took account of the 2006 evaluation of the HIV and AIDS Life Skills Education Programme, and the gap between current programmes (informed by the conditional grant framework and provincial business plans and reports), and available evidence of 'ideal' education sector HIV programmes (from research and international responses). It was also recognised that many developments had taken place since the promulgation of the initial policy on HIV and AIDS in 1999, and that it would be important to take stock of these developments in reviewing the strategy. The Department also recognised the new and more urgent mandate that came with the adoption of the NSP 2007-2011, and took note of the issues emerging from the mid-term review of the NSP. In addition, the heightened urgency in the response to HIV and AIDS by the new administration that came into office in 2009 also needed to be reflected.

Accordingly, the DBE decided to embark on a process aimed at developing a new integrated strategy on HIV and AIDS for the education system. It was also decided that the work already undertaken in the process of developing the Conditional Grant Proposal would be taken into account in developing a new strategy. In 2010 work began on developing a draft strategy document as a basis for further consultation. Following a series of interviews and discussions with key staff members in the DBE, and on the basis of a detailed review of documentation submitted as part of this process, a new draft strategy document was produced. This strategy document is intended to build on the HEDCOM decision and present clear direction on the way forward for all role-players in the school system.

3. SITUATION ANALYSIS

The situation analysis below is presented in three parts. The first section presents a brief overview of the situation regarding HIV and AIDS in South Africa generally; the second section focuses on the situation specifically among youth in South Africa – the section of society corresponding most closely to the school-going population; and the third looks briefly at the situation specifically in schools.

3.1 HIV and AIDS in South Africa

It is estimated that 33 million people were living with HIV globally in 2007, with 67% of this total from sub-Saharan Africa. Within sub-Saharan Africa, South Africa now faces a hyper-endemic HIV epidemic with more than 15% of the population between the ages of 15 and 49 living with HIV.³⁵ The 2008 South African National HIV survey found a HIV prevalence rate of 10.6% within the general population, equating to approximately 5.2 million South Africans who are HIV positive.³⁶ Although the HIV prevalence amongst South Africans above the age of two years has remained relatively stable at around 11% since 2002, there are significant differences in the prevalence rate by age group and by gender (Figure 1) as well as geographically and between race groups.

Gender and age

HSRC surveys conducted in 2002,³⁷ 2005³⁸ and 2008³⁹ indicate that females continue to have a higher HIV prevalence than males. In 2008, the HIV prevalence within the female population was substantially higher than males. From the figure below several points are relevant to basic education. Firstly, amongst the age group representing in-school youth most likely to be sexually

³⁵ UNAIDS. 2008 Report on the global AIDS epidemic. Geneva: UNAIDS; 2008.

³⁶ Shisana O, Rehle T, Simbayi LC, Zuma K, Jooste S, Pillay-van-Wyk V et al. South African national HIV prevalence, incidence, behaviour and communication survey, 2008: A turning tide among teenagers? Pretoria: Human Sciences Research Council; 2008.

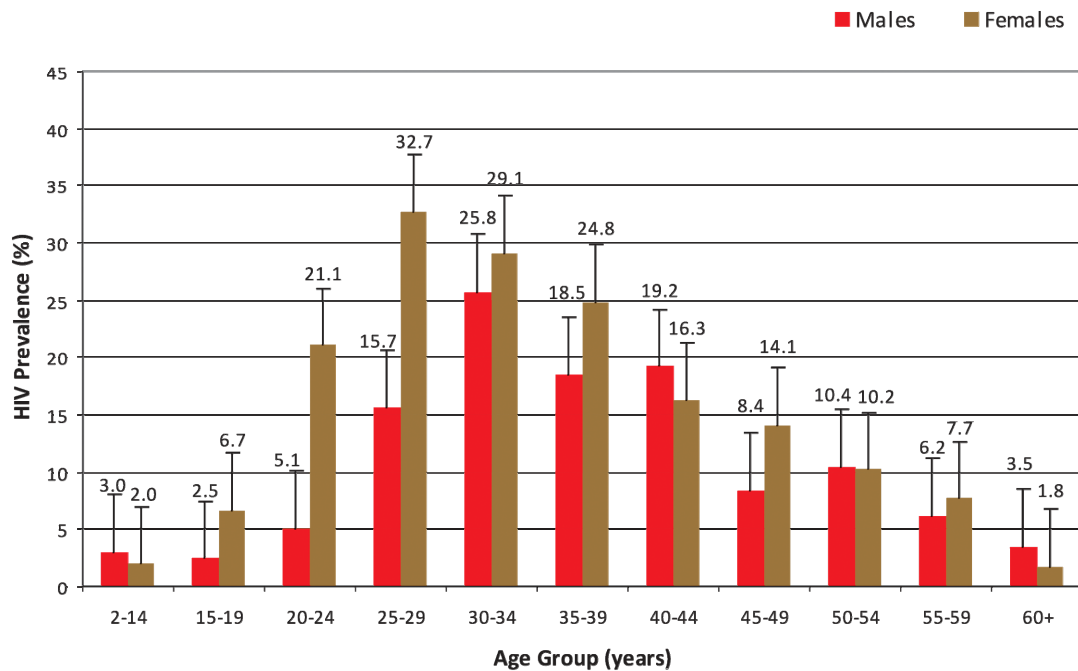
³⁷ Shisana O, Simbayi L, editors. Nelson Mandela HSRC study of HIV/AIDS: full report. South African national HIV prevalence, behavioural risks and mass media. Household survey 2002. Pretoria: Human Sciences research Council, 2002.

³⁸ Shisana O, Rehle T, Simbayi L, Parker W, Zuma K, Bhana A et al. South African national HIV prevalence, HIV incidence, behaviour and communication survey, 2005. Cape Town: Human Sciences Research Council, 2005.

³⁹ Shisana O, Rehle T, Simbayi LC, Zuma K, Jooste S, Pillay-van-Wyk V et al. South African national HIV prevalence, incidence, behaviour and communication survey, 2008: A turning tide among teenagers? Pretoria: Human Sciences Research Council; 2008.

active (15 - 19), girls and young women have almost three times the prevalence of boys and young men. In the age group just out of school not only does prevalence increase overall but for girls and young women it escalates to over 21%. This suggests, among other possibilities, that prevention programming is failing to provide sustainable resilience needed by these young people to cope with sexual decision-making during and after they leave school.

Figure 1: HIV prevalence by gender and age, South Africa, 2008⁴⁰



Also of concern for basic education is the **high prevalence rates for adults aged 25 - 39** who make up the majority of the teaching cadre. Of these, the highest rates are for those aged 25 - 29 which would reflect young teachers just entering careers in teaching. The implications for HR and for mitigation and care in the Department are significant.

Provincial variations

There is substantial provincial variation in the prevalence of HIV. Figure 2 shows the percentage of the population two years and older who are infected with HIV per province. KwaZulu-Natal and Mpumalanga have the highest rates of infection with 15.8% and 15.4% of the population respectively being infected. The Northern Cape and Western Cape have the lowest prevalence with 5.9% and 3.8% of the population respectively HIV positive.⁴¹ Even within provincial boundaries there is substantial variation in the prevalence rate between districts. Currently the

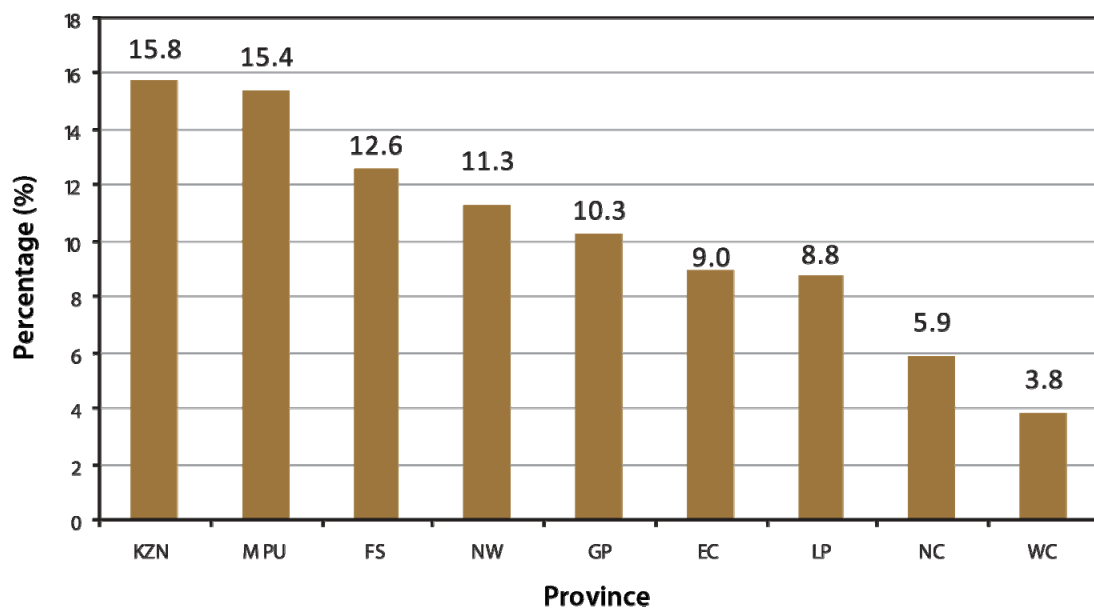
⁴⁰ Shisana O, Rehle T, Simbayi LC, Zuma K, Jooste S, Pillay-van-Wyk V et al. South African national HIV prevalence, incidence, behaviour and communication survey, 2008: A turning tide among teenagers? Pretoria: Human Sciences Research Council; 2008.

⁴¹ *ibid.*

districts of Ethekewini, Ugu and Umgungundlovu in southern KwaZulu-Natal and the district of Gert Sibande in southern Mpumalanga have prevalence rates of over 40%.⁴²

There is also circumstantial evidence currently being followed up in South Africa's *Know Your Epidemic* research that urban areas have significantly higher prevalence rates than many rural areas and that five of South Africa's cities⁴³ may contain over 50% of the country's epidemic.

Figure 2. HIV prevalence amongst people aged two years and older by province, 2008⁴⁴



Orphans

Although the impact of the HIV epidemic has resulted in an increase in the number of orphans, it is but one cause of orphanhood in South Africa. In 2007 the number of children of compulsory school-going age (7 to 15) who were maternal, paternal or two-parent orphans was 342 000, 1 476 247 and 484 500 respectively.⁴⁵ Orphans are also more likely to be out of school with 7.6% of two-parent orphans being out of school. This is in comparison to the national average of 4.6% of 7-15 year olds being out of school.⁴⁶ This remains an issue of some debate in social development circles for two reasons. Firstly, orphans, where they do require special attention and programming in terms of pro-poor and vulnerability mitigation services, cannot and should

⁴² South African National AIDS Council. HIV and AIDS: Business as usual? Pretoria: South African National AIDS Council; 2008.

⁴³ Durban, Cape Town, Johannesburg, Pretoria and Port Elizabeth, unpublished research emerging from UNAIDS Regional Support Team for eastern and southern Africa, HEARD and MRC.

⁴⁴ Shisana O, Rehle T, Simbayi LC, Zuma K, Jooste S, Pillay-van-Wyk V et al. South African national HIV prevalence, incidence, behaviour and communication survey, 2008: A turning tide among teenagers? Pretoria: Human Sciences Research Council; 2008.

⁴⁵ Statistics South Africa. Statistics South Africa Community Survey, 2007. Pretoria: Statistics South Africa; 2007.

⁴⁶ *ibid.*

not be distinguished by the 'status' of orphanhood.⁴⁷ Secondly, there is some controversy as to the extent and nature of increased vulnerability of orphans versus other children made vulnerable by a range of circumstances, most notably poverty. Programming here should take care not to exceptionalise HIV and AIDS as a factor separate from other factors.

3.2 HIV and AIDS amongst children and youth in South Africa

Globally, over 40% of all new infections in 2007 occurred among young people between 15 and 24 years of age, with 65% of these infections occurring in Africa. Young people are particularly vulnerable to HIV infection and the impact of HIV and AIDS. Thus, reducing their risk to HIV infection and introducing measures to alleviate the impacts of HIV and AIDS in their lives will be instrumental to determining the future course of the HIV epidemic in sub-Saharan Africa.

HIV prevalence by age, gender and province

A national survey conducted in 2008 by the HSRC⁴⁸ demonstrated that the HIV prevalence among children (2 - 14 years) had steadily declined from 5.6% in 2002 to 3.3% in 2005 and to 2.5% in 2008. A drop in HIV prevalence amongst youth (15 - 24 years) was also recorded between 2005 (10.3%) and 2008 (8.7%). HIV prevalence figures indicate that the proportion of young people infected with HIV increases significantly between childhood (2 - 14 years) and youth (15 - 24 years), suggesting that as children progress from childhood to youth their vulnerability to HIV infection increases substantially. This also indicates that late childhood and early youth years (15 - 17 years) are a particularly important period for prevention interventions that are aimed at reducing risk of HIV infection.

In 2008 the prevalence of HIV was slightly higher amongst male children (3%) than female children (2%) (2 - 14 years). The difference in HIV prevalence between male and female children increases as they move into late adolescence and young adulthood. In 2008, for instance, 6.7% of females between 15 and 19 years were HIV positive compared to 2.5% of males, while 21.1% of females between 20 and 24 years were HIV positive compared with 5.1% of males.⁴⁹

The Free State (4.1%), Mpumalanga (3.8%), and North West (3.2%) provinces had the highest HIV prevalence amongst youth (2 - 14 years) in 2008, while prevalence figures below 2.9% have been maintained in the other provinces. KwaZulu-Natal recorded a sharp decline in HIV prevalence amongst youth, decreasing from 7.9% in 2005 to 2.8% in 2008.⁵⁰ However, amongst the 15 - 24 year age group, KwaZulu-Natal was found to have the highest prevalence of HIV infection (15.3%) followed by Mpumalanga (13.5%) and Gauteng (10.1%).

⁴⁷ Operario D, Cluver L, Rees H, MacPhail C, Pettifor A. Orphanhood and completion of compulsory school education among young people in South Africa: findings from a national representative survey. *Journal of Research on Adolescence*. 2008; 18: 173–186.

⁴⁸ Shisana O, Rehle T, Simbayi LC, Zuma K, Jooste S, Pillay-van-Wyk V et al. South African national HIV prevalence, incidence, behaviour and communication survey, 2008: A turning tide among teenagers? Pretoria: Human Sciences Research Council; 2008.

⁴⁹ *ibid.*

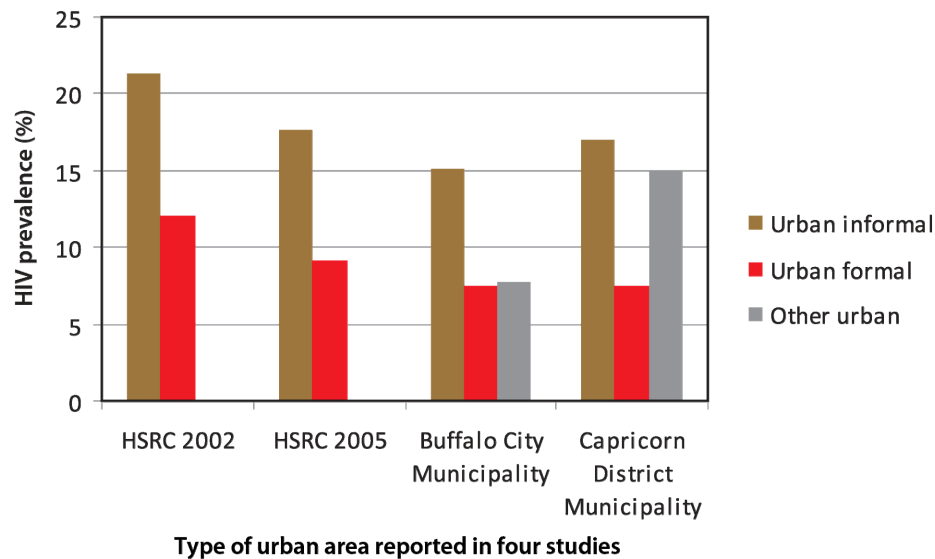
⁵⁰ *ibid.*

In terms of race groups, evidence from two national surveys have found that the prevalence of HIV infection amongst youth (15 - 24 years) is highest among Africans, followed by Coloureds, Whites and Indians. The Reproductive Health Research Unit (RHRU),⁵¹ found an HIV prevalence of 11.8% among African youth (15 - 24 years), similar to the prevalence recorded in the HSRC survey⁵² in 2002 (10.2%). HIV prevalence figures of 3.8%, 2% and 0.9% were found among Coloureds, Whites and Indians respectively in the RHRU study.

The HIV epidemic appears to be more concentrated among youth living in urban areas (urban informal and formal) than rural areas, and in informal areas compared to formal areas. The RHRU study⁵³ found that 59% of HIV positive youth were living in urban areas compared with 41% living in rural areas. HIV prevalence figures for youth (15-24 years) by geographic location were as follows: urban informal (17.4%), urban formal (9.8%), rural informal (8.7%) and rural formal (13.5%).

Similarly, results from four studies^{54,55,56} in South Africa have shown that HIV prevalence across age groups is higher in informal settlements compared to formal areas. The findings of the studies are illustrated in Figure 3.

Figure 3. HIV prevalence in formal vs. informal settlements in four SA studies^{54,55,56}



⁵¹ Pettifor A E, Rees H, Steffenson A, Hlongwa-Madikizela L, MacPhail C, Vermaak K, Kleinschmidt I. HIV and sexual behaviour among young South Africans: a national survey of 15-24 year olds. Johannesburg: Reproductive Health Research Unit, University of Witwatersrand; 2004.

⁵² Shisana O, Rehle T, Simbayi LC, Zuma K, Jooste S, Pillay-van-Wyk V et al. South African national HIV prevalence, HIV incidence, behaviour and communication survey. Cape Town: HSRC Press; 2002.

⁵³ Pettifor A E, Rees H, Steffenson A, Hlongwa-Madikizela L, MacPhail C, Vermaak K, Kleinschmidt I. HIV and sexual behaviour among young South Africans: a national survey of 15-24 year olds. Johannesburg: Reproductive Health Research Unit, University of Witwatersrand; 2004.

⁵⁴ Shisana O, Rehle T, Simbayi LC, Zuma K, Jooste S, Pillay-van-Wyk V et al. South African national HIV prevalence, HIV incidence, behaviour and communication survey. Cape Town: HSRC Press; 2002.

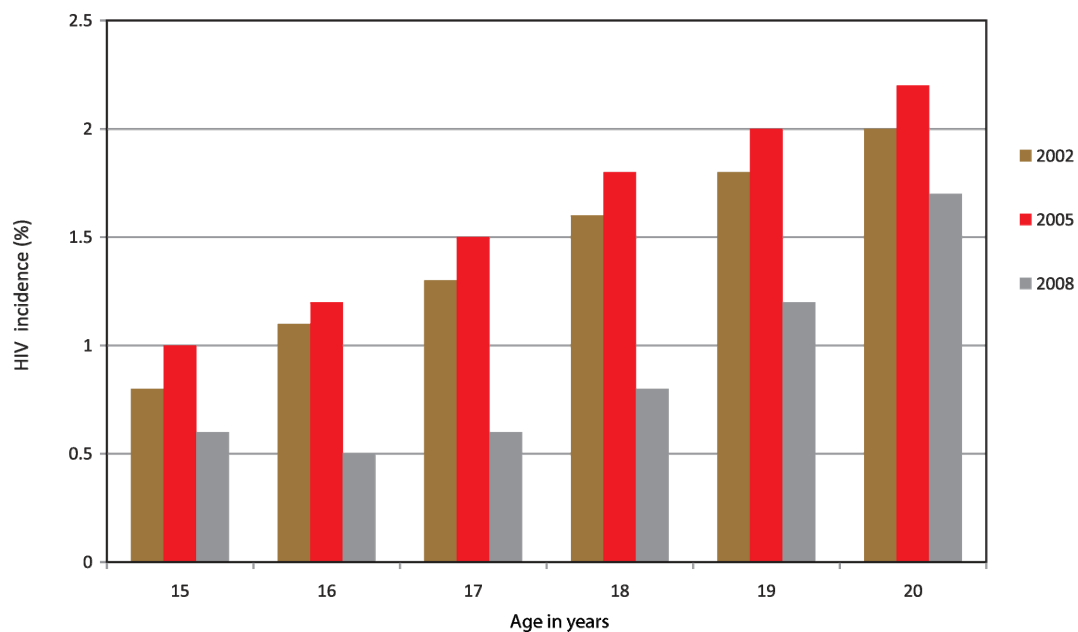
⁵⁵ Shisana O, Rehle T, Simbayi L, Parker W, Zuma K, Bhana A et al. South African national HIV prevalence, HIV incidence, behaviour and communication survey, 2005. Cape Town: Human Sciences Research Council, 2005.

⁵⁶ Thomas E. Unpublished work. Johannesburg. South African Medical Research Council/ WITS University; 2010.

HIV incidence

Epidemiological studies have shown that the highest rate of new infections occurs in young people aged between 15 and 24 years. The incidence of new infections increases as youth move from 15 to 20 years old, with an HIV incidence of 0.6% at 15 years and 1.7% at 20 years. As illustrated in Figure 4, the rate of new infections amongst youth between the ages of 15 and 20 has decreased substantially in South Africa between 2002 and 2008.

Figure 4. Comparison of HIV incidence in the 15 - 20 year age group, South Africa 2002, 2005, and 2008⁵⁷



3.3 Determinants of HIV (drivers of HIV infection among youth)

Behavioural drivers of HIV infection among youth

There are a number of key behavioural drivers that are associated with sexual risk activity and increased vulnerability to HIV infection amongst youth. These include early age of sexual debut, multiple sexual partnerships, unprotected sexual intercourse, intergenerational sex and transactional sex.

Sexual debut

There is a significant association between early sexual activity and increased risk of HIV infection. Risks of earlier sexual debut also include a higher likelihood of multiple sexual

⁵⁷ Shisana O, Rehle T, Simbayi LC, Zuma K, Jooste S, Pillay-van-Wyk V et al. South African national HIV prevalence, incidence, behaviour and communication survey, 2008: A turning tide among teenagers? Pretoria: Human Sciences Research Council; 2008.

partners, a lower likelihood of condom use at first sexual encounter and higher overall numbers of sexual partners.⁵⁸ According to RHRU,⁵⁹ 48% of youth between the ages of 15 and 19 years are engaging in sexual activity, with the mean age of sexual debut for males around 16.4 years and of females, 17 years. The HSRC national survey⁶⁰ indicates that in 2008 a higher proportion of males (11.3%) than females (5.9%) had their sexual debut before the age of 15 years. While the proportion of males reporting their sexual debut before 15 years had decreased since the 2002 (13.1%) and 2005 (11.9%) surveys, the proportion of females increased from 5.3% in 2002 to 5.9% in 2008.

Inter-generational sex

Intergenerational sex appears to be an enduring problem among young girls. For young people, and particularly girls under the age of 20, having older partners is a significant risk factor for HIV infection as older sexual partners have a higher likelihood of being HIV positive. The HSRC survey⁶¹ found that the percentage of youth (15-19 years) that reported having a sexual partner more than five years older rose from 9.6% in 2005 to 14.5% in 2008. Females (27.6%) within this age group were more likely than males (0.7%) to report having a sexual partner who was five years older. The high prevalence among females is a worrying finding as higher than average HIV infection rates (29.5%) have been found among female youth who have had sexual partners five years or more older than themselves.⁶²

Multiple and concurrent sexual partnerships

Having a higher overall number of sexual partners, a high turnover of sexual partners and concurrent sexual partners (or partners who have concurrent sexual partnerships) are all risk factors for HIV infection. Significant gender differences among youth are apparent in the proportion of youth engaged in multiple sexual partnerships. The HSRC survey⁶³ found that male youth (15-24 years) were significantly more likely to be engaged in multiple partnerships. The percentage of males engaging in multiple sexual partnerships increased from 23% in 2002 to 30.8% in 2008. In contrast, the proportion of females involved in multiple sexual partnerships decreased in recent years from 8.8% in 2002 to 6% in 2008. It appears that multiple sexual partnerships remain a significant challenge to be addressed, particularly amongst young males.

⁵⁸ Pettifor AE, van der Straten A, Dunbar M, Shiboski SC, Padian N. Early age of first sex: a risk factor for HIV infection among women in Zimbabwe. *AIDS*. 2004; 18: 1435-1442.

⁵⁹ Pettifor AE, Rees H, Steffenson A, Hlongwa-Madikizela L, MacPhail C, Vermaak K, Kleinschmidt I. HIV and sexual behaviour among young South Africans: a national survey of 15-24 year olds. Johannesburg: Reproductive Health Research Unit, University of Witwatersrand; 2004.

⁶⁰ Shisana O, Rehle T, Simbayi LC, Zuma K, Jooste S, Pillay-van-Wyk V et al. South African national HIV prevalence, incidence, behaviour and communication survey, 2008: A turning tide among teenagers? Pretoria: Human Sciences Research Council; 2008.

⁶¹ *ibid.*

⁶² Shisana O, Rehle T, Simbayi L, Parker W, Zuma K, Bhana A et al. South African national HIV prevalence, HIV incidence, behaviour and communication survey. Cape Town: HSRC Press; 2005.

⁶³ Shisana O, Rehle T, Simbayi LC, Zuma K, Jooste S, Pillay-van-Wyk V et al. South African national HIV prevalence, incidence, behaviour and communication survey, 2008: A turning tide among teenagers? Pretoria: Human Sciences Research Council; 2008.

Transactional sex

Transactional sex is the term used to describe sexual interactions that involve the exchange of sex for gifts, money, services or other forms of material or non-material gain. Transactional sex often takes place in circumstances of wealth inequality where peoples' need for economic security supersedes their health and safety concerns. Transactional sex serves to disempower women through reducing their ability to negotiate safer sex practices, particularly condom use.⁶⁴ Indeed, studies have shown that the greater the value of the gift, service or money exchanged for sex, the less likely it is that the couple will engage in safe sexual practices.^{65,66} Amongst female youth, reciprocity of sex in exchange for material goods leads to young women remaining in dysfunctional relationships, engaging in multiple sexual partnerships and involvement with older men.⁶⁷ An RHRU study⁶⁸ found that 3% of its sexually active sample had reportedly engaged in transactional sex within their lifetime, with no gender differences apparent within its sample.

Condom use

A successful achievement in recent years has been the reported increase in condom use among youth in South Africa. The proportion of youth (15 - 24 years) using a condom during their last sexual encounter has steadily increased in recent years from 57.1% in 2002 to 72.8% in 2005 and 87.4% in 2008.⁶⁹

The overall picture may however, mask less optimistic sub-trends. For example, the findings of Pettifor and colleagues⁷⁰ suggest that fewer than half of young people use condoms consistently during their sexual interactions. Roughly a third of their sample reported "always" using a condom with their sexual partner in the past year compared with 31% who "never" used a condom with their most recent sexual partner. A similarly low rate of consistent condom use has been found within rural schools in KwaZulu-Natal. In the study, 19.2% of sexually active learners reported consistent condom use with regular sexual partners, 22.4% reported consistent

⁶⁴ Pettifor AE, Measham DM, Rees HV, Padian NS. Sexual power and HIV risk, South Africa. *Emerging Infectious Diseases*. 2004; 10; 1996-2004.

⁶⁵ Luke N. Age and economic asymmetries in the sexual relationships of adolescent girls in sub-Saharan Africa. *Studies in Family Planning*. 2003; 3; 67-86.

⁶⁶ Wojciki JM. Socioeconomic status as a risk factor for HIV infection in women in east, central and southern Africa: a systematic review. *Journal of Biosocial Science*. 2005; 37; 1-36.

⁶⁷ Human Sciences Research Council. *Teenage pregnancy in South Africa: with a specific focus on school-going learners*. Pretoria: HSRC; 2009.

⁶⁸ Pettifor AE, Rees H, Steffenson A, Hlongwa-Madikizela L, MacPhail C, Vermaak K, Kleinschmidt I. HIV and sexual behaviour among young South Africans: a national survey of 15 - 24 year olds. Johannesburg: Reproductive Health Research Unit, University of Witwatersrand; 2004.

⁶⁹ Shisana O, Rehle T, Simbayi LC, Zuma K, Jooste S, Pillay-van-Wyk V et al. South African national HIV prevalence, incidence, behaviour and communication survey, 2008: A turning tide among teenagers? Pretoria: Human Sciences Research Council; 2008.

⁷⁰ Pettifor AE, Rees H, Steffenson A, Hlongwa-Madikizela L, MacPhail C, Vermaak K, Kleinschmidt I. HIV and sexual behaviour among young South Africans: a national survey of 15 - 24 year olds. Johannesburg: Reproductive Health Research Unit, University of Witwatersrand; 2004.

condom use with casual sexual partners, and only 12% used condoms consistently with regular and casual sexual partners.⁷¹

Similarly, slightly lower condom use rates were found in the RHRU survey⁷² with 56% of 15 to 19 year olds and 50% of 20 to 24 year olds reporting condom use at their last sexual encounter. The survey also recorded lower rates of condom use among youth in rural areas compared with youth living in urban areas.

In addition, a continuing challenge is to address the gender differences in condom use frequency. The 2008 HSRC survey indicated that 87.4% of male youth had reportedly used a condom during their last sexual encounter compared with 73.1% of females. The RHRU survey⁷³ also found marked gender differences in condom use frequency, with 57% of males and 48% of females reporting condom use at last sexual encounter. Gender differences in condom use were greater among males and females in the 20 to 24 age group than their younger counterparts.

Substance abuse

Alcohol and drugs have a disinhibiting effect on safer sex as a result of diminishing rational decision-making. Alcohol has been associated with higher risk of HIV infection, with heavier alcohol consumption linked to greater likelihoods of unprotected sex with non-monogamous partners, having multiple sexual partners and paying for or selling sex.⁷⁴ South African youth consider alcohol and drug abuse to be a serious issue in their lives, second only to their concerns about being infected with HIV.⁷⁵ In a national sample of youth, 24% of youth reported having engaged in sexual intercourse while under the influence of alcohol. Males were twice as likely as females to report having sex under the influence of alcohol. Drug use was reported amongst 11% of the 15 to 24 year olds in the sample, with 4% reporting that they had ever injected drug s in their lives.⁷⁶

Knowledge of HIV, HIV status and HIV prevention

Knowledge of HIV and AIDS, including HIV prevention, does not appear to be connected to increased adoption of HIV prevention practices among people who test HIV negative, but has

⁷¹ Taylor M, Dlamini SB, Nyawo N, Huver R, Jinabhai CC, de Vries H. Reasons for inconsistent condom use by rural South African high school students. *Acta Paediatrica*. 2007; 96; 287-291.

⁷² Pettifor AE, Rees H, Steffenson A, Hlongwa-Madikizela L, MacPhail C, Vermaak K, Kleinschmidt I. HIV and sexual behaviour among young South Africans: a national survey of 15 - 24 year olds. Johannesburg: Reproductive Health Research Unit, University of Witwatersrand; 2004.

⁷³ Pettifor AE, Rees H, Steffenson A, Hlongwa-Madikizela L, MacPhail C, Vermaak K, Kleinschmidt I. HIV and sexual behaviour among young South Africans: a national survey of 15-24 year olds. Johannesburg: Reproductive Health Research Unit, University of Witwatersrand; 2004.

⁷⁴ Weiser SD, Leiter K, Heisler M, McFarland W, Percy-de Korte F. A population-based study on alcohol and high-risk sexual behaviors in Botswana. *PLoS Medicine*. 2006; 3(10); e392.

⁷⁵ Pettifor AE, Rees H, Steffenson A, Hlongwa-Madikizela L, MacPhail C, Vermaak K, Kleinschmidt I. HIV and sexual behaviour among young South Africans: a national survey of 15-24 year olds. Johannesburg: Reproductive Health Research Unit, University of Witwatersrand; 2004.

⁷⁶ *ibid.*

been linked to increased prevention behaviours among those who test HIV positive.⁷⁷ There is now widespread recognition that a rational approach based on the assumption that new knowledge would lead to new behaviours is not a useful one. Alongside new knowledge (provided by teachers taught through the curriculum) is a range of life skills, attitudes and resiliencies that requires skills and rapport with youth beyond that which can be expected from teachers. Evidence strongly suggests that other mentors – not same-age peer educators – may have a strong role to play.

Acknowledging this does not, however, diminish the role and importance of knowledge as an intermediate factor to bring about behaviour change. The HSRC report⁷⁸ shows that the percentage of youth who have correct knowledge about methods of HIV prevention and who correctly reject major misconceptions of HIV transmission had significantly dropped from 2005 to 2008 amongst both males (2005 = 44.9%, 2008 = 30.4%) and females (2005 = 44.7%, 2008 = 27%).

Studies have also shown that the number of people having HIV tests and becoming aware of their HIV status has increased in recent years, although the proportion of youth who are aware of their HIV status is still relatively low. A national survey in 2004 found that roughly 12% of youth aged between 15 and 19 years had had a HIV test (males = 9%, females = 15%), while 63% of youth in this age group were interested in knowing what their HIV status was.⁷⁹ The HSRC study⁸⁰ reported an increase in the percentage of males and females (15-49 years) who were aware of their HIV status from 11.9% in 2005 (males = 10.2%, females = 19.9%) to 24.7% in 2008 (males=13.3%, females=28.7%). No significant gender differences in HIV testing were however found in the 2008 Youth Risk Behaviour Survey,⁸¹ which found that 21.5% of learners in Grade 8 to Grade 11 had had a HIV test in their life time.

Structural drivers of HIV infection among youth

Gender based violence and gender inequality

Gender inequity is globally recognised as one of the fundamental drivers of HIV and AIDS. Unequal power relationships between men and women result in men generally deciding the

⁷⁷ Johnson BT, Carey MP, Chaudoir SR, Reid AE. Sexual risk reduction for persons living with HIV - Research synthesis of randomized controlled trials, 1993 to 2004. *Journal of Acquired Immune Deficiency Syndrome*. 2006; 41: 642-650.

⁷⁸ Shisana O, Rehle T, Simbayi LC, Zuma K, Jooste S, Pillay-van-Wyk V et al. South African national HIV prevalence, incidence, behaviour and communication survey, 2008: A turning tide among teenagers? Pretoria: Human Sciences Research Council; 2008.

⁷⁹ Pettifor AE, Rees H, Steffenson A, Hlongwa-Madikizela L, MacPhail C, Vermaak K, Kleinschmidt I. HIV and sexual behaviour among young South Africans: a national survey of 15 - 24 year olds. Johannesburg: Reproductive Health Research Unit, University of Witwatersrand; 2004.

⁸⁰ Shisana O, Rehle T, Simbayi LC, Zuma K, Jooste S, Pillay-van-Wyk V et al. South African national HIV prevalence, incidence, behaviour and communication survey, 2008: A turning tide among teenagers? Pretoria: Human Sciences Research Council; 2008.

⁸¹ Reddy SP, James S, Sewpaul R, Koopman F, Funani NI, Sifunda S et al. Umthente Uhlaba Usamila – The South African Youth Risk Behaviour Survey 2008. Cape Town: South African Medical Research Council, 2010.

conditions under which sex occurs. In such situations women's ability to negotiate safer sex practices is constrained and can often lead to coerced or forced sexual intercourse.⁸²

Both gender-based violence and gender inequality are pertinent social problems that negatively impact on the sexual experiences of youth in South Africa, especially young females, and increase their risk of HIV infection. Many female youth report a lack of social power in their sexual relationships that increases their risk of being infected with HIV. In a national sample of youth (15 - 24 years), 27% of female youth felt a lack of social power within their sexual relationships stopped them from using condoms on a regular basis.⁸³ Females are more likely than males to experience forced sexual intercourse. Forced sexual intercourse was reported amongst 6% of youth (15 - 14 years) in a nationally representative sample,⁸⁴ with 11% of females between 15 and 19 years of age and 9% of females between 20 and 24 years reporting forced sexual intercourse. A third of female youth had not wanted to engage in their first sexual experience compared to 2% of male youth.

Stigma and discrimination

A number of factors contribute to the stigma surrounding HIV and AIDS. These can include a lack of understanding of HIV and AIDS and how HIV is transmitted, lack of access to treatment, the incurability of AIDS, and prejudice and anxieties that stem from a number of socially sensitive issues including sexuality, death and homosexuality.⁸⁵ The shame associated with being HIV positive, known as 'internalised stigma', often prevents people living with HIV (PLHIV) from seeking treatment, care and support or from carrying out normal daily routines such as going to work or attending school.⁸⁶

High levels of stigma and discrimination towards HIV positive people are still present in South Africa. A study published in 2007 found that internalised stigma was experienced by 30% of HIV positive people in the sample, while 40% of HIV positive people in their sample had experienced some form of discrimination as a result of their HIV status.⁸⁷ In addition, 20% had either lost a place to stay or a job due to their status. Another study conducted in Cape Town among young adults aged 14 - 22 years found that levels of stigma had increased between 2003 and 2006,

⁸² Human Sciences Research Council. Teenage pregnancy in South Africa: with a specific focus on school-going learners. Pretoria: HSRC; 2009.

⁸³ Pettifor AE, Measham DM, Rees HV, Padian NS. Sexual power and HIV risk, South Africa. *Emerging Infectious Diseases*. 2004; 10; 1996-2004.

⁸⁴ Pettifor AE, Rees H, Steffenson A, Hlongwa-Madikizela L, MacPhail C, Vermaak K, Kleinschmidt I. HIV and sexual behaviour among young South Africans: a national survey of 15-24 year olds. Johannesburg: Reproductive Health Research Unit, University of Witwatersrand; 2004.

⁸⁵ UNAIDS. HIV-related stigma, discrimination and human rights violations: case studies of successful programmes. Geneva: UNAIDS; 2005.

⁸⁶ *ibid.*

⁸⁷ Simbayi LC, Strebel A, Cloete A, Henda N, Mqeketo A, Magome K, Kalichman SC. Internalised stigma, discrimination, and depression among men and women living with HIV/AIDS in Cape Town, South Africa. *Social Science & Medicine*. 2007; 64; 1823-1831.

despite this age group being a key target age group for HIV education and prevention materials messages.⁸⁸

The stigma surrounding adolescent sexuality and HIV serves to constrain opportunities for open discussion and communication about sex and HIV and AIDS between youth and parents and teachers as well as health staff. Stigma also dissuades youth from accessing HIV and AIDS-related health services that can result in youth not receiving important HIV prevention knowledge and services.⁸⁹

Wealth inequality

Recent evidence indicates that the spread of the HIV epidemic is facilitated by economic inequalities that have an influence on sexual behaviours and the potential for HIV transmission. This is particularly apparent in South Africa, which has a high HIV prevalence and one of the highest Gini co-efficients in Africa, an indicator used to determine the income inequality in a country.^{90, 91}

Income inequality impacts on people's access to information, education and health care.⁹² Women, in particular, bear the brunt of the burden created by poverty and income inequality.⁹³ In South Africa, one in every two female-headed households (52%) is regarded as poor or very poor, compared with one in three (35%) male-headed households.⁹⁴

Income disparities between men and women can lead young girls to become involved in exploitative sexual relationships with much older men in an effort to improve their economic position, or merely to survive. Consequently, large numbers of women and girls find themselves in sexual relationships that drastically increase their risk of HIV infection.⁹⁵

Cultural beliefs and practices

Cultural attitudes and practices can contribute to the spread of HIV in South Africa through their impact on gender inequalities and other sex-related cultural beliefs and practices. HIV transmission can occur during some traditional health practices and rituals such as when using

⁸⁸ Maughan-Brown B. Stigma rises despite antiretroviral roll-out: a longitudinal analysis in South Africa. *Social Science & Medicine*. 2010; 70; 368-374.

⁸⁹ Human Sciences Research Council. *Teenage pregnancy in South Africa: with a specific focus on school-going learners*. Pretoria: HSRC; 2009.

⁹⁰ McIntosh WA, Thomas JK. Economic and other social determinants of the prevalence of HIV: a test of competing hypotheses. *The Sociological Quarterly*. 2004; 45; 303-324.

⁹¹ Piot P, Greener R, Russell S. Squaring the circle: AIDS, poverty, and human development. *PLoS Medicine*. 2007; 4; 1571-1575.

⁹² Redelinghuys N. Social dynamics fuelling the spread of HIV/AIDS in the Free State: Implications for prevention, care, treatment and support. *Acta Academia Supplementu*. 2006; 1; 362-385.

⁹³ *ibid*.

⁹⁴ Statistics South Africa. *Measuring poverty in South Africa*. Pretoria: Statistics South Africa; 2000.

⁹⁵ Redelinghuys N. Social dynamics fuelling the spread of HIV/AIDS in the Free State: Implications for prevention, care, treatment and support. *Acta Academia Supplementu*. 2006; 1; 362-385.

unsterilised equipment for male circumcisions.⁹⁶ Cultural beliefs around patriarchy and male dominance can have a profound impact on the nature of sexual interactions between men and women in South Africa. Some cultural beliefs condone the practice of multiple sexual partners or having sex with commercial workers among men and leave women feeling unable to insist on condom use during sexual intercourse.^{97, 98}

3.4 HIV and AIDS in the education sector in South Africa

General information

The world AIDS epidemic “continues to pose serious challenges, undermining broad progress in development and in poverty reduction, threatening basic human rights and seriously affecting the prospects of attaining the MDGs and the EFA goals.”⁹⁹ A number of gains have been made in prevention, treatment and care around the world and countries are moving towards the MDGs and EFA goals of universal enrolment in primary schools yet progress has been uneven. The extent to which this may be attributed to HIV and AIDS is not clear. However, what is clear is that access to quality education – even without HIV interventions – is a key determinant in reducing the impact of HIV and AIDS on society.

The specific impact of HIV and AIDS on the South African school system since 1999 has been difficult to monitor, partly because collecting HIV and AIDS specific data is extremely costly and often controversial, and partly because even with appropriate data it is difficult to disaggregate the impact of the pandemic from other socio-economic factors.

However, those proxy data which do exist indicate a mixed picture.

- ✘ While the number of orphans and children with increasingly sick family members has increased, this appears not to have impacted on attendance at school. In this regard the National School Nutrition Programme (NSNP) and the introduction of no-fee schools in the poorest schools may have counteracted the potential threat of increased vulnerability in school attendance.
- ✘ Several studies looking at teenage sexual practices suggest that teenagers in school are relatively protected against HIV infection and teen pregnancy and are reporting safer sexual behaviour than their same-age counterparts who are out of school.
- ✘ The impact of HIV and AIDS on educators and non-teaching staff was researched in a 2005 study commissioned by the Education Labour Relations Council (ELRC).¹⁰⁰ This large-scale study which included sero-prevalence testing found a prevalence rate of 12.7% among teachers. More than 4 000 South African teachers died of HIV and AIDS-related

⁹⁶ South African National AIDS Council. HIV & AIDS and STI Strategic Plan for South Africa 2007 - 2011. Pretoria: SANAC; 2007.

⁹⁷ Redelinghuys N. Social dynamics fuelling the spread of HIV/AIDS in the Free State: Implications for prevention, care, treatment and support. *Acta Academia Supplementum*. 2006: 1; 362-385.

⁹⁸ South African National AIDS Council. HIV & AIDS and STI Strategic Plan for South Africa 2007 - 2011. Pretoria: South African National AIDS Council; 2007.

⁹⁹ UNAIDS. A strategic approach: HIV & AIDS and education. Geneva: UNAIDS, May 2009.

¹⁰⁰ Education Labour Relations Council. Health of our educators: a focus on HIV/AIDS in South African public schools, 2004/2005 survey. Cape Town: HSRC Press; 2005.

complications in 2004 and 80% of teachers who died of HIV and AIDS-related complications were younger than 45 years of age.

- ✘ The study also found that HIV and AIDS-related illnesses cause low morale, high rates of absenteeism among teachers and was likely to lead to higher job mobility amongst educators as teachers die or leave the service for jobs elsewhere. This study has not been replicated and since data on educator illness, absenteeism and mortality has been difficult to collect, it is not known what the current occupational-specific impacts of HIV and AIDS are on educators and school support staff.

Educator information

It is certain that the global pandemic is having an impact on educators, on the manner in which schools are able to function and on the quality of education. As a group, educators have been found to have a HIV prevalence of 12.7% with the highest HIV prevalence found amongst male and female educators in the 25 - 34 age groups (21.4%).¹⁰¹ Researchers have noted, however, that HIV prevalence figures amongst educators are similar to that found within the general population.^{102,103} The key drivers of the epidemic within the educator population are believed to be lack of condom use, multiple partnerships, alcohol use and intergenerational sex.

Research has shown that educators residing in rural areas and working in rural schools had a higher HIV prevalence than their urban counterparts.¹⁰⁴ As with national community-based studies, the two provinces with the highest number of HIV positive educators were KwaZulu-Natal and Mpumalanga with rates of 21.8% and 19.1% respectively.¹⁰⁵

4. RESPONSE OVERVIEW: SOUTH AFRICA

4.1 The HIV and AIDS and STI National Strategic Plan 2007-2011

The beginnings of a coordinated national response to HIV and AIDS in South Africa can be traced back to the launch of the National AIDS Coordinating Committee of South Africa (NACOSA) in 1992. NACOSA was mandated to develop a national strategy on HIV and AIDS which cabinet endorsed in 1994. A review in 1997 highlighted the need to move beyond a health sector only, disease-specific approach to HIV and AIDS. In 1999 a National Strategic Plan (NSP 2000-2005) was developed and became the cornerstone of the national response to HIV and AIDS.

An assessment of NSP 2000 - 2005 was carried out and the findings and recommendations have guided further developments. In May 2006 SANAC mandated the Health Department to lead the process of developing a new five-year NSP for the 2007-2011 period. NSP 2007-2011 flows from the previous NSP and other national efforts of responding to HIV and AIDS, and it represents

¹⁰¹ Education Labour Relations Council. Health of our educators: a focus on HIV/AIDS in South African public schools, 2004/2005 survey. Cape Town: HSRC Press; 2005.

¹⁰² *ibid.*

¹⁰³ Education Labour Relations Council. Educator supply and demand in the public education system. Integrated report. Cape Town: HSRC Press, 2005.

¹⁰⁴ Education Labour Relations Council. Health of our educators: a focus on HIV/AIDS in South African public schools, 2004/2005 survey. Cape Town: HSRC Press; 2005.

¹⁰⁵ *ibid.*

South Africa's multi-sectoral response to the challenge of HIV infection and the wide-ranging impacts of AIDS.

The NSP has two primary aims and four key priority areas (see Annexure A). The primary aims of the NSP are to:

1. Reduce the rate of new HIV infections by 50% by 2011; and
2. Reduce the impact of HIV and AIDS on individuals, families, communities and society by expanding access to appropriate treatment, care and support to 80% of all HIV positive people and their families by 2011.

The four key priority areas are:

1. Prevention;
2. Treatment, care and support;
3. Research, monitoring and surveillance; and
4. Human rights and access to justice.

Mid-term review of the National Strategic Plan

A mid-term review of the NSP 2007 - 2011 was conducted in 2009, and the findings from this review have informed the development of the new Strategy for HIV and AIDS in South African Schools.

The mid-term review lists some achievements such as increased condom use, large scale knowledge campaigns, increased voluntary HIV counselling (VCT) and testing coverage and the increased roll-out of antiretroviral therapy (ART). It also lists response weaknesses such as weak coordination, too many ill-defined targets and lack of reporting from the private sector and civil society.

The review specifies particular areas for attention such as:

1. Insufficient progress on prevention;
2. Possibly decreasing knowledge on HIV;
3. Health systems obstacles to scaling up responses;
4. Lack of coordination and reporting on impact mitigation; and
5. Weak targets and reporting on human rights and access to justice actions.

The report recommended that at this point in the NSP implementation, the plan itself should not be changed but rather several priority areas should receive focus. With scaled-down targets and indicators, the report recommended the following priority areas up to the end of 2011:

1. Making the SANAC Secretariat functional;
2. Transforming HIV and AIDS information into HIV and AIDS intelligence;
3. Investing further effort in prevention, while continuing efforts to scale-up treatment;

4. Integrating ART with related health services into primary health care delivery;
5. Improving attention to, and coordination of, impact mitigation activities; and
6. Strengthening implementation of the Access to Human Rights and Justice priority area.

On prevention, a particular finding of the report speaks to this strategy. Whilst the NSP set out to implement life skills-based HIV education in 80% of primary and secondary schools in 2008, coverage of only 58% of schools was achieved. The target for 2011 is 98%. The report stated that while the Department had acted to strengthen and customise life skills, conduct peer education training camps and train educators and learners on substance abuse, it was not on target to achieve the NSP target of 98% by 2011.

4.2 Recent political developments towards the achievement of the NSP in South Africa

On the 11th March 2010 the cabinet announced that the country intended to launch a massive HIV Counselling and Testing (HCT) campaign that would assume an integral part of the country's efforts to achieve the targets of the NSP on HIV, AIDS and STIs. Prior to the launch on the 8th April President Jacob Zuma had a HIV test and released his test results to the public some weeks later. President Zuma and Deputy President Kgalema Motlanthe participated in the launch proceedings on the 25th April 2010 to mark the beginning of the largest HCT campaign that any country has undertaken.¹⁰⁶

The aim of the national HCT campaign is to encourage 15 million South Africans to voluntarily have an HIV test and learn their status over the following 14 months. The long-term campaign objectives are fourfold: to mobilise people to know their HIV status; to support people with key prevention interventions; to increase the incidence of health-seeking behaviour; and to increase access to treatment, care and support services.

A range of other HIV prevention activities and services would be included in the national HCT campaign including the treatment and management of STIs, widespread provision of condoms (100 for every person that undergoes a HIV test), embarking on a plan to introduce mass male circumcision, prevention of mother-to-child transmission, post-exposure prophylaxis for rape survivors and life skills education for learners. During this time, government would distribute another one billion condoms through public facilities.¹⁰⁷

¹⁰⁶ South African National AIDS Council. New date set for the launch of the national HIV counselling & testing campaign. Press statement. Pretoria: South African National AIDS Council; 2010.

¹⁰⁷ South African National AIDS Council. New date set for the launch of the national HIV counselling & testing campaign. Press statement. Pretoria: South African National AIDS Council; 2010.

5. WHY SCHOOLING IS KEY TO NATIONAL SUCCESS ON HIV

5.1 Universal recognition of the importance of schooling

The UNAIDS A Strategic Approach: HIV & AIDS and Education¹⁰⁸ stresses the centrality of education provision in combating the impact of HIV and AIDS:

“We now have evidence of the important role that education plays in offering protection against HIV. School-going children and young people are less likely to become infected than those who do not attend school, even if HIV and AIDS are not included in the curriculum. Education reduces the vulnerability of girls, and each year of schooling offers greater protective benefits. Where offered, well-planned and well-implemented education on life skills or sex and HIV has increased knowledge, developed skills, generated positive attitudes and reduced or modified sexual behaviour. The first line of the response should therefore be to provide more and better schooling. A second and complementary line of response can then be to introduce specifications tailored to the epidemic, such as providing HIV and sexuality education. In highly-affected settings, educating parents and learners about HIV treatment, care and support should also be prioritised.”

UNAIDS has recognised that education has the following impacts on HIV and AIDS:

- ✘ Access to quality education protects against HIV;
- ✘ Education can reach large numbers of children and young people;
- ✘ Education reduces the vulnerability of girls;
- ✘ Education can reach those who are not in school;
- ✘ HIV and AIDS education impacts on HIV-related knowledge, skills and behaviour;
- ✘ The higher the level of education, the greater the protection against HIV infection;
- ✘ Education can reduce stigma and discrimination; and

Education provides a cost-effective means of HIV prevention.

The proviso made at the beginning of this document in the imperative section is that schools are only a protective factor with regard to HIV and AIDS if they are safe spaces for all youths and adults, who work and learn within them. But the scope of school safety must be expanded beyond infrastructure concerns such as fencing and gates to include psychological and emotional safety. So how might a safe school be defined?

“A safe school may be defined as one that is free of danger and where there is an absence of possible harm; a place in which non-educators, educators and learners may work, teach and learn without fear of ridicule, intimidation, harassment, humiliation, or violence. A safe school is therefore a healthy school in that it is physically and psychologically safe. Indicators of safe schools include the presence of certain physical features such as secure walls, fencing and gates; buildings that are in

¹⁰⁸ UNAIDS. A strategic approach: HIV & AIDS and education. Geneva: UNAIDS, May 2009.

a good state of repair; and well-maintained school grounds. Safe schools are further characterised by good discipline, a culture conducive to teaching and learning, professional educator conduct, good governance and management practices, and an absence (or low level) of crime and violence.”¹⁰⁹

It is widely recognised that education systems have several comparative advantages over other services when it comes to the care and support of children. In addition, there are a number of factors that make schools a strategic place for children to access a range of services:¹¹⁰

- ✂ Schools are relatively accessible and they often provide a physical infrastructure in communities where other crucial infrastructure is absent. The education system has an existing infrastructure of around 25 850 public schools.¹¹¹ The space and grounds at schools have the potential for expanded use.
- ✂ Schools represent an existing network of many components, including school staff, learners, their caregivers, SGBs and the broader school community. Each component is a potentially valuable resource for care and support.
- ✂ The way schools are currently clustered creates opportunities for further collaboration and provides educators and middle management with more support.
- ✂ The school environment is an inclusive environment, which focuses on children and is committed to children’s development. The education system reaches approximately 11 500 000 children, including those most affected by and most at risk of HIV infection. Children spend a large amount of their time at school over many years. It is also an environment where all kinds of vulnerabilities are exposed and it therefore has the potential to work against stigma associated with HIV and AIDS. If children feel supported within the school, they will come to school and they will remain within the school.
- ✂ The school can also reach the younger and most vulnerable age group through school-going children and their families, for example, through child-to-child programmes.
- ✂ Educators see children every day for five days of the week and are therefore ideally placed to track their well-being, to recognise change in children’s lives, and to identify vulnerable children.

In communities with inadequate service provision, schools take on an ever-increasing burden of support.

6. RESPONSE OVERVIEW: EDUCATION

6.1 General milestones

The responsibility of the Basic Education sector must be located across the four Key Priority Areas of the NSP: Prevention; treatment, care and support; research, monitoring and surveillance; and human rights and access to justice. Indeed the South African Education System

¹⁰⁹ Squelch J. Do school governing bodies have a duty to create safe schools? *Perspectives in Education*. 2001; 19:137-149.

¹¹⁰ Giese S, Meintjes H, Monson J. Schools as nodes of care and support for children affected by HIV, AIDS and poverty. Cape Town: Children’s Institute, UCT; 2005.

¹¹¹ Department of Education. 2010 School realities report. Pretoria: Department of Education; 2010.

has been actively engaged in responding to its responsibilities under this and previous NSPs for some time. A number of policy and practical interventions have been undertaken, with the major milestones being the following:

- ✘ National Policy on HIV and AIDS for Learners and Educators in Public Schools and Students and Educators in Further Education and Training Institutions¹¹²
- ✘ HIV and AIDS in the Curriculum via Life Orientation (LO) and Life Skills (2002 - 2010)
- ✘ Programmes targeting poverty and vulnerability (including OVC)
- ✘ Guidelines, support materials and training for the Prevention and Management of Sexual Violence and Harassment
- ✘ An Audit Report on the Prevalence of Learner Pregnancy in Public Schools has been published
- ✘ A schools health and wellness strategy with a number of initiatives, programmes and pilots has been published
- ✘ Peer educator programmes
- ✘ The physical safety of learners and educators and the prevention and management of sexual violence and harassment is addressed by the Safe Schools campaign
- ✘ A research study on teachers titled, *Health of our educators: a focus on HIV/AIDS in South African public schools, 2004/2005 survey*.¹¹³
- ✘ The Conditional Grant for HIV and AIDS Life Skills Education Programme

6.2 The National Policy on HIV and AIDS for Learners and Educators in Public Schools and Students and Educators in Further Education and Training Institutions

The National Policy on HIV and AIDS for Learners and Educators in Public Schools and Students and Educators in Further Education and Training Institutions is of particular significance. Published in 1999, it recognized the duty of the State to ensure that schools are safe spaces in terms of physical protection from the virus and to ensure that there was adequate information and education on HIV and AIDS in schools. The policy provided a framework for the development of provincial and schools policies and strategic plans on HIV and AIDS.

Specifically, the policy aimed at:

- Increasing learner knowledge on HIV and AIDS through schools and specifically, through the curriculum;
- reducing discrimination against those affected and infected by HIV and AIDS; and
- introducing universal precautions for the safety of learners and educators at schools.

While there was little evidence of the large scale effects of HIV and AIDS on schools at the time, there were clear indications that negative effects would occur in the near future. As such, this

¹¹² Department of Education. National policy on HIV/AIDS for learners and educators in public schools, and students and educators for further education and training institutions. Pretoria: Department of Education; 1999.

¹¹³ Education Labour Relations Council. Health of our educators: a focus on HIV/AIDS in South African public schools, 2004/2005 survey. Cape Town: HSRC Press; 2005.

Policy was an important government intervention at the time to encourage and create a basis for systemic interventions in schools.

The Policy was a product of the time in the landscape of HIV and AIDS with a strong biomedical focus. However, its ethos and ideals were forward looking with its principles and objectives drawn from, and consistent with the country's constitution and new legislation enacted post-1994. However, the generality of the Policy objectives and guidelines were also consistent with the government's general strategy and plan on the one hand, and on the other, the restrictive conditions for HIV and AIDS interventions at the time.

Furthermore, there was a need for the Policy to align with other government policies and initiatives. The government's National Integrated Strategy included provision for treatment and the National Integrated Plan focused on life skills education in primary and secondary schools, VCT in the population at large, and Community and Home-Based Care.

The NSP followed the National Integrated Plan of 2000 - 2005 and the Operational Plan for Comprehensive HIV and AIDS Care, Management, and Treatment (CCMT). In 2006, the Department of Health (DOH) was mandated by the SANAC to lead development of a new 5-year plan (2007 - 2011).

Schools are an important practical component of the NSP; indeed they have been and still are a critical means for communicating, educating and channelling prevention and treatment initiatives to the youth attending school and to a sizable workforce in South Africa.

The focus on the school, whilst important, can be difficult to accomplish without adequate support or resources and it is these areas that are not substantially articulated within the policy. Furthermore, the notion that information should be integrated across a broader curriculum is fundamental rather than a topic to be constrained within a particular learning area. All educators are required to be equipped with the necessary skills to ensure the topic of HIV and AIDS and sexuality is mainstreamed throughout the curriculum. Building up curricula and lessons that incorporate HIV and AIDS across all learning areas requires a commitment of resources.

The notion articulated in the Policy that each school must have a strategic plan to respond to the epidemic, should be prepared to handle disclosures and be given support to handle confidentiality issues has been commended.¹¹⁴ An identified limitation however, is the lack of clarity on the strategies to support principals and educators in implementing these policy assignments. These are accepted to be complex areas to work in and educators and principals would benefit from support and guidance.

The fundamental role of the life-orientation learning area with a focus on life-skills should be fore-grounded in policy documents, as this seems to lie at the heart of addressing HIV and AIDS in schools. Similarly, educator training to implement the life-orientation learning area should receive more national and regional focus, as most regions have initiated such educator training processes. Structures to monitor the effect of life-skills training programmes in schools should also be addressed in policy documents.

¹¹⁴ *ibid.*

The underlying assumption in the Policy that knowledge alone will enable learners and students to make informed sexual choices and decisions must be reconsidered. The ELRC identifies a failure to address the issue of context – both how the messages around sex and sexuality,

HIV and AIDS are constructed, produced and reproduced, as well as the social context in which vulnerable members of the society find themselves. Not paying attention to how and where learners and students develop their sexual identities, and how issues of power, vulnerability, subjective hope, and so forth, play into problems learners and educators face in a lived context, reduce the effectiveness of the policy. The biomedical approach to information also potentially ignores important social aspects of the epidemic. It is also particularly important to identify groups who are more vulnerable to the epidemic such as women and children, who may need additional support.¹¹⁵

The Policy is explicit on the rights of the *infected* individual (for example, access, non-discriminatory practices, treatment, care and so on) but little mention is made of the growing number of learners and educators who are *affected* by HIV and AIDS. No attention has been given to the establishment of mechanisms to provide assistance to those affected, for example children and educators who have lost family members or who live in communities which have been impacted on. There is an absence within the Policy of mechanisms to address school absence for extended periods due to HIV and AIDS.¹¹⁶ This further relates to treatment and support which is needed for educators and learners who are infected but want to continue working and schooling. This also needs to be structured into policy norms, as illness is likely to increase the demands on educators.

While the Policy has a strong thrust on prevention, the continuum of care outlined in the public health approach, in particular early detection and treatment, care and support are not explicitly addressed in the Policy.

6.3 Review of policies in public education

The National Minister for Public Service and Administration through the Department of Public Service and Administration (DPSA) is responsible for the formulation of human resource management policy directives, including those dealing with employee assistance programmes (EAP). Recognising the impact of HIV and AIDS on South Africa and the public service, the Minister initiated an Impact and Action Project in January 2000, which was aimed at ensuring that the public service was able to sustain a quality service in spite of the progression of the AIDS epidemic.

This led to the development of a policy framework to guide departments on the minimum requirements to effectively manage HIV and AIDS in the workplace, and to ensure a co-ordinated public service response. This policy framework was amended in 2001 to ensure the proper management of HIV and AIDS in the workplace and is aimed at ensuring that the working environment supports effective and efficient service delivery while as far as reasonably possible,

¹¹⁵ ELRC, 2006; Workplace Policies in Public Education: A review focusing on HIV/AIDS.

¹¹⁶ *ibid.*

taking employees' personal circumstances including disability, HIV and AIDS and other health conditions into account.

Given the challenges and the expected impact of HIV and AIDS on the public service, the following approach was adopted within the South African public services:¹¹⁷

- Various government HIV and AIDS structures were established to manage the response to HIV and AIDS. These structures fulfil different functions aimed at building an effective public service HIV and AIDS workplace response.
- National policy setting minimum requirements to be met by Government departments/agencies was formulated and regulated.
- Guidelines were developed at national level to assist departments/agencies to implement in-house programmes and policies to manage the impact of HIV and AIDS.
- Individual departments put in place policies and programmes in line with the national norms and standards.

In 2005 a review was undertaken¹¹⁸ that focused on workplace policies developed by the DoE as well as policies developed by two unions, the South African Democratic Teachers Union (SADTU) and the National Professional Teachers' Organisation of South Africa (NAPTOSA). The review established that policy governs many aspects of the professional lives of educators and is central to their and the sector's response to crises such as the HIV and AIDS epidemic. As such, policy can contribute directly to curtailing the attrition of educators by encouraging and providing protection against threats such as HIV and AIDS, and by creating a positive and supportive working environment.

The policies reviewed were found to be well written and if implemented, would create a good environment for educators. A number of successes were noted, particularly in terms of the transformation of education structures. The findings suggested that problems centred on a lack of policy implementation resulting from disjunctures between the national office and provincial and district offices, as well as a lack of resources and inadequate planning and preparation for implementation.

6.4 The HIV and AIDS Life Skills Education Programme

History of the Life Skills Programme

In 2000, during his Tirisano address Kader Asmal, then Minister of Education, prioritised HIV and AIDS as a critical challenge that the education system would need to effectively address in the coming years. In an attempt to prevent the spread of HIV within South Africa's schooling system, the then DoE developed the HIV and AIDS Life Skills Education Programme, which was informed by the 1999 *National Policy on HIV/AIDS for Learners and Educators in Public Schools and*

¹¹⁷ Department of Public Service and Administration. Human Resources Development Strategy for the public service, 2002-2006. Pretoria: Department of Public Service and Administration; 2002.

¹¹⁸ Education Labour Relations Council. Workplace policies in education: a review focusing on HIV/AIDS. Cape Town: HSRC Press; 2005.

Students and Educators in Further Education and Training Institutions and the 2000 National Integrated Plan (NIP) for Children and Youth infected and affected with HIV/AIDS.

Its implementation is coordinated by a national coordinator within the DBE and is implemented by provincial and district coordinators and administrators in each of the provinces. In its early years, the Life Skills Programme was implemented in the GET band (Grades 4 - 9), but from 2005 was extended to the Foundation Phase (Grades R - 3) and the FET band (schools and colleges, Grades 10 - 12). The LO Learning Area has remained the primary vehicle for teaching the Life Skills Programme to learners. It has been implemented within all public schools across the country although implementation within special schools has been delayed.

The primary purpose of the programme is to reduce the vulnerability of young people to HIV infection and to equip them with the requisite knowledge and skills to make informed and responsible decisions regarding their sexual behaviour. The Life Skills Programme is a multi-faceted programme that consists of several components, including capacity building for educators and school management teams; the development of teaching and learning materials; OBE lessons within the life skills component of the LO Learning Area; peer education programmes; and the establishment of care and support teams that include community-based stakeholders. The main topic areas covered by the programme are sexuality and health education (including HIV and AIDS), substance abuse, child abuse, peer education, assertiveness, peer pressure, anti-bias, gender issues and other relevant skills that would enable learners to deal effectively with difficult situations.

Review of the Life Skills Programme

Several evaluations of the Life Skills Programme that have been undertaken in recent years have examined teachers' and learners' perceptions and opinions of the programme as well as its influence on the attitudes and behaviour of learners. These evaluations have uncovered similar themes in their findings. The Life Skills Programme, for instance, has been identified by learners as a primary source of information about HIV and AIDS, while Grade 5 - 7 learners identified family members as additional sources of information and the media was considered an important source by Grade 8 - 10 learners.¹¹⁹ In a study conducted in Gauteng, schools were identified by 95% of participating learners as a common source of information about HIV and AIDS. However, learners did appear to be receiving information about HIV and AIDS from sources external to their schooling environment. Slightly fewer learners in the sample considered schools to be their most useful source of information (61%), or believed that they had learned the most about HIV and AIDS from their school (47.7%).¹²⁰

Several studies have shown that exposure to the Life Skills Programme is associated with an improvement in learners' knowledge about HIV and AIDS, common modes of transmission and prevention methods.^{121,122,123,124} The Programme has produced other favourable gains amongst

¹¹⁹ Department of Education. National evaluation of the impact of the DoE HIV & AIDS Life Skills Programme on the behaviour of learners. Pretoria: Department of Education; 2006.

¹²⁰ Bhana A, Brookes H, Makiwane M, Naidoo, K. Evaluation of the impact of the life orientation programme on HIV/AIDS in Gauteng schools – pilot study. Pretoria: HSRC; 2005.

¹²¹ *ibid.*

learners that include a heightened level of risk perception for HIV infection,¹²⁵ an increased understanding of abstinence as a prevention method and increased approval of abstinence as a behavioural choice for teenagers.¹²⁶ However, some studies have found gaps in learners' knowledge that need to be addressed by the Programme. In a national evaluation of the Programme,¹²⁷ learners failed to identify unprotected sex as a mode of HIV transmission, while a small proportion of Gauteng learners showed acceptance of common myths surrounding HIV and AIDS.¹²⁸

In terms of the impact on learners' attitudes and behaviour, evaluations have produced mixed results. A national evaluation conducted in 2006 reported that the Life Skills Programme¹²⁹ had made a positive impact on learners' behaviour, on their attitude towards people different from themselves, and on the way in which learners treat and interact with others. A reduction in the number of sexual partners among Grade 9 male learners in KwaZulu-Natal was found by Reddy and colleagues,¹³⁰ while a study by Visser¹³¹ found that increases in learner knowledge had failed to reduce learners' engagement in high risk sexual behaviours. In a Gauteng-based study, 90% of learners reported that LO lessons had helped them to protect themselves from HIV infection and to accept PLHIV, but only 34.4% believed that the classes were responsible for making the greatest impact on their behaviour and attitudes.¹³²

Learners appear to hold differing opinions as to the appropriateness of the curriculum of the Life Skills Programme. Bhana and colleagues¹³³ reported that most learners in their sample were happy with the materials supplied to them, but a third felt that there was insufficient information given to them for their age. In contrast, over half the learners felt there was too much emphasis on condom use (55.3%), sex (51%) and abstinence (60%), and just under half believed that the materials encourage learners to believe that it is okay for them to have sex as long as it is safe (49.4%). Amongst Grade 9 learners in KwaZulu-Natal, findings showed that exposure to the programme had not contributed to an increase in sexual activity, nor had it

¹²² Department of Education. National evaluation of the impact of the DoE HIV & AIDS Life Skills Programme on the behaviour of learners. Pretoria: Department of Education; 2006.

¹²³ Reddy P, James S, McCauley A. Programming for HIV prevention in South African schools: a report on programme implementation. Horizons Final Report. Washington, DC: Population Council; 2005.

¹²⁴ Visser MJ. Life skills training as HIV/AIDS preventative strategy in secondary schools: evaluation of a large scale implementation process. *Journal of Social Aspects of HIV/AIDS*. 2005; 2; 203-216.

¹²⁵ Bhana A, Brookes H, Makiwane M, Naidoo, K. Evaluation of the impact of the life orientation programme on HIV/AIDS in Gauteng schools – pilot study. Pretoria: HSRC; 2005.

¹²⁶ Reddy P, James S, McCauley A. Programming for HIV prevention in South African schools: a report on programme implementation. Horizons Final Report. Washington, DC: Population Council; 2005.

¹²⁷ Department of Education. National evaluation of the impact of the DoE HIV & AIDS Life Skills Programme on the behaviour of learners. Pretoria: Department of Education; 2006.

¹²⁸ Bhana A, Brookes H, Makiwane M, Naidoo, K. Evaluation of the impact of the life orientation programme on HIV/AIDS in Gauteng schools – pilot study. Pretoria: HSRC; 2005.

¹²⁹ Department of Education. National evaluation of the impact of the DoE HIV & AIDS Life Skills Programme on the behaviour of learners. Pretoria: Department of Education; 2006.

¹³⁰ Reddy P, James S, McCauley A. Programming for HIV prevention in South African schools: a report on programme implementation. Horizons Final Report. Washington, DC: Population Council; 2005.

¹³¹ Visser MJ. Life skills training as HIV/AIDS preventative strategy in secondary schools: evaluation of a large scale implementation process. *Journal of Social Aspects of HIV/AIDS*. 2005; 2; 203-216.

¹³² Bhana A, Brookes H, Makiwane M, Naidoo, K. Evaluation of the impact of the life orientation programme on HIV/AIDS in Gauteng schools – pilot study. Pretoria: HSRC; 2005.

¹³³ *ibid.*

raised learners' intentions to engage in sexual activity.¹³⁴ The findings of Reddy and colleagues¹³⁵ also highlighted the importance of gender sensitivity in the development and implementation of the Life Skills Programme. The researchers found important gender differences with regard to learners' needs and to the outcome of the Programme regarding learner's attitudes towards sex and sexual behaviour. The findings showed that the Programme had impacted on males and females differently, suggesting that future programme revisions should show gender sensitivity, taking into account the specific information, skills and learning needs of males and females.

Teachers play a critical role in the implementation of the Life Skills Programme and their effectiveness impacts on the success of the Programme. Research has shown that the majority of teachers believe in the importance of LO lessons for learners and the responsibility of schools to educate learners about sex and sexuality and HIV and AIDS.¹³⁶ Despite teachers' best efforts, their role in providing HIV education and prevention knowledge to learners is often undermined by a lack of resources and support.

A lack of teacher training, resources and support is a common finding of the evaluations.^{137, 138} Bhana and colleagues¹³⁹ found that roughly half the teachers in their study had not received teaching materials from the DoE and the majority of the teachers had not received Department training support in the LO programme. In addition, a third of the primary school and three-quarters of high school teachers felt there were insufficient LO teachers in their schools, with the ratio of LO teachers to learners ranging from 1:131 to 1:550.

Research suggests that the curriculum content of the Life Skills Programme can create anxiety for some teachers conducting LO lessons, especially when the content to be taught conflicts with their personal values.¹⁴⁰ For instance, Bhana and colleagues¹⁴¹ found that some Gauteng teachers felt the materials to be used were too explicit (40%) and placed too much focus on sex and sexuality (35%) and HIV and AIDS (46%). Teachers in KwaZulu-Natal have also reported feelings of uncertainty in teaching some of the details of the curriculum topics.¹⁴²

Other challenges expressed by these teachers included trying to manage learners' responses and beliefs about HIV and AIDS in a diplomatic manner, and encouraging the participation of all learners in classroom discussions, even those that considered HIV and AIDS to be of no concern to them personally. An important concern to arise from this study related to the way in which

¹³⁴ Reddy P, James S, McCauley A. Programming for HIV prevention in South African schools: a report on programme implementation. Horizons Final Report. Washington, DC: Population Council; 2005.

¹³⁵ *ibid.*

¹³⁶ Bhana A, Brookes H, Makiwane M, Naidoo, K. Evaluation of the impact of the life orientation programme on HIV/AIDS in Gauteng schools – pilot study. Pretoria: HSRC; 2005.

¹³⁷ *ibid.*

¹³⁸ Department of Education. National evaluation of the impact of the DoE HIV & AIDS Life Skills Programme on the behaviour of learners. Pretoria: Department of Education; 2006.

¹³⁹ Bhana A, Brookes H, Makiwane M, Naidoo, K. Evaluation of the impact of the life orientation programme on HIV/AIDS in Gauteng schools – pilot study. Pretoria: HSRC; 2005.

¹⁴⁰ Department of Education. National evaluation of the impact of the DoE HIV & AIDS Life Skills Programme on the behaviour of learners.

¹⁴¹ Bhana A, Brookes H, Makiwane M, Naidoo, K. Evaluation of the impact of the life orientation programme on HIV/AIDS in Gauteng schools – pilot study. Pretoria: HSRC; 2005.

¹⁴² Reddy P, James S, McCauley A. Programming for HIV prevention in South African schools: a report on programme implementation. Horizons Final Report. Washington, DC: Population Council; 2005.

lessons were being taught to learners, that is, teachers were primarily providing learners with the requisite knowledge and information and were neglecting to focus on the development of learners' skills and abilities.

Evaluation findings have shown that the implementation of the Life Skills Programme in some schools has not been satisfactory, nor had a positive impact on the development of school policies and support structures for HIV infected and affected learners.¹⁴³ An evaluation of the Programme across 16 high schools and four primary schools in Gauteng found that the Programme had not been implemented uniformly. Thirty percent of the schools were not implementing the Life Skills Programme within every grade in the school, with higher grades more likely to be exempt or assigned a shorter time period for the Programme. Often several classes from the same grade would be brought together for LO lessons, while other schools merged classes from different grades. In addition, learners' responses showed that 10% had not received lessons on sex, sexuality and HIV and AIDS and a third felt that they had had very few lessons about these topics.¹⁴⁴

Successes and challenges

Successes and achievements

A comprehensive report of the Life Skills Programme released in 2010 identified several noteworthy successes and achievements. The Programme had contributed to schools becoming centres of care and support for communities; it had led to some schools establishing food gardens and clothing distribution initiatives for OVC; and had also enhanced the skills and abilities of teachers to help and support children adversely affected by psychological and social issues. Among learners, the peer education programme had helped improve learners' perceptions of life, encouraging them to take responsibility for their lives and focus on their goals and future.

Research has provided evidence to suggest that the Life Skills Programme has undoubtedly supplied learners with important and useful information about HIV and AIDS which has resulted in positive behavioural and attitudinal outcomes among learners.^{145,146}

Challenges

Several challenges have been identified in relation to the programme's implementation. Firstly, it appears that some Model C schools chose not to implement the programme within their school setting because they did not consider the social problems dealt with by the programme to be relevant for their learners.¹⁴⁷ Similar findings have been found in other studies,¹⁴⁸ although

¹⁴³ Department of Education. National evaluation of the impact of the DoE HIV & AIDS Life Skills Programme on the behaviour of learners. Pretoria: Department of Education; 2006.

¹⁴⁴ Bhana A, Brookes H, Makiwane M, Naidoo, K. Evaluation of the impact of the life orientation programme on HIV/AIDS in Gauteng schools – pilot study. Pretoria: HSRC; 2005.

¹⁴⁵ *ibid.*

¹⁴⁶ Reddy P, James S, McCauley A. Programming for HIV prevention in South African schools: a report on programme implementation. Horizons Final Report. Washington, DC: Population Council; 2005.

¹⁴⁷ Department of Education. National evaluation of the impact of the DoE HIV & AIDS Life Skills Programme on the behaviour of learners. Pretoria: Department of Education; 2006.

the reasons for non-implementation were unclear. An evaluation of the Life Skills Programme in Gauteng schools found that there were significant organisational challenges that impeded the effective implementation, some of which were associated with teachers' availability, attitudes towards teaching the programme content, and their relationship with learners.¹⁴⁹


Secondly, some schools failed to develop implementation plans to address risk behaviours among learners. A lack of involvement of SMTs within programme implementation was also found in certain schools. It was found that there was a need to train more teachers on an ongoing basis in programme delivery because of their frequent rotation to different Learning Areas within the Life Skills Programme. Research has shown that teachers feel there is a shortage of adequately trained LO teachers available in schools.¹⁵⁰ A constant challenge facing the Life Skills Programme is the adequacy of age appropriate material. Studies have shown that teachers are often uncomfortable about teaching the content and details to children and often have to suspend their conflicting values or resort to sharing their personal attitudes and values with children. Research also indicated that the materials are often regarded as placing too much emphasis on explicit sexual behaviours.^{151,152}

Strategic pointers to the way forward in life skills

A comprehensive education sector response

According to UNESCO, a comprehensive education sector response needs to take a holistic, sector-wide view of the impacts and challenges brought about by the HIV epidemic and must mobilise and deploy all components and capacities of the education system to address and mitigate those impacts.¹⁵³ UNESCO proposes a comprehensive education sector response that consists of five key components, namely (1) quality education, (2) content, curriculum and learning materials, (3) educator training and support, (4) policy management and systems, and (5) approaches and illustrative entry points. According to UNESCO, experience suggests that optimal success in addressing the HIV epidemic in the education sector is dependent on all five components working effectively and in synchronicity with the education system.

A comprehensive education sector response entails the following:

-  Quality education supplied to learners must be rights-based, learner-centred, gender-responsive, inclusive, culturally sensitive, age-specific, scientifically accurate and delivered in safe and secure learning environments.

¹⁴⁸ Bhana A, Brookes H, Makiwane M, Naidoo, K. Evaluation of the impact of the life orientation programme on HIV/AIDS in Gauteng schools – pilot study. Pretoria: HSRC; 2005.

¹⁴⁹ Visser MJ. Life skills training as HIV/AIDS preventative strategy in secondary schools: evaluation of a large scale implementation process. *Journal of Social Aspects of HIV/AIDS*. 2005; 2; 203-216.

¹⁵⁰ Bhana A, Brookes H, Makiwane M, Naidoo, K. Evaluation of the impact of the life orientation programme on HIV/AIDS in Gauteng schools – pilot study. Pretoria: HSRC; 2005.

¹⁵¹ *ibid.*

¹⁵² Reddy P, James S, McCauley A. Programming for HIV prevention in South African schools: a report on programme implementation. Horizons Final Report. Washington, DC: Population Council; 2005.

¹⁵³ UNESCO. EDUCAIDS: towards a comprehensive education sector response. Paris: UNESCO; 2007.

- ✘ The content of the HIV and AIDS curriculum and learning materials must be evidence-based, exposed to learners at an early age, built on learners' existing knowledge and skills bases, and based on interactive teaching methodologies.
- ✘ Teachers must be provided with pre- and in-service training to build their technical knowledge and confidence as well as to address any personal vulnerabilities to HIV infection or the impacts associated with HIV and AIDS. Teachers should be provided with appropriate learning materials and resources, especially for those who are HIV positive.
- ✘ Sectoral and workplace policies that address HIV and AIDS, violence, discrimination and abuse must be established and firmly adhered to.
- ✘ Lastly, a comprehensive response entails a holistic effort that maximises the use of various approaches, opportunities and entry points to address any vulnerabilities and risk behaviours within the education sector that create and perpetuate HIV-related risk.¹⁵⁴

Given the huge and widespread impacts and challenges brought about by HIV epidemics in southern Africa, schools are often placed in a position where they may be required to provide more than HIV prevention education to their learners. The outcome of a technical consultation meeting in 2007 with the United Nations and various other stakeholder including government officials, NGO members, and research institutions identified several key elements that are necessary within an integrated treatment, care and support programme for schools in southern Africa. These included the following elements:

- ✘ Ensuring the continuation of education for learners;
- ✘ Providing psycho-social support to learners affected by or infected with HIV;
- ✘ Facilitating access to treatment education that includes increasing understanding of antiretroviral (ARV) medications and support for those teachers and students that are taking ARVs;
- ✘ Responding to basic needs of learners that can include establishing a school-based feeding programme, creating vegetable gardens on school grounds, and clothing collection and distribution; and
- ✘ Developing the livelihood skills of learners to improve agricultural skills to promote food security to families living in poverty.

Policies and procedures for preventing and safely managing accidents and injuries at school (UNESCO, 2008).¹⁵⁵

United Nations Guidelines on sexuality education¹⁵⁶

The International Technical Guidance on Sexuality Education developed by the United Nations in 2009 defines key concepts of comprehensive sexuality education as:

¹⁵⁴ UNESCO. *EDUCAIDS: towards a comprehensive education sector response*. Paris: UNESCO; 2007.

¹⁵⁵ UNESCO. *School-centred HIV and AIDS care and support in southern Africa: technical consultation report, 22-24 May, 2008, Gaborone, Botswana*. Paris: UNESCO; 2008.

¹⁵⁶ The following three sections are taken verbatim from the factsheet published for global use by youth organisations and those working with youth, *The linkages between the MDGs and comprehensive sexuality education for young people: fact sheet on MDG 2* produced by the Youth Coalition based in Ottawa and Ontario, Canada.

1. Relationships;
2. Values, Attitudes and Skills;
3. Culture, Society and Human Rights;
4. Human Development;
5. Sexual Behaviour; and
6. Sexual and Reproductive Health.

What makes sexuality education comprehensive?

Effective sexuality education can provide young people with age appropriate, culturally relevant and scientifically correct information. It includes structured opportunities for young people to explore their attitudes and values, and to practice the skills they need to be able to make informed decisions about their sexual lives.

The International Technical Guidelines on Sexuality Education lists 18 characteristics of programmes that have been effective. These characteristics include:

- ⓧ Addressing specific situations that may lead to risky sexual behaviour or unwanted or unprotected sexual intercourse and how to avoid and get out of these situations;
- ⓧ Assessing the reproductive health needs and behaviours of young people;
- ⓧ Addressing personal values and perceptions of family and peer norms about engaging in sexual activity and having multiple partners; and
- ⓧ Focusing on specific risk and protective factors that affect particular sexual behaviours and that are amenable to change by the curriculum-based programme.

The most prevalent sexuality education curricula are designed to reduce risks related to STIs, HIV and AIDS or unintended pregnancies. These programmes are often too medical-oriented, fear-based and seldom address the varied needs of young people. The curricula rarely address relationships, social and cultural factors and positive aspects of sexuality, such as sex as a natural, pleasurable, life-affirming event. Research has also suggested that abstinence as a behavioural goal is not the same as the abstinence-only education programmes

To bring about a behavioural change among young people, comprehensive sexuality education strategies should be adopted to increase knowledge and skills of young people in making healthy and informed choices rather than limiting their rights and choices. Furthermore, comprehensive sexuality education needs to be paired with programmes aiming at providing access to comprehensive sexual and reproductive services for youth.

Comprehensive sexuality education and human rights

The United Nations Charter on the Rights of the Child (UNCRC) states that all children and young people have the right to access information that will allow them to make decisions about their health (Article 17), including family planning (Article 24). They have the right to education that

will help them learn, develop and reach their full potential and prepare them to be understanding and tolerant towards others (Article 29).

Sexual and reproductive rights are a vital part of human rights. Many international consensus documents recognise the right of young people to seek/access information regarding their sexual and reproductive health. For example, articles 6.13 and 6.15 of the Programme of Action of the International Conference on Population and Development (ICPD) call on countries to meet the needs and aspirations of youth to ensure their integration and participation in all spheres of society including participation in the political process and preparation for leadership roles. Furthermore, the Programme of Action urges countries to actively involve young people in the planning, implementation and evaluation of development activities that have a direct impact on their daily lives, highlighting the importance of sexuality education and sexual and reproductive health concerns in this regard.

6.5 Educator roles in a time of HIV

A recent pilot project among educators in pre-service and in-service training in higher education institutions pointed to some of the key roles expected of educators in a time of HIV.¹⁵⁷ It situated these roles within three broad critical areas of professional practice:

- Teacher roles (prevention agent, caregiver, leader/role model);
- Teacher sensitivities (awareness of vulnerable learners and colleagues, gender issues, cultural heritage, contextual assets and constraints; and
- Teacher agency (willingness to reflect and act).

The roles were described as:

Biomedical HIV and AIDS knowledge: In their roles as educators and as role models it will be expected and is essential that basic knowledge of HIV and AIDS is learned and internalised.

Confidence in relation to professional practice: Educators will need to be confident with regard to integrating HIV and AIDS into the curriculum as well as to providing learners with HIV and AIDS information and with support and advice outside of the curriculum.

Awareness of context: This requires of educators a consciousness that HIV and AIDS affects everyone indiscriminately and that it will have impacts in their own lives, in the lives of their colleagues and learners and in the classroom itself.

Acting as a preventative agent: Educators are obligated by policy to provide prevention education and to prevent any learner from being stigmatised or discriminated against. It is obvious already to most educators that prevention education is not just limited to the classroom. This function will require educators to be well informed about the facts and the socio-cultural contexts of HIV transmission. It will in addition require overcoming learner apathy in the classroom and establishing legitimacy in the community. In order to achieve these

¹⁵⁷ HEAIDS. HIV and AIDS in teacher education - evaluation report of a pilot project in South African higher education institutions. Pretoria: Higher Education South Africa; 2010.

educators have to feel comfortable addressing sexuality related issues which in turn assumes the need for teachers to consider their identity in relation to their sexuality as well as their position on teaching sexuality related issues.

Performing a caregiver role: Educators across the country have always found themselves performing a caregiver role including providing a caring environment for learners. With South Africa's commitment to creating a caring and supportive environment for teaching and learning and with an at least temporarily increasing impact of HIV and AIDS in the country this function will continue to be an important one. Research evidence points to the added burden that the caregiving role places on educators and to the extra time needed, as well as the added responsibility.

Collegial sensitivity: In the teaching community it is likely that educators will have colleagues who are infected with or affected by HIV. Whether educators disclose or not, HIV and AIDS can have an impact on lives, productivity and organisational climate in schools and in departments. Sensitivity, supporting colleagues and resisting and rolling back stigma and discrimination will be required of all educators.

Reflexivity: Educators in a time of HIV will be called upon to heighten their self awareness of their values, attitudes, beliefs and behaviour in relation to HIV and AIDS. Non-discrimination, empathy and responsible sexual behavior, including knowing their own HIV status, are some of issues on which reflection-driven action will be required.

Leadership: Learners and communities often look to educators to be role-models and to act in ways that 'live out' transmitted knowledge and rights-based approaches.

6.6 Supporting HIV positive learners

While the majority of sexually active South Africans still do not know their status, recent government initiatives aim to change this through HIV testing. It is not a given that an increased number of learners knowing their status will mean an increased number disclosing, but with increased knowledge, HIV positive learners will have access in caring and supportive schools.

Learner health is always an aspect of the school environment and of classroom participation and climate. Educators play a role with HIV and AIDS, as they do for other diseases or conditions of ill-health, through alertness to symptoms and appropriate referral, thus making issues of confidentiality and sensitivity applicable.

Where learners have publically disclosed, confidentiality becomes less of an issue while potential discrimination or stigma become factors to be addressed.

Schools need to explore policies around learner release for treatment, prioritisation for HIV positive learners in nutrition schemes (due to the requirements of ART), potential learner support or 'buddy' schemes, a heightened vulnerability watch, and reporting and referral systems.

Further to this, educators need to remain vigilant in identifying psycho-social problems that AIDS orphans may experience and refer orphans to relevant health and social services where needed. Indeed, research has shown that AIDS orphans in particular suffer more mental health problems than other children including depression, post-traumatic stress disorder, suicidal ideation, and peer and behavioural problems.¹⁵⁸ However, it has been found that problems relating to conduct disorders, delinquency and depression can be effectively addressed by ensuring that AIDS orphans are beneficiaries of feeding programmes and no fee programmes at schools, and if one of their carers is receiving a government support grant.¹⁵⁹

6.7 School HCT campaign strategy

The school HIV Counselling and Testing (HCT) campaign strategy is an extension of the broader national HCT campaign. Studies have linked countries that have recorded reductions in HIV transmission rates with combined multiple risk reduction strategies, strong leadership and active community engagement.¹⁶⁰ Large scale interventions such as these require unprecedented national mobilisation and the collective action of every sector of society including education. Expanding access to HCT in schools provides an opportunity for significant scale-up of the national HCT programme while also initiating behaviour change.

A task team has been established to develop a strategy and implementation plan for the school HCT campaign, comprising representatives from various government departments and implementing partners. The school HCT campaign aims to test learners aged 12 years and older for HIV. The campaign aims to promote prevention messaging about healthy lifestyles irrespective of HIV status; to mobilise people to know their HIV status; to increase the availability of HCT services for youth outside of health facilities through novel partnerships between public, private and non-governmental institutions; to increase health seeking behaviour; and to increase access to treatment, care and support services. The campaign will include educators, support staff, SGBs and parents to ensure a comprehensive approach involving the entire school community. Additionally, this will ensure ongoing psycho-social support for learners both in and outside school.

Essentially, the campaign is a two phased approach comprising firstly advocacy and social mobilisation which will then be followed by screening and testing for chronic diseases for all stakeholders. Through the existing HIV and AIDS Life Skills Education Programme, social mobilisation and advocacy aim to address issues of stigma and discrimination - significant barriers to accessing treatment, care and support services - while the screening and testing phase will focus on HIV testing and screening for key health barriers to learning including vision, hearing, body mass index and tuberculosis (TB).

¹⁵⁸ Cluver L, Gardner F, Operario D. Psychological distress amongst AIDS-orphaned children in urban South Africa. *Journal of Child Psychology and Psychiatry*. 2007; 48; 755 – 763.

¹⁵⁹ *ibid.*

¹⁶⁰ Coates TJ, Richter L, Caceres, C. Behavioural strategies for reducing HIV transmission: how to make them work better. *The Lancet*. 2008; 372; 669-684.

SECTION TWO THE STRATEGY

7.1 Key Strategy Principles

There are ten key principles that underpin the strategy.

1. All interventions focused on combating HIV and AIDS in support of the NSP will be designed to have simultaneous positive effects on the goals attached to the broad strategic areas of *Schooling 2025*,¹⁶¹ namely, *The improvement of learning outcomes and Improved access to education*.
2. Comprehensiveness will ensure that the strategy constructs interventions to address the range of individual and structural key drivers of HIV and AIDS amongst school-going youth, educators, school support staff and DBE officials in South Africa.
3. An outcomes-based approach aligns the strategy with Government's new direction and operating paradigms and ensures that all efforts are focused on achieving measurable success.
4. Interventions will be evidence-based and will rigorously scale-up proven effective responses.
5. A caring and supportive school environment will be developed, not just in response to HIV but as part of South Africa's commitment to SADC to enhance care and support for teaching and learning.
6. Schools will be utilised as centres for enhancing access of young people to services for sexual and reproductive health, including HIV.
7. Programmes and interventions aimed at supporting various constituencies will be constituency-focused and will include consultation with and participation by the constituency. For example, learner interventions will be child/youth-centred and will consult with and ensure participation by learners, while educator interventions will be educator-specific and will include consultations with and participation by educators.
8. Interventions will build on existing programmes and services and never duplicate or waste resources.
9. District offices and officials will play a critical support role to schools in developing and implementing HIV and AIDS programmes. Their capacity to do so will be enhanced.
10. Parents and communities will be involved and their support and resources will be harnessed.

¹⁶¹ Department of Basic Education. Towards a Basic Education Sector Plan (working document). Pretoria: Department of Education; 2010.

7.2 Strategy intended impacts

There are four major intended impacts¹⁶² of this strategy:

1. Improved learner and educator retention within the education system through HIV-related interventions.
2. A contribution to decreased HIV incidence among 15-19 year olds and among educators, school support staff and officials.¹⁶³
3. Increased sexual and reproductive health among learners, educators, school support staff and officials.
4. Increased physical and psychological safety in all South African schools.

7.3 Strategy goals

There are three major strategy goals against which the strategy will be evaluated:

1. Enhanced protective factor of schools and the basic education sector with regard to HIV prevention, support and mitigation.
2. Increased knowledge, skills and confidence among learners, educators, school support staff and officials to take self-appropriate sexual and reproductive decisions.
3. Increased access to sexual and reproductive health services including HIV services by learners, educators, school support staff and officials.

7.4 Strategy objectives

The strategy has four objectives, aligned to the NSP:

1. To support South Africa's HIV prevention strategy by increasing **sexual and reproductive knowledge, skills and appropriate decision-making** among learners, educators, school support staff and officials.
2. To mitigate the impact of HIV by providing a **caring, supportive and enabling environment** for learners, educators, school support staff and officials in all South African schools and in the country's education departments.
3. To **transparently monitor and evaluate** all goals, objectives and outcomes in line with Government's monitoring and evaluation (M&E) framework and to **research** all components of this strategy.
4. To ensure the provision of a **safe, rights-based environment in schools and in the country's education departments**, including zero tolerance of discrimination, stigma and any form of sexual harassment/abuse.

¹⁶² The impact of the interventions can be measured in national impact evaluation studies. However, the contribution of education-specific interventions to outcomes may be difficult to isolate given the range of interventions that are currently being implemented within and outside of schools to prevent and mitigate the impact of HIV and AIDS.

¹⁶³ Implementation of the strategy in its entirety is critical if it is to effectively contribute to the decrease in HIV incidence.

7.5 Strategy outcomes

In order to realise the objectives the following seven outcomes will need to be achieved over the strategy period. Each outcome is elaborated further below:

1. The DBE and all provinces have integrated all components of this HIV strategy and its subsequent policy into their core work, evaluation and reporting systems.
2. Sexual and reproductive health education including HIV is a mandatory, timetabled and assessed subject delivered in all South African schools.
3. Age appropriate sexual and reproductive health and HIV-related life skills are delivered through co-curricular means in all South African schools.
4. Educators receive pre-service and in-service training on sexual and reproductive health including HIV.
5. Every South African school and education department has a communicated plan in place to increase access to sexual and reproductive health and HIV services for learners, educators, school support staff and officials. Service provision for educators, school support staff and officials must be integrated within employee assistance programmes (EAP).
6. Every South African school implements and monitors a communicated safety plan that includes components on physical safety and psychological/emotional safety, including zero tolerance of discrimination, stigma and any form of sexual harassment/abuse.
7. Barriers to retention and achievement in school for learners who are HIV affected or infected are mitigated by implementation of pro-poor policies.

7.6 Log frame: Strategy outputs, performance measures and activities

The table below summarises the key performance measures and activities to achieve the strategy outputs:

STRATEGY OUTCOME	OUTPUTS	ACTIVITIES ¹⁶⁴
<p>The DBE and all provinces have integrated all components of this HIV strategy and its subsequent policy into their core work, evaluation and reporting systems</p>	<ul style="list-style-type: none"> ⓧ A revised national policy on HIV and AIDS in the education system ⓧ A comprehensive, integrated national plan for responding to HIV and AIDS in the school system ⓧ Appropriate structures for coordinating the response at national and provincial levels ⓧ Appropriate planning frameworks, including strategic and operational planning templates for guiding activity at provincial level ⓧ Appropriate reporting frameworks, including quarterly and annual reporting templates for reporting to provincial and national oversight bodies ⓧ Resources commensurate with the HIV and AIDS challenge at national and provincial levels, including guideline allocations in the equitable share formula ⓧ Educator supply and demand planning that is responsive to the HIV and AIDS impact ⓧ Improved monitoring, analysis and modelling of enrolment and other system data ⓧ Improved prevalence and incidence monitoring for the sector ⓧ Improved M&E of strategy implementation 	<ul style="list-style-type: none"> ⓧ A series of consultations will be held with key players including branches within the DBE, provinces, unions, learners, academics and researchers, other countries which have acted successfully against HIV and AIDS and international agencies such as UNESCO and UNICEF ⓧ Simultaneous consultation with SANAC will take place on setting targets for the objectives in line with both the current NSP and possible evolving thinking for a new 2012 - 2016 NSP period ⓧ Further detailed activities for all outputs attached to this outcome will be put in place in a national implementation plan

¹⁶⁴ Activities in a national strategy can only be given at a high strategic level. More detailed activities will be elaborated in an implementation plan still to be finalised.

STRATEGY OUTCOME	OUTPUTS	ACTIVITIES
Sexual and reproductive health education, including HIV is a mandatory, timetabled and assessed subject delivered in all South African schools	<ul style="list-style-type: none"> ✘ Enhanced national curriculum statement (NCS) and supporting teaching modes and materials 	<ul style="list-style-type: none"> ✘ A review task team will evaluate current Life Skills education curriculum against international good practice and recommend enhancements- where indicated- to the curriculum, to teaching practice and to support materials. This team will align with current processes in DBE to review the curriculum. ✘ Current weaknesses will be corrected; guidelines and materials for delivering it will be enhanced.
Age appropriate sexual and reproductive health and HIV-related life skills are delivered through co-curricular means in all South African schools ¹⁶⁵	<ul style="list-style-type: none"> ✘ A database of evaluated support programmes including peer education is available ✘ Trained and evaluated 'life skills' support personnel attached to targeted schools and tested through pilot programmes 	<ul style="list-style-type: none"> ✘ Create a database of evaluated support programmes, including peer education. ✘ Pilot programme to attach 'life skills' support personnel to targeted schools
Educators receive pre-service and in-service training on sexual and reproductive health including HIV ¹⁶⁶	<ul style="list-style-type: none"> ✘ Enhanced curriculum for teacher training in personal sexual and reproductive health decision-making and the teaching of sexual and reproductive health education to learners ✘ Systems of psychological support for educators will be investigated. 	<ul style="list-style-type: none"> ✘ Liaise with teacher relevant development stakeholders (branch, DHET, HEIs, educators) to review current curriculum for the classroom (pre-service and in-service) ✘ Consult with the Department of Higher Education and the higher education institutions to improve educator training curriculum and materials.

¹⁶⁵ Innovative ways of attaching support programmes to schools and thus providing learners with 'life coaches' will be investigated and recommendations, including budgetary considerations, will be made.

¹⁶⁶ For teaching and for own lives.

STRATEGY OUTCOME	OUTPUT	ACTIVITIES
<p>Every South African school and education Department has a communicated plan in place to increase access to sexual and reproductive health and HIV services for learners, educators, school support staff and officials. Service provision for educators, school support staff and officials must be integrated within EAPs</p>	<ul style="list-style-type: none"> ✘ School HIV Counselling and Testing (HCT) campaign will be implemented ✘ Enhanced EAP plans across all departments to include socio-psychological support of teachers, school support staff and officials due to their dealing with HIV, other health-related matters as well as stressful issues in their careers ✘ Template and materials in support of school plans for access to sexual and reproductive health services ✘ Capacity plans for districts to support schools in developing 'Access to Reproductive Health and HIV Services' Plans ✘ School plans for enhancing access to sexual and reproductive health services 	<ul style="list-style-type: none"> ✘ Implementation of the school HCT campaign for learners, school support staff and officials ✘ The DBE and provinces in consultation with stakeholders review current EAPs and benchmark against best practice global standards for workplace HIV-related EAP (International Labour Organisation (ILO)) ✘ Analyse current and emerging care and support initiatives impacting on the access of learners and educators to sexual and reproductive health services including HIV services for synergies supporting this intent. ✘ Develop enhanced EAP programmes
<p>Every South African school implements and monitors a communicated safety plan that includes components on physical safety and psychological/emotional safety, including zero tolerance for discrimination, stigma and any form of sexual harassment/abuse.</p>	<ul style="list-style-type: none"> ✘ Component templates and support materials for issues of physical safety and zero tolerance for discrimination, stigma and any form of sexual harassment/abuse in school and workplace safety plans ✘ School safety plan per school dealing with physical safety and zero tolerance for discrimination, stigma and any form of sexual harassment/abuse in school 	<ul style="list-style-type: none"> ✘ Integrate issues of sexual and reproductive health and rights, HIV and stigma into the school safety policy process and programme ✘ Develop school safety plans in line with the policy and programmes ✘ Strengthen the elimination of stigma and discrimination in Life Skills education curriculum and co-curricular activities

STRATEGY OUTCOMES	OUTPUTS	ACTIVITIES
Barriers to retention and achievement in school for learners who are HIV affected or infected are mitigated by implementation of pro-poor policies ¹⁶⁷	<ul style="list-style-type: none"> ✘ Mapping of pro-poor policies currently implemented in the schooling system and relationship with educational outcomes ✘ Inclusion of HIV and AIDS as a source of vulnerability that pro-poor policies aim to address and measurement of impact 	<ul style="list-style-type: none"> ✘ Map pro-poor policies linked to HIV and AIDS responses implemented and assess their effect on strategy outputs and outcomes ✘ Take steps to integrate HIV responses, care and support and pro-poor policies

¹⁶⁷ Pro-poor policies have a positive impact on the ability of orphans and other children made vulnerable by HIV and AIDS amongst others, to access and stay in school. However, pro-poor policy interventions are currently running parallel to other interventions to prevent and mitigate the impact of HIV and AIDS. The range of interventions currently implemented to prevent HIV and AIDS will be integrated into a comprehensive package of care and support for learners.

8. FINANCIAL IMPLICATIONS

The financial implications of a new comprehensive strategy for responding to HIV and AIDS in the school system can only be determined with some accuracy once the detailed strategic and operational plans have been elaborated at both national and provincial levels. Some elements can, however, already be anticipated.

It is clear for example, that once the new strategy has been formally adopted, a new approach will need to be taken towards the conditional grant mechanisms for HIV and AIDS.

8.1 Should the conditional grant be retained?

In the short-term, yes. The main reason for this is captured in the current grant framework; to enable the Department to provide overall guidance, and to ensure congruency, coherence and alignment with the government's NSP for HIV and AIDS. This enabled the (then) DoE to play an oversight role in the implementation of the Life Skills Programme in schools.

This becomes even more important as the programme is reshaped and expanded through new activities. The DBE would want to ensure that each province is able to plan and implement the key (non-negotiable) interventions considered absolutely necessary to achieve the outcomes and objectives of the national strategy in support of the country's NSP. Whilst provincial mechanisms and delivery may be varied, the activity itself may be crucial. In addition, the grant framework will allow for the introduction of consistent and uniform performance indicators for government to assess the (varied) effectiveness of these programmes to inform further programme design and delivery. Sustained monitoring and accountability for the HIV and AIDS intervention is key to government's agenda and should be coordinated at a national level.

8.2 Motivating changes in approach from the current grant

Because a conditional grant already exists, DBE will examine the following options:

1. There is no doubt that the existing envisaged amounts will be insufficient to make a significant contribution to achieving the outcomes in the new strategy. The implication is that the DBE may consider with some haste applying to expand the existing conditional grant, in terms of priorities and activities as well as its funding allocation.
2. In terms of the division of the grant between provinces, the provincial allocations are based solely on the learner population. This ensures that funding follows the concentration of learners but at the same time it ignores the varied HIV prevalence between provinces (which directly indicates the provinces/areas with the highest concentration of vulnerable or persons most in need of care and support). Moving forward, it is possible that the national strategy may wish to negotiate new calculating mechanisms that better reflect the burden of HIV and AIDS on schools in provinces.
3. Re-specify the guideline percentages on use of the grant funding between the various key priority areas.

4. To ensure that the new priority areas are given adequate focus, planning and implementation, it is recommended that the Department specify where a certain level of focus/use is non-negotiable (for example, a minimum of x% must be used for y activity).
5. The proposed transformation of the HIV and AIDS Life Skills Education Programme introduces a number of new elements and activities to the programme. This will affect the current grant goal, purpose, expected outcomes and outputs (and the indicators that measure this), the conditions of the grant as well as its allocation/use.
6. In terms of governance, the same reporting processes apply as with the existing grant. The DBE will need to consider how to improve its ability to collect and analyse key data and what this may mean for M&E systems and procedures.
7. No changes are proposed to the stipulations in the sections of the 2009 Division of Revenue Act.
8. A widely recognised need is that of an applied minimum standard reporting on agreed performance indicators and the assessment of programme effectiveness. This requires provincial Education Departments to request that schools collect and report on key performance indicators more consistently than might currently be the case. In addition, provinces would be called upon to ensure the maintenance of adequate data reporting and verification processes.

9. REQUIREMENTS FOR EFFECTIVE IMPLEMENTATION

In order to create the conditions for the successful implementation of the new strategy, a number of key requirements have been identified. These relate to both structures and mechanisms that have to be put in place, and are set out in some detail below:

9.1 Development of implementation plans

The strategic framework set out in this strategy document is a broad guide to the strategic direction which the DBE wishes to respond to HIV and AIDS in the school system. In order to serve as an effective guide to action, the strategic framework will need to be elaborated into much more detailed implementation plans by those divisions of the Department that will bear direct responsibility for the implementation of those plans, as well as by the corresponding units in the nine provincial Departments of Education. This process of elaboration will need to take place as part of the annual strategic and operational planning cycle, and should be planned to coincide with the preparation of the strategic and operational plans commencing with the 2011/12 financial year.

9.2 Provincial strategic and operational planning

If provinces are to develop detailed strategic and implementation plans of their own within the framework of the national strategy, then it would be essential that clear parameters are provided for those plans. This process will be assisted by the development and articulation of clear objectives, guidelines on programme activities, indicators and targets, and the inclusion of these into the templates used for guiding the annual strategic and operational planning and

reporting processes. This will require detailed coordination and planning at the level of the DBE before liaison with the National Treasury around inclusion in the templates.

In addition, guidance material put in place by the DBE to assist provinces in their thinking, planning and implementation will likely speed up implementation considerably.

9.3 Core responsibility for delivery by mainstreaming units

While responses to HIV and AIDS have been mainstreamed into a few diverse units of the DBE, many others still regard the issues as being safely outside of their immediate areas of responsibility. Even in some of the units where staff has been engaged in activities related to the response to HIV and AIDS, this work is generally viewed as assisting the Health in Education Chief Directorate with their work.

The successful implementation of the strategy will rest heavily on each of the affected units, at national, provincial, district and school levels, understanding and accepting the responsibility to respond effectively to HIV and AIDS as integral to their diverse portfolios.

9.4 Structures to manage the mainstreaming and coordination within DBE

A Departmental Forum on HIV and AIDS has been in existence since 2008. Various branches and units of the Department have had representation on the Forum, and it has served as a structure for information dissemination and the informal coordination of activities. In 2010, the Departmental HIV and AIDS Forum was subsumed under the Chief Director's Forum. In the light of the new strategy with the emphasis on the mainstreaming, integration and acceleration of the response, it may be necessary to replace it with a Departmental Committee, with an explicit mandate to coordinate and strengthen the work of the affected units and to monitor against outcome indicators in the DBE.

9.5 Appropriate structures to manage the coordination with provinces

In the absence of the conditional grant as the main coordinating mechanism in the future, it will become increasingly important to have a structure that is capable of aligning and coordinating policy, operational activities, budgetary priorities, staffing and other norms and standards between the DBE and the nine provincial Departments of Education. In this regard, the establishment of a HEDCOM sub-committee on HIV and AIDS in basic education would be one of the options that the Director-General will consider together with his colleagues in HEDCOM.

10. CONCLUSION

This new strategy for responding comprehensively to HIV and AIDS in the basic education sector represents a change of pace and a widening of the remit for HIV and AIDS in the DBE and in the provincial Departments of Education. The strategy is driven by key national strategic values, needs and obligations to protect the nation's youth, strive for gender equity in particular via the provision of sexual and reproductive health and to roll back HIV and AIDS.

The strategy aims to mainstream, integrate, coordinate and accelerate schooling responses. It rests on key strategic components aligned to those of the National Strategic Plan for HIV and AIDS and addresses the context, the history of responses both broadly and specifically in the education sector, key youth drivers to the epidemic and evidence on successful responses. This strategy builds on the policy adopted in 1999 and aims, in its successful implementation, to comprehensively address HIV and AIDS related schooling issues, thus contributing significantly to enhanced education outcomes. The final version of the strategy will, in turn, lay the basis for a new and more comprehensive policy on HIV and AIDS for the schooling system.

ANNEXURE A: SOUTH AFRICA'S NATIONAL STRATEGIC PLAN 2007 - 2011

The primary aims of the NSP are to:

1. Reduce the rate of new HIV infections by 50% by 2011
2. Reduce the impact of HIV and AIDS on individuals, families, communities and society by expanding access to appropriate treatment, care and support to 80% of all HIV positive people and their families by 2011

The NSP provides the basis for an integrated response to the epidemic – the interventions needed to reach the NSP's goals are structured under four key priority areas: Prevention; treatment, care and support; research, monitoring, and surveillance; human rights and access to justice.

Key Priority Area 1: Prevention

1. Reduce vulnerability to HIV infection through strengthening poverty reduction strategies, support to families and communities and HIV testing;
2. Reduce sexual transmission of HIV through strengthening behaviour change programmes, interventions and curricula for the prevention of sexual transmission of HIV customised for different groups with a focus on those more vulnerable to and at higher risk of HIV infection and developing and integrating a package of sexual and reproductive health and HIV prevention services into all relevant health services
3. Reduce mother-to-child transmission of HIV
4. Minimise the risk of HIV transmission through blood and blood products

Key Priority Area 2: Treatment, care and support

1. Increase coverage of voluntary counselling and testing and promote regular HIV testing
2. Enable people living with HIV and AIDS to lead healthy and productive lives by providing appropriate packages of treatment, care and support to 80% of HIV positive people and their families by 2011, strengthening the health system and removing barriers to access
3. Address the special needs of pregnant women and children
4. Mitigate the impacts of HIV and AIDS and create an enabling social environment for care, treatment and support

Key Priority Area 3: Research, monitoring, and surveillance

1. Develop and implement a monitoring and evaluation framework to monitor inputs, process, outputs, outcomes and impact
2. Support research in the development of new prevention technologies
3. Develop and support a comprehensive research agenda including operations research, behavioural research, epidemiological trials and other research for new technologies for prevention and care
4. Conduct regular surveillance

Key Priority Area 4: Human rights and access to justice

1. Ensure public knowledge of and adherence to the existing legal and policy framework
2. Mobilise society, and build leadership of PLHIV in order to mitigate against stigma and discrimination
3. Identify and remove legal, policy, religious and cultural barriers to effective HIV prevention, treatment and support
4. Focus on the human rights of women and girls, and people with disabilities, and mobilise society to promote gender and sexual equality to address gender-based violence

A mid-term review of NSP 2007-2011 was conducted in 2009, and the findings of this review have informed the development of the new Strategy for HIV and AIDS in Basic Education.

ANNEXURE B: SOUTH AFRICA'S COMMITMENT TO SEXUAL AND REPRODUCTIVE HEALTH RIGHTS

Owing to the determined efforts of government and many civil society organisations, many policies and laws relating to reproductive health have been passed since 1994.¹⁶⁸ At present, South Africa's reproductive health policies and legislation are among the most comprehensive and progressive in the world in terms of the importance and recognition they assign to sexual and reproductive health rights. Changes in law and policy were accompanied by major restructuring within health programmes and administration. Most notably, the establishment of a Mother, Child and Women's Health Directorate within the DOH in 1995 was an important milestone for South Africa that acknowledged the disproportionate burden of reproductive health problems borne by South African women.¹⁶⁹ In addition, initiatives to address inadequacies in the provision of adolescent sexual and reproductive health services have also been introduced through the implementation of the National Adolescent-Friendly Clinic Initiative (NAFCI) that aimed to improve the quality of health services delivered to adolescents at primary health care level.¹⁷⁰

1. DOMESTIC LEGISLATION

The Children's Act (No. 38 of 2005: Children's Act, 2005)

The new Children's Act has laid out provision for children's access to health care information, contraceptives, HIV testing and consent for medical treatment and surgical operations. In terms of legislation that has bearing on children's access to health-related information and education, the Act states that every child has the right to:

1. Access information on health promotion and the prevention and treatment of ill-health and disease, sexuality and reproduction;
2. Access information regarding his or her health status;
3. Access information regarding the causes and treatment of his or her health status; and
4. Confidentiality regarding his or her health status and the health status of a parent, care-giver or family member, except when maintaining such confidentiality is not in the best interests of the child.

In terms of consent to medical treatment and surgical operations, the Act states that children may consent to their own medical treatment, to medical treatment of his/her child, or to surgical operations if they are over the age of 12 years or of sufficient maturity and mental capacity to understand the benefits, risks and implications of undergoing such treatment.

¹⁶⁸ Cooper D, Morroni C, Orner P, Moodley J, Harries J, Cullingworth L, Hoffman M. Ten years of democracy in South Africa: documenting transformation in reproductive health policy and status. *Reproductive Health Matters*. 2004; 12; 70-85.

¹⁶⁹ *ibid.*

¹⁷⁰ Dickson-Tetteh K, Pettifor A, Moleko W. Working with public sector clinics to provide adolescent-friendly services in South Africa. *Reproductive Health Matters* 2001;10: 160-169.

This includes provision for consent to having an HIV test. In the case of termination of pregnancy, the Choice of Termination of Pregnancy Act, 1996 (No. 92 of 1996) states that a pregnant minor may consent to undergo a legal termination of pregnancy.

The Act also makes provision for access to contraceptives for children. Specifically, the Act states that no person may refuse to sell condoms to a child over the age of 12 years or provide a child over the age of 12 years with condoms on request where condoms are provided or distributed free of charge. Regarding other means of contraception such as oral contraceptives, such contraceptives may be provided to a child on request by the child without parental consent if the child is at least 12 years of age, if proper medical advice is given to the child, and if a medical examination is carried out on the child to determine whether there are any medical reasons why a specific contraceptive should not be provided to the child. Children's actions in accessing contraceptives are also to be kept confidential by health staff.

Criminal Law (Sexual Offences and Related Matters) Amendment Act (No. 32 of 2007)

An amendment to South Africa's Criminal Law Act in 2007 served to broaden the definition of rape, address gender disparities to what constituted rape, and introduce stricter sentences for offenders. More specifically the Amendment introduced a new, expanded statutory offence for rape that was applicable to all forms of sexual penetration without consent, irrespective of gender. The Amendment also gave consideration to children and mentally disabled persons through enacting comprehensive provisions dealing with the creation of new, expanded or amended sexual offences against children and persons who are mentally disabled.

These provisions include offences relating to sexual exploitation or grooming, exposure to or display of pornography and the creation of child pornography and aim to address the particular vulnerability of children and persons who are mentally disabled in respect of sexual abuse or exploitation. The Act made provision for certain services for victims of sexual offences to minimise or, as far as possible, eliminate secondary traumatisation, including affording a victim of certain sexual offences the right to require that the alleged perpetrator be tested for his or her HIV status and the right to receive Post Exposure Prophylaxis in certain circumstances.

2. INTERNATIONAL TREATIES RATIFIED BY SOUTH AFRICA

The United Nations Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the African Women's/Maputo Protocol) are two major treaties that clearly set out African states' obligations and duties in relation to women's reproductive health. Through the ratification and domestication of these treaties, African states can make major steps towards achieving women's reproductive health rights, rolling back HIV and AIDS on the continent and ensuring the MDGs are reached by 2015.

2.1 African Women's Protocol/Maputo Protocol

The African Women's Protocol, otherwise known as The Maputo Protocol, was adopted by the African Union in 2003 and ratified by South Africa in December 2004. Developed by African governments, the treaty offers a historic vision of what African states' duties are in relation to

women's reproductive health rights and has thus far offered the broadest protection for reproductive rights, including reproductive health. In addition, it was the first international treaty that mentioned HIV and AIDS and linked it specifically to reproductive health rights.

1. The African Women's Protocol contains a number of "global firsts";
2. It addresses HIV and AIDS, articulating both the right of women to protect themselves from HIV and AIDS and other STIs and access to affordable, adequate and accessible health care;
3. It calls for the prohibition of harmful practices, including female genital mutilation; and
4. It includes a right to abortion where the pregnancy is as a result of rape, incest or sexual assault, the pregnancy endangers the life and health of the pregnant woman or in the case of fatal foetal abnormality.

Articles 14(1 and 2) of the African Women's Protocol clearly set out three major components of women and girls reproductive health care:

1. Reproductive and sexual decision-making, including the number and spacing of children, contraceptive choice and the right to self-protection from HIV;
2. Access to information about HIV and AIDS and reproductive health; and
3. Access to reproductive health services, including ante-natal services.

Box 1: References to women's reproductive health rights

Article. 14

1. State Parties shall ensure that right to health of women, including sexual and reproductive health, is respected and promoted. This includes:
 - (a) the right to control their fertility;
 - (b) the right to decide whether to have children, the number of children and the spacing of children;
 - (c) the right to choose any method of contraception;
 - (d) the right to self-protection and to be protected against sexually transmitted infections (STIs), including HIV/AIDS;
 - (e) the right to be informed on one's health status and on the health status of one's partner, particularly if affected with sexually transmitted infection, including HIV/AIDS, in accordance with internationally recognised standards and best practices;
 - (f) the right to have family planning education.
2. State parties shall take all appropriate measures to:
 - (a) provide adequate, affordable and accessible health services, including information, education and communication programmes to women, especially those in rural areas;
 - (b) establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding;
 - (c) protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest and where the continued pregnancy endangers the mental and physical health of the mother or the foetus.

Reproductive rights: Violence against women

According to the treaty, State Parties shall adopt and implement appropriate measures to ensure the protection of every woman's right to respect for her dignity and protection of women from all forms of violence, particularly sexual and verbal violence. The provisions in the African Women's Protocol make reference to "unwanted or forced sex"¹⁷¹ and hold the state accountable for preventing and responding to gender based violence in both the public and private spheres. This is a particularly important provision in the context of HIV and AIDS in Africa where many countries have failed to criminalise marital rape. The provisions suggest that states must take more effective measures to deal with domestic violence and ensure that perpetrators are identified and punished. In addition the treaty declares that State Parties undertake to protect asylum-seeking women, refugees, returnees and internally displaced persons against all forms of violence, rape and other forms of sexual exploitation, and to ensure that such acts are considered war crimes, genocide and/or crimes against humanity and that their perpetrators are brought to justice before a competent criminal jurisdiction.

Consent to marriage and equality

The right to consent to marriage and equality in marriage is particularly important in respect of adolescent reproductive health because of the health impact of early marriage. Lack of equality in marriage may impact on women's ability to make decisions about sex and contraception, and may expose them to HIV infection.

According to the African Women's Protocol, State Parties should ensure that men and women enjoy equal rights and are regarded as equal partners in marriage. Further, the state shall enact appropriate legislative measures to guarantee that marriage does not take place without the free and full consent of both parties and in situations where the woman is below 18 years of age.

2.2. The United Nations Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)

The United Nations Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) sets out an expansive international agenda to eradicate discrimination against women and promote equal treatment. The treaty, commonly known as the Treaty for the Rights of Women, was adopted by the United Nations General Assembly in 1979 and was ratified by South Africa in December 1995. As of March, 2010, 186 countries had ratified the Treaty. Only seven countries have not ratified it namely Sudan, Somalia, Iran, the United States, Nauru, Palau, and Tonga. Within the Treaty a number of provisions can be found that support the reproductive health rights of women.

Reproductive health care

The right to health, including reproductive and sexual health, encompasses a duty to ensure the availability of health care. The right to health is also relevant in the context of HIV and AIDS

¹⁷¹ Protocol, art. 4.

where women may need to access services related to pregnancy, contraception and preventing HIV transmission to their children. CEDAW includes specific provisions (See Box 2) relating to reproductive health, including health services related to family planning¹⁷² on the basis of equality with men and appropriate services for pregnancy, delivery and post-delivery.¹⁷³ CEDAW also states that the special needs of rural women must be taken into account.¹⁷⁴

Box 2: References to reproductive rights of women in CEDAW

Art. 12(1): State Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

Art. 12(2): State Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

Art. 14(2): State Parties shall take all adequate measures to eliminate discrimination against women in rural areas [and] to ensure to such women the right ...

(b) to have access to adequate health care facilities, including information, counselling and services in family planning.

Right to be free from sexual and gender-based violence and practices that harm women and girls

CEDAW makes provisions for the right to be free from sexual and gender based violence as violence has an impact on women's ability to make decisions about reproduction. Women living with HIV have been subjected to violence when they have disclosed their HIV status. The Treaty also outlines the right of women and girls' to be free from practices that pose harm to them in any way, including practices that have an impact of reproductive health, such as female genital mutilation. References to these rights are outlined in Box 3.

¹⁷² CEDAW, art. 12(1).

¹⁷³ CEDAW, art. 12(2).

¹⁷⁴ CEDAW, art. 14.

Box 3: References to rights to be free from sexual and gender-based violence and practices that harm women and girls

Art. 2(f): [State Parties shall undertake] to take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women.

Art 5(a): [State Parties shall undertake] to modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and other practices which are based on the idea of the inferiority or superiority of either of the sexes or on stereotyped roles for men and women.

Art. 6: State Parties shall take all appropriate measures, including legislation, to suppress all forms of traffic in women and exploitation of prostitution of women.

Right to access sexual and reproductive health education and family planning information

The right to access sexual and reproductive health education and family planning information is important in enabling people to exercise their reproductive rights and to protect their health. The provisions CEDAW makes to fulfil these obligations are outlined in Box 4.

Box 4: References to rights to access sexual and reproductive health education and family planning information

Art. 10: State Parties shall take all appropriate measures to eliminate discrimination against women in order to ensure to them equal rights with men in the field of education and in particular to ensure, on a basis of equality of men and women:

(c) the elimination of any stereotyped concept of the roles of men and women at all levels and in all forms of education by encouraging coeducation and other types of education which will help to achieve this aim and, in particular, by the revision of text books and school programmes and the adaption of teaching methods; ...

(h) State Parties ... shall ... ensure access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning.

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