The Management of HIV/AIDS in Secondary Public Schools in South Africa: An Overview of Policy.

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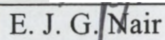
Submitted in partial fulfilment of the requirements for the degree of
Master in Technology: Education (Management)
Durban Institute of Technology

Declaration of Originality

I, Eugene John Gilbert Nair, declare that this dissertation is my own work. Where use has been made of the work of others, it has been acknowledged and referenced.



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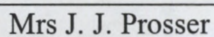

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Dedication

To my children, Andre Bradley, Pascal Connor and Megan Chloe for their patience and understanding while I was busy with this study. Most importantly, to my wife Krishnee, without whose support this mountain would be much steeper to climb, for your inspiration, ideas, input and for instilling in me that, " I can do anything through Christ who strengthens me." (Philippians 4:13).

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I would like to acknowledge the advice and encouragement given to me by my colleague Rajen Bobbychun. To my supervisor, Mrs J J Prosser, I would like to thank her for her support, guidance and thoroughness in the supervision of this dissertation. I wish you a well-earned retirement.

Abstract

As the HIV/AIDS epidemic in South Africa accelerates, HIV sero-prevalence studies report increasing risk among young people in the general population. These young people are found predominantly in schools. It is for this reason that the researcher embarked on this study. The emphasis of the study is to evaluate the management of HIV/AIDS in secondary public schools in South Africa, particularly, an overview of the policy.

The management of HIV/AIDS in public schools in South Africa falls under the jurisdiction of the National Department of Education at macro level and the school management team at micro level. This involves a variety of people: policy-makers, Ministers of Education, the provincial Department of Education and Culture, as well as parents, School Governing Body members, educators and learners.

The study examines the HIV/AIDS policy of the Government of South Africa (Government Gazette Volume 410 Number 30372) and four other inter-related policies, as applicable to the National Department of Education, for their strengths and weaknesses and examines ways in which these could be improved.

Many issues that could be implemented in the management of the disease at school level are discussed, including constraints to the programme. Also, numerous recommendations are offered to improve the implementation of the present policy. Ultimately, the success of any HIV/AIDS education programme can only judged if it leads to a behaviour change in the recipient and this is highlighted throughout the study.

LIST OF ACRONYMS AND ABBREVIATIONS

AIDS	-	Acquired Immunodeficiency Syndrome
ATICC	-	AIDS Training, Information and Counselling Centre
CBOs	-	Community-Based Organisations
CD4T	-	Composite Descriptive Four Thymus
DoE	-	National Department of Education
FETC	-	Further Education and Training Certificate
FBOs	-	Faith-Based Organisations
GETC	-	General Education and Training Certificate
HFLE	-	Health and Family Life Education
HIV	-	Human Immunodeficiency Virus
ICRW	-	International Centre for Research on Women
IDASA	-	Institute for a Democratic Alternative in South Africa
IEC	-	Information, Education, Communication
IIEP	-	International Institute for Educational Planning
IMB	-	Information-Motivation-Behavioural
KZNDEC	-	KwaZulu-Natal Department of Education and Culture
LEA	-	Local Education Agency
LIP	-	lymphocytic interstitial pneumonia
NGOs	-	Non-Governmental Organisations
NIP	-	National Integrated Plan

OBE	-	Outcomes-Based Education
PCP	-	pneumocystis carinii pneumonia
PPASA	-	Planned Parenthood Association of South Africa
SABC	-	South African Broadcasting Corporation
SGB	-	School Governing Body
SMT	-	School Management Team
STDs	-	Sexually Transmitted Diseases
STIs	-	Sexually Transmitted Infections
UN	-	United Nations
UNAIDS	-	Joint United Nations Programmes on HIV/AIDS
UNESCO	-	United Nations Educational, Scientific and Cultural Organisation
UNFPA	-	United Nations Population Fund
UNICEF	-	United Nations Children's Fund
USA	-	United States of America
VCT	-	Voluntary Counselling and Testing
WHO	-	World Health Organisation

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CHAPTER ONE

1.1 Introduction

Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) has rapidly become the main cause of death in many countries in Southern Africa and of all the countries in this region, South Africa has one of the highest rates of infection in the world. In KwaZulu-Natal, the province with the highest infection rate, 36,2% of the population has the virus (Barnett and Whiteside, 2002:118). The prevalence rate of HIV in South Africa in 2002 was 14,1%. This is expected to rise to 16,1% by 2007 (Berman, 2003:358). The frightening feature of this epidemic is that currently there is no readily accessible treatment in developing countries such as South Africa. Thus, the most efficient means of fighting HIV/AIDS is the introduction of behaviour change intervention through Life Skills education, including promoting abstinence, delay of sexual activity and the use of condoms. These are difficult messages to communicate to adolescents and young adults.

For a long time HIV/AIDS was considered to be essentially a medical problem. It has become clear that prevention is essential and that education may perhaps be the most powerful weapon that can be used against the transmission of HIV/AIDS. As HIV/AIDS affects the human body it also affects the education system (Kelly, 2000:3). For years it was ignored in schools as though it was unimportant. Now, because more educators are absent from school, educators are leaving teaching or dying due to illnesses, HIV/AIDS and its effect on schools is a recognised problem. As a consequence of HIV/AIDS the pool of teaching personnel is reducing and learners are, themselves, becoming infected: some are admitted to preschool already infected, some are forced to leave school to care for their infected parents or siblings. School principals, educators and clerical staff are also becoming ill and are dying. Kelly

(2000:4) also explains that HIV/AIDS affects the demand for education: there are fewer learners to educate, fewer children wanting to be educated and fewer children whose parents can afford education. The costs of maintaining educational services are increasing, whereas the actual demand for education has, however, declined. What are also affected are those not only who supply education but the quality of the educational process, including management. There is a risk that the whole system of education may be disorganised and paralysed by fear because of the lack of guidance of what should be done when even resources which are available for education have been reduced.

Despite the invisible impact of HIV/AIDS on the education system, the development need for education and for curriculum change and flexibility has risen significantly. As deaths mounts among young to middle-aged adults, increased numbers of young people with education, training and appropriate skills are needed to replace them. Schools and tertiary training institutions need to train students in those skills that the country requires so that they can get jobs, but also in those skills which can assist the family survival directly (e.g. food production, home economics, handicrafts). There is a need to influence learners regarding sexual reproductive health, including HIV/AIDS, so that they grow up with reduced risks of infection. This requires educators with the appropriate sensitisation, training, support and behaviour change resources to make HIV prevention efforts effective with learners.

Both educators and learners need assistance to develop supportive attitudes to people with HIV/AIDS. They also need to actively reduce stigma, discrimination and the paralysing fear that make them feel like there is nothing that they can do. Many learners have to combine education and increased household roles; many will have increased psychological needs and

be facing orphanhood which will be up to 30-40% in the hardest hit countries within a few years (Jackson: 2002:306).

The Department of Education's reluctance to confront and accept the above-mentioned realities was characteristic, until 2000, of a general response to the epidemic of HIV/AIDS. This attitude has also made a great contribution to the spread of the epidemic: "--- a country in which denial flourishes is a country whose citizens are vulnerable to the silent spread of HIV" (UNAIDS 2000:38). In the words of the English poet, T S Elliot, "--- humankind cannot bear too much reality." Instead we prefer to ignore a situation, to question whether it is as bad as it is made out to be, to find alternative ways of accounting for potential dangers and threats.

Until the second half of the 1990s, the public sector in most countries but, more especially, the educational sector, worked behind a huge wall of silence that effectively denied the threat and challenge posed by HIV/AIDS. Towards the latter part of 1993, the International Institute for Educational Planning held a workshop in Paris for educational planners and policy-makers on how HIV/AIDS was likely to impact on the education sector. The International Institute subsequently disseminated a comprehensive report on this issue. Schaeffer (1994 cited in Kelly 2000:10) stated that it took six years before education ministers in African countries began to recognise the importance of this report. During these six years the HIV/AIDS situation in general and in the education sector in particular, grew steadily worse.

Of all the countries in the Southern African region, South Africa's response to the HIV/AIDS epidemic, has been in the recent past characterised, "--- by denial, ministerial wrangling, the misallocation of resources, and has been muted throughout by those forces either resisting or pushing for political transformation" (Webb 1997:77). The financial allocation of funds to

counter the epidemic bear testimony to the poor manner in which South Africa has handled the disease. Statistics show that Zambia's HIV/AIDS budget for 1991 was US$ 5 Million, which is more than three times that of South Africa (Webb 1997:76). Even Mozambique, racked by civil wars, spent twice as much in 1991 on AIDS education than did South Africa (Webb 1997:77). Only recently has the South African government realised the seriousness of the problem. In 1995 the government spent R14 Million on the development of an "AIDS education" play called Sarafina II. This figure represented one fifth of the HIV/AIDS budget for that year (Webb 1997:78). Many saw this as wastage of public funds as the emphasis was more on entertainment than on HIV/AIDS education. Numerous letters to newspaper editors bear testimony to this.

The South African budget for tackling this disease continues to increase by an amount of "R10 per person per year" or a total of R400 Million per year for the whole country budgeted for fighting this epidemic in the 2001-2005 financial years (Republic of South Africa. HIV/AIDS and STD Strategic Plan for South Africa 2000:24). This disease has taken on epidemic proportions in that it is now prevalent in sub-Saharan Africa. Funding by the United States for global HIV/AIDS activities increased by US$ 65 Million in 2000 and is set to increase by an additional US$ 100 Million in 2001. An additional US$ 180 Million in funding for activities in Africa was announced at the historic Security Council meeting in January 2000 (UNAIDS, June 2000:113).

1.2 Reasons for Choosing the Topic

This study will examine the various programmes available in the National Department of Education (DoE) and its schools to see if they have been successfully implemented in the management of the HIV/AIDS epidemic. As the main programme is concerned with Life

Skills education, found in the Life Orientation learning area, this intervention will be closely examined.

The researcher chose this topic because many schools have begun to experience the effects of the epidemic, as principals, educators, learners and their families fall ill. A vaccine has not yet been discovered against the HIV/AIDS infection and will not probably be available in the next ten years and it is even less likely that a cure for HIV/AIDS will be found. Before this disease is brought under control its effects will deteriorate further and it will become more widespread. Almost every principal has educators, learners and employees in his/her school with HIV/AIDS. Principals are only too aware of the effect of this problem and that their illness disrupts teaching and learning. Also healthy educators will have to take on extra work where colleagues are absent through illness; learners, who are not infected, will become affected by peers and family members, who have the disease; learners, who are ill, will fall behind with their studies; schools will have to carry the burden when family members die. Many schools will be crippled by the disease and prevented from carrying on their work.

Especially in the last four years, extraordinary strides have been made in imparting to learners the basic facts about HIV/AIDS, how it is transmitted and how it can be prevented. A remarkably high proportion of learners of all ages in most parts of South Africa know about HIV/AIDS and most can repeat the basic facts about the transmission and prevention of HIV/AIDS infection (UNAIDS, 2000:40). However, there are a number of learners that are still vulnerable to HIV/AIDS because they do not know the basic facts. Pockets of ignorance and misinformation survive even in the worst affected populations. The right to information about HIV/AIDS transmission and prevention has sometimes been denied to young people on the grounds that they are, or should be, sexually abstinent. In some places, therefore, young

people are more vulnerable than their elders because they are less likely to know enough about HIV/AIDS to protect them (UNAIDS, 2000:42).

Results from a survey done in South Africa by UNAIDS reveals the likelihood that a boy, now aged 15, will eventually die of HIV/AIDS as being much higher than the likelihood that a man, now aged 35-49, who is currently infected with HIV/AIDS, will. To add to this pessimistic scenario, UNAIDS also maintains that the proportion of young people, who will die of HIV/AIDS, is appallingly high in many countries, including South Africa. In virtually any country where 15% or more of all adults are currently infected with HIV, at least 35% of boys, now aged 15, will die of HIV/AIDS (UNAIDS, 2000:25).

The last decade in South Africa has seen the development by the DoE of a rich body of experience and expertise. In the Year 2000 the DoE released policies, strategies and technologies to combat the disease.

In the light of the information described above, that is, of situation infection susceptibility and prevention measures, the researcher decided to investigate HIV/AIDS policies made available in schools with a view to deciding on their effectiveness. The researcher is particularly concerned with the problem of the gap between policies and implementation, both at local and national level. The researcher believes that local departments may provide the critical link between local and national activities. District offices, for example, are well placed to analyse, document and disseminate what they learn from the local responses and so can press and negotiate with national authorities to implement the necessary changes and reforms. There are numerous examples of good HIV/AIDS projects and successful interventions that are

successful in a given environment. These local projects are of value because having been tested and their work illustrated, they can be implemented nationally.

The DoE has a vital role to play in educating learners and educators in preventing the spread of the disease. This is an important aspect of the function of the DoE and regional Departments of Education in the nine provinces. The researcher hopes that the findings from this research will have a practical application, in that they can contribute towards practical issues of developing a policy on HIV/AIDS in the DoE.

1.3 Research Questions

The researcher will concentrate on obtaining answers to the following questions:

- Are educators adequately trained to handle the HIV/AIDS problem?
- What education programmes, drama, films and videos are available to learners, educators and parents?
- What measures are taken to ensure confidentiality?
- What counselling, if any, is available?
- How can health service be involved?

1.4 Objectives of the research

The main concerns of this research will be with the following:

- Identifying both the strengths and weaknesses of HIV/AIDS policies.
- Evaluating the Life Skills Programme in schools.
- Exploring management solutions to HIV/AIDS epidemic.

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1.5 Analysis of key concepts for this research

The following key concepts were extracted from Jackson (2002).

HIV- refers to the human immunodeficiency virus. HIV is a lenti-virus, which means that it can live in its host for a long period of time without causing any overt manifestations of illness. The virus attacks and ultimately leads to the deterioration of the human immune system. HIV is detected either through the viral load by which a recently developed test measures the level of the AIDS virus in a person's blood stream. Another form of detection is through the presence of antibodies in the blood, which show up generally from 3-6 months after the virus has been contracted. In rare cases it may take up to one year from the time a person is infected with HIV before the antibodies emerge as a result of HIV infection.

Window period - this is the period of time between the point when the virus is contracted and when it is detected through the presence of antibodies. The window period is a cause for serious concern in that HIV test results may not accurately reflect an individual's true sero-positive status. Hence, the results may indicate that a person does not have the disease, when, in fact, he/she is infected. For this reason, individuals who engage in "high-risk behaviour" should be tested for 6 months or even one year after participation in risky behaviour. Despite existing rigorous screening procedures, the window period gives rise to problems not only with donated blood but also with donated organs for transplant purposes. If an HIV positive person donates blood or if organs are harvested in the window period, the HIV test results are likely to be negative, but the donee may later sero-convert. It is important to note that even though HIV infections result from transfusions of blood screened as negative for the HIV antibody, the prevalence of donating blood in the window period is extremely rare.

1.6 Summary

This growing concern for the effective functioning of education systems, especially in countries where the HIV/AIDS prevalence rates are high, has resulted in a number of concrete developments. Some education ministries have established dedicated HIV/AIDS units to co-ordinate plan for and manage the national educational response to the epidemic, while a number of them are working on the development of strategic plans for a comprehensive education sector response to HIV/AIDS. Almost all are giving attention to building their own capacity to respond to the needs for information and to promote understanding of feasible actions.

HIV/AIDS is a reality that all South Africans have to face. South Africa has lagged behind other countries and the fruits of this are what the country now faces. However, through a revamp of their priorities, the government is making an effort to stem the rate of HIV/AIDS infections.

AIDS- refers to the acquired immune deficiency syndrome, that is, the advanced, symptomatic, final phase of the HIV infection. It eventually leads to death. At this point in the disease progression, the immune system is completely compromised. Therefore, a number of opportunistic illnesses will appear in the individuals who are infected, the most common of which is pneumocystis carinii pneumonia (PCP). This occurs in both adults and children. Children develop a lung condition called lymphocytic interstitial pneumonia (LIP), which frequently occurs in the absence of other opportunistic lung infections Children also frequently have serious bacterial infections such as otitis media, septicemia (bacteria in the bloodstream), meningitis and cytomegalovirus disease, a herpes virus that is normally present in the salivary glands. Additional diagnoses for adolescents include invasive cervical cancer; pulmonary tuberculosis, recurrent pneumonia, recurrent salmonella, septicemia and a Composite Descriptive Four Thymus-cell (CD4T-cell) count of less than 200. A healthy CD4 T-cell count is usually 800-1000. Symptoms of AIDS appear in adults (on average), ten years after being infected with HIV, whereas the progression for children and infants is more rapid. Adults usually die within two years after receiving a diagnosis of AIDS. The symptoms of AIDS include, weight loss, diarrhoea, fatigue, swollen glands, persistent cough, viral infections such as colds and influenza, skin rashes or disease and oral thrush. Although many of these symptoms may be caused by other infections, these symptoms may persist for months without obvious reason.

Universal precautions - this is a reference to the standard infection control procedures or precautionary measures aimed at the prevention of HIV transmission from one person to another, which are used universally. It includes basic hygiene and the wearing of protective clothing such as latex or rubber gloves and the use of plastic bags when there is a risk of exposure to blood, blood borne pathogens, or bloodstained body fluids.

1.7 References

Barnett, T. and Whiteside, A. 2002. AIDS in the Twenty First Century: Disease and Globalisation. New York:Palgrave.

Berman, J.K. 2003. South Africa Survey 2002/2003. Johannesburg: South African Institute of Race Relations.

Jackson, H. 2002. AIDS Africa-Continent in Crisis. Harare: SAfAIDS.

Kelly, M. 2000. "Planning for education in the context of HIV/AIDS. Fundamentals of educational Planning." 6. Paris: International Institute for Education Planning. http://www.dpmf.org/bulletin-jan-03/hiv-policy-kelly.html

Republic of South Africa. Department of Health. HIV/AIDS/ STD Directorate, 2000. HIV/AIDS and STD Strategic Plan for South Africa. 2000-2005. Pretoria: Government Printers.

Schaeffer, S. 1994. "The impact of HIV/AIDS on education: A review of the literature and experience." Background paper presented at the International Institute for Educational Planning (IIEP) Seminar, Paris, 8-10 December 1993. Paris: (IIEP).

UNAIDS. 2000. Report on the Global HIV/AIDS epidemic. June 2000. Geneva: UNAIDS.

Webb, D. 1997. HIV and AIDS in Africa. London: Pluto Press.

CHAPTER TWO

2. LITERATURE REVIEW

2.1 Introduction

This Chapter is an overview of the literature surrounding the management of HIV/AIDS in secondary schools in South Africa. It commences with statistics of the disease in South Africa followed by a global overview. The situation in KwaZulu-Natal, the province with the highest sero-prevalence rate of HIV/AIDS, is analysed in terms of the youth. A summary of the education policies pertaining to the disease is summarised. HIV/AIDS and Life Skills education, the major intervention of the Department of Education in schools concludes the Chapter.

2.2 HIV/AIDS Statistics

South Africa at present is experiencing an HIV/AIDS epidemic. An epidemic is defined in the Oxford English Dictionary as "The rapid spread of a disease among many people in the same place." 4,2 million South Africans are infected with HIV/AIDS, the largest number from any single country (UNAIDS, 2000:9). This represents nearly one quarter of the population (24, 5% using 2000 estimates), although the number of partners and other family members affected are much higher (Barnett and Whiteside, 2002:118). 1 700 South Africans are infected every day, making the South African epidemic the most severe and fastest growing in the world (Guest, 2001: x).

For the purpose of differentiation, the following age groupings are extracted from the South African education policy documents:

- Children- persons aged 2-13 years.
- Adolescents- persons aged 13-19 years.
- Youth- persons aged 15-25 years.

The epidemic is most severe in KwaZulu-Natal. In 2000, the province had a sero-prevalence rate of 36.2% amongst women attending antenatal clinics (Barnett and Whiteside, 2002:118).

Province	**1998 in %**	**1999 in %**	**2000 in %**
Western Cape	5,2	7,1	8,7
Northern Cape	9,9	10,1	11,2
Limpopo	11,5	11,4	13,2
Eastern Cape	15,9	18,0	20,2
North-West	21,3	23,0	22,9
Free State	22,8	27,9	27,9
Gauteng	22,5	23,9	29,4
Mpumulanga	30,0	27,3	29,7
KwaZulu-Natal	32,5	32,5	36,2
National	**22,8**	**22,4**	**24,5**

Table 1: The provincial breakdown of HIV prevalence rates in women attending antenatal clinics in South Africa.

UNAIDS estimates that every day around 6,000 people (aged 15-24 years) contract HIV and young people account now for nearly half of all new annual infections (UNAIDS, 2000:9). In some countries the proportion is even greater, exceeding 60% of new infections in sub-Saharan Africa and many parts of Asia (UNAIDS, 2000:13).

The risk of and vulnerability to HIV/AIDS infection among young women are particularly striking: young women now account for 62% of the 11,8 million young people living with HIV/AIDS (UNICEF/UNAIDS/WHO, 2002). In Western Kenya, nearly one in four females (15-19 years) were infected with HIV/AIDS by the mid-1990s, compared with one in twenty

five males in the same age group (Glynn *et al.*, 2001: 55). In Zambia, sixteen times as many females as compared to males (15-19 years) are infected (Glynn *et al.*, 2001: 56). Most importantly, perhaps, is the fact that only a very small number of young people who are infected are even aware of it. The epidemic among young people, predicted ten years ago, represents one of the most severe challenges to the future health and development of many countries. It requires hard thinking and setting new priorities in HIV/AIDS prevention and sexual and reproductive health service delivery in the coming decades.

Rates of pregnancy and Sexually Transmitted Infections (STIs) among adolescents (aged 13-19) indicate the extent of unprotected sexual activity among young people and, therefore, of their vulnerability to HIV/AIDS. In Brazil, Hungary and Kenya recent data show that more than 25% of boys aged 15-19 years report having sex before the age of 15 (UNICEF/UNAIDS/WHO, 2002:131). In Bangladesh, 88% of unmarried boys and 35% of unmarried girls, living in urban areas, have had sex before the age of 18 (UNICEF/UNAIDS/WHO, 2002:134). Males and females under the age of 15 account approximately for one third of the 333 million new cases of curable STIs per year (UNICEF/UNAIDS/WHO, 2002:99). Without appropriate treatment for STIs the risks of contracting HIV increases three to fivefold (Wasserheit, 1992:65). South African youth represent one of the greatest "at risk" groups of HIV/AIDS infection, with rates estimated to be 23%-27% for females aged 15-25 and 8%-15% for males in the same age group (UNAIDS, 2000: 47).

Moletsane *et al.*, (2002:38) estimate the following HIV positive groups (in terms of race and gender) in KwaZulu-Natal in the 15-19 year old group:

Race	Males %	Females %
White	0,26	1,25
Indian	0,26	1,29
African	2,58	15,64

Table 2: HIV positive groups in terms of race and gender in KwaZulu-Natal in 15-19 year olds.

It must be noted that the higher percentage of HIV positive African females is due to the fact that this group is known to take on older men as sexual partners (UNAIDS, 2000:47). This gender aspect of the HIV/AIDS epidemic is reflected throughout sub-Saharan Africa. 58% of the region's 26 million females and 42% males are estimated to be HIV positive (Kimani, 2002:2). These numbers are expected to get worse until the disease peaks. However, the projected number of South Africans, who will become infected, can be limited if the proper and effective intervention is introduced.

Economic, social and political conditions in many developing countries may create circumstances that make young people particularly vulnerable to HIV/AIDS infection: some children and adolescents may be living on the fringes of society, out of reach of formal school and community-based services; street children may be fugitives from violent homes or orphaned as a result of losing one or both parents to HIV/AIDS; children and adolescents may become isolated because of prejudice and discrimination on account of their alternate sexual orientation; economic circumstances may compel children and adolescents to sell or barter sex for protection, a meal or a place to sleep; sexual interaction may be one of the few opportunities these young people have to experience human warmth and intimacy.

Families, who are in search of security in an age when globalisation is disrupting local economics and family structures, force an estimated one million young people each year into the sex trade. In many parts of the world, the age of marriage for girls is significantly lower than that of men. In addition, husbands may have multiple partners or high rates of partner change, contributing further to young women's risk and vulnerability. Frequency of sex in marriage (often on demand) along with pressure to become pregnant, results in women being unable to adopt protective strategies. Drug use may also be part of the culture of "at risk youth" who use drugs to escape feelings of loneliness, boredom and despair.

The face of HIV /AIDS is becoming ever younger, not only in terms of the number under the age of 25 who are HIV positive, but also in terms of the burdensome economic and social consequences of the HIV/AIDS epidemic. Taking action to minimise the threat of HIV/AIDS to young people is both a matter of protecting their human rights and necessary for slowing the HIV/AIDS epidemic. Our experience to date shows that intervention against HIV/AIDS must form effective partnership with young people to be effective. Intervention derives its effectiveness from the fact that the young are less resistant to change than are adults and are generally more willing to examine the social norms that contribute to their risk of and vulnerability to HIV/AIDS.

2.3 The Republic of South Africa. Policies on HIV/AIDS

A summary of the policy documents pertaining to the management of HIV/AIDS in the educational environment follows. Although some documents deal with a number of government departments and their policies, it must be emphasized that only issues pertaining to educational institutions have been included.

2.3.1 Republic of South Africa. Department of Education. 1999. National Policy on HIV/AIDS for learners and educators in public schools and students in further education and training institutions: as extracted from the National Education Policy Act, 1996 (No.27 of 1996 - as per Government Gazette Volume 410 Number 30372, dated 16 August 1999).

This Policy provides guidelines which educational institutions should follow and addresses four main topics:

- Human rights issues, and in particular non-discrimination.
- Health aspects, including how transmission and infection occur.
- How to create a safe learning environment.
- Education on HIV/AIDS.

2.3.1.1 Human Rights

The Policy states that there should be no discrimination against learners or educators who are HIV positive or suspected to be HIV Positive. No learner or educator is compelled to disclose his/her HIV status. Learners and educators should respect the rights and dignity of others as reflected in the Constitution. The Bill of Rights states that all citizens have a right to privacy and confidentiality.

Learners with HIV/AIDS may not be denied admission to continue attendance at a learning institution, but should attend classes for as long as they are able to function effectively. Those who become too ill to attend classes should be able to work at home with the support of the educational institution. Educators have a right to be appointed, teach and be promoted regardless of their HIV/AIDS status.

2.3.1.2 Health aspects in Teaching Institutions

Transmission and infection

HIV/AIDS is spread by having unprotected sex with an infected person, through contact with infected blood and from an infected mother to her unborn baby. The risk of HIV transmissions, which can develop into AIDS, during teaching, play activities, sport and social contact is minimal as there is no risk from saliva, sweat, tears, urine, respiratory droplets, handshaking, kissing, swimming, pool water, toilets, food or drinks. Any risk that may exist in a teaching institution can be eliminated by good hygiene practices and taking standard infection control measures (also known as "universal precautions") such as using clinical gloves when contact is likely with blood or body fluids and using disinfectants when cleaning up.

All teaching institutions should implement standard precautions to effectively minimise the risk of transmission of all blood-borne diseases, including HIV. There should be training for learners and educators on how to handle accidents and to apply "common sense precautions" during sport and play and there should be at least two properly equipped first aid boxes that are always available.

2.3.1.3 Education on HIV/AIDS

HIV/AIDS education should be given to all learners, educators and staff members in a "Life Skills Education Programme" in an educational institution. The secondary school Life Skill's education concentrates on skills, such as self-esteem, self-respect, communication, and decision-making. It focuses on reproductive health, tolerance, respect for and understanding of different values and cultures, as well as encouraging a culture of abstaining from or postponing sexual activity, changing lifestyles and if there is sexual activity, it is engaged in responsibly (Republic of South Africa. Department of Health:1999).

Age appropriate education on HIV/AIDS must form part of the curriculum for all learners from pre-primary to secondary school level. This means that issues that can be understood by learners are covered in their curricula. For example a body image exercise will be done with pre-school scholars and menstruation with pre-teenagers. The aim of Life Skills education is to enable learners and educators to understand how HIV is transmitted and how infection can be prevented; make informed and responsible choices regarding their own health and that of others; apply standard precautions and "First Aid" practices to protect themselves and others from infection and display non - discriminatory behaviour.

To facilitate these measures, a teaching institution should develop its own practical HIV/AIDS policy based on the National Policy and include in its Code of Conduct guidelines on avoiding unacceptable behaviour, which may be discriminatory or increase the risk of HIV/AIDS infection. Teaching institutions should also involve and inform parents about their HIV/AIDS programmes.

2.3.2 Republic of South Africa. Department of Health. 2000. National HIV/AIDS and STD Directorate. HIV/AIDS /STD Strategic Plan for South Africa. 2000-2005.

2.3.2.1 Introduction

This plan was completed in January 2000. Youth were the specific focus in the fight against HIV/AIDS as those between the ages of 15-25 years are most vulnerable to HIV infection. In addition, youth must be protected against future HIV infections for the future economic growth of the country. In this Section the strategies that relate to youth will be described to emphasise the need for all sectors of society to allocate significant amount of their resources and energies to this age group.

2.3.2.2 Objectives/Applicable Actions of the National Department of Education (DoE).

The table below shows the objectives and the applicable actions that the Department of Education needs to address.

Objectives	Applicable Actions
Promote improved health-seeking behaviour and adoption of safe sex practices.	Produce and disseminate Information, Education and Communication (IEC) material and messages to various stakeholders, for example, parents, child minders and pre-school educators. Implement Life Skills education in all primary and secondary schools.
Broaden responsibility for the prevention of HIV/AIDS to all sectors of government and to local communities.	Develop sector specific policies and plans for the prevention of HIV/AIDS & STDs, focusing especially on the following sectors: youth and women.
Improve access to and use of male and female condoms, especially for ages 15-25 years	Expand condom distribution through non-traditional outlets like toilets in teaching institutions, cafeterias, the traditional outlets being clinics, hospitals, pharmacies and doctors' surgeries. Increase acceptance, positive attitudes and perceptions of youth towards the use of condoms to prevent pregnancies, the spread of HIV and STIs.
Increase access to "youth friendly" reproductive health services-including STD management, Voluntary Counselling and Testing (VCT) and rapid testing facilities to promote the youth knowing their health and HIV status and also for them to receive prompt treatment.	Make clinics and Health Care Workers "youth friendly". This means that Health Care Workers should deliver a service to the youth without being judgemental of their age or gender. Make schools places where youth can access friendly and supportive counselling services.
Develop and implement programmes to support the health and social needs of children affected by HIV/AIDS.	Promote advocacy of all relevant issues that affect children for example, admission into school irrespective of the learner's HIV status. Mobilise financial and material resources for orphans and child-headed households (a child-headed household is one in which both parents are deceased and an elder child cares for the siblings). School principals should work together with the Department of Social Welfare to provide meals for children and to integrate learners into homes that are willing to care for them. Investigate legal protection for "child-headed households". Provide social welfare, legal and human rights support to protect educational and constitutional rights. All learners have a right to education and this right should not be denied by school principals. Learners should be admitted to any school irrespective of their HIV status.

Table 3: Objectives and Applicable Actions that the DoE needs to address, as collated by the researcher.

2.3.3 Republic of South Africa. Department of Health. 1999. National and Integrated Plan for children infected and affected by AIDS

The National Integrated Plan was developed in early 2000. Giving effect to a unique collaboration between three Government Departments, namely Education, Health and Social Development (and recently Agriculture as well), its aim is to ensure access to an appropriate and effective integrated system of prevention, care and support for children infected and affected by HIV/AIDS. The key features of the NIP are:

- Life Skills education, that is to educate learners about sexuality and how to make healthy choices.
- Voluntary Counselling and Testing (VCT) by which there is increased access to counselling and testing for HIV, making children more conscious of the risk of HIV infection and to serve as a key entry point to other services. For example if a pregnant learner goes for VCT, and learns of her positive HIV status she can be referred to the "prevention of mother to child transmission programme," where she can be given anti-retro viral treatment or be given the option of termination of pregnancy.

2.3.3.1 Budget

Create a mechanism to inform stakeholders of NIP targets and progress. The main funding for the NIP is via conditional grants to provinces. Conditional grants refer to a government grant to the provinces, which are then responsible for developing/implementing HIV/AIDS programmes. The budget of R1 946 Billion was spread over a three-year period, that is, R250 million for 2003/4, R680 Million for 2004/5 and R746 Million for 2005/6 (Smart, 2003:26).

2.3.3.2 <u>Voluntary Counselling And Testing (VCT) Policies</u>

Young people are increasingly vulnerable to HIV infection. Youth who are 15 years of age and older, may consent to HIV testing without the permission of parents or guardians and must be given their test results. This information may not be given to their parents without the consent of the youth concerned. Children under 14 years of age should receive VCT services only with parental or guardian consent and only if there is clearly a benefit to them.

A VCT policy and guidelines, specifically for children, had been identified as urgent and national consultation on this was held late in 2000. Common concerns were identified:
advice, support, assistance and legal services were needed for juvenile offenders, pregnant children, undocumented child migrants, children who were homeless, children who had survived sexual assault and rape, children with disabilities, children who lived on the streets, children in foster homes and places of safety, children in hospitals and clinics, children who cared for their parents, siblings and other family members, children who had been orphaned by HIV/AIDS, children who were placed in institutions for the mentally challenged and children who were attending nursery, primary and secondary schools.

Government services should ensure that children should have all relevant information in a language that they understand. This should include their HIV/AIDS status. It is in the best interests of children if they know about their health so that they can make decisions regarding their reproductive and sexual health. It is in the best interest of children that they are able to participate in any decision to disclose their own HIV/AIDS status or the HIV/AIDS status of a parent or caregiver. It is in the best interests of children to have access to both pre-test counselling and post-test counselling when undergoing an HIV/AIDS test.

2.3.4 Republic of South Africa. Department of Education. 2000. HIV/AIDS-Implementation plan.

2.3.4.1 Introduction

The Minister of Education has identified nine priorities, for the development of an education and training system for the 21st century that will contribute to the health and prosperity of all. These nine priorities are:

- We must make our provincial systems work by making co-operative government work.
- We must break the back of illiteracy among adults and youth in five years.
- Schools must become centres of community life.
- We must end conditions of physical degradation in South African schools.
- We must develop the professional quality of our teaching force.
- We must ensure the success of active learning through Outcomes-Based Education.
- We must create a vibrant further education and training system to equip youth and adults to meet the social and economic needs of the 21st century.
- We must implement a rational, seamless higher education system that grasps the intellectual and professional challenges facing South Africans in the 21st century.
- We must deal urgently and purposefully with the HIV/AIDS emergency in and through the education and training system.

The Minister's nine priorities have been organised into five core programme areas for implementation. These are:

- HIV/AIDS.
- School effectiveness and teacher professionalism.
- Literacy.

- Further education and training and higher education.
- Organisational effectiveness of the national and provincial departments of education.

2.3.4.2 Core Programme 1 HIV/AIDS

Priority : We must deal urgently and purposefully with the HIVAIDS emergency in and through the education and training systems.

2.3.4.2.1 Project 1: Awareness, information and advocacy

Strategic Objectives:

- To raise awareness and the level of knowledge of HIV/AIDS among educators, learners, students and departmental employees at all levels and in all institutions in the education and training system.
- To promote values which inculcate respect for girls and women and recognise the rights of girls and women to free choice in sexual relations.

Outcomes:

- Increased awareness, understanding knowledge and sensitivity of the causes of HIV/AIDS, its consequences and impact on individuals, communities and society in general.
- Eradication of non-discriminatory practices against individuals affected by HIV/AIDS.
- Development of HIV/AIDS policy for the education and training system.
- Change of attitude and behaviour towards sexuality including an increased respect for girls and women.

Performance indicators:

- Myths about HIV/AIDS are eradicated.
- Increased acceptance of the need to practise safe sex.
- Establishment of non-discriminatory practises in all education and training institutions, including departments of education.
- Finalisation of the HIV/AIDS policy.
- Popular material on HIV/AIDS is readily available.
- Visible change of attitude towards girls and women.

2.3.4.2.2 Project 2: HIV/AIDS in the curriculum

Strategic objectives:

- To ensure that Life Skills and HIV/AIDS education are integrated into the curriculum at all levels of the education and training system.

Outcomes:

- Every learner understands the causes and consequences of HIV/AIDS.
- All learners lead healthy lifestyles and take responsible decisions regarding their sexual behaviour.

Performance indicators:

- Life Skills and HIV/AIDS education is integrated across the curriculum.
- Increase in knowledge of and changed attitudes towards sexuality and HIV/AIDS among learners.
- Reduction in incidence of HIV/AIDS among learners.

2.3.4.2.3 Project 3: HIV/AIDS and the education system

Strategic Objective:

- To develop planning models for analysing and understanding the impact of HIV/AIDS on the education and training system.

Outcomes:

- Plans and strategies to respond to the impact of HIV/AIDS on the sustainability (meaning that the education department needs to train an ample supply of educators so that it is not put in a position where it lacks human resources. Teaching should take place in classes of desirable educator /learner ratio).
- Establishment of care and support systems for learners and educators affected by HIV/AIDS.

Performance indicators:

- An evaluation of the programme and the impact on behaviour change should be continually undertaken.
- Improved data and planning models are available.
- Impact studies on all aspects related to the education and training system have been initiated and/or completed.
- Responsiveness of national and provincial education plans and strategies relating to the impact of HIV/AIDS.

2.3.5 <u>Republic of South Africa. Department of Education. 2000. The HIV/AIDS Emergency-Guidelines for Educators</u>

This booklet was circulated to all schools in South Africa in 2000. It is a comprehensive document that should form the "bible" for HIV/AIDS education in each school.

1. It commences with the facts about HIV/AIDS:

- What HIV and AIDS are.
- How the disease is spread/not spread.
- Issues why prevention is vitally important.
- The magnitude of the epidemic.

2 Eight key messages about preventing HIV/AIDS:

- Have safer sex; abstinence is promoted but if the learner is sexually active then condoms should be used.
- Love and trust within a relationship.
- Saying "Yes" saying "No" in seeking permission before sexual intercourse.
- Avoiding child abuse; "run and tell" action.
- You do not have to have lots of boyfriends and girlfriends to get HIV.
- Using a condom will also protect you from STDs, infertility and unwanted pregnancy.
- Condoms can be fun.
- Use of drugs and alcohol in lowering inhibitions.

3. The key questions educators should ask about sexuality education and attempt to answer such questions fully, truthfully and practically as possible. Examples of these are:

- Should we just tell young people not to have sex?
- Are children not too young for this sort of information?
- Is talking about sex against my culture?

- Will I encourage immorality?

4. Prevention of disease transmission in schools. Issues here include:

   - Universal precautions.
   - The management of accidents/injuries in the school environment.
   - Sexual relationships (and their repercussions) at schools.
   - Human rights issues: discrimination, prejudice, and confidentiality.

5. A school's own policy on HIV/AIDS is discussed.

The document ends with a declaration by President Mbeki of partnerships between youth, women, parents and educators, business people, the private sector, welfare, and health department against HIV/AIDS.

2.4 <u>COMMON ISSUES OF THE FIVE POLICIES</u>

The policies discussed are:

- Republic of South Africa. Department of Education. 2000. The HIV/AIDS Emergency-Guidelines for Educators.
- Republic of South Africa. Department of Health. 1999. National and Integrated Plan for children infected and affected by AIDS.
- Republic of South Africa. Department of Health. 2000. National HIV/AIDS and STD Directorate. HIV/AIDS /STD Strategic Plan for South Africa. 2000-2005.
- Republic of South Africa. Department of Education. 1999. National Policy on HIV/AIDS for learners and educators in public schools and students in further education and training institutions.
- Republic of South Africa. Department of Education. 2000. HIV/AIDS-Implementation plan.

The heading extractions from these five policies regarding the management of HIV/AIDS in schools are:

- HIV/AIDS education and issues to be included.
- Plans and strategies to respond to the impact of HIV/AIDS prevention.
- Covering universal precautions.
- Prejudice, discrimination and confidentiality issues.
- Counselling regarding HIV/AIDS.
- Condoms: other prevention strategies.
- Care and support.

The above are described in Table: 4 and Table: 5 overleaf.

The first part of Table: 4, on page 42, covers the National Policy on HIV/AIDS and the HIV/AIDS/STD Strategic Plan. The second part of Table: 4, on page 43, covers the remaining three government policies discussed.

	HIV/AIDS education and issues to be included	Plans and strategies to respond to the impact of HIV/AIDS prevention	Covering universal precautions	Prejudice, discrimination and confidentiality issues	Counselling regarding HIV/AIDS	Condoms: Prevention Strategies	Care and Support
National Policy August 1999	Life Skills education in all primary and secondary schools	Each school must have a planned strategy to cope with the HIV/AIDS epidemic	Strict adherence to universal precautions under all circumstances at all institutions is advised	Creating a culture of non-discrimination and equality. Confidentiality is assured	a. For refusal to study with and /or to be taught by an infected person b. "Living with hope" c. Counselling for the future.	Includes providing information on appropriate prevention and avoidance measures, including the use of condoms	Establishment of a Health Advisory Committee.
Strategic Plan January 2000	Life Skills education in all primary and secondary schools	Develop sector specific policies and plans for HIV and STI/D prevention	________	__________	Increase the number of persons seeking VCT	For males and females	Develop and implement programmes to support learners and educators

Guide-lines for Educators	Life Skills education across the curriculum	Each school must have a planned policy to cope with HIV/AIDS	Include a First Aid Kit and its contents The management of accidents and injuries at school.	Advocates a culture of non-discrimination and non-prejudicial treatment of those infected and affected	Promotes VCT	------------------	Supporting sick learners and colleagues
Implemen-tation Plan	In the curriculum	Policy to be developed	________	Protection from discrimination	______________	__________	Sensitive treatment for the infected.
National Integrated Plan Jan 2000	HIV/AIDS and Life Skills education	5 year strategic plan. Four broad based programmes identified in the plan	________	____________	VCT increase access to counselling and testing	__________	Community based care and support programmes .

Table 4: Common issues of the DoE's policies as collated by the researcher.

2. 4.2 COMMON ISSUES OF JAMAICAN AND USA POLICIES

Purpose of this comparison: Jamaica was chosen because it has a similar HIV/AIDS problem to South Africa Following sub-Saharan Africa, this country has the next highest infection rate (UNAIDS 2000:17) The USA was chosen because it is a First World country and does not have a high HIV/AIDS infection rate. Knowledge about both education programmes could benefit South African education policy planners and certain strategies used in Jamaica and United States of America could be implemented here.

	HIV/AIDS education and issues to be included	**Plans and Strategies to respond to the Impact of HIV/AIDS Prevention**	**Covering Universal Precautions**	**Prejudice, Discrimination and Confidentiality issues.**	**Counselling regarding HIV/AIDS**	**Condom: Prevention Strategies**	**Care and Support**
Jamaica	Health and Family Life Education (HFLE) HIV/AIDS education. HFLE programme for all pre-primary, primary and secondary school learners.	————	Strict adherence to universal precautions under all circumstances at all institutions is advised	Creating a culture of non-discrimination, and equality. Confidentiality is assured	a. For refusal to study with and/or to be taught by an infected person b. "Living with hope" c. Counselling for the future	Includes providing information on appropriate prevention and avoidance measures, including the use of condoms	————
USA	a. HIV/AIDS education and training for all personnel, that is learners, parents and school members b. Life Skills education across the curriculum	Local education agency develops HIV/AIDS plan.	Universal precautions are implemented	Creating a culture of non-discrimination, and equality. Confidentiality is assured	————	————	————

Table 5: Common issues of the Jamaican and American HIV/AIDS policies as collated by the researcher.

2.5 South Africa's recent past

After the democratic elections in 1994, a newly unified National Department of Education (DoE) adopted the slogan "*Tirisano*", a Latin word meaning, "working together for change." The Department's programme is driven by the need to overcome the devastation of apartheid and provide a system of education that builds on values such as democracy, human dignity, equality and social justice. Also, a commitment is made to establishing a system of lifelong learning to enable South Africans to respond to the enormous economic and social challenges of the 21st Century (http: education.pwv.gov.za/HIVAIDS_ Folder/AIDSPolicy.html)

The DoE chose to do this in two ways in its programme:

- To send qualified educators to schools also disadvantaged by a high learner/educator ratio and with unqualified or under-qualified educators. However, this strategy has not worked as many educators resigned. This plan was a failure and some of the former structural inequalities remained (Moroney, 2002:4).
- To introduce a new curriculum, called Curriculum 2005.Curriculum 2005 is based on the principles of Outcomes-Based Education (OBE) which was to replace memorisation of factual information and develop an inquiring mind to acquire knowledge, skills and attitudes.

The OBE programme is designed around the needs, capabilities and interests of the learner. The structure of OBE takes the form that each grade has specified outcomes. The educators, learners and parents know these outcomes and work towards them. Learners are assessed on their emotional responses, interpersonal skills and practical capabilities in completing a task.

This programme met with much resistance from educators, learners and parents. Educators had not been formally trained to handle this new method of instruction. Many educators felt that the one week of OBE training provided by the Department of KwaZulu-Natal Education and Culture was not adequate for them to handle this task. Many educators did not have the knowledge and skills necessary to teach according to the principles of OBE and the new learning areas that were introduced in the curriculum (Moroney, 2002: 4).

2.6 Life Orientation

One of the nine learning areas is Life Orientation. HIV/AIDS, sexuality education and Life Skills are covered in this learning area. Between November 1995 and March 1998 a Life Skills and HIV/AIDS Education Programme was developed and implemented in secondary schools (Grades 8-12) as part of the National HIV/AIDS Programme. The South African Government and the European Union jointly funded the programme (Wildeman, 2001:3). The programme was instituted because of the continuous rise in the incidence of HIV infection in South Africa and indicated the government's commitment to prevent and curb the spread of HIV/AIDS and STIs (Department of Health, 1999).

It was felt that one of the most effective ways of launching such a programme would be to make it part of the formal school curriculum (Department of Health, 1999). The Life Skills and HIV/AIDS programme is not an official part of the OBE curriculum. It is an additional programme that is to cut across disciplines in the curriculum (Moroney, 2002:6).

The Department of Education has determined nine outcomes for Life Orientation that each learner should achieve:

- Understand and accept himself or herself as an unique and worthwhile human being.
- Use skills and display attitudes and values.
- Improve relationships in families, groups, and communities.
- Respect the rights of others to hold personal beliefs and values.
- Demonstrate value and respect for human rights.
- Practise acquired life and decision- making skills.
- Access career and other opportunities and set goals that will enable him or her to make the best use of his or her potential and talents.
- Demonstrate the values and attitudes necessary for a healthy lifestyle.
- Evaluate and participate in activities that demonstrate effective human development.
- The outcomes in order to achieve its aim.

(adapted from Moroney, 2002:23).

The secondary schools Life Skills' education programme, concentrates on skills, such as self-esteem, self-respect, communication, and decision-making. It focuses on reproductive health, tolerance, respect and understanding different values and cultures, encouraging a culture of abstaining from or postponing sexual activity, changing lifestyles and if there is sexual activity it is done responsibly (Department of Health, 1999).

For the success of this intervention strategy, the Department of Education provides training for one or two educators in every school, so that these educators are able to pass the information to other educators in their schools. Educators who have Life Skills and HIV/AIDS training inevitably became the Life Orientation educators when the new curriculum was officially introduced into schools in 2000. However, this training was implemented haphazardly. Many schools did not receive training and even if they did, some of the educators who were trained were re-deployed, promoted, retired or died. Therefore, some schools were not able to implement Life Orientation and Life Skills and HIV/AIDS education as part of the curriculum (Moroney, 2002:5).

In 1999, the decision was taken to extend the programme to primary schools (Grades 1-7). For primary school learners a more diverse programme was developed, teaching them in addition to general health and hygiene, self-respect, self-esteem and to protect themselves from exploitation and abuse. The programme encourages a spirit of non-discrimination and attitudes of love, care and sharing.

A key element of both programmes in HIV/AIDS education is explaining the following:

- Exactly what HIV and AIDS mean.
- How the virus is transmitted.
- The myths surrounding the epidemic.
- Knowledge and prevention of STIs and HIV/AIDS.
- Human sexuality and reproduction.
- The importance of setting goals in relation to a healthy and balanced lifestyle.

(KwaZulu Natal Department of Education and Culture, 2000b: 6)

It is important to notice that none of these goals focus on attitudes towards HIV Positive people, none focus on gender relations and only one deal with skills, while the rest centre on knowledge. The researcher gathered from educators that they only teach the above prescribed curriculum since most did not have formal training in the area of Life Orientation.

Both the primary and secondary school programmes approach sexuality and HIV/AIDS education in an age appropriate and sensitive way. In 2002 the initial phases of both programmes were completed but there is still a long way to go. The Departments of Education and Health report that many children at school have experience with essential Life Skills and are aware of the basic facts surrounding HIV/AIDS (Department of Health, 1999).

The national policy on HIV/AIDS education states that HIV/AIDS education is essentially part of the curriculum and all learners from Grades R-12 will eventually be exposed to it. The official DoE's policy is that learners and students must receive education about HIV/AIDS and abstinence, in the context of Life Skills education, should be encouraged. Life Skills and HIV/AIDS education should not be presented in isolation, but should be integrated into the curriculum. Both should be presented in a scientific, but understandable way. Appropriate course content should be available in the pre-service and in-service training of educators so that they can cope with HIV/AIDS in schools. Sufficient educators to teach about the epidemic should also be provided. (Department of Education, 1999).

Contrary to this, the researcher has discovered that all teaching about HIV/AIDS education is in the Life Orientation class in a significant number of schools. Furthermore, the development of peer education, by which learners themselves play an increasing role in not only spreading Life Skills and HIV/AIDS information, but also dictating the pace and direction of programmes, is receiving attention. In particular, learners will be encouraged to develop greater understanding, acceptance and compassion for those infected and affected by HIV/AIDS. School communities and others will also be encouraged to play a greater role in caring for people living with AIDS.

2.7 HIV/AIDS Life Skills Programme- Study by Moroney

The researcher had attempted to obtain research studies in the management of HIV/AIDS in schools in South Africa and Southern Africa, but without any success. Some researchers examined some aspects of the management of the disease at school, for example there was a study on the evaluation of the Life Skills programme.

The fullest study (to date) was conducted by Moroney (2002) entitled, "Teaching HIV/AIDS Education using the Life Skills Approach in two Durban area High Schools." This study looks at a HIV/AIDS intervention project, of Life Skills education, in two high schools: one a pre-dominantly Indian suburban school, which the researcher refers to as an "advantaged" school. The researcher uses this term because the school has advantages in many spheres of education: in the curriculum offered, in the physical facilities available, in the quality /qualifications of educators and in infrastructure. The other school analysed has only African learners and is

situated near an informal settlement. This school, when compared to the Indian school, was "disadvantaged".

South Africans have been bombarded with information about how HIV/AIDS can be contracted and transmitted. This basic knowledge is also reinforced in schools. According to Moroney, learners at both schools still do not have full knowledge about the transmission of HIV. She concluded that learners at both schools were not fully educated in basic HIV/AIDS, despite exposure to the Life Skills Programme. However, the learners from the advantaged school were able to correctly identify the ways of transmitting HIV, but many learners incorrectly believed that kissing could transmit HIV. Even more disturbing was the knowledge content of the disadvantaged learners. Only 15% of these learners identified unprotected vaginal intercourse as a way of transmitting the disease. More than half of these learners identified oral sex with an HIV Positive person as a way of transmitting the disease. In fact it is one of the least risky ways of contracting the disease (Moroney, 2002:56). Another shocking result is that of unprotected anal intercourse, as one of the most dangerous ways of contracting HIV, is identified by only 18% of the learners (Moroney, 2002:47). On average only 7 out of 40 learners know that vaginal and anal unprotected sexual intercourse could transmit HIV. She concludes that in both schools, especially the disadvantaged one, HIV/AIDS education had failed dismally.

Moroney also finds that learners from the advantaged school have more knowledge of HIV/AIDS and are less sexually active, than learners from the disadvantage school, who have less HIV/AIDS knowledge. The deduction here, perhaps, is the message of abstinence that one can be in a sexual relationship without having penetrative sex.

Although this may be an encouraging sign of the impact of the HIV/AIDS educational programmes, Moroney finds that those learners, who are having sex, are less knowledgeable about how to protect themselves and so putting their health at risk. It is sadly those learners who are putting themselves at risk who are in greater need of a better HIV/AIDS education.

Moroney surveys learners of different sex and race groups and with different experiences, parental communication and exposure to various content and teaching methods. The two schools that are used in the research are situated in urban and semi-urban areas and have more resources than most South African schools. One can only suppose that the knowledge and skills of educators in many of other poorly resourced schools, especially in rural areas, are inferior to the two schools used in her research. The final conclusion that she reaches is that learners at the two schools surveyed are "woefully unprepared in the areas of life skills and their application, especially as they relate to avoiding HIV/AIDS" (Moroney, 2002:54).

2.8 Sexuality education and sex education in schools

Parents are the first socialisation agents for their children and are expected to educate them in all aspects of life. A powerful tool of education is communication, both verbal and non-verbal. Children learn from modelling their behaviour on that of significant others. Schools are a source of secondary socialisation where learners, through formal training, are taught about life and its challenges. There are various arguments concerning who should take responsibility for providing sexuality education to children.

According to Schofield (1996:114) sex education is primarily the domain of parents. Baldwin (1990) cited in Schofield (1996:116) reveals that adolescents and parents do discuss sexuality issues. Lefkowitz *et al.,* (1995:115) support this by saying that parents are viewed as accessible, inexpensive and often a willing source of information for adolescents and children. Preparing children for adulthood is one of the most important things parents do, but many parents feel uncomfortable talking about sex. The notion that talking to children about sex, contraceptives and the right to abortion makes them want to experiment has been rejected. Parents are sometimes embarrassed to talk about sex or may think that if they do, children may indulge in sexual activity. This may imply that communication about sexual issues to children is not an easy task for most parents.

Meredith (1989:7) states that learners see the school as a repressive institution and therefore sexually liberating education cannot be provided within this context. However, there is some justification for school-based sex education that the classroom provides for in the most formal, controlled and an accessible manner to adolescents during a critical period of learning and psychosocial development. Others have found that schools have the authority to give factual knowledge whereas parents are seen as only random sources of information. The school also offers the young person a source of legitimacy, a yardstick by which the values of the family and society may be judged (Meredith, 1989:4).

A study in Britain by Isobel Allen, cited in Meredith (1989:7), reveals that in a study of a geographic spread of 200 families, 95% of teenagers and 96% of parents believed that schools should continue to provide sex education, while 27% parents believed that

it should be the responsibility of parents. Kazakiwicz and Rea (1975, cited in Schofield, 1996: 47) maintain that British educators feel that sex education is the most difficult subject to teach and that they are not trained to do so. On the other hand the study by Allen *et al* argues that what is problematic is more the delivery than the content of sex education. They also recommend that outsiders may be used to give talks or lead discussions at schools. Priority should be given to training educators in the skills needed to handle these topics (Allen *et al.*, 1975 cited in Schofield, 1996: 48).

According to the Population Council (2000:12), many young people report that they would prefer to have parents or other family members as primary sources of information and advice about sexuality and sexual health. Sometimes the home environment does not support this type of parent- child communication. Also adults in a household may not have accurate information to advise their children about sexual risks. Some young people may find it embarrassing or frightening to discuss intimate issues with their parents. Some parents may prefer to rely on schools to educate their children about matters they themselves find difficult or embarrassing to discuss. Other trusted adults in the community, such as educators, health workers and counsellors, can help to fill the gap if they have a good relationship with the young people concerned.

From these discussions one can deduce that both parents and children have responsibility in communicating needs about sexuality issues. If there is a lack of education about sexuality, children may develop low self-esteem and make poor decisions about life issues. Education about sexuality and sexual relationships (both at

home and at school) is necessary so that youth will make informed decisions about life.

2.9 Approaches in Youth Prevention Programmes

Social workers are often called to intervene in youth problems for the purpose of preventing teenage pregnancies and other social problems in communities (Franklin, 2000:65). Prevention programmes can be on two levels, that is primary prevention that prevents behaviour leading to pregnancy and programmes to intervene when pregnancy has occurred and to prevent further pregnancies.

Primary prevention programmes should be based on current sexual knowledge and attitudes, giving information on sexual behaviour as well as the use of contraception and measures to delay sexual intercourse to reduce sexual risk-taking behaviour. Decision-making skills, communication and interpersonal skills should be part of the strategy to help youth and parents to talk about sex. Other skills would be to help youth abstain from sex, postpone sex or reduce the frequency of sexual intercourse, while also promoting effective contraceptive use.

Another useful intervention is the Information-Motivation-Behavioural skills model developed by Fisher and Fisher, as cited in Schofield (1996:52). This model (IMB) focuses on the acquisition of accurate information about HIV/AIDS transmission, followed by motivation to avoid risk and to engage in preventive behaviours. Peers are important in enhancing the motivation and development of positive attitudes to prevent infection and this should be followed by the development of assertive skills to encourage partners to accept protective methods.

It should be noted that not only social workers deal with youth issues, but also youth care workers are a fast growing profession. They help to reduce youth problems, while building up the necessary skills for effective living. Communities also need to be involved in preventive strategies so that they encourage the use of learned skills and also educate their own children.

2. 10 Adolescent risk-taking behaviour

Adolescents, when compared to other groups, are particularly vulnerable in the contraction of HIV/AIDS. Although sexual activity before marriage is dissuaded by social custom, pre-marital sex continues to be widespread in many developing countries. Adolescents reach physical maturity earlier and the longer delay in marriage results in a longer time-span between these two events. This leads to more sexually active unmarried adolescents than ever before (Blanc *et al.,* 1998:111). Unwanted teenage pregnancy is one of the most worrying consequences of this trend. However, today HIV/AIDS has increased adolescents' danger in their transition to adulthood.

The policy document, HIV/AIDS and STD Strategic Plan for South Africa 2000-2005, (covered earlier), has revealed that youth are one of the specific groups targeted for prevention strategy. However, knowledge of the causes of the transmission of HIV/AIDS, which is already high in this group, does not necessarily lead to appropriate behaviour change.

In sub-Saharan Africa, one issue of great concern is the erosion of traditional practices and beliefs that incorporate control over pre-marital sexual behaviour. A particular

aspect is the decline of the role of the grandmother in providing adolescent girls with pre-marital sexual advice and instructions on appropriate behaviour. This has been caused by the rejection of traditional norms and values and also the general increase in education. The selection of one's marital partner by parents, as occurred in tribal Africa and extensively in India, is a traditional practice that is on the decrease. This was identified by Letamo and Bainame (1997:99) as a factor, contributing to the justification of having multiple partners in Botswana.

Gage (1998:158) notes that adolescents make irrational decisions in a rational way, in that adolescents persist in high-risk sexual behaviours although they have knowledge regarding the transmission of HIV/AIDS. Many adolescents often have a feeling of infallibility and ignore the known dangers their actions pose to themselves. In sub-Saharan Africa, polygamy is common. This encourages male adolescents to seek multiple sexual partners. Simultaneously female adolescents, in their desire to secure a husband, accept this behaviour. In some cultures, fertility ranks as important and a woman who has children, irrespective of marital status, is socially accepted as compared to a woman that has not had any children. The decision to use condoms becomes unnecessary.

The power that men have is entrenched in the patriarchal system, which is riddled with economic and social inequalities: an example is that men get better jobs and are better paid than women Varga (1996: 55). Gage (1998:158) states that young people feel the added stress of being caught among traditional gender expectations, western ideals and also a global society.

2.11 School-based HIV prevention information, education, and skills development

The relationship between education and the risk of HIV/AIDS infection is complex. In sub-Saharan Africa, for example, more developed countries and better-educated people tend to have higher rates of HIV/AIDS infection. However, while better-educated people seem to have been more susceptible to HIV/AIDS at the onset of the epidemic, they also appear to be changing their behaviour more rapidly. In the future, as better-educated groups take steps to protect themselves, it is likely that those at highest risk of acquiring HIV/AIDS will be people with less education. Therefore, increasing access to education in general and HIV/AIDS related education in particular, should lead more people to change their behaviour and so protect themselves from HIV/AIDS (Hargreaves and Glynn, 2002: 496).

HIV related education could have an even greater effect on prevention efforts, if it is linked with other HIV prevention efforts in the community. Research has shown that education about sexual health does not promote early activity or promiscuity, as some critics contend, but rather delays the initiation of sex and encourages safer sexual behaviour. In 1997 an UNAIDS review of 53 sexual health education programmes found that about half of these programmes had no effect on sexual behaviour, while the remaining half of these programmes either delayed the onset of sexual activity or reduced the rates of unplanned pregnancy and STIs (UNAIDS 1997, cited in Population Council, 2000:27).

HIV/AIDS prevention programmes in schools have the potential to reach large numbers of young people before they become sexually active, as well as when they are struggling with their emerging sexual identities, feelings and relationships. For some young people, school is the most important institution in their experience and school policies and programmes can help many adults as well (including school personnel, parents and the wider community) cope with HIV/AIDS. For example, HIV/AIDS prevention programmes can promote tolerance and respect for people infected with HIV/AIDS and can reduce the stigmatisation of teacher and students affected by the virus and offer them social support (WHO 1999, cited in Population Council, 2000:28).

Ideally, school-based HIV/AIDS prevention programmes should begin early and be sustained and phased in by age from early childhood through adolescence. This is particularly desirable in developing countries where primary school attendance rates may be relatively high, but few students reach secondary school. Content appropriate for children should be integrated into Life Skills education programmes at an early age, before children become sexually active.

Educators, who are appropriately trained and respected by students, should be involved as much as possible in HIV/AIDS prevention education. However, programme designers should be aware of the barriers to effective educator-led sexuality education. For example, many educators are embarrassed when talking about sex and feel they will lose self-esteem in their students' eyes if they do so. Sometimes non-school specialists can be recruited for this work, but even then educators should be trained how to identify issues that merit discussion and how to provide for referral

to further services for students, including information providers. A school-based HIV/AIDS education programme in Masaka, Uganda failed because educators did not feel comfortable talking about sex and condoms in front of learners, although they had been trained. The authors of that study speculate that if educators' attitudes towards the programme remain negative, the programme will be implemented in a desultory, inconsistent way (Kinsman *et al.,* 2001: 92).

2.12 Creating a safe environment for successful school-based intervention

Programme designers should recognise that not all schools are salutary places for young people, especially for young girls. In the regions of the world most seriously affected by HIV/AIDS, epidemiological data reveal that young women are infected in school, as a result of unsafe and sometimes coerced sex with classmates or educators. In Mwanza, Tanzania, for example, parents of children at one school complained that educators were sexually harassing girls. The school appointed several guardians, that is female staff members to whom the girls (and boys, if necessary) could turn if they had questions about sexual health or if they were being harassed by an educator or classmate. The guardians reported allegations to the district authorities, who, in turn, supported the guardians if they faced threats from educators. Training the guardians to help the girls, moreover, helped guardians deal with issues of sexual harassment in their own lives. The involvement of other institutions, including district authorities and the courts in addition to the schools themselves, reinforced the importance of prevention for the entire community and created the kind of collective will that seems to be required to slow the spread of the virus (UNICEF/UNAIDS/WHO 2002, as cited in Population Council, 2002:30).

Programme designers and implementers should also be aware of the consequences HIV/AIDS has on the number of available educators and on young people's ability to stay in school. In sub-Saharan Africa, high rates of infection among educators and learners have devastated many schools (UNAIDS, 2002:33). Furthermore, data from studies on girls' educational attainment in agricultural communities indicate that often they are pulled out of school earlier than boys to fulfil household responsibilities, for example, when adult household members become ill or die as a result of HIV/AIDS (UNAIDS, 2002:34). In addition, as household resources to hire agricultural labourers decline, girls are likely to be pulled out of school for food production (Levine *et al.*, 1996: 283).

Creating a safe environment for young people includes providing them with accurate information that promotes frank honest discussion about risky sexual behaviour. Programmes that endorse the importance of virginity for girls do not necessarily protect girls from infection with HIV or STIs. Studies carried out by the International Centre for Research on women found that girls may engage in other forms of risky behaviour, such as anal sex, in order to remain, at least technically, virgins. Promoting either postponement of sex or the practice of protected sex seem to be more successful in encouraging safer behaviour than programmes that promote abstinence (Weiss *et al.*, 1996, cited in Population Council, 2002:30).

2.13 Community support for HIV/AIDS and Sexual Health Education

School-based HIV/AIDS prevention programmes are likely to fail if strong community support for them is lacking. Many communities and governments resist school-based HIV/AIDS prevention programmes, fearing that discussion of sex will encourage immoral behaviour. Community members must be involved in the earliest planning stages, through community meetings, parent-educator associations and religious centres.

Evidence-based programmes, that is, programmes that are informed by surveys from research, often help convince communities of the necessity of HIV/AIDS prevention in schools. Such evidence may provide information on HIV/AIDS and STI prevalence among young people in an area, rates of unwanted pregnancy and sexual violence.

School health teams of learners, educators, parents and health workers, should be supported by community advisory committees, consisting of HIV/AIDS prevention counsellors, community members infected with HIV/AIDS, politicians, sports stars and others who want to build community support for HIV/AIDS prevention and help obtain funding for programmes. Ideally, each level of community administration should at least, be aware of, if not involved in, the planning of a school health education programme. School health programmes need leadership: WHO recommends the formation of school health teams, comprising learners, educators, parents and health workers, to co-ordinate and monitor all health promotion activities, including HIV/AIDS prevention (WHO, 1999:4).

2.14 Conclusion

This literature review has shown that the involvement of parents, especially through a school's governing body (SGB) is vital for the success of any school-based HIV/AIDS programme. If this is done then the following criticism of the programme extracted from The Daily News, dated 12 May 2004, would be unnecessary.

"As a parent and medical doctor I object to the current Grade 9 sex education programme in schools, especially the Health /Education Department's manual Soul City skills...

I refuse to allow my child to be exposed to the sexually explicit material and immoral ideas in this book, including:

- *Thigh sex.*
- *Pictures of the erect penis.*
- *Pictures of naked couples having sex.*
- *How to have penetrative sex.*
- *The 'morning after' pill and abortion if the condom rule is disobeyed.*

Most religions and cultures view homosexuality as immoral and unnatural. Do parents really want their children to be encouraged to accept it is as an alternative lifestyle?

Teenagers are told to decide for themselves when they are ready for sex. Could a Grade 9 pupil ever be ready for sex? Apparently, 'if you're mature enough to ask for a condom'. Really? A mature Grade 9 pupil?

Furthermore: 'Safe sex equals condom sex', according to this manual. I see no warning that condom sex is 80-85% safe. Therefore it is not 'safe', but only lessens the risk of acquiring HIV. Safe sex is sex within a marriage, with a faithful partner.

As a parent it is my right to teach my children my values and religion.

It is not the Department of Health/Education's right to decide what my child should know about sex.

Doctor A Booysen

Overport"

HIV/AIDS is a world-wide epidemic that is prevalent in sub-Saharan Africa. South Africa, with its fastest growing HIV rate, is at the forefront of the epidemic. The DoE's response to the epidemic is to introduce a Life Skills approach to the prevention and ultimate eradication of the disease. Policies governing this have been put into place.

2.15 Summary

This Chapter covered the statistics of the HIV/AIDS epidemic as applicable in South Africa and globally. The South African Government has put into place policies to control the spread of the disease. These policies were summarised and examined for important common features. The policies of Jamaica, which has similar problems to South Africa and those of the United States of America, were examined. The Life Skills programme was discussed and ways at improving it were explored.

2.16 References

Barnett, T. and Whiteside, A. 2002. AIDS in the Twenty First Century: Disease and Globalisation. New York: Palgrave.

Blanc, A.K. and Way, A.A. 1998. "Sexual behaviour and contraceptive knowledge and use among adolescents in developing countries." Studies in Family Planning. 29. (2). 106-116.

Canadian Association of Principals. 1993. AIDS. Preparing your school and community. Montreal: Shannon and McCall.

Franklin, C. and Corcoran, J. 2000. "Preventing Adolescent Pregnancy. A review and Programs and Practices." Social Work. 1. (45).

Gage, A.J. 1998. "Sexual activity and contraceptive Use. The components of the decision making process". Studies in Family Planning. 29. (2). 154-168.

Glynn, J.R., Careal, M., Auvert, M., Kahindo, M. and Chege, J. 2001. "Why do young women have a much higher prevalence of HIV than young men?" A study in Kisumu, Kenya and Ndola, Zambia. AIDS 15. (4). 51- 60.

Guest, Emma. 2001. Children of AIDS: Africa's Orphan Crisis. Pietermaritzburg: University of Natal Press

Hargreaves, J.R. and Glynn, J.R. 2002. "Educational attainment and HIV-1 infection in developing countries: A systematic review." Tropical Medicine and International Health. 7. (6). 489-498.

http: education .//pwv. gov.za/HIV/AIDS_ folder/AIDS Policy.html

Kimani, D. 2002. Study Says Violence is a Major Cause of HIV Infection in East Africa.http://allafrica.com/stories.200209090348.html

Kinsman, J. 2001. "Evaluation of a comprehensive school based AIDS education programme in rural Masaka, Uganda." Health Education Research.16. (11). 85-100.

KwaZulu - Natal Department of Education and Culture. 2000b. Outcomes-Based Education Re-Training Workshop- Document: Life Orientation. Ulundi: Provincial Printers.

Lefkowitz, E.S., Kahhlbaugh, P.E. and Sigman, M.D. 1995. Turn-Taking in mother Adolescent Conversations About Sexuality and Conflict. Plenum Publishing Corporation.

Letamo, G. and Bainame, K. 1997. "The socio-economic and cultural context of the spread of HIV/AIDS in Botswana." Health Transition Review, Supplement 3. (7). 97-102.

Levine, C., Michaels, D. and Back, S.D. 1996. "Orphans of the HIV/AIDS pandemic." Jonathan Mann and Daniel Tarantola (eds), AIDS in the World 11. New York: Oxford University Press. 278-286.

Meredith, P. 1989. Sex Education : Political issues in Britain. Polity: Cambridge.

Moletsane, R., Morrell, R., Unterhalter, E. and Epstein, D. 2002. "Instituting Gender Equality in School: Working in an HIV/AIDS Environment" Perspectives in Education. 20. (2). 37- 53.

Moroney, E. 2002. Teaching HIV/AIDS Education using the Life Skills Approach in two Durban area High Schools. Unpublished M.Ed. dissertation. University of Natal:Durban.

Population Council/International Centre for Research on Women. 2000. Adolescent Girls' Livelihoods- Essential Questions. Essential Tools: A Report on a Workshop. New York and Washington, DC: Population Council and ICRW.

Republic of South Africa. Department of Education. 1999. National Policy on HIV/AIDS for learners and educators in public schools and students in further education and training institutions. Pretoria: Government Printers.

Republic of South Africa. Department of Education. 2000. HIV/AIDS-Implementation plan. Pretoria: Government Printers.

Republic of South Africa. Department of Education. 2000.The HIV/AIDS Emergency-Guidelines for Educators by R.Jeweks. Pretoria: Government Printers.

Republic of South Africa. Department of Health. 1999. National and Integrated Plan for children infected and affected by AIDS. Pretoria: Government Printers.

Republic of South Africa. Department of Health. 2000. National HIV/AIDS and STD Directorate. HIV/AIDS /STD Strategic Plan for South Africa. 2000-2005. Pretoria: Government Printers.

Schofield, M. 1996. The Sexual Behaviour of Young People. Harmonds Worth: Penguin Press.

Smart, R. 2003. Children affected by HIV/AIDS in South Africa . Arcadia: Save the Children (UK).

UNAIDS. 2000. Report on the Global HIV/AIDS epidemic, June 2000. Geneva: UNAIDS.

United Nations. 2001. "Global Crisis – Global Action," 26th Special session of the General Assembly to review and address the problem of HIV/AIDS. Geneva: UNAIDS.

Varga, C.A. 1997. "Sexual decision-making and negotiation in the midst of AIDS: Youth in KwaZulu-Natal, South Africa." Health Transition Review. Supplement 3, 7, 44-67.

Wasserheit, J.N. 1992. "Epidemiological synergy: Interrelationships between human immunodeficiency virus infection and other sexually transmitted diseases.". Sexually Transmitted Diseases. 19(2) .61-77.

WHO. 1999. "Preventing HIV/AIDS/STI and Related Discrimination: An Important responsibility of Health Promoting Schools," WHO Information Series on School Health, document 6. Geneva: WHO.

Wildeman, R. 2001. Funding the Fight Against HIV/AIDS: Funding the Life Skills and HIV/AIDS Programme. Idasa: Cape Town.

CHAPTER THREE

3.1 Introduction

This Chapter focuses on the management of HIV/AIDS in secondary schools and an evaluation of the Life Skills and HIV/AIDS Programmes for schools in South Africa. The major government HIV/AIDS intervention is that of Life Skills education. This Chapter also attempts to answer the following research questions:

- Are educators adequately trained to handle the HIV/AIDS problem?
- What education programmes, dramas, films and videos are available to learners, educators and parents?
- What measures are taken to ensure confidentiality?
- What counselling, if any, is available?
- How can health services be involved?

3.2 Evaluation of the Life Skills programme

Each province implemented the Life Skills curriculum and this was done in a very short period of time. The researcher has reviewed the contents of an available Life Skills and HIV/AIDS programme and feels that some probing questions need to be addressed in order to improve its delivery and its success rate. These questions are as follows:

3.2.1 Moral issues in teaching about HIV/AIDS

Should AIDS education programmes take the stance that sexual activity should only occur within the context of marriage or monogamous relationships? Is this stance appropriate in the light of studies showing the extent and nature of sexual activity of youth and adults? Should morality about HIV/AIDS be discussed within the context of spiritual or religious values?

3.2.2 Explicitness of materials

How explicit should a programme's vocabulary and audio-visual materials be?

As far as selecting instructional materials, most provinces have supplied materials to schools for their HIV/AIDS programmes. The initial challenge was to locate contemporary South African materials. Has the challenge been met? Are there adequate materials for all grade levels and for all learners? Is the latest information available for all educators?

3.2.3 Presentation of prevention methods

Most programmes present sexual abstinence and marital fidelity as the most effective means of prevention. Most programmes present the use of condoms, albeit on a limited basis, as a means to reduce the risk. Is the balance between the options presented appropriately?

3.2.4 Issues related to sexuality:

Many educators seek to avoid a discussion of sexual issues such as homosexuality, abortion, and certain sexual practices. Many programmes leave the choice about such as issues to school governing bodies, school principals or educators. Is that sufficient?

3.2.5 Promoting attitudes conducive to preventive behaviour.

Most programmes make reference to decision-making skills in their objectives. Do all such programmes include opportunities for learners to practise such skills? Do such programmes make extensive use of role-playing, scenario-writing, simulations and discussions or trigger videos? Are concepts such as "peer influence" and "assertiveness" training built into such programmes?

3.2.6 Placement of HIV/AIDS programmes in the core curriculum.

The DoE has decided that AIDS education will be mandatory. Many provinces have not introduced such programmes, particularly at secondary schools. What is the DoE's decision concerning examination in HIV/AIDS education?

3.3 An identification of constraints preventing the response of schools and some solutions included

There are a number of constraints, both external and internal in a school's district, which will prevent its response to HIV/AIDS. Such constraints should be recognised and plans made to overcome their impact on a school.

3.3.1 External Constraints: Among the external constraints are avoidance of the issue; misinformation and media hype; new information; moral and religious concerns; concerns about homosexuality; attitudes towards sexuality; concern about the degree of explicitness; unprepared or unwilling educators; parental objections. These constraints have been elaborated below.

3.3.1.1 Avoidance of the Issue

Although the vast majority of schools in South Africa have benefited from active and positive leadership from some school principals, there is still a need to ensure that the SGB has addressed the issue of HIV/AIDS before disclosures from the school members create a crisis. Although educators, learners and employees hear of HIV Positive people from the media and the community, they do not know how to handle this situation.

3.3.1.2 Misinformation.

There continues to be a public misconception about the transmission of HIV/AIDS. This can be dispelled by detailed, accurate information and by providing that information to parents, religious leaders and other influential members in the community. If a school performs this educational function for learners and parents then the school performs a valuable public service.

Incomplete or distorted coverage in the media about HIV/AIDS or HIV/AIDS programmes can destroy a school's efforts. A typical example here is the stance taken by President Mbeki and the so-called "dissident group." This group maintained that HIV does not cause AIDS and was a major backward step in the fight against HIV/AIDS. This approach was eagerly received by those not wanting to practise safe sex and negated much of the headway made against HIV/AIDS. Being pro-active about providing information and education and taking the initiative informing the local media about HIV/AIDS will, with the help of the public health officials, place the school in the best possible position.

3.3.1.3 New Information

Almost daily, there are media reports about HIV/AIDS. Educators must keep abreast of the latest developments and ensure that they have access to reliable, up-to-date information. Instructional staff with specific enquiries should be able to contact public health officials directly.

3.3.1.4 Moral and Religious Concerns

HIV/AIDS education may become a target for attacks by individuals or groups who object to discussions on sex, condoms and related behavioural issues in schools. Reaction may also

occur against specific materials or the appropriateness of the curriculum for certain grade levels. The best strategy of a school management team is to ensure that learners and parents are well informed about the school's programme. In a school's surrounding community most religious organisations have taken positions supporting HIV/AIDS education.

3.3.1.5 Concerns about homosexuality

According to a Canadian study, resistance to HIV/AIDS education can arise from concerns and fears about addressing homosexuality in the classroom (Canadian Association of Principals,1993:24). Parents may be unwilling to acknowledge the possibility that their adolescent children may experiment with homosexuality. On the other hand, many young people believe, incorrectly, that they are immune to infection if they are heterosexual. Learners who consider themselves homosexual or who have friends or family members who are homosexual need to have questions answered in a climate that emphasises that it is not who you are that creates the risk, but what you do.

3.3.1.6 Attitudes about sexuality.

Since sexuality is a private matter, there is often reluctance from some that sex education should be offered at school. Public opinion polls clearly show that most parent do want such programmes. The School Management Team should emphasise that parents will continue to be the primary educators of their children about sex. They should point out that school programmes attempt to dispel misinformation provided through the media or by the peers.

3.3.1.7 Concern about the degree of explicitness.

Disagreement may occur in a community about how explicit the HIV/AIDS education programme should be. Advice from public health officials consistently advises that

information should be given in as frank and open a manner as possible. However, in some communities this may be difficult. A successful strategy to overcome community concern is to use public health personnel, such as nurses, to introduce the programme or be present in classes discussing certain topics.

3.3.1.8 Unprepared or unwilling educators

The best way to approach staff training about HIV/AIDS education is to first involve the entire staff in awareness or information sessions, then specific sessions can be organised for educators who will deliver the programme. Even with preparation, some educators may continue to be uncomfortable teaching about HIV/AIDS. Alternatives include team teaching sessions and the use of public health personnel. It is not advisable to force an educator to deliver HIV/AIDS education.

3.3.1.9 Parental objections

Most South African schools allow individual parents to exclude their children from HIV/AIDS education programmes. Such provision often defuses any opposition to the programme.

3.3.2. Internal Constraints: In analysing the Life Skills and HIV/AIDS education programme, the following constraints were identified in policy development; research and programmes:

3.3.2.1 Policy development

There is a lack of research about School Governing Body (SGB) policies' on HIV/AIDS.

There are few model SGB policies available which address the issue of HIV/AIDS in a

comprehensive way. Most policies are, in fact, procedures to manage infected learners or employees. Each SMT should have their own policy on HIV/AIDS, which is unique to their institution.

3.3.2.2 Research

Mary Crewe believes that when the education sector did try to do HIV/AIDS education it did not think carefully enough how it should do done. What was not paramount was how to save lives; what was paramount was how to maintain dignity and how to push a certain value system and ideologies. Crewe says that at the University of Pretoria they are going to mainstream HIV /AIDS through every facet of campus life, including curricula.
(Crewe, 2000).

HIV/AIDS programmes were developed without the benefit of comprehensive research on HIV/AIDS and sexual behaviour. There has been an insufficient evaluation of HIV/AIDS programmes, particularly in regard to their impact on behaviour. Studies that demonstrate that sex education programmes do not increase sexual activity need to be widely disseminated. There are a few studies which show how "high-risk" populations such as "street-children" should be reached by HIV/AIDS education programmes. There are few, if any, case studies that offer advice to administrators on how to manage the public disclosure of learners or educators infected with the HIV.

3.3.2.3 Programmes

HIV/AIDS programmes have been primarily aimed at all learners. Few programmes exist for groups that practise high-risk behaviours. Life skills programmes have avoided basic health issues associated with HIV/AIDS. Many HIV/AIDS programmes

describe goals for decision- making, self-esteem and other life skills in vague terms. The "abstinence" or "just say no" models used in sexuality or drug abuse programmes prove minimally effective in secondary schools because adolescents are at a stage of their development, when they assert their own value systems, influenced by strong peer pressure. Are we making the same mistake with the current HIV/AIDS programme? Are we emphasising self- esteem in current HIV/AIDS programme?

3.3.2.4 Professional Development

There is no systematic method by which most educators in South Africa can access the latest information about HIV/AIDS. To date, in-service programmes have only prepared those educators who are delivering the programme. School principals, counsellors and SGB personnel should have HIV/AIDS education. All employees should have a basic level of awareness and information.

3.3.2.5 Choosing and evaluating the facilitator of the HIV/AIDS Programme

The success of HIV/AIDS education programmes depends on the competency and commitment of the instructor. It is, therefore, critical that the educators selected to teach the programme are chosen wisely. According to Wagman *et al.,* 1981, (cited in Canadian Association of Principals, 1993:47) effective HIV/AIDS educators should be:

- Knowledgeable about the content of Life Skills education and HIV/AIDS.
- Skilled in using appropriate communication and teaching techniques.
- They should also have personal qualities that promote the goals of the programme.

The first two criteria can be addressed through training programmes, either before or after the educators are selected.

3.4 Research Questions

3.4.1 Are educators adequately trained to handle the HIV/AIDS problem?

James, in her research, (cited in African Studies, 2002:179) found that very few educators in the Durban area were officially trained in Life Skills education. This is in direct contradiction to Clause 2.10.3 of the Government Gazette, which states that "all educators should be trained to give guidance on HIV/AIDS." Moroney found that an educator in the advantaged school, a Guidance Counsellor, received one week's training in Life Orientation and also participated in a year-long HIV/AIDS education course offered by the KwaZulu-Natal Department of Education and Culture. In contrast, an educator at the disadvantaged school received no specific training in Life Orientation and none whatsoever in HIV/AIDS education. Moroney's findings were consistent with the findings of other researchers on Life Skills and HIV/AIDS education in South Africa (Moroney, 2002: 37).

3.4.2 What education programmes, drama, films and videos are available to learners, educators and parents?

There is a lack of linguistically and culturally adapted videos for secondary school learners. There is no resource centre for educational information from which educators can order materials. Instead many educators report going to the Department of Health located at Prince Wing in Addington Hospital and to the AIDS Training, Information and Counselling Centre (ATICC) at the eThekwini Health Department for resources like posters, pamphlets, books and videos. According to officials from the Health Department and the Planned Parenthood Association of South Africa (PPASA), Health officials visit schools delivering

HIV/AIDS/STIs awareness programmes. The presentations include dramas, videos, slide presentations, charts and handouts. These are listed below:

Title	**Age**	**Length**	**Description**
AIDS: Facts or fears	Teens	10 minutes	How one cannot get AIDS
AIDS in your school	Teens	23 minutes	Illustrates what AIDS is, how it is spread and how people with AIDS like to be treated. Teenagers' questions are answered by experts
Hypothetical: Does Dracula have AIDS?	Teens and adults	60 minutes	A stimulating panel discussion highlighting controversial ethical, social and moral issues
Just a regular kid. An AIDS story	Teens	45 minutes	Set in a school in America, this story shows the fears and prejudices of those confronted with AIDS
Who cares wins	Teens and adults	40 minutes	Portrays the destructive power of AIDS through the characters of Phil, a married man who progresses from being HIV Positive to having full blown AIDS. It shows the tragedy of his life as well as the warmth of family support
Whose problem?	Teens	24 minutes	Facilitates group discussion
Umuntu, Umuntu-Ngabantu	Teen and adults	30 minutes	A documentary of people in KwaZulu-Natal living with HIV

Table 6: Videos used in secondary schools (Greathead *et al.*, 1998:188)

3.4.3 What measures are taken to ensure confidentiality?

Compulsory disclosure of a learner's or educator's HIV status to an educational institution or the authorities is not permitted, as this would serve no meaningful purpose, because school principals are forced by law not to discriminate against an individual on the basis of his/her HIV status. Also disclosure is not going to benefit an individual in accessing treatment or finance from the educational institution. In the case of disclosure by learners and educators, school principals should be prepared to handle such disclosures and be given support to handle confidentiality issues.

In cases where the medical condition diagnosed is HIV/AIDS, the Health Act, 1977, only requires the person performing the diagnosis to inform an immediate family member and the persons giving care to the patient. When death occurs, the persons responsible for the preparation of the body of the deceased must be informed of the presence of the disease.

3.4.4 What counselling, if any, is available?

Studies have shown that young people have a keen interest in knowing their status. Voluntary Counselling and Testing (VCT) allows adolescents to evaluate their own behaviour and its consequences. It provides advice and skills for staying HIV Negative, treatment and sources of support for those who are HIV Positive. VCT has been shown to decrease risk behaviour and may, therefore, result in the decreased transmission of HIV/AIDS, as well as a reduction in the personal and social impact of HIV/AIDS infection. As more people realise that they are vulnerable to HIV/AIDS they will choose to be tested. They will also gain knowledge to decrease their risk. The level of stigma associated with HIV/AIDS may decrease in the

community. People infected with HIV/AIDS will benefit from a system of ongoing care and support.

The support for the role of counselling at the time before and after testing emerges strongly and is justified by international experiences. Voluntary counselling and testing should be developed for a larger population. It should be wide scale in order to accomplish primary and secondary prevention goals. The development of a national population VCT programme may be a very effective way to decrease HIV/AIDS incidence in South Africa.

The youth sector is the sector that is most at risk. For youth who test negative, counselling and testing will help to ensure that they remain negative. For those who test positive, early detection of HIV/AIDS infection and the provision of an appropriate counselling service will assist in reducing the spread of the disease and will reduce the psycho-social impact associated with living with HIV/AIDS.

3.4.5 How can health services be involved?

Health services have staff that are trained on handling youth and their problems, for example teenage pregnancies and rape survivors. Their services should provide a full range of information, technologies and services to young people in a welcoming, confidential, conveniently located and affordable setting. These services can be located in a shopping centre or community hall or integrated into existing clinics or recreational facilities. The Health Department in conjunction with the Education Department can schedule their times to allow for youth attendance, for example, 2-4pm daily for this group. During this time staff

should present talks on HIV/AIDS, contraceptive use, STIs, and substance abuse. There should also be films or videos that can inform youth on appropriate health matters.

The Health and Education Departments can enter into partnerships with non-governmental organisations like Lovelife, Lifeline and Childline. Each department can strengthen the partnership and monitor their progress by referral from one to another and also getting involved in joint programmes for example abstinence campaigns. Meeting the prevention needs of young people requires the efforts of all sectors of society, not just health. Partnership must also include other governmental and non-governmental organisations, the private sector, and civil society organisations such as Faith-Based Organisations (FBOs) and Community-Based Organisations (CBOs). Presently the Health Department, PPASA, Lovelife, Lifeline Social Work Agencies and the South African Police Services all go into schools and deliver Life Skills programmes. This is done in an unco-ordinated manner with threats of duplication. Each has a different programme, a different style of presentation, with different messages. Therefore, if the DoE is serious about reducing the risks and vulnerability of young people, then it should actively monitor and evaluate existing prevention initiatives in order to establish what works and what does not and why. The DoE should use this partnership opportunity for new and innovative ways to reach young people what they need. A possible recommendation is that teams comprising different disciplines should go into schools presenting a composite programme to add value to the ongoing Life Skills programme run in schools.

3.5 Conclusion

The fight against HIV/AIDS in schools calls for the involvement of all people associated with educational institutions, namely learners, educators, parents and health care professionals. Numerous issues have to be considered in order to develop a successful Life Skills programme, which is essential to prevent disease transmission among learners and educators.

3.6. Summary

This Chapter discussed the main intervention of the DoE in fighting HIV/AIDS in schools, namely, that of a Life Skills programme. Details of issues that must be addressed in order for a successful Life Skills programme to be developed were also discussed.

3.7. References

Canadian Association of Principals. 1993. AIDS. Preparing your school and community. Montreal: Shannon and McCall.

Crewe, M. 2000. "Education at the Crossroads." Paper presented to the Second Convention of African School Leaders, St. Stithians College, 23rd August 2000.

Greathead, E., Devendish, C., and Funnel, G. 1998. Responsible Teenage sexuality. A manual for teachers, youth leaders and health professionals. Pretoria: J.L van Schaik Publishers.

James, D. 2002. "To Take the Information Down to the People: Life Skills and HIV/AIDS Peer Educators in the Durban Area." African Studies, 61,(1), 169-199.

Moroney, E. 2002. Teaching HIV/AIDS Education using the Life Skills Approach in two Durban area High Schools. Unpublished M.Ed. dissertation, University of Natal:Durban

CHAPTER FOUR

4.1 Introduction

The United Nations Educational, Scientific and Cultural Organisation (UNESCO) sees education resting on four pillars: learning to know, learning to do, learning to live together and learning to be (UNESCO, 1996). Until recently, education's response to HIV/AIDS has focused almost entirely on developing the learner in only the first three of these areas: better knowledge about the disease, skills that enhance the ability to protect oneself against infection and acknowledgement of the rights and dignity of those infected or affected by the disease. It has underplayed the need to develop the DoE's capacity in all four areas. Thus, the DoE has not given sufficient attention to the following:

- Enhancing the DoE's knowledge and understanding of the impact of the disease on itself and its institution.
- Doing something to ensure that concern for HIV/AIDS remains central in the DoE agenda and in particular, taking steps to ensure that where rates of infection are high, schools continue to function and deliver education of acceptable quality.
- Developing comprehensive policies that demonstrate care and concern for educators and learners who are infected or affected by HIV/AIDS. This should embody a compassionate, humane and effective regulatory framework for dealing with the disease and its impact.
- The DoE is living with HIV/AIDS and, hence, in need of radical re-consideration of its policies, procedures and programmes.

4.1.1 Towards a More Comprehensive Education Sector Policy Response to HIV/AIDS.

In recent years there has been increased awareness of the threat that HIV/AIDS poses to all systems of education. Widespread concern has led to the holding of several conferences, seminars and workshops in Africa and elsewhere on the education sector's response to HIV/AIDS (Badcock-Walters, 2001). As a result the following has occurred:

- Increasing recognition by education ministries that HIV/AIDS is a systemic problem that leaves no part of the education sector unaffected.
- Growth in awareness that the response must extend beyond the curriculum and penetrate the policies, plans and procedures that govern every part of the system.
- The identification of strategic lines of action to guide a broad-based response by the education sector to HIV/AIDS.
- That HIV/AIDS has worsened the often poor teaching environment at some schools. It also increases the scale of existing problems of supply, quality and output.

This growing concern for the effective functioning of education systems, especially in countries where the HIV/AIDS rates are high, has resulted in a number of concrete developments. Some education ministries have established HIV/AIDS units to co-ordinate, plan and manage the national educational response to the epidemic. A number of countries are working on the development of strategic plans for a comprehensive education sector response to HIV/AIDS. Almost every country, is giving attention to building its own capacity to respond to the call for information and to promote understanding of practical and feasible actions. Some countries, particularly in Southern Africa, have conducted

impact assessments of the disease on its human resources. Stimulated by the Association of African Universities, the Association of Commonwealth Universities and the South African University Vice-Chancellors' Association, the university sector has begun to build HIV/AIDS into its policy framework. Some universities include HIV/AIDS in their programmes and have established HIV/AIDS units or networks.

It would appear, therefore, that education policy makers are finally coming to recognise the need for comprehensive, policy-based action if they are to prevent HIV/AIDS from destroying education systems entirely by weakening demand and access, reducing their potential to supply educational services, eroding quality, increasing costs and destroying the human resource base needed for the very functioning of the system. What is needed now is for education to take further steps in this direction, buttressing itself with a conducive, workable policy, planning and management framework that will strengthen its ability to deal with HIV/AIDS as a systemic issue and creatively manage its impact.

4.1.2 Opportunity in Crisis: Towards a Radical Re-evaluation of Educational Policy

The HIV/AIDS epidemic has challenged the education sector to take one further step: to seize the opportunity presented by the HIV/AIDS crisis to work towards more relevant educational provision. There is universal agreement on the need for more education, better education and more relevant education. But the crisis with which HIV/AIDS confronts the sector is also a challenge to consider radically new approaches in the provision of educational services. What is needed is a complete re-examination of education and its role in fostering a deep and harmonious form of human development. With HIV/AIDS, it cannot be business as usual. Education in a world with HIV/AIDS cannot be the same as

education in an HIV/AIDS-free world. There is still need for educational policy makers to come to terms with this.

4.2 Limitations of the Study

HIV/AIDS programmes analysed were, unfortunately, from readings of First World countries, especially the Canadian programme. Obtaining programmes of developing countries proved very difficult. Various issues, for example finance, do not make implementing these programmes in our schools, in their entirety, possible. However, we could extract what can be presentably and practically applied in our schools and use all resources to implement these.

4.3 Recommendations

4.3.1 Introduction

The researcher recommends that the following norms and standards for Life Skills and HIV/AIDS education at school level be given special attention when policies on HIV/AIDS awareness and prevention are developed. Based on international and national research on policies, experience and guidelines, the following framework is recommended by the researcher for the implementation of a successful Life Skills and HIV/AIDS education programme in schools.

Since the principal is in charge of all school activity, he/she normally takes the initiative for implementation, often by designating a Life Orientation educator or a vice-principal to arrange a Life Skills education programme. The principal should ensure that a Life Skills,

sexuality and HIV/AIDS education programme in the school includes the following features, whenever practically possible:

- Policy development.
- Selection and training for staff.
- Content.
- Methodology.
- The principal's role in the management and implementation of HIV/AIDS programme.
- Social marketing.
- Mandatory HIV/AIDS education for graduation.
- Voluntary counselling and testing.

4.3.2 Policy Development.

The principal and his/her School Management Team (SMT) should initiate and develop teams to review existing policies to ensure that they conform to existing law and up to date research on HIV/AIDS awareness and prevention. Policies should emphasise the development and implementation of age appropriate, culturally relevant educational programmes. These programmes should provide practical guidelines for principals, educators and learners on how to avoid contracting the disease.

4.3.3 Selection and training of staff.

The success of Life Skills and HIV/AIDS education programmes depends upon the commitment of instructors. It is, therefore, critical that educators selected to teach the programme are chosen wisely. The selection of staff to teach the Life Orientation learning area is done haphazardly in the schools which the researcher visited. In most cases the learning area was given to any educator "just to make up his/her teaching load." Moroney

(2002: 51) and James (2002, as cited in African Studies 16, 1:179), discovered similar responses in schools they researched.

A comprehensive training of all educators teaching the Life Skills, HIV/AIDS educational programme must be mandatory. James (2002, as cited in African Studies 16, 1:181) and Moroney (2002:59) and various other researchers have found that many educators offering Life Skills are not trained at all or are poorly trained and, therefore, offer a haphazard programme to learners. Moroney (2002:62) was doubtful whether further research on the Life Skills, HIV/AIDS education programme will yield results that suggest an effective delivery of the Life Skills programme. Moroney (2000: 62) suggests that money should instead be used to train or re-train educators offering this programme.

It is recommended that Life Skills and HIV/AIDS instructors have the following qualities:

- Belief that Life Skills and HIV/AIDS education is an important and much needed curriculum offering.
- Willingness to and enthusiasm in educating this subject.
- Comfortable with own sexuality.
- Informed about the subject matter and new developments in the subject.
- Clear on own personal code of ethics/values.
- Open-minded and non-judgemental with respect to values, attitudes, beliefs and behaviour which may differ from his/her own.
- Respectful of differing cultural and religious values and beliefs.
- Committed to the rights of parents as the primary sex educators of their children.
- Ability to relate effectively, that is with honesty, warmth, and sensitivity to learners.

- Willingness to learn; excited rather than threatened by the prospect of new information and teaching methodologies.
- Respected by learners, parents, administrators and fellow educators.

4.3.4 Content

HIV/AIDS programmes for learners should be incorporated into the curriculum and not offered occasionally. It is important to present the HIV/AIDS education to every grade level so that learner's knowledge and attitudes about the disease will translate into safer sexual practices and avoidance of high-risk behaviour.

Although the South African policy states that an HIV/AIDS, Life Skills programme should be cross-curriculum, in practice this is not often done. Research done by Moroney (2002:62) at two schools shows that this programme is limited only to the Life Orientation learning area.

Some suggestions on how Life Skills and HIV/AIDS programmes can be integrated into the curriculum in secondary schools are:

- **Mathematics**. In mathematics classes, learners should study and solve problems using HIV/AIDS-related statistics: For example they can translate statistics into simple graphs.

- **English.** One activity could involve a study of the correct use of HIV/AIDS-related buzzwords. In addition, speakers, including a child with HIV/AIDS, should talk to students and students may respond by writing poems to describe their feelings. Responses to speakers could include questions such as, "How did it feel to have someone living with HIV/AIDS here in class?" "Was there a question that you would

have liked to ask but either didn't or couldn't?" "Do you have different feelings or understandings about people who are living with HIV/AIDS than you had before you met and heard the speakers?" The above questions could be used in the English oral lesson in the form of speeches or debates or could be used in essay writing.

- **Social studies/geography**. Students could study HIV/AIDS distribution maps and talk about the needs of people with HIV/AIDS in rural against urban settings.
- **Science**. Students could test different brands of condoms for their ability to protect as well as testing the viscosity benefits of water-based over petroleum-based lubricants.
- **Art**. Students may design panels for the HIV/AIDS Memorial Quilt commemorating people they knew or, if they did not know anyone who had died of HIV/AIDS, they could design a panel for one of several "make-believe" people, based on the personality profiles provided.
- **Sewing**. Students learn to sew panels for the HIV/AIDS Memorial Quilt.
- **Cooking**. Students plan a diet for HIV/AIDS patients based on information about their health needs. In addition, students taste various food supplements.
- **Physical Education**. Students use the "Now That You Know" series to learn about the physical limitations of people with HIV/AIDS. They run up and down the basketball court with ten-kilogram weights strapped to their ankles to simulate how tired a person with HIV/AIDS might feel.

The DoE HIV/AIDS policy places much emphasis on Life Skills education. The following are requirements of the Life Skills programme:

Content must be age appropriate and cover positive self-esteem and self-concepts; information on relationships; sexuality; phases of development and reproduction; HIV/AIDS and sexually transmitted infections; all options for prevention; alcohol and substance abuse; common-sense precautions; care and support; skills; norms; attitudes and values and promote the use of health and social services. Skills aspects should include decision-making, resisting peer pressure, assertiveness, communication, conflict resolution and negotiation. With regard to norms, attitudes and values, learners should be taught about respect for self and others, non-discrimination, loyalty in relationships, self-control, commitment, being loving, caring and supportive, being empathetic and understanding, responsibility and the right to protect oneself.

Options for prevention should include abstinence, being faithful to one uninfected partner in a long standing relationship and practising safer sex by using a condom correctly, taking into account age appropriateness and cultural and religious sensitivities. This is greatly stressed in South African policy.

4.3.5 Programme Goals:

It is critically important that AIDS education programmes focus on behavioural change. This is lacking in KwaZulu-Natal Department of Education and Culture (KZNDEC) as researched by Moroney (2002: 62). Yarber (1987, as cited in Canadian Association of Principals, 1993:18) suggests the following list of goals:

4.3.6 Following HIV/AIDS instruction, the learner should:

- Practice a sexual lifestyle that avoids exposure to the HIV/AIDS virus.
- Be alert to his/her health status watching for HIV/AIDS symptoms if he/she has practised high-risk behaviour.
- Be helpful and supportive to a friend who has HIV/AIDS.
- Be an advocate of AIDS education, research, health care and the rights of those infected with the HIV/AIDS virus.

Behaviour based goals are long-term goals that can be achieved, with continual instruction. For these goals to be achieved, a visible behaviour change is accomplished. In HIV/AIDS programme, a sexually active learner could move away from unsafe sexual practices and use a condom in every sexual experience.

4.3.7 Behaviour-based goals for HIV/AIDS education programmes:

- Firstly, programmes should be designed to eliminate misinformation about HIV/AIDS and to reduce the panic associated with the disease.
- Secondly, programmes should be designed to help young people delay sexual intercourse.
- Thirdly, teenagers who are sexually active should receive information so that they will use condoms each time they have intercourse.
- Fourthly, all HIV/AIDS education programmes should encourage compassion for people with HIV/AIDS and for people who are infected with HIV/AIDS.

4.4 Methodology

Active participation by learners in a range of activities such as role-playing, discussion and brainstorming should be implemented to help learners in order to personalise knowledge and risk factors. This is in line with the Outcomes-Based approach, concepts and principles.

Educators must provide clear statements on the consequences of risk behaviour. Learners must have the opportunity to observe other learners practising the skills and to do so themselves through role-playing. An example of a role-play in class is teaching learners assertiveness skills; learners could watch the actors and then be able to personalise the situation and learn the skill of being able to say "NO!" However, if the educator is not creative, or does not have the time, this will contribute to the limitations of learning of skills. Much of the success of the programme will, therefore, depend on the educators' enthusiasm for the learning area.

4.5 The principal's role in the management and implementation of HIV/AIDS programme

In implementing this vital part of the school's educational role, the principal should ensure that the following steps are taken:

- The principal as a leader and member of the SMT in conjunction with the School Governing Body (SGB) should prepare a school policy on HIV/AIDS using the national policy, which must then be prominently displayed and made known to parents, educators and learners.

  To assist principals and SGBs in the development of their own policies, the researcher recommends that the Department of Education should create and

circulate a basic policy guide to all educational institutions. Institutions could then adapt this basic policy to meet their own individual requirements. None of the almost hundred schools visited by the researcher had any HIV/AIDS policy on display.

- He/She should take the lead in forming a co-ordinating committee comprising trained educators, learners and parents to support the programme. Health promoting teams should be set up in schools, consisting of parents, learners (as age appropriate), educators, an attorney who is prepared to volunteer his/her time and is familiar with education law, people who are living with HIV/AIDS (as their own experiences can be most helpful), representatives from social services, health services, other NGOs, CBOs, including religious, racial and ethnic group leaders The researcher spoke to many officials from the departments and organisations mentioned above, and they have indicated that this is part of the partnership against HIV/AIDS and they are willing to be part of the school health promoting team.
- A minimum of ten hours a term should be set aside to offer the programme during school hours. Allensworth *et al.,* (1989, as cited in the Canadian Association of Principals, 1993:21), suggest that HIV/AIDS programmes must apply principles related to learning and behaviour change. Research has demonstrated that 40 to 50 hours per year of health instruction are required to change behaviour. Currently most South African HIV/AIDS programmes range from 4 to10 hours per year. If the HIV/AIDS programmes are not implemented in a Life Skills health programme of 40 to 50 hours per year, do we have any hope of changing sexual behaviour? Support provided by the home, community and media programmes like Scamto Ground Breakers, an informative youth education programme on

South African Broadcasting Corporation (SABC) Channel One, reinforces the educational message in the classroom. One must, however, guard against the contradictory messages found in talk shows, sitcoms and soap operas.

- He/she should motivate for additional activities to support curriculum-based programmes. This may be special events, "awareness campaigns", peer group education which involves the HIV/AIDS training of peer leaders who then conduct peer HIV/AIDS education and the involvement of governmental organisations, for example, the Department of Health and non-governmental organisations, for example, Lovelife.
- At the Principals' Forum, discussions should include how they should support one another in the Life Skills programme, so that there is a continuity of education from pre-school through to secondary school. The programme should start preferably at pre school level, be integrated into all learning areas by working with fellow educators and should be linked to other health issues such as pregnancy, sexual and substance abuse, violence and gender equality. There should also be adequate and suitable learning materials/teaching aids available at schools.
- Educators attending HIV/AIDS training courses must report fully to their principals, untrained colleagues and other stakeholders; including parents, members of the school's governing body and other community leaders, as soon as possible (within two weeks) after completing their training.

  This, unfortunately, is not being implemented because educators are often not given the opportunity to do so by their principals.
- A supportive environment that is free of stigma and discrimination beyond the classroom should be created, involving parents, community leaders, faith-based

organisations and health facilities. There should be a school-based care support system for learners and educators infected with and affected by HIV/AIDS.

4.6 Social Marketing

Social marketing is the design, implementation and control of programmes calculated to influence the acceptability of social ideas and involving considerations of product planning, pricing, communications distributions and marketing research. Social marketing starts with an analysis of the potential targets of the message, rather than in concentrating on the message itself. According to Health Promotion (1989, as cited in Canadian Association of Principals, 1993:22) such marketing emphasises that different "markets" or groups of learners are reached by different "messages". To date most HIV/AIDS programmes have attempted to reach all students with the same message. Social marketing suggests diverse messages should be delivered through different routes.

4.7 Mandatory HIV/AIDS education for graduation

The American Academy of Paediatrics in 1998, made a call to their Department of Education to make HIV/AIDS education for graduation, mandatory. This approach will ensure that every matriculant, diplomate or graduate has the necessary knowledge, skills and attitude to stop HIV/AIDS from spreading. Mary Crewe stated in 1997 that HIV /AIDS should become an examinable subject, if the South African government is serious about fighting the epidemic (Crewe, 2000). This approach will also help to destroy the stigma and discrimination that prevails in South African community. Williams (2002:44), in her research asked lecturers at the University of Natal whether HIV/AIDS was an examinable component of the curriculum. They responded by stating that it is not

examined specifically, but is required by assignment and research projects and marks are allocated.

4.8 Voluntary Counselling and Testing (VCT)

The National Blood Transfusion Services report having recruited 72% of blood donors through their mobile clinics, which means that only 28% of blood donors use formal clinics. The DoE should use this principle of allowing mobile clinics into educational institutions so that VCT becomes more accessible to learners. The researcher was a regular blood donor (four times a year) from 1992-2002 when mobile clinics visited his workplace. However, in the past two years the researcher has not donated a single pint of blood although he passes a donor clinic, weekly. This emphasises the importance of what mobile VCT clinics could achieve.

4.9 Summary

An HIV/AIDS Life Skills programme, no matter how good on paper, loses its effectiveness and relevance if it is implemented haphazardly. Various factors have been discussed in this study. The researcher must agree with other researchers that the implementation of the present programme in our schools is a dismal failure. The implementation needs a complete revamp and the recommendations, should be seriously considered.

There has been a substantial amount of research undertaken in the field of HIV/AIDS in sub-Saharan Africa in recent years. The above recommendations are in keeping with the foreword to the July 2002 (pii) edition of "Perspectives in Education", which states that

the there are four principal areas for educators: Firstly, to help to prevent the spread of HIV, secondly, to provide social support and to work with others in order to provide care; thirdly, to protect the education sectors capacity, to provide adequate levels of education and respond to a new learning need. Lastly, to manage the education sectors response to the crisis. Educators must of necessity move from a narrow HIV/AIDS education to a broader HIV/AIDS education Curriculum Campaign. A broad multi-disciplinary approach by educators to the epidemic is essential (Coombe, 2000: viii).

Ultimately, the education policy must filter down to a change in behaviour of the recipient. If it does not, the end result then, no matter how good the HIV/AIDS education policy and programmes look on paper, they cannot be deemed successful. Policy makers need never to lose sight of this issue.

4.5 References

Badcock-Walters, P. 2001. HIV/AIDS impact on education in Africa. An analysis of conferences, workshops, seminars, meetings and summits focusing on HIV/AIDS impact on education in Africa, December 1999 to June 2001. Paper presented at an ADEA Biennial Meeting, Arusha, Tanzania, 7–11 October 2001.

Canadian Association of Principals. 1993. AIDS. Preparing your school and community. Montreal: Shannon and McCall.

Coombe, C. 2002. Foreword- HIV/AIDS and Education. Perspectives in Education. 20. (2). 2-4.

Crewe, M. 2000. "Education at the Crossroads." Paper presented to the Second Convention of African School Leaders, St. Stithians College, 23rd August 2000.

James, D. 2002. "To Take the Information Down to the People: Life Skills and HIV/AIDS Peer Educators in the Durban Area." African Studies. 61. (1). 169-199.

Moroney, E. 2002. Teaching HIV/AIDS Education using the Life Skills Approach in two Durban area High Schools. Unpublished M.Ed. dissertation, University of Natal:Durban.

Rugulema, G. and Khanye,V. 2002. "Mainstreaming HIV/AIDS in the Education Systems in Sub-Saharan Africa: Some Preliminary Insights." Perspectives in Education. 20. (2). 20-29

UNESCO. 1996. "Learning: The Treasure Within." Report to UNESCO of the International Commission on Education for the Twenty-First Century (The Delors Report). Paris: UNESCO.

BIBLIOGRAPHY

Akouluze, R., Rugalema, G. and Khanye, V. 2001. Taking stock of promising approaches in HIV/AIDS and education in Sub-Saharan Africa: What works, why and how. A synthesis of country case studies. Paper presented at an ADEA Biennial Meeting, Arusha, Tanzania. 7–11 October 2001.

Badcock-Walters, P. 2001. HIV/AIDS impact on education in Africa. An analysis of conferences, workshops, seminars, meetings and summits focusing on HIV/AIDS impact on education in Africa. December, 1999 to June 2001. Paper presented at an ADEA Biennial Meeting, Arusha, Tanzania. 7–11 October 2001.

Barnett, T. and Whiteside, A. 2002. AIDS in the Twenty First Century: Disease and Globalisation. New York: Palgrave.

Berman, J.K. 2003. South Africa Survey 2002/2003. Johannesburg: South African Institute of Race Relations.

Blanc, A.K. and Way, A.A. 1998. "Sexual behaviour and contraceptive knowledge and use among adolescents in developing countries." Studies in Family Planning. 29. (2). 106-116.

Canadian Association of Principals. 1993. AIDS. Preparing your school and community. Montreal: Shannon and McCall.

Coombe, C. 2002. Foreword- "HIV/AIDS and Education." Perspectives in Education. 20. (2). 2-4.

Crewe, M. 2000. "Education at the Crossroads." Paper presented to the Second Convention of African School Leaders, St. Stithians College, 23rd August 2000.

Diciement, R. 1992. Adolescents and AIDS. A generation in jeopardy. London: Sage Publishers.

Du Toit, J.D. 1996. "AIDS prevention in KwaZulu Natal." AIDS Analysis Africa. Howard Place: Whiteside and van Niftrik Publications.

Ellen, J.M., Boyer, C.B., Tschann, J.M. and Shafers, M.A. 1996. "Adolescents perceived risk for STDs and HIV infection." Journal of Adolescents Health. 18. 177-181.

Franklin, C. and Corcoran, J. 2000. "Preventing Adolescent Pregnancy. A Review of Programs and Practices." Social Work. 1. (45).

Gage, A.J. 1998. "Sexual activity and contraceptive use. The components of the decision making process". Studies in Family Planning. 29. (2). 154-168.

Glynn, J.R., Careal, M., Auvert, M., Kahindo, M. and Chege, J. 2001. "Why do young women have a much higher prevalence of HIV than young men?" A study in Kisumu, Kenya and Ndola, Zambia. AIDS 15. (4). 51- 60.

Greathead, E., Devendish, C. and Funnel, G. 1998. Responsible Teenage sexuality. A manual for teachers, youth leaders and health professionals. Pretoria: J.L van Schaik Publishers.

Gregson, S. 2001. "School Based and HIV control in sub Saharan Africa. From discord to harmony?" Journal of International Development. 13. 467-485.

Guest, Emma. 2001. Children of AIDS: Africa's Orphan Crisis. Pietermaritzburg: University of Natal Press.

Hambridge, M. 1995. Report of a case study on the impact of Drama Aide on STD level among high school scholars. Is Drama Aide making a difference? Evaluation of the Drama Aide Programme. University of Natal: Centre for Cultural and Media Studies, Durban.

Hargreaves, J.R. and Glynn, J.R. 2002. "Educational attainment and HIV-1 infection in developing countries: A systematic review." Tropical Medicine and International Health. 7. (6). 489-498.

Jackson, H. 2002. AIDS Africa-Continent in Crisis. Harare: SAfAIDS.

James, D. 2002. "To Take the Information Down to the People: Life Skills and HIV/AIDS Peer Educators in the Durban Area." African Studies. 61. (1). 169-199.

Kelly, M. 2000. "Planning for Education in the Context of HIV/AIDS. Fundamentals of Educational Planning." 6. Paris: International Institute for Education Planning. http://www.dpmf.org/bulletin-jan-03/hiv-policy-kelly.html

Kelly, M. 2002. "Preventing HIV transmission through education." Perspectives in Education. 20. (2). 7-8.

Key, S.W. and Denoon, D.J. 1998. "AIDS Weekly Plus." 1. (2). 10.

Kimani, D. 2002. Study Says Violence is a Major Cause of HIV Infection in East Africa.http://allafrica.com/stories.200209090348.html

Kinsman, J. 2001. "Evaluation of a comprehensive school-based AIDS education programme in rural Masaka, Uganda." Health Education Research. 16. (11). 85-100.

Kuhn, L., Steinberg, M. and Mathews, C. 1990. "Participation of school community in AIDS education . An evaluation of a high school programme in South Africa." AIDS Care. South African Medical Journal.

KwaZulu-Natal Department of Education and Culture. 2000a. Outcomes- Based Education Retraining Workshop Document: General Advocacy. Ulundi : Provincial Printers.

KwaZulu-Natal Department of Education and Culture. 2000b. Outcomes-Based Education Retraining Workshop-Document: Life Orientation. Ulundi : Provincial Printers.

Lefkowitz, E.S., Kahhlbaugh, P.E. and Sigman, M.D. 1995. Turn-Taking in Mother-Adolescent Conversations About Sexuality and Conflict. London: Plenum Publishing Corporation.

Letamo, G. and Bainame, K. 1997. "The socio-economic and cultural context of the spread of HIV/AIDS in Botswana." Health Transition Review, Supplement 3. (7). 97-102.

Levine, C., Michaels, D. and Back, S.D. 1996. "Orphans of the HIV/AIDS pandemic." Jonathan Mann and Daniel Tarantola (eds), AIDS in the World. New York: Oxford University Press. (11). 278-286.

Mace, D.R. 1974. Teaching of human sexuality in schools for health. Geneva: World Health Organisation.

Meredith, P. 1989. Sex Education: Political issues in Britain. Cambridge: Polity.

Moletsane, R., Morrell, R., Unterhalter, E. and Epstein, D. 2002. "Instituting Gender Equality in School: Working in an HIV/AIDS Environment." Perspectives in Education. 20. (2). 37-53.

Moroney, E. 2002. Teaching HIV/AIDS Education using the Life Skills Approach in two Durban area High Schools. Unpublished M.Ed. dissertation. University of Natal: Durban.

Population Council /International Centre for Research on Women. 2000. "Adolescent Girls' Livelihoods-Essential Questions. Essential Tools: A Report on a Workshop." New York and Washington, DC: Population Council and ICRW.

Population Council. 2002. HIV/AIDS Prevention Guidance for Reproductive Health Professionals in Developing-Country Settings. New York: UNFPA.

Republic of South Africa. Department of Health. Lovelife and HIV/AIDS Education Programmes. 1999. Teachers' Resource Guide. Government Printers: Pretoria.

Rogers, R.S. 1974. Sex Education Rationale and Reaction. London: Cambridge University Press.

Rugulema, G. and Khanye, V. 2002. "Mainstreaming HIV/AIDS in the Education Systems in Sub-Saharan Africa: Some Preliminary Insights." Perspectives in Education. 20. (2). 20-29.

Schaeffer, S. 1994. "The impact of HIV/AIDS on education: A review of the literature and experience." Background paper presented at the International Institute for Educational Planning. IIEP Seminar. Paris, 8-10 December 1993. Paris: IIEP.

Schofield, M. 1996. The Sexual Behaviour of Young People. Harmondsworth: Penguin Press.

Shore, D. and Gochros, H.L. 1981. Sexual problems of adolescents in institutions. Illinois: Charles C Thomas.

Smart, R. 2003. Children affected by HIV/AIDS in South Africa . Arcadia: Save the Children (UK).

UNAIDS. 1997. "Impact of HIV and Sexual Health Education on the Sexual Behaviour of Young People." A Review Update. Document UNAIDS/97.4. Geneva: UNAIDS.

UNAIDS. 2000. Report on the Global HIV/AIDS Epidemic. June 2000. Geneva: UNAIDS.

UNESCO. 1996. "Learning: The Treasure Within." Report to UNESCO of the International Commission on Education for the Twenty-First Century. The Delors Report. Paris: UNESCO.

UNESCO. 2000. World Education Forum. Final Report. Paris: UNESCO.

UNICEF/UNAIDS/WHO. 2002. "Young people and HIV/AIDS: Opportunity in Crisis." New York and Geneva: UNICEF/UNAIDS/WHO.

United Nations. 2001. "Global Crisis-Global Action." 26th Special session of the General Assembly to review and address the problem of HIV/AIDS. Geneva: UNAIDS.

Varga, C.A. 1997. "Sexual decision- making and negotiation in the midst of AIDS: Youth in KwaZulu-Natal, South Africa." Health Transition Review. Supplement 3. (7). 44-67.

Wasserheit, J.N. 1992. "Epidemiological synergy: Interrelationships between human immunodeficiency virus infection and other sexually transmitted diseases." Sexually Transmitted Diseases. 19. (2). 61-77.

Webb, D. 1997. HIV and AIDS in Africa. London: Pluto Press.

Weiss, E., Whelan, D. and Gupta G. R. 1996. Vulnerability and Opportunity: Adolescents and HIV/AIDS in the Developing World. Washington DC: ICRW.

WHO. 1999. "Preventing HIV/AIDS/STI and Related Discrimination: An Important responsibility of Health Promoting Schools." WHO Information Series on School Health. Document 6. Geneva: WHO.

WHO/UNESCO. 1995. "School Health Education to Prevent AIDS and Sexually Transmitted Diseases: A Resource Package for Curriculum Planners." Document. WHO/UNESCO/GPA/94/ 1.2.3. Geneva: WHO.

Wildeman, R. 2001. Funding the Fight Against HIV/AIDS: Funding the Life Skills and HIV/AIDS Programme. Cape Town: Idasa.

Williams, A.M. 2002. An investigative study into ways of incorporating HIV/AIDS education into academic curricula at the University of Natal. Unpublished M.Ed. Dissertation. University of Natal: Durban.

THE POLICIES

Republic of South Africa. Department of Education. 1999. National Policy on HIV/AIDS for learners and educators in public schools and students in further education and training institutions. Pretoria: Government Printers.

Republic of South Africa. Department of Education. 2000. HIV/AIDS-Implementation plan. Pretoria: Government Printers.

Republic of South Africa. Department of Education. 2000. The HIV/AIDS Emergency-Guidelines for Educators by R.Jeweks. Pretoria: Government Printers.

Republic of South Africa. Department of Health. 1999. National and Integrated Plan for children infected and affected by AIDS. Pretoria: Government Printers.

Republic of South Africa. Department of Health. 2000. National HIV/AIDS and STD Directorate. HIV/AIDS /STD Strategic Plan for South Africa. 2000-2005. Pretoria: Government Printers.