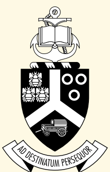
# Bodies count

## AIDS Review 2006

Jonathan D. Jansen

Series Editor: Mary Crewe



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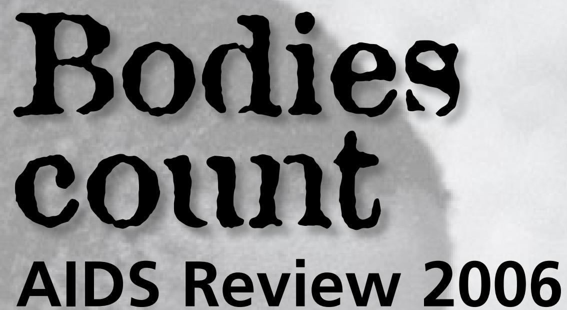


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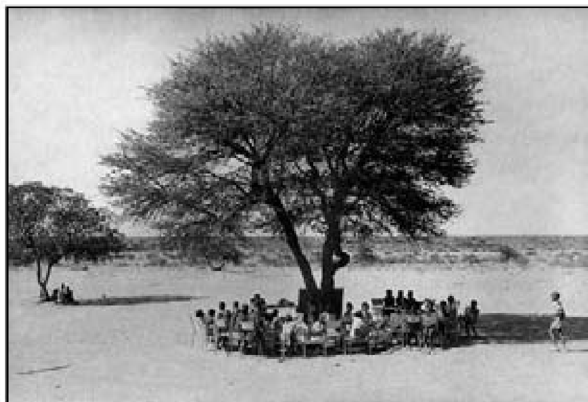

# Foreword

This is the seventh *AIDS Review* published by the Centre for the Study of AIDS, based at the University of Pretoria. These *Reviews* are regarded as some of the most critical and interesting writing about HIV and AIDS in South Africa. They are widely prescribed as core reading in university courses in the United States of America, the United Kingdom, Australia, India and Brazil. All of the *Reviews* have had more than two print runs and what they provide is a challenge and critique to the conventional wisdoms that have developed around HIV and AIDS and the ways in which issues raised by the epidemic should be addressed. There is a troubling orthodoxy in many of the HIV and AIDS responses and the main function of the *Reviews* is to address this orthodoxy that tends to stifle debate and dissent.

Past *Reviews* have taken issues of human rights, sexuality and masculinities, food security, care and support, the political response and families and placed them under scrutiny. ***Bodies Count AIDS Review 2006*** discusses the role of education and the response of the educational system to HIV and AIDS.

It has long been believed that schools were one of the most effective places to address HIV and AIDS. Indeed AIDS education in schools has often been referred to as a 'social vaccine' equipping young people with a lifetime protection against infection and giving them the means to develop and sustain sexual behaviour that will not carry the risk of infection. There has been an emphasis on the role of teachers to ensure that HIV and AIDS education is taught in schools and that teachers can also act in some way as social mediators of the impact of HIV and AIDS on young people.

Whether in fact schools are a good place for HIV and AIDS education to take place has rarely been debated. Whether teachers can, or indeed should be expected to do HIV and AIDS education as part of their work as teachers has not been discussed to any significant extent – least of all by teacher unions and professional bodies. It is all too often, and erroneously believed that, if teachers do not, or are unwilling to do HIV and AIDS education then this is because they have personal issues with their own sexuality and sexual behaviour, rather than asking whether HIV and AIDS education should be part and parcel of the work of teachers. As *AIDS Review 2006* states, what people want

> *is for schools to respond to every conceivable social problem. Schools solve the skills problem. Schools*

*resolve the unemployment problem. Schools deal with the problems of violence. Schools serve the religious and spiritual needs of communities. Schools… should be community facilities… Schools teach values. Schools instill discipline. Schools address moral problems. Schools redress health and nutrition problems. Schools prepare students for university. Schools prepare students for the world of work. Schools provide a bridge for students into 'the real world'. Schools tackle problems of drug abuse and teenage pregnancy. Schools teach teamwork. Schools celebrate and preserve culture. Schools challenge the ills of racism and sexism. Schools teach positive social relations. Schools nurture future leaders.*

There is a belief in education's powers to change society (schools must address HIV and AIDS), teach young people about safe sex, teach them about ABC, address morality and stigma, end HIV- and AIDS-related discrimination and take responsibility for families in crisis and the needs of young children affected, traumatised and orphaned by HIV and AIDS.

This *Review* investigates whether schools can do what is expected from them in relation to HIV and AIDS. How do schools breathe life into the National Policy on HIV and AIDS in Schools, who is expected to do the work, who will monitor that the work is done? What are the roles of the National Departments of Health and Social Development in acting on the information that schools will have gathered of the impact of HIV and AIDS on the families of the learners and on the learners themselves? Who is monitoring in a serious way the numbers of teachers living with HIV and AIDS, who is supporting and sustaining these teachers and where is the critical debate about the ways in which teachers themselves behave?

How should teachers respond to the epidemic? Is an education response really just lodged in teaching the ABCs or safer sex, or attempts to get schools, governing bodies and parents to take the epidemic seriously? Isn't dealing with HIV and AIDS in the education system also about rethinking how teachers are trained? How do teachers teach young people who are anxious and fearful of the future and traumatised by the present? Do teachers understand enough about how the whole process of teaching and learning will be affected by this epidemic? How do teachers teach in a country with falling life expectancy, high unemployment and high rates of infection and death? Surely the whole activity labeled as 'education' has to be reconceptualised? How should schooling and the school day be structured? What needs to be taught? How do young people support themselves financially if young people are regarded as 'adult' enough to head up child-headed households and they then are also 'adult' enough

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to start being employed? How do we train teachers to teach in classrooms that carry the marks of a society living through such an epidemic, how do we change our perceptions of teaching and learning, how do we ensure enough teachers and enough support for teachers and pupils, how do we understand the role of education in an active rather than in a passive way in a country with such an epidemic? Schools cannot be buttressed against the epidemic and expect to carry on as usual – schools and the whole understanding of 'education' have to change.

The central question to this *Review* is why schools, education departments and parents find it difficult to respond in deep and sustained ways to what everyone (well, almost everyone) agrees is the single most important challenge to democracy and development in post-apartheid South Africa.

***Bodies count*** in very real ways – it's not just about how many bodies are in a school, or how many bodies are reached through HIV and AIDS educational interventions or how many bodies are tested and put onto treatments. Such often mindless body counts oversimplify the epidemic and reduces responses to numbers and uniformity. The bodies count as a whole, but each individual body also counts as a site of complex, conflicting and puzzling emotions and responses to education. Its about how we make these bodies of young people and their teachers and parents count enough so that there is a serious, compassionate, educationally informed and sophisticated response to HIV and AIDS – so that these various bodies are valued above all else.

The views expressed in this *Review* are soley those of the author and the Centre for the Study of AIDS.

*Mary Crewe*
*Director, Centre for the Study of AIDS*

## *AIDS Reviews*:

2000 – *To the edge* by Hein Marais
2001 – *Who cares?* by Tim Trengove Jones
2002 – *Whose right?* by Chantal Kissoon, Mary Caesar and Tashia Jithoo
2003 – *(Over) extended* by Vanessa Barolsky
2004 – *(Un) Real* by Kgamadi Kometsi
2005 – *What's cooking?* by Jimmy Pieterse and Barry van Wyk
*Buckling* by Hein Marais (an extraordinary *Review)*
*2006* – *Bodies Count* by Jonathan D. Jansen

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# What the Review does

This *Review* offers a critical examination of the place called school. It takes a statistical overview of HIV/AIDS within schools and school citizens (teachers, principals, students and governors), and goes on to provide a window on how real people affected by and infected with the virus experience life inside schools. It brings together a discussion on HIV/AIDS in South Africa with a critical examination of context, curriculum and classrooms as these spaces are negotiated every day by real students, teachers and principals.

The *Review* acknowledges the fact that HIV/AIDS statistics are constantly contested in the political domain, and so it has tried to focus largely on more recent data derived from evidence-based studies. At the same time, this report works with the notion that data do not speak for themselves – they come to life through new questions, novel concepts, invasive methods and challenging assumptions. The predominance of epidemiological body counts might lend a numerical reasonableness to the pandemic, and suggest an ordered world. It might also provide the necessary shock value in a society that is officially still in denial. But it cannot tell us what lies behind the statistics. As this *Review* will show, the numbers cannot account for the noise and the silences, the anxieties and the hopefulness, the guilt and the empathy, the shame and the courage, the policies and the practices – and the bodies that carry all these emotions into a place called school.

***How is education possible when there's a body in the middle of the room?***

The *Review* transposes the metaphor of the body, powerfully described by Freema Lebaz-Luwisch in the context of teaching peace in the Middle East, to re-examine how schools are constructed in the pandemic. The body, in this case, is a way of drawing attention to the physical, emotional, psychic, political, religious, moral and policy presence of real humans living with HIV/AIDS. It is a non-reductionist metaphor that shifts the gaze away from school-level actors as simply cognitive beings whose minds must be changed by psychologists, or statistical indices to be counted by epidemiologists, or sin-stained souls to be saved by evangelists.

In the end, the *Review* asks new questions of familiar data: questions about the new kinds of policy, politics and research that need to be pursued if education is to have a significant role in countering UNICEF's position on the pandemic that 'the worse is yet to come'.

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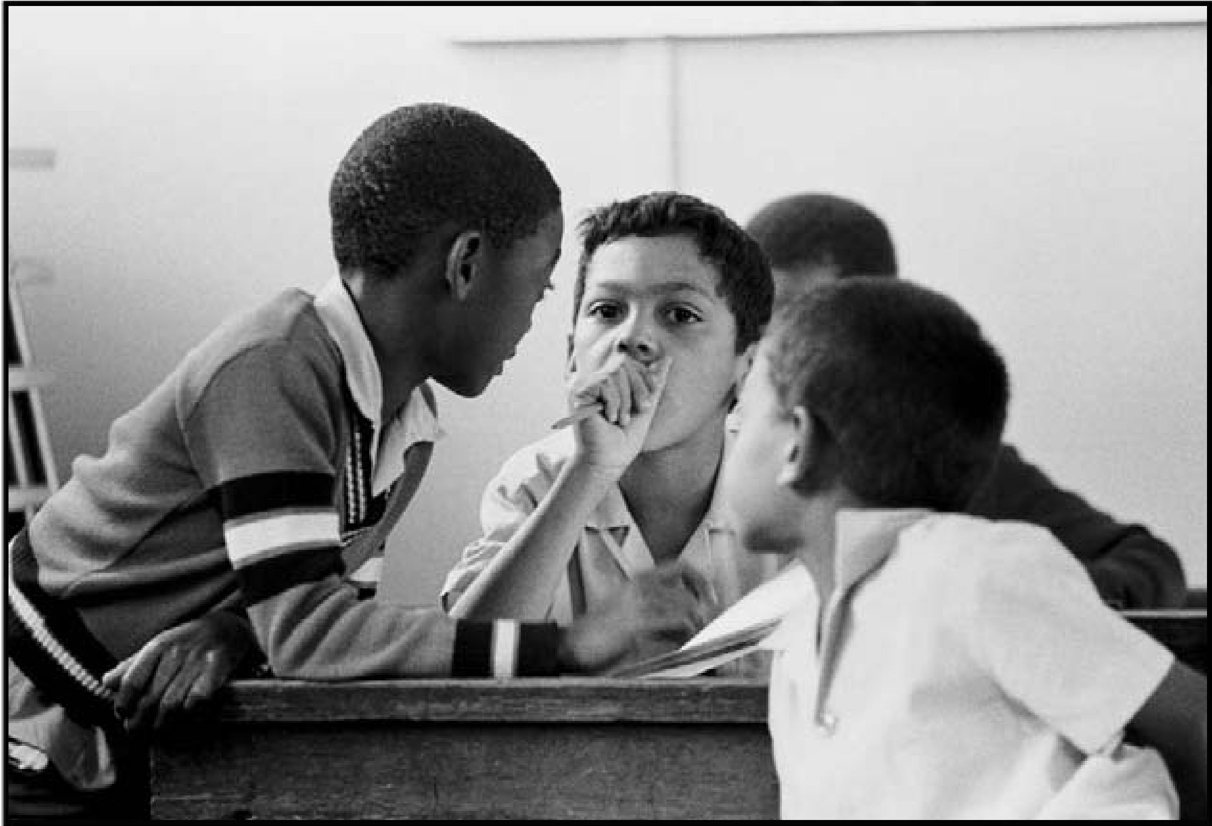

# What the problem is

Schools are demanding places. These traditional places of teaching and learning are at once a site on which the powerful project dominant and preferred images of school and society, and simultaneously a battleground for all kinds of constituent struggles about the past, the present and the future. Those in political power seldom have their way in schools, even as one policy document after another is designed to change schools. Those outside of governmental power nevertheless see the school as a place in which to pursue struggles for recognition.

This explains why educational practice is never a mirror image of policy ideals.

***What those in power want is for schools to respond to every conceivable social problem.***

What those in power want is for schools to respond to every conceivable social problem. Schools solve the skills problem. Schools resolve the unemployment problem. Schools deal with the problems of violence. Schools serve the religious and spiritual needs of communities. Schools are places which should be community facilities – after all, they stand vacant for many hours per day. Schools teach values. Schools instill discipline. Schools address moral problems. Schools employ adults. Schools redress health and nutrition problems. Schools prepare students for university. Schools prepare students for the world of work. Schools provide a bridge for students into 'the real world'. Schools tackle problems of drug abuse and teenage pregnancy. Schools teach teamwork. Schools celebrate and preserve culture. Schools challenge the ills of racism and sexism. Schools teach positive social relations. Schools nurture future leaders.

What those outside government want is for schools to address their issues and concerns. The human rights lobby wants to see human rights inserted into the curriculum so that we never repeat the mistakes of the past. The peace education lobby wants peace education inserted into the curriculum so that students find alternative ways of resolving personal, national and international conflicts in a violent and dangerous world. The anti-racist lobby wants schools to tackle discriminatory practices head on so that students move beyond the tolerance of differences to confronting racial prejudice directly and embracing nonracial community affirmatively. The business lobby

wants schools to insert business education into the curriculum so that students learn basic values such as entrepreneurship, teamwork, enterprise and competition. The parent lobby wants schools to affirm domestic values while providing quality education that ensures that their children get ahead.

And then there is AIDS. No subject has gripped the public imagination more than the constant reports warning of a pandemic that will decimate the workforce, kill babies, exert stress on the health-care and social-welfare systems, and alter the conventional meanings of 'the family' throughout African society.

***Not only is the AIDS agenda marginal to almost everything else that schools do, but in fact the AIDS challenge is to be found nowhere inside the core business of a South African school.***

This message of devastation reaches schools with more subtle warnings about loss. In this space called school the message warns about the number of teachers who will die and who will be hard to replace; the number of learners who fail to show up because of the toll of infant mortality; the numbers of affected teachers, learners, parents and governors; the number of older learners who contract the disease; the number of children without parents who now take care of what are called 'child-headed households'; the impact of ill teachers on classroom productivity and learner performance; and the number of student teachers in training who die before they even reach the classroom.

Such a disturbing portrait of AIDS and schools offers compelling reasons, one would think, to make HIV/AIDS central to everything schools do. Yet, as the AIDS agenda competes with a myriad other constituent interests – from human rights to physical education to arts and culture – for representation in the school curriculum, there is a striking observation to be made: that AIDS simply does not appear to be central to teaching, learning, curricula and assessment within schools and classrooms. In fact, not only is the AIDS agenda marginal to almost everything else that schools do, but in fact the AIDS challenge is to be found nowhere inside the core business of a South African school.

This does not mean that there is no official response to the AIDS pandemic as far as schools are concerned. Quite the contrary. There are policy documents, planning directives, monitoring reports, political submissions, curriculum insertions, financial accounts, teacher training workshops,

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advocacy campaigns, peer education sessions, care interventions, prevention efforts and even treatment initiatives. There is certainly a lot of busyness around HIV/AIDS. Yet, for all this ostensible activity, there is a lack of depth, direction and detail with respect to HIV/AIDS in the everyday practices of schools and their constituencies.

The purpose of this *Review* is to explain why this is the case, i.e. why schools find it difficult to respond in deep and sustained ways to what everyone (well, almost everyone) agrees is the single most important challenge to democracy and development in post-apartheid South Africa.

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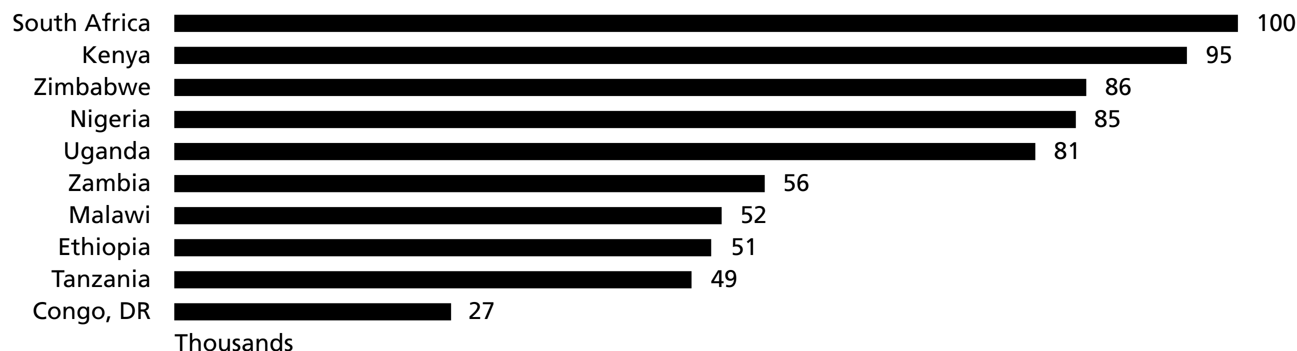
# What the numbers say

Many children in South Africa do not even make it into school, as child mortality approaches 100 per 10 000 births. The hardships of attending school and staying in school impact heavily on those children orphaned by AIDS – about one million such young people. In a province like KwaZulu-Natal, this means somewhere between 6% and 8% of all children in that region. Once in school, children carry the burden of AIDS, with an estimated 350 000 primary-school children infected (Thom 2007). Those who teach these children are not immune from infection either, with close to 25% of the teacher population in certain age groups and subject areas infected. Of this about 61 000 of these teachers (more than 65% of infected teachers) are women. AIDS-related deaths among teachers stood at 1% in 2000 and were expected to reach 5% by 2010; one study found an increase of 70% in teacher deaths between 1999 and 2000. An early study (1999) projected a cumulative attrition rate that requires as many as 60 000 new teachers by 2010. And a subsequent study found that the numbers of children who have lost a teacher because of AIDS is most stark in South Africa, compared to other Southern African Development Community countries. The three graphs that follow show the impact of HIV/AIDS on schools, and are reproduced from Shell and Zeitlin (2000):

## Figure 1: Teacherless children

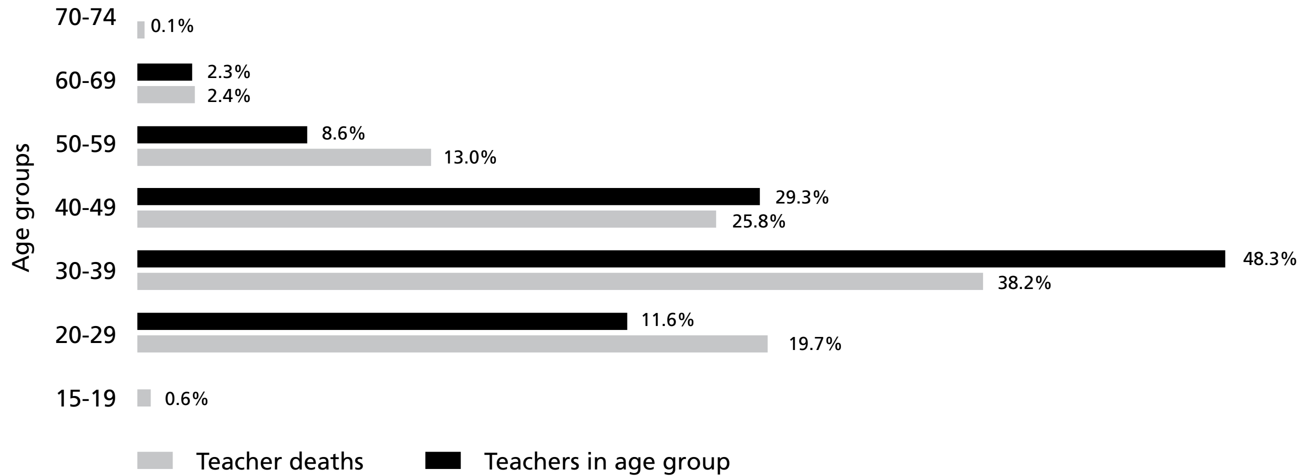
**Primary school children who lost a teacher to AIDS**

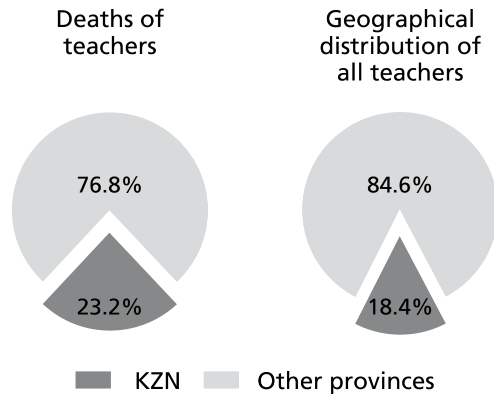



Source: UNICEF, *The Progress of Nations 2000*, p. 8; UNAIDS

## Figure 2: A dearth of teachers

**Deaths occuring in the teaching profession in South Africa, by age group, August 1999 to May 2000**




Source: Hassan Lorgat, Breaking the silence: AIDS kills teachers too, SADTU report in the *Educators' Voice* (June/July 2000) based on Persal statistics (n=701). The Persal system is used to pay all government employees; Stats SA 1996 Census, 10 per cent sample.

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The picture remains bleak for young people in school and for those who have recently left school, with 34% of all new infections occurring among youth in the 15-24 year age-group. Again, young women bear a disproportionately high share of the burden, with 90% of all recent HIV infections accounted for by women in the 15-24 year age-group.

## Table 1: Comparison of HIV prevalence in South African educators with the general population

| Male educators (2004) | | | | Male general population (2002) | | | |
|---|---|---|---|---|---|---|---|
| Age | Prevalence (%) | Lower limit (%) | Upper limit (%) | Age | Prevalence (%) | Lower limit (%) | Upper limit (%) |
| 25-29 | 12.3 | 9.0 | 16.7 | 25-29 | 22.0 | 14.6 | 31.9 |
| 30-34 | 19.0 | 16.5 | 21.9 | 30-34 | 24.1 | 16.8 | 33.3 |
| 35-39 | 16.6 | 14.3 | 19.2 | 35-39 | 18.4 | 11.6 | 27.8 |
| 40-44 | 10.5 | 8.6 | 12.9 | 40-44 | 12.4 | 7.8 | 19.4 |
| 45-49 | 7.6 | 5.4 | 10.5 | 45-49 | 11.9 | 7.1 | 19.4 |
| 50-54 | 5.8 | 3.8 | 8.6 | 50-54 | 5.4 | 2.8 | 10.3 |
| 55+ | 1.6 | 0.5 | 4.9 | 55+ | 7.0 | 2.9 | 15.8 |
| Female educators (2004) | | | | Female general population (2002) | | | |
| 25-29 | 21.5 | 17.7 | 25.9 | 25-29 | 32.0 | 24.8 | 40.1 |
| 30-34 | 24.2 | 22.1 | 26.5 | 30-34 | 24.1 | 17.3 | 32.5 |
| 35-39 | 14.1 | 12.6 | 15.8 | 35-39 | 13.8 | 8.7 | 21.1 |
| 40-44 | 10.1 | 8.7 | 11.6 | 40-44 | 19.0 | 12.9 | 27.2 |
| 45-49 | 6.3 | 5.2 | 7.7 | 45-49 | 11.2 | 6.6 | 18.5 |
| 50-54 | 3.8 | 2.8 | 5.3 | 50-54 | 8.5 | 4.7 | 14.7 |
| 55+ | 3.7 | 2.4 | 5.7 | 55+ | 6.6 | 4.0 | 10.7 |

Source: Shisana *et al*. (2004), p. 55

## Table 2: HIV prevalence by various demographic characteristics of public-sector educators, South Africa: 2004

| Characteristic | | N | HIV-positive percentage | 95% confidence interval |
|---|---|---|---|---|
| Total | | 17 088 | 12.7% | 12.0-13.5 |
| **Sex** | Men | 5 455 | 12.7% | 11.6-13.9 |
| | Women | 11 621 | 12.8% | 12.0-13.6 |
| **Race** | African | 12 022 | 16.3% | 15.5-17.1 |
| | White | 2 165 | 0.4% | 0.2-0.8 |
| | Coloured | 2 309 | 0.7% | 0.4-1.3 |
| | Indian | 533 | 1.0% | 0.5-2.1 |
| **Age** | Less than 24 years | 240 | 6.5% | 3.4-12.0 |
| | 25-34 years | 4 282 | 21.4% | 19.9-23.0 |
| | 35-44 years | 7 443 | 12.8% | 11.8-13.8 |
| | 45-54 years | 4 274 | 5.8% | 5.0-6.7 |
| | 55 years and above | 842 | 3.1% | 2.1-4.6 |
| **Marital status** | Married, civil | 3 329 | 7.9% | 6.9-9.1 |
| | Married, traditional (lobola/dowry) | 635 | 15.4% | 12.5-18.9 |
| | Married, religious | 3 288 | 5.5% | 4.5-6.7 |
| | Married, civil and traditional (lobola/dowry) | 1 358 | 8.6% | 7.1-10.3 |
| | Married, civil and religious | 1 931 | 7.6% | 6.2-9.2 |
| | Single, never married | 4 589 | 22.9% | 21.5-24.4 |
| | Married, but separated | 174 | 12.0% | 7.7-18.2 |
| | Divorced | 967 | 11.2% | 9.0-13.9 |
| | Living together, but not married | 95 | 12.2% | 6.5-21.9 |
| | Widow/widower | 663 | 18.8% | 15.4-22.6 |
| | Other | 24 | 14.7% | 5.5-33.5 |

Source: Shisana *et al*. (2004), pp. 53-54

Most of the studies on HIV prevalence, such as the ones cited above, are based on projections that might have overestimated the proportions of HIV-infected people. More recent empirical studies deploy methodologies that measure prevalence and incidence, and that yield a more precise picture with respect to teachers. These studies suggest several important conclusions:

- that HIV prevalence is high among teachers and similar to the general population
- that prevalence is highest among African teachers, standing at 16%
- that HIV prevalence is highest, at 21.4%, among teachers in the 25-34 year age-range
- that single teachers are 2.7 times more likely to be HIV positive than married people
- that educators at lower grades of employment (such as ordinary teachers) exhibit higher prevalence than senior teachers and principals
- that HIV prevalence varies by subject matter (learning area), with the highest recorded HIV proportion among those teaching additional languages (23%) and the lowest prevalence among technology teachers (7.4%)
- that HIV prevalence is lower for experienced teachers (those teaching for more than 15 years) and higher for younger, inexperienced teachers
- that districts with more than 20% HIV prevalence are found in KwaZulu-Natal, Mpumalanga and the Eastern Cape and, again, low prevalence is found in the Western Cape and the Northern Cape (less than 5%)
- that among male teachers HIV prevalence increases rapidly from 6.6% to 12.3% by age 25-29 years and peaks at 19% by age 30-34 years
- that HIV prevalence among female teachers increases from 6.5% in the 18-24 age group to 21.5% by age 25-29 years and peaks at 24.2% by age 30-34 years
- that HIV prevalence varies by level of teacher qualification, with teachers with degrees having a lower prevalence (10%) than those with diplomas (15.9%) and lower qualifications (14%).

## Table 3: Overall HIV prevalence among educators by socio-economic status in South Africa: 2004

| Socio-economic status | N | Percentage who were HIV positive | 95% confidence interval |
|---|---|---|---|
| **Level of qualification** | | | |
| First degree and above | 8 551 | 10.0% | 9.1-10.9 |
| Diploma | 7 094 | 15.9% | 14.8-17.0 |
| Grade 12 and under | 1 420 | 14.0% | 11.9-16.4 |
| **Annual income** | | | |
| Low | 2 915 | 17.5% | 16.0-19.2 |
| Medium | 13 231 | 12.1% | 11.3-12.9 |
| High | 813 | 5.4% | 4.0-7.4 |
| **Household economy** | | | |
| Not enough money | 1 253 | 15.5% | 13.3-18.0 |
| Money for food, etc. | 8 588 | 14.7% | 13.8-15.6 |
| Have most important things | 5 880 | 10.7% | 9.6-11.9 |
| Some extra money | 1 250 | 3.9% | 2.7-5.6 |

Source: Shisana *et al*. (2004), p. 58

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## Table 4: HIV prevalence by learning area taught (or trained in), South Africa: 2004

| Learning areas | Number of teachers teaching (or trained in brackets) | Percentage who were HIV positive | 95% confidence interval |
|---|---|---|---|
| Foundation phase | 10 552<br>(3 871) | 12.9%<br>(12.7%) | 11.6-14.2<br>(10.7-14.9) |
| Foundation languages | 9 922<br>(22 044) | 11.2%<br>(11.5%) | 10.0-12.6<br>(10.5-12.5) |
| Additional languages | 1 086<br>(2 215) | 23.6%<br>(24.0%) | 19.2-28.7<br>(20.1-28.4) |
| Arts and culture | 2 777<br>(2 349) | 13.2%<br>(10.8%) | 9.7-17.6<br>(6.6-17.0) |
| Economics and management sciences | 4 059<br>(3 108) | 14.1%<br>(15.3%) | 11.7-16.9<br>(12.3-18.9) |
| Social sciences | 2 255<br>(8 860) | 11.8%<br>(11.8%) | 9.3-15.0<br>(10.0-14.0) |
| Life orientation | 8 814<br>(6 167) | 13.4%<br>(11.3%) | 11.4-15.7<br>(8.6-14.7) |
| Mathematics | 6 129<br>(7 978) | 12.9%<br>(13.8%) | 11.5-14.4<br>(12.4-15.4) |
| Natural sciences | 5 752<br>(7 464) | 12.6%<br>(13.9%) | 10.3-15.2<br>(11.7-16.4) |
| Technology | 5 429<br>(1 708) | 7.4%<br>(8.2%) | 4.7-11.7<br>(5.7-11.5) |
| Special | 59<br>(298) | 0.0%<br>(11.9%) | 0.0<br>(4.1-30.5) |
| Other | 233<br>(5 589) | 13.8%<br>(13.4%) | 11.9-16.1<br>(10.9-16.5) |

Source: Shisana *et al.* (2004), p.67

## Table 5: Overall HIV prevalence by type of educational institution, position in educational system and years of teaching experience, South Africa: 2004

| Type of institution | N | Percentage who are HIV positive | 95% confidence interval |
|---|---|---|---|
| Primary school | 9 528 | 12.3% | 11.4-13.3 |
| Combined | 1 447 | 16.5% | 13.7-19.7 |
| Secondary / high school | 6 006 | 12.5% | 11.2-14.0 |
| **Position in educational system** | | | |
| Educator teacher | 12 669 | 14.1% | 13.2-15.0 |
| Senior teacher | 1 846 | 9.6% | 8.1-11.4 |
| Education specialist | 534 | 10.0% | 7.5-13.1 |
| Deputy principal / principal | 1 709 | 7.3% | 6.0-8.8 |
| **Years of teaching experience** | | | |
| 0-4 | 2 031 | 21.1% | 19.1-23.3 |
| 5-9 | 2 724 | 19.5% | 17.8-21.4 |
| 10-14 | 4 484 | 14.8% | 13.5-16.2 |
| 15-19 | 2 712 | 8.8% | 7.6-10.2 |
| 20-24 | 2 416 | 7.0% | 5.9-8.3 |
| 25-29 | 1 494 | 5.4% | 4.1-7.1 |
| 30+ | 1 105 | 2.6% | 1.8-3.8 |

Source: Shisana *et al*. (2004), p.68

## Table 6: Overall HIV prevalence among educators by province, South Africa: 2004

| Province | N | Percentage who are HIV positive | 95% confidence interval |
|---|---|---|---|
| Western Cape | 2 134 | 1.1% | 0.6-2.0 |
| Eastern Cape | 1 855 | 13.8% | 12.0-15.8 |
| Northern Cape | 891 | 4.3% | 2.9-6.5 |
| Free State | 1 152 | 12.4% | 10.1-15.0 |
| KwaZulu-Natal | 3 627 | 21.8% | 19.8-23.9 |
| North West | 1 437 | 10.4% | 8.7-12.4 |
| Gauteng | 2 772 | 6.4% | 5.4-7.7 |
| Mpumalanga | 1 315 | 19.1% | 16.2-22.3 |
| Limpopo | 1 905 | 8.6% | 7.3-10.1 |

Source: Shisana *et al*. (2004), p.59

What these statistics show, very powerfully, is how the pandemic encroaches on educational institutions, with devastating effects for school and society. Within the boundaries of what is called ‘the school’, the concentrated effects of the pandemic hit everyone hard (Fleisch 2007; Brookes, Shisana & Richter 2004).

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# What the school experiences tell

What is the context within which these statistics take on daily meaning in the routines of teaching and learning inside schools and classrooms? Or in the powerful and disturbing words of Freema Lebaz-Luwisch (2004, p.9), "*How is education possible when there's a body in the middle of the room?*" Teaching and learning, in her view, have to take account of the emotions, fears, vulnerabilities and anger of teachers and students before any dialogue is possible within the classroom about difficult subjects; teaching must, moreover, account for "*the body that carries these feelings and experiences*" (*Ibid*).

***Teaching must, moreover, account for the body that carries these feelings and experiences.***

Student teachers die before they reach school. Teachers die while in school. Teachers fall ill and drop in and out of school as their health deteriorates. Teachers with HIV and AIDS face a terrible stigma when they do come to school in a society that has yet to come to terms with HIV/AIDS prejudice. Teachers who are infected face an excessive drain on their basic health care coverage, and further health care demands on an income long stripped of any notion of 'disposable income'. Infected teachers grow weaker at the very point that the administrative demands of teaching grow stronger. Teachers now need to have the emotional capacity not only to care for themselves, but to care for increasingly vulnerable children who are also infected and affected by HIV/AIDS. For teachers in poor, rural communities, there are no longer just the usual challenges, but now also this additional phenomenon called HIV/AIDS.

Then add HIV/AIDS to the other stressors that students have long brought to school, such as poverty, malnutrition, violence, instability and the pervasive problem of academic under-preparedness. Inevitably, HIV and AIDS, along with all the other stressors, take their toll on individual morale, on human emotions, on physical energy, and on the professional commitment of teachers. Even resilience has its limits.

Learners either do not reach school or they reach school sick. They too carry multiple burdens of poverty exacerbated by the AIDS pandemic. Learners struggle to concentrate. They fail to achieve because of poor nutrition, long-distance travel to remote schools (often by foot), poor home conditions to support learning, lack of materials to support learning at school, and unqualified and unmotivated teachers. And yet the heavy demands officially placed on learning in terms of performance or outcome

measures do not distinguish between a rural child in a poor school and an urban child in a well-resourced school. Long-standing problems of poor schooling in poor communities are now magnified by AIDS. Well-described research documents the pervasive lack of a culture of learning which has just got a lot worse.

School governors – members of governing bodies – do little to help. Members of governing bodies, familiar only with their traditional roles of formulating and implementing school policies, have yet to come to terms with the fact that the teachers they appoint (or recommend for appointment) and the students in their charge are bodies that carry the burden of the pandemic. Governors, too, are caught up in ignorance and fear about the disease, and in many school districts are themselves affected and infected (Maile 2005).

***Well-described research documents the pervasive lack of a culture of learning which has just got a lot worse.***

In such schools, teaching and learning affect each other in a deadly pattern. Learners already lose significant amounts of instructional time because of routine and cyclical factors. The *routine factors* include the deeply ingrained culture of black schooling made visible since the 1976 uprisings, so that dedicated teaching, managerial discipline, parental involvement in schooling and learner commitment have been irretrievably lost. These routine factors – the inertia of black schooling, or what Seymour Sarason calls "the behavioural and programmatic regularities of the school" – largely account for the astonishing finding that township learners are exposed to about one third of the instructional time that learners in former white schools enjoy. This bald statistic does not even imply that what is taught is taught accurately; it is simply an observation about when the teachers in township schools show up for classes. There is enough evidence to indicate that this in itself (showing up) says little about the accuracy, depth and quality of teaching, especially in disadvantaged schools.

The *cyclical factors* affecting instructional time are the almost predictable teacher strikes or examination down-time when large periods of instructional time are lost at certain points in the calendar year to activities other than learning. In a bad year, such as 2007, a teacher strike might at least double the instructional time lost through routine factors and which lead to at least 3 months of vital teaching time disappearing. Since the privileged urban schools seldom lose any time at all to routine factors, and are exceptionally well-placed to manage cyclical factors (even assuming that the teachers in such schools participate in strikes), the effects for the middle classes are minimal.

What AIDS does is to now make teaching and learning even more unpredictable. The teacher who now attends

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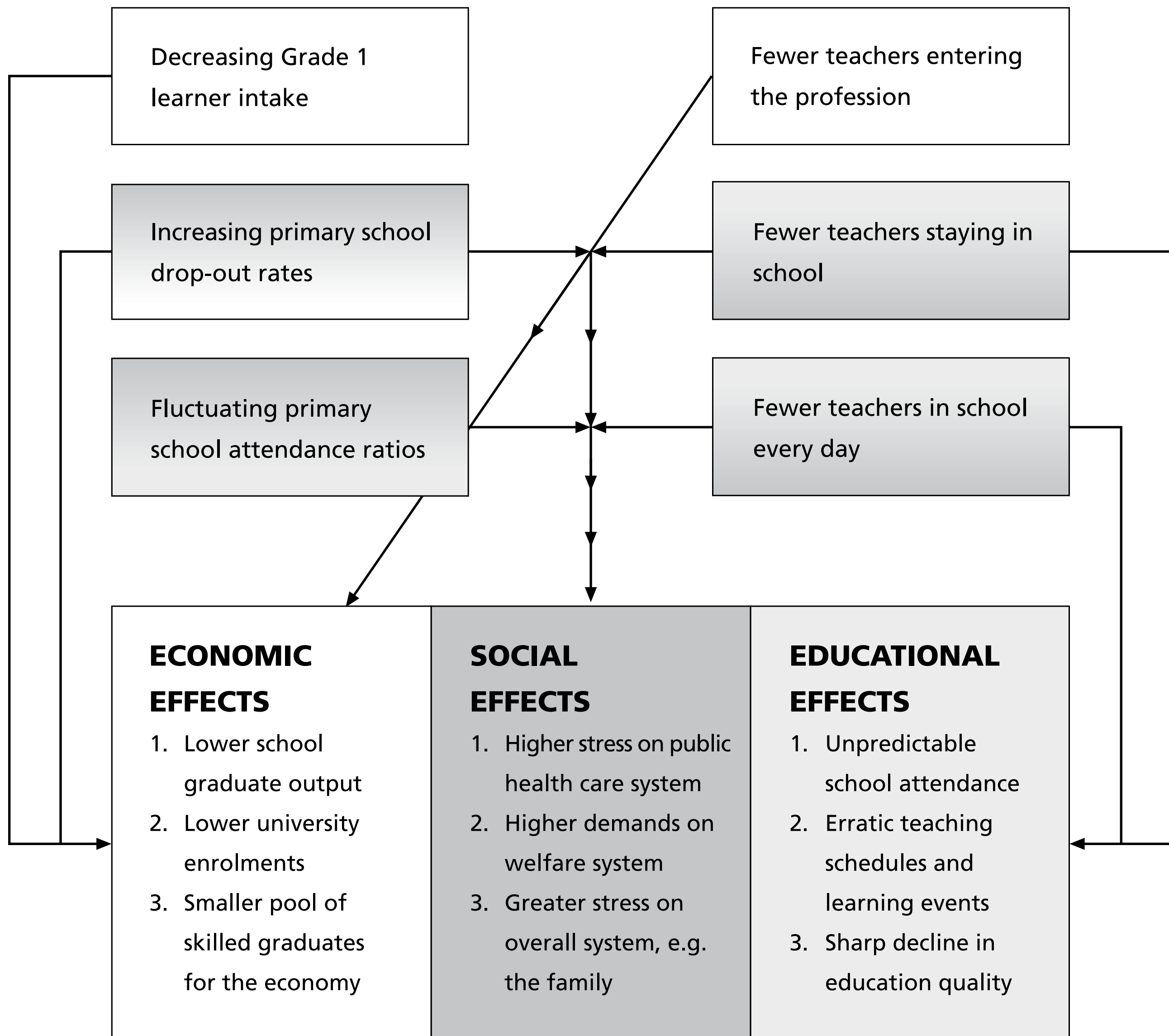
school when she is well enough, and stays away when she is ill, adds *exceptional factors* to the further loss in instructional time. The cumulative effects of absentee teachers on actual instructional time means that learning, already fragile because of the apartheid legacy and the other factors, is severely compromised. This explains the extraordinary finding that in some provinces, the longer a learner stays in school, the less mathematics he or she knows. While time lost owing to the absence of ill teachers is seldom disaggregated, it can safely be assumed that a sick or dead teacher will make a direct difference to learning attainment in schools already under-served because of other losses of time.

The extraordinary situation in such classrooms is that teachers and learners are infected and affected: both need support, guidance, assistance and treatment. Both are subjected to erratic attendance, so that when teachers show up, it does not mean that learners are present. When learners attend, it does not mean the teacher is able to attend. Schools and classrooms – when statistics reflect the lived experiences of those who teach and learn – are fragile ecologies. Yet there is little in-depth and sustained ethnographic research that documents fully and vividly *life in schools* during and through the HIV/AIDS pandemic.

What the following model attempts to do, nonetheless, is to demonstrate the multilevel and interactional effects of HIV/AIDS on fragile school environments in South Africa.

**Figure 3: Multilevel and interactional effects of HIV/AIDS in fragile school environments**



The left-hand side of the model shows clearly that learner and teacher behaviours are intimately connected to each other, and that the combined effects of what happens to teachers and learners has several knock-on effects on the economy, on education and on the social system.

What AIDS does is to increase mortality rates, so that fewer students enroll in Grade 1. It must be noted in this regard that Grade 1 enrolments in South Africa were dropping anyway as a result of declining birth rates (one of the lowest on the continent), and this had a direct effect on initial intake into the educational system. AIDS of course exacerbates the decline. It remains a challenge for research to account for the relative contribution of AIDS and other factors to the enrolment uptake (such as the choice of smaller family sizes among the growing middle classes), but what cannot be discounted is that AIDS has a significant impact on enrolment (Shell & Zeitlin 2000).

But children also enroll and then become HIV symptomatic during the early years of schooling. This means that learners drop out of school as ill health takes effect and leave a further dent in current enrolments which, as indicated, started from a low base anyway. The model also shows that learner numbers fluctuate even before HIV-positive children finally leave when their health does not allow their return to school. Both the fluctuations and the eventual drop-out rates have huge implications for the system.

The right-hand side of the model shows that fewer teachers enter the profession as a result of AIDS. There are not yet specific statistics, but it is known that a percentage of student teachers in training die before they have a chance to teach formally in schools. This is serious, again, because of the declining trends in teacher enrolments quite apart from HIV/AIDS, a function of the closure and incorporation of the teachers' colleges – once the main producer of new teachers – and a result of young black students' distaste for the profession, given their almost uniformly negative experiences of school teaching over twelve years. As with learners, teachers eventually drop out of schooling because of chronic illness caused by AIDS and those who attend do so erratically as the disease begins to progress and impact on daily health.

***Fewer teachers enter the profession as a result of AIDS.***

The model shows how among teachers and learners these three factors – decline, disease and death – interact with combined effects in the social, economic and educational spheres.

The immediate **social effects** start with the high stress placed on the public health-care system. More teachers and learners now require care and treatment, and the

costs of maintaining health are very high for poor learners and for teachers whose salaries are low compared to other professionals.

Similarly, the overall welfare system comes under stress. As studies have shown, the public demand on disability grants has spiraled out of control within a short period of time (Nattrass 2007). Such grants play a crucial role in poverty relief in poor communities and for this reason the grants, perhaps predictably, are also a target for all kinds of corruption.

AIDS has redefined the traditional concept of the family so that the growth in child-headed households has direct effects on the social system. The system now has to take account of such devastation, especially in poor and rural households where adults have disappeared from surrounding support networks.

***AIDS has redefined the traditional concept of the family so that the growth in child-headed households has direct effects on the social system.***

The **economic effects** of these interacting factors are only seen much later, with a shrinking pool of skilled graduates emerging from the public university system. The numbers of graduates are not only small in relation to economic demand, as presidential programmes like ASGISA and JIPSA have experienced, but imbalanced in relation to the areas of greatest need – such as engineering and teaching – which has serious consequences for the economy. AIDS makes this worse since fewer students attend school, fewer therefore graduate from school, and fewer then enter university, where such skills are chiefly produced.

The **educational effects** shown in the model include unpredictable school attendance by teachers and learners, and therefore erratic teaching schedules and learning events in school. The most immediate impact of such unpredictability is the impact on the quality of education. This is important because there is evidence that in township schools, children are exposed to less than a third of the instructional time given to children in the more established, former white schools. As with the other factors in the model, an already deteriorating situation is made much worse by the impact of AIDS on teaching and learning.

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# What the teachers do

How do teachers deal with the stringent curriculum demands on academic performance when simply staying alive and staying healthy overshadows almost everything else? Nothing in the existing organisation of the curriculum for public schooling even begins to take account of these realities. It remains a striking feature of the official curriculum that while it formally includes HIV/AIDS at the margins of a life skills subject in primary schools, the engine of what drives school content is what is tested at the end of a year of academic study, i.e. formal knowledge in the main subjects such as numeracy and literacy. It is a standard claim in curriculum theory and politics: the knowledge that matters in schools and classrooms is the knowledge that gets tested; in other words, what matters is the certificate that will assign real-life places in the job market or further education, not the kind of peripheral knowledge – such as HIV/AIDS – that is included for other reasons. (More about this later.) 'Show me your curriculum and I'll show you who is in power' applies strongly to the South African context. The mere inclusion of a subject matter or topic says nothing about the status and power of such knowledge within the curriculum.

***'Show me your curriculum and I'll show you who is in power' applies strongly to the South African context.***

What matters is what is tested. South African schools have never been tested as much as in the present. School calendars are organised less around teaching and more around testing. Teachers teach according to the test to be given. Learners are placed under constant pressure in a cycle of continuous assessment that 'counts' towards the final mark in the all-important terminal assessment. This is not only a Grade 12 or 'matric' phenomenon; it is something that envelops the full range of school years from Grade 1 through to Grade 12. The additional or special subjects (such as human rights or values or drug abuse or HIV/AIDS) simply do not count in terms of where teachers place their energies and therefore where students allocate their learning attention. Testing (and the *double entendre* is intended) allocates significance, not the mere inclusion of formal content.

In this testing game, a transnational phenomenon, principals and the general school leadership become entwined in, and contribute to, the madness. This is not to suggest that AIDS knowledge should be tested in formal examinations; it is simply to explain how schools in South Africa are organised, and why HIV/AIDS therefore receives such poor exposure. Yet to extend the metaphor, most students

and teachers are not tested for their HIV status, despite the fact that participation in the testing of official knowledge may be meaningless for those whose lives will be brought to an abrupt and painful end. There are bodies in the room, but you would not know this from the things schools deem important.

In this deadly game there is yet another dimension of school life that receives little attention in education policy and research. It is the fact that the bodies of teachers and students are often entangled in a deadly embrace (Naylor 2002). As teenage pregnancies in schools soar, it is becoming more and more evident that sexual relationships between teachers and students further contribute to a very dangerous liaison in the school. Students are older and teachers are younger, making such liaisons appear reasonable outside of the professional expectations of educators. But older teachers prey on younger, vulnerable girls and where poverty is acute, there is a dependent relationship that develops in this context. HIV/AIDS is therefore not only what infected adults and children bring into the school, it is a pandemic that recreates itself within the school as well.

***The bodies of teachers and students are often entangled in a deadly embrace.***

Another dimension of school life that impacts directly on the capacity of schools to respond is the growing managerialism that has overtaken everyday lives in schools. Every teacher tells the same story: that the paperwork has increased and that what first attracted them to schooling – the teaching – is under more and more pressure. Particularly for South African teachers, the belief in the redemptive powers of policy has not yet weakened. As a result, more and more policies are thrust on schools every year, more and more demands are made on teachers to administer and account for trivia, and more and more stress is placed on these bodies. Every policy that enters the school gates assumes that teachers can simply take on board one more set of responsibilities in an endless capacity for change. On top of this comes something as demanding as HIV/AIDS which does not only demand physical time, but also enormous emotional energies from those already affected and infected as a result of the pandemic.

What this detailed exposition of life in schools attempts to do is describe the complexity of the public space called ‘the school’ and, in so doing, to make the case that simple and simplistic interventions that seek to alter the sexual behaviour of those who occupy schools and classrooms have yet to work themselves through this multi-layered reality. At a very basic level, the question must be posed again: ‘How is education possible when there’s a body in the middle of the room?’

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# What the powers hold

Speaking recently at a large teacher union conference of more than 500 principals in one of the rural northern provinces of South Africa, I took the opportunity to talk to the crisis of HIV/AIDS. I highlighted the responsibility of teachers to confront this reality and to make sure learners were warned of the perils of reckless sex. At the end of the talk, a contingent of principals came to instruct me that I was wrong, that HIV did not cause AIDS, and that I should be attentive to the President's views on the subject. My heart sank: here was evidence that the leaders of (mainly) rural schools where learners were most vulnerable did not believe some of the very basic information that could protect their charges from death.

***The single most important threat to schools is the mixed messages being sent by those in political power.***

The single most important threat to schools is the mixed messages being sent by those in political power. In communities which are largely illiterate, the messages of the politically powerful carry much more weight than in middle-class communities. Schools are located within such communities, and those who lead and teach in schools are not immune to political messages.

Political messages on HIV/AIDS have been consistently dangerous. People hear messages that question the causality that links HIV to AIDS. People are receptive to messages that question the scientific treatments available and the efficacy of anti-retroviral drugs. People are drawn to alternative treatments which are often described as alternative remedies. People see the attack on favoured politicians who hold such dangerous views as politically motivated and, at worse, racially motivated.

This is not to deny, as will be shown later, that there are from time to time rational and accurate messages about HIV/AIDS in political or policy statements. It is, rather, that the scientific messages are mixed with nonsensical messages that together create a noisy confusion which leaves poor and illiterate people, or those in denial (like the principals) dangerously vulnerable to infection and death.

It is common cause within the medical and scientific communities that a health message must be simple, accurate, direct, honest and clear. It should, moreover, be a consistent

message that conveys clear information about causes and consequences. It should not give false hope, but offer realistic options that are accessible to those most in need of treatment. It should seek prevention as a first option and promote safe-keeping. It should target those most vulnerable, and be conscious of context (e.g. the gendered experiences of poor women) when delivering the simple message.

Political authority in South Africa has violated every one of these rules on how to convey health messages in developing countries. The message is mixed, it gives false hope, it questions science with non-science, it extends erroneous beliefs, and it feeds into an already sceptical school environment.

There is no reason to believe that this confused health message has changed at all in the current political environment in South Africa. If anything, there is evidence of a digging-in of political obstinacy around HIV/AIDS, as demonstrated by the firing of the Deputy Minister of Health, a person widely regarded as challenging the denialist viewpoint by taking an independent stance that rallied the scientific and the activist communities around the fight against the disease.

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# What the policies claim

When juxtaposed against the political messages from the Presidency, the HIV/AIDS policy for schools is remarkably clear, scientific and direct with respect to health message. Published in 1999 under the Minister of Education, Kader Asmal, as the *National Policy on HIV/AIDS, for Learners and Educators in Public Schools, and Students and Educators in Further Education and Training Institutions*, the document provides detailed and accurate scientific information on how AIDS is caused, the role of the virus, the progression of the disease, and the fact that at present no cure is available.

The policy makes clear statements about the rights of infected teachers and students, and about the importance of not discriminating against those who are infected. Detailed information is provided about how to support those who are infected and where such persons can receive further information and counselling to assist them through their illness. The policy makes clear what safety measures should be taken to prevent accidental transmission of the virus, such as during contact sports, and debunks the familiar myths about how the disease is spread. Finally, the policy requires that HIV/AIDS be incorporated into the curriculum and makes special mention of the Life Skills learning area.

In short, the official policy document on HIV/AIDS for schools is a modern document that would find resonance with science and policy in any progressive democracy. It stands in stark contrast to the politically obtuse position of those in the rest of government and in the President's Office. What matters, of course, is not this one document, but the multiplicity of policies and political statements that together transmit the mixed public health messages described earlier.

***The official policy document on HIV/AIDS for schools is a modern document that would find resonance with science and policy in any progressive democracy.***

As policy shades into planning, there seems to be every indication that within the realm of schools, there is formal recognition and commitment to fighting the pandemic. The new Strategic Plan 2007-2011 of the national Department of Education contains a powerful, albeit single, statement by the Minister of Education: "The scourge of HIV/AIDS poses a threat to life and we must manage it effectively to care for both the infected and affected" (p.7). HIV/AIDS certainly gets the political nod of recognition in this simple – if singular – sentence.

But to what extent has this single signal of political recognition in the Strategic Plan filtered down and led to implementation in schools?

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The problem is that there is very little substantive attention to HIV/AIDS within the Department of Education. There is no reference to the pandemic in the vision, mission and values statement of the department. While it could be argued that such a statement is necessarily broad and therefore could not be expected to single out HIV/AIDS, the more serious criticism is that there is no mention of the pandemic at all in the Five-Year Broad Priorities of the new strategic plan.

The five priorities given are dealing with poverty, skills development, quality improvement, health and education, and institutional development. But even the obvious candidate heading for policy specification is generic and silent on the subject: "Broadening of the total state of health and wellness of educators and learners. Placing emphasis on the Life Skills Programme to promote healthy lifestyles among educators and learners to protect investments in human capital." That is it. No reference to bodies in the room. Only an economist statement about bodies as investments.

***The problem is that there is very little substantive attention to HIV/AIDS within the Department of Education.***

What defines governmental attention to HIV/AIDS, certainly from within the Department of Education, is that attention to the pandemic is divided between two 'branches'.

First, there is the branch called *Social and School Enrichment*, headed by a senior official at the Deputy Director General level. On its website, this branch makes reference to one of its functions as being "to provide support and strengthen curricula-driven HIV and AIDS activities through peer education". But is this translated into action through the new Strategic Plan? Programme 5 in the Strategic Plan (2007-2011) is also called *Social and School Enrichment*, under which the following chief directorates are placed:

- Equity in Education, under which fall three directorates, Gender Equity, Race and Values, and Rural Education
- Health in Education, under which fall two directorates, Health Promotion and the National School Nutrition Programme
- Social Inclusion, under which fall two directorates, School Safety and Enrichment Programmes, and Adult Basic Education and Training (ABET).

Strikingly, under Health in Education there is no reference at all to HIV/AIDS. Within Health Promotion, the directorate where such amplification would be expected, there too is no reference to the pandemic at all. General references to wellness and health appear in each of the five-year columns and rows of activities. Where specific ills or illnesses are pointed out, the references are to deworming or drug and substance abuse. There is no specific reference

to the single most important threat today to life in South Africa, HIV/AIDS. It would no doubt be argued from within the bureaucracy that such attention to HIV/AIDS is covered under references to Peer Education, Care and Support Programmes; but that is the precise point – it is merely covered.

Second, there is another Branch called General Education and Training Schools, also headed by a senior official at the Deputy Director General level. There is no reference in the purpose and functions of this branch to HIV/AIDS. In the strategic objectives and performance measures for every one of the five years of the new strategic plan, there is not a single reference to HIV/AIDS. Through interviews with the officials in GET Schools it was found that their main function is to integrate HIV/AIDS into the curriculum via the Life Skills curriculum.

***In the strategic objectives and performance measures for every one of the five years of the new strategic plan, there is not a single reference to HIV/AIDS.***

Why are these HIV/AIDS endeavours of the two branches not combined into one function under one leadership? None of the officials interviewed were very clear about this issue, nor were they clear about what the other branch did except in broad terms. The Social Enrichment officials provided peer education and the GET Schools people engaged in curriculum integration. And so, in a Strategic Plan for the next five years that amounts more than 185 pages there are only scant references to HIV/AIDS, including singular repetitions of the same phrase towards the end of the document: "HIV/AIDS Prevention, Care and Support".

As policies shade into plans, and plans shade into actual programmes, what does the Department of Education actually do with bodies in the middle of the (class)room?

The national Department receives a conditional grant of R6 million for Life Skills: HIV and AIDS (Education). The key objectives of this grant are:

- To train 600 master trainers (in nodal areas) on the integration of Life Skills: HIV and AIDS across all learning areas of the curriculum
- To train 25 000 Intermediate, Senior Phase and FET educators to integrate the programmes in the learning areas of the curriculum
- To use the results of the review of the impact of the Life Skills programme conducted at 915 selected schools and an in-depth study of 100 schools in all the nine provinces to improve the content and approach of the Life Skills programme (to become more needs based)
- To implement peer education, care and support programmes for learners and educators in at least 15 000 schools (60% of the total)

- To support the effective management of the implementation of the Life Skills programme in all nine provinces.

The responsibilities described in the approved business plan for the financial year include:

- An intervention workshop focusing on teachers and learners, to ascertain learners' needs. The workshop is intended to help augment the programme
- Aligning the Life Skills: HIV and AIDS Intermediate and Senior Phase materials with the National Curriculum Statements
- Ensuring a budget allocation for the salaries of 12 co-ordinators and nine finance administrators who are to be placed in the provinces.

***When the small-scale interventions of government are put into perspective, the sheer inadequacy of official response is brought into stark relief.***

There are several striking features of the programme-level activities of the national department. First, it is a busy unit that provides training, peer support, curriculum revision and alignment, needs analyses, and personnel deployment and compensation. Second, a great deal depends on what the provinces do with the funding they receive. In this respect provinces such as Limpopo appear to deviate from the plans and will fail to reach their targets. Third, it is striking what a small percentage of funding is available for HIV/AIDS, with R6 million as a management fee for the national department and about R145 million for the provinces. Fourth, it is clear that apart from the expected positive self-reports (these are always positive in government interventions), this busy-ness does not alter *the systemic problems* that undermine effective response changes as far as the pandemic is concerned. As this Annual Report concludes:

> *The programme does not appear to have impacted positively on the systems, procedures and policies of schools, to an extent that very few schools indicated that they have established support structures for the infected and affected learners. This also suggests that in the main, the extent to which the programme has been integrated into other activities of the school is limited.*

When the small-scale interventions of government are put into perspective, where 29 000 public institutions, 350 000 teachers and 12 million children occupy this precarious zone called 'the school', the sheer inadequacy of official response is brought into stark relief.

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# What the practice reveals

Until we have detailed, sensitive and comprehensive ethnographic accounts of teachers and teaching inside the schools and classrooms of the country with the largest HIV/AIDS epidemic in the world, we will continue to stumble in our understandings of what kinds of change are possible and durable in South African education. This section draws on myriad small-scale qualitative studies often executed in isolated locales in remote areas of different provinces. It tries to compose a portrait of what emerges collectively from these accounts of teachers and teaching, and learners and learning, inside a post-apartheid school.

***Teachers do not talk about the pandemic to each other, nor does this constitute everyday discussions in schools and classrooms.***

## Silence

It does not take long to find in these studies a deadly silence about HIV/AIDS in schools and classrooms in the post-1994 period. There is a powerful collection of interviews with teachers in rural KwaZulu-Natal that captures the emotions and experiences of silence so fully:

> *This is not a spoken issue in our school. People are still secretive about their illness until they go down to the grave.*
>
> *No. In this culture there is no such talk. So you only hear that the parent died of natural causes.*
>
> *On the side of the learners, the high rate of absenteeism makes one to be skeptical that somewhere somehow something is not right, although one cannot say that the cause is HIV/AIDS.*
>
> *No, interestingly enough here nobody has actually come to me, not once, and said "I am affected" ... We have had children lose parents; lose brothers you know, all that kind of thing. But interestingly enough in this school, yes I am sure there are kids [who have HIV/AIDS]. I know there are one or two, we think. I am sure they have got it but we are not going to go and ask them to tell us. But nobody has actually physically come and said, I am concerned because I have AIDS.*

Teachers do not talk about the pandemic to each other, nor does this constitute everyday discussions in schools and classrooms. It might be that there are absentee teachers and ill learners, but nobody talks – despite the bodies in the classroom. Silence does not necessarily mean

denial of the powerful presence of the syndrome: after all, there must be a simple explanation for the constant stream of teachers and learners to constant funeral services in overcrowded cemeteries. Silence denotes many things in schools. It is an expression of fear, guilt and shame. It offers protection against retaliation. It offers relief from having to face up to the hard and observed reality of missing children, ailing teachers and dying parents. It offers anonymity among the bodies piling up in the school. Silence, in short, is sanity for many teachers.

Silence of course has negative consequences. The failure to talk or open up means that teachers often carry on their own the heavy burden of infection or loss. This silence frequently extends to not talking outside of school either, to family and friends, or even to counsellors and care-givers. Many teachers in South Africa suffer and die alone because of this self-imposed silence. Silence also means of course that learners adopt the same habits. Who wants to be known as an AIDS child? And if a child has lost a sibling or a parent, surely that means that the child is also infected or has AIDS? Silence condones destructive behaviour; it holds back important warnings of death and disease; and it unwittingly gives credence to myth, superstition and denial, especially when such knowledge comes from those in authority.

**_Silence, in short, is sanity for many teachers._**

It would be misleading, however, to dismiss this very loud silence in schools and society as irrational or worse, as a demonstration of ignorance. Quite the opposite. There are daily examples in South African schools of what happens to those who stand out, who look different from the rest, who do not fit the mode, and whose mere presence is interpreted as a threat to those around them. To speak is to risk marginalisation; to speak is to risk physical harm, to speak out is to be associated with 'them', to speak is to cast doubt on one's own status, to speak is to invite self-accusation, to draw unnecessary attention to oneself.

Silence of course does not mean the absence of *official talk*. In fact, one way of sustaining silence is to hind behind the cover of the official curriculum. A Life Orientation teacher *has to* teach about HIV/AIDS; it is required of all teachers with such a subject designation and therefore there is no personal culpability or individual risk attached to this kind of speaking. This is official talk, a notion of the teacher as the public servant, the salaried employee, the mere transmitter of the content (in this case HIV/AIDS) to the learners in the classroom. What we do not yet know, of course, is whether even this official responsibility is carried out to begin with; there is enough evidence from other studies which indicate that teachers find ways of subverting official knowledge and, especially, of avoiding controversial knowledge. It is a fair guess that if the enacted curriculum (what teach-

ers actually do) is compared with the official curriculum (what teachers are required to do) then a significant discrepancy can be expected.

But official talk as another form of silence in the classroom around HIV/AIDS is not simply about not delivering information. The static delivery of information occurs via textbooks and other forms of printed material: that is not teaching. When the subject is taught in an intellectually engaging way, and students are drawn out into discussions about the personal meanings of the subject, and begin to be inspired to take that knowledge into action, then a profound episode of teaching has taken place.

Even here the research is slim: assuming that the teacher does teach HIV/AIDS (and so information is delivered), but in ways that do not engage, inspire and personalise, then this is simply another way of silencing official knowledge. Where there is no emotional or intellectual commitment to a controversial subject like HIV/AIDS, the argument is that teaching which leads to a change in the meaning of the students' experience (that is learning) simply does not happen. In short, "what is taught is at least as important as how it is taught" (Rees *et al.*, 2000, p.287).

The purpose of this extended discussion on silence in the classroom is to demonstrate the many dimensions of closing down, stifling and silencing talk about HIV/AIDS. In this conception of silencing the absence of the spoken word is simply one way of keeping quiet. There are many others that relegate HIV/AIDS talk to a minor voice drowned out by the tested knowledge that defines the daily lives of school learners.

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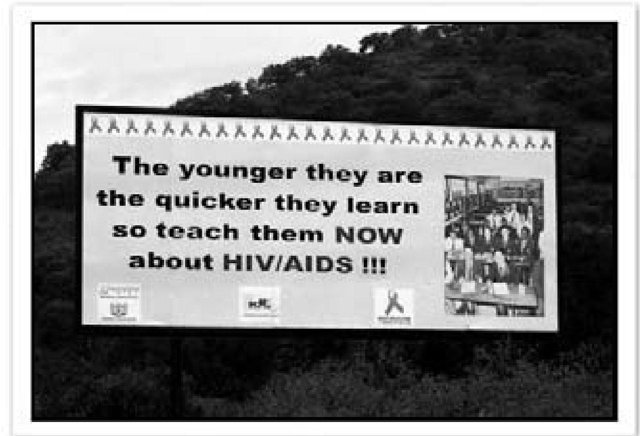


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## Stigma

Schools are places that sort people into all kinds of categories and possibilities – into higher and standard grades, into exempt and non-exempt candidates for university study, into the bright science and mathematics streams and into the less bright humanities and social science streams, and into the physically able and competitive students and the spectators required to observe the others at play. Schools are ruthless in allocating and withholding status, allowing students to passing in a myriad different ways, with or without merit, and allowing them to fail in all kinds of ways.

And so schools thrive on difference, and make such difference in attainment public through award and punishment. Schools, moreover, become the playing grounds preparing students to accept the order of things in 'the real world', to which they will be forced to adapt.  The notion of schools as great theatres of egalitarian rule has long been debunked by critical sociologists of schooling, and it is into this dramatically unequal space that HIV/AIDS recently entered.

***Schools thrive on difference, and make such difference in attainment public through award and punishment.***

In this place called school, which long ago developed ruthless classificatory systems of the desired and undesirable, HIV/AIDS will carry an inevitable stigma of identification. For no other public dilemma does the physical and the social meanings of the word *stigma* match so perfectly: "an identifying mark or characteristic; a specific diagnostic sign of a disease; a small spot, scar, or opening on a plant or animal" reads my online Google dictionary.

What this means is that unlike academic marks, which are invisible until allocated, the sorting system of schools in the case of HIV/AIDS can often work with identifiable marks, those tell-tale signs of infection. The scars on the body become a powerful way of separating the healthy from the unhealthy, the desired from the undesirable, and the normal from the deviant. The spot or blemish on the skin, the emaciated body, the tiring teacher, the worn-out learner are all signs on the basis of which stigma is imputed. Whether such physical signs are attributed to HIV/AIDS or to a host of other diseases, the school environment is enough of a sorting culture to invite the burden of stigma.

The stigma of HIV/AIDS is a terrible badge to wear in such an intolerant society and in an intolerant school environment this imputation of deviance is what lies at the heart of the struggle for openness and acknowledgement. When the rationalists among AIDS activists and health professionals appeal to students and teachers, 'Know your status', they underestimate how incredibly damning it is to wear this stigma around one's neck as one negotiates the many

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ways in which schools seek to sort, classify, label and lambaste those who do not fit the institutional norm.

Such stigma is especially felt among adolescents as they seek to establish their own identities as young adults. The familiar challenges of social confidence, peer group acceptance and identity acknowledgement are fragile elements in the life of the adolescent. When HIV/AIDS arrived on the scene it made an already difficult situation almost unbearable. To be labeled as HIV positive, as having AIDS or as coming from a family in which someone died of AIDS 'marks' one with the stigma in ways that destroy not only personal self-esteem and social confidence, but physical life itself.

***None of the interventions on HIV/AIDS in schools and classrooms even begin to tackle the social reality of stigmatisation.***

None of the interventions on HIV/AIDS in schools and classrooms even begin to tackle the social reality of stigmatisation. Interventions are rational: devise a message, target an audience, train messengers, write materials, convey the message, demonstrate consequences, provide support, issue condoms, direct towards treatment, and expect results. But what about the stigma attached to fragile bodies? What about the emotional distress of being stigmatised? What about the deeply embedded cultures of schooling that make stigmatisation with respect to HIV/AIDS so indistinguishable from what happens anyway in the ways that schools sort people?

Teachers carrying stigma are located within a special place in the pandemic. The teacher is the moral authority in the classroom, the person who should have known better. The teacher is the conveyor of educational information – but what else will she 'convey', parents fear, through contact with their innocent loved ones in the classroom? Since most middle-class parents insist on smaller classes so that their child is more likely to enjoy the close and intimate attention of the educator, this ambition suddenly turns on its own logic – for now it is precisely those assumptions of closeness that suggest the risk of social, educational and epidemiological contamination.

If the threat of contamination is real for teachers, it is equally real for learners with HIV/AIDS. Parents become completely irrational when that a child in a classroom is discovered to be HIV positive or to have AIDS, or is even suspected of doing so. No or scientific advice or medical reassurance will convince even the most educated parents that their child is safe. This is not to minimise the rare but real possibility that bleeding on a sports-field or cuts in the science lab could expose other learners (and teachers) to infected blood. It is simply to argue that what stigmatisation does is to exaggerate difference into irrational fear of the other, a fear that breeds in a societal culture long embedded in intolerance and discrimination, and a schooling culture

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that separates bodies based on any number of desirable and undesirable human traits and talents.

Stigma, to conclude, is not simply carried in the mind and the emotions; it is also carried as signs on the body moving inside the contained and intimate spaces of the school. And this is what gives HIV/AIDS such powerful meanings in South African schools and classrooms.

## Sin

In any Monday morning assembly, the overwhelming majority of South African schools, black and white, continue a ritual of what happened in churches on the previous day – they hold solemn ceremonies in which moral virtues, spiritual values and scriptural reprimand are conveyed with seamless ease. Right and wrong in this environment are intimately connected to conservative Christian values, given special meaning in the fundamental pedagogics of the apartheid state. It is crucial to understand, therefore, the theological context within which teachers, principals and students come to terms with HIV/AIDS in their schools.

***It is impossible to understand these resiliencies of understanding of the pandemic in schools without grasping the still stubborn connection between AIDS and sin.***

Social researchers might refer to this dilemma as 'the sin cocktail', a deviant behaviour that is associated with extreme practices, such as aberrant sexuality, that lie outside an established norm for human conduct. In South African schools, this norm is, among other things, strongly linked to what is conservatively Christian, pure, innocent, and obedient to God. This norm is free of perversion and insists on sexual abstinence, for the norm demands sexual relations take place inside the marriage pact. It is a norm that regards only heterosexual love and denies that any other kind of love is possible. It is a norm that disallows condom usage, since this is seen as doing nothing other than promoting promiscuous behaviour among teenagers. It is a norm in which family is constructed as a mother and a father and their children.

What conservative Christian values inside schools do, however, is not simply to define a norm worthy of emulation. It then concludes and insists that any sign of disease and death is a direct result of divine punishment of the aberrant or the deviant. This would clearly not hold in the case of heart disease or mental illness. But it is a profound and unshakeable link made with HIV/AIDS. Because the virus was initially associated with homosexuality – an unmistakable deviance within conservative Christianity – every and any manifestation of HIV or AIDS is now seen as a consequence of sin.

It is impossible to understand these resiliencies of understanding of the pandemic in schools without grasping the still stubborn connection between AIDS and sin, in particular, and between disease and punishment, more broadly. These are deeply held beliefs and values inside South African schools, and not only among those with an expressed theological commitment. It is, in conservative Christianity, something taught fervently and frequently through images of past plagues in the Old Testament and the future plagues of apocalyptic times. It is the theology

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of 'the wages of sin', and no amount of rational discourse about compassion for the HIV-positive teacher or, incredulously, even for the victims of infected blood transfusions, enables these Christian warriors to rise above such belief systems.

This means that the perpetrators of such pernicious belief systems need not be a flaming evangelicals – or even Christian – to have imbibed such views and values. It simply means that those who live in, and pass through schools are inducted into such sin discourses that become a vital part of the lens through which school dwellers understand and respond to HIV and AIDS. It is seldom articulated as directly as here, and might even be denied under interrogation. But the notion that the teacher or student who is HIV positive or a person with AIDS 'did something wrong' is deeply embedded in the consciousness not only of church and society, but of schools and classrooms.

In this respect the deeply religious commitments of teachers and learners are a double-edged sword. On the one hand, religious beliefs can be a very powerful medium for withdrawal from what are seen as sinful acts and, in the process, save lives. On the other hand, the mobilisation of such faith communities behind the notion that the use of condoms encourages promiscuity and interferes with the biological process – as in the dogmas of the Catholic Church – can reap havoc among the most vulnerable in schools (Muthikrishna *et al*. 2006).

***The discourses of sin explain the pervasive guilt and shame among those who suffer from the physical and social distress brought upon them by HIV and AIDS.***

The discourses of sin explain the pervasive guilt and shame among those who suffer from the physical and social distress brought upon them by HIV and AIDS. It is not simply that the accusers say or imply that a teacher or student 'did something wrong', it is also that the person with HIV begins to believe this, being part of the same social system that produces such discourses. Perhaps unsurprisingly, people with HIV and AIDS may turn to the god of their accusers, seeking repentance from sin and relief from guilt, as is often expressed in teacher stories. Few become cynical and atheist because of their terrible experiences with the disease; they are more likely to turn inward and lay the blame on their own souls.

This is a complex terrain, and yet seldom understood or engaged with, in the strategy to combat HIV and AIDS in or outside South African schools.

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## Race

AIDS takes its meanings from the social context within which it operates. In this regard schools provide a powerful social context within which to study the limits and potential of what is possible outside of them. And so on entering a school (or for that matter a university) it becomes clear from simple observation that racially, this is a deeply divided space. Black and white students, especially in high schools, tend to congregate on the basis of race. Black and white teachers, where they do happen to be together in the same school, assemble more readily on the basis of race than on the basis of other identity, e.g. teaching the same subject matter.

Black schools, our research shows, teach a curriculum that emphasises black heroes and struggles. White schools, we found, tend to lay stress on events in European and white history. That this can happen within a nation with a centralised curriculum is the subject for a different review. None of this is uniquely South African, of course, as Beverly Daniel Tatum showed in her book on race in the American education system, *Why are All the Black Kids Sitting Together in the Cafeteria?* It should not surprise us, therefore, that race plays a primary role in the understanding of HIV and AIDS in South Africa's schools, and contributes to the challenges of reversing the pandemic at least in educational institutions.

In many white schools HIV and AIDS is seen as a black problem, just as previously the virus was once dismissed simply as a homosexual problem. In previously Indian schools, although they are now integrated, AIDS is a problem of the 'other group', i.e. Africans. AIDS discourses inside schools (and universities) are racialised discourses.

The process of racialising the AIDS discourse starts with origins, and how students understand where the virus came from and how it entered human populations. It assumes promiscuity and sexual aberration, the kinds of behaviour imputed to black people. And so for school dwellers the connection is drawn directly between race and disease, as recent South African studies have shown (Govender 2006).

***AIDS discourses inside schools (and universities) are racialised discourses.***

Inasmuch as the charge that HIV/AIDS is linked to race is the discourse of the racist, so too the anti-charge by some black South Africans is that AIDS exists precisely because of a white conspiracy. What Govender (2006) found about racial conspiracy theories among African youth in township high schools mirrors precisely the kinds of conjecture found among African leaders within government – that there is no such thing as HIV/AIDS, but that if it exists, it is a construction of whiteness and colonialism against black subjects. And as Helene Joffe (1995, p.2) once argued in her *Social Representations of AIDS*:

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*The blaming of certain groups for AIDS leaves those who blame feeling protected and safe. Paradoxically, the projection of blame onto the 'other' renders those who blame more vulnerable to the virus because they feel no need to take precautions against it.*

Schools, therefore, are places in which race and representation play out in full view of the bodies carrying the burden of death and disease. How AIDS is understood, and resolved, is linked to deep-seated understandings of who gets it, where it comes from, how it travels, and why it persists. AIDS has an identity which is at any one time linked to sexual identity, gendered identity and racial identity. Race remains one of the most enduring identities around which the politics of AIDS denial and AIDS attribution continues.

## Culture

Another complicating aspect of how teachers and students experience and live with HIV/AIDS is the complex matter of culture. In one of the largest studies that set out to map the barriers to basic education in the context of AIDS, culture emerged as a key variable in teacher and learner attitudes towards the pandemic.

Culture, especially in rural schools and communities, is a powerful mediator of scientific discourses about AIDS. Culture is summoned to justify sex with young girls, multiple partners, unprotected intercourse, sex with virgins, forced penetration and a host of dangerous liaisons. Rigid and conservative forms of masculinity serve as the driving force in many of these behaviours, and can be very difficult to engage with and reverse through rational appeals to the causes and consequences of infection.

***Culture, especially in rural schools and communities, is a powerful mediator of scientific discourses about AIDS.***

It would be a mistake, though, to view cultural understandings of the pandemic as limited to rural, uneducated masses. As the recent court case involving a senior politician has shown, these beliefs are much more widespread and include sophisticated urbanites. It would be easy for those outside of such traditional culture and belief systems to dismiss such interpretations and justifications as a consequence of ignorance – but that would be simplistic. The fact is that teachers and learners bring these understandings into schools and act on these understandings within the practice of sex and sexual relations. As one teacher put it:

> *Learners have indicated to me over the years, in general discussion in terms of English speeches and talks and so on, that according to culture, some cultural beliefs you know, wearing a condom is just not on. This thing about our African learners wanting to have a child before marriage and so on, which is on the increase, is a cultural belief that a woman must be able to produce or have a child. So it could be cultural as well (Muthukrishna 2006, p.103).*

Similar studies link some teacher and learner understandings of HIV/AIDS, this time in rural areas, to witchcraft. Illness simply means the ill person is bewitched. The pedagogic implications are clear – that cultural beliefs must be ascertained and then mobilised both as a force for change, where such local knowledge can assist efforts to combat risk behaviour, and as a target for alteration, where traditional belief systems can exacerbate an already spiralling crisis.

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## Class

Schools are places of economic exchange, with direct consequences for the AIDS pandemic. Teachers, especially in rural and poor areas, are major money earners compared to the masses of unemployed in the surrounding community. Girls come from this community. For young and older male teachers, and for girls, this steep class differential creates opportunity.

This statement refers not only the violent 'taking' of girls in terms of the predatory sexual behaviour of male teachers. It refers also to agreements in terms of which financial and other kinds of support change hands. Suspending moral judgement for the moment, as teachers get younger and enrolled students get older, there is the further reality that the age differences between those who teach and those who learn might not be so great after all, and that romantic liaisons might appear quite reasonable.

***Schools are places of economic exchange, with direct consequences for the AIDS pandemic.***

Nevertheless, in the context of the desperate poverty within communities, the teacher has the means to engage in sexual relationships, into which girls are drawn because of the economic benefits of such liaisons. This is an important and understudied dimension of the HIV/AIDS pandemic, and one that needs data to establish the scale and the consequences of teacher-student relations where money plays a role.

Girl students also find other means through which to optimise earning opportunities. There is some evidence that pregnancy, which carries a high risk of HIV infection in high prevalence areas, is a means for achieving government support. As one teacher put it:

> *Sorry to say young black girls, but that's what we seem to be seeing, is that a lot of them fall pregnant because they want the child support grant of R180,00 ... as ridiculous as that sounds (Muthukrishna 2006, p.104).*

Placing middle-class sensibilities on hold, these kinds of reasoning and transactions in extreme poverty make a lot of sense to those at the lowest end of the class spectrum.

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# What the research says

Schools are sexually charged places (Children's Institute 2007; Govender 2006; Napier 2007; Peltzer 2006; Maharaj 2001; Niehaus 2000). Population researchers conclude that "sex and death lurk on the playgrounds and in the classrooms as much as they do at truck stops and near military installations" (Shell & Zeitlin 2000, p.139). They conclude that the chances of students attending school becoming HIV positive are actually much higher than if those students were to drop out of school. The policy implications of this kind of finding are staggering, and set clear limits on the optimistic and uncritical accounts of schools as natural mediators of the crisis.

***The chances of students attending school becoming HIV positive are actually much higher than if those students were to drop out of school.***

Teachers, principals, students and governors bring their sexual identities into the school and enact those sexual identities, stereotypes and preferences within the school. The erroneous notion of the school as some sanitised space in which sexually pure teachers transmit vital knowledge about prevention to sexually innocent youth to protect them from infection in 'the real world' outside of school might go some way to explaining the persistence of the pandemic in educational institutions.

Teachers have sex with each other. Principals have sex with teachers. Teachers and principals have sex with students. Students have sex with each other. Such transactions and transgressions are commonplace in many South African schools, as any sample of Sunday newspapers reveal with increasing frequency as the pandemic hits youth in the education system (IRIN 2007; Steenkamp & Hoffman 2007; Davids & Makwabe 2007).

We summarise, below, some lessons learnt from teachers' stories of living with virus (Machawira 2007; Muthukrishna 2006; Ramsuran 2006). We take the bald statistics provided up to this point, and give the numbers meaning within the day-to-day struggles of teachers to teach, guide, counsel, disclose, learn, lead, manage, negotiate and share their lives inside real school environments.

These stories of teachers' lives are a response to Baxen and Breidlid's (2004) insightful critique of the research on HIV/AIDS and education, where they make the point that "there is a marked lack of studies that focus research at the micro level, in this instance, teachers and schools" and their related and pertinent observation that

*... where teachers have been subjects of research, they have been positioned as deliverers of an uncontested, already negotiated body of HIV/AIDS knowledge within spaces (schools and institutions) that are unproblematic. In this regard, teachers have consequently been targets of training programmes that have largely portrayed them as lacking knowledge and skills to teach life skills or sex education programmes effectively (p.17, their emphasis).*

Teachers' stories show clearly that the boundaries erected around a school are porous, and that sexual behaviour within the surrounding community exists in a dynamic relationship with sexual behaviour within the school. The virus travels in real bodies into and out of the school gates every day. The stigmatisation of teachers and students living with AIDS happens in the school and in the community, ensuring a seamless struggle for recognition and survival in the lives of the infected.

***The virus travels in real bodies into and out of the school gates every day.***

Teacher stories tell of school systems which are deeply implicated in a moral discourse of guilt and punishment. Teacher stories show school systems that have yet to come to terms with the labour relations implications of the pandemic. Teacher stories collapse the distance between teaching and learning in ways that no other subject can: "When I teach (about HIV/AIDS) it reminds me of myself." Teacher stories uncover the double gaze of recrimination – of teachers looking at students who are infected and of students staring back at teachers who are infected. Teacher stories expose a curriculum that privileges prevention over care, and of information discharge over interpersonal engagement.

Teacher stories reveal carefree love lives in which being a teacher can still attract sexual attention when money and security are real needs in impoverished communities. Teacher stories demonstrate the economic vulnerability of professional educators in the face of the high costs of life-saving medication. Teacher stories offer insight into educator loneliness and isolation right in the middle of this bustling and energetic space called school. And yet teacher stories express hope and desire – such as commitment to further studies and new relationships – in the midst of the personal devastation of the disease.

What is to be done? There are any number of small-scale studies which show that education interventions have at least modest effects on knowledge and behaviour change among teachers and students in South African schools (Karnell *et al*. 2006; Boer & Mashamba 2005; Peltzer 2003; James *et al*. 2006; Peltzer 2003). Yet the *systemic effects* of the pandemic on the education system remain unaltered because of the ways in which schools allocate curricular

and social significance to what content is taught, how it is taught, how often it is taught, and whether it is taught at all.

Schools exist, we have shown, in a dynamic relationship with society. The messages from political authority overshadow, mingle with and distort the curricular messages in the classroom. Mixed messages from the powerful to the barely literate and the poor have devastating consequences in such communities. In these contexts, "gossip and rumour [as] oral forms create moral readings of behaviour and shape folk discourses of AIDS that resist dominant epidemiological explanations" (Stadler 2003, p.357).

For schools, as for society, the body count is high. Those bodies in the room carry fear, anxiety, depression, disappointment, guilt, desire, embarrassment, hope and dread. The humans in the room are not simply bodies to be counted so that 'we know' the state of the pandemic, nor are these humans simply minds to be changed so that behaviour can be altered; that is far too simple. Those bodies demand emotions to be reckoned with, illness to be accepted, status to be disclosed, pain to be shared, medicines to be paid, interconnectedness to be acknowledged, fear to be allayed, jobs to be protected, and humanity to be restored.

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# What schools should do

What would the education system look like if it was organised around, and in response to, the all-pervasive effects of the HIV/AIDS crisis? What would the organisation of schools look like if national and provincial governments really decided to come to terms with the pandemic? What kind of curriculum would represent an effective response to the still-growing tide of infections in the poorest communities? And what would teaching and learning look like if school dwellers recognised that there were bodies in the middle of the room?

In this section the *Review* moves beyond what can be called *the macro-planning implications* for education, in terms of which there are some powerful and eloquent statements of what the education system should look like and respond (see, for example, UNAIDS 2006; Allemano 2003; Bennell 2003; Carr-Hill *et al*. 2002; Act Africa 2000; Kelly 2000). These macro-planning studies and position papers focus on the supply and demand estimates for teachers as a result of the pandemic; AIDS-related drop-out and attrition rates in national systems; the rising costs of labour due to AIDS; the system outputs with respect to graduates; changing enrolment patterns over time; and the economic and demographic trajectories of the pandemic as it maps onto education systems.

These are important studies, but there is little in the literature on how schools as micro-ecologies can be imagined differently if these institutions themselves shared responsibility for addressing the pandemic. Apart from propositional claims about what learners should be told, there is little else in the literature about the nature and organisation of schools as responsive agents. And yet there is growing evidence that school design has an impact on both academic behaviour and what are called non-achievement behaviours in schools (Lackney 2000). This is what this final section of the *Review* offers against the backdrop of the analytical line held forth thus far.

***If the education system was designed for responsiveness to the pandemic, the organisation, content, delivery and outcomes of schooling would be very, very different from the standard arrangement.***

One point is clear: if the education system was designed for responsiveness to the pandemic, the organisation, content, delivery and outcomes of schooling would be very, very different from the standard arrangement. Sociologists of education make the point regularly that schools are remarkably impervious to external changes, whether

mandated or not. For this reason schools across the world look remarkably similar.

There is an office for administrators, key among which is the principal. There are little blocks of spaces for teaching called classrooms. There are standard toilets for the inmates. There is ground outside for playing. There is a bell that starts things and ends things. Uniforms accomplish their purpose – uniformity. Boards and chalk are in every classroom. Timetables demand strict patterns of adherence. Tests discipline and determine who proceeds and who is held back. Children move through successive grades on a strictly annual basis. Teachers talk, children listen.

Seymour Sarason, the anthropologist of education, talks about "the behavioural and programmatic realities of the school". Larry Cuban (1993), the school historian, tells how schools have remained more or less the same over a century despite thousands of models, innovations and experiments entering through the school gate. Michael Fullan (2003), the education change expert, observes surface change more often than deep change in the ways school respond to external mandates. David Tyack (1993), another historian, also recounts the difficulties of disturbing what he calls "the grammar of schooling".

Whatever follows, therefore, in this list of 'things schools should do', must be read against this strong evidence that change is difficult, and that any normative ideals for what education should be must be tempered against the reality of inertia in this remarkable institution, the public school. This is especially the case in the face of a pandemic that still denies itself and silences its victims in South African society.

## Integrate education, health care and social welfare into one systemic function

***A school system that is responsive to the pandemic will collapse the public duties of education, health care and social welfare into one systemic function.***

A school system that is responsive to the pandemic will collapse the public duties of education, health care and social welfare into one systemic function. This will be difficult, for political appeals to 'inter-sectoral co-operation' simply do not work, given how bureaucratic territories are defined, personal egos maintained and public resources defended within the silos of each and every government department. Yet it will take nothing less that such an integrated resourcing plan to begin to ameliorate the complex of problems that come with the disease.

The same children who require education are the children who head households, a task for which they are not emotionally and physically prepared. The same children who

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head households are the ones without the financial income to provide even the basics of domestic support. These children also need to care for the multiple needs (health, nutrition, security, play, etc.) of younger siblings, activities that will have a direct impact on their ability to attend school regularly and to learn in preparation for the assignments and tests that schools demand. It is impossible, therefore, to separate out these functions by assuming that school attendance, participation and performance can happen without building in the supportive health and welfare systems to make this already onerous task for affected and infected learners remotely possible.

***Good education predicts good health. Good health enables good education. Good welfare support ensures both.***

Freudenberg and Ruglis (2007), in their call to reframe school drop-outs as a public health issue, show convincingly that you cannot have one without the other. Good education predicts good health. Good health enables good education. Good welfare support ensures both. In other words, in the lived world these factors – health, education and welfare – interact and co-determine each other. There are even broader benefits to society, for

> *[b]y bringing together programs to improve health and school achievement and by making reducing school dropout rates a public health, educational, and human rights priority, public health professionals have the opportunity to make a lasting contribution to promoting population health and social justice (p.7).*

At the very least this will require the departments of health, education and social welfare to collapse defensive administrative and bureaucratic boundaries. It will need to ensure that such integration enjoys high levels of political support and financial resources to make this more than simply adding on different functions, but rather linking integration to improved health, secure households and enhanced learning attainments.

I adapt a table from Freudenberg and Ruglis (2007) to indicate how such integration might look like in practice in a broad health and education plan (that is, not specifically an HIV/AIDS plan):

## Health interventions that may contribute to improved school completion rates

| Type of intervention | Programme activities | How the intervention reduces drop-out rates |
|---|---|---|
| Co-ordinated school health programme | Health education; physical education; health services; nutrition services; counselling services; psychological services; healthy school environment; health promotion for staff, family and community; partnerships | Teaches decision-making skills for better life choices; reduces absenteeism; offers early intervention and referrals for learning, psychological and emotional health problems; makes schools more engaging; connects students to caring adults; engages communities in lives of young people |
| School-based health clinic | Primary and preventive health care, referrals, assistance in finding health insurance and health care for the family unit | Reduces health problems in the family unit; offers early intervention and treatment for psychological and physical health problems that can interrupt schooling; reduces teenage pregnancy |
| Sex, HIV infection, and pregnancy prevention programmes | Sex education; HIV infection prevention services; referrals for reproductive and sex health services; birth control; peer education; STD prevention | Reduces or delays teenage pregnancy; connects young people to caring adults or peers who can encourage healthy behaviour |
| Services for pregnant and parenting teens | Child care; parenting education; reproductive health services; continued participation in high school education | Encourages and supports teen mothers to continue schooling; delays second pregnancy |
| School climate | Policy changes to reduce stigmatisation and bullying; peer education; increased opportunities for close adult-student interactions | Improves student engagement in school activities; connects young people to caring adults; reduces bullying and stigmatisation |

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## Ameliorate the social system within which the schools are located

The thrust of the argument in this *Review* is that there are limits to what the education system can deliver without recognising that it is embedded within a powerful social system that interacts seamlessly with what happens inside schools. Just as trying to resolve problems of school violence is fruitless without addressing the problem of community violence, so too trying to change sexual behaviour patterns in the school is a worthless endeavour without simultaneously addressing the origins of these problems outside of the school fence.

It is, inescapably, a political act to demand that the public health messages that emanate from government departments and from the Presidency itself recognise the potentially devastating effects that prevarication and double-

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speak might have on the lives of young adults. The social communication network around schools must be corrected and it must be strengthened in order for schools to stand a reasonable chance of countering the worst effects of the pandemic.

This means that the media must be harnessed to give a consistently clear and direct message about the transmission mechanisms of the virus and the protective mechanisms that defend against it. It also means that local, provincial and national politicians must be challenged to deliver messages of similar clarity and consistency with school youth and, indeed, adults in mind. It means, further, that community organisations must form part of the single message system that reaches teachers and students long before they reach the gates of the school.

***The social communication network around schools must be corrected and it must be strengthened in order for schools to stand a reasonable chance of countering the worst effects of the pandemic.***

A very powerful part of the social system, especially in poor communities, is the network of peers, and here gangs and other social structures must be penetrated as part of the string of out-of-school actors and agencies that shape attitudes towards HIV/AIDS and risk-taking behaviours among school-going children. Children do not emerge from neat-and-tidy homes that drop them innocently into open classrooms. They come from local communities, from churches and mosques, from gangs and clubs, from cultural and sporting associations, and from peer affiliations down the street. Any effective response to the pandemic must reach these multiple layers of influence in the lives of young people who attend school.

Teachers, too emerge from these communities. But they also shape and form these communities, they set the trends and model the behaviour that makes it more or less difficult to counter the disease and its effects inside schools. By challenging the social system outside of schools the tasks of those inside schools become much easier.

The social messages that should be invoked in this broader social system must attack several dimensions of the problem simultaneously. They must speak to cultural mythologies about sex and sexuality, and undermine pernicious nonsense from the curative value of virgin intercourse for a person with HIV/AIDS, to male predator behaviours as a cultural obligation in black communities. They must undermine the racial and racist reasoning about the origins and spread of disease. They must confirm science and scientific reasoning around causality and treatment. And they must appeal to the spiritual and emotional dimensions of human lives to care and to recover from the stigma and slurs that result from openness about HIV status.

## Rethink the lock-step character of the school calendar and timetable

Until confronted with the options, it is hard for those who work in schools to recognise time and timetabling as a social construct. That is, the time set aside for a teaching period or a teaching day or a quarter or a year appears to those who work inside this institution called school to have a logic that explains itself. Of course schools start at 08h00 and finish at 15h00. Of course school gates are locked after 16h00. Of course weekends are dead time as far as the school premises are concerned. Of course there are school holidays three times a year. And so on. This arrangement of course is based on one single assumption: that schools serve healthy children and healthy teachers who are physically able and psychologically capable of following this organisational arrangement without interruption.

***Children and teachers who are ill simply cannot march to the inflexibilities of the existing timetable.***

Yet it is precisely this inflexibility that stands in the way of imagining and including those affected and infected as a result of the virus. For schools to respond efficaciously to the effects of HIV/AIDS, they will have to rethink the calendar.

Children and teachers who are ill simply cannot march to the inflexibilities of the existing timetable. As indicated in the earlier model of interactive effects of the pandemic on teaching and learning, there will have to be considerable flexibility in how and when and indeed how often instruction takes place.

It seems reasonable, for example, that schools design instructional episodes in ways that replay such instruction in repeated cycles of teaching within (or even outside of) a school year. That is, a teacher that is ill or a learner that has to absent herself to care for a mother dying of AIDS can 'drop in' to school to take lessons when they are available rather than miss a slice of the curriculum and be doomed simply because it is offered once only within a school calendar year.

This will require a simple and yet very complex re-orientation of language and understanding. At the moment, the only language available is one of 'drop out'. But the teleological force of the language of 'dropping out' has come to assume its own inexorable logic. As studies among migrant San families have shown, insisting that children in this community *dropped out* of school is to fail to see that they simply *dropped into* a range of schools in the areas to which the domestic unit moved as new grazing opportunities opened up for their cattle.

Similarly, recasting the timetable to optimise dropping-in opportunities for infected and affected teachers and

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learners will of course require a very different understanding of the possibilities for school organisation and a very different language for talking about those who come and leave. Obviously, such a model has financing implications, which will be discussed later, but the primary barrier here is one of imagination, not simply money.

## Change the normative resourcing model that governs school funding

Schools are funded with a normative image in mind: able-bodied children and teachers, children who live in communities around the school, principals who move up through the ranks of teaching to take on tasks of leadership, governors who are elected on the basis of their skills in business and accounting, and parents who are available to attend and participate in the running and support of the school. When a disabled teacher is appointed, school budgets simply are not geared for making the necessary adjustments in infrastructure to enable mobility. When a student is blind, there is not ready capacity to translate limited resources into the kinds of support systems, like Braille, needed to enable this student to learn among her seeing peers.

So too when the AIDS crisis hits a school and its surrounding community, the budget parameters of a public school simply do not allow for the kind of innovation that makes schooling possible for affected and infected teachers and learners.

The analysis presented in this *Review* indicates clearly that the resourcing model has to change, and change dramatically, if schools are to play any role as a responsive institution in the face of a hard-hitting epidemic.

***Budget parameters of a public school simply do not allow for the kind of innovation that makes schooling possible for affected and infected teachers and learners.***

The first implication of the analysis is that schools will need to increase the number of teachers available to teach in the proposed spiral curriculum, so that schools in one term, for example, offer multiple opportunities to access knowledge in a particular learning area (school subject). Clearly the doubling of teacher numbers is impossible under any kind of political economy, and especially in terms of South Africa's macro-economic settlement. But this could be done in a very different model by simply adding teachers to the pool.

For example, teachers could be hired to serve in a relief pool of about 10% additional teachers at the level of a school district, perhaps the most logical organisational placement for such supporting teachers. These would not

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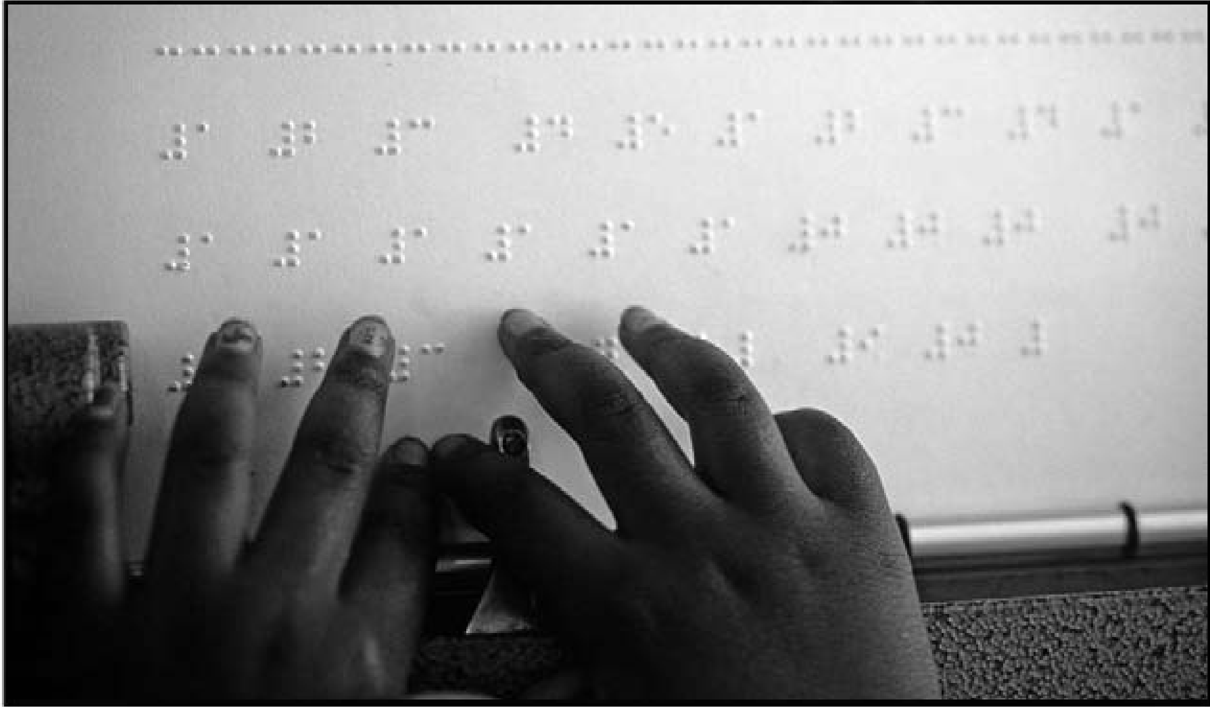

be conventional teachers, but rather teachers specially trained to have both conventional subject matter competence as well as an ability to teach and support those children who are affected and ill as a result of HIV. Such teachers would not be permanently attached to one school, but serve as relief teachers to a cluster of schools in a district on demand, as it were. What this means is that, intelligently deployed, the risk of interrupting instructional time in already fragile school environments is dramatically reduced.

Nor do these teachers need to be hired on full-term contracts, as with regular teachers. The costs of such a scheme could be cut significantly if the teachers so deployed were willing to work on a part-time basis and be remunerated on the basis of actual time spent in schools and classrooms. A further way of reducing the initial costs of such a scheme would be to target the poorest and hardest hit areas in terms of the epidemic, and to provide the critical relief that is not possible in severely underserved communities.

The resourcing model would of course require that a similar scheme, though much less costly, be developed for principals and school governors, also affected by HIV/AIDS. Once again a district-level intervention would make this logistically more feasible but given that fewer principals are required than teachers, a broader unit of organisation, such as a region that includes several districts, could be the location for such deployed administrators and governors.

Finally, the resourcing model would have to take account of school- or district-based clinics that provide health services for schools in response to the effects of HIV/AIDS. And, as will become clearer, the resourcing scheme will have to take account of possible physical changes to the rigid infrastructure that marks schools as schools, everywhere.

## Design an effective but parallel curriculum to the official curriculum

As indicated in this *Review*, South African schools work with a curriculum driven by powerful logics not unlike curricula in other parts of the globe. The external demands on the school curriculum favour formal knowledge with a high premium placed on the so-called gateway subjects, science and mathematics. Formal knowledge is official knowledge, and official knowledge is tested knowledge.

For teachers and students to value a curriculum, it must be part of this official knowledge. Yet there are hundreds of citations of small-scale curricula that claim to make a difference but merely at an intentional level, e.g. 'students declared an intention to use condoms after participating in a HIV/AIDS course'. For obvious reasons, such claims are shaky at best, and the lack of experimental, observational and tracer studies on curriculum effects render many of these studies suspect.

***This parallel curriculum, to be effective, will have to exist outside of the normal routines of teaching and testing in classrooms.***

The most pressing claims are that peer education schemes tend to work better, and it might well be that the way in which to reach children is not via debates about whether HIV/AIDS knowledge should be mainstreamed within the general curriculum or introduced as stand-alone subject material.

This parallel curriculum, to be effective, will have to exist outside of the normal routines of teaching and testing in classrooms. It will have to be based on a clearer understanding of what young people need, and what they respond to. It will have to mimic real-life situations and make consequences clear. It will have to deploy novel methods of teaching such as through drama, theatre

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and music. It will have to be based on the best scientific knowledge available.

It will have to deal with prevention as well as care. It will have to take on cultural myths and social stereotypes. It will probably have to be led by students themselves. There is some evidence that this kind of curriculum, as described, holds much more learner and learning appeal than formal delivery of factual knowledge in or outside the official curriculum (Norton & Mutonyi 2007).

A parallel curriculum must work with a clear understanding of the contextual interface between schools and society. It must address the kinds of exploitative practices in communities that render children vulnerable. It must acknowledge the limits of rational knowledge in the face of severe economic need. It must offer alternatives lodged within the realities of how and where children grow up and survive. And it must break through the myriad ways in which schools contribute to and exacerbate the crisis of HIV and AIDS.

## Imagine a different pedagogical model to carry the new curriculum

It is clear from research and experience that the weakest pedagogical model in teaching young people or adults is one in which the transmission of factual knowledge proceeds linearly from a known expert in the front of the classroom to assumed sieves and blank slates called learners at the back of the room. If this somewhat caricatured view of conventional teaching is true in general, it is especially true in the context of HIV/AIDS.

Schools are now loaded with information. Placards are everywhere: AIDS kills. Teachers instruct, though unevenly, via the Life Orientation curriculum. Communities, churches, clubs and other informal associations tell children about HIV and AIDS. There is, in one sense, overkill. But as suggested earlier, there is little evidence to prove effectiveness. What we do know, however, is the epidemic continues to spread and that students are less likely to benefit from formal instruction.

In the new pedagogical model, the notion of the authority has to change, and the references earlier to peers and peer group education must be taken seriously. The pedagogical model has to work with the principle that students already know a lot, even if what they know is dangerous and held as abstraction rather than as practised knowledge. The pedagogical model must therefore start with what learners bring to the learning situation, a starting principle of good teaching anywhere.

***In the new pedagogical model, the notion of the authority has to change, and the references earlier to peers and peer group education must be taken seriously.***

The pedagogical model must allow for teachers to come into the discussion as affected and infected themselves, even if this does not happen within the adult-child context of teaching and learning. This would be ideal, but the authority structures that govern education and social systems in South Africa in the present will make this impossible. But the same principles could apply in constructed educational opportunities where adults teach and learn from each other in structured conversations among their own peers.

The pedagogical model must be devoid of testing and examination, since this will undermine any serious attempts to relieve the curriculum from the strictures of formal knowledge. This does not mean that there should be no attempts to evaluate, even measure, what happens as a result of such interventions. However, the one feature that must distinguish this kind of model of teaching from the formal model is freedom from testing.

The pedagogical model must be resource-rich, multi-media where possible, and organised in ways that allow for self-

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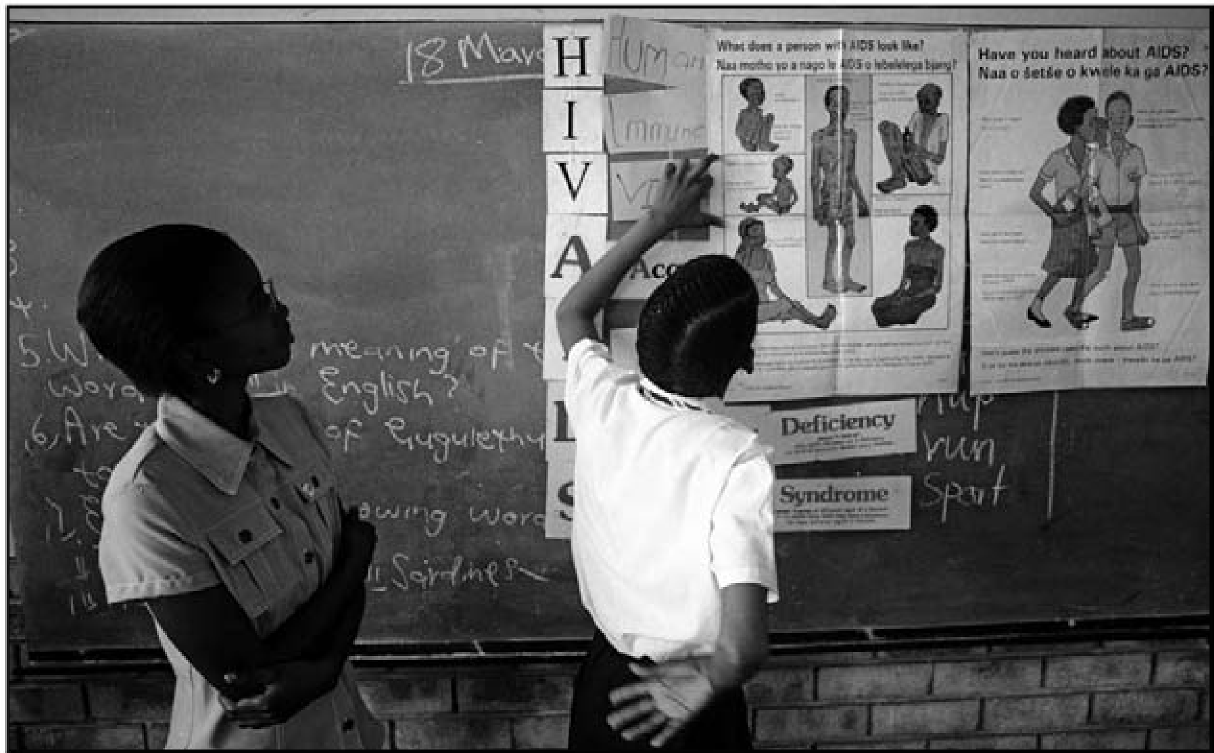


learning to proceed without reference to an expert at the front of the classroom. Ideally, therefore, a child restricted to home in the role of caregiver, and with basic reading and writing skills, should be able to take such interactive materials and to some extent guide her own learning in dire circumstances. This ideal has very significant implications for how we think about curriculum and pedagogical design, and here the proven methods of the distance learning experts can be of enormous value.

## Invent a different organisational design template for how schools are built

The current design of schools cannot cope with the pressures and demands of HIV/AIDS. Schools assume normality, defined as healthy teachers and learners. For schools to be responsive to the pandemic they will have to be redesigned radically differently.

First, schools will have to contain counselling and even testing centres within the school with all the demands of confidentiality and access that such programmes require. Bringing health care into the school environment requires a very different configuration of buildings and spaces.

Secondly, schools will require physical spaces in which teachers and students can rest during episodes of teaching and learning. The conventional 'sick bay' in many schools, a holding section for children with everything from measles to a bloody nose while they wait for their parents to collect them, is clearly anachronistic in the face of HIV/AIDS.

***For schools to be responsive to the pandemic they will have to be redesigned radically differently.***

Thirdly, schools will require smaller classrooms in which more children can stream through for shorter periods of time since the pedagogical model will have to assume that concentration time will be limited, as sick children and teachers try to attend and be attentive to teaching and learning in schools.

Fourthly, schools will have to create building spaces in which a parallel curriculum can be pursued. If the model mentioned earlier is adopted, this will mean large open areas for interactive teaching in which drama, film, theatre and music could happen outside of the narrow confines of a conventional classroom.

Fifthly, schools will require spaces in which children can isolate themselves when the physical and emotional burden of learning becomes too much in large groups, and where self-directed learning can be pursued without the pressure of a typical classroom. More and more, a model of learning will have to be adopted that does not assume that large class instruction can adequately meet the demands of affected and infected children.

Sixthly, schools will require spaces in which teachers, secretaries, principals, ground staff and others can also retreat to rest and recuperate during working hours. It should be a space in which confidential conversations can be encouraged, health messages conveyed, teacher struggles and stories shared, classroom coping mechanisms discussed, and teaching responsiveness to the pandemic affirmed.

Seventhly, schools will require boarding school components as the most realistic way in which to accommodate especially those children without parents, who would be left poor and destitute without the multi-purpose facilities and support mechanisms that can be provided. Whereas boarding schools historically served to accommodate children whose homes were located at great distances from school, a new purpose for boarding schools has to be defined now that the pandemic has struck families,

teachers and learners. This means that the traditional design of a boarding school attached to the main school buildings has itself to bring in health and care facilities alongside the provision of beds.

## Change and enlarge the range of competences for school leadership

The competences of school leaders are under review in South Africa, and all kinds of new curricular initiatives are in development through centres such as the Matthew Goniwe School for Leadership.

The scale of the pandemic in South Africa's schools requires a completely new set of competencies that should be learnt and demonstrated by any person who wishes to take leadership of a public school. Since the evidence is clear that school leadership matters in determining educational outcomes, the new regime of training and accreditation should require mastery of the following competences:

1. that school leaders are knowledgeable about the basic science of HIV/AIDS, including the causes and consequences of the disease, from an epidemiological perspective
2. that school leaders are knowledgeable about the ways in which HIV/AIDS expresses itself in school environments with respect to the behaviours of teachers and learners
3. that school leaders can demonstrate ways in which they can lead their schools in creative responses (social, curricular, health, organisational) for supporting affected and infected teachers and learners
4. that school leaders can prove that they can lead empathically with respect to the vulnerable on their staff and in their student bodies (sic)
5. that school leaders can communicate accurate social and health messages effectively among parents, students, teachers and governors
6. that school leaders can work with community organisations such as health clinics and social welfare officials in bringing multi-sectoral support agencies into the school
7. that school leaders can inspire and lead their teachers to create safe and secure spaces in their schools which offer care and support to the vulnerable within the school
8. that school leaders can display knowledge of laws and policies, including workplace mandates, that govern institutional behaviour towards those infected and affected by the disease
9. that school leaders can themselves lead exemplary lives in their social and sexual conduct within and outside the school
10. that school leaders are able to demonstrate flexibility within the work environment to manage the crises that inevitably flow from the effects of the pandemic, e.g. alternative scheduling plans.

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# Watchman, what of the night?

This *Review* has shown the interconnectedness between what happens in schools and what happens in society, and that it is important to understand the erection of fences around a school as creating essentially a false image of separateness and seclusion between these two powerful spheres of human existence. We have shown that students and teachers, governors and parents, and school leaders and support staff, move seamlessly between the school and the surrounding community. The broken fences in many township schools might in fact convey a much more realistic picture about the porous nature of the schools' supposed defence against external influences, including infection.

***These school citizens enter and leave the school with powerful social, cultural and political belief systems about HIV and AIDS.***

These school citizens enter and leave the school with powerful social, cultural and political belief systems about HIV and AIDS. Changing schools, ultimately, cannot be separated from the task of changing communities. This would be as true if the subject were violence or substance abuse, as it is true of HIV infection and AIDS. To deal effectively with simplistic remedies for countering the pandemic, it is important to begin by changing our conception of the link between school and society.

Schools are not innocent, as we have shown. They serve as places of sexual and economic exchange that might, paradoxically, make schools much more dangerous for those who stay inside of them than for those who drop out into the surrounding communities. This signals an important shift in understanding and approaching the pandemic: schools might in fact not be the best place in which to launch and sustain a response to HIV/AIDS.

The *Review* has also demonstrated the interconnection between what happens to teachers and what happens to students. The bodies of teachers and their learners are often tied together by intimacy and romance, through coercion and exploitation, through teaching and learning. These bodies face each other in the classroom, with both groups affected by HIV and AIDS, and often with both infected with this lethal virus. School citizens all too often face each other in silence,

or charge each other with sin, or withdraw from each other in shame.

It is through stories and research about stories that the *Review* has drawn attention to the conjoined and lived experiences of teachers and students inside of schools – their fears and fictions, their denials and desires, and their stereotypes and stigmas. Recognising the limits of macro-policy and planning perspectives on the pandemic, and the limitations of relying only on statistical estimations or demographic projections, this *Review* chose to shed qualitative light on schools as micro-ecologies within which real humans (bodies in the room) navigate and negotiate their lives in the midst of the HIV/AIDS pandemic.

***What is at stake is more than preventing infection or treating the infected and affected; there are bodies in the classroom, and they carry more than a virus.***

The *Review* concludes with something different, an attempt to imagine schools as physical, psychological and political spaces organised around and in response to HIV and AIDS. While educational planners recognise the need for multi-sectoral approaches and for interdisciplinary perspectives on schools as responding agents to HIV/AIDS, there is little in the literature to suggest rethinking schools themselves. There are sterling initiatives in research and practice on innovative and responsive school designs, but none of these efforts speak to (South) Africa's most devastating crisis: HIV and AIDS. The *Review* offers some ways of re-imagining these spaces called schools.

While the Review draws back from unbounded optimism about what schools can do in response to the pandemic, it also recognises that what is at stake is more than preventing infection or treating the infected and affected; there are bodies in the classroom, and they carry more than a virus. In this respect, the words of South Africa's Minister of Education at the 14th Conference of Commonwealth Education Ministers captures beautifully the heart of the *Review's* argument about bodies in the classroom, interconnectedness within society, and the importance of hope:

> *Given the importance of young people in the transmission patterns, the heart of HIV/AIDS prevention is located at the moment when a young person engages in sexual intercourse. Whether coerced, of free will or tied to economic station, it is a moment that reaches to the depths of a young person's sense of esteem, beauty, power, control, and the*

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*need for love or touch. It is not simply about knowledge or information. It is about the kind of understanding that can change decisions and behaviour during one of the most intense moments of human interaction. The foundation for effecting such decisions is based on a sense of self, a sense of one's place in the world, of one's personal power and integrity. That sense of self is itself a product of conceptions of gender, power, religion and the value of what it means to be human.*

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# Centre for the Study of AIDS

The Centre for the Study of AIDS (CSA) is located at the University of Pretoria. It is a 'stand alone' centre which is responsible for the development and co-ordination of a comprehensive University-wide response to AIDS. The Centre operates in collaboration with the Deans of all Faculties and through Interfaculty committees to ensure that a professional understanding of the epidemic is developed through curriculum innovation as well as through extensive research.

Support for students and staff is provided through peer-based education and counselling, through support groups and through training in HIV/AIDS in the workplace. The CSA in partnership with the Campus Clinic and staff at Pretoria Academic hospital offers a full ARV rollout with counselling, testing and treatment. A large number of student volunteers are involved in the various CSA programmes, as are many community groups, ASOs and NGOs.

To create a climate of debate and critique, the CSA publishes widely and hosts AIDS Forums and seminars. It has created web- and email-based debate and discussion forums and seeks to find new, innovative, creative and effective ways to address HIV/AIDS in South African society.

Together with the Centre for Human Rights and the Law Faculty at the University of Pretoria, the Centre has created the AIDS and Human Rights Research Unit. This research unit is continuing the research into the relationship between AIDS and human rights in the SADC countries, is engaged in the development of model legislation, of research in AIDS and sexualities and sexual rights, and in the placing of interns to work in various sub-Saharan parliaments and with parliamentarians to strengthen the role of parliaments and governance. The AHHRU recently published a book on aspects of its research – *Human Rights Under Threat,* edited by Frans Viljoen and Susan Precious.

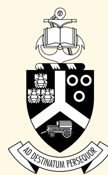
The *AIDS Review*, published annually since 2000, addresses major aspects of the South African response to the HIV/AIDS epidemic. *Review* 2000, written by Hein Marais and entitled *To the edge*, addressed the complex question as to why, despite the comprehensive National AIDS Plan adopted in 1994, South Africa has one of the fastest growing HIV epidemics in the world. *Review* 2001, written by Tim Trengove Jones and entitled *Who cares?* dealt with the levels of commitment and care – in the international community, in Africa and in South Africa. *Review* 2002, written by Chantal Kissoon, Mary Caesar and Tashia Jithoo and entitled *Whose right?* addressed the relationship

between AIDS and human rights in eight of the SADC countries and how the ways in which a rights-based or a policy-based approach has determined the ways in which people living with HIV or AIDS have been treated and the rights of populations affected.

*Review* 2003, written by Vanessa Barolsky and entitled *(Over) extended*, evaluated age, demographic changes and changing family and community structures. *Review* 2004, written by Kgamadi Kometsi and entitled *(Un) Real* looked at the dominant images of men in society and focused on masculinities in the South African context. *Review* 2005, written by Jimmy Pieterse and Barry van Wyk and entitled *What's cooking?* focused on the impact of HIV and AIDS on agriculture and the politics of food access and production. *AIDS Review* 2007 will address AIDS-related stigma.

In 2005 an extraordinary *Review*, *Buckling,* written by Hein Marais, and dealing with the impact of HIV and AIDS on South Africa was published. The second extraordinary *Review* addressing the tension between public health and human rights will be published in 2008.

The CSA operates in consultation with an advisory reference group – TARG – comprised of university staff and students from faculties and service groups as well as community representation. The CSA has developed a close partnership with a number of Southern and East African Universities through the Futures Leaders @ Work Beyond Borders initiative as well as the programme to develop university-based responses that address the needs of students and staff living with HIV and AIDS.

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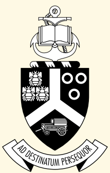


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