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HIV/AIDS AND THE EDUCATION SECTOR: THE FOUNDATIONS OF A CONTROL AND MANAGEMENT STRATEGY IN SOUTH AFRICA

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June 2000

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FOREWORD

This briefing paper was commissioned by the United Nations Economic Commission for Africa (UNECA). Detailed terms of reference requested the following information:

- *Analyse the socio-economic impact of HIV/AIDS on the education sector, on human development in South Africa.*
- *Assess current national strategies to fight the spread of HIV.*
- *What capacity does the education system need in order to change the behaviour of learners and educators, in order to save lives?*
- *What can the education system do to overcome shortages of skilled workers – in education, in other sectors?*
- *What needs to be done to protect teacher training, quality of education provision, curriculum coverage, planning and management from the consequences of HIV?*
- *What changes need to be made to the education system to make it more flexible so it can meet the needs of those who are out of school?*
- *What special steps need to be taken in the education system to help girls and women vulnerable to HIV?*
- *What role can education play in helping to mitigate the consequences of HIV in communities.*
- *What role can international communities play in mitigating the consequences of HIV?*

It is not possible to answer many of these questions, except by saying 'we don't know – yet'. Even to *try* to find answers would have required a far more extensive exploration of HIV/AIDS structures, experience and activities than was possible in the time available.

This paper confines its analysis primarily to issues of process, structure and content. Information was collected from government and agency documents, and from respondents at national, provincial, district and schools level who helped me understand their concerns and responsibilities. Inevitably, the paper takes the view from the top, by exploring national structures and plans. It would have been my preference to take the view from the coalface, where much valuable planning and relief work is underway. Those local practitioners I met impressed me by their knowledge and commitment, and their staunch unwillingness to be bowed by the traumas of sexual violence and HIV/AIDS.

I was fortunate to have the University of Pretoria's Centre for the Study of AIDS *AIDS Review 2000.* Its analysis of ten years' national experience of counter-attacking the HIV/AIDS pandemic is probably unique. On the other hand, this paper would have been very different if the Abt Associates impact analysis for the Department of Education had been available. It is not due until September 2000. The information and conclusions of this briefing paper will need review when they report to the Minister of Education.

I am grateful to all those who helped me in my work. I take responsibility for the paper's shortcomings. I believe that it is a work-in-progress and that throughout the coming months its vagaries can be reduced as more information becomes available.

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ATIC	AIDS Training and Information Centre
CBOs	Community-based Organisations
DfID	Department for International Development (United Kingdom)
DoE	Department of Education
DoF	Department of Finance
DoH	Department of Health
DoW	Department of Welfare
ECA	Economic Commission for Africa
ESKOM	Electricity Supply Corporation
EU	European Union
HIV	Human Immunodeficiency Virus
IDC	Inter-Departmental Committee on AIDS
IMC	Inter-Ministerial Committee on AIDS
MRC	Medical Research Council
MTEF	Medium-term Expenditure Framework
NACOSA	National Aids Coordinating Committee of South Africa
NACTT	National HIV/AIDS Care and Support Task Team
NGOs	Non-governmental Organisations
NPPHCN	National Progressive Primary Health Care Network
PWA	People (living) With AIDS
SADC	Southern Africa Development Community
SANAC	South African National AIDS Council
STDs	Sexually Transmitted Diseases
TTC	Teacher Training College
UNAIDS	United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
USAID	United States Agency for International Development

Eluding South Africa still is an answer to these questions: What might be an effective response to a disease that is, in discursive terms, as complex as AIDS in a country as divided, as wracked by contradictions and stereotypes, and as filled with silences as ours? Exactly what interventions should practically constitute that response?[1]

PART 1 INTRODUCTION

The UN Economic Commission for Africa has asked for details about what is being done in South Africa to control and manage HIV/AIDS in the education sector[2], and to mitigate its consequences.[3] Some of the questions posed by ECA's terms of reference are too difficult; others are too new. Still others are old questions, but common wisdom about the answer to them is being tested. Detailed answers are simply not available.

This paper is premised therefore, on the idea that while ECA's questions are important and legitimate, the first question should be: *what is being done to try to answer them?* That is, is there a foundation – an enabling environment – for creative, sustained and effective action on HIV/AIDS within the education sector?

The paper starts by considering what HIV/AIDS is doing to people in South Africa, to its society and economy, and some of the factors that have combined to make the pandemic so powerful. It then examines national AIDS programmes, and factors that have complicated implementation of strategic programmes. Lessons from the national effort may suggest principles for policy and practice in education.

The paper concludes by describing and commenting on the current framework for action on HIV/AIDS in the education sector.

PART 2 THE SPREAD OF HIV/AIDS IN SOUTH AFRICA

HIV/AIDS is spreading dramatically in South Africa. Factors which have nurtured the pandemic include the disruption of family and communal life; the legacy of apartheid and the migrant labour system; a good transport infrastructure and high mobility (allowing the spread of HIV into new communities); high levels of poverty and income inequality; very high levels of other STDs; the low status of women; social norms which accept or encourage high numbers of sexual partners; and resistance to the use of condoms.[4]

South Africa has the fastest growing HIV/AIDS epidemic in the world, with more people infected than in any other country. In 1999, at least one in every eight adults was thought to be HIV+, or about four million people. By June 2000, it was estimated that at least 20% of the population is infected. Rates are highest among youth, with an alarming increase observed among teenage girls. The highest rates are found in KwaZulu-Natal, Mpumalanga and Free State Provinces.

Table 1: Provincial Antenatal Clinic HIV Prevalence (%)[5]

	1999	1998	1997	1996	1995	1994	1993	1992	1991	1990
EC[6]	18.0	15.9	12.6	8.1	6.0	4.5	1.9	1.0	0.6	0.4
FS	27.9	22.8	20.0	17.5	11.0	9.2	4.1	2.9	1.5	0.6
GP	23.9	22.5	17.1	15.5	12.0	6.4	4.1	2.5	1.1	0.7
KZN	32.5	32.5	26.9	19.9	18.2	14.4	9.5	4.5	2.9	1.6
MP	27.3	30.0	22.6	15.8	16.2	12.2	2.4	2.2	1.2	0.4
NC	10.1	9.9	8.6	6.5	5.3	1.8	1.1	0.7	0.1	0.2
NP	11.4	11.5	8.2	8.0	4.9	3.0	1.8	1.1	0.5	0.3
NW	23.0	21.3	18.1	25.1	8.3	6.7	2.2	0.9	6.5	1.1
WC	7.1	5.2	6.3	3.1	1.7	1.2	0.6	0.3	0.1	0.1
RSA	**22.4**	**22.8**	**17.0**	**14.2**	**10.4**	**7.6**	**4.0**	**2.2**	**1.7**	**0.7**

The country will be in the most devastating throes of the AIDS epidemic by the year 2005, when, the Metropolitan Life Group estimates, more than six million South Africans will be infected, and about 2.5 million people will have died of AIDS or an AIDS-related illness. Ominously, even 'significant changes in sexual behaviour' will trim back those estimates only marginally, since projected casualties will occur mainly among people who have contracted HIV already.[7]

HIV/AIDS should be viewed as a 'slow onset disaster' – that is, a serious disruption of the functioning of society which causes widespread human, material or environmental losses.[8]

PART 3 SEXUALITY, HIV/AIDS AND CHILDREN[9]

It may be helpful, before looking at the impact of HIV/AIDS, to consider in more detail the fertile ground on which the pandemic thrives. Adolescent sexuality is only one of many elements in South Africa's complex social mix which determine the thrust and spread of HIV/AIDS. But it is one with which all educators must grapple, and the principal one to which the education system must respond.

A survey among youth 16-20 years old in urban townships found that 40% of young women and 60% of young men had more than one sexual partner in the previous six months; condom use was low. Failure to practice safe sex was related to pressure to engage in early and unprotected intercourse, coercion, pressure to have a child, lack of access to user-friendly health services, negative perceptions about condoms, and low perceptions about personal risk, in addition to lack of privacy and time.

Adolescents are sexually active when they are young: in rural KwaZulu-Natal, 76% of girls and 90% of boys are reported to be sexually experienced by the time they are 15-16. Boys start sexual intercourse earlier than girls (13.43 years versus 14.86 years), have more partners and nearly twice as often have an STD history. In Free State, teenagers reported they were sexually active at around 12 years old, due to experimentation or peer pressure, and relatively few practised safe sex. Adolescents rarely communicate with their parents or other adults about sexual and reproductive health issues.

A 1995 study by the National Progressive Primary Health Care Network (NPPHCN) found that many young people receive conflicting messages about sex and sexuality; that non-penetrative sex is not considered to be proper sex; that widely believed myths reinforce negative attitudes about safer sex and contraceptive use; and that most adolescents make decisions about sex in the absence of accurate information and access to support and services. The study concluded that these young people lack confidence and the skill to negotiate sexual issues, contraception and prevention of infection.

Violence is common and even considered the norm in sexual relationships. A qualitative study among Xhosa-speaking pregnant adolescent women revealed that violent and coercive male behaviour, combined with young women's limited understanding of their bodies and of the mechanics of sexual intercourse, directly affected their capacity to protect themselves against STDs, pregnancy and unwanted sexual intercourse. Communication between partners on sexual issues was non-existent, and conditions and timing of sex were defined by male partners, giving young women little or no opportunity to discuss or practice safer sex.

> *The dominant response has been to try and understand the disease within conventional frames of understanding – leaving hidden the many ways in which AIDS reconstructs the familiar and warps the assumptions we bring to bear on it. Thus AIDS is viewed as a reflection of the status quo, with the epidemic fuelled by poverty, migration, discrimination, powerlessness, and the like. All these factors apply. But they do not complete the circle of understanding we seek. AIDS is also a*

> *disease lodged in the behavioural patterns and value systems that become adapted to the presence of the disease. The people performing these shifts of conduct are not as helpless and passive as our reductionism would have us believe.*[10]

In some places, particularly where there is political violence and high crime levels, HIV has come to be accepted as a new and inevitable part of growing up. Young people who suspect they are infected with HIV may avoid a definite diagnosis, but at the same time seek to spread the infection as widely as possible.

The NPPHCN survey found that it is boys who determine when and how sex occurs, and that girls commonly experience rape, violence and assault, including within relationships. Another survey of urban youth found that 28% of the women aged 16-20 had been forced to have sex against their will. Adolescent women felt unable to refuse sex or to discuss safe sex, including contraception or condom use, for fear of violence. Some young men in the NPPHCN survey justified rape because of the perception that young girls have sex with older men for material gain. Research with pregnant and non-pregnant teenagers in one township found that all the girls (mean age 16.4 years) had had sexual intercourse and at least one boyfriend. A third described their first sexual experience as rape or forced sex, and two-thirds of both pregnant and non-pregnant teenagers had experienced sex against their wishes. Reasons given for not refusing sex included fear of abandonment or violence.

Semi-structured interviews with youth, mothers and policemen in one provincial town found that gaining and keeping boyfriends and girlfriends were critical to status and position within peer groups. Even when aware of it, mothers did not interfere with violence committed within relationships by their sons; the police were reluctant to press charges in cases of gender violence; and authority figures such as teachers were often responsible for sexual exploitation of teenage girls.

PART 4 THE IMPACT OF HIV/AIDS

Demographic Impact: Reducing Growth Rates

At least 20% of South Africans (15-49) are likely infected with HIV/AIDS. Half of South Africa's children who are 15 years old will probably die of HIV/AIDS[11]. On the basis of modelled trends HIV/AIDS will result in lower population growth rates due to increased infant, child and adult mortality, and lower fertility rates due to the death of potential mothers age 15-45. Infant, child and adult mortality rates are expected to double by 2010, and life expectancy will drop by 20 years, from 68 to 48 by 2010.

Orphanhood rates will increase by a factor of five: by 2005, South Africa will support nearly one million children without parents.

Economic Impact: Declining Productivity

It is anticipated that productivity will decline in all sectors due to illness on the job, absenteeism due to personal or family illness, and funeral attendance. Old Mutual Actuaries and Consultants forecast that the annual death rate in the workforce will rise from 5 to 30 per 1,000 workers. Hardest hit are the mineworkers, some 45% of whom are already HIV+ (late 1999). Educators constitute the largest cadre of workers in South Africa: at least 12% are HIV+.

Public sector services, in common with the private sector, will be affected by doubling or even tripling of medical benefits. Economic growth will slow because the economically active population will be reduced, leaders and managers will be among those worst affected, and fewer new skills will be coming into the labour market. The mobility of those who are carers, especially women, will be reduced. The representation of women generally in the labour market is expected to decline as more women than men are diverted to care for sick family members.

Market structures may change because of the redirection of individual and family expenditure away from 'luxuries' – like housing and education – and towards medical care, funerals, and associated costs.

Skilled labour wage rates may increase as the supply of skilled personnel dwindles. Government revenue and therefore public sector budgets will be squeezed as the country's tax base shrinks, at the same time as demand rises for social and health care and support. Private sector health benefits may be curtailed – effectively shifting responsibility for rising costs of employee healthcare to the state and to families.

Poverty levels will rise even further as parents who are sick and no longer bring in an income from employment die, and the number of child-headed households increases.

Social Consequences: Poverty, HIV/AIDS and Children

The first South African supplementary report on the UN Convention on the Rights of the Child (May 1999) described South Africa as a *'racially divided, traumatised, dehumanised and child welfare negligent society'*.

In South Africa there are about 18 million children, about half the total population of 38.8 million.[12] There are 6 million children under 6 years old, many of whom live in impoverished rural areas. About 60% of all children live in poverty. Of the 1.2 million children born annually in South Africa, 85,000 die before they are five. Maternal mortality was 150 per 100,000 (1998), reflecting weaknesses in health care delivery. Over 35% of child deaths are probably due to treatable conditions. More than 30% of African households depend on river water, and 16% have no toilet facilities.

One fifth of all children do not live with their mothers. About 39% of households are headed by women and the poverty rate in these households is double the rate in male-headed households. It was estimated in 1994 that 500,000 female children were victimised sexually each year.

It is projected that HIV/AIDS will account for a 100% increase in child mortality – from an anticipated 48.5 per 100,000 births without HIV/AIDS to almost 100 per 100,000 births in the year 2010.[13] In 1999, at one hospital in KwaZulu-Natal, 81% of all deaths in the paediatric ward were proven HIV/AIDS related deaths, or 90% for children under 3 years.[14]

South Africa, according to the *1999 Progress of Nations Report*,[15] is one of seven countries where the number of children orphaned by HIV/AIDS between 1994 and 1997 increased by more than 400%. In the same period, of children under 15, about 110 per 10,000 lost either their mother or both parents to HIV/AIDS. In KwaZulu-Natal, it is estimated that this year there will be between 197,000 and 278,000 HIV/AIDS orphans – that is, 5.8-8.8% of all children. By 2015, when the epidemic is expected to peak, orphans will constitute between nine and 12% of the total population of South Africa – or about 3.6-4.8 million children.

South Africa, as a result of the HIV/AIDS pandemic therefore, faces increasing numbers of children in distress. More and more often, traditional models of childcare are unable to accommodate the number of children affected by HIV/AIDS, especially where poor communities cannot absorb affected children without outside support.[16]

In this context, the South African Institute for Security Studies anticipates that 'age and AIDS will be significant contributors to an increase in the rate of crime over the next ten to twenty years. In a decade's time, every fourth South African will be aged between 15 and 24. It is at this age where people's propensity to commit crime is at its highest. At about the same time, there will be a boom in South Africa's orphan population as the AIDS epidemic takes its toll. Growing up without parents, and badly supervised by relatives and welfare organisations, this growing pool of orphans will be at greater than average risk to engage in criminal activity….As a result of an increase in the number of juveniles, especially orphaned juveniles, as a proportion of the general population, South Africa is likely to experience an increase in crime levels in the short- to medium-term (five to 20 years).'[17]

Table 2: The Consequences of the Pandemic: Projections to 2010[18]

	1999	2005	2010
Percentage of SA workforce that is HIV+	11.5%	20%	22.5%
Percentage of SA workforce that is AIDS sick	0.4%	1.65%	2.7%
New AIDS cases per annum	145,256	466,365	625,180
Number of AIDS Orphans	153,000	1,000,000	2,000,000
Life expectancy of SA population (years): Female	54	43	37
Life expectancy of SA population (years): Male	50	43	38

PART 5 THE IMPACT OF HIV/AIDS ON THE EDUCATION SECTOR

In 1998, there were 12.3 million learners in primary and secondary education, taught by about 370,000 educators, and supported by approximately 5,000 inspectors and subject advisers. In addition, 68,000 officials, managers and support personnel staffed the bureaucracy.

- *The education budget constitutes about one-fifth of the national budget;*
- *Educators are the largest cadre of workers in the country;*
- *Their salaries consume about 85% of the education budget.*

The Department of Education has commissioned Abt Associates to undertake a study of the actual and potential impact of the HIV/AIDS pandemic on the education sector.[19] Initial data have been presented to the Department by Abt Associates. The full report to the Minister of Education and his Department is expected by September 2000.

UNDP noted (1998) that for South Africa 'no sector specific data on the pandemic are either collected or available'.[20] Until the full data set is available from the Department of Education later this year, it is necessary to extrapolate impact probabilities from experience elsewhere in the SADC region, from occasional studies and reports, information on other sectors, demographic analysis, and anecdotal information available in South Africa.

Enrolments: Declining and Changing Demand for Education

HIV/AIDS will not stop population growth. Nor will it cause population numbers to fall. What it will do is slow the rate of population growth, and alter the structure of the population. The number of 20-40 year olds as a proportion of the entire population will decline. The number of orphaned children will grow, increasing the burden on extended families to meet the needs of such children.

In other SADC seriously affected by the AIDS pandemic, it is probable that by 2010, 30-35% of children will have lost one or both parents. The ability of relatives of such children to keep them in school will become a critical issue. In the context of widespread and deepening poverty, enrolment rates will decline, and drop-out rates will rise. In some cases, there will be a negative school population 'growth'. UNDP's 1998 *Human Development Report, Namibia*[21] suggests that by 2010 combined primary and secondary enrolments are likely to be eight per cent lower than total enrolment in 1998.

The UNDP 1998 *Human Development Report, South Africa* calculated that there were perhaps more than 258,000 HIV+ learners over 18 in the system in that year. The entry-level cohort was already in decline: an average five per cent per annum shrinkage was observed over the previous three years.

Drop-out rates due to poverty, illness, lack of motivation and trauma will to increase. Absenteeism among children who are care-givers or heads of households, those who help to supplement family income, and those who are ill, is bound to rise. Children who are orphaned will be particularly hard-hit. There may be an increased demand by sick parents for early childhood education, and an increase in preschool intake. This may be offset by fewer births and more deaths of under-fives. There may be greater demand for second-chance education by learners returning to education after absence from the system, or for more flexible learning opportunities for those who are ill, care-givers, or wage-earners.

Families will have less disposable income. This means in part that families will be less able to supplement state expenditure on education; school fees, voluntary funds, transport costs and uniforms – as well as private education and tutoring for some – may become unaffordable, leading inevitably to greater demands on state provisioning.

Educators: Reducing Supply and Quality of Education

In SADC countries, skilled workers seem more vulnerable to the disease: this includes teachers, health workers, government employees and other formal sector members. There is evidence that government ministries and private sector firms are losing key workers to HIV/AIDS at increasing rates. Teachers and other educators are relatively well educated, mobile, and affluent, and thus fall into a population category which is particularly at risk. The incidence of HIV infection among teachers is likely to be above that for the population as a whole. Rates as high as 40% have been reported from parts of Malawi and Uganda. The loss of such valuable human resources is serious and must be factored into overall human resource development planning.

South Africa has an educator cadre of approximately 443,000. Assuming, very crudely, an infection rate of 20-30%, and that, on average, a person who is HIV+ dies within seven years of infection, by 2010 at least 88,000-133,000 educators will have died. There will be in addition, uncountable others who are ill, absent, and dying, or pre-occupied and busy with family crises. As professionals, teachers will often be required to take on responsibility for orphans within the extended family.

Swaziland's recent impact assessment suggested that teachers will leave the profession because they are attracted to better jobs in other sectors where skilled personnel are laid low by HIV/AIDS. A recent assessment by JTK Associates for the Swaziland Ministry of Education estimated that, for every teacher lost, 2.6 more would have to be trained to keep up with demand. And even then, teacher:pupil ratios were expected to decline to 1:50 by 2005[22].

Teacher recruitment targets may be lower than at present if enrolments decline as expected. At the same time however, given uncertainty about likely levels of chronic morbidity, mortality and other types of 'wastage', it is very difficult to make teacher recruitment projections with any degree of confidence. And nothing can make up for the loss of the education service's most experienced senior teachers and managers, and its hard-won cadre of science and mathematics specialists. Recruitment of new trainees to replace teachers lost to the service will be inhibited by fewer numbers of less well-qualified secondary school graduates presenting themselves for teacher training.

Finally, there may be resistance among school managers, educators and support staff against working with HIV+ learners and educators, resulting in dysfunctional education in some areas.

Classrooms: Trauma for Learners and Teachers

Quite apart from its appalling direct death toll, the HIV/AIDS pandemic will have a traumatic impact on all educators and learners. This means that, unless there are appropriate interventions, HIV/AIDS will seriously affect the quality of learning outcomes. At any one time, 30-40% of teachers who are HIV+ will have developed full-blown AIDS. Their work as teachers will be seriously compromised by prolonged periods of illness. Once teachers know they are HIV+, they are likely to lose interest in continuing professional development. And, even among teachers who believe they are not infected (or, most probably, simply do not want to be tested), morale is likely to fall significantly. They will have to cope both emotionally and financially with sickness and death among relatives, friends and colleagues, and wrestle with the uncertainty about their own future and that of their dependents. At the same time, most will also have to take on additional teaching and other work-related duties in order to cover for sick colleagues.

Management: Compromised Leadership

Educational management and development is already fragile at national, provincial and district levels. Provincial and district administrations are finding it difficult, and sometimes impossible, to find sufficient skilled personnel to run complex administrations. At schools level, many principals have not yet received sufficient support or training to enable them to be creative about local management of education. The situation will become worse as the pandemic takes hold. Some private sector companies are training three or four replacements for skilled personnel they expect to lose to HIV/AIDS. No action has yet been taken to secure and protect skilled professionals in the education sector.

There is a commonly-held belief that it is rural people, the unskilled and unemployed who will become infected. In fact, all evidence shows that it is the brightest and best educated who are most vulnerable. They are the future leaders, managers, directors and specialists, and the most difficult to replace. They are the ones who might have led schools and communities in the fight against the pandemic had they lived. They are the ones who would have kept the financial and personnel procedures operating properly. They are the ones who could have guided children and their families through the coming crisis.

As well as managers, the system will lose experienced teacher-mentors and teacher educators in universities and colleges whose career experience cannot be replaced. Younger and less-confident educators will take their place. As a result, the quality of teacher education will inevitably decline.

Summary: HIV/AIDS and the Education System

What does all this mean for education? *Fewer children will enrol in school* because HIV+ mothers die young, with fewer progeny; children die of AIDS complications; and children who are ill, impoverished, orphaned, or careers for younger children, or those who are earners or producers, are out of school. *Qualified teachers, teacher educators, and officials will be lost to education*. They are particularly vulnerable to infection because of

their comparatively high incomes, often remote postings, and social mobility. Other teachers will be lost as they leave education for better jobs elsewhere. TTCs' capacity to keep up with educator attrition will be undermined by their own staff losses. There are likely anyway to be fewer tertiary students as secondary school output and quality goes down, and as higher education itself declines due to staff attrition. *Management, administration and financial control is already fragile*, and HIV/AIDS may make it even more difficult for the system to provide formal education of the scope and quality envisioned by the post-1994 Department of Education. *Sick and death benefit costs are rising*, along with *additional costs for teacher training*. The government will come under increasing pressure to finance other social sectors. Contributions from parents and communities will decline, and many households will no longer be willing or able to keep children in school. Thus the cost of schooling will be shifted back to government. What is ultimately incalculable is the *trauma which will overwhelm individuals and communities*. At the very least, in pragmatic rather than humanitarian terms, *school effectiveness will decline* where 30-40% of teachers, officials and children are ill, lacking morale, and unable to concentrate on learning, teaching and professional matters. All of this means that there will be a *real reversal of development gains*, that *further development will be more difficult*, and that *current development goals will be unattainable*.

PART 6 SOUTH AFRICA'S NATIONAL HIV/AIDS STRATEGY

Background

South Africa is large, diverse and, by SSA standards, relatively well-resourced. It nurtures sophisticated media, an articulate, reasonably well-informed, and critical press. Social services, health services and education services, while struggling to recover from 50 years of apartheid rule, are in place and more or less adequately efficient. Medical schemes complement government clinics and hospitals. Social services operate fairly routinely. Schools enrol kids and teachers teach. There is a place – of some kind – for almost every South African child in school, and enough reasonably well-trained teachers for its classrooms. There is a vibrant (if often under-resourced) NGO/CBO community, and a private sector with some conscience.

While it has taken time for the level and nature of the HIV/AIDS pandemic to be acknowledged in South Africa, there are nevertheless many local schemes for people affected by AIDS: for orphans and street kids, disadvantaged schools, indigents, and rural and inner city women who are victims of sexual violence, among others. They exist in the urban and rural areas, on farms and in towns. Some of these programmes are run by religious organisations, others by individuals, local or national community organisations, charitable trusts and private sector institutions. Websites[23] are being established to enable networks of practitioners to keep in touch, and many people have the technology to access them.

The private sector is addressing the anticipated impact of the pandemic on the South African economy: a number of companies, particularly those in insurance, health, banking and accounting, are looking at HIV/AIDS and staff performance, profits and losses, and investment opportunities. The Metropolitan Life Group has, for example, established an AIDS Research Unit providing advice to public, NGO and private sectors.

A Foundation for National, Multisectoral Action

This briefing note could identify a handful of these initiatives, and analyse the contribution they make to HIV/AIDS impact management, or the lessons they provide for human resource development in South Africa. On the other hand, there is probably as yet no agreement about what criteria should be applied when analysing the benefits or otherwise of individual programmes. Further, the parameters of this assignment do not allow for such detailed micro-analysis.

It is perhaps just as useful for now to examine the extent to which the foundation for launching a national HIV/AIDS prevention, control and management strategy for the education sector is in place in South Africa. Experience in the region suggests that for change to take place, an enabling environment needs to exist. There are at least five elements which need to be in place to sustain the intense creative action now required in

order to make headway made against the ravages of HIV/AIDS in South Africa. The principal elements are:

- consensus
- information, policy and planning
- resources
- partners, and
- management capacity.

Is there a degree of consensus about what the problems are, and what needs to be done to address them? Is there a policy and planning framework? Are there adequate human and financial resources for implementation? Are authorities – in and out of government – working consultatively and in partnership? Do appropriate management capacities and infrastructures exist for making decisions and implementing them?

What information? South Africa collects information and reports systematically on the pandemic.[24] Regular reports are available: the 1997 and 2000 national reviews, the 1998 HIV/AIDS Survey by the Department of Health, and annual UNDP reports, NACTT's Rapid Appraisal, and so on. A standard modelling construct has been devised and applied (the Doyle model[25]) to predict the course of the pandemic.

For the most part, information collection and reporting has thus far tended to concentrate on medical matters. Apart from annual contributions from the UN group, little information is available about how the pandemic will influence the organisation and operation of individual public and private sub-sectors. There is no coherent national or sectoral research agenda which would allow data to be systematised, analysed, and made available as a basis for strategic planning.

What consensus, policy and plan? South Africa has had HIV/AIDS strategies in place since 1994.

(1) **The *South African Strategy and Implementation Plan***, endorsed by Cabinet in 1994, was a consultative formulation prepared through NACOSA (the National AIDS Coordinating Committee of South Africa launched in 1992). The costed plan was comprehensive and practical, and designed to prevent the spread of HIV/AIDS, to reduce the impact of HIV/AIDS, and to harness existing and potential resources.[26] It viewed the epidemic as *both* a medical and a social issue.

By 1998, the National AIDS Programme, located in the Department of Health's Directorate: HIV/AIDS and STDs, had 18 staff and 7 consultants. Nine provincial programmes were in place by that year. District level HIV/AIDS or communicable disease coordinators were being put in place, complemented by 15 AIDS Training, Information and Counselling Centres in eight provinces.[27]

(2) The Minister of Health has announced (June 2000) the launch of a new ***HIV/AIDS/STD Strategic Plan for South Africa, 2000-2005***, for funding purposes. The document is intended to be a broad national strategic plan to guide the country's response as whole to the pandemic. It is described as a guidance document to enable all stakeholders to develop and harmonise strategic and operational plans for (a) reducing numbers of new HIV infections, and (b) reducing the impact of HIV/AIDS on individuals, families and communities. The plan focuses on four areas: prevention,

treatment and support, human and legal rights, and monitoring, research and surveillance.[28]

There is nothing in the document which speaks to the potential social, economic and infrastructural impact of the pandemic on vital national sectors like labour, education, agriculture, the public service, or business. It is concerned with learning about the predisposing factors of the epidemic, preventing or finding a cure for HIV/AIDS, and monitoring health interventions. In a sense it is perhaps a step backwards.

The strategic plan document sets out a structure for implementation at national and provincial levels (Figure 1).

(3) The ***National Integrated Plan for Children Infected and Affected by HIV/AIDS*** has been drafted for Cabinet approval. The plan, driven thus far by the Department of Health, has been designed cooperatively by the Departments of Health, Education and Welfare. Although this plan is aimed principally at implementing and supplementing the Life Skills Programme for schools, its elements speak directly to alleviating the impact of the pandemic on children and their families. The overall goal of the plan is 'to ensure that children have access to integrated prevention and support services which address their basic needs for food, shelter, health care, family or alternative care, information, education, and protection from abuse and maltreatment'.[29]It is designed to strengthen the teaching of Life Skills in primary and secondary schools; to develop strategies for caring for orphans and people living with HIV/AIDS; and to find ways to make voluntary testing and counselling available.[30]

(4) These are only three facets of government's total HIV/AIDS strategy. The full range of activities is outlined in the *National Integrated Plan for Children*, Annexure B.

What resources? During the '90s the AIDS budget doubled, and further funds were raised from European Union, the Belgian government, and other international agencies. HIV/AIDS was ranked as one of government's 20 social priorities, potentially earning the programme privileged access to resources: almost R50 million in foreign funding was raised to finance it. In 2000, R450 million, additional to sectoral budgets, has been allocated by the Department of Finance over three years for the new integrated strategy on children affected by HIV/AIDS involving the Departments of Health, Education and Welfare. Provincial administrations are currently preparing business plans for using these funds (to be finalised 7 July 2000). USAID, DfID, EU and other international cooperation agencies continue to make substantial financial and technical contributions to government and NGOs.

During the 1990s, budgets were generous, not lavish. They were nevertheless substantially under-spent. In the 1996/97 financial year for example, only 14% of the programme budget (R80 million) was spent three-quarters through the financial year, and R14.6 million was rolled over to the next financial year. Small amounts could be used easily, but large amounts had to pass through time-consuming tender processes. That meant lots of small projects, often pilot projects, which did not amount to a coherent or consistent programmed response. At the same time, cuts in support to HIV/AIDS service organisations forced some to close.

Forty per cent of government's 1999/2000 HIV/AIDS budget was unspent. Funding for community organisations was cut by 43% in the current budget, although the total HIV/AIDS budget increased by 73%.

The problem of getting resources into provinces and districts where implementation takes place, and then out to schools, NGOs and CBOs who are providing first-line support to families, communities and institutions is being addressed by the Department of Finance. Issues of allocation, management, common funding mechanisms, and accountability are all involved.

Which partners? International agencies, including the EU, DfID, and USAID in particular, have made substantial technical and financial contributions to national HIV/AIDS activities. Some universities – University of Natal Durban, and the University of Pretoria in particular – are highlighting HIV/AIDS issues and addressing them. Approximately 650 AIDS-related NGOs, most of them working at local level, are operating at grassroots.

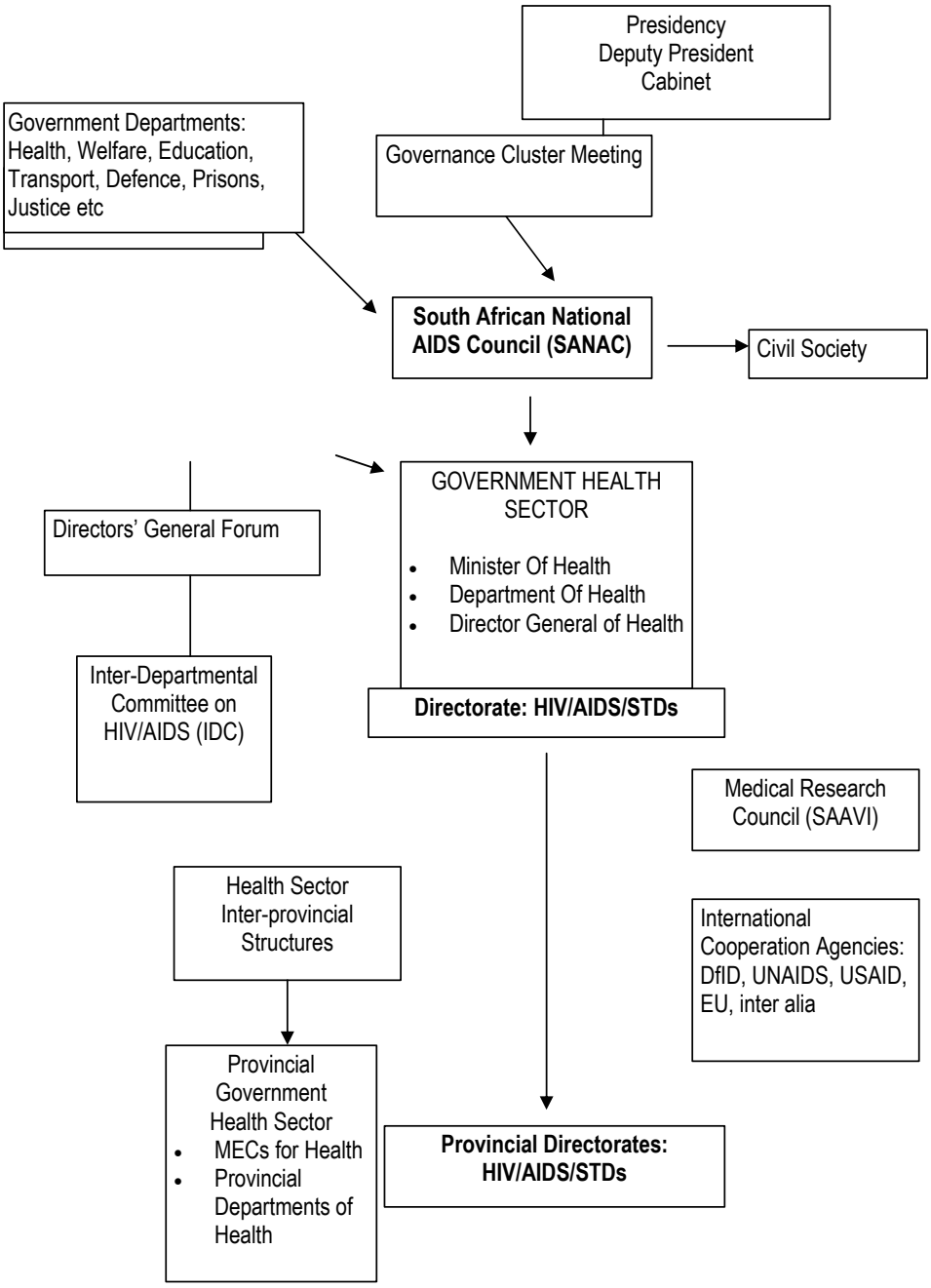
The 1994 national plan made clear that an effective response to the pandemic hinged not only on a programme of activities mounted by the state: effective implementation depended on how well they could be coordinated and harmonised with the endeavours of civil society. The mutual trust, effective consultation, and practical collaboration on which the plan depended has however never materialised. The multi-faceted national infrastructure responsible for coordination and coherence has been re-designing itself regularly over the past six years. Whether this is a cause or effect of organisational and procedural problems among partners is not clear.

The DoH's new organigram (Figure 1) is complex in the extreme. Even so, it does not reflect all participating structures and partners, but only those related to the health sector. It is only vaguely understood by those struggling in its mesh. If it is replicated at provincial and local levels confusion may be compounded – in terms of reporting and communication, allocation of resources to government and nongovernment units, and lines of responsibility, accountability and delegation. It continues to be difficult to understand and analyse who is doing what, and how each relates to the other. It is perhaps symptomatic of the DoH approach to HIV/AIDS that international organisations are hanging in a vacuum, that NGOs and CBOs are only mentioned as they are represented officially on the South African National AIDS Council (SANAC), and that nowhere is provision made for impact planning and mitigation.

What management capacity? South Africa's HIV/AIDS strategy has been driven primarily by the HIV/AIDS and STD Directorate of the Department of Health. Practical implementation of the plan has been the responsibility of coordinators in provincial health departments, supported by (often understaffed and under-resourced) AIDS Training and Information Centres (ATICs).

At the outset in 1994, provincial authorities responsible for implementing the plan were understaffed, slow to set up formal AIDS programmes, and failed initially to appoint provincial coordinators with enough clout and experience. There was little capacity to achieve national plan objectives. Coordinators were linked to health departments as a support function to district structures, and had little opportunity for cross-sectoral coordination.

FIGURE 1: HEALTH SECTOR NATIONAL AND PROVINCIAL STRUCTURES (HIV/AIDS/STD STRATEGIC PLAN FOR SOUTH AFRICA, 2000-2005)



Lessons from the 1994 HIV/AIDS Programme

In theory, the 1994 National AIDS Plan could have worked. Instead, the HIV prevalence rate rose from 0.7% in 1990 to over 22% in 1999. The plan was not implemented as envisaged. South Africa has failed to manage and control the spread of HIV/AIDS and as a result, 'we stand deprived of cogent understandings of many of the social dynamics that help the disease's spread….And so we are left stranded with only the faintest grasp of what can or cannot, what does or does not work as we seek to stave off the disaster of the AIDS epidemic'.[31]

This following review of plan implementation concentrates on issues generally related to children and their communities. Most information relates to national programmes. Little systematic information is readily available about what benefits might or might not be accruing to individual children, their parents and teachers, and their schools.

What was accomplished?

Focus on children. Government, nongovernment, and agency personnel have ensured that HIV/AIDS policy places strong emphasis on children who are infected and affected by AIDS, and this is reflected in the Provincial departments are finalising HIV/AIDS business plans to be funded by the three-year special allocation from the Department of Finance. The total national/provincial allocation for HIV/AIDS work in education cannot be estimated. Financial and technical support comes from DoF, provincial legislatures, international development cooperation partners, and the business community. The most significant sum for education is R450 million released in June 2000 as extra-budgetary support for Life Skills and related programmes over the next three years (starting with R75 million in 2000). There is an Inter-Ministerial Committee on Youth at Risk and a draft Strategic Framework for a South African HIV/AIDS Youth Programme.

Structures. There is an HIV/AIDS coordinator in each province. A structure is in place for developing, implementing and monitoring national HIV/AIDS programmes, including

- The *Inter-Ministerial Committee on HIV/AIDS (IMC)*: Ministers and Deputy Ministers meeting monthly to provide political and policy guidance and to promote the Partnership Against AIDS Campaign;
- The *Inter-Departmental Committee on HIV/AIDS (IDC)*: to develop workplace policies and minimum HIV/AIDS programmes for all government departments;
- The *South African National AIDS Council (SANAC)*: a multisectoral body chaired by the Deputy President to oversee national programme implementation; advise government on policy; advocate and strengthen collaborative strategies; mobilise resources; and recommend appropriate research; and
- SANAC's *Technical Task Teams* in the areas of prevention, care and support, social mobilisation, research/monitoring/surveillance and evaluation, and legal issues/human rights;
- The *National Aids Coordinating Committee of South Africa (NACOSA):* now established as an independent NGO focused on lobbying, advocacy, networking and NGO capacity-building, and operating in all nine provinces, as well as at national level.

Education, health and welfare in general. Programmes are in place to address the management of STDs, poverty alleviation, and universal household food security, and to improve collaboration between HIV/AIDS/STD and TB programmes. The South African

AIDS Vaccine Initiative has been established to develop affordable preventive vaccine for universal use in SADC by 2005. The Department of Education has established workplace policies for educators at national level, and a policy for learners and educators at all levels.[32]

Children in school. The Life Skills programme has been approved by the Department of Education. Learners are being taught, and teachers and counsellors trained within this context.

Children who are infected or affected by HIV/AIDS. The new national strategy for children (presented by the Departments of Education, Health and Welfare, and monitored by NACTT) presents a coherent package for teaching and learning about HIV/AIDS. Counselling and mentoring programmes are underway. Children under the age of 6 have access to free health care, and the Department of Welfare has developed proposals to encourage foster care and adoption of HIV/AIDS orphans.

Business contributions. The private sector has been active. ESKOM by 1995/96 declared HIV/AIDS a strategic priority, followed by others including Anglo-American, Telkom, ABSA Bank, BP South Africa, Tongaat-Hulett and Afrox, Harmony Gold Mines (Lesedi Project), and Metropolitan Life Group. Business supports a variety of programmes: the Soul City TV show; care and support of HIV/AIDS-affected individuals using PWAs as coordinators; campaigns targetting men and boys involved in soccer; AIDS counselling and education. The Treatment Action Campaign has forged strong links with labour. Spoornet sponsored 'On the Right Track' in 1999, a women-focused train conference with various stopovers involving government officials, politicians, and civil society.

Nongovernment organisations. There are about 650 active NGOs 'with an interest in HIV/AIDS': working on HIV/AIDS, along with workplace, community-based, health, religious, legal, media, academic and other groups. There is substantial potential for marshalling the resources, expertise and commitment accumulated among such organisations into a coordinated state-led campaign.

Review and monitoring. National policy, planning and implementation is under constant review. The University of Pretoria and the University of Natal Durban have led the evaluation process, but various government documents – like recently published strategic plans – provide regular assessments. Further objective analysis and hard-nosed evaluation of implementation at local levels is required.

What went wrong?

Despite the commitment of the government to address the HIV/AIDS pandemic, the scale and magnitude of its efforts have not been sufficient to deflect the pandemic.[33] *AIDS Review 2000*[34] suggests that 1994 plan implementation has been impeded principally by problems of process and context, structure and organisation, rather than by the technical content of the plan, and identifies complicating factors.

Lack of political commitment. Political leaders wear the HIV/AIDS red ribbon. But too often they have not been committed personally to fight the pandemic, to master the technical, social and ethical details of the struggle, and to stand and deliver. Education Minister Kader Asmal is one exception to this rule.

> *[Plan implementation] emphasised the biomedical, behaviourist model of health intervention. This model hinges on aiding and persuading individuals to make certain behavioural choices despite the constraints created by social status. It is an approach that avoids looking at the complex social transactions people perform in order to position themselves as advantageously as possible in society. Essentially, it is a rationalist approach that sees behaviour as the outcome of transparent, predictable and consistent decisions that can be altered by new, equally rational, inputs. Applied to HIV/AIDS it runs into two problems: HIV/AIDS is a disease that seems to defy rationality, and the approach shows a profound lack of knowledge and understanding of stressed social behaviour.* [35]

Contextual complexities. During the period of the 1994 plan, South Africa was making a fundamental political transition which inevitably occupied the time, energy, and best resources of politicians, activists, policy-makers and officials.

Lack of vision and authority. The decision to lodge the National AIDS Plan within DoH reinforced the perception of HIV/AIDS as a medical issue. After 1998, the HIV/AIDS Unit's prominence declined, it lacked access to executive power, and its work was couched in a biomedical framework. The Unit's head was appointed at Director level, and her authority was nominal. The 1994 plan was not effectively linked with other efforts aimed at socio-economic transformation.

Lack of management capacity at national level. The 1994 plan was introduced at a time when the public bureaucracy was restructuring. In fact, 'the tragedy of South Africa and the AIDS epidemic is that the time at which something could be done was also the time of the transition. So, despite the warning and the incredible research, the plan effectively went onto the backburner'.[36] There have been – sometimes intolerable – bureaucratic and other delays in appointing staff; a lack of familiarity with government's procedures; struggles with a rules- and regulations-bound bureaucracy; and a mood of general insecurity among the bureaucracy's complex regulatory and procedural systems.

Criticism of government has been interpreted as an attack, and therefore unconstructive. Trust between government and potential partners was fragile; divisions have developed among personnel organisations working on HIV/AIDS. This persists to the present.

Lack of capacity and commitment at provincial and local levels. Responsibility for practical action lies within the jurisdiction of provinces. They have too often lacked commitment, understanding and leadership capacity. Some provinces have not spent their HIV/AIDS allocations, but the quasi-federal nature of government has meant that national departments have had no control over provincial spending priorities. In several provinces, HIV/AIDS work has been sustained largely by NGOs and CBOs.

Inertia has too often characterised provincial AIDS programmes. They have had difficulty assigning responsibilities and authority needed to coordinate a programme through various levels. They, like many NGOs, mistrusted or even resented centralisation at national level, and the tendency for 'national government to be prescriptive and patronising while much of the work lies with the provinces'.[37]

Desultory partnerships. Anticipated cooperation between government, civil society, trade unions, and the business community failed to take off. Government seemed to shun the skills and experiences of local organisations and NGOs. National and community groups were further demoralised when the bulk of international development

agency support was directed through Ministry of Health and away from the NGO sector. Mutual trust failed amidst funding problems, organisational difficulties, staff losses and strategic confusion. Even NACOSA had to battle for its existence, as its role as a body that would coordinate HIV/AIDS activities in concert with government dissolved in the mid '90s.

Diversions. The Sarafina II scandal, the Virodene controversy, the AZT debacle, and the confusion generated by the position taken by President Mbeki early in 2000, generally led to the demise during the 1990s of a shared vision for AIDS. All have distracted public and politicians from AIDS education and prevention work, and diverted energies away from the real challenges of implementation towards specific controversies.

Conclusion

In 2000, government has attempted to revamp its national campaign strategies. There is inevitably a degree of cynicism about whether it will succeed. The *Pretoria News* reported on 28 June that 'the government's Partnership Against AIDS programme director…said the government had 'grand plans' to fight the epidemic, but failed to answer questions about details. [She] listed recent Youth Day campaigns, empowerment of communities, school-based AIDS education, and the South African National AIDS Council among government responses to the epidemic. "Government is doing something, and government is committed to the cause", she said.'

Government plans may be coherent, but implementation has been deeply flawed. Lessons from the 1990s suggest that lack of vision, political commitment, management capacity at all levels, and ability to work effectively with local partners continue to inhibit performance. The lessons of the '90s are not necessarily being factored into new structures and organisational paradigms.

PART 7 EFFORTS TO MANAGE THE IMPACT OF HIV/AIDS ON THE EDUCATION SECTOR

Within this context, and with the lessons of the '90s in mind, it is time to consider South Africa's attempts to cope with the impact of the pandemic on education.

South Africa's new draft HIV/AIDS strategic plan (2000-2005) concentrates principally on biomedical problems. It is essential now – and this has been a recurrent theme of this paper – to recognise that HIV/AIDS is not just a set of health issues. The pandemic inevitably brings with it social, economic, management and planning consequences for education in South Africa.

1980-2000: *The Health Problem*

Problem:	There is a deadly virus which is killing people.
Action:	We need to contain the virus.
Strategy:	What needs to be done? Who is responsible? Who is accountable?

2000+: *The Social and Institutional Problem* (as well as the continuing health problem)

Problem:	The deadly virus has not been contained; it is having a profound affect on our communities, societies, and cultures, quite apart from its impact on individuals.
Action:	We need to understand how the virus is affecting our communities and institutions, to learn to live with the virus which we are failing to contain, and to mitigate its impact as much as possible.
Strategy:	What needs to be done? Who is responsible? Who is accountable?

Practical experience and anecdotal evidence in the region suggests that an effective response to HIV/AIDS requires four balanced focuses by educators, education policy-makers and planners, and their partners in other sectors.

(1) ***Learning*.** The sector needs information about **conditions which encourage the spread of HIV/AIDS** and **how best to educate those at risk**. Much has been learned from the history of the pandemic in the SADC region; much more needs to be learned about sexual practices and HIV/AIDS-related behaviours. Evidence about sexual violence and abuse, bisexuality and same-sex relationships, incest, intercourse with young children complicate current understandings of HIV/AIDS as a disease which is spread by heterosexual consensual sex. New and more robust evidence must inform HIV/AIDS teaching and learning, particularly in Life Skills programmes.[38]

(2) ***Preventing.*** Children, their parents and communities need comprehensive health education aimed at **preventing and controlling the spread** of the disease among young people in and out of school. This has been the principal strategic focus up to now, as HIV/AIDS campaigns have emphasised health issues, and been driven by health personnel.

(3) ***Understanding*.** The sector needs much more information in order to comprehend **the impact of the pandemic on the education sector** – on the teaching service, classrooms, teachers, children, communities, and sector management. This is increasingly important as the plague spreads through all communities. The sector also needs to understand what is happening to skilled workers in other sectors of the economy.

(4) ***Responding*.** The education sector needs to devise and put in place strategies for **reducing, managing and controlling the impact** of the pandemic on the education sector; and to **predict and respond to the impact** of the pandemic in a variety of ways. Considered and creative responses to mitigate and manage the pandemic's consequences for education are now vital if education and training of reasonable quality is to be provided in South Africa.

Agreement about the need to take action in all four ways is only slowly emerging in South Africa, in part because HIV/AIDS planning is led principally by DoH. The narrow health-focused approach also reflects a reluctance to recognise in any practical way that matters have gone beyond just trying to prevent the spread of HIV/AIDS. The education sector should expect to move urgently into a new planning and management paradigm which responds to the influence of the pandemic on South African's lives.

The Responsibilities of South African Departments of Education

Quality Education for All. The Department of Education is committed to quality education for all. Its first White Paper on Education and Training (March 1995) spelled out DoE's obligations:

> *The overarching goal of policy must be to enable all individuals to value, have access to, and succeed in lifelong education and training of good quality. Educational and management processes must therefore put the learners first, recognizing and building on their knowledge and experience, and responding to their needs. An integrated approach to education and training will increase access, mobility and quality in the national learning system.*
>
> *The system must increasingly open access to education and training opportunity of good quality to all children, youth and adults...The Constitution guarantees equal access to basic education for all. The satisfaction of this guarantee must be the basis of policy. It goes well beyond the provision of schooling. It must provide an increasing range of learning possibilities, offering learners greater flexibility in choosing what, where, when, how and at what pace they learn.*
>
> *'There must be special emphasis on the redress of educational inequalities among those sections of our people who have suffered particular disadvantages, or who are especially vulnerable, including street children, out-of-school youth, the disabled and citizens with special educational needs....*[39]

When these obligations were spelled out, overcoming the legacy of the apartheid holocaust was DoE's priority. DoE's commitments remain the same in the face of the HIV/AIDS pandemic: departments of education are responsible to provide access to quality education for all learners. It is this general responsibility which is being particularly challenged by the HIV/AIDS pandemic. It is the quality and extent of education provision itself which is at risk.

The Department of Education has recognised its responsibility to 'minimise the social, economic and developmental consequences of HIV/AIDS to the education system, all

learners, students and educators, and to provide leadership to implement an HIV/AIDS policy'.[40]

Children's Rights and HIV/AIDS. The Nineteenth Session of the Committee on the Rights of the Child (October 1998) recommended that HIV/AIDS programmes should be children's rights-centred, that states, programmes and agencies of the United Nations system, and NGOs, should be encouraged to adopt a children's rights-centred approach to HIV/AIDS, that states should incorporate the rights of the child in their national HIV/AIDS policies and programmes, and include national HIV/AIDS programme structures into the national monitoring and coordinating mechanisms for children's rights.[41]

The South African Law Commission's *Consultative Paper on Children Infected and Affected by HIV/AIDS*[42] specified that

- Learners with HIV/AIDS should not be unfairly discriminated against; any special measures to be taken in respect of a learner with HIV/AIDS should be fair and justifiable in the light of medical facts, school conditions and the best interests of the learner or those of other learners.
- No learner should be defined admission to or attendance at school on the basis of his or her HIV status.
- Testing of learners for HIV for admission to or attendance at school is prohibited.
- The needs of learners with HIV should be accommodated within the school environment, as far as is reasonably practicable.
- A learner's HIV status is confidential and may not be disclosed without his or her consent, or the consent of his or her parent or guardian. No learner, or his or her parent or guardian is compelled to disclose his or her status to the school authorities.
- All schools should implement universal precautions to eliminate the risk of transmission of blood-borne pathogens, including HIV, in the school environment.
- While the risk of HIV in contact play and sport is insignificant, all schools should take measures to eliminate this risk. This includes the use of universal precautions, and prohibiting any learner from participating in any contact sport with an open wound, sore, break in the skin or open skin lesion.
- A continuing HIV/AIDS education programme should be implemented at all schools for all learners, educators and other staff. This includes, inter alia, cultivating an enabling environment and a culture of non-discrimination towards persons with HIV, and encouraging learners to use health care, counselling and support services offered by community service organisations and other disciplines.

The resource manual *HIV/AIDS and the Law*[43] identifies children's rights which are directly in jeopardy because of HIV/AIDS.

- Access to education – the Bill of Rights specifies the right to basic education. A child cannot be excluded from any school because of his/her HIV status.
- Right to sexuality education – the CRC states that a child should have access to information that will help develop his/her physical and emotional wellbeing. The Children's Charter of South Africa states that children have a right to be educated about sexuality and AIDS. All children therefore have a right to sexuality education.
- Testing of children and confidentiality of results – the Child Care Act protects the rights of children, including their medical treatment. At the age of 14, a child can legally consent to an HIV test and he/she has the right to keep the results private.

- Adoption – Child Welfare requires that future parents be told if a child is HIV+.
- Right to contraception and reproductive health – the Constitution provides that all children have the right to health. Children thus have the right to protect and control their reproductive health.

The National Department of Education's Strategy and Work Plans: Tirisano[44]

DoE's current strategy on HIV/AIDS gives practical substance to concerns about health of learners and educators on one hand, and its impact on the education service on the other. Minister Kader Asmal's *Call to Action: Tirisano* (July 1999) committed his Department to reconstruction and development in all phases of the system, and at every level, working with all partners in education. There are nine priorities in the *Call to Action*, including HIV/AIDS:

> *We must deal urgently and purposefully with the HIV/AIDS emergency in and through the education and training system. This is the priority that underlies all priorities, for unless we succeed, we face a future full of suffering and loss, with untold consequences for our communities and the education institutions that serve them. The Ministry of Education will work alongside the Ministry of Health to ensure that the national education system plays its part to stem the epidemic, and to ensure that the rights of all persons infected with the HIV/AIDS virus are fully protected.*[45]

The Department of Education's *Corporate Plan (2000-2004)* outlines how the national department will fulfil its mandate. Its *Implementation Plan for Tirisano (2000-2004)* specifies strategic objectives and anticipated outcomes within each programme.[46]

Tirisano Programme 1: HIV/AIDS

Project 1: Awareness, information and advocacy

- ***Strategic Objectives***: to raise awareness and the level of knowledge of HIV/AIDS among all educators and learners; to promote values, which inculcate respect for girls and women and recognise their right to free choice in sexual relations.

- ***Anticipated Outcomes***: increased awareness, understanding, knowledge and sensitivity of the causes of HIV/AIDS, its consequences and impact on individuals, communities and society in general; eradication of discriminatory practices against individuals affected by HIV/AIDS; development of HIV/AIDS policy for the education and training system; change of attitude and behaviour towards sexuality.

- ***Outputs***: copies of HIV/AIDS policy distributed to all education and training institutions (February 2000); information materials available in all education and training institutions (October 2000); gender sensitivity part of all learning programmes (ongoing, starting October 2000).

- ***Performance Indicators****:* myths about HIV/AIDS are eradicated; increased acceptance of the need to practice safe sex; establishment of non-discriminatory practices in all education and training institutions, including departments of education; finalisation of the HIV/AIDS policy; popular material on HIV/AIDS is readily available; visible change of attitude towards girls and women.

Project 2: HIV/AIDS within the curriculum

- ***Strategic Objectives***: to ensure that life skills and HIV/AIDS education are integrated into the curriculum at all levels.

- ***Anticipated Outcomes***: every learner understands the causes and consequences of HIV/AIDS; all learners lead healthy lifestyles and take responsible decisions regarding their sexual behaviour.

- ***Outputs***: materials for primary schools (June 2000); educators trained to facilitate life skills and sexuality in education (ongoing, starting June 2000).

- ***Performance Indicators***: Life Skills and HIV/AIDS education is integrated across the curriculum; Increase in knowledge of, and changed attitudes towards, sexuality and HIV/AIDS among learners; reduction in incidence of HIV/AIDS among learners.

Project 3: HIV/AIDS and the Education System

- ***Strategic Objective***: to develop planning models for analysing and understanding the impact of HIV/AIDS on the education and training system.

- ***Anticipated Outcomes***: plans and strategies to respond to the impact of HIV/AIDS on the sustainability of the education and training system, and the human resource needs of the education and training system in particular, and of the country more generally; establishment of care and support systems for learners and educators affected by HIV/AIDS.

- ***Outputs***: national plan to deal with the impact of HIV/AIDS on the education and training system (December 2000); impact studies (December 2000); reliable statistical database on the impact of HIV/AIDS (July 2000).

- ***Performance Indicators***: improved data and planning models are available; impact studies on all aspects related to the education and training system have been initiated and/or completed; responsiveness of national and provincial education plans and strategies to the impact of HIV/AIDS.

Taking Action

Some systems, procedures, and decision-making structures for driving Tirisano's HIV/AIDS programme are provisionally in place. Experienced people have been appointed at national level, including an HIV/AIDS advisor to the Minister, and a 'champion' for DoE's HIV/AIDS programmes. The Chief-Director: General Education (the 'champion' for HIV/AIDS issues) is accountable for implementation of programmes. Day-to-day responsibilities for components of DoE's strategy are concentrated in two of DoE's four branches.

Branch: Planning and Monitoring
- Chief Directorate: Human Resources and Planning (***labour relations***)
- Chief Directorate: Financial and Physical Planning
  - Directorate: Education Management Information Service (***impact assessment***)
- Chief Directorate: Corporate Services
  - Directorate: Staffing Services (***headquarters HIV/AIDS workplace policy***)

Branch: General Education
- Chief Directorate: General Education (***HIV/AIDS coordination***)
  - Directorate: School Education (***Life Skills Project Committee***, with DoH and DoW)

Units are intended to work collegially with guidance from the HIV/AIDS 'champion', although the inter-Branch committee on HIV/AIDS has not yet met this year.

Two HIV/AIDS contract posts are being made available to each provincial education department for three years. Although these posts are generally meant to be for HIV/AIDS-in-education coordination, they are most closely linked to implementation of the Life Skills curriculum in schools.

It will take time before structures and personnel are working effectively. Directorates and individual personnel lack clear mandates, perhaps because the parameters of the task are not yet appreciated. Officials are under such pressure that there is little time for cooperation. Tensions inevitably rise between staff in different departments, different directorates, and at different levels. As a result, structures are out of phase, and disjunctures and overlaps arise.

Overworked officials consequently tend to focus narrowly on a single task or set of tasks which can be carved out of the whole, and for which tangible outcomes can relatively easily be identified. This results in inconsistency and lack of coherence. It also means that as personnel change, so the focus changes: implementation depends heavily on the energy, commitment and professional preferences of the individual in post.

Provincial education departments are finalising HIV/AIDS business plans to be funded by the three-year special allocation from the Department of Finance. The total national/provincial allocation for HIV/AIDS work in education cannot be estimated. Financial and technical support comes from DoF, provincial legislatures, international development cooperation partners, and the business community. The most significant sum for education is R450 million approved in June 2000 as extra-budgetary support for Life Skills and related programmes over the next three years (starting with R75 million in 2000).

In June 2000, the resourcing scene was chaotic: business plans were not ready at national or provincial level; funds expected from agencies had not been secured; and procedural requirements for accessing funds were time-consuming and complicated. Where budgets were ready, funding delays disrupted planning and action.

NGOs and CBIs in general felt they were substantially under-resourced in current partnership arrangements, and little is known about how this problem is being resolved.

DoE is committed to cooperation in theory; in practice, it is not clear how service providers at provincial and local levels are to be strengthened, resourced and sustained.

Sustainability and affordability of programmes, costing of services, provision for cooperating funding mechanisms, and effective use of resources are matters still to be clarified by the Departments of Finance and Education.

Working on Health Issues: Learning and Preventing

National Policy on HIV/AIDS for Learners, Students and Educators[47]

In August 1999, DoE published policy and guidelines for learning institutions, where increasing numbers of staff and students are HIV+. Government Gazette No 20372 specifies that:

- the constitutional rights of all learners and educators must be protected equally
- there should be no compulsory disclosure of HIV/AIDS status
- the testing of learners as a prerequisite for attendance at an institution, or of an educator as a prerequisite of service, is prohibited
- no HIV+ learner or educator maybe discriminated again, but treated in a just, humane and life-affirming way
- no learner may be denied admission to or continued attendance at an institution because of his or her actual or perceived HIV status
- no educator may be denied appointment to a post because of his or her actual or perceived HIV status
- learners and educators who are HIV+ should lead as full a life as possible
- infection control measures must be universally applied to ensure safe institutional environments
- learners must receive education about HIV/AIDS and abstinence in the context of life-skills education as part of the integrated curriculum
- educational institutions will ensure that learners acquire age- and context-appropriate knowledge and skills so they can behave in ways that will protect them from infection
- educators need more knowledge of, and skills to deal with, HIV/AIDS and should be trained to give guidance on HIV/AIDS.

The Director-General of Education, and Heads of provincial departments of education are responsible for implementing this policy. Every education department is required to designate an HIV/AIDS Programme Manager, and a working group to communicate policy to all staff, to implement, monitor and evaluate DoE's HIV/AIDS programme, and to advise management regarding programme implementation and progress. The principal is responsible for implementation of the policy at school. School governing bodies are expected to take reasonable measures to supplement government allocations for health and safety equipment.

The Life Skills Programme. In November 1995, the Department of Health and the Department of Education formed the National Coordinating Committee for Life Skills and HIV/AIDS whose highest priority was to establish a Life Skills and HIV/AIDS education course in secondary schools (Grades 8-12). The goal of the programme is to increase knowledge, develop skills, promote positive and responsible attitudes, and provide motivational support.[48]

The National Project Committee supervised the development of the Life Skills curriculum, and guidelines for its implementation at national level. At provincial level, each Department of Education is preparing its own implementation plans.

In 1998, the Planned Parenthood Association of South Africa (PPASA) and Community Agency for Social Enquiry (CASE) reviewed teacher preparation and curriculum implementation and according to the Department of Health, identified the following problems: teachers need further inservice training to deal with Life Skills; master trainers and teachers lost to the programme need to be replaced; and those working on the programme need to be regularly re-trained; and more work needs to be done with officials at middle management levels (area and district managers, and principals), and with representatives of school governing bodies.

In March 2000, a joint assessment of the Life Skills programme in more than 250 secondary schools in KwaZulu-Natal Province concluded that while the Life Skills programme is a 'key strategy in the state's response to the epidemic, we know little about the programme's effectiveness, or the way in which Life Skills training combines with other resources in families or in communities to influence reproductive outcomes'. [49] The study concluded that coverage and content of life skills education vary greatly between schools: While 95% offer at least one of the 11 Life Skills topics, 18% offer a full Life Skills curriculum. The Core Life Skills Programme (six topics) are offered to 22% of students at some point in the secondary school cycle, and are more likely to be taught in schools that require higher fees and other parental contributions, and which have better materials and facilities in general. Students in schools with a predominantly African student body are least likely to receive training. Gender, age and qualifications of principals do not seem to determine whether or not the Life Skills topics are offered. But the survey showed that schools where principals judge students to be at high or moderate risk for pregnancy or infection were the least likely to offer Life Skills topics.

There are currently about 21,3000 primary schools with 8.4 million learners. This means training 64,000 primary school educators, and 21,000 lay counsellors. At secondary level, there are 4,966 secondary and 2,542 combined schools, with over four million learners. Monitoring implementation of Life Skills activities on such a large scale has been difficult, and a national survey to determine the programme's effectiveness will take place in 2000. Materials need updating and revision, more master teachers and counsellors need to be trained, and models of peer-group support need to be explored.

Western Cape Province Department of Education: Life Skills. WCED is appointing three HIV/AIDS-dedicated staff: a manager, a coordinator, and a technical support staff member. Its work is focused very specifically on implementation of the Life Skills Programme in secondary and primary schools: a business plan for HIV/AIDS-Life Skills education; workshops and intersectoral meetings; a situation analysis of Life Skills teaching at secondary level; an audit of NGO-Life Skills projects currently running in schools; dissemination of UNAIDS documents to all schools. Twenty school clinics have been established by the Department in the Province and the full school clinic programme will roll-out during the next two years to all schools. Clinics are supported by area medical/social/psychology teams[50].

Gauteng Department of Education. The Department has launched the Life Skills programme. Its Deputy Director-General outlined the Department's attempts to control

violence in schools on which the pandemic thrives. GDE now has in draft a training module to help principals and other educators to deal with sexual violence and harassment, and create appropriate guidelines for policy and practice in school. District officials are being trained, with support from DoH, to provide assistance to teachers on HIV/AIDS, Life Skills curriculum, sexual and substance abuse, teaching learners to say NO to drugs and violence, and developing greater assertiveness among young women. The Victim Empowerment Programme focuses on informal settlements in the Vaal area of the province, to empower women who are particularly vulnerable to male abuse. The Department's employee assistance programme is designed to assist education staff to deal with sexual harassment in the workplace.

The HIV/AIDS Emergency Guidelines for Educators. DoE's guidance notes for teachers in all South Africa schools are being distributed through provincial structures. The guidelines establish HIV/AIDS as a national emergency which will affect every learner and educator. DoE calls for a concerted 'struggle' against the pandemic by all organs of society, for openness, dignity in illness, and care for those affected by HIV/AIDS. It sets out the role of educators: exemplifying responsible sexual behaviour, spreading correct information, leading discussion among learners and parents, creating a work environment which does not discriminate against those who are affected, and supporting those who are ill, and thus 'making the school a centre of hope and care in the community'.

The booklet targets male educators especially:

> *Male educators have a special responsibility. There must be an end to the practice of male teachers demanding sex with schoolgirls or female teachers. It shows selfish disrespect for the rights and dignity of women and young girls. Having sex with learners betrays the trust of the community. It is also against the law. It is a disciplinary offence.*[51]

HIV/AIDS in the Workplace. The Corporate Services Chief Directorate of DoE has prepared guidelines on HIV/AIDS in the workplace for personnel at headquarters. Guidelines and procedures for reporting, testing, and counselling are in place.

Working on Education Sector Impact Issues: Understanding and Responding

It is not enough to confine resources and energies to controlling the spread of HIV/AIDS. It is necessary at the same time to learn to live with the virus. Policy makers and planners need to have access to knowledge about demographic and other consequences of the pandemic in order to plan appropriate interventions, policies and investments. Better information collection and analysis will make it possible to monitor and adapt to the changing epidemic.

Information is needed on illness and death, duration of illness, and age distributions. This will provide the basis for education sector projections which take account of the pandemic.

> *In order to limit susceptibility and reduce potential impact, the present paucity of hard data must be supplemented with at least some dip-stick indicators in key groups. The alarming inclination to ignore the reality of the situation is exacerbated by the fact that it is eminently deniable. Once established as a benchmark for identified risk categories in education, this information must become the basis for accurate projection and the instrument of transparent address.*[52]

It is necessary then to be able to analyse and understand how the pandemic will influence staff attrition (especially in key skills like science and maths), costs for replacement, the extent and quality of services at all levels, changing demand for services, drop-outs and retention rates. It is essential to explore the psycho-social effects of the pandemic on the school community, on morale and performance. Policy, planning and strategic action in education can then respond to the impact of HIV/AIDS in ways that slow the spread of the epidemic, reduce its impact, and perhaps circumvent its worst consequences.

There is little evidence that, outside the University of Pretoria's Centre for the Study of AIDS, and the University of Natal Durban's Health Education and HIV/AIDS Research Division, much work is being done on collecting and analysing information about the social and other effects of the pandemic. A survey of education management units in universities and colleges revealed nothing of significance underway on the pandemic. Information from the Centre for Education Policy Development suggests that while the Centre, and its associated Education Policy Units, recognise the importance of the pandemic for education policy, planning and management, none have taken it on as a priority issue. For the present therefore, it seems that the Department of Education alone is responsible for data collection and accurate forecasting and modelling within the sector.

> *Our AIDS response has been compromised by the failure to confront and critique the ways in which notions of cultural traits and community values have colluded with the epidemic and sabotaged effective interventions. We don't yet know how people culturally and socially process a phenomenon as complex and frightening as this disease.*[53]

The Department's concerns about the effects of the pandemic are set out in *HIV/AIDS Impact Assessment in the Education Sector in South Africa* (DoE, 1999, in draft). The paper assumes that HIV/AIDS threatens to destroy recent development achievements. It recognises that 'the demand, supply and quality of learning and teaching will be affected by the HIV/AIDS epidemic' and that this in turn will 'affect the pattern of human development and economic growth in South Africa'. In this regard, it has taken action to inform itself about the planning implications of, and possible responses to, the pandemic.

Abt Associates have been commissioned to carry out an assessment of the potential impact of HIV/AIDS for the Department of Education. Its scope of work (*Assessing the Impact of HIV/AIDS on the Education Sector*, DoE, 1999) is focuses on thinking about HIV/AIDS in the sector, enabling educators to factor HIV/AIDS into their planning, and assisting the Department to develop appropriate strategic responses. The assessment focuses on understanding the impact of HIV/AIDS on society, and human resource development in South Africa; on the supply of education; and on the demand for education.

The assessment is looking at the **impact of HIV/AIDS on society and human resource development**: To what extent will skills requirements in South Africa and in the education sector in particular, be affected? What are the skills requirements and supply trends in the education sector and in the wider labour market? How vulnerable are educators and other education staff compared to other occupational categories? How do staff attrition and mobility patterns compare with those in other sectors? What changes in expenditure patterns may be shown by affected households? Abt have already (May

2000) supplied some basic information to the Department of Education on trends in the epidemic and determinants of susceptibility, the projected demographic impact of HIV/AIDS for the population,[54] key social and economic impacts from household to macro-levels and determinants of vulnerability, implications for government, and issues such as demands on other sectors and available resources, key policy directions, and trends in the economy and society relevant to interpreting the influence of HIV/AIDS.

The assessment also examines HIV/AIDS' i**mpact on the supply of education**: How many educators and other employees are HIV+? What is the current trend in enrolment in teacher training courses? What is the level of absenteeism? What impact does HIV/AIDS have on the morale of educators? What levels of staff turnover can be expected in the education sector? How mobile are educators? What are the current/projected costs or inefficiencies caused by absenteeism, sick leave, pensions, and compassionate leave? What is the type and extent of impact on employee benefits due to deaths and illnesses? Abt's summarise their approach as follows:

Key questions	Data sources and methods
How many employees in various categories will be infected with HIV, develop AIDS, and die of AIDS now and in future years?	• Identification of key data for planning and eg strata of employees with DOE planners • PERSAL download of education employee profile • Key informant interviews and literature review for risk assessment • Customised projections of HIV infection, AIDS cases, and AIDS deaths to 2020 based on input data • Validation data from PERSAL or other sources on deaths and medical boarding if available
What are likely impacts of HIV/AIDS on: - Absenteeism of employees - Employee attrition - Contact time between educators and learners - Other aspects of department functioning	• Review of public service and specific education sector employment frameworks and practices in relation to eg conditions of service, benefits, illness, absenteeism, ill-health retirement, recruitment • Review of past trends in eg absenteeism, enrollment of new staff, attrition rates and factors affecting these (if available) • Review of experiences of AIDS-related absenteeism in other settings and applicability to DOE • Key informant interviews to identify relevant issues, practice and experience of impacts • Modelling of various scenarios and associated costs using above data and customised projections
Do DOE and provincial policies, employment frameworks and function optimally assist management of HIV/AIDS impacts?	• Review of education sector general and HIV/AIDS policy documents, systems and capacity for eg employee assistance, training, HIV/AIDS prevention, recruitment. • Key informant interviews and review of documentation
What are the key areas of department response?	• Identification of issues arising from the assessment, circulation of findings and discussion in strategic planning workshop.

The third focus of the assessment concerns the pandemic's **impact on the demand for education**: What are current prevalence rates among learners in various education sub-sectors? What influence is HIV/AIDS (and related illness or its other consequences) having on school attendance, enrolments, drop-out and repetition rates? What demographic changes can be expected, in terms of mortality, morbidity, orphaning, population growth rates, and changes in life expectancy and population structure. What implications does the decline in projected enrolment and attendance rates have for staffing and infrastructure planning at national, provincial and local levels? What special

learning needs will the pandemic create? How will be pandemic influence the capacity of the Department to improve access, participation and equity with respect particularly to children of poverty, orphans, disabled and ill learners, rural populations, and girl-children. What response should it make to meet their needs? Abt Associates are exploring demand-related issues in the following way:

Key questions	Data sources and methods
What are projected future numbers of learners?	• Key informant interviews to understand planning processes and data requirements • Projections of numbers of children and young people to 2020 based on 1996 census data • Feeding results of demographic projections into planning models to identify implications for teacher and infrastructure planning (to be combined with projections of HIV/AIDS impacts on teachers and expected labour market impacts.
How many learners at various levels of the system will be infected with HIV, develop AIDS, and die of AIDS now and in future years?	• Projections of HIV infection, AIDS cases, and AIDS deaths in relevant age bands to 2020
How many children will be orphaned by AIDS and at what ages?	• Customised projections of orphans to 2020
How do households respond to illness and death of breadwinners? Which households and household members are likely to be most vulnerable? What are likely implications for education of orphans, HIV infected children and other children affected by AIDS? What are likely effects on eg enrollment, absenteeism and drop-out?	• Literature review • Key informant interviews • Review of data on the current profile of learners and factors affecting enrollment, performance, equity etc

Do education sector policies, systems, structures and capacity optimally assist HIV prevention among learners? Are these optimal for management of HIV/AIDS impacts among infected and affected learners?	• Review of education sector AIDS and other policy documents
	• Assessment of capacity, systems (including course structures) and other aspects of practice at all levels in the education sector of relevance to issues such as:
	  • prevention
	  • care and support
	  • financing of education, especially at tertiary level
	  • enabling infected or affected learners to contribute to society and the economy
	• Assessment of relevant responses by other sectors (eg health, welfare).
	• Key informant interviews[55]

What are the key areas of departmental response?	• Workshop with key informants to discuss strategic issues raised and develop an agenda for action and more detailed planning where required.

The assessment explores all sub-sectors of education including primary, secondary and tertiary levels, early childhood development and administrative, management and support functions, vocational/ technical education and adult education. HIV/AIDS demographic projections are being made using the most recently calibrated version of the Metropolitan Life-Doyle Model.[56] Projections of impacts on employees will be coordinated with public service projections made for the Department of Public Service Administration. All analyses are gender-sensitive.

PART 8 CONCLUSION

Is there a foundation – an enabling environment – for creative, sustained and effective action on HIV/AIDS within the education sector? The answer is a qualified yes.

Planning

The South African 'national HIV/AIDS programme' as spelled out in the *HIV/AIDS/STD Strategic Plan for South Africa, 2000-2005* is essentially a health promotion scheme. It does not speak to the economic, social and other consequences of the pandemic, and to that extent is not in effect a national programme.

There is an HIV/AIDS-in-education programme – under the aegis of Tirisano –set out by the national Department of Education. Provincial departments of education are encouraged to promote programme targets at local level. The HIV/AIDS Programme reflects both health and social concerns, although practical emphasis has so far been placed on extension of the Life Skills programme. There are at least three big questions here.

Will DoE flesh out the social and economic impact side of its Call to Action? The Department's strategies for the most part reflect the Department of Health's biomedical concerns, and concentrate on Life Skills – prevention and care.

It is now time to take a hard look at the health of the system itself, and its ability to withstand the pandemic's onslaught on

- teachers, managers and children,
- the education sector's organisational structures and systems,
- its management capacity,
- its leadership and, ultimately
- the quality of education it provides.

Will DoE develop workable strategies to protect education quality? Education is big business. It consumes over 20% of the national budget. It touches the life of each South African. Its survival response needs to be urgent, efficient, timely and creative. Its survival strategies need to be implemented vigorously, by managers who are capable of taking hard decisions.

> *AIDS is insidiously attacking and weakening the productive capability of ministries' human resources. The manner in which management addresses AIDS in the workplace will determine whether they survive the first decade of the 21st century. The danger is that ministries will wait until the impact of AIDS becomes noticeable in the quality of what they provide, and the indicators of their performance, and only then implement an AIDS intervention programme.*[57]

The South African business community, faced with the hard realities of staff attrition, low morale, and reduced performance, is finding ways to respond practically to the ravages

of HIV/AIDS. When the profitability of big business is at risk, managers, accountants, actuaries and human resource specialists respond. What business is bigger than the nation's education system? Why should DoE not respond as urgently, on the basis of as precise knowledge about the future, when the nation's children are at risk?

Will DoE be able to respond to changing education and training needs in the public and private sectors in a way that sustains personal and economic growth and development? DoE is responsible for ensuring a sufficient supply of skilled workers for South Africa. Further, as children pull out of school because of the pandemic, DoE will need to find strategies to 'provide an increasing range of learning possibilities, offering learners greater flexibility in choosing what, where, when, how and at what pace they learn.'[58] So far, these concerns are not reflected in DoE's planning documents.

Abt Associates *Scope of Work* stresses that its own 'ability to develop detailed, costed plans to address various impacts will be limited by time and other resource constraints; relatively lengthy, complex processes are likely to be required to develop specific plans which can be meaningfully costed. However, the project is expected to leave the sector well prepared to develop such plans.'[59] The processes that the Department of Education initiates when the impact assessment has been submitted later in the year will clearly be critical. Information and strategies without consensus on what needs to be done, manageable programmes, and people who can implement them are a waste of time.

Partners and Resources

DoE has numerous potential partners, in and out of government. The *National Integrated Plan for Children Infected and Affected by HIV/AIDS* lists a few: the Civil Military Alliance, trade unions, the Workplace Forum, traditional leaders and healers, various care, counselling and support units and NGOs, faith-based organisations, business sector initiatives, the media, international development cooperation agencies, NGOs and CBOs[60].

At all levels however, cooperation and coordination problems persist. The principle is constantly reiterated nevertheless: the education sector must harness every resource available to it in order to counter this plague. What is certain is that at local level, CBOs, religious organisations, and NGOs are already – in most cases despite or in the absence of official strategy – making a difference in the lives of women and children. They are providing support to teachers and heads as counsellors; they are training children and teachers in peer counselling; they are teaching the lessons of safe sex; they are working in communities to defuse violence and to care for those who are abused and violated. It is no longer acceptable to ignore their presence, and to deny them the resources they need. They are at the coal face. They are doing the job. They are supporting teachers and care workers. Their contribution is not just considerable; it is fundamental – however fragmented it may be. Plans, strategies and funding procedures must recognise this fact.

The international agencies too are not just silent funding partners as the DoH organigram would suggest. In the presence of viable national and local plans, they are able to supplement national HIV/AIDS financial allocations. It is clear however that they have another role as well. Like NGOs, religious organisations and CBOs, their personnel represent extra hands, additional skills, and fresh insights. USAID and DfID are providing technical support to the Departments of Health and Education. The pandemic

will force agencies and governments alike to re-consider the role of technical assistance, where essential skills and management capacities are decimated locally.

Management Capacity

Management skills are already in short supply in the education sector.[61] A national, provincial and district levels there are barely enough people to keep the formal system operating reasonably efficiently. There are certainly not enough people – in terms of numbers and skills – to undertake to keep the system running, while at the same time implementing creative new educational strategies necessary to counter this plague. The shortage of staff at national and provincial headquarters is clearly evident.

Implementation of the 1994 National HIV/AIDS Plan demonstrated that management capacity is one of the fundamental stumbling blocks to strategic success. Many of the same problems persist and inhibit education's response to HIV/AIDS. While there is no doubt about the commitment of the Minister of Education to counter-attack, managers responsible for implementing HIV/AIDS strategies at national, provincial and district levels may lack full understanding of the nature of the pandemic, and the ability to develop viable strategies. Units at all levels are understaffed, and they do not have regular access to planners, demographers, economists, sociologists and anthropologists, care workers and others whose advice and assistance is required.

In some cases, education officials are overcome by inertia: the challenge is too big, the resources too widely dispersed. Perhaps too, headquarters bureaucrats do not listen enough to the messages coming from schools, heads and teachers, and district officials. The frontline is coping, it is planning, and it is implementing – because it has to. The anxious flurry which sometimes characterises committee work, and inter- and intra-sectoral work at national level is often balanced by the focused determination of many ordinary teachers to care for their students.

The idea of a 'culture of care' in schools, of the school as the principal Community-based Organisation (CBO) as far as HIV/AIDS and sexual violence is concerned, need to be explored and cultivated. Investigation may show that it is indeed proper to start strategic planning with local managers and their partners, and to create support structures which put them and their schools at the centre of the national HIV/AIDS campaign.

[1] Hein Marais (2000). *To the Edge: AIDS Review 2000*. Pretoria: University of Pretoria, Centre for the Study of AIDS, p 8.
[2] Education sector: the complete cycle of pre-employment learning from the preparatory or preprimary phase through primary and secondary schooling, to both formal and semiformal postschool and tertiary activity. It embraces all those agencies, authorities and bodies inside and outside government which have responsibility for, or an interest in, education.
[3] The terms of reference for the country case study for the UN Economic Commission for Africa (ECA) asked: What capacity does the education system need in order to change the behaviour of learners and educators, in order to save lives? What can the education system do to overcome shortages of skilled workers – in education, in other sectors? What needs to be done to protect teacher training, quality of education provision, curriculum coverage, planning and management from the consequences of HIV/AIDS? What changes need to be made to the education system to make it more flexible so it can meet the needs of those who are out of school? What special steps need to be taken in the education system to help girls and women vulnerable to HIV/AIDS? What role can education play in helping to mitigate the consequences of HIV/AIDS in communities?
[4] See Marais, *op cit*. I am grateful to Rose Smart, former Director, Directorate: HIV/AIDS and STDs, MoH, for permission to use *Children Living with HIV/AIDS in South Africa: A Rapid Appraisal* (November 1999), prepared for the National HIV/AIDS Care and Support Task Team (NACTT), and funded by Save the Children (UK).
[5] Deane Moore and Stephen Kramer [n.d.], *HIV/AIDS: Getting Down to Business*, p 14.
[6] Eastern Cape, Free State, Gauteng, KwaZulu-Natal, Mpumalanga, Northern Cape, North West, Western Cape, Republic of South Africa.
[7] Marais, *op cit,* p 5.
[8] D Burger (1999), *Managing the HIV/AIDS Disaster Beyond 2000,* in Jan Nieuwenhuis (2000), *The Management Challenge of the National Policy on HIV/AIDS for Learners and Educators: Is It Feasible?*, p 11.
[9] Any human being under the age of 18 is defined as a child.
[10] Marais, *op cit*, p 11.
[11] *Pretoria News*, 28 June 2000, information from UNAIDS.
[12] The SA National Council for Child Welfare's publication *HIV/AIDS and the Care of Children* uses a figure of 19 775 600 children under the age of 18 in 1997.
[13] UNDP (1999), *HIV/AIDS and Human Development, South Africa 1998,* p 10.
[14] Personal communication, Neil McKerrow, KwaZulu-Natal Department of Health, in Smart, *op cit*.
[15] UNICEF (1999), *The Progress of Nations 1999*.
[16] Smart, *op cit,* pp 28-29.
[17] Martin Schonteich (1999). *Age and AIDS: South Africa's Crime Time Bomb?* in African Security Review, Vol 8, No 4. Institute for Security Studies, South Africa.
[18] The HIV/AIDS epidemic has progressed more or less in line with model projections during the 1990s. These projections are based on the most recent statistics, using the Metropolitan-Doyle model. 'The Metropolitan-Doyle model was first published in October 1990, with a view to producing reliable estimates of the progress of HIV/AIDS in South Africa. The model and its projects have been extensively used in Southern Africa by many sectors for the past eight years, and have performed well when used in practical applications at the sub-group and general population level. The model is continually reviewed in the light of new demographic and population statistics, as well as interventions which may influence the course of the epidemic and result in changing incidence of infection, morbidity and mortality. The model is able to consider various interventions into the epidemic. These include behavioural changes (increased condom usage, reduced numbers of partners, etc) and medical interventions (improved treatment of STDs, vaccinations, treatment/cure of HIV positive and AIDS sick individuals).' (Moore and Kramer, *op cit,* Metropolitan Group, AIDS Research Unit, p 14.)
[19] See Abt Associates (November 1999), *Assessing the Impact of HIV/AIDS on the Education Sector: Proposed Scope of Work*.
[20] UNDP, *op cit.*
[21] UNDP with UN Country Team, Namibia (1999), *Namibia: Human Development Report*.
[22] Kingdom of Swaziland (Kingdom of), Ministry of Education (1999), *Impact Assessment of HIV/AIDS on the Education Sector*. (Paper prepared for the Ministry of Education by JTK Associates, Mbabane.)
[23] **Error! Bookmark not defined. Error! Bookmark not defined. Error! Bookmark not defined. Error! Bookmark not defined. Error! Bookmark not defined.**, for example
[24] Department of Health sampling and testing is done with the participation of provincial coordinators, SA Blood Transfusion Services, South African Institute of Medical Research laboratories, Virology Departments of Cape Town and Natal Universities, the National Institute of Virology, Makweng Provincial Laboratory of the Northern Province and Medical Research Council.
[25] See note 18.
[26] Marais, *op cit*, pp 12-13.
[27] *ibid,* p 21.
[28] Department of Health (February 2000), *HIV/AIDS/STD Strategic Plan for South Africa, 2000-2005.*
[29] *ibid,* p 12.
[30] *ibid,* p 13.
[31] Marais, *op cit,* p 10.

[32] Republic of South Africa, Government Gazette No 20372 (August 1999), *National Policy on HIV/AIDS, for Learners and Educators in Further Education and Training Institutions*.
[33] Quarraisha Karim, Director, Directorate of HIV/AIDS and STDs, Department of Health, 1999 quoted in Marais, *op cit,* p 6.
[34] Marais, *op cit*.
[35] *ibid*, p 15.
[36] *ibid,* p 15, quoting Mark Gevisser, *Weekly Mail and Guardian.*
[37] Marais, *op* cit, p 17.
[38] See Wnajira Kiama*, Where are Kenya's Homosexuals?,* in *Aids Analysis Africa*, Feb/Mar 1999, p 9: 'networks of men who have sex with men can be found across the continent….[There are] a good number of men who are constitutionally homosexual but socially heterosexual, so as to fit in the society….Men having sex with men is not only common among young people, but fashionable. Just as young men like to wear an earring, they are also opting to try out homosexual practice….The taboos surrounding men who have sex with men have meant that few, if any, attempts have been made to provide AIDS education and support to them.' See also Rex Winsbury, *AIDS in Prisons*, in *AIDS Analysis Africa*, Oct/Nov 1999, p 11: 'The traditional African reluctance to admit or discuss same-sex sexual activity (which of course remains illegal in many African countries) is beginning to break down [as some recent studies have shown]'.
[39] Republic of South Africa, Government Gazette No 16312 (March 1995), *White Paper on Education and Training*, p 21.
[40] Government Gazette, *op cit,* pp 4-5.
[41] Smart, *op cit,* p 58.
[42] *ibid,* p 42.
[43] AIDS Law Project and Lawyers for Human Rights (1997), *HIV/AIDS and the Law*.
[44] Department of Education (1999), *Call to Action: Tirisano*. Department of Education (1999), *Corporate Plan, January 2000-December 2004.* Department of Education (1999), *Implementation Plan for Tirisano, January 2000-December 2004.*
[45] DoE, *Call to Action, op cit*, p 15.
[46] DoE, *Call to Action: Tirisano*, *op cit; Corporate Plan, January 2000-December 2004*, *op cit; Implementation Plan for Tirisano, January 2000-December 2004*, *op cit.*
[47] Republic of South Africa, Government Gazette No 20372 (August 1999), *National Policy on HIV/AIDS for Learners and Educators in Public Schools, And Students and Educators in Further Education and Training Institutions*.
[48] South Africa Department of Health and South Africa Department of Education (1997/98), *Life Skills and HIV/AIDS Education Programme: Project Report*. The project aimed to ensure learners could understand sex and sexuality, gender and STDs; identify ways in which HIV/AIDS can be transmitted; identify and mobilise community resources; evaluate sexual practices and respond appropriately and under pressure; accept and learn to live with being HIV+ show compassion to others who are HIV+; and learn how to cope with loss and deprivation in the family and community as a result of HIV/AIDS.
[49] Tulane University, South Africa Population Council, University of Natal Durban (2000), *Assessment of Life Skills Programmes*. p 5.
[50] Western Cape Education Department (2000), *1999 Initiatives to Sustain the HIV/AIDS Life Skills Education Programme in Secondary Schools, and Planning for the Implementation of Primary School Programmes; Para-Educational Services; Revised Business Plan for HIV/AIDS Life Skills Education, April 2000-March 2003; Primary and Secondary School Monthly Report Forms; Operational Plan for HIV/AIDS Life Skills Education.*
[51] Department of Education (2000), *The HIV/AIDS Emergency Guidelines for Educators,* p 2.
[52] Peter Badcock-Walters (2000), *AIDS Brief: Education Sector (draft),* University of Natal HEARD, p 4.
[53] Marais, *op cit,* p 10.
[54] Detailed projections broken down by skills categories in the labour force will not be available.
[55] Nor is this assessment expected to provide in-depth assessment of the success of implementation of various policies and programmes eg Life Skills, but should indicate major challenges and obstacles to be addressed.
[56] See also note 18.
[57] *Pretoria News Business Report*, 1 June 2000.
[58] Republic of South Africa, Government Gazette No 16312 (March 1995), *White Paper on Education and Training*, p 21.
[59] Abt Associates, *op cit*, p 2.
[60] *National Integrated Plan for Children Infected and Affected by HIV/AIDS*, op cit, Annex B.
[61] Department of Education (1996), *Changing Management to Manage Change in Education: Report of the Task Team on Education Management Development.*