Being a teacher in the context of the HIV and AIDS pandemic

READER

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Project Co-ordinator: Barbara Michel, Director: Higher Education HIV/AIDS Programme

The core module on HIV/AIDS is required in all pre- and in-service professional teacher education qualifications up to NQF Level 6. It specifies the minimum competences to be achieved by all qualifying educators across all phases of schooling and all learning areas.

Authors

Ian Moll and Tessa Welch of the South African Institute for Distance Education.

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The HEAIDS programme of HESA
P O Box 27392
Sunnyside
Pretoria 0132
South Africa
admin@hesa.org.za
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It is important to give your learners some insight into how HIV and AIDS work from a biological point of view. This extract from a book called How 2B AIDS Aware, a project of Tabeisa (Technical and Business Education Initiative in South Africa), is an attempt to present quite complex biological information in an accessible way. Most of the information that we read about HIV and AIDS is either so medically complex that it is not comprehensible to the lay person, or so condensed that it misrepresents the facts. If we understand what HIV is and what it does in our bodies, it becomes easier to understand how HIV is transmitted (as well as how it isn’t transmitted). This gives us greater power in the fight to prevent its spread.
We've just said that one of the things that we would do in this book is learn more about HIV. So that's what we'll do first. Where do we begin? Before we go any further, let's check what the letters "HIV" stand for.

So, okay, we've found out that the letters stand for Human Immuno-deficiency Virus. But does that really help us understand more about HIV?

Let's look at HIV in much more detail. HIV is a virus. There are thousands of different types of viruses. Many diseases in plants and animals are caused by viruses. Some are not that serious, such as the common cold, but others are much more serious, such as yellow fever, polio and ebola. HIV is also a very serious virus that can lead to AIDS, and we'll find out more about AIDS later in this book.
So what is a virus?

When we have a virus, many thousands (if not millions!) of tiny things called virus particles, or virions, might be attacking the cells of our bodies. One virus particle on its own won't cause too much trouble, but when you get a whole group of them together, there can be real problems!

It's a bit like if friends invite themselves round for a meal. One friend will be no problem at all, but there could be problems if a bus-load of friends came along all at once!
A virus particle is a very small thing that is not really alive. But what do we mean "not alive"? Let's compare a virus particle with ourselves. We are alive, and for us to stay alive we need to breathe and we need food.

We need to do these things because our bodies are made of living cells. The cells of our body need oxygen (which we get from breathing) and they need energy (which we get from food).

A virus particle does not need food and it does not breathe. In fact, on its own, a virus particle can do very little and is fairly useless. We will see that a virus particle needs to get into a living cell before it can "do" anything.

So back to what we can do. As well as feeding and breathing, we can also reproduce to make more people.
So can a virus particle reproduce?

Well, although they do not breathe or eat, viruses can reproduce, but just like a human, a virus particle can only reproduce with a bit of help. It gets this help from whatever living cell it gets into. Viruses can be a bit choosy about what cells they will go into. Some viruses will only affect plants, others can affect humans or animals. Even then they can be very choosy about which plant, or which type of animal they infect.

Because we are looking at how HIV affects us, we will look at how viruses reproduce in our bodies.

First the virus must get into our bodies. Once inside our bodies, the virus then has to get into a living cell. We said earlier that these cells need oxygen and energy. When it is inside a living cell, the virus particle becomes active, and it can use the parts of the living cell to reproduce itself. In this process, the living cell is often destroyed.

So a virus without a cell is fairly boring, but a virus inside a living cell can create all sorts of problems. The important thing to remember is that all a virus particle is interested in is reproducing to make as many more particles as it can.
The only way it can do this is by invading a living cell and using the cell’s machinery to make more virus particles.

Think of it this way: if we want to build a house, we start with a plan. But the plan on its own is no good. We need to get help from a builder, and we need the right materials.

A virus contains the plan for making copies of itself, but cannot make these new copies without help. Like us with our house, a virus needs to find the right materials and a builder. It gets both the help and the building materials from a living cell, which it uses to reproduce itself.
All the virus does is provide the plan. It needs the cell to put the plan into action. If the virus does not have a cell to reproduce in, it is useless, like a plan without a builder.

So a virus wants to reproduce. It has the plan for reproduction but it needs a living cell before it can reproduce. Our bodies are made of living cells. If a few virus particles get into our bodies, at first these few particles won’t cause much of a problem. But once in our bodies, their only aim is to find cells that they can reproduce in, and then they keep on reproducing!

**What does HIV look like?**

A single HIV virus particle looks like a small ball. The inside of the ball is made of layers of protein. These layers protect the plan of the virus particle that it needs to reproduce and make even more virus particles.

The plan is found in the centre of the ball. In HIV, the plan is made of ribonucleic acid, or “RNA” for short. The two strips of RNA found in the centre are the plan for making more protein. We also have RNA in the cells of our body, where it controls the making of protein.
What's a protein?

Our bodies are full of protein. Our nails, hair and skin are all made of protein, and that’s just on the outside. In fact, our bodies contain about 100,000 different kinds of protein, some very large and some very small.

Proteins are found in muscles, where they help to keep the body’s shape and structure. Proteins also speed up chemical reactions in our body, and they help to fight infection and transport oxygen from our lungs around our body. So proteins are essential to keep our bodies going.

All proteins are made from amino acids. Amino acids are compounds made of carbon, hydrogen, nitrogen and oxygen. There are over 20 different kinds of amino acid that join together to make protein.

Remember our builder? If he had 20 different kinds of brick to build houses, they could look different depending on which bricks he used and how he used them.

The amino acids are a bit like bricks that make up proteins. Depending on which amino acids are used and how they are joined together, different kinds of protein can be made. Each protein has a particular role in the structure and workings of our bodies.
We say the HIV particle is like a tiny ball; but while most balls are smooth on the outside, this virus has lots of bits sticking out of it. These bits that stick out also contain protein, and are called glycoproteins. Just as there are many different proteins, there are many different glycoproteins.

We’ll see later how important these glycoproteins are when HIV gets into our bodies.

We’ve seen what HIV looks like, so the next question is:

**How big is one HIV virus?**

One HIV particle is very small in size: its diameter is only 100 nanometres. But just how small is that?

If we take a ruler one metre long and divide it into ten equal pieces, how much will each measure? Yes, ten centimetres or 0.1 metres. Now divide one of these pieces into another ten equal pieces. Each piece will measure 1 centimetre or 0.01 metres. Then divide one of these pieces into ten more equal parts.

Where are we now? Well, we are getting a bit bored, but we’re down to pieces that are only 1 millimetre long, or 0.001 metres (and it’s getting difficult to divide them up!).

So far we have got to 1 millimetre, but a nanometre is much, much smaller than this. You would have to take 1 millimetre and divide it into 1 million equal pieces to get to a nanometre! A nanometre is 0.000000001 metres!

We said earlier that an HIV particle is only 100 nanometres wide. In fact, viruses are so small that they cannot be seen through a normal microscope.
1. One HIV particle is 100nm in diameter. Try to work out its size in millimetres, centimetres and metres.

2. How many HIV particles could fit across a pinhead that has a diameter of 2 millimetres?

Although we're only interested in HIV, there are lots of different types of viruses, which each have different shapes and sizes. All of them are interested in the same thing: getting into cells and reproducing!
TO SUM UP

HIV is a virus. It is not really alive, and it doesn't breathe or eat.

A virus particle needs to get into a living cell before it can “do” anything. Once inside a living cell, the virus particle can reproduce itself to make more virus particles.

HIV particles are only 100 nanometres in size – which is very small!

HIV particles are made of protein and contain ribonucleic acid, or “RNA” for short. RNA is the plan that HIV uses to reproduce itself.

Attached to the outer coat of the HIV particles are the glycoproteins.
It is often said that there is certain information that people, especially young people, must know about HIV and AIDS. This information is crucial to their health and well-being in the contemporary era. If they are denied access to this information – whether it be through conservatism, ignorance, prejudice, or even embarrassment on the part of their parents, caregivers or teachers – then their lives are at risk. Their abilities to become well rounded human beings in matters of sexuality, social responsibility and personal morality are also undermined. This chapter is an excellent presentation of the basic facts that we should all know about HIV and AIDS. It was produced by UNICEF precisely to distil this information and provide it in an easy-to-understand format for all of us.
Why it is important to share and act on information about HIV/AIDS

People in every country of the world are affected by AIDS (acquired immune deficiency syndrome). HIV/AIDS is becoming more of a global crisis every day. At present, 40 million adults and children are living with HIV/AIDS, and at least 10.4 million children currently under the age of 15 have lost one or both parents to AIDS.

The disease increasingly affects young people. Of the 5 million new infections in 2001, approximately half are among young people between the ages of 15 and 24. Young women are especially vulnerable. An estimated 11.8 million young people are living with HIV/AIDS – 7.3 million young women and 4.5 million young men.

AIDS is caused by the human immunodeficiency virus (HIV). HIV damages the body’s defences against other diseases. Medication can help people with HIV/AIDS live longer, but the disease so far has no vaccine or cure.

Prevention is the most effective strategy against the spread of HIV/AIDS. Every person in every country should know how to avoid getting and spreading the disease.

Condoms can save lives by preventing the sexual transmission of HIV. Access to testing and counselling must be given high priority in every country. Everyone has the right to voluntary and confidential counselling and testing for HIV/AIDS and the right to be protected from discrimination of any kind related to her or his HIV/AIDS status.

For those living with or affected by HIV/AIDS, care and compassion are needed. Measures should be taken to remove the social, cultural and political barriers that might block access to HIV/AIDS services and programmes.
Key Messages:

What every family and community has a right to know about HIV/AIDS

1. AIDS is an incurable but preventable disease. HIV, the virus that causes AIDS, spreads through unprotected sex (intercourse without a condom), transfusions of unscreened blood, contaminated needles and syringes (most often those used for injecting drugs), and from an infected woman to her child during pregnancy, childbirth or breastfeeding.

2. All people, including children, are at risk for HIV/AIDS. Everyone needs information and education about the disease and access to condoms to reduce this risk.

3. Anyone who suspects that he or she might be infected with HIV should contact a health worker or an HIV/AIDS centre to receive confidential counselling and testing.

4. The risk of getting HIV through sex can be reduced if people don’t have sex, if they reduce the number of sex partners, if uninfected partners have sex only with each other, or if people have safer sex – sex without penetration or while using a condom. Correct and consistent use of condoms can save lives by preventing the spread of HIV.
5. Girls are especially vulnerable to HIV infection and need support to protect themselves and be protected against unwanted and unsafe sex.

6. Parents and teachers can help young people protect themselves from HIV/AIDS by talking with them about how to avoid getting and spreading the disease, including the correct and consistent use of male or female condoms.

7. HIV infection can be passed from a mother to her child during pregnancy or childbirth or through breastfeeding. Pregnant women or new mothers who are infected with HIV, or suspect that they are infected, should consult a qualified health worker to seek testing and counselling.

8. HIV can be spread by unsterilized needles or syringes, most often those used for injecting drugs. Used razor blades, knives or tools that cut or pierce the skin also carry some risk of spreading HIV.

9. People who have a sexually transmitted infection (STI) are at greater risk of getting HIV and of spreading HIV to others. People with STIs should seek prompt treatment and avoid sexual intercourse or practice safer sex (non-penetrative sex or sex using a condom).
AIDS is an incurable but preventable disease. HIV, the virus that causes AIDS, spreads through unprotected sex (intercourse without a condom), transfusions of unscreened blood, contaminated needles and syringes (most often those used for injecting drugs), and from an infected woman to her child during pregnancy, childbirth or breastfeeding.

AIDS is caused by the human immunodeficiency virus (HIV), which damages the body’s defence system.

People infected with HIV usually live for years without any signs of the disease. They may look and feel healthy, but they can still pass on the virus to others.

AIDS is the late stage of HIV infection. People who have AIDS grow weaker because their bodies lose the ability to fight off illnesses. In adults, AIDS develops 7 to 10 years after infection, on average. In young children it usually develops much faster. AIDS is not curable, but new medicines can help people with AIDS live healthier for longer periods.

In most cases, HIV is passed from one person to another through unprotected sexual intercourse, during which the semen, vaginal fluid or blood of an infected person passes into the body of another person.

HIV can also pass from one person to another through the use of unsterilized needles and syringes (most often those used for injecting drugs), razor blades, knives or other instruments for injecting, cutting or piercing the body, and through transfusions of infected blood. All blood for transfusions should be screened for HIV.
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It is not possible to get HIV/AIDS from touching those who are infected. Hugging, shaking hands, coughing and sneezing will not spread the disease. HIV/AIDS cannot be transmitted through toilet seats, telephones, plates, glasses, eating utensils, towels, bed linen, swimming pools or public baths. HIV/AIDS is not spread by mosquitoes or other insects.

2. All people, including children, are at risk for HIV/AIDS. Everyone needs information and education about the disease and access to condoms to reduce this risk.

Babies and young children living with HIV/AIDS have special needs for good nutrition, immunization and regular health care to avoid complications from common childhood illnesses, which can be fatal. If the child is infected, it is likely that the mother, and probably also the father, is infected. Home care visits might be needed.

In countries with high rates of HIV infection, children are not only at risk of being infected, but they are also affected by the impact of HIV/AIDS on their families and communities.

- If children lose parents, teachers and caregivers to HIV/AIDS, they will need help in understanding what is happening and dealing with their loss and grief.

- Orphaned children might have to assume responsibilities as the head of the household and will undoubtedly face great economic difficulties. If orphaned children are cared for by others, then that family’s limited resources must stretch to accommodate the additional needs of these children.

- Children living with HIV/AIDS or with families affected by HIV/AIDS may be stigmatized or isolated from their community and denied access to health services and school. Good-quality training on HIV/AIDS for teachers and peer educators can increase understanding and compassion and lessen discrimination.
Efforts should be made to keep HIV/AIDS-affected families together. Efforts should also be made to avoid institutionalizing orphaned children. Orphans are less traumatized if they are cared for by the extended family or the community.

Few young people receive the accurate and appropriate information they need. School-aged children should be provided with age-appropriate information on HIV/AIDS and life skills before they become sexually active. Education at this stage has been shown to delay sexual activity and to teach responsibility.

Children living in institutions, on the streets or in refugee camps are at even greater risk of being infected with HIV than are other children. Support services need to be provided accordingly.

3. Anyone who suspects that he or she might be infected with HIV should contact a health worker or an HIV/AIDS centre to receive confidential counselling and testing.

HIV counselling and testing can help in the early detection of HIV infection and in enabling those who are infected to get the support services they need, manage other infectious diseases they might have, and learn about living with HIV/AIDS and how to avoid infecting others. Counselling and testing can also help those not infected to remain uninfected through education about safer sex.

If the result of an HIV/AIDS test is negative, this means the person tested is not infected or it is too early to detect the virus. The HIV blood test may not detect infection up to the first six months. The test should be repeated six months after any possible exposure to HIV infection. Since an infected person can transmit the virus at any time, it is important to use a condom during sex or to avoid penetration.

Families and communities should demand and support confidential HIV/AIDS counselling, testing and information to help protect adults and children from the disease.
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An HIV/AIDS test can help couples decide whether to have children. If one partner is infected, he or she could infect the other while attempting to conceive.

It is possible to stop HIV from spreading to the next generation if young people know the facts about HIV transmission, abstain from sex, and have access to condoms.

4. The risk of getting HIV through sex can be reduced if people don’t have sex, if they reduce the number of sex partners, if uninfected partners have sex only with each other, or if people have safer sex — sex without penetration or while using a condom. Correct and consistent use of condoms can save lives by preventing the spread of HIV.

Mutual fidelity between two uninfected partners protects them both from HIV/AIDS.

The more sex partners people have, the greater the risk that one of them will have HIV/AIDS and pass it on. However, anyone can have HIV/AIDS — it is not restricted to those who have many sex partners.

- A blood test is the most accurate way to tell if someone is infected with HIV. An infected person may look completely healthy.

Unless partners have sex only with each other and are sure that they are both uninfected, they should practice safer sex. Safer sex means non-penetrative sex (where the penis does not enter the mouth, vagina or rectum) or the use of a new latex condom for every act of intercourse. (Latex condoms are less likely to break or leak than animal-skin condoms or the thinner ‘more sensitive’ condoms.) Condoms should never be re-used.

- A condom should always be used during all penetrative sex unless it is absolutely certain that both partners are free of HIV infection. A person can become infected through even one occasion of unprotected penetrative sex (sex without a condom).
● Condoms must be used for vaginal and anal intercourse for HIV prevention.

Condoms with lubrication (slippery liquid or gel) already on them are less likely to tear during handling or use. If the condom is not lubricated enough, a water-based lubricant, such as silicone or glycerine, should be added. If such lubricants are not available, saliva can be used. Lubricants made from oil or petroleum (cooking oil or shortening, mineral or baby oil, petroleum jellies such as Vaseline, most lotions) should never be used because they can damage the condom. A well-lubricated condom is absolutely essential for protection during anal intercourse.

● HIV can be transmitted through oral sex. Hence, a condom should be used on a man, and a flat piece of latex or ‘dam’ on a woman.

Because most sexually transmitted infections (STIs) can be spread through genital contact, a condom should be used before genital contact begins.

Sex without penetration is another way to have safer sex that greatly decreases the risk of getting infected with HIV (though even this does not protect against all STIs).

A safe alternative to the male condom is the female condom. The female condom is a soft, loose-fitting polyurethane sheath that lines the vagina. It has a soft ring at each end. The ring at the closed end is used to put the device inside the vagina and to hold it in place during sex. The other ring stays outside the vagina and partly covers the labia. Before sex begins, the woman inserts the female condom with her fingers. Unlike the male condom, the female condom can be used with any
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lubricant—whether water-based, oil-based or petroleum-based—because it is made from polyurethane.

Drinking alcohol or taking drugs interferes with judgement. Even those who understand the risks of AIDS and the importance of safer sex may become careless after drinking or using drugs.

5. Girls are especially vulnerable to HIV infection and need support to protect themselves and be protected against unwanted and unsafe sex.

In many countries, HIV rates are much higher among teenage girls than teenage boys. Teenage girls are more susceptible to HIV infection because:

- young girls may not understand the risk or may be unable to protect themselves from sexual advances
- their vaginal membranes are thinner and more susceptible to infection than those of mature women
- they are sometimes targeted by older men who seek young women with little or no sexual experience because they are less likely to be infected.

Girls and women have the right to refuse unwanted and unprotected sex. Parents and teachers should discuss this issue with girls and boys to make them aware of girls’ and women’s rights, to teach boys to respect girls as equals, and to help girls avoid or defend themselves against unwanted sexual advances.
Parents and teachers can help young people protect themselves from HIV/AIDS by talking with them about how to avoid getting and spreading the disease, including the correct and consistent use of male or female condoms.

Young people need to understand the risks of HIV/AIDS. Parents, teachers, health workers, guardians or the person in the community in charge of rites of passage can warn young people about the risk of HIV/AIDS, other STIs and unplanned pregnancy.

It can be awkward to discuss sexual issues with young people. One way to begin the discussion with school-aged children is to ask them what they have heard about HIV/AIDS. If any of their information is wrong, take the opportunity to provide them with the correct information. Talking with and listening to young people is very important. If the parent is uncomfortable with the discussion, he or she can ask a teacher, a relative or someone who is good at discussing sensitive issues for advice on how to talk to the child about this.

Young people need to be informed that there is no vaccination and no cure for HIV/AIDS. They need to understand that prevention is the only protection against the disease. Young people also need to be empowered to refuse sex.

Children need to know that they do not run the risk of getting HIV from ordinary social contact with children or adults who are HIV infected.

Those living with HIV/AIDS need care and support. Young people can help by showing them compassion.
HIV infection can be passed from a mother to her child during pregnancy or childbirth or through breastfeeding. Pregnant women or new mothers who are infected with HIV, or suspect that they are infected, should consult a qualified health worker to seek testing and counselling.

The most effective way to reduce transmission of HIV from the mother to the child is to prevent HIV infection in women.

Empowering women and promoting safer sex, condom use and better detection and treatment of STIs can reduce HIV infection in women. If a woman discovers that she is HIV positive, she needs emotional support and counselling to help her make decisions and plan for her future. Community support groups and NGOs can support women in making these decisions.

Pregnant women need to know:

- that treatment with specified medicines during pregnancy can greatly reduce the risk of passing the infection to the infant
- that special care during pregnancy and delivery can reduce the risks of passing the infection to the infant.

New mothers need to know the different options for feeding their infants and the related risks. Health workers can assist in identifying a feeding method that can maximize the infant’s chance of growing up healthy and free of HIV.

Babies born to women who have not received medication and are infected with HIV have about a 1-in-3 chance of being born with HIV. More than two thirds of the infants infected with HIV may die before they are five years old.
HIV can be spread by unsterilized needles or syringes, most often those used for injecting drugs. Used razor blades, knives or tools that cut or pierce the skin also carry some risk of spreading HIV.

An unsterilized needle or syringe can pass HIV from one person to another. Nothing should be used to pierce a person’s skin unless it has been sterilized.

People who inject themselves with drugs or have unprotected sex with injecting drug users are at high risk of becoming infected with HIV. People who inject drugs should always use a clean needle and syringe, and never use another person’s needle or syringe.

Injections should be given only by a trained health worker. For each child or adult being immunized, a new or fully sterilized needle and syringe should be used.

Sharing needles and syringes with anyone, including family members, may transmit HIV or other life-threatening diseases. No one should share needles or syringes. Parents should ask the health worker to use a new or sterilized needle for every person.

Any kind of cut using an unsterilized object such as a razor or knife can transmit HIV. The cutting instrument must be fully sterilized for each person, including family members, or rinsed with bleach and/or boiling water.

Any instrument that is used to cut a newborn’s umbilical cord must be sterilized. Particular care should be taken when handling the placenta and any blood from the delivery. Protective (latex) gloves should be used if available.

Equipment for dental treatment, tattooing, facial marking, ear piercing and acupuncture is not safe unless the equipment is sterilized for each person. The person performing the procedure should take care to avoid any contact with blood during the procedure.
9. People who have a sexually transmitted infection (STI) are at greater risk of getting HIV and of spreading HIV to others. People with STIs should seek prompt treatment and avoid sexual intercourse or practice safer sex (non-penetrative sex or sex using a condom).

Sexually transmitted infections (STIs) are infections that are spread through sexual contact, either through the exchange of body fluids (sperm, vaginal fluid or blood) or by contact with the skin of the genital area (particularly if there are lesions such as blisters, abrasions or cuts, often caused by the STI itself).

STIs often cause serious physical suffering and damage.

Any STI, such as gonorrhoea or syphilis, can increase the risk of catching or transmitting HIV. Persons suffering from an STI have a 5 to 10 times higher risk of becoming infected with HIV if they have unprotected sexual intercourse with an HIV-infected person.

- Correct and consistent use of latex condoms when engaging in sexual intercourse — vaginal, anal or oral — can greatly reduce the spread of most STIs, including HIV.
People who suspect that they have an STI should seek prompt treatment from a health worker in order to be diagnosed and get treatment. They should avoid sexual intercourse or practice safer sex (non-penetrative sex or sex using a condom). If found to have an STI, they should tell their partner. If both partners are not treated for an STI, they will continue infecting each other with the STI. Most STIs are curable.

A man infected with an STI may have pain or discomfort while urinating; discharge from his penis; or sores, blisters, bumps and rashes on the genitals or inside of the mouth. A woman infected with an STI may have discharge from the vagina that has a strange colour or bad smell, pain or itching around the genital area, and pain or unexpected bleeding from the vagina during or after intercourse. More severe infections can cause fever, pain in the abdomen, and infertility. However, many STIs in women produce no symptoms at all — and some STIs in men also may not have any noticeable symptoms.

Also, not every problem in the genital area is an STI. There are some infections, such as candidiasis and urinary tract infections, that are not spread by sexual intercourse but cause great discomfort in the genital area.

The traditional method of diagnosing STIs is by laboratory tests. However, these are often unavailable or too expensive. Since 1990, WHO has recommended 'syndromic management' of STIs in people with symptoms of STI. The main features of syndromic management are:

- classification of the main germs by the clinical syndromes produced
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- use of flow charts derived from this classification to manage a particular syndrome
- treatment for all important causes of the syndrome
- notification and treatment of sex partners
- no expensive laboratory procedures.

The syndromic approach using flow charts offers accessible and immediate treatment that is cost-effective and efficient.
For a little while, it looked like Oscar might not be the only grouch on "Sesame Street." This week, the South African version of the highly-acclaimed children's television program debuted a new Muppet -- Kami, an HIV-positive furry orphan. Such ground-breaking steps for "Sesame Street" did not come without its share of controversy. Ironically, the brunt of the protests came not from viewers in South Africa, but from the U.S. Congress. The ridiculous opposition to cuddly Kami shows that there are people besides preschoolers that could stand to learn a lesson or two from Big Bird and company.

Joel Schneider, vice president of Sesame Workshop -- the producer of "Sesame Street" -- made the announcement of Kami's creation this summer at the International AIDS Conference in Barcelona, Spain. Faster than you can say Tickle-me-Elmo, though, six crusading House Republicans led by Rep. Billy Tauzin (La.) were quick to remind the Corporation for Public Broadcasting, the backer of PBS, who held its purse strings. "Sesame Street" itself receives almost $5 million a year in federal funds.

The GOP congressmen objected on the ground that an HIV-positive Muppet would present issues inappropriate for preschoolers. Their rapacious response to PBS was unnecessary and unfounded. Sesame Workshop clearly stated that Kami would appear only in South Africa, and the Republicans' reaction was based on unconfirmed rumors of the possibility of a U.S. appearance. In fact, PBS president Pat Mitchell said Tauzin's office was informed that Kami would not be seen in America the same day that he and his cohorts sent out a letter questioning the motives of PBS.

But let's examine what issues our representatives feared exposing to children. On television, Kami conveniently will only say that she has no parents and is infected with HIV. How she contracted the disease will not be an issue, although we can assume it was from her mother, a common situation in South Africa. So Tauzin and his minions can forget the possibility of Kami discussing how she shot up with some infected hypodermic needles. Neither can they expect a frank discussion of the possibility of contracting HIV through unprotected sex. After all, the kid is only five years old.
That leaves us to deal with the most subversive issues of all -- acceptance and tolerance (gasp!). The people behind the South African "Sesame Street," called "Takalani Sesame," want to teach kids to accept children who are otherwise like them. Thus, they should not be afraid to befriend, touch and play with their HIV-infected peers. In South Africa, where one in nine people is infected with HIV/AIDS, this is a crucial message. Obviously, "Sesame Street" wants no more than to teach kids to love and accept each other -- frightening prospects, indeed.

The announcement of Kami's creation also had conservative groups chomping at the bit. For example, the American Family Association says homosexual activists are using "Sesame Street" to reach young, impressionable minds. The group obviously failed to consider that many HIV/AIDS victims are children, not to mention straight too. Then again, these are the same kind of people who accused Bert and Ernie of being a closeted gay couple. Plus, it's laughable to consider the Muppets as a plausible outlet for a homosexual agenda. Last time I checked, Muppets did not have sex lives, let alone sex organs. For crying out loud, their bodies end in someone else's elbow. Such speculations that attempt to discount the lessons to be learned from Kami are trivial compared to the real intentions of the producers of "Sesame Street."

There is an interesting exception to the protesting conservatives. The Reverend Jerry Falwell, infamous for his recent attempts to out the purple Teletubby Tinky Winky, even agrees with the presence of Kami (newsflash: Hell just froze over) -- that is, as long as the Muppet's sexuality is left out of the picture. Maybe it's time for conservatives to tune back in to the mother ship.

However staunchly Sesame Workshop asserts the fact that an HIV-positive Muppet is not in store for America, one is left to wonder why not. Parents could rely on "Sesame Street" to handle the issue delicately and in a manner understandable to children. The show has already proved capable of doing so. In the past, it has dealt with death, and more recently, Sept. 11. HIV/AIDS is, by no means, rare in this country, and introducing a sympathetic character like Kami to U.S. airwaves would help American children identify with infected kids both here and abroad. The world is becoming too small to shelter the youngest generations from such worldly issues that may be uncomfortable or difficult to discuss with them.

So kudos to "Takalani Sesame" for rolling out the red carpet for Kami. And maybe someone should tell the adults how to get to Sesame Street.
Baba's gifts

A short story by

Jenny Robson
Nomthandazo Zondo

MaNdlovu looks about a yard and yes, it is clean. Everything is in place for her husband's homecoming from the mines. Her children are clean too, well scrubbed. Dlamini will be pleased to find such good order when he arrives.

But still MaNdlovu cannot relax. She feels her heart beating too fast. On her back, the baby is restless, sensing her nervousness. How will she say the words she must speak to her husband?

Her son, Vukile, comes back from checking the cattle. The sight of him gives her heart a little peace. Her first-born! So strong and so handsome at twelve years in his smart white shirt.

He says, "Ma, what is it my father will bring me from the city? What do you think Baba's gift for me will be?"

MaNdlovu enjoys teasing her son.
"Maybe it will be a box of matches, my Vukile? Yes, that will be a fine gift! A nice box full of matches for you!"

Teasing Vukile makes her feel a little less nervous.
"No, no, Ma!" Vukile wails. "Not a box of matches. I want a football! Will Baba bring me a football, do you think?"

MaNdlovu feels her fierce love for her son wash through her and make her brave. And she will need to be brave when her husband comes. For the sake of her family, for Vukile and little Ntombi and the baby, she must have courage. There are things she has to say. She has been saying the words over and over in her mind. But what if the words are wrong? What if they only make Dlamini angry? He is a man quick to anger. And sometimes she is afraid of him, especially when he has just returned from the city, smelling of strange city smells.

The sun is low beside the hill and over her tidy yard. Soon it will be time for the bus to arrive. So MaNdlovu walks the dusty downhill path with her baby sleeping on her back. Should she speak to her husband as soon as he is off the bus? Maybe it will be best to get the words out right at the start.

The bus arrives after an hour's waiting. MaNdlovu watches her husband alight. He looks like a stranger in his city clothes after all the months he has been gone. She forgets when she is alone how tall and strong Dlamini is. She greets him, smiling shyly to show she is joyful that he has returned. Because the people in the bus are staring down at her, watching.

Dlamini hands her a packet.
"See, MaNdlovu, I have brought chicken pieces for our supper."
She thanks him for the gift. She lifts his heavy box of belongings onto her head. He is still talking as he strides ahead of her, as the bus rattles off in a cloud of evening dust.

"How have the rains been, my wife? And my mother? Is she well? Did you take her to the clinic for her chest?"

And now? Is this a good time to speak, while they are still some distance from home and alone on the path? MaNdlovu takes a deep breath and addresses her husband's broad back.

"Dlamini, my husband, I have serious things to ask you. Will you listen well before you answer me?"

But her husband has already seen his friends. He is calling out loud greetings to them and they call back to him across the grass.

MaNdlovu accepts that now is not the right time. She continues on her way home with the box pressing down on her head and the baby tearful and restless against her back. She must make tea and prepare the chicken pieces. Meanwhile her husband has taken the path to his parents' home.

I will speak to him before supper then, she promises herself. That will be the right time. With the good smell of chicken cooking.

Back home, Vukile is still waiting, his friends gathered around him.

"Have you seen Baba's gift for me, Ma? Is it a football? Did you see it?"

MaNdlovu walks to their sleeping quarters with the fine corrugated roof. She sets the heavy box down, then looks around to make sure that all is well. Yes, the large bed is smooth under its white and blue cover. Such a lonely bed it has been all these months. And how many nights has she lain there unable to sleep wondering whether Dlamini is sleeping alone in the city or whether some city woman, wearing strong perfume, is lying beside him?

"You all know what your husbands do when they are away! Even if you keep silent, still you know very well!"

That is what Nurse Margaret said at the clinic in town. Nurse Margaret with her big face that makes her look almost like a man. Nurse Margaret who says the most scandalous things and speaks about the most private affairs there in the clinic waiting-room. Sometimes MaNdlovu wants to cover her ears with her hands. Sometimes she wants to run out of the clinic so she won't hear.

"Yes, ladies! The time is past when these things must be kept secret. For your own sakes, for the sakes of your children, we must speak these things out loud."

There is shouting in the yard now. Vukile is yelling at the top of his voice.

"A football! I have a football! Baba, this is the best gift! Ma, come and look!"

MaNdlovu leaves the sleeping quarters, and there is her fine son, smiling as if his face will come apart, kicking the ball now with his friends who have appeared from all directions. And there is little Ntombi, holding a doll up to the sky and talking to it as if it were alive.

Dlamini is smiling. He sees her and says, "I have a gift for you too."

He holds up a white blouse patterned with small red flowers. So white and so soft! MaNdlovu presses it against her face.

She sees that Dlamini is smiling down at her now, so she begins, "My husband, there is something we must speak about. It is for the children's sake and because you have been gone in the city so many months . . ."

But Dlamini interrupts her, "Why is the chicken not cooking yet? My parents will come soon, wanting to eat."

So MaNdlovu goes into the kitchen to prepare the food. Maybe it is better this way. She will wait till after supper, when Dlamini's parents are gone and the children are fast asleep.
She will wait till she and Dlamini are alone together in the bedroom. That will be the best
time. Yes, that is the time for husbands and wives to share important talk.

She cooks the chicken while Vukile plays with his football and Ntombi talks to her doll.
And then Dlamini's parents arrive. His mother sits stroking the scarf her son has given her.
His father taps tobacco into his pipe from the large yellow tin his son has brought him.
MaNdlovu moves about quietly, serving tea and food, anxious to show that she is a capable,
dutiful daughter-in-law.

She hears her mother-in-law say, "You chose well, my son. Your wife has been a good
woman whilst you were away."

MaNdlovu is happy to hear this because Dlamini will be feeling kindly towards her, and
then maybe he will listen to what she has to say. Maybe he will agree to her request.

There at the clinic waiting-room Nurse Margaret had said, "You will do this thing carefully.
We all know how they are stuck in their ways and do not like new ideas. Especially new
ideas from their wives."

Oh and it had been such a shock! Such a terrible shock and shame to see Nurse
Margaret there, holding a wooden penis! Nurse Margaret, who wasn't even married!
MaNdlovu had looked down at the floor, wishing she were somewhere else, anywhere else.

"And see, this is how the condom goes on," Nurse Margaret had said. She demonstrated
with hands at were almost the size of a man's. This is your protection, ladies. This is the way
to stop city diseases coming into your homes. Especially the HIV virus that brings AIDS. It is
all over the cities now. But with this condom, you can stop it from entering your home and
making orphans of your children . . ."

MaNdlovu still feels faint when she remembers this. Though some of the women at the
clinic laughed and joked about the size of Nurse Margaret's wooden penis, MaNdlovu could
not laugh; the shame was too great.

The time has almost come. The night is dark now except for the round yellow moon. And her
parents-in-law have left; proudly carrying the gifts their son has brought them. Dlamini
himself is bathing in the warm water she prepared. And soon, soon, they will be together in
the sleeping quarters. Together and alone in the darkness. But before that, she must speak.

What if it makes him angry? What if it makes him suspicious? She is afraid he will
shout at her, "Why is my wife keeping such things in her bag? Is it because she is seeing
other men while her husband is gone?"

MaNdlovu finds that her hands are shaking as she walks across to the sleeping quarters
in the moonlit darkness. And there is Dlamini, already in bed beneath the blue-and-white
cover: he looks so big lying there; his presence fills the whole room. She can feel the sweat
lying on her face. She feels the word 'condom' sticking in her throat, almost choking her.

"Come to bed, wife," he says. "I have been away from you a long time."

With her hands still shaking, MaNdlovu opens the cupboard door, opens her clinic bag.
She holds up a condom in its foil cover.

She says, "Please Dlamini. It is for the sake of the children. It is because there are
diseases in the city, diseases that kill. Nurse Margaret told us."

Is it anger in his eyes? Is he about to shout at her? The lamplight is blinding her and she
cannot see her husband's face. It seems much time passes before he answers. In her hand, the
small square package is trembling wildly.

At last Dlamini replies with a laugh, "Nurse Margaret! Why do you listen to Nurse
Margaret? She is an ugly woman who will never be married. So now she tries to destroy the
marriages of other women. You throw that nonsense away, MaNdlovu. And then you join me here in bed."

And even though he is laughing, MaNdlovu knows she must do what he instructs, no matter what Nurse Margaret has explained. Dlamini has turned the lamp off now. In the darkness, without her small square package of protection, MaNdlovu gets into bed beside her husband. He still smells of the city, despite his bath.
Why South Africa?

Tony Barnett and Alan Whiteside

This is an extract from a book, ‘AIDS in the Twenty-First Century: Disease and Globalisation’.

The book as a whole is about the social and economic impacts of HIV/AIDS. The thesis of the book is that the HIV/AIDS epidemic can be linked to national and global inequalities. The chapter from which this extract is taken is entitled ‘Why Africa?’ and it gives an historical, geographical, economic analysis of the patterns of inequality in Africa that leads to an explanation for why the impact of HIV and AIDS is greatest in our continent. This extract concentrates on the underlying reasons for HIV prevalence in South Africa.

The concluding paragraph to the chapter can serve as an introduction to this extract:
‘Geographic disadvantage, disorder, relative deprivation, inequality and poverty: we have see these in different ways in the case studies in this chapter. They are all characteristics of a risk environment where susceptibility [to HIV and AIDS] is high. They are the horsemen of the twenty-first century apocalypse in Africa.’

...
The HIV/AIDS epidemic began to spread through South and southern Africa in the late 1980s. The 1990s saw an explosion in HIV prevalence and the already extremely high rates continue to rise. Adult HIV prevalence was estimated at 19.94% at the end of 1999. South Africa’s peculiar history has made it fertile ground for the spread of HIV. …

The legacy

The AIDS epidemic reflects the history of this region. Migration and mobility have created patterns of sexual behaviour and mixing which are perfect for the spread of sexually transmitted disease. Indeed we note that the migrant-sending countries have higher rates of HIV prevalence than South Africa itself. South Africa is the crucible for HIV transmission in the region. Labour comes into an area of high sero-prevalence, where working and living conditions encourage sexual epidemics are established. In the periphery there are neither the resources not the ability to establish AIDS control programmes. In the longer term it is these communities that bear the cost of increased illness and deaths.

Then there is inequality. In 1993 in South Africa, the richest 10% of the population received 47.3% of the income, whereas the poorest 40% of the people had only a 9.1% share. Land inequalities mean that 71% of the rural population – mainly black – lived on 14% of the land, while the balance of farmland was owned by only 67,000 farmers, almost all white (Whiteside and Sunter, 2000). The same situation pertains in Zimbabwe, although here the ‘land reform’ means that the major landowners are black cronies of the leadership. There are also regional inequalities: in 1998, per capita income in Mozambique was US$210, in Lesotho US$570 – compared to South Africa’s US$3,310.

Breakdown of family structure in the rural areas and townships, government policy towards its black population and the violence that accompanied the end of apartheid combined to create a widespread philosophy of fatalism. This perception that ‘what will be, will be’ in turn diminished individual worth, responsibility and accountability. The feeling is still prevalent and makes people live for today without valuing tomorrow. It can be summed up in a shrug of the shoulders and the response: ‘If AIDS kills me in five years’ time, so what?’

Conflict resulting from the cycle of oppression and resistance led to the widespread destruction and disruption of civil society. The ANC’s political slogan of the late 1980s, ‘Make the townships ungovernable’, Armed forces proliferated, including the defence force, homeland armies, liberation movements, self-defence units and political militias, as well as shadowy groups of vigilantes and unofficial police and intelligence units. Apart from internal conflict, wars were being fought by South Africans in Angola, Mozambique and Namibia. Conflict between the armed wings of the political parties continued up to the 1994 election, and in KwaZulu-Natal continued beyond the election albeit at a much lower level. Conflict results in inability to absorb and act on messages contained in educational programmes about HIV. Military forces have higher levels of infection than the general population and are more likely to spread their infections.

An astonishing fact that emerged from the Truth and Reconciliation Commission (TRC) was the use of HIV as a weapon. According to submissions made by two apartheid-era security officers, Willie Nortje and Andries van Heerden, speaking at the TRCa in 1999, HIV positive askaris (former ANC operatives who had gone over to work for the apartheid state security forces) were used to spread the disease. These men, known to be HIV positive, were
employed in 1990 in two Hillbrow hotels in Johannesburg with explicit instructions to infect sex workers (Roberts, 1999).

The ending of apartheid and election of the new government in 1994 resulted in relaxation of the draconian controls on society. But these were not replaced immediately by a strong civil society – hardly surprising, as this is something that has to be built over time rather than imposed. In addition, there was no immediate redistribution of resources or lessening of income inequality.

Crime and gang violence are now endemic in South Africa. As a consequence, rape and gang rape have become potent methods of recorded. The true figure is no doubt very much higher (Institute of Security Studies, 1999). Rape has much higher odds of HIV transmission because of physical trauma; its frequency tells us something about the nature of gender relations in the South African communities.

Political changes have not meant prosperity for all South Africans. Unemployment has risen since 1994. Job shedding started in the late 1980s, largely due to sanctions. However it increased sharply after 1994 when South Africa joined the World Trade Organisation and import tariffs ceased. A million jobs, mostly unskilled, were lost between 1993 and 1997, offset against 60,000 skilled jobs gained. In South Africa about 35% of the labour force lacks formal employment and a far larger proportion lack the skills needed to participate in export industries. Ironically, the economic autarky associated with apartheid protected South Africa against some global forces. Globalisation may have positive outcomes in countries where the labour force is able to obtain long-term employment and participate in the production of goods and opportunities and eventually raised household incomes. But in South Africa things are different. The labour force lacks skills, the strong union movement protects those in employment and Western countries have been less than generous with Favoured Nation status and preferential tariffs.

The upshot of global changes in the structure of demand for goods and services and competition has been to marginalise different components of the labour force in direct proportion to their skills and ability to find employment in sectors that are competitive in the global economy. (Tomlinson, 2000)

What applies in South Africa applies equally in the rest of southern Africa. With the exception of Botswana these countries are poorer than South Africa. They have less resilience and, in the case of Angola and Mozambique, have been victims of the view taken by powerful nations that wars are engagements best played away from home.

**South African society and AIDS – the Carletonville study**

We have an insight into the situation in urban South Africa from the Carletonville study. This important long-term study is based in the mining community of Carletonville, about 100 kilometres from Johannesburg and 50 kilometres from Soweto. It began in 1997, and aims to understand social and economic factors contributing to the rapid spread of HIV and AIDS in urban South Africa.

The rate of infection among adolescent girls in the study area is nearly 60% (Gilgen et al., 2000, p. 8) A large number of men in this community live in mine hostels. There are adjacent
‘hot-spots’ in which more than 50% of the women say they are commercial sex workers. The study shows that a range of factors raise individual susceptibility to infection: active or poorly treated STIs, the use of alcohol, and high numbers of lifetime sexual partners. Among men, protective factors were membership of a sports club and circumcision (about half the men were circumcised), while among the protective factors for women was membership of a burial society or church. For all, living a squatter area raised the chance of exposure to infection (Gilgen et al, 2000, chapter 4). All the risk factors are associated with low levels of social cohesion, poor women and relatively better-off men.

These preliminary data from a long-term study are entirely predictable. They confirm that if you put people in circumstances where they cannot maintain stable relationships, where they are mobile, where life is risky and pleasures are few and necessarily cheap, then sexually transmitted diseases will be rampant. If, further, there are inadequate medical services and little is available in the way of immediate, accessible and effective treatment for STIs, then HIV will move in very fast indeed. Some of the people in Carletonville – the miners, the sex workers and others – had relatively good incomes. But they had these in a poor country and in a poor community.
Girls and boys experience the realities of HIV and AIDS differently. This chapter explores the gender identities of learners at a secondary school in KwaZulu-Natal, and examines how emerging sexuality and the power relations of gender influence the way that young people use and respond to knowledge about HIV and AIDS. The case study reported here shows that it is unfortunately the case that boys often use their sexuality as an instrument of power, forcing unprotected sex on girls. Girls themselves often collude in these practices in pursuit of their own sexual identities in a harsh, sexist social environment. At the same time, there are individual learners who are demonstrated more liberated practices in their relationships. These issues are of enormous significance for the way that HIV and AIDS interventions are developed in schools. This chapter gives us insights into the way that the gendered, and often oppressive, understandings of boys and girls need to be incorporated into school policies and programmes regarding HIV and AIDS.
South Africa is one of the countries worst affected by AIDS. An estimated 4.2 million people are HIV positive. This represents nearly one quarter of the population (22.4% using 1999 estimates), although the numbers affected as partners, children, family members, friends, community members, political representatives, workmates or employers are much larger (AIDS Foundation, 2001; Whiteside and Sunter, 2000). Children are infected at the rate of 50,000 a year (McGreal, 2000).

We do not know what the rates of HIV infection are in schools. Using data taken from a 2000 national Metropolitan Life study, which estimates infection rates by age and race, it is possible to give some sense of the 'health' of the school population. Amongst 15-19 year olds, 15.64% of African females are likely to be HIV positive, compared to 2.58% of African males. This is explained by the fact that males tend to have sex with females of the same age or younger, whereas females tend to have sex with older males who, particularly in the age category above 30, have high levels of infection. The raced nature of the pandemic can be seen in equivalent figures, for white (1.25% and 0.26%) and Indian (1.29% and 0.26%) females and males respectively (figures supplied by Chris Desmond of HEARD, University of Natal, Durban).

For the last ten years, educationists have perceived HIV/AIDS as an emergency. A host of initiatives have been launched to address the epidemic and its anticipated reach into education. This view has produced two scenarios: a decline in the number of learners – primarily as a result of infant mortality – and a decline in the number of teachers on account of AIDS mortality. In 1997, the government introduced the Life Skills and HIV/AIDS Education programme. The Department of Education set up a central group of life skills trainers throughout the country who developed a core curriculum for teacher training and for classroom use. Learning materials were widely distributed. A formal committee structure was appointed at provincial level, to oversee the training and curriculum development work (Ntuli, Mkhwanazi & Harrison, 2000). However, the impact of this initiative was limited, partly because of its very prescriptive approach to dealing with HIV (Crewe, 1997) and partly because of insufficient attention to the programme by the majority of school principals (Snyder, 2000). The lack of teacher commitment to the programme has also been remarked upon.

It has recently been acknowledged that 'quick fix' solutions are inadequate and there have been moves towards embracing a more holistic approach. In 2000, the new Minister of Education prioritized HIV/AIDS in his Tirasano plan of action. Objectives include gender equity in schools, promoting conflict resolution, developing self esteem, building a democratic school culture and securing schools against violence (Harrison et al, 2000). A key question is "whether schools which failed to utilize the 'simple' life skills solution are equipped to engage the more complex whole school solutions. There have also been a range of non-governmental organization (NGO) initiatives to produce learning materials, train teachers, conduct school-based workshops with learners and work with parents and the broader community (Griggs, 1997). Despite all these efforts, the rate of infection has continued to rise. All South Africans are currently affected by HIV/AIDS, but the ability of society to act effectively is severely constrained.

**Gender and HIV/AIDS**

Although the statistics indicate enormous gender disparities in rates of infection between boys and girls, the Education Department does not make particular mention of gender politics.
in its strategies. The extent of sexual violence worldwide and its implication in the HIV epidemic has recently begun to be documented (Gordon and Crehan, 1999). Research in South Africa confirms that unequal gender relations and extensive sexual violence often makes it impossible for women to insist on condom use and exposes them to increased risks of infection because of coerced sex (Abrahams and Jewkes, 2000; Jewkes et al.1999). The high rates of violence against women, a proportion of whom are at school, would seem to suggest schools as a key site for interventions to address violence and HIV. Erika George's study of South African schools, based on extensive interviews with learners, teachers, parents and school administrators in three provinces, documents how widespread sexual violence is, both in schools and on the way to school (George, 2001). Schools are simply not the safe places of rational learning portrayed in the literature on school based interventions.

Learners' perceptions

The fieldwork on which this article draws was conducted in two black working class township schools in Durban. The schools serve African learners exclusively, with an even mix of boys and girls. They contain significant numbers of learners over the age of 20. 20% live in homes with four of fewer people, 30% in homes with five or six people, 20% live in homes containing seven people and 31% live in homes with more than seven people. The class nature of the schools is best revealed by looking at employment. 27% of fathers and 42% of mothers are unemployed. Amongst the fathers, 'driver' was the most common occupation (16%) followed by 'builder' (6%) and 'farmer' and security officer' (4%). Amongst mothers, 'teacher' (10%), 'clerk'(4%) and 'driver' and 'security officer' (2%) were the most common.

Data gathering included a survey of learners to gather baseline data, interviews with principals and teachers, whole class discussions and small group discussions with single sex groups of learners in the senior school. The two schools are relatively well resourced compared to other township schools. Compared to former white schools, however, their staff:student ratios are high, school textbooks and stationery are in short supply and facilities such as sports fields do not exist. No formal life skills curriculum had been introduced into either school at the time the study was conducted. In response to a survey question, "Who did you first learn about HIV/AIDS from?" 40% of the learners identified television, 20% radio, 15% parents, 9% teachers and 4% friends. The relatively small proportion who learned about HIV/AIDS from teachers can be explained by the lack of life skills training in the formal curriculum of either school. Interviews with teachers revealed that some gave lessons or held discussions in their class about HIV/AIDS. While 92% of learners said they had had a lesson on AIDS in school, most of these lessons were not given by class teachers, but by 'other' (probably an NGO). Eighty eight percent of the learners have a good knowledge of AIDS. Seventy percent identified unprotected sex as a cause of AIDS. While these levels of knowledge are impressive at one level, viewed from another they are alarming. Thirty percent of the sample did not identify unprotected sex as causing AIDS. Given the considerable public exposure of learners to AIDS education, this is alarming. Consequently, respondents were confused about the symptoms of the disease. Most (69%) thought it was associated with getting thinner, 46% thought open sores were a symptom and 28% associated tiredness with AIDS.
Masculinity, Femininity and Risk

What the girls knew about HIV/AIDS was set in a powerful context of their first hand experience of rape and sexual assault. At least three of the 15 girls we interviewed had suffered this experience. All the others spoke of knowing at least one friend or relative who had been raped. A number of the girls spoke of the stigma attached to having been raped and the fear of telling anyone, including their mothers, if it had happened to them. It is possible that several more had actually been raped or sexually abused, but did not disclose to us.

Mbali: Last year I tried to tell my mom about him. My mom was asking me, "What’s the problem?" "Nothing." "What's your problem at school? Why are you sad like that?" I'm afraid to tell her about this problem ...When I'm young some guy was taking me to the bush and doing sex with me.

Thembi: I think that maybe when I'm walking the streets some guy will come and catch me and maybe rape me. Maybe if I was a boy there will be something that will scare me but right now because I'm a girl I'm very afraid of rape.

Thabi: I had a problem when I was doing grade two. After school the old man come to us with my friend, Philile and he take us to the... bushes. Then he abuse us, he raped us ... and he told us to go home. "Don't tell anybody because I will kill you." So I was afraid to tell my mom until now.

The girls' fear of rape was often associated with the fear of contracting HIV. They know that they are supposed to control sex, making sure of the use of condoms, or abstaining and remaining virgins.

Gugu: Ngisaba ingculazi. Ehe ngisaba yond ngoba nje futhu uyabo kusikhathi samanje abantu aha rapanayo baningi kakhulu. Hayi okwe sex ke ukuthi bese angi kayi miseli nje. Futhu angikaze ngiye (I'm scared of AIDS. I'm scared of it because these days there are many people who get raped. No to sex! I am not ready for it. I am still a virgin) …

They also live under the threat of coerced sex with a boyfriend (which they did not always define as rape). They felt that having a boyfriend involved the choice of having sex with him, or losing him.

Dudu: To tell the truth I'm afraid of being in a relationship. Most of the boys today... all of them to be in a relationship you must do sex ...I don't believe in that kind of a relationship. You can tell him by the words that you love him.

The girls reported that not using condoms, and, indeed, becoming pregnant, was seen as a way of expressing love and trust:

Gugu: Girls sleep with the boy to keep the boy, because there will be others who will be jealous. In order to keep the boy you have to get pregnant.

Zandi: Other girls they say, "Oh! You want to use a condom. I don't want to use a condom. You don't trust me. I'm the only girl for you."

Clearly, it is not only the boys who are seen as putting pressure on girls to refrain from condom-use. Thus one of the simplest ways in which education about HIV/AIDS is
undertaken – advocating condom use – is strongly countered by the girls’ understandings of love, sexuality, and violence. Girls also have sex for money or to achieve status:

*Thobi:* My mother does not have any Money ... maybe I will sleep with someone to get money ... and is very bad ... Of course you want to look good. Next time I have everything. I have my pedal pushers. I have my tee-shirt... when I finish school I can have...a cell phone and be like everyone else...I will go to university and pass and then I will get a job and I will have everything that I want.

*Thabi:* ... it's status ... many of them do it for the status.

The girls are neither simple victims nor rational receivers of a simple message. The complexity and contradictions expressed with regard to their sexuality is also evident in their views concerning their futures. While many identified with the expectation on them to become good wives and mothers, many also expressed more ambitious and less conventional aspirations. As Zandi said:

I think I'll be a psychiatrist because I like helping people who are sick of mental disorders. And I feel sorry for people who are mentally disturbed. I won’t be staying with my parents then. I will be at my own house ... But I will support my family. Marriage, I don't think I’ll get married.

*Lebo:* Why not?

*Zandi:* I don't like it...Maybe sometimes you get somebody who is gonna beat you ... I don't think about marriage but I'll see when it comes.

While the girls sometimes use aspects of the discourse of violence and refer to experiences of domination, they refuse the identities ascribed to them. However, their capacity to act as they think is severely constrained by family conditions and society more broadly. Similar complexities are evident in the ways the boys respond.

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**Boys Making Sense of HIV/AIDS**

In a variety of ways and in different locations, boys have obtained knowledge about AIDS. Their knowledge gives them status because, in an environment saturated with AIDS messages, mastery thereof is a newly available 'sign of masculinity'.

Kenneth, a Grade 10 student aged about 17 years, dominated the 35 minutes long period devoted to a discussion of AIDS. He had the 'right' answers because he had been trained in a Durban Metro Health department, four-day peer educator course. However, he hid behind the knowledge and did not open himself or discuss difficult emotional and sexual issues. Although he claimed to be sexually abstinent, this sounded more like a chorus learnt at a training session than a reflection of his actual behaviour.

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**Sex is Good**

A number of studies have explored the emphasis that young African men put on having girlfriends and engaging in hetero sex. These are defining features of township masculinity. Unfortunately, they often coincide with misogynistic attitudes, violence and hostility towards ideas of gender equality, particularly in the realm of relationships (Shefer and Ruiters, 1998; Wood and Jewkes, 2001). Boys make use of a gendered grammar that takes as given the representation of men as uncontrolled slaves of their sexual lust. They therefore feel no need
to apologize for predatory sexual behaviour or the effects of such behaviour on girls. In a national survey of 2 000 young people, 23% of the sample agreed that "having many sexual partners means I am cool/hip" and 81% agreed that having sex was not the result of "what other people thought but because I enjoy it" (LoveLife, 2001). Eighty six respondents (72 male and 14 female) at our two schools indicated that their first sexual encounter took place at the age of 12 years or younger. We are entitled to make no inference about the consensual nature of these acts. Comparative and impressionistic information suggests, however, that boys were seeking to realise their masculinity by having sex, while at least some of the girls may have been coerced. At the other end of the spectrum, 36 respondents indicated that they had sex three or more times a week: 29 of these were males. Finally, of the 50 respondents who had three or more sexual partners "in the last month", 44 were male and six female. It was not easy to get boys to acknowledge the centrality of sex in class or focus group discussions, but some revealing views were expressed in whole-class discussions. When the subject of rape was raised, the following response was forthcoming:

Other girls who are wearing a short skirt, like this, and they are too keen ... the way she walks, shaking herself, [and you say] Ei, this girl is making me feel so nice [laughter] and you imagine yourself over her rolling like a chicken in the oats [loud laughter] and you understand yourself and you say ‘I must get this girl' and ... and if you are asking to have sex with her, and maybe she don't say yes to you, then you think I must rape this girl... [laughter]

Later in the same discussion, a member of the class said that: "Most of the boys have more than one girlfriend. If she tells you that she wants to leave you, then you just ...just get another girlfriend ... if you have a girlfriend in bed and you do not have sex with her...you go out, leave her...sex is the most fun you can have”.

Two suggestions have been put forward to suggest why, in this day and age, such sexual trends continue to be observed. Leclerc-Madlala (1997) says that despair and anger drive young men to "infect one, infect all". Wood and Jewkes (2001) argue that the fragility of masculinity amongst township boys (who have no life prospects on account of poverty) leads them to lay great stress on sex. It is a stress born of desperation and vulnerability, rather than power, although in the act of giving it effect, boys certainly do exercise the patriarchal dividend.

Love, Sex and Fidelity

A surprising feature of the interviews conducted in class were the high levels of maturity and sensitivity exhibited by many of the boys. Many were already contributing to the family purse. Most preferred to have one girlfriend and said that sex was important and, in some instances, warranted waiting for parental approval. The informants were not boastful about their lives. Rather, they were deeply concerned about their life prospects and valued intimacy from male and female friends alike. This is a far cry from the image of routine relational violence which much of the literature reveals (Wood and Jewkes, 1987).

RM: Have you got a girlfriend?
Mandla: Yes.
RM: One or two or three or four?
Mandla: One.
RM: Lots of boys have got lots of girlfriends, so are you not the same?
Mandla: I don't go with a squad. If I have one girlfriend.. I have one girlfriend.
And what does your relationship with your girlfriend give you?

**Mandla:** It gave me some love experience cause she teach me some things I don't know and I teach her some things she don't know.

**RM:** Is she also at school?

**Mandla:** Yah, she also at school.

**RM:** Is it important for you that you are her only boyfriend?

**Mandla:** Yah, I think so I'm the only boyfriend.

**RM:** If you see her with another boy what would you do? What would you think?

**Mandla:** With the boy which I don't know?

**RM:** Yes.

**Mandla:** I'll go and ask her what's going on between him and her, and then she tells. If there is something wrong I just leave her. If they are in love...I will leave her but if they are friends I don't mind.

**RM:** So you trust her?

**Mandla:** Yah I trust her very much.

**RM:** And have you ever spent nights with her?

**Mandla:** No, no, no. They wouldn't allow me to have her.

**RM:** Are you saying your parents don't allow you or her parents won't allow?

**Mandla:** My parents won't allow me. Even her parents won't allow me.

**RM:** Why not?

**Mandla:** Because we are so young you know. We are schooling so we shouldn't do this thing ... having an affair with her.

**RM:** So what are you saying, that sex is not part of your relationship?

**Mandla:** Not for me, no. They got disease now. AIDS aha! It's a killer you know. So I don't wanna get AIDS.

The male learners showed a striking willingness to ignore peer prescription and to take responsibility for their own actions.

These boys still believe that men make decisions in the house, that it is a man's responsibility to earn, that it is important not to be frightened in the face of danger. But there are important changes occurring which are easy to miss in context where African youth are closely associated in the public mind with crime and anti-social behaviour. It may be significant that 5000 (the largest category) of male respondents identified "talking to friends" as a good way of dealing with sadness. This can be contrasted with other, less helpful responses such as getting drunk (8%), getting angry (16%), taking exercise (20%) and by avoiding the source of grief (34%).

**Stigma**

It remains a major feature of the AIDS pandemic that people are reluctant to be tested and infected people are reluctant to disclose. Doing research into AIDS is eerie – the likelihood of many of our 2 500-odd learner subjects and 60 teachers being HIV positive is high. Yet at neither school does anybody openly declare their status or, as far as we know, actually know it. There are probably many reasons for this but the death of Gugu Dlamini over Christmas 1998 highlighted the levels of stigma attached to disclosure. She was stoned to death for openly disclosing. The reason – "degrading her neighborhood by disclosing that she had the disease and bringing shame on her community" (Sunday Times, 27 December 1998).

At the funerals that punctuate weekend routines, the cause of death is seldom revealed – because it remains a cause of shame (Sunday Tribune Perspectives, 26 November 2000). Death by AIDS is a stigma. Because it is 'inappropriate' (it takes the young and hitherto
healthy) and because it is linked to sex and unregulated sex in particular, and is publicly seen
as a sign of irresponsibility (Marcus, 1999). Instead, therefore, of talking about it, learners
acknowledge its presence but keep it at a distance. Why find out, they ask, because "then
you're going to worry too much." (Class discussion, October, 2000).

Being sexually active from a young age has become a key feature of gender identities
in South Africa, but we should not simply accept that this is automatic. Elsewhere in the
world, abstinence and the delaying of sexual intercourse into early adulthood are the norm
(China, for example). Some evidence that there are young people in South Africa who take
this view is suggested by the high figures in the survey of abstinence and in high levels of
church attendance amongst the youth. Seventy nine percent of youth surveyed in the
LoveLife project identified 'going to church' as an important or very important preferred
weekend activity (LoveLife, 2001).

**Policies, Schools and Identities**

The results of our survey suggest that girls and boys have different responses to knowledge
about HIV/AIDS. However, neither have fixed responses. While they appropriate elements
from both discourses we have identified – that knowledge about HIV/AIDS can be utilised as
protection and that knowledge about HIV/AIDS is of 'no use' because of patriarchal gender
regimes, they simultaneously undercut these understandings. Generally, African working
class girls, because of their personal histories, experience of widespread sexual assault and
the patriarchal gender regimes they inhabit at home, at school and in their communities, have
less possibility of using their knowledge in emancipatory ways and developing gender
identities which enlarge the scope for choice and transformation of their lives. African
working class boys, on the other hand, while sometimes able to deploy their knowledge
about HIV/AIDS to exhibit power, are generally currently positioned in a social world
characterised by failure and hopelessness, where they do not have control of their futures. It
is in relationships with girls and other boys that they have rights and power, and this is often
conveyed through violent and careless expressions of sexuality. Of course, this is by no
means the case for all these boys. Some demonstrate the capacity for self reflection and are
optimistic with regard to friendships and intimate relationships with women. The complex
understandings exhibited by boys and girls are of enormous importance in planning and
pacing interventions in schools. Unless policies and programmes understand school contexts
– which both comply with and are capable of undermining existing gender regimes – and
unless these policies and practices take seriously the diverse responses of learners, they will
talk past the realities and will themselves become disarticulated from engagement with the
epidemic and efforts to ameliorate its tragic effects.

Work that consciously focuses on the construction of gender identities and
acknowledges the social, personal and historical forces which go into the making of these
identities is vital for long-term success. More attention needs to be paid to the meaning of
risk-taking and to achieving gender equity.

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Gender-based violence and HIV/AIDS in South Africa

Susan Fox

The short story, *Baba’s Gifts* (Reading 4), confronts us with a stark portrayal of the degree to which women’s rights are of fundamental concern in the context of HIV and AIDS. Previous articles in this volume have made it clear that women are more vulnerable than men to contracting the HI-virus, for a range of reasons that include social, political and physiological factors. Any successful intervention in the area must tackle the question of the rights of women to control their own lives, including their own sexuality, and to act in their own best interests in relation to the spread of the disease. The current chapter (an extract from a longer research report) provides a useful overview of some of the basic principles and problems that we must think about in attempting to confront issues of gender, violence and the spread of HIV.
Predictors and indicators of gender-based violence

The following indicators of gender-based violence and HIV infection are useful for understanding gender-based violence in relation to AIDS. Violence against women and children around the world has been reported to be most common where:

- gender roles are rigidly defined and enforced;
- the concept of masculinity is linked to toughness, male honour, or dominance;
- physical punishment of women and children is culturally tolerated;
- violence is accepted as a means of interpersonal conflict resolution;
- women are economically dependent and have limited access to employment, education, training, money and credit;
- children do not receive adequate care during times when their parents are absent;
- conditions of poverty result in children working, which include conditions that make them vulnerable to sexual exploitation; or where girls and women are at risk of rape in the course of their daily subsistence tasks;
- there are disincentives to reporting sexual violence to judicial authorities;
- there is a low conviction rate for crimes of violence and cases of gender-based violence are inadequately documented, followed up and prosecuted; and
- there are few or no organizations dealing with gender-based violence in research, law, education, social activism, political advocacy, and service provision (see Heise et al. 1999:8).

In contrast, violence against women and children has been reported to be at low levels where:

- women have power and authority outside of the family;
- family members intervene to prevent and reduce the likelihood of domestic violence;
- there are all-women collectives;
- there are community sanctions against gender-based violence; and
- women are economically independent from men (Heise et al. 1999:9).

International literature indicates that amongst men, predictors and indicators for the use of violence against an intimate partner are as follows:

- family background: poverty in childhood and adolescence, having witnessed or experienced violence within the family as a child;
- educational status: low academic achievement;
emotional factors: low self-esteem, emotional dependence, insecurity, exhibition of anger and hostility, depression, personality disorders;

relationship factors: economic stress, poor family functioning, sense of inadequacy of not living up to the ideal of a family provider;

community factors: weak community sanctions against domestic violence, low social capital;

social factors: traditional gender norms; social norms supportive of violence, no easy access to divorce for women, adults routinely resorting to violence to solve conflicts, notions of manhood linked to dominance, male honour, and aggression, and

political factors: inadequate rights frameworks, weak laws against gender-based violence, high levels of violent crime and other forms of violence.

Gender-based violence and HIV/AIDS in South Africa

The legal status of women changed with the 1996 Constitution, and with a range of other Acts passed since then – for example, the Domestic Violence Act, Maintenance Act, Promotion of Equality and Prevention of Unfair Discrimination Act, Recognition of Customary Marriages Act, Choice of Termination of Pregnancy Act. This period also included the entrenching of universal civil citizenship, equality and human rights. However, the economic and social conditions under which most South African women still live effectively renders them citizens without rights. The position of women, particularly women in rural areas, remains tightly circumscribed. The bounds of ‘custom’ and ‘tradition’ are in some cases being maintained with the co-operation of some women’s organizations.

The implementation and acceptability of recent laws addressing gender equality and gender-based violence has been hampered by continuing discriminatory attitudes and practices amongst law enforcement agencies and health service providers; by lack of, or uneven distribution of resources; by ignorance; and by inadequacies in protocols, training and skills provision. These factors have contributed to secondary victimization, lack of trust in law-enforcement agencies and health care providers, under-reporting of incidents of gender-based violence, low conviction rates of offenders, and increasing HIV prevalence.

According to the South African Demographic and Health Survey of 1998, the highest incidence of abuse by a partner in the last year was among 15-24 year old girls (7.3% for age group 15-19; 7.9% for age group 20-24). The Nelson Mandela Foundation/HSRC HIV/AIDS Survey 2002 found that the 25-29 year age group was most at risk of HIV infection, with an HIV prevalence rate of 28%. In the 15-29 year age group, the prevalence level for African women was significantly higher than that of African men (17.6% compared to 13.5%).

The findings of these two studies indicate the high vulnerability of young women to HIV infection, and the gendered nature of the HIV epidemic. Unequal power in sexual relations is implicated in the sexual transmission of HIV in many respects. As has been noted, there is a low conviction rate for crimes of violence as a result of inadequate and under-resourced policing and judicial systems. Unequal relationships are often mediated through transactional sex as a means of exchange for food, shelter and goods.

In South Africa, HIV/AIDS has compounded the situation of women. It has exacerbated their economic and social insecurity. Caring for sick and dying family and community members has increased the workload of women and girls, sometimes taking them out of education and economic spheres of activity.
Negotiating safer sex, disclosing one’s HIV status to one’s partner, and seeking counselling and treatment are limited by fear. For women, this fear relates not only to stigmatization, but to violence and destitution.

Organizations working in the field of gender-based violence and health (specifically HIV/AIDS) advocate a human rights framework that integrates gender equity with sexual and reproductive rights and with socio-economic rights.

In the absence of a national strategy for dealing specifically with violence against women, much is being done by organizations – mainly non-governmental and community-based organizations – in providing services to women who have been violated, beaten, and abused.

In the face of the enormous psychological, personal, family, social and economic toll exacted by the levels of gender-based violence in South Africa, many of the organizations working in this field under great pressure have been effectively limited to a crisis response.
The research into the health of South Africa’s educators, coordinated by the Human Sciences Research Council, was commissioned by the Education Labour Relations Council. As the summary on the back of the book states:

‘Education is an essential ingredient of the socio-economic development of any country, and educators are a vital part of any nation’s educational system. If educators are sick, or absent from school, or leave the profession, the nation stands to lose. (...) Prior to this report, there were no primary level South African national data assessing the ill-health and attrition of educators.’

The extract that follows is from the section headed ‘Discussion of the Findings’. The fundamental questions that it addresses are:

• how different the HIV prevalence rates of teachers are when compared to those of the general population, and
• what the prevalence rates are in terms of a range of variables such as gender, race, rural/urban, province, and even learning area.
5.1 Profile of educators

South African educators in the public sector were predominantly women, African, older than 34 years, married, and the majority had diplomas or degrees and rated themselves as not well off financially. SGBs paid a small percentage of educators. With respect to employment benefits, the majority of educators had medical aid and most had no housing subsidy. Most educators were members of unions; the rates of union membership were high regardless of race, set of respondent, marital status and educational qualification. The rate of union membership was to ever in young educators (18-24 years), those paid by SGBs and those with low income.

The dominance of females among South African educators in the public sector mirrors one aspect of gender roles in the society. In many societies, certain occupations are regarded as traditionally male, while 'caring' occupations such as nursing and teaching are traditionally female.

The majority of educators had at least ten years' teaching experience. They generally had high educational qualifications but not necessarily in the learning areas they were teaching. More teachers were teaching the foundation phase, economics and management, life orientation and technology learning areas than were trained in these areas. Many educators were trained in learning areas in which they did not teach. Specifically, there were more educators trained in foundation languages, additional languages, social sciences, mathematics and natural sciences than they were teaching, suggesting that the training is not aligned to the teaching needs. (This matter will be taken Further in the human resource report to he completed in July 2005).

5.2 Prevalence of HIV

5.2.1 Overall HIV prevalence

The observed findings suggest that HIV/AIDS seriously affects South African educators: the true figure lies somewhere between 42,809 and 47,801. When the HIV prevalence of educators was compared to the general population - controlling for age, and sex - male educators had lower prevalence compared to the general population, Older female educators also had a lower HIV prevalence, but none of these differences were statistically significant, suggesting that the HIV prevalence among educators is similar to that of the general population. When comparing the educators with health professionals, the differences were also not statistically significant (12.7% among educators compared with 14.7% among professionals in the public health sector (Shisana et al. 2003). These results suggest that the HIV prevalence among South African public educators may reflect that of the community in which they live.

When comparing these findings with those observed in other countries in Africa, it appears that the prevalence of HIV among South African educators is much higher than that observed in Senegal (0.5%), Nigeria (5.8%) and Ghana (9.2%) but similar to that observed in Cameroon (11.8%). In all these countries except Ghana, the HIV prevalence among educators is also similar to the national HIV prevalence (Tamukong 2004). Since educators in South Africa are responsible for imparting knowledge to learners on HIV prevention as part of the life skills programme, one would have expected them to have a much lower HIV prevalence than the general population. What these findings suggest is that the life skills programme
might have not contributed to sexual behavior change among educators and hence they have a similar risk of acquiring HIV as the general population. Clearly knowledge is not sufficient to influence behavior change. Self efficacy in safe sex practices is crucial when attempting to understand behavior change. This is discussed further below.

5.2.2 Gender differences in HIV prevalence

Overall, the HIV prevalence did not vary by sex of the educator; this was the case even after controlling (through multiple logistic regression) for other socio-demographic, socioeconomic and sexual behavior variables. However, differences were observed when the analysis was restricted to women and men aged 25-34 years. The HIV prevalence among educators aged 25-29 (female: 21.5%, 95% CI: 17.7, 25.9; male: 12.3%. 95% CI: 8.9,16.6) and those aged 30-34 (female: 24.2%, 95% CI: 22.1,26.5; male: 19.4%, 95% CI: 16.5,21.9) differ by sex and age of the educator. Clearly in the younger age groups there were significant differences by sex of the educator. This distribution is similar to the epidemiological curve observed in the general population of South Africa (Nelson Mandela/HSRC Study of HIV/AIDS 2002). This is expected because men and women in these age groups are at the height of their reproductive period. Non-marital pregnancy was more common among African and coloured women than among whites and non-existent among Indian women educators. The study also found that the level of marital pregnancy at each reproductive age was higher than the corresponding level of non-marital pregnancy. In the absence of microbicides that kill the HIV virus while preserving the sperm, women are likely to continue to risk acquiring HIV in the process of trying to conceive, and men are also likely to continue to become infected while attempting to impregnate their partners. Given the observed findings that single people had a significantly higher rate of HIV (22.9%) than married persons (8.2%), it would be advisable for single people to avoid non-marital pregnancy.

Gender is considered to be key in containing the spread of HIV. The combination of biology, gender construction, socio-economic status and behavior contribute to high rates of HIV in women (Shisana 8; Davids 2004). This study found high rates of HIV in women aged 25-34 years compared to their male counterparts. As observed earlier, women are a majority within the education sector and if more women continue to be infected this will negatively affect the supply of education in South Africa. For this reason, there is a need to understand the gender dimension that may account for high HIV prevalence in this group. First it is known that women are biologically more susceptible to HIV infection than men, mainly because of their biological make-up (International Council of Nurses, WHO and UNAIDS 2000). Second, gender and socio-economic disparities contribute to high rates of HIV infection. These are explored further below.

Young women had a higher estimated HIV prevalence despite the observation that they reported to have lower rates of multiple sexual partners than their male counterparts. This result suggests that infection happens for women within a single sexual relationship where either trust or ignorance of HIV status of the partner may interfere with condom use. Another possibility is that while the women might be faithful to one partner the other partner may not be faithful to them as reported by men in this study. Because of gender construction in our society that disempowers women in negotiating safe sex, younger women are at increased risk of HIV. Ackerman and De Klerk (2002) also note that social factors such as the high rate of rape, the unfavorable economic position of women, and the inability to insist on condom usage make South African women unable to negotiate the timing of sex and the conditions under which it occurs. The phenomenon of men having multiple partners also suggests that
women and men have different norms that determine their behavior. Even among educated communities women's and men's sexuality is viewed differently. Having multiple partners is generally more acceptable for men than women. Traditionally a man's need for sex and the right to more than one partner have been sanctioned or accepted in many African Cultures (Manuh 1998).

Other practices that are acceptable for men include age mixing of sex partners. It is acceptable for men to have younger sexual partners but this practice is frowned upon for females. The results suggest the majority of educators in this study had partners, who were, within ten years of their age. However when the analysis was done by sex of the respondent, the results showed that 14.1% of the men had a partner who was ten years younger than themselves compared to 0.6% of women. This result suggests that older men tend to have sex with much younger women who implies that there are power dynamics in sexual relations which increase risk of infection; among younger women. But it is also possible that older men who have younger female sexual partners increase their risk of HIV because HIV is more prevalent in younger women. Luke (2003) examined more than 45 quantitative studies in sub-Saharan Africa and found that relationships with older partners and those that involve economic transactions are common and that these asymmetries are associated with unsafe sexual behaviors and increased risk of HIV infection. Although the reasons that adolescent girls engage in sexual relationships with older men are varied, receipt of financial benefits is a major motivation. Encouraging people to have sexual relations with partners; in their age group could break this vicious cycle.

Gender disparities were evident among educators. Women educators were more advantaged than men in the following areas: they were more likely than men to get a post in the area near their families; to get a post in the city; to be married at the start of their career; less likely to be redeployed; and less likely to move to different areas in the past ten years, and when they moved they were more likely than men to move with their family.

There were areas, mainly in the economic sphere, where women were disadvantaged, which may increase their vulnerability to HIV: they were less educated than their male counterparts; they were more likely to be employed in the lower ranks and much less likely to be principals or deputy principals -hence they were more likely to earn less money than male educators: they were less likely to have a housing subsidy or to have medical aid. The roles and responsibilities of women with regard to domestic work, carried over and above their education responsibilities, were more than those of men; specifically, more women than men were likely to take care of a family member who had HIV/AIDS or who died from AIDS.

In examining the data on behaviors that increase women's risk of HIV the study found the following: in the group with the highest HIV prevalence (persons aged 25-34 years), women were less likely than men to report having used a condom during the last sexual act. This is not a surprise since male condoms can only be worn by males and female condoms are not accessible due to cost. In addition, women were more likely than men to report not having a sexual partner and less likely to have multiple partners in the past 12 months, suggesting it is the sexual behavior of their male partners which increases their risk for HIV infection.

5.2.3 Racial differences in HIV prevalence

There were major differences in HIV prevalence by race. The highest prevalence was among Africans; 16% were found to be HIV positive. The prevalence among other racial groups
was less than 1%. It is important to note that the relative high CVr values for whites, coloureds and Indians (0.31, 0.29 and 0.39) resulted from the very low prevalence rate (r) values, suggesting that the prevalence of HIV among these groups should be interpreted with caution. It could be that other race groups knew their HIV status and hence did not give a specimen for HIV testing. Further analysis showed that there was a marginally significant association between knowing own HIV status prior to this study and giving a specimen for HIV testing in the current survey. Those who did not give a specimen were slightly more likely (93%) than those who did to know their HIV status already (negative). This observation is consistent throughout the races except among Indian/Asians. This analysis shows that the observed racial differences on HIV cannot be explained by differential willingness to give a specimen for HIV testing.

The differences in age distribution among the different racial groups may also account for why African educators had higher HIV prevalence than other racial groups. African educators were more likely to lie aged between 23 and 34 years (30.3% among males and 25.5% among females) compared to coloureds (22.6% males and 21.46 females), Indian (15.7% males and 21.9% females) and whites (15.1% males and 19.1% females). African educators were more concentrated in the high HIV-risk ages of 25-34 years than other racial groups, which makes them more vulnerable to HIV because the age group of 25-34 years is when many enter serious sexual relationships, leading to reproduction.

The observed HIV prevalence in Africans is similar to that of the general population but those for whites, coloureds and Indians differ from those of the general population (Nelson Mandela/HSRC Study of HIV/AIDS 2002). In the education population study, Africans had an HIV prevalence of 16% compared to 18.4% in the general population; other racial groups had prevalence under 1%. In the general population, among people aged 15-49 years, whites had an HIV prevalence of 6.2%, coloureds 6.6% and Indians 1.8%. This suggests that exposure to risk differs substantially by race. Some of the reasons for the observed differences may lie in exposure to risk factors. Upon completion of their education Africans, were more likely than other races to get jobs away from family and also to get jobs in rural areas. Furthermore, staying away from home overnight was more common among Africans than other racial groups and this was found to be related to HIV status. The study found that there was a strong relationship between mobility and HIV prevalence, particularly migration to rural areas.

5.2.4 HIV status and socio-economic status

Africans were more likely than other racial groups to belong to the low socio-economic strata: they were more likely to have no money for basic needs such as food; to earn less; to have lesser qualification; and to be on the bottom end of the teaching profession. Specifically, HIV prevalence was highest among junior educators and lowest among senior educators, education specialists and principals or deputy principals. In addition, educators who had low socio-economic SLIMS had a much higher HIV prevalence when compared to those in the high socio-economic group. The difference was substantial. Educators earning more than 8132 000 per annum have a prevalence of 5.4% and those earning R60 000 or less per annum had a prevalence of 17.5%. Even after controlling for other socio-economic and sexual behavior variables through logistic regression, income was still related to HIV status. Low socio-economic status increases vulnerability to HIV because the power to negotiate safe sex is related to economic power and also access to prevention information and healthcare is limited as a result of less income. The findings support the earlier observation that links
poverty with vulnerability to HIV (Calvin 2000; button 2000). Africans may be at the bottom end of the S000-econolIic ladder as a result of apartheid, with its bantu education system that provided inferior education to Africans.

5.2.5 Rural differences in HIV prevalence

In the general population, HIV prevalence is lower in rural areas but higher in urban areas (Nelson Mandela/HSRC Study of HIV/AIDS 2002). However, in the education population the reverse, was found. This is probably because educators placed in rural areas may have a higher disposable income compared to adults living in these rural areas, and given that they are less likely to move with their spouses or regular partners, they are likely to have multiple sexual partners. This matter is discussed further below.

5.2.6 Migration and HIV

Migration and mobility have long been identified as risks to HIV infection and also facilitate the spread of HIV in Southern Africa (see for example, Lurie, Williams, Zuma, Mkaya-Mwamburi, Garnett, Surm, Sweat, Gittelsohn & Karim 2003). Main factors increasing the vulnerability of mobile populations are, in particular, the obligation to travel regularly and live away from spouses, and separation from socio-cultural norms that regulate behavior in stable communities, as well as work in isolated environments with limited recreation, easy access to commercial sex workers, drugs and alcohol and a sense of anonymity which allows for more sexual freedom. These are just a few factors that might be relevant for educators who are mobile or migrating. This study found that educators residing in rural areas and those working in rural schools had higher HIV prevalence than educators residing in urban areas and teaching in urban schools. Educators whose residence was further than 10 km away from home also had a slightly higher HIV prevalence than those who traveled less than 10 km to their school, but the differences were not significant. Teachers in poorer rural areas fall in the high-income group by local standards, possibly resulting in them being seen as a desirable group with whom to have sexual relationships. This suggests that income may be an additional risk factor: higher income earners are able also to buy sex and alcohol for example. This risk factor, was also found by Shisana, Zungu-Dinvayi, Toefy, Simbayi, Malik and Zuma (?004), suggesting that the affluent groups in society may be at risk not only because of the power to buy luxuries, but also to attract risks such as multiple partners and so on.

5.2.7 HIV prevalence: differences by type of school: primary, secondary or combined

Comparing the HIV status of educators at primary, combined and secondary / high schools, HIV prevalence, was highest (16.5%) among educators teaching in schools which combined primary and secondary education compared to those that separated these. However, this is confounded by race and province. These combined schools are mostly found in the Eastern Cape and they are located in the North West provinces, and they- are located in African schools.

5.2.8 HIV prevalence: differences by learning area

Investigation also extended to the extent of the problem of HIV among educators teaching different learning areas. The observed HIV prevalence among educators teaching the different learning areas was more than 100 % except for technology educators whose
prevalence was 7.4% and those teaching additional languages, whose prevalence was 23.3%. Most of the latter were of African origin. It is important to note that economics and management science, mathematics and science educators are as likely to be living with HIV as any other educators from other learning areas, except the two mentioned above.

5.2.9 HIV prevalence: differences by length of teaching experience

Further analysis of HIV prevalence, which took into account educators working experience, showed that the prevalence was highest among educators with the least teaching experience (0-4 and 5-9 years) and lowest among those who had been teaching for more than 15 years. As younger educators leave the system because of HIV/AIDS related illness and older educators retire because of aging and other reasons such as health or moving to better jobs, the supply of educators will be affected.

5.2.10 HIV prevalence: differences by province and district

The HIV prevalence was highest in KwaZulu-Natal and Mpumalanga and lowest in the Western Cape and Northern Cape provinces. Comparing the provincial HIV estimates derived from women in the education study, with those from antenatal clinic attendees and the population data, the estimates for educators were far lower than those of pregnant women. In five provinces KwaZulu-Natal, Mphumalanga, Free State, Eastern Cape and Limpopo) they were similar to the general population based on household surveys; the rest had far lower HIV prevalence than compared to the population in those provinces. These findings suggest that more resources for HIV prevention, treatment and care would be needed for KwaZulu-Natal and Mphumalana to reduce the impact of HIV on the education system.

To determine the areas warranting targeted interventions it was essential to estimate HIV prevalence by district council. The results revealed that the very high HIV prevalence (=>20%) was found in only 11 out of 54 districts, located in KwaZulu-Natal (8), Mpumalanga (2) and Eastern Cape (1). The districts with the lowest HIV prevalence were Western Cape and Northern Cape where the prevalence was less than 5%. The metropolitan district councils had HIV prevalence of less than 10%. The observation that it is not all districts that have extremely high HIV prevalence helps in planning strategies for mitigating the impact of HIV/AIDS. The low prevalence in the Western Cape, Northern Cape and metropolitan council’s needs to be further analysed to understand what is being done that contributes to lower HIV infections among educators in these areas. This analysis will be presented in the forthcoming July 2005 report.
The South African government responds to HIV and AIDS

Anso Thom and Kerry Cullinan

On the website, Health-e.org.za, on 28 November 2004, two journalists posted a media digest of the response of the South African government to HIV and AIDS from the time when the first two AIDS deaths were reported in 1982.
The first two official AIDS deaths in South Africa were recorded in 1982. This timeline tracks the course of the epidemic in South Africa from then until now.

1982
The first two official AIDS deaths are recorded.

1983
The Department of Health reassures South Africans that AIDS only poses a threat to “homosexuals”.
“Homosexuality is not accepted by the majority of the population and certainly not by the Afrikaans speaking population. To advocate that homosexuals use the condom is therefore very difficult,” says Dr Coen Slabber, Director General of the Health Department.

1985
Government sets up an AIDS advisory group that includes immunologist Reuben Sher.

1987
“Although a relatively small number of cases has been diagnosed so far in South Africa, the disease certainly has the potential to become a major problem.” -- Dr Willie van Niekerk, Minister of Health and Population Development.
The Chamber of Mines identifies 130 employees with HIV/AIDS. Alarmed by the potential threat posed by “foreign” mineworkers, government passes regulations allowing non-citizens with HIV/AIDS to be denied entry or deported.

1988
“Promiscuity is the greatest danger, whether one likes it or not.” Dr Willie van Niekerk, Minister of Health and Population Development.
PFP spokesperson on health, Dr Marius Barnard, asks that HIV/AIDS “carriers” be isolated. The contracts of HIV positive mineworkers from surrounding countries are not renewed. Government launches its first AIDS awareness campaign but R4-million of the campaign’s budget is spent on the “Info song”, to promote the Department of Information.

1989
Dr Reuben Sher warns that HIV/AIDS could become “a biological holocaust”.

1990
"Everyone must strive for themselves and those closest to them to change their risky sexual behaviour and settle for a single sex partner, preferably within a marriage.” - Dr Rina Venter, Health Minister.
In 1990 the first antenatal surveys to test for HIV are carried out, and 0.7% of pregnant women test HIV positive.
“Those of us in exile are especially in the unfortunate situation of being in the areas where the incidence of this disease is high. We cannot afford to allow the AIDS epidemic to ruin the realisation of our dreams. Existing statistics indicate that we are still at the beginning of the AIDS epidemic in our country. Unattended, however, this will result in untold damage and suffering by the end of the century,” Umkhonto we Sizwe leader Chris Hani tells a meeting in Maputo.
1991
For the first time, the number of heterosexually contracted HIV infections is equal to that of homosexually contracted infections.

1992
The National AIDS Convention of South Africa (NACOSA) is formed to begin developing a national strategy to cope with AIDS. The free National AIDS helpline is started.

1993
The National Health Department reports that the number of recorded HIV infections has increased by 60% in the previous two years.

1994
Health Minister Nkosazana Zuma accepts the NACOSA strategy as the foundation of the government’s AIDS plan.

1995
NACOSA’s appeal for AIDS to be located in the President’s Office is refused.

1996
NACOSA holds a briefing on AIDS for Members of Parliament, but only 14 MPs attend. Public outcry over government’s allocation of R14.3-million to Sarafina II, a play supposed to educate South Africans about HIV/AIDS. No proper tender procedures were followed, the educational content of the play is questionable and hardly anyone gets to see the play.

1997
“The vision which fuelled our struggle for freedom; the deployment of energies and resources; the unity and commitment to common goals – all these are needed if we are to bring AIDS under control. Future generations will judge us on the adequacy of our response,” President Nelson Mandela tells a meeting in Switzerland in one of his few speeches that mentions AIDS during his presidency.
* An Inter-ministerial Committee on HIV/AIDS is established in Parliament

1998
Government replaces the Medicines Control Council after it refuses to fast-track approval for Virodene, the AIDS treatment promoted by Mbeki and Nkosazana Zuma, which is later found to contain a toxic industrial solvent. Government decides not to make AZT available to pregnant women.
9 October: The 'Partnership Against AIDS' is launched by then Deputy President Thabo Mbeki to mobilise all South Africans to work together.
10 December: Treatment Action Campaign is launched

1999
“There also exists a large volume of scientific literature alleging that, among other things, the toxicity of [AZT] is such that it is a danger to health,” Mbeki tells the National Council of Provinces on 29 October, in the first public indication that he is starting to question orthodox views about HIV/AIDS.
2 December: The Department of Health has its first contact with AIDS “dissidents” when Charles Geshekter meets Health Minister Manto Tshabalala-Msimang.
2000
January: President Mbeki contacts dissident David Rasnick and asks his help to answer a number of questions about HIV and AIDS.
May 6: Mbeki establishes Presidential Advisory Panel on AIDS consisting of orthodox and “dissident” scientists to look at issues such as “what causes the immune deficiency that leads to deaths from AIDS”.
July: South Africa hosts the International AIDS Conference in Durban. Prominent scientists issue the ‘Durban Declaration” outlining that HIV causes AIDS. Presidential spokesperson Parks Mankahhala says it belongs in the dustbin.
The Sunday Times publishes an exchange of letters about AIDS between Mbeki and DA leader Tony Leon. In these, Mbeki claims that racist notions about African sexuality and rape are driving notions about the AIDS epidemic.
“The government constantly invents new obstacles and when they are resolved creates further obstacles to pursue an unscientific policy.” – TAC press statement, August.
September: During a debate on AIDS in Parliament, Mbeki says that “a virus cannot cause a syndrome” and warns that “if any Members of Parliament are taking these [antiretroviral] drugs, they need to have a look at that otherwise they are going to suffer negative consequences”.  
26 October: Presidential spokesperson Parks Mankahhala dies. While there is official denial that he died of AIDS, a document later circulated in ANC circles claims that he was killed by ARV drugs.

2001
“Is our government treating the lives of over four million predominantly poor black people as dispensable?” TAC press statement, 1 June.
21 August: TAC, Dr Haroon Salojee and the Children’s Rights Centre file a motion in the Pretoria High Court intended to compel the Health minister and provincial MECs to make nevirapine available to all women who give birth in state hospitals.
September: Mbeki questions the accuracy of incidence of AIDS death statistics. “And thus does it happen that other who consider themselves to be our leaders take to the streets carrying their placards, to demand that because we are germ carriers and human beings of a lower order that cannot subject its passions to reason, we must perforce adopt strange opinions, to save a depraved and diseased people from perishing from self-inflicted disease,” says Mbeki in an address at Fort Hare University, 12 October.
December: The Pretoria High Court orders government to provide nevirapine to all pregnant women deemed by superintendents of state hospitals to need it.

2002
ANC leader Peter Mokaba distributes “Castro Hlongwane, Caravans, Cats, Geese, Foot and Mouth and Statistics” within the party. The document claims that those who oppose the AIDS dissidents are inspired by racist beliefs about African promiscuity. The document’s embedded electronic signature is later traced to Mbeki.
February: TAC and Medicins sans Frontieres announce that they are importing ARV drugs from Brazil.
5 April: The Constitutional Court upholds the ‘nevirapine judgement’.
“The denial of the facts about AIDS is not only an outrage against the truth. It is a profound insult to those South Africans who are living with and dying from the effects of the virus.” – Judge Edwin Cameron, 13 April.
17 April: Cabinet decides that ARVs should be made available to all rape survivors as post-exposure prophylaxis, and that government should examine ways to introduce ARVs into
public health.
9 June: Outspoken AIDS dissident and ANC leader Peter Mokaba dies of “natural causes”.
August: Anglo-American says it will give its workers ARVs.
December: "South Africa cannot afford drugs to fight HIV and Aids partly because it needs submarines to deter attacks from nations such as the US," the Guardian quotes Minister Tshabalala-Msimang as saying.

2003
14 February: 10 000 people march at the opening of Parliament calling for ARVs for all those who need them.
March: Health Minister Tshabalala-Msimang appoints AIDS dissident Roberto Giraldo as her nutritional adviser.
“We voted for this government, we accept its legitimacy and its laws. But we cannot accept its unjust policy on HIV/AIDS that is causing the deaths of more than 600 people every day. Today we break the law to end an unjust policy not an unjust government.” -- TAC at the launch of its civil disobedience campaign, 20 March.
Personally, I don’t know anybody who has died of AIDS. I really honestly don’t.” Thabo Mbeki says in an interview in the Washington Post on 25 September.
19 November: Cabinet gives the go-ahead to a comprehensive AIDS treatment plan that will offer free ARVs in all districts of the country.
Minister Tshabalala-Msimang continues to advocate a diet of beetroot, olive oil, African potato and garlic for people with HIV.

2004
Government is criticised for taking too long to offer ARVs in all health districts.
This reading contains the Executive Summary of the report on this survey. The main objectives of the study were to:

- determine the HIV prevalence among South African children;
- identify social and community risk factors that predispose children to HIV infection;
- determine the number of orphans and child-headed households to assist in proper planning and to intervene where necessary;
- assess children's knowledge of HIV/AIDS prevention – an important factor in children's vulnerability to HIV infection.

The survey found that children run a much greater risk of contracting HIV than previously thought. The report explores some of the reasons for this. It also provides insight into the numbers of children who have been orphaned, and also the percentage of children who are heading households.

The report helps us to get the big picture of the impact of HIV and AIDS on the children in our country. This can provide us with an informed basis for action in the school communities in which we find ourselves.
A total of 3,988 children aged 2 to 18 years participated in the survey. Caregivers of 2,138 children 2 to 11 years of age answered a questionnaire on the child's behalf. A total of 740 children 12 to 14 years of age directly answered a separate questionnaire. An additional 1,110 children between 15 and 18 years of age, answered a youth questionnaire. Of the 3,988 children, 3,294 (82.6 per cent) provided a saliva specimen for HIV testing.

The results show HIV prevalence among children 2 to 18 years of age to be 5.4%. Prevalence was nearly constant across age groups and did not vary significantly. There were insufficient numbers to compare prevalence across race groups. The prevalence was higher than expected. Further studies are necessary to verify this finding.

Maternal orphan rate is 3.3% for children 2 to 18 years of age. One tenth of children have lost a parent/caregiver by 9 years of age and 15 per cent have lost a parent/caregiver by the age of 14 years. Among children 15 to 18 years, almost 25% have lost at least one parent/caregiver. Children of African descent, children in poor households, and children living in informal settlements are most affected. Comparison with previous surveys on orphanhood show that orphanhood has not substantially increased since 1995. This finding suggests that South Africa has not yet experienced the full impact of HIV/AIDS on orphanhood and that there is still time to anticipate and prepare for an increase in orphanhood.

3% of children 12 to 18 years of age said they were the head of the household. Overall, 0.5% of households claimed to be headed by a child between 14 and 18 years of age. This finding is higher than the 0.25% of households headed by children from the 1999 October Household Survey. However, South Africa may not yet have experienced the full impact of HIV/AIDS resulting in child-headed households.

This study identified three components of child vulnerability to HIV infection over and above vertical transmission. These were: risk environments, care and protection of children and knowledge and communication about sex and HIV/AIDS. For ethical and legal reasons, the study did not ask children about sexual abuse. Numbers were insufficient to compare HIV prevalence with these three components of child vulnerability.

Risk environments included levels of poverty, settlement type, businesses at home and exposure to alcohol/drug use. 45% of children live in homes where there is not enough money for food and clothes. Of the households surveyed with at least one child 2 to 11 years of age, 12.7% run businesses from home, mainly spaza shops and taverns. Almost .32% of children are exposed to someone in their home and neighbourhood who gets drunk once a month.

Measurement of care and protection of children in homes found that:
1.3% of children 2 to 11 years and 4.2% of children 12 to 14 years had a caregiver younger than 18 years of age.
At least 5% of children 2 to 11 years of age and over 10% of children 12 to 14 years of age are not adequately monitored.

Examination of high risk practices where children are unprotected showed that almost 50% of children 2 to 11 years of age and 75% of children 12 to 14 years are sent out of the home alone on errands.
At least a third of children aged 2 to 11 and two thirds of children aged 12 to 14 years are allowed outside the home yard without adult supervision.
15% of children 2 to 11 years and almost 50% of children 12 to 14 years are left at home alone.
Almost a third of children 2 to 14 years of age are left at home in the care of a person 15 years or younger.

Measurement of care and protection in schools found that:
Traveling to and from school is a risk with the majority of children traveling to school on foot mostly accompanied by their peers with little adult protection.
Under half of children surveyed say educators watch children arrive and leave school.
A third of children say educators watch children during breaks and monitor toilets.
Two thirds of children report that educators ensure that no unauthorised person enters their school.
Two fifths of children report boys sexually harass girls.
15% of children report that male educators propose relationships with learners.

Investigation of knowledge and communication about HIV/AIDS found that:
About one tenth of caregivers of children 2 to 11 have discussed sex and HIV/AIDS with them. Almost a third have talked about sexual abuse. Caregivers are significantly more likely to discuss these topics with girls than with boys in their care. Two thirds of caregivers say they are comfortable talking about sex and HIV/AIDS with children in their care.
Just over 40% of children 12 to 14 years of age report that their parents/caregivers have spoken to them about sex and HIV/AIDS. Half of all children in this age group report that their parents/caregivers have discussed sexual abuse with them. Again parents/caregivers are significantly more likely to have discussed these topics with girls.
70% of children 12 and over feel comfortable talking with a family member about sex and HIV/AIDS.
Schools and educators are the most important source of information on HIV/AIDS for children 12 to 14 years of age followed by family, the main source being their mothers.
Only 1.5% and 1.2% of children have learned about sex and sexual abuse from their fathers.
Among children 12 to 14 years of age, only half agree that HIV can be transmitted through unprotected vaginal sex. Just over two thirds of children said that condoms protected a person from getting HIV/AIDS. Correct knowledge of how HIV is transmitted and how to protect against contracting this disease was higher among children whose parents/caregivers had spoken to them about HIV/AIDS.
National policy on HIV/Aids for schools


GENERAL NOTICES

NOTICE 1926 OF 1999

DEPARTMENT OF EDUCATION

NATIONAL EDUCATION POLICY ACT, 1996 (NO. 27 OF 1996)

NATIONAL POLICY ON HIV/AIDS, FOR LEARNERS AND EDUCATORS IN PUBLIC SCHOOLS, AND STUDENTS AND EDUCATORS IN FURTHER EDUCATION AND TRAINING INSTITUTIONS

I, Kader Asmal, Minister of Education, after consultation with the Council of Education Ministers, hereby publish the national policy on HIV/AIDS for learners in public schools, and students and educators in further education and training institutions, in terms of section 3(4) of the National Education Policy Act, 1996 (No. 27 of 1996), as set out in the Schedule.

PROFESSOR KADER ASMAL
MINISTER OF EDUCATION
AUGUST 1999
SCHEDULE

NATIONAL POLICY ON HIV/AIDS FOR LEARNERS AND EDUCATORS IN PUBLIC SCHOOLS AND STUDENTS AND EDUCATORS IN FURTHER EDUCATION AND TRAINING INSTITUTIONS

PREAMBLE

Acquired Immune Deficiency Syndrome (AIDS) is a communicable disease that is caused by the Human Immunodeficiency Virus (HIV).

In South Africa, HIV is spread mainly through sexual contact between men and women. In addition, around one third of babies born to HIV-infected women will be infected at birth or through breast-feeding. The risk of transmission of the virus from mother to baby is reduced by antiretroviral drugs.

Infection through contact with HIV-infected blood, intravenous drug use and homosexual sex does occur in South Africa, but constitutes a very small proportion of all infections. Blood transfusions are thoroughly screened and the chances of infection from transfusion are extremely low.

People do not develop AIDS as soon as they are infected with HIV. Most experience a long period of around 5 - 8 years during which they feel well and remain productive members of families and workforces. In this asymptomatic period, they can pass their infection on to other people without realising that they are HIV infected.

During the asymptomatic period, the virus gradually weakens the infected person's immune system, making it increasingly difficult to fight off other infections. Symptoms start to occur and people develop conditions such as skin rashes, chronic diarrhoea, weight loss, fevers, swollen lymph glands and certain cancers. Many of these problems can be prevented or treated effectively. Although these infections can be treated, the underlying HIV infection cannot be cured.

Once HIV-infected people have a severe infection or cancer (a condition known as symptomatic AIDS) they usually die within 1 to 2 years. The estimated average time from HIV infection to death in South Africa is 6 to 10 years. Many HIV infected people progress to AIDS and death in much shorter periods. Some live for 10 years or more with minimal health problems, but virtually all will eventually die of AIDS.

HIV-infected babies generally survive for shorter periods than HIV-infected adults. Many die within two years of birth, and most will die before they turn five. However, a significant number may survive even into their teenage years before developing AIDS.

No cure for HIV infection is available at present. Any cure which is discovered may well be unaffordable for most South Africans.
HIV/AIDS is one of the major challenges to all South Africans. The findings of the 1998 HIV survey among pregnant women attending public antenatal clinics of the Department of Health, show that the HIV/AIDS epidemic in South Africa is among the most severe in the world and it continues to increase at an alarming pace. The rate of increase is estimated at 33.8%. Using these figures, it is estimated that one in eight of the country's sexually active population those over the age of 14 years - is now infected. In the antenatal survey, the prevalence of HIV/AIDS among pregnant women under the age of 20 years has risen by a frightening 65.4% from 1997 to 1998.

According to the 1998 United Nations Report on HIV/AIDS Human Development in South Africa, it is estimated that almost 25% of the general population will be HIV positive by the year 2010. The achievements of recent decades, particularly in relation to life expectancy and educational attainment, will inevitably be slowed down by the impact of current high rates of HIV prevalence and the rise in AIDS-related illnesses and deaths. This will place increased pressures on learners, students and educators. Because the Ministry of Education acknowledges the seriousness of the HIV/AIDS epidemic, and international and local evidence suggests that there is a great deal that can be done to influence the course of the epidemic,

The Ministry is committed 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. This policy seeks to contribute towards promoting effective prevention and care within the context of the public education system.

In keeping with international standards and in accordance with education law and the constitutional guarantees of the right to a basic education, the right not to be unjustly discriminated against, the right to life and bodily integrity, the right to privacy, the right to freedom of access to information, the right to freedom of conscience, religion,thought, belief and opinion, the right to freedom of association, the right to a safe environment, and the best interests of the child, the following shall constitute national policy.

1 DEFINITIONS

In this policy any expression to which a meaning has been assigned in the South African Schools Act, 1996 (Act No. 84 of 1996), the Further Education and Training Act, 1998 (Act No. 98 of 1998) and the Employment of Educators Act, 1998 (Act No. 76 of 1998), shall have that meaning and, unless the context otherwise indicates

"AIDS" means the acquired immune deficiency syndrome, that is the final phase of HIV infection;

"HIV" means the human immunodeficiency virus;

"institution" means an institution for further education and training, including an institution contemplated in section 38 of the Further Education and Training Act, 1998 (Act No. 98 of 1998);

"sexual abuse" means abuse of a person targeting their sexual organs, e.g. rape, touching their private parts, or inserting objects into their private parts;
"unfair discrimination" means direct or indirect unfair discrimination against anyone on one or more grounds in terms of the Constitution of the Republic of South Africa, 1996 (Act No.108 of 1996);

"universal precautions" refers to the concept used worldwide in the context of HIV/AIDS to indicate standard infection control procedures or precautionary measures aimed at the prevention of HIV transmission from one person to another and includes procedures concerning basic hygiene and the wearing of protective clothing such as latex or rubber gloves or plastic bags when there is a risk of exposure to blood, blood-borne pathogens or blood-stained body fluids;

"violence" means violent conduct or treatment that harms the person of the victim, for example assault and rape;

"window period" means the period of up to three months before HIV antibodies appear in the blood following HIV infection. During this period HIV tests cannot determine whether a person is infected with HIV or not.

2 PREMISES

2.1 Although there are no known cases of the transmission of HIV in schools or institutions, there are learners with HIV/AIDS in schools. More and more children who acquire HIV prenatally will, with adequate medical care, reach school-going age and attend school. Consequently a large proportion of the learner and student population and educators are at risk of contracting HIV/AIDS.

2.2 HIV cannot be transmitted through day-to-day social contact. The virus is transmitted only through blood, semen, vaginal and cervical fluids and breast milk. Although the virus has been identified in other body fluids such as saliva and urine, no scientific evidence exists to show that these fluids can cause transmission of HIV.

2.3 Because of the increase in infection rates, learners, students and educators with HIV/AIDS will increasingly form part of the population of schools and institutions. Since many young people are sexually active, increasing numbers of learners attending primary and secondary schools, and students attending institutions might be infected. Moreover, there is a risk of HIV transmission as a result of sexual abuse of children in our country. Intravenous drug abuse is also a source of HIV transmission among learners and students. Although the possibility is remote, recipients of infected blood products during blood transfusions (for instance haemophiliacs), may also be present at schools and institutions. Because of the increasing prevalence of HIV/AIDS in schools, it is imperative that each school must have a planned strategy to cope with the epidemic.

2.4 Because of the nature of HIV antibody testing and the "window period" or "apparently well period" between infection and the onset of clearly identifiable symptoms, it is impossible to know with absolute certainty who has HIV/AIDS and who does not. Although the Department of Health conducts tests among women attending ante-natal clinics in public health facilities in South Africa as a mechanism of monitoring the progression of the HIV epidemic in South Africa, testing for HIV/AIDS for employment or attendance at schools is prohibited.
2.5 Compulsory disclosure of a learner's, student's or educator's HIV/AIDS status to school or institution authorities is not advocated as this would serve no meaningful purpose. In case of disclosure, educators should be prepared to handle such disclosures and be given support to handle confidentiality issues.

2.6 Learners and students with HIV/AIDS should lead as full a life as possible and should not be denied the opportunity to receive an education to the maximum of their ability. Likewise, educators with HIV/AIDS should lead as full a professional life as possible, with the same rights and opportunities as other educators and with no unfair discrimination being practiced against them. Infection control measures and adaptations must be universally applied and carried out regardless of the known or unknown HIV status of individuals concerned.

2.6.1 The risk of transmission of HIV in the day-to-day school or institution environment in the context of physical injuries, can be effectively eliminated by following standard infection-control procedures or precautionary measures (also known as universal precautions) and good hygiene practices under all circumstances. This would imply that in situations of potential exposure, such as in dealing with accidental or other physical injuries, or medical intervention on school or institution premises in case of illness, all persons should be considered as potentially infected and their blood and body fluids treated as such.

2.6.2 Strict adherence to universal precautions under all circumstances in the school or institution is advised.

2.6.3 Current scientific evidence suggests that the risk of HIV transmission during teaching, sport and play activities is insignificant. There is no risk of transmission from saliva, sweat, tears, urine, respiratory droplets, handshaking, swimming-pool water, communal bath water, toilets, food or drinking water. The statement about the insignificant risk of transmission during teaching, sport and play activities, however, holds true only if universal precautions are adhered to. Adequate wound management has to take place in the classroom and laboratory or on the sports field or playground when a learner or student sustains an open bleeding wound. Contact sports such as boxing and rugby could probably be regarded as sports representing a higher risk of HIV transmission than other sports, although the inherent risk of transmission during any such sport is very low.

2.6.4 Public funds should be made available to ensure the application of universal precautions and the supply of adequate information and education on HIV transmission. The State's duty to take all reasonable steps to ensure safe school and institution environments, is regarded as a sound investment in the future of South Africa.

2.6.5 Within the context of sexual relations, the risk of contracting HIV is significant. There are high levels of sexually active persons within the learner population group in schools. This increases the risk of HIV transmission in schools and institutions for further education and training considerably. Besides sexuality education, morality and life skills education being provided by educators, parents should be encouraged to provide their children with healthy morals, sexuality education and guidance.
2.7 The constitutional rights of all learners, students and educators must be protected on an equal basis. If a suitably qualified person ascertains that a learner, student or educator poses a medically recognized significant health risk to others, appropriate measures should be taken. A medically recognised significant health risk in the context of HIV/AIDS could include the presence of untreatable contagious (highly communicable) diseases, uncontrollable bleeding, unmanageable wounds, or sexual or physically aggressive behaviour, which may create the risk of HIV transmission.

2.8 Furthermore, learners and students with infectious illnesses such as measles, German measles, chicken pox, whooping cough and mumps should be kept away from the school or institution to protect all other members of the school or institution, especially those whose immune systems may be impaired by HIV/AIDS.

2.9 Schools and institutions should inform parents of vaccination/inoculation programmes and of their possible significance for the wellbeing of learners and students with HIV/AIDS. Local health clinics could be approached to assist with immunisation.

2.10 Learners and students must receive education about HIV/AIDS and abstinence in the context of life-skills education on an ongoing basis. Life-skills and HIV/AIDS education should not be presented as isolated learning content, but should be integrated in the whole curriculum. It should be presented in a scientific but understandable way. Appropriate course content should be available for the pre-service and in-service training of educators to cope with HIV/AIDS in schools. Enough educators to educate learners about the epidemic should also be provided.

2.10.1 The purpose of education about HIV/AIDS is to prevent the spread of HIV infection, to allay excessive fears of the epidemic, to reduce the stigma attached to it and to instill nondiscriminatory attitudes towards persons with HIV/AIDS. Education should ensure that learners and students acquire age and context-appropriate knowledge and skills in order that they may adopt and maintain behaviour that will protect them from HIV infection.

2.10.2 In the primary grades, the regular educator should provide education about HIV/AIDS, while in secondary grades the guidance counselor would ideally be the appropriate educator. Because of the sensitive nature of the learning content, the educators selected to offer this education should be specifically trained and supported by the support staff responsible for life skills and HIV/AIDS education in the school and province. The educators should feel at ease with the content and should be a rolemodel with whom learners and students can easily identify. Educators should also be informed by the principal and educator unions of courses for educators to improve their knowledge of, and skills to deal with, HIV/AIDS.
2.10.3 All educators should be trained to give guidance on HIV/AIDS. Educators should respect their position of trust and the constitutional rights of all learners and students in the context of HIV/AIDS.

2.11 In order to meet the demands of the wide variety of circumstances posed by the South African community and to acknowledge the importance of governing bodies, councils and parents in the education partnership, this national policy is intended as broad principles only. It is envisaged that the governing body of a school, acting within its functions under the South African Schools Act, 1996, and the Council of a Further Education and Training Institution, acting within its functions under the Further Education and Training Act, 1998, or any provincial law, should preferably give operational effect to the national policy by developing and adopting an HIV/AIDS implementation plan that would reflect the needs, ethos and values of a specific school or institution and its community within the framework of the national policy.

3 NON-DISCRIMINATION AND EQUALITY WITH REGARD TO LEARNERS, STUDENTS AND EDUCATORS WITH HIV/AIDS

3.1 No learner, student or educator with HIV/AIDS may be unfairly discriminated against directly or indirectly. Educators should be alert to unfair accusations against any person suspected to have HIV/AIDS.

3.2 Learners, students, educators and other staff with HIV/AIDS should be treated in a just, humane and life-affirming way.

3.3 Any special measures in respect of a learner, student or educator with HIV should be fair and justifiable in the light of medical facts, established legal rules and principles; ethical guidelines; the best interest of the learner, student and educator with HIV/AIDS; school or institution conditions; and the best interest of other learners, students and educators.

3.4 To prevent discrimination, all learners, students and educators should be educated about fundamental human rights as contained in the Constitution of the Republic of South Africa, 1996.

4 HIV/AIDS TESTING AND THE ADMISSION OF LEARNERS TO A SCHOOL AND STUDENTS TO AN INSTITUTION, OR THE APPOINTMENT OF EDUCATORS

4.1 No learner or student may be denied admission to or continued attendance at a school or an institution on account of his or her HIV/AIDS status or perceived HIV/AIDS status.

4.2 No educator may be denied the right to be appointed in a post, to teach or to be promoted on account of his or her HIV/AIDS status or perceived HIV/AIDS status. HIV/AIDS status may not be a reason for dismissal of an educator, nor for refusing to conclude, or continue, or renew an educator's employment contract, nor to treat him or her in any unfair discriminatory manner.

4.3 There is no medical justification for routine testing of learners, students or educators for evidence of HIV infection. The testing of learners or students for HIV/AIDS as a prerequisite for admission to, or continued attendance at school or institution, to
determine the incidence of HIV/AIDS at schools or institutions, is prohibited. The testing of educators for HIV/AIDS as a prerequisite for appointment or continued service is prohibited.

5 ATTENDANCE AT SCHOOLS AND INSTITUTIONS BY LEARNERS OR STUDENTS WITH HIV/AIDS

5.1 Learners and students with HIV have the right to attend any school or institution. The needs of learners and students with HIV/AIDS with regard to their right to basic education should as far as is reasonably practicable be accommodated in the school or institution.

5.2 Learners and students with HIV/AIDS are expected to attend classes in accordance with statutory requirements for as long as they are able to do so effectively.

5.3 Learners of compulsory school-going age with HIV/AIDS, who are unable to benefit from attendance at school or home education, may be granted exemption from attendance in terms of section 4(1) of the South African Schools Act, 1996, by the Head of Department, after consultation with the principal, the parent and the medical practitioner where possible.

5.4 If and when learners and students with HIV/AIDS become incapacitated through illness, the school or institution should make work available to them for study at home and should support continued learning where possible. Parents should, where practically possible, be allowed to educate their children at home in accordance with the policy for home education in terms of section 51 of the South African Schools Act, 1996, or provide older learners with distance education.

5.5 Learners and students who cannot be accommodated in this way or who develop HIV/AIDS-related behavioural problems or neurological damage, should be accommodated, as far as is practically possible, within the education system in special schools or specialised residential institutions for learners with special education needs. Educators in these institutions must be empowered to take care of and support HIV-positive learners. However, placement in special schools should not be used as an excuse to remove HIV-positive learners from mainstream schools.

6 DISCLOSURE OF HIV/AIDS-RELATED INFORMATION AND CONFIDENTIALITY

6.1 No learner or student (or parent on behalf of a learner or student), or educator, is compelled to disclose his or her HIV/AIDS status to the school or institution or employer. (In cases where the medical condition diagnosed is the HIV/AIDS disease, the Regulations relating to communicable diseases and the notification of notifiable medical conditions Health Act, 1977 only require the person performing the diagnosis to inform the immediate family members and the persons giving care to the person and, in cases of HIV/AIDS-related death, the persons responsible for the preparation of the body of the deceased.)

6.2 Voluntary disclosure of a learner's, student's or educator's HIV/AIDS status to the appropriate authority should be welcomed and an enabling environment should be
6.3 A holistic programme for life-skills and HIV/AIDS education should encourage disclosure. In the event of voluntary disclosure, it may be in the best interests of a learner or student with HIV/AIDS if a member of the staff of the school or institution directly involved with the care of the learner or student, is informed of his or her HIV/AIDS status. An educator may disclose his or her HIV/AIDS status to the principal of the school or institution.

6.4 Any person to whom any information about the medical condition of a learner, student or educator with HIV/AIDS has been divulged, must keep this information confidential.

6.5 Unauthorised disclosure of HIV/AIDS-related information could give rise to legal liability.

6.6 No employer can require an applicant for a job to undergo an HIV test before he/she is considered for employment. An employee cannot be dismissed, retrenched or refused a job simply because he or she is HIV positive.

7 A SAFE SCHOOL AND INSTITUTION ENVIRONMENT

7.1 The MEC should make provision for all schools and institutions to implement universal precautions to eliminate the risk of transmission of all blood-borne pathogens, including HIV, effectively in the school or institution environment. Universal precautions include the following:

7.1.1 The basis for advocating the consistent application of universal precautions lies in the assumption that in situations of potential exposure to HIV, all persons are potentially infected and all blood should be treated as such. All blood, open wounds, sores, breaks in the skin, grazes and open skin lesions, as well as all body fluids and excretions which could be stained or contaminated with blood (for example tears, saliva, mucus, phlegm, urine, vomit, faeces and pus) should therefore be treated as potentially infectious.

(a) Blood, especially in large spills such as from nosebleeds, and old blood or blood stains, should be handled with extreme caution.

(b) Skin exposed accidentally to blood should be washed immediately with soap and running water.

(c) All bleeding wounds, sores, breaks in the skin, grazes and open skin lesions should ideally be cleaned immediately with running water and/or other antiseptics.

(d) If there is a biting or scratching incident where the skin is broken, the wound should be washed and cleansed under running water, dried, treated with antiseptic and covered with a waterproof dressing.
(e) Blood splashes to the face (mucous membranes of eyes, nose or mouth) should be
flushed with running water for at least three minutes.

(f) Disposable bags and incinerators must be made available to dispose of sanitary
wear.

7.1.2 All open wounds, sores, breaks in the skin, grazes and open skin lesions should at all
times be covered completely and securely with a non-porous or waterproof dressing
or plaster so that there is no risk of exposure to blood.

7.1.3 Cleansing and washing should always be done with running water and not in
containers of water. Where running tap water is not available, containers should be
used to pour water over the area to be cleansed. Schools without running water should
keep a supply, e.g. in a 25-litre drum, on hand specifically for use in emergencies.
This water can be kept fresh for a long period of time by adding a disinfectant, such as
Milton, to it.

7.1.4 All persons attending to blood spills, open wounds, sores, breaks in the skin, grazes,
open skin lesions, body fluids and excretions should wear protective latex gloves or
plastic bags over their hands to eliminate the risk of HIV transmission effectively.
Bleeding can be managed by compression with material that will absorb the blood,
e.g. a towel.

7.1.5 If a surface has been contaminated with body fluids and excretions which could be
stained or contaminated with blood (for instance tears, saliva, mucus, phlegm, urine,
vomit, faeces and pus), that surface should be cleaned with running water and fresh,
clean household bleach (1:10 solution), and paper or disposable cloths. The person
doing the cleaning must wear protective gloves or plastic bags.

7.1.6 Blood-contaminated material should be sealed in a plastic bag and incinerated or sent
to an appropriate disposal firm. Tissues and toilet paper can readily be flushed down a
toilet.

7.1.7 If instruments (for instance scissors) become contaminated with blood or other body
fluids, they should be washed and placed in a strong household bleach solution for at
least one hour before drying and re-using.

7.1.8 Needles and syringes should not be re-used, but should be safely disposed of.

7.2 All schools and institutions should train learners, students, educators and staff in first aid,
and have available and maintain at least two first aid kits, each of which should contain
the following:

(a) two large and two medium pairs of disposable latex gloves;

(b) two large and two medium pairs of household rubber gloves for handling blood-
soaked material in specific instances (for example when broken glass makes the use
of latex gloves inappropriate);
(c) absorbent material, waterproof plasters, disinfectant (such as hypochlorite), scissors, cotton wool, gauze tape, tissues, containers for water and a resuscitation mouth piece or similar device with which mouth-to-mouth resuscitation could be applied without any contact being made with blood or other body fluids.

(d) protective eye wear; and

(e) a protective face mask to cover nose and mouth.

7.3 Universal precautions are in essence barriers to prevent contact with blood or body fluids. Adequate barriers can also be established by using less sophisticated devices than those described in 7.2, such as

(a) unbroken plastic bags on hands where latex or rubber gloves are not available;

(b) common household bleach for use as disinfectant, diluted one part bleach to ten parts water (1:10 solution) made up as needed.

(c) spectacles; and

(d) a scarf.

7.4 Each classroom or other teaching area should preferably have a pair of latex or household rubber gloves.

7.5 Latex or household rubber gloves should be available at every sports event and should also be carried by the playground supervisor.

7.6 First-aid kits and appropriate cleaning equipment should be stored in one or more selected rooms in the school or institution and should be accessible at all times, also by the playground supervisor.

7.7 Used items should be dealt with as indicated in paragraphs 7.1.6 and 7.1.7.

7.8 The contents of the first-aid kits, or the availability of other suitable barriers, should be checked each week against a contents list by a designated staff member of the school or institution. Expired and depleted items should be replaced immediately.

7.9 A fully equipped first-aid kit should be available at all school or institution events, outings and tours, and should be kept on vehicles for the transport of learners to such events.

7.10 All learners, students, educators and other staff members, including sports coaches, should be given appropriate information and training on HIV transmission, the handling and use of first-aid kits, the application of universal precautions and the importance of adherence universal precautions.

7.10.1 Learners, students, educators and other staff members should be trained to manage their own bleeding or injuries and to assist and protect others.
7.10.2 Learners, especially those in pre-primary and primary schools, and students should be instructed never to touch the blood, open wounds, sores, breaks in the skin, grazes and open skin lesions of others, nor to handle emergencies such as nosebleeds, cuts and scrapes of friends on their own. They should be taught to call for the assistance of an educator or other staff member immediately.

7.10.3 Learners and students should be taught that all open wounds, sores, breaks in the skin, grazes and open skin lesions on all persons should be kept covered completely with waterproof dressings or plasters at all times, not only when they occur in the school or institution environment.

7.11 All cleaning staff, learners, students, educators and parents should be informed about the universal precautions that will be adhered to at a school or an institution.

7.12 A copy of this policy must be kept in the media centre of each school or institution.

8 PREVENTION OF HIV TRANSMISSION DURING PLAY AND SPORT

8.1 The risk of HIV transmission as a result of contact play and contact sport is generally insignificant.

8.1.1 The risk increases where open wounds, sores, breaks in the skin, grazes, open skin lesions or mucous membranes of learners, students and educators are exposed to infected blood.

8.1.2 Certain contact sports may represent an increased risk of HIV transmission.

8.2 Adequate wound management, in the form of the application of universal precautions, is essential to contain the risk of HIV transmission during contact play and contact sport.

8.2.1 No learner, student or educator may participate in contact play or contact sport with an open wound, sore, break in the skin, graze or open skin lesion.

8.2.2 If bleeding occurs during contact play or contact sport, the injured player should be removed from the playground or sports field immediately and treated appropriately as described in paragraphs 7.1.1 to 7.1.4. Only then may the player resume playing and only for as long as any open wound, sore, break in the skin, graze or open skin lesion remains completely and securely covered.

8.2.3 Blood-stained clothes must be changed.

8.2.4 The same precautions should be applied to injured educators, staff members and injured spectators.

8.3 A fully equipped first-aid kit should be available wherever contact play or contact sport takes place.

8.4 Sports participants, including coaches, with HIV/AIDS should seek medical counselling before participation in sport, in order to assess risks to their own health as well as the risk of HIV transmission to other participants.
8.5 Staff members acting as sports administrators, managers and coaches should ensure the availability of first-aid kits and the adherence to universal precautions in the event of bleeding during participation in sport.

8.6 Staff members acting as sports administrators, managers and coaches have special opportunities for meaningful education of sports participants with respect to HIV/AIDS. They should encourage sports participants to seek medical and other appropriate counselling where appropriate.

9 EDUCATION ON HIV/AIDS

9.1 A continuing life-skills and HIV/AIDS education programme must be implemented at all schools and institutions for all learners, students, educators and other staff members. Measures must also be implemented at hostels.

9.2 Age-appropriate education on HIV/AIDS must form part of the curriculum for all learners and students, and should be integrated in the life-skills education programme for pre-primary, primary and secondary school learners. This should include the following:

9.2.1 providing information on HIV/AIDS and developing the life skills necessary for the prevention of HIV transmission;

9.2.2 inculcating from an early age onwards basic first-aid principles, including how to deal with bleeding with the necessary safety precautions;

9.2.3 emphasising the role of drugs, sexual abuse and violence, and sexually transmitted diseases (STDs) in the transmission of HIV, and empowering learners to deal with these situations;

9.2.4 encouraging learners and students to make use of health care, counselling and support services (including services related to reproductive health care and the prevention and treatment of sexually transmitted diseases) offered by community service organisations and other disciplines;

9.2.5 teaching learners and students how to behave towards persons with HIV/AIDS, raising awareness on prejudice and stereotypes around HIV/AIDS;

9.2.6 cultivating an enabling environment and a culture of nondiscrimination towards persons with HIV/AIDS; and

9.2.7 providing information on appropriate prevention and avoidance measures, including abstinence from sexual intercourse and immorality, the use of condoms, faithfulness to one's partner, obtaining prompt medical treatment for sexually transmitted diseases and tuberculosis, avoiding traumatic contact with blood, and the application of universal precautions.

9.3 Education and information regarding HIV/AIDS must be given in an accurate and scientific manner and in language and terms that are understandable.
9.4 Parents of learners and students must be informed about all life-skills and HIV/AIDS education offered at the school and institution, the learning content and methodology to be used, as well as values that will be imparted. They should be invited to participate in parental guidance sessions and should be made aware of their role as sexuality educators and imparters of values at home.

9.5 Educators may not have sexual relations with learners or students. Should this happen, the matter has to be handled in terms of the Employment of Educators Act, 1998.

9.6 If learners, students or educators are infected with HIV, they should be informed that they can still lead normal, healthy lives for many years by taking care of their health.

10 DUTIES AND RESPONSIBILITIES OF LEARNERS, STUDENTS, EDUCATORS AND PARENTS

10.1 All learners, students and educators should respect the rights of other learners, students and educators.

10.2 The Code of Conduct adopted for learners at a school or for students at an institution should include provisions regarding the unacceptability of behaviour that may create the risk of HIV transmission.

10.3 The ultimate responsibility for the behaviour of a learner or a student rests with his or her parents. Parents of all learners and students:

10.3.1 are expected to require learners or students to observe all rules aimed at preventing behaviour which may create a risk of HIV transmission; and

10.3.2 are encouraged to take an active interest in acquiring any information or knowledge on HIV/AIDS supplied by the school or institution, and to attend meetings convened for them by the governing body or council.

10.4 It is recommended that a learner, student or educator with HIV/AIDS and his or her parent, in the case of learners or students, should consult medical opinion to assess whether the learner, student or educator, owing to his or her condition or conduct, poses a medically recognized significant health risk to others. If such a risk is established, the principal of the school or institution should be informed. The principal of the school or institution must take the necessary steps to ensure the health and safety of other learners, students, educators and staff members.

10.5 Educators have a particular duty to ensure that the rights and dignity of all learners, students and educators are respected and protected.

11 REFUSAL TO STUDY WITH OR TEACH A LEARNER OR STUDENT WITH HIV/AIDS, OR TO WORK WITH OR BE TAUGHT BY AN EDUCATOR WITH HIV/AIDS

11.1 Refusal to study with a learner or student, or to work with or be taught by an educator or other staff member with, or perceived to have HIV/AIDS, should be preempted by
providing accurate and understandable information on HIV/AIDS to all educators, staff members, learners, students and their parents.

11.2 Learners and students who refuse to study with a fellow learner or student or be taught by an educator or educators and staff who refuse to work with a fellow educator or staff member or to teach or interact with a learner or student with or perceived to have HIV/AIDS and are concerned that they themselves will be infected, should be counselled.

11.3 The situation should be resolved by the principal and educators in accordance with the principles contained in this policy, the code of conduct for learners, or the code of professional ethics for educators. Should the matter not be resolved through counselling and mediation, disciplinary steps may be taken.

12 SCHOOL AND INSTITUTIONAL IMPLEMENTATION PLANS

12.1 Within the terms of its functions under the South African Schools Act, 1996, the Further Education and Training Act, 1998, or any applicable provincial law, the governing body of a school or the council of an institution may develop and adopt its own implementation plan on HIV/AIDS to give operational effect to the national policy.

12.2 A provincial education policy for HIV/AIDS, based on the national policy, can serve as a guideline for governing bodies when compiling an implementation plan.

12.3 Major roleplayers in the wider school or institution community (for example religious and traditional leaders, representatives of the medical or health care professions or traditional healers) should be involved in developing an implementation plan on HIV/AIDS for the school or institution.

12.4 Within the basic principles laid down in this national policy, the school or institution implementation plan on HIV/AIDS should take into account the needs and values of the specific school or institution and the specific communities it serves. Consultation on the school or institution implementation plan could address and attempt to resolve complex questions, such as discretion regarding mandatory sexuality education, or whether condoms need to be made accessible within a school or institution as a preventive measure, and if so under what circumstances.

13 HEALTH ADVISORY COMMITTEE

13.1 Where community resources make this possible, it is recommended that each school and institution should establish its own Health Advisory Committee as a committee of the governing body or council. Where the establishment of such a committee is not possible, the school or institution should draw on expertise available to it within the education and health systems. The Health Advisory Committee may as far as possible use the assistance of community health workers led by a nurse, or local clinics.

13.2 Where it is possible to establish a Health Advisory Committee, the Committee should:

13.2.1 be set up by the governing body or council and should consist of educators and other staff, representatives of the parents of learners at the school or students at the
institution, representatives of the learners or students, and representatives from the medical or health care professions;

13.2.2 elect its own chairperson who should preferably be a person with knowledge in the field of health care;

13.2.3 advise the governing body or council on all health matters, including HIV/AIDS;

13.2.4 be responsible for developing and promoting a school or institution plan of implementation on HIV/AIDS and review the plan from time to time, especially as new scientific knowledge about HIV/AIDS becomes available; and

13.2.5 be consulted on the provisions relating to the prevention of HIV transmission in the Code of Conduct.

14 IMPLEMENTATION OF THIS NATIONAL POLICY ON HIV/AIDS

14.1 The Director-General of Education and the Heads of provincial departments of education are responsible for the implementation of this policy, in accordance with their responsibilities in terms of the Constitution of the Republic of South Africa, 1996, and any applicable law. Every education department must designate an HIV/AIDS Programme Manager and a working group to communicate the policy to all staff, to implement, monitor and evaluate the Department's HIV/AIDS programme, to advise management regarding programme implementation and progress, and to create a supportive and nondiscriminatory environment.

14.2 The principal or the head of a hostel is responsible for the practical implementation of this policy at school, institutional or hostel level, and for maintaining an adequate standard of safety according to this policy.

14.3 It is recommended that a school governing body or the council of an institution should take all reasonable measures within its means to supplement the resources supplied by the State in order to ensure the availability at the school or institution of adequate barriers (even in the form of less sophisticated material) to prevent contact with blood or body fluids.

14.4 Strict adherence to universal precautions under all circumstances (including play and sports activities) is advised, as the State will be liable for any damage or loss caused as a result of any act or omission in connection with any educational activity conducted by a public school or institution.

15 REGULAR REVIEW

This policy will be reviewed regularly and adapted to changed circumstances.

16 APPLICATION

16.1 This policy applies to public schools which enroll learners in one or more grades between grade zero and grade twelve, to further education and training institutions, and to educators.
16.2 Copies of this policy must be made available to independent schools registered with the provincial departments of education.

17 INTERPRETATION

In all instances, this policy should be interpreted to ensure respect for the rights of learners, students and educators with HIV/AIDS, as well as other learners, students, educators and members of the school and institution communities.
One of the central issues in caring for people who live with or are affected by HIV and AIDS is the issue of their overall well being or mental health. This chapter reflects on one of the most difficult issues that caregivers of young children in particular face, namely the “silent suffering on part of children” in the day-to-day struggle with the realities of HIV and AIDS. To focus on general children’s well-being in this way means to go beyond obvious health conditions, and to seek to enhance general functioning – or “competency” – in everyday life. Dawes speaks here of the importance of positive support for vulnerable children in family, school and community contexts. His argument is that schools are key sites in ensuring mental health and well-being in children in an era of HIV and AIDS.
This paper addresses a challenge of critical importance for the area of child mental health. It attempts a preliminary examination of the question, “Why should schools be key sites for addressing children’s mental health needs at this point in our history?”

The paper will proceed to consider four points:

1. Child mental health and public policy – a situation of neglect
2. Why should child mental health be a priority public health issue?
3. Child mental health problems in the context of HIV/AIDS.
4. “What is to be done” in the education context (apologies to V.I.L.).

**Child mental health and public policy – a situation of neglect**

**A working definition of child mental health**
Definitions of child mental health extend from a broad notion of “welfare” or well being, to freedom from mental disorder. In an earlier paper, Dawes et al (1997) suggested the following definition. It incorporates both approaches and focuses on health rather than pathology: “Child mental health refers to the degree of age-appropriate bio-psychosocial development achieved using available resources.”

Positive child development can be segmented into what may be referred to as the five Cs: Competence, Connection, Character, Confidence, and Caring (compassion) (Lerner, Fisher and Weinberg, 2000). The Cs represent:
“five clusters of individual attributes – for example, intellectual ability and social and behavioural skills; positive bonds with people and institutions; integrity and moral centeredness; positive self-regard, a sense of self efficacy and courage; and humane values, empathy, and a sense of social justice, respectively.” (pp. 16-17).
All are relatively easy to measure, all are indicators of psychological health, and they are useful focal points for school-based intervention.

**Why should competency-based child mental health be a priority public health issue?**
Simply because the future well being of the nation depends as much on physically healthy individuals as it does on psychologically competent and caring people. No matter how physically healthy they are, adults whose childhood experience has compromised the development of the five key competencies will be less able to play a positive and productive role in the society, and are therefore a serious risk to the well-being of their communities and the nation.

Maintaining a broad conception of children’s welfare and mental health matters both for the current well being of children, and for their future. As we strive to promote the mental health of children, we should therefore not only restrict ourselves to a narrow concern with psychopathological disorders and the treatment of those children who have diagnosed conditions.

Of course tertiary services to psychologically disturbed children are essential and need to be expanded. They are woefully inadequate. However, if we are concerned about prevention, our efforts need to strengthen key competencies that are likely to promote positive functioning in both childhood and in the adult to be. Early intervention and sustained preventive initiatives in settings such as schools will in any event assist in reducing the numbers of those who present with disorders.

The evidence is quite clear that positive sources of support for vulnerable children at the level of the family, the school and the wider community play important roles in reducing
the risks to development for children living in adverse conditions (Luthar, Cicchetti and Becker, 2000).

School environments in particular have the capacity to build the five competencies. When other components of the child’s support structure are under threat or falling apart as is the case in the AIDS pandemic, schools are potentially critical resources for the containment of children’s distress and for promotion of resilience and coping. Schools also permit universal level interventions over different periods of child development. At the same time, however, when they are dysfunctional, schools compound vulnerability and undermine the competencies.

Child psychopathology and psychological distress have multiple determinants beyond the school. However, it is commonly the case that problems outside the school express themselves in school. For example, neglect and abuse in the home may produce a child who is withdrawn and failing in school. The school staff needs to be able to recognise the child’s problem as a signal of distress rather than recalcitrance, and they need to know that problems in the home may be responsible.

The need to move child mental health out of the last carriage of the policy train

Mental health issues have always occupied the last coach on the child health policy train. This is true for the so-called developed countries, but it is even more evident in less well-off parts of the world (Dawes et al, 1997). The psychological well being of communities experiencing deep poverty and threats to personal survival such as violence and abuse is understandably viewed as lower in priority than survival and provision of basic amenities. Poverty contexts are well known to pose high levels of risk to health and indeed survival, and it is crucial that they be addressed. In a context of limited resources, the first call will necessarily be for the promotion of child survival, health and safety. In addition, many of the outcomes of threats to physical health associated with poverty, are often very visible to those in the child’s immediate environment. Children do not thrive; they become obviously ill; they have clear signs of under or malnutrition; they are likely to be injured in unsafe homes and neighbourhoods; and they may develop obvious physical disabilities as a function of pre, peri and postnatal environmental insults.

It is difficult to place child mental health firmly on the policy agenda (and commit the funds) for two key reasons in my view. First: because mental health conditions, with few exceptions, do not constitute clinical emergencies, and nor do they pose a threat to the child’s survival. Second: because in many instances children’s emotional suffering does not shout out to us. It is relatively invisible. It is neglected in the over-stretched emotional economy of the poverty-stressed home and the under-resourced school. Problems of the mind and emotions do not ring the survival and well-being bells as loudly as physical conditions. There are of course obvious exceptions such as Downes syndrome, epilepsy, psychotic disorders, severe depression, and conditions such as anorexia / bulimia.

Characteristically, child mental health problems and clinical conditions that do not have their origins in organic conditions (and include mental handicap), may be clustered along three principle axes along which children express their distress and responses to trauma. I have caricatured them as quiet, misery, naughtiness, and craziness:

1. Internalising disorders – characterised by fear, anxiety, or depression (quiet misery – anxiety and depression).
2. Externalising disorders – characterised by problems of conduct and aggression (naughtiness – badness).
3. Psychotic disorders – characterised by major disturbances in thought processes, reality testing, and relationships (craziness).
While externalising and psychotic disorders tend to make themselves felt in the everyday world of the home and the school, internalising problems commonly do not unless the parent or the teacher is tuned to listen to the signs, and just as important, has the time and energy to be turned on by them. This is a crucial point, and it is an energy or cost efficiency problem if you like.

Caregivers who are under stress, and teachers whose work environments place impossible demands on them, will simply tend to attend to matters (and children) whose condition or behaviour calls their attention. This is one reason why temperamentally passive children tend to be more at risk for under-nutrition than their more difficult siblings (Richter, 1994).

The condition of many troubled children is rendered invisible in a world of day-to-day struggle and the reality of HIV/AIDS. Silent suffering in the part of children is a relief to those responsible for them. They do not cause much of a bother until their suffering begins to express itself externally in the form of ‘difficult or naughty’ behaviour. While a clinician may understand the “naughtiness” to reflect distress, it is understandable that they are commonly defined by teachers and parents as bad kids – rather than distressed or troubled kids. It is interesting that if one talks to parents living in poverty, it is commonly the difficult and disobedient child who causes them concern, and not the quiet invisible and withdrawn one. Applying the “bad child” label is of course one early step in supplying this child with a negative identity. Negative identities are all too often celebrated among South African youth whose attributes and life situations have given them little hope for the future (witness if you will the number of ‘no fear’ and ‘bad boys’ bumper stickers around). In contemporary South Africa, the development of negative identities should be a major public health challenge.

**Child mental health problems in the context of HIV/AIDS**

There are high variations in prevalence rates for child and adolescent disorders in developing countries. In the South African case, the data is sketchy and uneven in quality (Dawes et al, 1997). A major source of the problem is likely to be found in differences in research methodology, and much of the South African data relies on clinic samples. Unfortunately, these tell us little about the population at risk. The use of different research instruments in different studies is an additional source of variation (Robertson & Berger, 1994). We have no agreed benchmark assessment devices for screening child mental health problems – a variety of assessment instruments are deployed. It is not surprising that morbidity estimates vary from study to study. In sum, there are no reliable national epidemiological studies in South Africa. We really do not know the scale of the problem.

However, we have to proceed from some baseline. If we follow the UNICEF/NCRC (1993) situational analysis, and Schoeman et al (1989), whose figures fall within the middle of a range of estimates, we can estimate a prevalence rate of 15% for child and adolescent psychological disorders, (including mental handicap). South Africa has some 18 million children under 19 years of age, and children under 15 years constitute 80% of the this group. Eighty two percent of the under 15s are African and live in high-risk urban and rural contexts.

Thus at a prevalence rate of 15%, we can expect a need for at least secondary level services for around 1.8 million African children under 15 years alone. Key areas of need which need immediate attention are urban informal settlements and rural communities.

These figures do not tell us anything of the extent of psychosocial problems in the remainder of children who do not present with clinical disorders. We need the data, but common sense will tell us that the problem is significant, and will only be exacerbated by the
mental health consequences of HIV/AIDS – an issue that is only beginning to raise its head on the research horizon.

So apart from the threats to child health and well-being posed by endemic poverty and violence, at the present time and well into the future, the effects on children of issues related to HIV/AIDS will bare heavily on the preschool and school population, making themselves felt in the classroom and the playfields.

How will HIV/AIDS impact on the psychological well being of school children?

1. Increasing numbers of children will be living with living with infected caregivers
   - Stigma resulting in social isolation, emotional distress and exclusion by peers and adults. Primary Impacts on the five Cs: Confidence and self esteem compromised; emotional and social competence compromised.
   - Increasing economic and food security resulting in malnutrition; no money for school fees and uniforms resulting in exclusion or school drop out. Primary Impacts on the five Cs: Physical functioning, intellectual competence and emotional competence.
   - Increasing care and domestic responsibilities (girls in particular) resulting in less time for studying. Primary Impacts on the five Cs: Intellectual competence will be compromised, but arguably, a caring orientation may well be strengthened.

2. Increasing numbers of caregivers will die of AIDS related conditions and causing a child care crisis
   - Further economic insecurity caused by the shock of income loss. Primary Impacts on the 5 Cs: as above.
   - Increased vulnerability due to low levels of supervision and monitoring (depends on age and sex: young children to abuse at the hands of both kin and others; older children to risky behaviour; girl children to commercial sexual exploitation) Primary Impacts on the 5 Cs: physical risk, low moral centeredness; low self-regard, a poor sense of social justice:
     “five clusters of individual attributes – for example, intellectual ability and social and behavioural skills; positive bonds with people and institutions; integrity and moral centeredness; positive self-regard, a sense of self efficacy and courage; and humane values, empathy, and a sense of social justice, respectively.” (pp. 16-17).
   - Increased food insecurity. Primary Impacts on the 5 Cs: as above.
   - Loss of crucial documents leading to school exclusion and problems with access to social grants. Primary Impacts on the 5 Cs: Threats to physical well-being, and loss of opportunities for learning.
   - Girl children leave school to care for young children. Primary Impacts on the 5 Cs: loss of opportunities for learning.
   - Increased mobility between places of residence may lead to changes in school and loss of learning opportunities.

3. Increasing numbers of children with HIV/AIDS will be at school.

4. Increasing numbers of teachers will be living with AIDS and dying of the associated infections.
   We do not know the scale of the problem yet, but there is no doubt that that there will be teacher attrition due to illness and death. Children will be affected by this loss at two levels: emotional and in terms of reduced teacher capacity – and reduced capacity therefore to prepare our young for the future. At the very least, there is an urgent need to
train surviving teachers to assist school children to cope with the loss of those who have passed on, and to train new generations of teachers to replace them. What is clear is that many thousands of children will face the death of kin as well as other carers such as teachers with whom relationships will have developed. There is a profound sense that many children will have to live with multiple losses due to the death of these people. There is little doubt that the experience of common place death will have a considerable impact on the emotional life of these children.

“What might be done?” in the education context
We started with the question: “Why should schools be key sites for addressing children’s mental health needs at this point in our history?” The answer is that particularly in the current and future HIV/AIDS crisis, the school has a role to play that is beyond the traditional educational focus.

As family support systems are increasingly compromised and children affected by AIDS have few supportive resources left to them, the school has the potential to be a place of refuge, support, and care. Positive school environments can do much to provide sound developmental settings for children who would otherwise have few resources on which to build their competences. This is well established.

The answer to the challenge that faces us does not lie in squads of therapists in schools. Many children will need specialised counselling services. However, addressing the problem with tertiary level solutions is neither cost effective nor efficient. The solution also does not lie in expecting teachers to go beyond their over-stretched schedules to become therapists to children – although many do already.

Rather it lies in creating school environments within which children feel safe and supported, rather than excluded and vulnerable. It lies in creating school environments that care for children in a much broader sense. Children who grow up feeling cared for will be more likely to feel psychologically able to care for others. It means understanding the different needs of children at different levels of development. Six year olds require different responses to 12 year olds.

For school staff to be able to create a caring environment for children, school heads and teachers must feel cared for and supported by their departments and ministries. At present many clearly do not feel cared for. Creation of a caring enabling school environment requires a fundamental commitment to enabling schools to play this role, and accountability for those who undermine that role. It is a huge challenge. We know that there are significant threats to the ability of schools to play this role. For example, schools characterised by poorly trained staff, poorly motivated staff, poor staff-pupil ratios, low levels of staff and pupil discipline, poor leadership and in particular low levels of accountability among staff constitute high risk environments for children and staff. Such institutions are likely to contribute significantly to poor cognitive, emotional and behaviour outcomes.

Evidence suggests that in many cases, whole school development is needed for such institutions in parallel with the introduction of no more than the most simple interventions to reduce commonly occurring key risks to children’s mental health - violence; sexual abuse).

Finally, complex interventions for teachers and children simply will not work if the support base for such interventions is lacking.

Conclusion

President Mandela, in his acceptance speech on being awarded the Nobel Prize, said that children are: “at once the most vulnerable citizens in any society, and the greatest of our
“treasures”. As well as signifying his particular interest in matters affecting children, the
former president’s statement echoes a growing awareness that the foundations of adult health
and psychological functioning are laid during childhood and adolescence.

South Africa has a powerful Bill of Rights, and has ratified the UN Convention on the
Rights of the Child. These provisions have stimulated considerable advances in the provision
of health services to young children in particular. However despite these positive changes, the
evidence suggests that our children are not being treated as Madiba would have us treat them,
and indeed as they deserve to be treated.

It is often said, all too glibly that “The Children are our future”. To that end, we strive
to create a future generation that carries forward our heritage and values. This is the way we
attempt to guarantee our cultural survival. What our children take forward is nurtured in the
many developmental settings we create for our children, be this in terms of their health and
psychological well being, their opportunities for work, and their capacity to create positive
relationships with others.

I therefore prefer to reverse the “Children are our future” slogan, and substitute the
phrase: “We are our children’s future”. What this does is place the responsibility for the
development of the five Cs, and the current well-being of today’s child and tomorrow’s adult,
squarely where it belongs: in the hands of the current parent, carer and teacher.

Because children are a relatively powerless and excluded group, it is particularly
those who spend significant time with children, who must be primarily responsible for
providing the conditions that lay own the socio-cultural and blueprints for the future of the
next generation. These templates include key dimensions of mental health outlined above that
can be promoted in school. Where those closest to the child are vulnerable and when their
caring capacities are compromised, then it is the role of the state to step in as the enabling
agent.

The promotion of the mental health of the child in the school must start with the
systemic health of all levels of the educational environment. A key factor in all this is the full
professional and legal accountability of all the individuals who play a role in that system. If
indeed our children are truly “precious” and if indeed we wish a positive future for them, then
the way forward is clear.

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**Affected**
Persons living with HIV and AIDS, and other related individuals including their families, friends, and advocates whose lives are directly influenced by HIV infection and its physical, psychological, and sociological ramifications.
Source: http://www.unaids.org/Unaids/EN/Resources/Terminology/glossary+of+hiv_aids-related+terms

**AIDS (acquired immunodeficiency syndrome)**
An advanced stage of infection with HIV (human immunodeficiency virus) in which the immune system is weakened. The individual becomes more susceptible to a variety of infections (called opportunistic infections) and other conditions, such as cancer. A diagnosis of AIDS is made based on clinical criteria and/or the results of blood tests.

**Antiretrovirals (ARVs)**
Drugs and substances used to kill or inhibit the multiplication of retroviruses such as HIV.

**Antiretroviral treatment (ART)**
A treatment that uses antiretroviral medicines to suppress viral replication and improve symptoms. Effective antiretroviral therapy requires the simultaneous use of three or four antiretroviral medicines as specified in the WHO 'Guidelines for a Public Health Approach, Scaling up antiretroviral therapy in resource-limited settings' (June 2002). These guidelines are intended to support and facilitate proper management and scale-up of antiretroviral therapy, providing recommended first and second line treatment for adults and for children, reasons for changing ART, monitoring patients, side effects of ART, and specific recommendations for certain patient subgroups.
Source: http://www.unaids.org/Unaids/EN/Resources/Terminology/glossary+of+hiv_aids-related+terms

**CD4 count**
Destruction of CD4+ lymphocytes is the major cause of the immunodeficiency observed in AIDS, and decreasing CD4+ lymphocyte levels appear to be the best indicator for developing opportunistic infections. Although CD4 counts fall, the total T cell level remains fairly constant through the course of HIV disease, due to a concomitant increase in the CD8+ cells. The ratio of CD4+ to CD8+ cells is therefore an important measure of disease progression. See CD8 (T8) Cells; Immunodeficiency.

**Condom**
A flexible sheath (usually made of thin latex or polyurethane) designed to cover the penis (male condom) or vulva/vagina (female condom) during sexual intercourse for contraceptive purposes or as a means of preventing STIs.
**Epidemic**
A disease that spreads rapidly through a demographic segment of the human population, such as everyone in a given geographic area; a military base, or similar population unit; or everyone of a certain age or sex, such as the children or women of a region. Epidemic diseases can be spread from person to person or from a contaminated source such as food or water.

**HIV - human immunodeficiency virus**
A type of sexually transmitted retrovirus that can also be transmitted through exposure to infected blood or body fluids. HIV infection causes acquired immunodeficiency syndrome (AIDS).

During the initial infection with HIV, when the virus comes in contact with the mucosal surface and finds susceptible T cells, the first site at which there is truly massive production of the virus is lymphoid tissue. This leads to a burst of massive viremia, with wide dissemination of the virus to lymphoid organs. The resulting immune response to suppress the virus is only partially successful and some virus escapes. Eventually, this results in high viral turnover that leads to destruction of the immune system. HIV disease is, therefore, characterized by a gradual deterioration of immune functions. During the course of infection, crucial immune cells, called CD4+ T cells, are disabled and killed, and their numbers progressively decline.

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Source: http://www.unaids.org/Unaids/EN/Resources/Terminology/glossary+of+hiv_aids-related+terms

**HIV negative**
Showing no evidence of infection with HIV (e.g. absence of antibodies against HIV) in a blood or tissue test. Synonymous with seronegative.
Source: http://www.unaids.org/Unaids/EN/Resources/Terminology/glossary+of+hiv_aids-related+terms

**HIV positive**
Showing indications of infection with HIV (e.g. presence of antibodies against HIV) on a test of blood or tissue. Synonymous with seropositive. Test may occasionally show false positive results.
Source: http://www.unaids.org/Unaids/EN/Resources/Terminology/glossary+of+hiv_aids-related+terms

**HIV prevalence**
Usually given as a percentage. HIV prevalence quantifies the proportion of individuals in a population who have HIV at a specific point in time. UNAIDS normally reports HIV prevalence among adults, aged 15–49.
Source: http://www.unaids.org/Unaids/EN/Resources/Terminology/glossary+of+hiv_aids-related+terms

**Immune system**
The body’s natural system of defense against foreign agents, such as bacteria and viruses.

**Immunosuppressive process**
A state of the body in which the immune system is damaged and does not perform its normal functions. Immunosuppression may be induced by drugs (e.g., in chemotherapy) or result from certain disease processes, such as HIV infection.
Infected
Infection typically begins when HIV encounters a CD4+ cell. The HIV surface protein gp120 binds tightly to the CD4 molecule on the cell's surface. The membranes of the virus and the cell fuse, a process governed by gp41, another surface protein. The viral core, containing HIV's RNA, proteins, and enzymes, is released into the cell.

Lymph glands
Small, bean-sized organs of the immune system, distributed widely throughout the body. Lymph fluid is filtered through the lymph glands in which all types of lymphocytes take up temporary residence. Antigens that enter the body find their way into lymph or blood and are filtered out by the lymph glands or spleen, respectively, for attack by the immune system.

Mother to child transmission (MTCT)
Infants born to HIV-infected mothers acquire the infection either through pregnancy, delivery or breastfeeding. Prophylactic measures taken during pregnancy and breastfeeding can reduce the incidence of transmission.

Opportunistic infections
Illnesses caused by organisms that usually do not cause disease in a person with a normal immune system. Opportunistic infections are known as such because they take advantage of a weakened immune system to cause illness. Those common in persons diagnosed with AIDS include pneumocystis pneumonia, chronic cryptosporidia diarrhea, histoplasmosis, and cytomegalovirus eye infection.

Orphans and vulnerable children (OVCs)
In the context of HIV/AIDS, it is preferable to say ‘children orphaned by AIDS’ or ‘orphans and other children made vulnerable by HIV/AIDS’. Referring to these children as ‘AIDS orphans’ not only stigmatizes them, but also labels them as HIV-positive, which they may not necessarily be. Identifying a human being by his/her medical condition alone shows a lack of respect for the individual.
Source: http://www.unaids.org/Unaids/EN/Resources/Terminology/glossary+of+hiv_aids-related+terms

Pandemic
A disease prevalent throughout an entire country, continent, or the whole world. See also Epidemic.

People Living with HIV/AIDS (PLWHA)
With reference to those living with HIV/AIDS, it is preferable to avoid certain terms: AIDS patient should only be used in a medical context (most of the time, a person with AIDS is not in the role of patient); the term AIDS sufferer implies that the individual in question is powerless, with no control over his/her life. It is preferable to use 'people living with HIV/AIDS (PLWHA)', since this reflects the fact that an infected person may continue to live well and productively for many years. Referring to PLWHA as innocent victims (which is often used to describe HIV-positive children or people who have acquired HIV medically) wrongly implies that people infected in other ways are somehow deserving of punishment. It is preferable to use PLWHA, or 'people with medically-acquired HIV', or 'children with HIV'.
Source: http://www.unaids.org/Unaids/EN/Resources/Terminology/glossary+of+hiv_aids-related+terms

Resistance to treatment
Reduction in a pathogen's sensitivity to a particular drug. Resistance is thought to result usually from a genetic mutation. In HIV, such mutations can change the structure of viral enzymes and proteins so that an antiviral drug can no longer bind with them as well as it used to. Resistance detected by searching a pathogen's genetic makeup for mutations thought to confer lower susceptibility is called "genotypic resistance." Resistance that is found by successfully growing laboratory cultures of the pathogen in the presence of a drug is called "phenotypic resistance."
Retrovirus
A type of virus that, when not infecting a cell, stores its genetic information on a single-stranded RNA molecule instead of the more usual double-stranded DNA. HIV is an example of a retrovirus. After a retrovirus penetrates a cell, it constructs a DNA version of its genes using a special enzyme called reverse transcriptase. This DNA then becomes part of the cell's genetic material.
Source: http://www.unaids.org/Unaids/EN/Resources/Terminology/glossary+of+hiv_aids-related+terms

Safe Sex
A term often referring to sexual activity that lowers the risk for HIV transmission. A broader definition might include relations that lower the risk for disease, unintended pregnancy, violence, coercion, or abuse of power.

Sexual abuse
The abuse of a person targeting their sexual organs, e.g. rape, touching their private parts, or inserting objects into their private parts.

Sexually transmitted infection (STI)
Also called venereal disease (VD) (an older public health term) or sexually transmitted infections (STIs). Sexually transmitted diseases are infections spread by the transfer of organisms from person to person during sexual contact. In addition to the "traditional" STDs (syphilis and gonorrhea), the spectrum of STDs now includes HIV infection, which causes AIDS; Chlamydia trachomatis infections; human papilloma virus (HPV) infection; genital herpes; chancroid; genital mycoplasmas; hepatitis B; trichomoniasis; enteric infections; and ectoparasitic diseases (i.e., diseases caused by organisms that live on the outside of the host's body). The complexity and scope of STDs have increased dramatically since the 1980s; more than 20 micro-organisms and syndromes are now recognized as belonging in this category.

T cells
(Also known as CD4 cells.) A type of cell in the immune system that normally orchestrates the immune response by signaling other cells in the immune system to perform their special functions. HIV causes destruction of CD4 cells. This is the major cause of the immunodeficiency observed in AIDS.

Side Effects
The actions or effects of a drug (or vaccine) other than those desired. The term usually refers to undesired or negative effects, such as headache, skin irritation, or liver damage. Experimental drugs must be evaluated for both immediate and long-term side effects.

Strain of the virus
Subgroup of a species (also called taxon)

Traditional remedies
These remedies are prescribed by traditional healers who are established health care workers within their communities. It has been estimated that roughly 80% of South Africa’s population consult traditional healers as
their first contact for advice and/or treatment concerns. Traditional healers treat all age groups and all problems, using and giving medicines that are readily available and affordable. Their treatment tends to be holistic, dealing with the psychosocial aspects of disease as well as with the physical symptoms.


**Tuberculosis (TB)**

A bacterial infection caused by Mycobacterium tuberculosis. TB bacteria are spread by airborne droplets expelled from the lungs when a person with active TB coughs, sneezes, or speaks. Exposure to these droplets can lead to infection in the air sacs of the lungs. The immune defenses of healthy people usually prevent TB infection from spreading beyond a very small area of the lungs. If the body's immune system is impaired because of HIV infection, aging, malnutrition, or other factors, the TB bacterium may begin to spread more widely in the lungs or to other tissues. TB is seen with increasing frequency among HIV-infected persons. Most cases of TB occur in the lungs (pulmonary TB). However, the disease may also occur in the larynx, lymph nodes, brain, kidneys, or bones (extrapulmonary TB). Extrapulmonary TB infections are more common among persons living with HIV.


**Viral load**

The amount of HIV in the circulating blood. Monitoring a person's viral load is important because of the apparent correlation between the amount of virus in the blood and the severity of the disease. Sicker patients generally have more virus than those with less advanced disease. A new, sensitive, rapid test-called the viral load assay for HIV-1 infection-can be used to monitor the HIV viral load. This procedure may help clinicians to decide when to give anti-HIV therapy or to switch drugs. It may also help investigators determine more quickly if experimental HIV therapies are effective.


**Virus**

Organism composed mainly of nucleic acid within a protein coat. When viruses enter a living plant, animal, or bacterial cell, they make use of the host cell's chemical energy, protein, and nucleic acid-synthesizing ability to replicate themselves. After the infected host cell makes viral components and virus particles are released, the host cell is often dissolved. Some viruses do not kill cells but transform them into a cancerous state. Some cause illness and then seem to disappear, while remaining latent and later causing another, sometimes much more severe, form of disease. In humans, viruses cause measles, mumps, yellow fever, poliomyelitis, influenza, and the common cold, among others. Some viral infections can be treated with drugs.


**Voluntary Counselling and Testing**

The provision of professional, client centered counselling and testing services, in an easily accessible, non-threatening, non-discriminating environment, where clients are treated equally and with dignity and respect, where client information is kept confidential, where through an ongoing process of pre-test, post-test and follow-up counselling clients are facilitated to understand their personal situation, realize their abilities and are empowered to make appropriate choices; where HIV testing is not enforced either overtly or covertly and is based on standard protocols; and where services are available for prevention, treatment and care of STIs, (including HIV), opportunistic infections (and for PMTCT); and where follow-up services and referrals are provided.

Source: http://www.whoindia.org/CDS/CD/HIV/hiv-vctc.htm

**Universal precautions**

Universal precautions are infection control guidelines designed to protect workers from exposure to diseases spread by blood and certain body fluids.

Source: http://www.ccohs.ca/oshanswers/prevention/ppe/universa.html

**Window period**

The period of up to three months before HIV antibodies appear in the blood following HIV infection. During this period HIV tests cannot determine whether a person is infected with HIV or not.
References for Readings


