Department of Basic Education

Integrated Strategy on HIV, STIs and TB

2012 – 2016

basic education

Department:
Basic Education
REPUBLIC OF SOUTH AFRICA

ACKNOWLEDGEMENTS

ISBN number: 978-1-4315-1846-3

Suggested Citation: Department of Basic Education Integrated Strategy on HIV, STIs and TB 2012 – 2016. Pretoria. 2012.

The *Department of Basic Education Integrated Strategy on HIV, STIs and TB 2012 – 2016* was developed by the Department of Basic Education with technical support from the Health Economics and HIV/AIDS Research Division (HEARD), University of KwaZulu-Natal, and financial support from the United States Agency for International Development (USAID). The Joint United Nations Programme on HIV/AIDS (UNAIDS) provided technical support to the Department for the development of the logic model and Monitoring & Evaluation Framework.

The Strategy was developed through an extensive consultative process with various directorates within the national and provincial departments of Basic Education and with a range of stakeholders working in the education sector, including teacher unions, school governing bodies, learner representative organisations, other government departments, research institutions, universities, development partners and non-governmental organisations.

The Department of Basic Education acknowledges every individual and organisation that participated in this consultation process, as well as those that submitted written inputs.

The Strategy will guide the implementation of HIV, STIs and TB programmes within the Department of Basic Education and will provide guidance for the development of a new policy on HIV and TB in the sector. As such, comments and suggestions are welcomed and should be sent to the Director-General: Basic Education for the attention of the Health Promotion Directorate, Private Bag X895, Pretoria, 0001.

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Design, layout and printing: Kashan Advertising [www.kashan.co.za] through technical support of the Sexual HIV Prevention Programme (SHIPP).

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This publication was made possible with the generous funding of USAID.

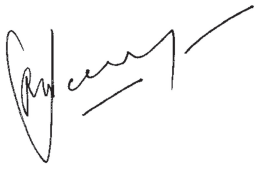
FOREWORD

There is now global recognition that HIV and TB are not only a challenge for the health system alone, but also a challenge for the education, economic, social and cultural systems of our society. HIV has the potential to undermine our efforts to achieve improved quality basic education: Outcome 1 of government.

South Africa commemorated World AIDS Day on 1 December 2011 by unveiling the new National Strategic Plan (NSP) on HIV, STIs and TB 2012 – 2016. The twenty year vision of this plan is for the country to achieve zero new HIV, STI and TB infections; zero deaths associated with HIV and TB and zero discrimination. The plan builds on successes achieved over the past five years. Key amongst these has been the first decline in new infections amongst young people, largely attributed to school-based HIV and AIDS programmes, mass information campaigns and increasing condom use in this group.

Over the past two years, the Department of Basic Education has been crafting an *Integrated Strategy on HIV, STIs and TB* aligned to this country vision, and to new global thinking on the twin epidemics of HIV and TB. The Strategy presents a holistic response for learners, educators and officials in the schooling system. We have consulted extensively with education officials, educators, teacher unions, learners, school governing bodies, key government departments, development partners, non-governmental organisations, universities and academic institutions through various means, including consultation workshops in each province during the course of 2011. This final document has benefitted immeasurably from this process.

We are pleased with the overwhelming support received for the Strategy and its outcomes, affirming the correctness of our approach. We will once more depend on the continued co-operation and support of all our officials and various partners and stakeholders to ensure implementation of all components of the Strategy. Only in this way will we achieve the ambitious objectives we have set ourselves as Basic Education's contribution to the multi-sectoral country response.



MR PB SOOBRAYAN
DIRECTOR-GENERAL: DEPARTMENT OF BASIC EDUCATION
DATE: JANUARY 2013

LIST OF ACRONYMS

AEF	Aid Effectiveness Framework
AIDS	Acquired Immune Deficiency Syndrome
APP	Annual Performance Plan
ART	Antiretroviral Therapy
ARV	Antiretroviral
CAPS	Curriculum and Assessment Policy Statement
CCMT	Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment
CEM	Council of Education Ministers
CPTD	Continuing Professional Teacher Development
CSTL	Care and Support for Teaching and Learning Programme
DBE	Department of Basic Education
DBST	District-Based Support Team
DoE	Department of Education
DoH	Department of Health
DoL	Department of Labour
DOTS	Directly Observed Therapy Short Course
DPSA	Department of Public Service and Administration
DSD	Department of Social Development
EAP	Employee Assistance Programme
EFA	Education For All
EHW	Employee Health and Wellness
EH&WSF	Employee Health and Wellness Strategic Framework for the Public Service
ELRC	Education Labour Relations Council
EMIS	Education Management Information System
GET	General Education and Training
GHS	General Household Survey
HBC	High Burden Country
HCT	HIV Counselling and Testing
HEDCOM	Heads of Education Departments Committee
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
HPSP	Health Promoting Schools Programme
HRC	Human Rights Commission
HSRC	Human Sciences Research Council
ICCD	Inter-departmental Coordinating Committee on Disability
ICPD	International Conference on Population and Development
ICT	Information and Communications Technology
ILO	International Labour Organization
IPT	Isoniazid Preventive Therapy
LO	Life Orientation
LS	Life Skills

LURITS	Learner Unit Record Information Tracking System
MDG	Millennium Development Goal
MDR-TB	Multi-Drug Resistant Tuberculosis
M&E	Monitoring and Evaluation
MMC	Medical Male Circumcision
MRC	Medical Research Council
NACCA	National Action Committee for Children Affected by HIV and AIDS
NACOSA	National AIDS Coordinating Committee of South Africa
NAPTOSA	National Professional Teachers Association of South Africa
NCS	National Curriculum Statement
NGO	Non-Governmental Organisation
NIP	National Integrated Plan (2000)
NSNP	National School Nutrition Programme
NSP	National Strategic Plan on HIV, STIs and TB, 2012 – 2016
NTT	National Task Team
OVC	Orphans and Vulnerable Children
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-To-Child Transmission
PPCT-OVC	Prevention Palliative Care for Teachers, Orphans and Vulnerable Children
PrEP	Pre-Exposure Prophylaxis
PTB	Pulmonary Tuberculosis
PTT	Provincial Task Team
RHRU	Reproductive Health and HIV Research Unit
RMC	Resource Mobilisation Committee (SANAC)
SACMEQ	Southern and Eastern African Consortium for Monitoring Educational Quality
SADC	Southern African Development Community
SADTU	South African Democratic Teachers Union
SANAC	South African National AIDS Council
SBST	School-Based Support Team
SGB	School Governing Body
SHERQ	Safety, Health, Environment, Risk and Quality Management Policy
SIAS	Screening, Identification, Assessment and Support
SMART	Specific, Measurable, Attainable, Relevant and Timebound (indicators)
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TAT	Test And Treat
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCRC	United Nations Charter on Rights of the Child
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization
XDR-TB	Extensively Drug Resistant TB

NOTE ON TERMINOLOGY

This document references the *UNAIDS Terminology Guidelines (January 2011)*.

There is often confusion in the case of a number of terms such as *HIV prevalence* and *HIV incidence*, and *TB infection* and *TB disease*. Below is a short explanation of selected terms found in the Strategy.

Adolescent

The World Health Organization defines an adolescent as a person aged between 10 and 19 years.

Child

The Bill of Rights, section 28(3), in the Constitution of the Republic of South Africa, 1996, defines a child as a person under the age of 18 years.

Young people

The United Nations, for statistical purposes, defines 'youth' as those persons between the ages of 15 and 24 years, without prejudice to other definitions by member states. This definition was made during preparations for the International Youth Year (1985), and endorsed by the General Assembly (see A/36/215 and resolution 36/28, 1981). All United Nations statistics on youth are based on this definition, as illustrated by the annual yearbooks of statistics published by the United Nations system on demography, education, employment and health.

HIV prevalence

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

HIV incidence

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

TB infection

TB infection occurs when someone breathes in TB bacteria (released when someone with infectious TB coughs or sneezes). The TB bacteria enter the lungs and in most cases lie dormant within the body's defence cells (macrophages) deep in the lung. This is called latent

TB. Latent TB is not infectious and causes no illness or disease. However, latent TB can progress to TB disease if the immune system is weakened by, for example, HIV, diabetes, smoking and cancer, or in cases when very young children are exposed to the bacteria. It is estimated up to 80% of the adult South African population is infected with latent TB.

TB disease

TB disease occurs when the body's immune system is unable to contain the TB bacilli and they multiply, causing tissue damage and development of the disease. The type of TB disease depends on where the TB bacilli are found and on the degree of immune suppression. The most common symptoms are a persistent cough (often bloody), fever, night sweats and weight loss.

Treatment adherence

Treatment adherence is defined as the degree to which a patient sticks to a treatment regimen and takes the correct dosage of a drug at the correct time as prescribed. Good treatment adherence enables medication to work effectively and prevents drug resistance.

Sexuality education

Sexuality education is defined as an age-appropriate, culturally relevant approach to teaching about sex and relationships by providing scientifically accurate, realistic and non-judgemental information. Sexuality education provides an individual with opportunities to explore their values and attitudes and to build decision-making, communication and risk reduction skills about many other aspects of sexuality.[1]

Safe school

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

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1 UNESCO. *International Technical Guidance on Sexuality Education.* Paris: UNESCO, 2010.

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SECTION ONE: THE CONTEXT TO THE STRATEGY

1. PURPOSE OF THIS DOCUMENT

The Department of Basic Education (DBE) Integrated Strategy on HIV, STIs and TB 2012 – 2016 represents the DBE's vision for a five-year period and articulates the intentions of the Department as it responds to the HIV, STI and TB crises in South Africa and their impact on educational outcomes and the delivery of quality basic education.

The Strategy's focus and outcomes have been shaped by two of the DBE's seminal results-based guiding documents: i) The Delivery Agreement for Outcome 1 (improved quality of basic education) that forms part of a wider set of 12 key outcomes set by government to be achieved by 2014, and ii) the Action Plan to 2014: Towards the Realisation of Schooling 2025, which will ensure support for the core mandate of the DBE.

The purpose of this document is to integrate efforts to address the prevention, diagnosis and treatment of HIV and TB, including care and support, within its implementation in schools and the DBE work environment, thus responding to the renewed commitments that have been made by government, civil society and the private sector with the new *National Strategic Plan on HIV, STIs and TB 2012 – 2016* (*NSP 2012 – 2016*).[2]

The Strategy has been developed with close attention to the new *NSP 2012 – 2016*, incorporating new global and local thinking on how to roll back HIV, STIs and TB. The strategy articulates government's intention to provide school environments that are caring, safe, conducive to learning, and aligned to the education sector's duty of care in schooling. Furthermore, the Strategy seeks to support a coordinated, sustainable and comprehensive national response to South Africa's HIV, STI and TB crises; a response informed by current evidence on HIV prevalence, incidence and impact among youth, educators and officials, as well as the protective role that education can play in reducing young people's vulnerability to HIV and TB.

The Strategy is grounded upon a rights-based approach and draws on leading international education initiatives to which South Africa has already subscribed, such as the United Nation's Education for All.[3] It aligns itself with the four strategic objectives of the NSP which are to: i) Address social and structural drivers of HIV, STI and TB prevention, care and impact; ii) Prevent new HIV, STI and TB infections; iii) Sustain health and wellness, and iv) Ensure protection of human rights and improve access to justice.

The Strategy is founded on seven key imperatives. These imperatives gave rise to the need for a revised and integrated strategy and have informed the focus and outcomes which the Strategy sets out to achieve.

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2 SANAC. *National Strategic Plan on HIV and AIDS, STIs and TB 2012 – 2016*. Pretoria: South African National AIDS Council, 2011.

3 Launched at the World Conference on Education for All in 1990 by UNESCO, UNDP, UNFPA, UNICEF and the World Bank, and reaffirmed in Dakar in 2000, *Dakar Framework for Action*, UNESCO, April 2000.

Imperative one	:	Alignment with government's outcomes focused plans
Imperative two	:	The impact of HIV and TB on the education sector and educational outcomes
Imperative three	:	Education as a protective factor – the role of prevention
Imperative four	:	The duty of care in schooling, for learners, educators and officials
Imperative five	:	Alignment with the *NSP 2012 – 2016*
Imperative six	:	Lessons from available evidence on effective responses
Imperative seven	:	A sustainable, comprehensive and measured response.

These seven imperatives have provided the basis for the development of the three key strategic outcomes of the strategy that will fundamentally shift the relationship between schooling in South Africa and the country's response to HIV, STIs and TB. These outcomes are themselves closely aligned with best international thinking and the current and emerging recommendations of global agencies.

These outcomes are:

1. Increased HIV, STIs and TB knowledge and skills among learners, educators and officials
2. Decrease in risky sexual behaviour among learners, educators and officials; and
3. Decreased barriers to retention in school, in particular for vulnerable learners.

The Strategy will thus guide the development and implementation of interventions beyond the *HIV and AIDS Life Skills Education Programme* (which was the primary intervention instituted by the Department in response to the *National Policy on HIV and AIDS for Learners and Educators in Public Schools and Students and Educators in Further Education and Training Institutions*) towards providing a more holistic response to the challenge of HIV and TB, ensuring safe and caring schooling and work environments, free from discrimination and stigma. It recognises the heightened vulnerability of girl children and adolescent girls, and the need to address the problems of gender inequality and gender-based violence that lie at the root of this. Support for HIV-positive and TB-infected learners, educators and officials will be paramount, as will support for those within the education system made vulnerable by HIV and TB, especially orphans and children with disabilities.

The Development of the Department of Basic Education *Integrated Strategy on HIV, STIs and TB 2012 – 2016*

During 2009 the DBE took a strategic decision to move the *HIV and AIDS Life Skills Education Programme* from the General Education and Training branch (GET Curriculum and Assessment Chief Directorate) to the then Social and School Enrichment branch (Health in Education Chief Directorate), which is now known as the Social Mobilisation and Support Services branch (Care and Support in Schools Chief Directorate). This decision was based on a desire to

strengthen the integration and alignment of the programme with the HIV and health-related programmes in the DBE. The Life Skills Programme had increasingly shifted to incorporate activities beyond curriculum concerns, including care and support-related activities, partly in response to the realities on the ground in schools and in education districts.

The DBE also began to align its work, including the Life Skills Conditional Grant Framework, to the *NSP 2007 – 2011* to facilitate improved focus and reporting against the NSP targets, and to enable the department to fulfil the requirements set by the South African National AIDS Council (SANAC). In December 2008 the pillars of this new integrated and comprehensive approach to HIV were presented to and accepted by the Heads of Education Departments Committee (HEDCOM).

In 2009 the then Chief Directorate: Health in Education began to conduct background research and to develop a well-reasoned rationale for the Strategy. This research took into account the 2006 evaluation study of the *HIV and AIDS Life Skills Education Programme*, and the gap between current programmes (informed by the conditional grant framework and provincial business plans and reports), and best practice education sector HIV programmes (from research and international evidence). It also recognised that many developments had taken place since the promulgation of the initial policy on HIV in 1999, which needed be taken into account in developing the rationale for the Strategy. The department also recognised the new and more urgent mandate that came with the adoption of the *NSP 2007 – 2011*, and took note of the issues emerging from the mid-term review of the NSP. The renewed urgency given to the response to HIV and TB by the new administration that came into office in 2009 also had to be reflected in the education sector response.

Accordingly, the DBE embarked on a process aimed at developing an integrated strategy on HIV for the schooling system. It was decided that the work already undertaken in the process of developing the conditional grant proposal would be taken into account in developing a strategy. In 2010 work began on developing a draft strategy document as a basis for further consultation. Following a series of interviews and discussions with key staff members in the DBE across branches, and on the basis of a detailed review of documentation submitted as part of this process, a new draft strategy document was produced. It was presented to senior management, HEDCOM and the Committee of Education Ministers (CEM) in 2010 and approval for a wider consultation was granted.

The Strategy was then published in draft form for wide and inclusive public consultation in 2011. This process commenced in March 2011, with a national seminar at which the Deputy Minister of Basic Education announced the draft strategy and formally opened the consultation process. The consultation process was extensive and covered a wide range of stakeholders at a national level, within the DBE, and at a provincial level, with the nine provincial education departments and their local networks (see Annexure A).

This consultation took place while the new *NSP 2012 – 2016* was being developed and discussed through SANAC. The processes were aligned in order to provide an opportunity for the DBE

to ensure the Strategy's relevance in relation to the new focus of the NSP, including the dual epidemics of TB and HIV, and a better alignment of targets and progress-reporting indicators.

The Strategy will guide the national department in consultation with provinces and constituencies in the production of a new national policy on HIV in the schooling sector. The DBE strategy must be carefully examined by provinces and implemented in a manner that is integrated with other provincial priorities and plans.

The target audience for the DBE Strategy includes senior management within the DBE, HEDCOM members, CEM, senior provincial managers, provincial HIV coordinators, teacher unions and learner organisations, key government departments, supporting NGOs, senior members at SANAC, and development partners and agencies.

The success of the Strategy in achieving its key outcomes will be closely reviewed through a monitoring and evaluation (M&E) framework (Annexure B) that is designed to report on the contribution of the strategy to the core mandate of the DBE and the goals of the *NSP 2012 – 2016*, and to provide a management tool for provinces and districts to routinely review and strengthen Strategy implementation.

2. SITUATION ANALYSIS

The analysis below provides a brief, general overview of the situation with regard to HIV, STIs and TB in South Africa, which is followed by a focus on South African youth, age group that corresponds most closely to the school-going population. The section concludes with a brief look at the situation in the education environment, and includes educators, officials and learners.

2.1 HIV and TB in South Africa

Global figures show that 33.3 million people were living with HIV in 2009, with 69% of this total from sub-Saharan Africa.[4] South Africa is now faced with a hyper-endemic HIV epidemic with almost 18% of the population between the ages of 15 and 49 living with HIV[5] – a total of 5.7 million South Africans. Females, particularly those in younger age groups, have a higher HIV prevalence than their male counterparts (Figure 1).[6] This gender difference and the high HIV prevalence figures for adults between 25 and 39 years, suggest that young South African teachers may be carrying a disproportionately high burden of HIV. This is supported by research conducted by the Education Labour Relations Council (ELRC), which found an HIV prevalence of 21.4% amongst educators between the ages of 25 and 34 years in 2004/2005.[7] Furthermore, their research indicated that 40% of the 4 000 educators who died of HIV-related complications in 2004 were younger than 45 years.

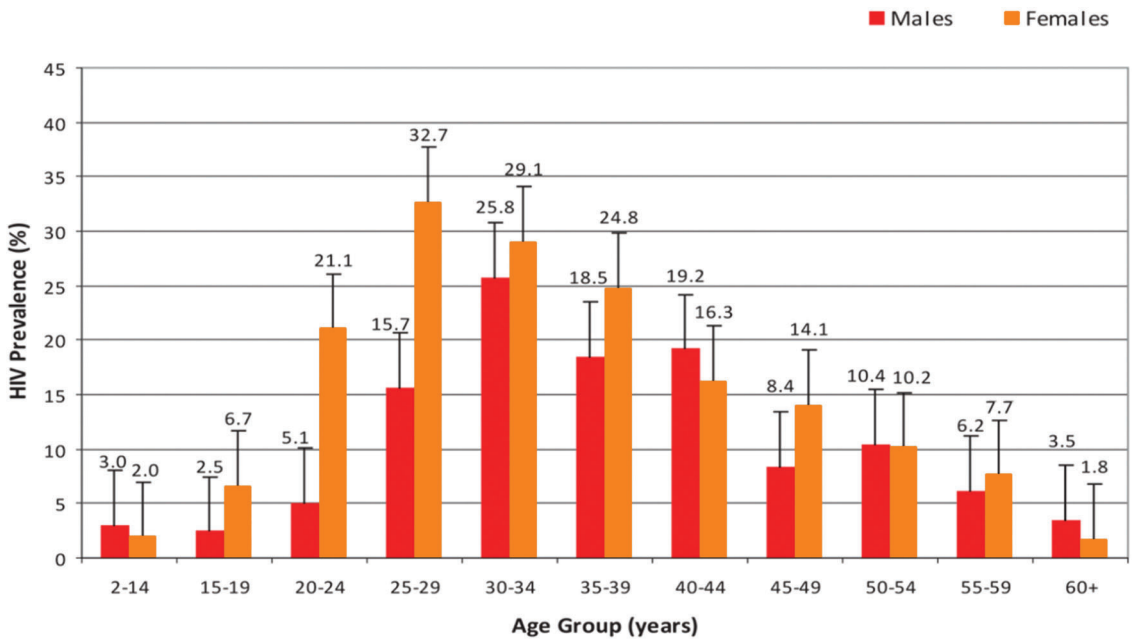

Figure 1: HIV prevalence by gender and age, South Africa, 2008[8]

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4 UNAIDS. *Report on the global AIDS epidemic.* Geneva: UNAIDS, 2010.

5 *Ibid*

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

7 ELRC. *The health of our educators: A focus on HIV/AIDS in South African public schools, 2004/2005 survey.* Cape Town: HSRC Press, 2005.

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

KwaZulu-Natal (15.8%) and Mpumalanga (15.4%) have the highest percentage of individuals living with HIV as well as the highest prevalence of educators living with HIV – 21.8% and 19.1% respectively.[9] The Northern Cape (5.9%) and Western Cape (3.8%), in comparison, have the lowest HIV prevalence. Evidence also points to higher HIV prevalence in urban informal areas, particularly in those situated in the five cities[10] in South Africa.[11,12,13,14] The converse is true for educators. Educators living in rural areas and working in rural schools have a higher HIV prevalence than their urban counterparts.[15]

TB is also a significant health problem in South Africa. South Africa's TB incidence rate of 981 per 100 000 is almost six times higher than the mean incidence of 21 other high-burden countries (HBC).[16] Up to 80% of the adult South African population is infected with the TB bacterium (but does not necessarily have active TB). People living with HIV are more likely to contract TB and represent 73% of new TB cases and 55% of all current TB cases.[17] Furthermore, of all new TB cases in the country 16% are children and 25% of children with TB are HIV-positive. The high level of active TB disease in individuals with HIV (co-morbidity) and the potential curability of TB demands that the DBE's Integrated Strategy include relevant components of the World Health Organization's (WHO) *Stop TB Strategy*[18] as well as the three 'I's for people living with HIV (PLHIV), namely, **I**nfection control, **I**soniazid prevention therapy, and **I**ntensive case finding.

Worldwide, approximately 41% of all new HIV infections in 2009 occurred among young people between 15 and 24 years.[19] Reducing risk of HIV infection in young people and introducing measures to alleviate the impacts of HIV on their lives is fundamental in determining the future course of the epidemic in sub-Saharan Africa. South African national survey data[20] shows a steady decline in HIV prevalence among children (2–14 years) and young people (15–24 years) between 2002 and 2008; in 2008 2.5% of children aged 2–14 years were HIV-positive and 8.7% of young people were HIV-positive. However, young females still carry a disproportionate burden of HIV that increases substantively as they move from adolescence (6.7%) into young adulthood (21.1%).[21] HIV incidence among young people has declined in

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9 *Ibid*

10 Durban, Cape Town, Johannesburg, Pretoria, and Port Elizabeth.

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

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

13 Thomas E. Unpublished work. Johannesburg: South African Medical Research Council/ WITS University, 2010.

14 Unpublished research emerging from UNAIDS Regional Support team for eastern and southern Africa. HEARD and MRC.

15 ELRC. *The health of our educators: A focus on HIV/AIDS in South African public schools, 2004/2005 survey.* Cape Town: HSRC Press, 2005.

16 WHO. *Global Tuberculosis Control: WHO Report 2011.*

17 National Department of Health. The National Tuberculosis Control Programme, National Tuberculosis Policy Guidelines 2009. Republic of South Africa, 2009.

18 WHO. *Global Tuberculosis Control: WHO Report 2011.*

19 WHO. *Global Tuberculosis Control: WHO Report 2011.*

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

21 *Ibid*

recent years, although recent evidence shows that the percentage of new infections increases among young people as they move from middle to late adolescence (Figure 2).[22]

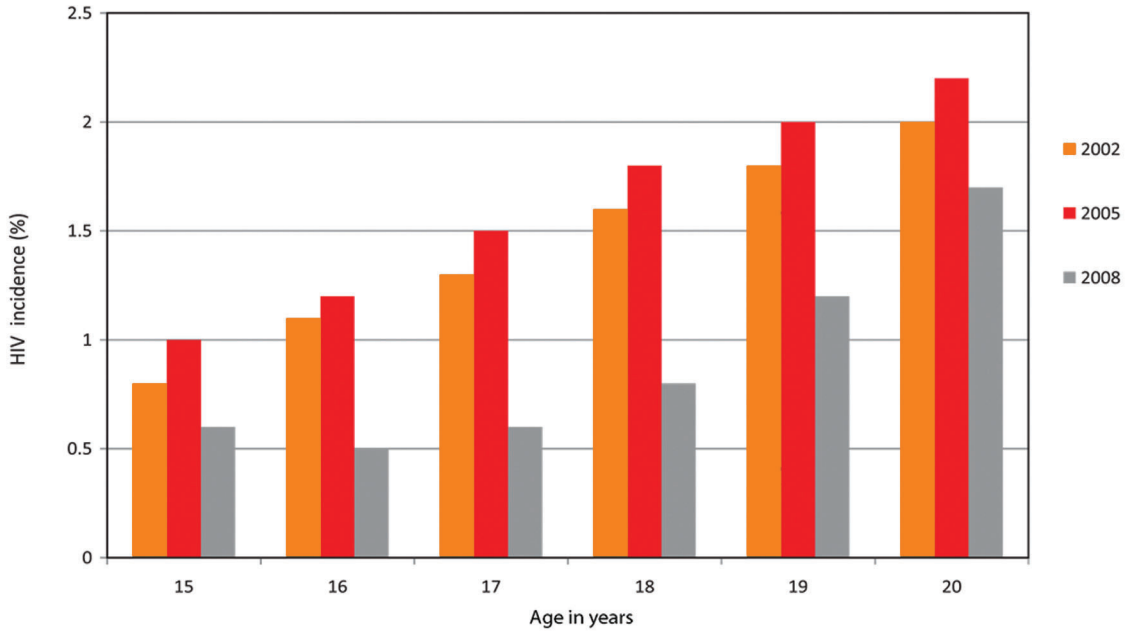

Figure 2: Comparison of HIV incidence in the 15–20 year age group, South Africa 2002, 2005, and 2008[23]

Figures 1 and 2 highlight the fact that susceptibility to HIV infection increases substantially in late adolescence, which makes this a critical age for exposure to HIV-prevention interventions. Reponses aimed at preventing or mitigating the impact of HIV among young people must also be guided by evidence indicating that urban, informal areas have the highest concentrations of HIV-positive young people.[24]

Several behavioural and structural drivers have been found to increase the vulnerability of young people to HIV infection in South Africa. Behavioural drivers include early sexual debut,[25] inconsistent condom use,[26] multiple and concurrent sexual partners,[27] intergenerational sex,[28] transactional sex,[29] substance abuse,[30] a lack of knowledge of HIV status[31] and a lack

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22 *Ibid*

23 *Ibid*

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

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

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

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

28 *Ibid*

29 *Ibid*

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

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

of knowledge of HIV-prevention methods.[32] There is evidence that suggests that there are gender differences in these behavioural drivers. Young males are more likely to make their sexual debut at an earlier age,[33] to have sex under the influence of alcohol,[34,35] be ignorant of their HIV status[36] and to engage in multiple and concurrent sexual partnerships.[37] In contrast, young females are more likely to engage in transactional[38] and intergenerational sex[39] and engage in sex without a condom.[40]

Structural drivers of the HIV epidemic in South Africa include gender inequality, which may give rise to gender-based violence and coercive and unsafe sexual encounters,[41] income inequality, which can reduce individuals' access to information, services and treatment for HIV and TB,[42] cultural beliefs and practices such as patriarchy and unsafe male circumcision;[43] stigma and discrimination around TB and HIV,[44] mobility and migration,[45] and a low level of education.[46] Research has found that young women who have not completed high school are more than three times more likely to be infected with HIV than those who have completed high school.[47] Structural factors significantly compound a young person's risk of HIV infection, and are much more difficult to address than the behavioural drivers of the epidemic.

Biomedical interventions that seek to reduce vulnerability to HIV infection through a various means have demonstrated significant levels of success. For example, voluntary medical male circumcision (VMMC) is one of the most effective HIV-prevention methods for men. Studies

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

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

34 *Ibid*

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

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

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

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

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

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

41 Dickman B, and Roux A. Complainants with learning disabilities in sexual abuse cases: a 10-year review of a psycho-legal project in Cape Town, South Africa. *British Journal of Learning Disabilities.* 2005: 33(3); pp. 138–144.

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

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

44 Maughan-Brown B. Stigma rises despite antiretroviral roll-out: a longitudinal analysis in South Africa. *Social Science and Medicine.* 2010: 70, pp. 368–374.

45 *National Strategic Plan on HIV, STIs and TB 2012 – 2016.* Pretoria: South African National AIDS Council, 2011.

46 Pettifor AE, Levandowski BA, MacPhail C, Padian NS, Cohen MS, Rees, HV. (2008). Keep them in school: the importance of education as a protective factor against HIV infection among young South African women. *International Journal of Epidemiology: 2008.* 37; pp. 1266–1273.

47 *Ibid*

have shown that MMC can reduce the risk of female-to-male HIV transmission by almost 76 percent.[48] Pre-exposure prophylaxis (PrEP) is also an important emerging HIV-infection prevention strategy. PrEP was shown to provide high levels of protection against HIV amongst study cohorts with a high level of treatment adherence to a once-a-day drug regime (up to 73% in some female study groups).[49] South Africa's national prevention of mother-to-child transmission (PMTCT) programme has succeeded in reducing the rate of mother-to-child transmission to below 4% at four to eight weeks after birth.[50] The prevention and early treatment of STIs is also an important component of HIV-intervention programmes.[51,52] Although several recent randomised controlled trials have shown that STI control has little impact on HIV incidence, reviews of observational intervention studies indicate that this result has more to do with problems inherent to the study design and population rather than the underlying concept itself.[53]

One of the most devastating impacts of the HIV epidemic in South Africa is the increase in the number of orphans and vulnerable children (OVC), although it is acknowledged that there are other causes of orphanhood. In 2009 there were 905 453 maternal orphans in South Africa, which equated to 4% of the child population[54] and 6% of school-going children,[55] many of whom were not receiving social grants.[56] Research suggests that orphans and children in AIDS-sick homes may be at greater risk of HIV infection.[57] They also experience more depression, post-traumatic stress symptoms, conduct problems, poor peer attachments and somatic complaints[58,59] than non-orphans. In addition, in HIV-affected families, young people are more at risk of TB infection, as well as negative health and psychosocial outcomes, such as physical and emotional abuse.[60] The educational impacts identified by these children include missing and dropping out of school, hunger at school due to household poverty and difficulty concentrating.

However, this must be placed in the wider context of addressing vulnerability among children and learners in general. For instance, in 2009 approximately 4% of all children attending school

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48 Auvert B,Taljaard D, Rech D, *et al. Effect of the Orange Farm (South Africa) male circumcision roll-out (ANRS-12126) on the spread of HIV.* Abstract presented at IAS 2011, Rome, July 2011.

49 Baeten, J, Celum, C. Partners PrEP Study. Presentation at IAS 2011, Rome, July 2011.

50 Goga, A, *et al.* Impact of the national prevention of mother to child transmission (PMTCT) program on mother-to-child transmission of HIV (MTCT), South Africa, 2010. Presented at 6th IAS conference, Rome, July 2011.

51 SANAC. *National Strategic Plan on HIV and AIDS, STIs and TB 2012 – 2016*. Pretoria: South African National AIDS Council, 2011.

52 Hayes R, Watson-Jones D, Celum C, van de Wigert J, Wassweheit J. Treatment of sexually transmitted infections for HIV prevention: end of the road or new beginning? AIDS: 2010. 24(4); S15–S26.

53 *Ibid*

54 Department for Social Development, *Estimation of Orphans in SA from Vital Registration Data*. South Africa: April 2010. The DSD uses maternal orphans for the calculations as estimating paternal orphans is difficult for a variety of reasons, not least because father's details are optional in the child's birth registration process.

55 DBE. *Report on the 2009 General Household Report: Focus on Schooling,* Pretoria: August, 2011.

56 *Ibid*

57 Cluver L, Operario, D. Intergenerational linkages of AIDS: Vulnerability of orphaned children to HIV infection. *IDS Bulletin:* 2008; 39(5).

58 Cluver L, Gardner, F. The psychological well-being of children orphaned by AIDS in Cape Town, South Africa. *Annals of General Psychiatry:* 2006; 5(8), doi:10.1186/1744–859X-5-8.

59 Cluver L, Gardner, F, Operario, D. Poverty and psychological health among AIDS-orphaned children in Cape Town, South Africa. *AIDS Care:* 2009; 21(6); pp. 732–741.

60 Cluver L, *et al.* Infectious disease and TB co-occurrence amongst children with AIDS-affected caregivers. Presented at 5th South African AIDS Conference, Durban, 2011.

had a disability.[61] The *Policy Framework for Orphans and Other Children made Vulnerable by HIV and AIDS South Africa*[62] clearly places orphans within this wider context and consistently talks about orphans and 'other vulnerable children' (OVCs) as one group, demanding a multi-sectoral and cross-departmental coordinated response.

It must be recognised that other factors beyond HIV and TB can render youth vulnerable to school dropout. Reports issued by the DBE on learner retention and dropout have reported an overall dropout rate of 4% of learners, increasing to 11.8% amongst Grade 11 learners. The retention rate of learners between Grades 9 and 12 is approximately 60%, and although the survival rate of learners in the education sector has increased over the last 40 years, recent figures indicate that fewer than 50% of Grade 1 learners will reach Grade 12.[63,64] School dropout is rarely caused by a single event in a learner's life and is often the culmination of many interrelated factors, which include both in-school and out-of-school factors.[65,66] Out-of-school factors such as living in an isolated community, being eligible for, but unable, to access social welfare grants, not living with biological parents, and orphanhood and disability, increase a learner's vulnerability to dropping out of school.[67] In addition, teenage pregnancy and substance abuse, combined with a lack of stimulation and support from educators and other school staff can cause learners to disengage from school and eventually drop out.[68]

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61 DBE. *Report on the 2009 General Household Report: Focus on Schooling*, Pretoria: August, 2011.

62 Department of Social Development. *Policy Framework for Orphans and Other Children made Vulnerable by HIV and AIDS.* South Africa, Pretoria: July, 2005.

63 Department of Education. Ministerial committee on learner retention in the South African schooling system: Progress report to the Minister of Education, Mrs GNM Pandor, M.P., October, 2007.

64 DBE. Report on dropout and learner retention strategy to Portfolio Committee on Education. June, 2011.

65 Fleisch B, Shindler J, Perry H. Who is out of school? Evidence from the Community Survey 2007, South Africa. *International Journal of Educational Development:* 2010; doi:10.1016/j.ijedudev.2010.05.002.

66 Strassburg S, Mery-Gibert S, Russel B. *Left unfinished: Temporary absence and dropout from South African schools. Findings from the Access to Education Study Volume 2.* Johannesburg: Social Surveys Africa and Centre for Applied Legal Studies, November, 2010.

67 Fleisch B, Shindler J, Perry H. Who is out of school? Evidence from the Community Survey 2007, South Africa. *International Journal of Educational Development:* 2010; doi:10.1016/j.ijedudev.2010.05.002.

68 Strassburg S, Mery-Gibert S, Russel B. *Left unfinished: Temporary absence and dropout from South African schools. Findings from the Access to Education Study Volume 2.* Johannesburg: Social Surveys Africa and Centre for Applied Legal Studies, November, 2010.

3. RESPONSE OVERVIEW: SA NATIONAL STRATEGIC PLANS

3.1 The *HIV & AIDS and STI NSP 2007 – 2011 (NSP 2007 – 2011)*

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

An assessment of *NSP 2000 – 2005* was carried out and the findings and recommendations guided the development of the NSP for the 2007 – 2011 period. The *NSP 2007 – 2011* had two primary aims and four key priority areas. Its primary aims were to:

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

The four key priority areas were:

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

Mid-term review of the *National Strategic Plan 2007 – 2011*

A mid-term review of the *NSP 2007 – 2011* was conducted in 2009, and the findings from this review contributed to the development of the DBE *Integrated Strategy on HIV, STIs and TB 2012 – 2016*. The mid-term review listed some achievements such as increased condom use, large-scale knowledge campaigns, increased HIV counselling and testing (HCT) coverage, and the increased rollout of antiretroviral therapy (ART). It also listed response weaknesses such as weak coordination, too many ill-defined targets and a lack of reporting from the private sector and civil society.

The review specified particular areas for attention, including:

1. Insufficient progress on prevention
2. A possible decrease in knowledge of HIV

3. Health systems obstacles to scaling up of responses
4. Lack of coordination and reporting on impact mitigation
5. Weak targets and reporting on human rights and access to justice actions.

The report recommended that instead of changing the plan at this point in its implementation, several priority areas should receive focus. With scaled-down targets and indicators, the report recommended that the following areas be given priority until the end of 2011:

1. Making the SANAC secretariat functional
2. Transforming HIV information into HIV intelligence
3. Investing further effort in prevention, while continuing efforts to scale up treatment
4. Integrating ART with related health services into primary healthcare delivery
5. Improving attention to, and coordination of, impact mitigation activities
6. Strengthening implementation of the Human Rights and Access to Justice priority area.

Although the NSP 2007 – 2011 set out to implement life skills-based HIV education in 80% of primary and secondary schools by 2008, coverage of only 58% of schools had been achieved by that year. The target for 2011 was 98%. The report stated that while the DBE had acted to strengthen and customise life skills, conduct peer-education training camps and train educators and learners on substance abuse, it was not on target to achieve the NSP target of 98% by 2011.[69]

3.2 Political developments towards the achievement of the *NSP 2007 – 2011* in South Africa

In 2007 the Deputy President revived SANAC, which saw the involvement of key stakeholders that included government, civil society and the private sector. In 2009, government announced a renewed commitment to scale up the national response, with increased targets being set for the roll out of ART, condom distribution, VCT and PMTCT. On World AIDS Day 2009, the President announced the launch of a massive campaign to mobilise all South Africans to get tested and ensure that every South African knows his or her HIV status.

In March 2010, as part of this accelerated response to HIV, cabinet announced its intention to launch a nationwide HIV Counselling and Testing (HCT) campaign that would be integral to the country's efforts to achieve the targets of the *NSP 2007 – 2011* on HIV and STIs. A range of other HIV-prevention activities and services were also to be included in the national HCT campaign, including the treatment and management of STIs; widespread provision of condoms (100 for every person that underwent an HIV test); a plan to introduce VMMC; an expanded

[69] SANAC. *National Strategic Plan 2007 – 2011: Mid-term review.* Pretoria: SANAC, 2010.

PMTCT programme; PrEP for rape survivors; and life skills education for learners. During this time, government planned to distribute another one billion condoms through public facilities.[70]

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

The campaign lasted just over a year and ended in June 2011. However, although it achieved considerable success – just over 12 million tested – it did not achieve its ambitious target of 15 million. It also exposed weaknesses in the capacity of the public health system to implement such a large and multi-faceted campaign and provide the necessary follow-up for people who had been tested.[71,72,73]

3.3 Overview of the *TB National Strategic Plan 2007 – 2011*

The *NSP 2007 – 2011* did not address TB and a separate NSP focusing solely on the TB epidemic was developed. The main goal of the *NSP TB 2007 – 2011* was to reduce the burden of TB disease in the country through early diagnosis and initiation of appropriate treatment to reduce TB mortality and prevent continued TB transmission.

Key activities were outlined under seven strategic objectives:

1. To strengthen the implementation of the Directly Observed Therapy Short Course (DOTS) strategy
2. To address TB and HIV, MDR and XDR-TB
3. To strengthen health systems
4. To work collaboratively with all care providers
5. To empower people with TB, as well as the communities they live in
6. To coordinate and implement TB research
7. To strengthen infection control.

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70 SANAC. New date set for the launch of the national HIV counselling and testing campaign. Press statement. Pretoria: South African National AIDS Council, 2010.

71 Colvin, M. *End-of-term Review of the NSP 2007 – 2011. Final Report*. 4 November, 2011.

72 Mushwana, S. Investigating the impact and challenges of implementing the National Counselling and Testing Campaign in the Ga-Motupa Community in Limpopo. Masters Dissertation, University of Stellenbosch, 2011.

73 SANAC. World AIDS Day 2010. Retrieved from http://www.sanac.org.za/?task=4&subtask=1

The targets to be achieved were:

1. An increase in case-detection rate from 55% to 70% by 2011
2. A sputum result Test and Treat (TAT) in less than 48 hours in 80% of all facilities by 2010
3. A reduction of the defaulter rate from 10% to below 5% by 2011
4. An increase in the smear-conversion rate for new smear-positive patients from 55% to more than 75% by 2011
5. An increase in cure rates for new sputum smear-positive Pulmonary Tuberculosis (PTB) from 56% to 85% by 2010
6. A reduction in TB death rates from 71 to 60 per 100 000 by 2011
7. 100% of all patients with confirmed MDR-TB started on treatment by 2007
8. 100% of all patients with confirmed XDR-TB started on treatment by 2007
9. An increase in the HIV-testing rate among TB patients from 41% to 100% by 2011.

A major review of the TB programme was conducted in July 2009 with a number of international partners, including WHO, the United States Centre for Disease Control (CDC), Stop TB Partnership, and the President's Emergency Fund for AIDS Relief (PEPFAR). The review listed a number of achievements such as a demonstrable improvement in case detection (78%) of new infectious TB cases, and significant progress by the National Health Laboratory Services (NHLS) in most provinces in access to treatment, turnaround time of test results and quality assurance of sputum-smear microscopy, culture and drug sensitivity tests, which included the introduction of rapid diagnosis of Multi-Drug Resistant TB (MDR-TB).

However, a variety of challenges remained. These included:

- Although the increase in cases notified was driven primarily by HIV, in more than 70% of TB patients also living with HIV, less than half knew their HIV status
- TB screening for people living with HIV was around 40%, but of these only 4% were on Isoniazid Preventive Therapy (IPT)
- Late initiation of ART in TB patients resulted in high mortality because ART services were centralised (hospital level) while TB services were provided at clinic level
- The treatment success rate for new infectious TB cases was 73% in 2009 (the global target was >85%), with high death rate at 7% and default rate at 8%, and unevaluated patients at 6%.

The review noted that the degree of response to the TB epidemic was not yet commensurate with its size, both in terms of service coverage, human and financial resources and the infrastructure required to reverse the tide of the epidemic. The mid-term review made the following recommendations to address the major challenges:

- Establish and implement all possible mechanisms to intensify case finding particularly, but not solely, in high-risk groups such as PLHIV, prisoners and miners
- Consider major efforts to intensify the use of IPT among HIV-positive persons
- Ensure all TB patients are tested for HIV
- Intensify and decentralise provision of ART to match the TB-treatment network, to ensure that patients with HIV-associated TB receive it in time to impact on mortality rates
- Promote implementation of patient-centred approaches to TB care, including sustainable expansion of community-based care and strict DOT to enhance treatment adherence and reduce treatment default.

3.4 The *National Strategic Plan on HIV, STIs and TB (2012 – 2016)*

The *NSP 2012 – 2016* was launched on World AIDS Day, 1 December 2011. The key issue that emerged during the course of its development in 2010 and 2011 was the recognition that TB had now become the leading cause of death in PLHIV, and was a major cause of mortality and illness among children and young people in South Africa. The *NSP 2012 – 2016* aims to address both HIV and TB epidemics. In this respect, the DBE Strategy is aligned with the *NSP 2012 – 2016*.

The *NSP 2012 – 2016* has five goals, namely:

1. Reduce new HIV infections by at least 50% using a combination of prevention approaches
2. Initiate at least 80% of eligible patients on ART, with 70% alive and on treatment five years after initiation
3. Reduce the number of new TB infections as well as deaths from TB by 50%
4. Ensure an enabling and accessible legal framework that protects and promotes human rights in order to support implementation of the NSP
5. Reduce self-reported stigma related to HIV and TB by at least 50%.

There are four strategic objectives, namely:

1. Address social and structural drivers of HIV and TB prevention, care and impact
2. Prevent new HIV, STI and TB infections
3. Sustain health and wellness
4. Ensure protection of human rights and increased access to justice.

The NSP makes several key recommendations for action for the education sector, with a focus on children and youth:

- Targeted interventions for key populations, including young women between the ages of 15 and 24 years, young people not attending school and girls who drop out of school before matriculating
- Reduce the vulnerability to HIV infection of young people, specifically orphans and learners aged 10 to 14, by retaining them in schools
- Prevent HIV, STIs, TB and unplanned pregnancies in adolescents and youth through the implementation of comprehensive packages of services in schools
- Build skills, increase knowledge, shift attitudes, change harmful social norms and risky behaviour, and promote human rights values by providing HIV life skills education in all schools and grades as a compulsory part of the education curricula and co-curricular activities
- Recognise the impact of alcohol and substance abuse on HIV transmission and improve alcohol and substance abuse education in schools
- Implement an integrated school health programme (ISHP) that includes a package of SRH and rights services, as well as sexuality and TB education material appropriate for each school phase. This package must be available in all schools, including private and special schools
- Introduce school-based screening and support for children with HIV, TB and STIs
- Provide specialised support and establish referral systems for HIV-positive children and adolescents who may have complex disclosure issues and behaviour which does not comply with medical advice (treatment adherence)
- Prioritise schools which focus on children with disabilities, and improve integration of disability programmes into mainstream schools
- Provide policies on confidentiality, discrimination, routine medical screening and testing of employees, respiratory infection control, treatment, sick leave, psychosocial support, and job modification/alternative placement, where necessary. All workplace wellness programmes should address HIV, STIs and TB in an integrated manner that is aligned with national standards.

Schools are an important practical component of the *NSP 2012 – 2016*. Aside from schooling being a protective factor against HIV infection, schools are a critical means for communicating, educating and channelling prevention and treatment initiatives to the youth attending school and to a considerable workforce in South Africa.

4. RESPONSE OVERVIEW: EDUCATION

4.1 General Milestones

The responsibilities of the education sector encompass all four strategic objectives of the *NSP 2012 – 2016*. TB will become a new area of priority for the DBE and will require an additional set of guidelines for infection control in schools and the extended education environment, and an integrated holistic approach to prevention, detection, treatment, care and support in the same manner as for HIV. It is acknowledged that some schools have encountered TB among learners, educators and officials in the past and have developed appropriate responses. These need to be standardised at national level.

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

1. *National Policy on HIV/AIDS for Learners and Educators in Public Schools and Students and Educators in Further Education and Training Institutions*[74]
2. HIV and AIDS Life Skill education in the curriculum via the Life Orientation (LO) learning area (2002 – 2010)
3. Programmes targeting poverty and vulnerability (including the National School Nutrition Programme [NSNP], no-fee schools and scholar transport programmes)
4. Guidelines, support materials and training for the prevention and management of sexual violence and harassment
5. The publication of an desktop review on the prevalence of learner pregnancy in public schools, *Teenage Pregnancy in South Africa with a specific focus on school going learners*
6. Peer education programmes
7. The Safe Schools campaign, which addresses the physical safety of learners and educators and the prevention and management of sexual violence and harassment
8. A research study on teachers entitled, *The health of our educators: A focus on HIV/AIDS in South African public schools, 2004/2005 survey.*[75]

Although education responses were developed, this was not done through a comprehensive or integrated process. As is evident from the following review of some of these initiatives, the results suffered due to gaps in alignment, knowledge and collaboration.

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

[75] ELRC. *The health of our educators: a focus on HIV/AIDS in South African public schools, 2004/2005 survey.* Cape Town: HSRC Press, 2005.

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

The National Policy on HIV and AIDS for Learners and Educators in Public Schools and Students and Educators in Further Education and Training Institutions, published in 1999, was the education sector's first effort at responding to the impact of HIV on the schooling system and its constituents, and created a basis for systemic interventions in schools.

It recognised the duty of the State to ensure that schools were safe spaces in terms of physical protection from the virus, and that there was adequate information and education on HIV in schools. It provided a framework for the development of provincial and school policies and strategic plans on HIV.

Specifically, the aim of this policy was to:

- Increase learner knowledge on HIV through schools, specifically through the curriculum
- Reduce discrimination against HIV-positive or HIV-affected persons
- Introduce universal precautions for the safety of learners and educators at schools.

Although the policy was a product of its time in the landscape of HIV and had a strong biomedical focus, its ethos and ideals were progressive and its principles and objectives were drawn from, and consistent with, the country's constitution and new legislation, enacted post-1994. However, although the general nature of the policy objectives and guidelines was consistent with government's general strategy and plan on the one hand, it was restricted by the conditions for HIV interventions at the time.

The notion that each school should have a strategic plan to respond to the epidemic, and should be prepared to handle disclosures and be given support to handle confidentiality issues has been commended,[76] although the lack of clarity on strategies to support principals and educators in implementing these policy assignments has been identified as a limitation. Educators and principals would have benefitted from support and guidance in these complex areas.

Furthermore, there was a need for the policy to align itself with other government policies and initiatives. The *National Integrated Plan of 2000 – 2005* focused on life skills education in primary and secondary schools, HIV counselling and testing in the population at large, and community and home-based care. The NSP followed the *National Integrated Plan of 2000 – 2005* and the *Operational Plan for Comprehensive HIV and AIDS Care, Management, and Treatment* (CCMT). The Policy Framework for Orphans and Other Children Made Vulnerable by HIV and AIDS South Africa[77] gave the DBE a defined and critical role, and in 2006 the Department of Health (DoH) was mandated by SANAC to lead development of a new five-year plan (2007 – 2011).

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[76] *Ibid*

[77] Op. cit. DSD. July, 2005.

The underlying assumption in the policy that knowledge alone would enable learners and students to make informed sexual choices and decisions had to be reconsidered. The ELRC identified a failure to address the issue of context – how the messages around sex and sexuality and HIV were constructed, produced and reproduced, and the social context in which vulnerable members of the society found themselves.[78] Inadequate attention to how and where learners and students developed their sexual identities, and how issues of power, vulnerability, subjective hope, and so forth, played into the problems learners and educators faced in a lived context, and reduced the effectiveness of the policy within the school environment. The biomedical approach to information also potentially ignored the important social aspects of the epidemic. It was also necessary to identify and focus on groups who were more vulnerable to the epidemic, such as women and girl children, people with disabilities, and orphans, who may have needed additional support.[79]

The policy also made no mention of TB (although this has only recently been recognised as an emergency epidemic). A range of procedures, consistent with the holistic approach being developed for HIV and dealing with the TB epidemic, had to be developed with workplace practice in mind. The policy was explicit on the rights of the HIV-positive individual (i.e. access, non-discriminatory practices, treatment, care and so on) but little mention was made of the growing number of learners and educators who were *affected* by HIV. No attention was given to the establishment of mechanisms to provide assistance to those affected, for example children and educators who had lost family members or those who were living in communities that had been affected. There was an absence of mechanisms to address school absence for extended periods because of HIV and TB.[80] This extended further to treatment and support needed for educators and learners who were HIV-positive or had TB disease, but wanted to continue working and going to school. This issue had to be structured into policy norms, since illness was likely to increase the demand on educators, especially if continued education was required for TB- or HIV-infected children who may have been absent from school for prolonged periods.

While there was a strong thrust for prevention, the continuum of care outlined in the public health approach, in particular early detection and treatment, care and support, were not explicitly addressed in the policy.

4.3 Review of Policies in Public Education

The National Minister for Public Service and Administration and the DPSA are responsible for the formulation of human resource management policy directives, including those that deal with employee health and wellness. In recognition of the impact of HIV on South Africa and the public service, the minister initiated an Impact and Action Project in January 2000, aimed at ensuring that the public service was able to sustain quality service in spite of the progression of the HIV epidemic. This led to the development of a policy framework to guide departments on the minimum requirements to effectively manage HIV in the workplace, and

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78 ELRC. *Workplace policies in public education: A review focusing on HIV/AIDS.* Cape Town: HSRC Press, 2005.

79 *Ibid*

80 *Ibid*

ensure a coordinated public service response. This policy framework was amended in 2001 to ensure the proper management of HIV in the workplace and was aimed at ensuring that the working environment supported effective and efficient service delivery as far as was reasonably possible.

In 2005, a further review was undertaken[81] that focused on workplace policies developed by the (then) Department of Education (DoE) and policies developed by the South African Democratic Teachers Union (SADTU) and the National Professional Teachers' Organisation of South Africa (NAPTOSA). The review established that policy governed many aspects of the professional lives of educators and was central to the sector's response to crises such as the HIV epidemic. Policy could therefore contribute directly to curtailing the attrition of educators by encouraging and providing protection against threats such as HIV, and by creating a positive and supportive working environment.

The policies reviewed in the ELRC report[82] were found to be well written and if implemented, would create a good environment for educators. A number of successes were noted, particularly in terms of the transformation of education structures. However, the findings suggested that problems centred on a lack of policy implementation resulting from disjuncture between the national office and provincial and district offices, and a lack of resources and inadequate planning and preparation for implementation.

In 2008, DPSA produced the Employee Health and Wellness Strategic Framework (EH&WSF) for the Public Service, which was an expansion of the 2001 policy. It took employees' personal circumstances, including disability, HIV and other health conditions, into consideration.[83] It incorporated an inclusive and needs-driven platform and a set of guidelines for operational policies for all government line departments for the health and wellness of public servants, their families and citizens. It was based on DPSA's experience with its previous programme, and international best practice, such as the *WHO Global Plan of Action on Workers Health 2008 – 2017*, the *ILO Decent Work Agenda in Africa 2007 – 2015*, and the *WHO Social Determinants of Health 2008.*

The framework had four pillars:

1. HIV and AIDS and TB Management
2. Health and Productivity Management
3. Safety, Health, Environment, Risk and Quality Management Policy (SHERQ)
4. Wellness Management

Although Pillar 1 directly addressed the needs and concerns of all government departments for HIV, and AIDS and TB management, DPSA proposed setting up a Joint Policy and Operational

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81 ELRC. *Workplace policies in public education: A review focusing on HIV/AIDS.* Cape Town: HSRC Press, 2005.

82 *Ibid*

83 Department of Public Service and Administration. *Human Resources Development Strategy for the public service, 2002 – 2006.* Pretoria: Department of Public Service and Administration, 2002.

Plans Task Team to facilitate collaboration between DBE, DoH, Department of Labour (DoL) and DPSA around all the pillars to address capacity issues, and provide an operational lead on implementing the EH&WSF.

National, provincial and district workplace policies had to take the changing face of the HIV epidemic (e.g. ART meant PLHIV could have long and productive study and work lives) into account by addressing the demands for TB control and prevention in the school and education environment, and strengthening the care and support response encouraged by initiatives such as the Care and Support for Teaching and Learning (CSTL) Programme.

SADTU and the ELRC have both implemented interventions amongst educators and learners to mitigate the spread of HIV and promote access to treatment and support services. The ELRC – Prevention, Care and Treatment Access Project (ELRC-PCTA), launched in 2007, catered for government school educators who were living with and affected by HIV and AIDS. The project was implemented under the leadership of the ELRC with several national teachers' unions as implementing partners of the programme.

In 2008 the ELRC-PCTA provided training to master trainers, peer educators and lay counsellors who would assist in the delivery of information about HIV prevention, VCT services, treatment, care and support to other educators and learners in the schooling system. In 2008 alone 4 595 educators were reached through community outreach promoting HIV and AIDS prevention, 751 educators were trained in HIV-related stigma and discrimination, and 20 educators were trained to deliver counselling and testing.[84]

SADTU's Prevention Palliative Care for Teachers, Orphans and Vulnerable Children (PPCT-OVC) programme grew out of the PCTA pilot project and was implemented among educators, orphans and vulnerable children in the schooling system between 2007 and 2012. It aimed to increase access to HIV and AIDS prevention, awareness, VCT, care, treatment and support, and reduce stigma and discrimination in the workplace and school community by promoting human rights and a safe environment. Phase one of the PPCT-OVC programme was rolled out in the Eastern Cape, KwaZulu-Natal and Mpumalanga and achieved the following results:

- 12 union leaders and 36 teachers were trained in HIV prevention, care and treatment access
- 10 560 school community members attended events focusing on prevention
- 240 union offices were used as condom distribution sites
- 21 support groups were established, with 715 educators attending regularly
- 1 908 orphans and vulnerable children in 38 schools were supported with grants of R900 each (for uniforms, shoes etc)
- 1 766 SADTU members received counselling and testing.[85]

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84 ELRC. PCTA: *Year one: Annual Report, October 2007 – September 2008.* ELRC, 2008.

85 SADTU. *SADTU E-Voice* #1. Online newsletter of the South African Democratic Teachers' Union.http://www.sadtu.org.za/newsletter/sadtu-evoice-1

By 2009 the OVC programme was providing school uniforms, toiletries, school shoes and other items to 3 318 OVC from six provinces. These children were also being taught life skills so that they would know their rights and responsibilities, respect other people's rights and report any form of abuse.[86]

4.4 The HIV and AIDS Life Skills Education Programme

History of the Life Skills Programme

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

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

The Life Skills Programme is a multi-faceted programme consisting of several components, including capacity-building for educators and school-management teams; the development of teaching and learning materials; lessons within the LO learning area and other learning areas; peer education programmes; and the establishment of care and support teams that include community-based stakeholders. The main topics covered by the programme are sexuality and health education (including HIV), substance abuse, child abuse, peer education, assertiveness skills, peer pressure, prevention of discrimination, gender issues and other relevant skills to enable learners to deal effectively with difficult situations. The LO learning area is focused on supporting the holistic development of learners by helping them to acquire the skills, knowledge, values and moral principles needed to live meaningful and successful lives.[87,88] In other words, the LO learning area balances the development of learners' knowledge and skills while helping them acquire the values and moral principles necessary to live successful lives.

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86 SADTU Secretariat. SADTU marks World AIDS Day. Media Statement, 1 December 2009. http://www.sadtu.org.za/node/164

87 DBE. *Grades 7–9 Life Orientation Curriculum and Assessment Policy Statement: Final draft.* Pretoria, 2011.

88 DBE. *Grades 10–12 Life Orientation Curriculum and Assessment Policy Statement: Final draft.* Pretoria, 2011.

Review of the Life Skills Programme

Several evaluations of the Life Skills Programme undertaken in recent years have examined teacher and learner perceptions and opinions of the programme as well as its influence on the attitudes and behaviour of learners. These evaluations have all uncovered similar themes in their findings.

Learners identified the Life Skills Programme as a primary source of information about HIV. Several studies showed that exposure to the Life Skills Programme was associated with an improvement in learners' knowledge about HIV, common modes of transmission and prevention methods.[89,90,91,92] The programme produced other favourable gains amongst learners, including a heightened level of risk perception for HIV infection,[93] an increased understanding of abstinence as a prevention method, and increased approval of abstinence as a behavioural choice for teenagers.[94]

However, some studies found gaps in learners' knowledge that needed to be addressed by the Programme. In a national evaluation of the programme,[95] learners failed to identify unprotected sex as a mode of HIV transmission, while a small proportion of Gauteng learners showed acceptance of common myths surrounding HIV.[96] The Southern and Eastern African Consortium for Monitoring Educational Quality (SACMEQ) Policy Brief Number 5, (April 2011) further revealed that during 2007, about two-thirds of Grade 6 learners (65%) lacked the minimal knowledge about HIV and AIDS required for protecting and promoting their health.

In terms of the impact on learner attitudes and behaviour, evaluation studies have produced mixed results. A national evaluation conducted in 2006[97] reported that the Life Skills Programme had made a positive impact on learners' behaviour, on their attitude towards people different from themselves, and on the way in which they treated and interacted with others. Reddy and colleagues,[98] discovered that there was reduction in the number of sexual partners among Grade 9 male learners in KwaZulu-Natal while a study by Visser[99] found that an increase in

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89 *Ibid*

90 Department of Education. *National evaluation of the impact of the DoE HIV AIDS Life Skills Programme on the behaviour of learners.* Pretoria: Department of Education, 2006.

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

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

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

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

95 Department of Education. *National evaluation of the impact of the DoE HIV AIDS Life Skills Programme on the behaviour of learners.* Pretoria: Department of Education, 2006.

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

97 Department of Education. *National evaluation of the impact of the DoE HIV AIDS Life Skills Programme on the behaviour of learners.* Pretoria: Department of Education, 2006.

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

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

learner knowledge failed to reduce engagement in high-risk sexual behaviour. In a Gauteng-based study, 90% of learners reported that LO lessons had helped them to protect themselves from HIV infection and to accept people living with HIV and AIDS, but only 34.4% believed that the classes made the greatest impact on their behaviour and attitudes.[100]

Learners appeared to hold differing opinions as to the appropriateness of the curriculum of the Life Skills Programme. Bhana and colleagues[101] reported that most learners in their sample were happy with the materials supplied to them, but a third felt that there was insufficient information given to them for their age. In contrast, over half the learners felt there was too much emphasis on condom use (55.3%), sex (51%) and abstinence (60%), and just under half believed that the materials sanctioned sex as long as it was safe (49.4%). Amongst Grade 9 learners in KwaZulu-Natal, findings showed that exposure to the programme had neither contributed to an increase in sexual activity, nor had it increased the intention of learners to engage in sexual activity.[102] The findings of Reddy and colleagues[103] also highlighted the importance of gender sensitivity in developing and implementing the Life Skills Programme. The researchers found important gender differences in learners' needs and the outcome of the programme with respect to learner's attitudes towards sex and sexual behaviour. The findings showed that the programme had different effects on male and female learners, suggesting that future programme revisions should inculcate gender sensitivity, taking into account the specific information, skills and learning needs of male and female learners.

Teachers played a critical role in the implementation of the Life Skills Programme and their effectiveness had an impact on the overall success of the programme. Research showed that the majority of teachers believed in the importance of LO lessons for learners and the responsibility of schools to educate learners about sex, sexuality and HIV.[104] Despite their best efforts, the role of teachers in providing HIV education and prevention knowledge to learners was often undermined by a lack of resources, support, training and teacher development.[105, 106]

Bhana and colleagues[107] found that about half the teachers in their study had not received teaching materials from the DoE.[108] Among those educators who did have the requisite teaching materials many were concerned about the age appropriateness of the materials and their explicit sexual content, which could potentially create discomfort for educators teaching LO

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

101 *Ibid*

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

103 *Ibid*

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

105 *Ibid*

106 Department of Education. *National evaluation of the impact of the DoE HIV AIDS Life Skills Programme on the behaviour of learners.* Pretoria: Department of Education, 2006.

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

108 *Ibid*

lessons.[109] Teachers in KwaZulu-Natal also reported feelings of uncertainty in teaching some of the details of the curriculum topics,[110] exacerbated in situations where the content conflicted with their own personal and/or cultural values.[111]

Research also showed that very few educators received training support from the department to teach the LO programme.[112] Educator training to implement the LO learning area should thus receive more national and regional focus, since most regions have initiated such educator training processes. Structures to monitor the effect of the Life Skills and LO programmes in schools should also be addressed in policy documents. The observations made in the CAPS assessment in 2011[113] concerning the need for new participatory methodologies to teach LO and Life Skills, as well as the provision of scripted lesson plans, improved teacher training for LO. Inclusion of previously omitted key topic areas is critical, and has direct implications for educator training and follow-up support. The DBE has responded to the recommendations of the Curriculum and Assessment Policy Statement (CAPS) assessment by commissioning the development of innovative scripted lesson plans, and has recognised that Life Skills and LO teachers require specialised training in non-traditional teaching methods.

Plans to improve teacher training for delivery of the Life Skills and LO Programme must include efforts to equip educators to teach LO using participatory and child-centred pedagogies. Research reveals that teachers often neglect to focus on the development of learner skills and abilities within LO lessons.[114] These findings were reinforced by the SACMEQ Report (April 2011), which found significant differences between grade 6 learners and their teachers when it came to HIV and AIDS knowledge. It is easy to assume that teachers with high levels of knowledge on HIV and AIDS will be able to transmit this information to learners. These findings suggest, however, that the teaching pedagogy and/or activities that educators are employing to teach learners about HIV and AIDS may not be conducive to bringing about the improvements in HIV knowledge and skills that the Life Skills and LO Programmes set out to achieve. The *National Policy Framework for Teacher Education and Development in South Africa* acknowledged these pedagogical and content-related concerns and their need to be addressed during teacher pre-service and in-service training.[115]

Evaluation findings have shown that the implementation of the Life Skills Programme in some schools has not been satisfactory. Some Model C schools have refused to implement the Life Skills Programme and other schools only partially implemented the programme in

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

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

111 Department of Education. *National evaluation of the impact of the DoE HIV/AIDS Life Skills Programme on the behaviour of learners.* Pretoria: Department of Education, 2006.

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

113 Kirby D. *A Way Forward: Recommendations to the South African DBE to Design and Implement an Effective HIV Education Curriculum that Reduces Sexual Risk for HIV.* July 2011.

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

115 Department of Education. *National Policy Framework for Teacher Education and Development in South Africa.* Pretoria, 2006.

certain grades, and with varying timeframes.[116,117] Often several classes from the same grade would be brought together for LO lessons, while other schools merged classes from different grades. In one study, learners' responses showed that 10% had not received lessons on sex, sexuality and HIV and a third felt that they had had very few lessons about these topics.[118] Other research revealed that schools failed to develop school policies and support structures for HIV-positive and HIV-affected learners.[119] A lack of support from School Management Teams, heavy workloads among teachers, negative attitudes towards teaching the programme content, and teacher-learner relations, were also found to hinder the effective implementation of the Life Skills and LO Programmes in certain provinces.[120]

However, a number of noteworthy successes and achievements of the Life Skills Programme have been identified.[121] In some schools, for instance, the programme has contributed to schools becoming centres of care and support for communities through the establishment of food gardens and clothing distribution initiatives for orphans and vulnerable children as well as through the enhancement of teachers' skills and abilities to help and support children, adversely affected by psychological and social issues. Among learners, the peer education programme has helped improve learners' perceptions of life, encouraging them to take responsibility for their lives and focus on their goals and future.[122]

Recommendations for a comprehensive education sector response

According to UNESCO, a comprehensive education sector response needs to take a holistic, sector-wide view of the impacts and challenges brought about by the HIV epidemic and must mobilise and deploy all components and capacities of the education system to address and mitigate these.[123] UNESCO proposes a comprehensive education sector response with five key components, namely: (1) quality education, (2) content, curriculum and learning materials, (3) educator training and support, (4) policy management and systems, and (5) approaches and illustrative entry points. In addition, knowledge of TB, especially prevention and infection control, must be included in efforts to address these components.

UNESCO recommends that quality education to strengthen HIV prevention and mitigate the negative impacts of the HIV epidemic must be grounded within a rights-based response. Education-sector responses, therefore, must recognise and uphold the rights of children by allowing and encouraging access to information so that they can make decisions about their health and family planning, and providing education that will enable them to learn, develop

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116 *Ibid*

117 Department of Education. *National evaluation of the impact of the DoE HIV/AIDS Life Skills Programme on the behaviour of learners.* Pretoria: Department of Education, 2006.

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

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

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

121 DBE. *Comprehensive report for the Life Skills: HIV and AIDS Education Programme.* Pretoria, 2010.

122 *Ibid*

123 UNESCO. *EDUCAIDS: towards a comprehensive education sector response.* Paris: UNESCO, 2007.

and reach their full potential as responsible and tolerant human beings.[124] Other international consensus documents urge countries to provide young people with opportunities for participation in all spheres of society, including participation in the development, planning and evaluation of activities such as school-based HIV and TB responses that have an impact on their daily lives.[125]

Sexuality education is an arena in which learner involvement and participation is critical. It should be designed to provide structured opportunities for young people to explore their attitudes and values, and to practice the skills they need to be able to make informed decisions about their sexual lives. The UNESCO *International Technical Guidance on Sexuality Education*[126] recommends that sexuality education programmes incorporate the following topics:

1. Relationships
2. Values, attitudes and skills
3. Culture, society and human rights
4. Human development
5. Sexual behaviour
6. Sexual and reproductive health

Comprehensive sexuality education programmes also need to take into account the 18 characteristics of effective programmes in their development, delivery and implementation. Evidence dictates that sexuality education and HIV and AIDS education programmes should be comprised of 12 or more sessions (up to 30 sessions), implemented in logical sequence over a two- to three-year period.[127] Thus, although mainstreaming of life skills and HIV and AIDS education into multiple learning areas in school curricula is of some benefit, what is needed is concentrated life skills and HIV and AIDS education delivered through one learning area over a sustained period of time. These sessions should also be combined with programmes aimed at providing access to specialised sexual and reproductive health services for youth.[128]

Beyond those issues related to quality education and curriculum content, education sector responses are also required to alleviate the challenging and devastating impacts of the HIV and TB epidemics in southern Africa. These may include the following elements, some of which have already been undertaken by some schools to a greater or lesser degree, but should perhaps be made more mainstream within the context of implementing the Care and Support for Teaching and Learning Programme:

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124 United Nations. The Convention on the Rights of the Child. New York: United Nations, 1990.

125 UNFPA. *Programme of Action of the International Conference on Population and Development.* Egypt: UNFPA, 1995.

126 UNESCO. *International Technical Guidance on Sexuality Education.* Paris: UNESCO, 2010.

127 Kirby D, Laris BA. Effective curriculum-based sex and STD/HIV education programmes for adolescents. *Child Development Perspectives.* 2009: 3(1), pp. 21–29.

128 UNESCO. *International Technical Guidance on Sexuality Education.* Paris: UNESCO, 2010.

- **Ensuring the continuation of education for learners**
- **Providing psycho-social support** to learners, educators and officials affected by HIV and/or TB or those who are HIV-positive and/or infected with TB
- **Facilitating access to treatment education.** This includes improving understanding of antiretroviral (ARV) medications and why it is important to complete a course of TB treatment. It should also include support for those teachers, officials and learners who are receiving ART or being treated for TB disease.
- **Responding to the basic needs of learners.** This could include initiatives like establishing a school-based feeding programme, creating vegetable gardens on school grounds, and clothing collection and distribution.
- **Developing the livelihood skills of learners** to improve agricultural skills to promote food security for families living in poverty.

Educator roles in the time of HIV

A recent pilot project among educators in pre-service and in-service training in higher education institutions isolated some of the key roles expected of educators in the context of the HIV epidemic.[129] These roles were classified within three broad critical areas of professional practice:

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

The roles were described as:

Biomedical HIV knowledge: In their roles as educators and as role models it is expected and essential that basic knowledge of HIV and TB is learnt and internalised.

Confidence in relation to professional practice: Educators should be confident about integrating HIV and TB into the curriculum and providing learners with HIV and TB information and with support and advice outside of the curriculum.

Awareness of context: Educators must be aware that HIV and TB affect everyone indiscriminately and will have repercussions in their own lives, in the lives of their colleagues and learners, and in the classroom itself.

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[129] HEAIDS. *HIV and AIDS in teacher education: Evaluation report of a pilot project in South African higher education institutions.* Pretoria: Higher Education South Africa, 2010.

Acting as a preventative agent: Educators are obligated by policy to provide prevention education and prevent any learner from being stigmatised or discriminated against. It is already obvious to most educators that prevention education is not just limited to the classroom. This function will require educators to be well informed about the facts and the socio-cultural contexts of HIV and TB transmission. It also requires that they overcome learner apathy in the classroom and establish legitimacy in the community. In order to achieve this, educators need to feel comfortable about addressing sexuality-related issues, which in turn assumes the need for teachers to consider their identity in relation to their own sexuality as well as their position on teaching sexuality-related issues.

Performing a caregiver role: Educators typically perform a caregiver role that includes providing a caring environment for learners. With South Africa's commitment to creating a caring and supportive environment for teaching and learning in the context of the increasing (albeit temporary) impact of HIV and TB, this function will continue to be an important one. Research evidence points to the added burden that the caregiving role places on educators and to the extra time needed, and added responsibility.

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

Reflexivity: Educators in a time of HIV and TB are encouraged to develop a heightened awareness of their values, attitudes, beliefs and behaviour in relation to both conditions. Non-discrimination, empathy and responsible sexual behaviour, including knowing their own HIV status, are some of the issues on which reflection-driven action will be required.

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

These findings support the strategy outcomes and outputs that speak to the need for appropriate and effective enhancement of educator skills through their pre-service and in-service training and development programmes to develop their personal and professional competence with respect to managing the ways in which HIV affects them and their learners.

4.5 Supporting HIV-positive Learners, Educators and Officials

Although the majority of sexually active South Africans still do not know their status, recent government initiatives have aimed to change this through HIV testing. In 2008 a national survey of Grade 8 to 11 learners revealed that only 21.5% of learners had been for a HIV test. Efforts to increase the number of learners who know their status may not translate into an increased number of disclosures among learners, but with increased knowledge, HIV-positive learners will require caring and supportive school environments.

Given the large number of children and youth that are already infected, the implementation of a comprehensive package of services is essential, as is the availability of ART. While there are various challenges surrounding the availability of public health sites that cater for children and young people on ART, government's commitment is for an increased number of HIV-positive people, including school-going children, to have access to treatment. In the school environment the implication is that schools will have an increasing cohort of learners on ART who need regular access to health facilities and healthcare workers to assist with treatment protocols, adherence and management.

Research amongst Ugandan adolescents who were infected at around the time of their birth has drawn attention to other programmatic gaps which countries need to work towards addressing.[130] Strengthening prevention services and access to these services, in order for HIV-positive adolescents to gain information about contraception, family planning, safe sex, HIV prevention, and PMTCT is critical, given that a considerable percentage of the HIV-positive adolescents in the sample were sexually active, practising unsafe sex and/or wanting to have children later in life. Establishing transition clinics for the exclusive use of adolescents, strengthening of support groups through which adolescents can access important sexual and reproductive health information and services, and the involvement of parents in discussions about sexuality with their adolescent children were also identified as important programmatic elements which would help fulfil the sexual and reproductive health needs of HIV-positive adolescents.[131]

Schools also need to explore policies around learner release for treatment, prioritisation of HIV-positive learners in nutrition programmes (because of the nutritional requirements of an ART regimen), potential learner support or 'buddy' schemes, a heightened vulnerability watch, and reporting and referral systems. The impact of ART on functions, such as hearing, that have a bearing on the ability of learners to learn effectively, will need to be accounted for.

At present there is a dearth of research into the impairments HIV-positive learners may experience as a result of their illness or ART. South African research in infants found significant motor delays among 66% of HIV-positive infants in the sample, compared with only 5.7% in the age-matched sample.[132] Living with HIV can also result in chronic fatigue, fever and frequent bouts of ill health in learners that can result in concentration and learning difficulties and developmental deterioration.[133] Educators need to be aware of and prepared for the complications and disabling effects of HIV and/or ART in their learners. Further research in this area is sorely needed.

Learner health is always an important component of the school environment and of classroom

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130 Birungi H, Mugisha JF, Nyombi J, Obare F, Evelia H, Nyinkavu H. *Sexual and reproductive health needs of adolescents perinatally infected with HIV in Uganda.* Frontiers in Reproductive Health (FRONTIERS), Population Council and The AIDS Support Organization (TASO), Uganda, July 2008.

131 *Ibid*

132 Ferguson G, Jelsma J. The prevalence of motor delay among HIV-infected children living in Cape Town, South Africa. *International Journal of Rehabilitation Research*. 2009: 32(2); pp.108–14.

133 Beyers C, Hay J. Supporting HIV-Positive Learners in Inclusive Classes in South Africa: Is It the Responsibility of Teachers? *Journal of Social Science*. 2011: 26(2); pp. 99–104.

participation and climate. Educators have a responsibility to play a role in relation to HIV and TB, as they do for other diseases or conditions of ill health, by being alert to symptoms. They should also be aware of the appropriate referral protocols, where issues of confidentiality and sensitivity apply. Where learners have publicly disclosed their status, confidentiality is less of an issue, but potential discrimination and stigmatisation become factors to be addressed. Stigma and discrimination were experienced by many HIV-positive learners in a study in Tanzania and Namibia, and prevented many HIV-positive learners from disclosing their status. In many cases educators' attitudes were perceived by HIV-positive learners as indifferent, which created difficulties for those learners who wanted to access ART or participate effectively in the classroom.[134] Educators responsible for delivering life skills education to HIV-positive learners need to recognise that they have the same aspirations for the future as those learners not infected with HIV. In particular, life skills education for HIV-positive learners needs to help learners understand their sexuality, balance their sexual and reproductive desires with their responsibilities, accept their identity as HIV-positive individuals, and make informed choices.[135]

Further to this, educators need to remain vigilant in identifying physical health and psycho-social problems that HIV-positive learners and learners with TB may experience and refer them to relevant health and social services where necessary.

Schools must also be responsive to the impact that HIV and TB may have on its own educators and officials – directly, through personal exposure, or indirectly through the possible strain of supporting HIV-positive learners, learners with TB, and OVCs within their professional environment.

Schools need to have clear policies and practical guidelines in place to manage and mitigate the impact of HIV, STIs and TB on their learners, educators and officials in order to provide an environment that is conducive to learner retention and educational success as well as educator and official wellbeing. Research has shown that school HIV and AIDS policies are effective tools for creating school environments conducive to teaching about HIV and AIDS and sexuality.[136,137]

4.6 Care and Support for Learners, Educators and Officials affected by HIV, STIs and TB

The Action Plan to 2014 recognises the centrality of teacher and learner wellbeing to attaining the educational outcomes of access, retention and achievement. The plan highlights this in the following goals:

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134 UNESCO. *Supporting the educational needs of HIV positive learners: Lessons from Namibia and Tanzania.* Paris: UNESCO, 2008.

135 Birungi H, Mugisha JF, Nyombi J, Obare F, Evelia H, Nyinkavu H. *Sexual and reproductive health needs of adolescents perinatally infected with HIV in Uganda.* Frontiers in Reproductive Health (FRONTIERS), Population Council and The AIDS Support Organization (TASO), Uganda, July 2008.

136 Helleve A., *et al.* Teachers' confidence in teaching HIV/AIDS and sexuality in South African and Tanzanian schools. *Scandinavian Journal of Public Health*. 2009: 37(2); pp. 55–64.

137 Mathews C, Boon H, Flisher AJ, Schaalma HP. Factors associated with teachers' implementation of HIV/AIDS education in secondary schools in Cape Town, South Africa. *AIDS Care*. 2006: 18(4); pp. 388–397.

1. Strive for a teacher workforce that is healthy and enjoys a sense of job satisfaction
2. Ensure that the physical infrastructure and environment of every school inspires learners to want to come to school and learn, and teachers to teach
3. Use the school as a location to promote access for children to the full range of public health and poverty reduction interventions.

This is further articulated in the Care and Support for Teaching and Learning (CSTL) Programme. It is through this initiative that the DBE aims to fulfil its role of delivering and expanding appropriate care and support services in and through schools. SADC education ministers adopted the CSTL Programme in 2008. The goal of the programme is to realise the educational rights of all children, including those who are most vulnerable, by transforming schools into inclusive centres of learning, care and support. The intention of the CSTL Programme is to prevent and mitigate factors that have a negative impact on the enrolment, retention, performance and progress of vulnerable learners in schools by addressing barriers to teaching and learning. South Africa is one of six countries (together with Swaziland, Zambia, Madagascar, Democratic Republic of Congo and Mozambique) implementing Phase 1 of the programme between 2008 and 2014.

CSTL is not a new policy or programme. It is a comprehensive, coordinated, multi-sectoral response created to address barriers to teaching and learning. CSTL offers an overarching framework to make a coherent whole from the range of existing care and support initiatives currently implemented in and through schools. It promotes mainstreaming or a systemic response to the care and support needs of learners, educators and officials based on a strong policy mandate both within and outside the education sector. Through this initiative, the DBE aims to fulfil two roles, namely:

- To deliver and expand appropriate care and support services in and through schools such as no-fee schools, the NSNP and HIV and AIDS Life Skills Programmes
- To create an enabling environment within the education system for other stakeholders, such as the DoH and DSD, to support learners, educators and officials through programmes on school health services and access to social grants and psycho-social support, among others.

The following nine priority areas have been identified for programme implementation in South Africa:

- ***Nutrition*** – is intended to address barriers to learning associated with hunger and malnutrition. Nutritional support, through the provision of a daily hot, cooked, nutritious meal enhances the learning capacity of learners. Nutritional support thus speaks not only to the delivery of feeding programmes, but also measures to ensure quality food, nutrition education and food production.
- ***Health Promotion*** – involves the process of enabling educators, officials and learners to increase control over their health and its determinants, towards improving and promoting their overall health and wellbeing. This would include the HIV and AIDS Life Skills Education Programme, and prevention and management of drug and substance use, for example.

- ***Infrastructure, Water and Sanitation*** – involves the provision and maintenance of habitable and appropriate physical school structures. This priority area puts a focus on water and sanitation because they are fundamental determinants of learner and educator health and wellbeing.
- ***Social Welfare Services*** – refers to the role of schools and educators in the implementation of child care and protection legislation and in promoting access to social welfare services, enabling documents and social assistance grants, such as the child support grant
- ***Safety and Protection*** – One of the priority mandates of the DBE is to ensure that the school is a safe and protective environment for both learners and educators. Safety and protection concerns are not limited to physical infrastructure of the school, but also to the psychological and emotional safety of learners and educators. Schools should thus be free of all forms of violence, abuse and bullying
- ***Psycho-social Support*** – involves the provision of care and support in response to the emotional, mental and social needs of learners (and in particular vulnerable learners), educators and officials. All of these are critical for educational and overall development
- ***Curriculum Support*** – includes efforts to ensure that the curriculum is efficiently and effectively delivered to learners by appropriately skilled and supported educators within a learning environment that reflects and celebrates diversity. It suggests that the school management and educators should ensure a flexible curriculum that accommodates a range of learning needs. Learners who are too ill to attend schools, such as learners who are TB- or HIV-infected, should be supported to study at home or accommodated in residential facilities for learners with special education needs
- ***Co-curricular Support*** – is intended to support and augment curriculum implementation in and outside of the school. Co-curricular programmes are critical to reinforce the curriculum currently taught within the Life Orientation Programme and to address issues that are not dealt with in the limited time allocated to LO. Through this co-curricular support will assist in changing social norms within schools and promoting the physical, social and emotional health and wellness of learners. Peer education, sport, enrichment programmes, and school clubs have all been implemented in schools across South Africa
- ***Material Support*** – refers to the provision of resources or services to address material or financial barriers to education, including the establishment of no-fee schools in the poorest of communities, to assist with uniforms and transport for children who cannot afford them and the provision of teaching and learning support materials.

This Strategy builds on these imperatives and places the learner at the centre of care and support. The CSTL framework recognises that the effects of poverty, HIV and AIDS, and TB on school communities place ever-increasing additional responsibilities on educators to further support the psycho-social needs of learners in order to improve learner attendance and performance in the classroom. Further evidence has revealed that educators and officials also require care and support to address their own personal challenges in relation to HIV,

STIs and TB. This is reflected in a 2005 ELRC report,[138] which revealed an HIV prevalence of 12.7% amongst educators. The proportion of attrition amongst educators due to medical reasons grew from 4.6% to 8.7% between 1997/98 and 2003/04, signalling the need to expand care and support services for educators within the schooling environment.

The Strategy identifies the need to provide a broad base of support within the school environment for learners, educators and officials who become HIV-positive and/or contract TB. At the same time, it acknowledges the wider impact of HIV on personal lives through the incapacity or death of family and friends due to HIV or TB, and the increase in vulnerability for learners. This is especially so for orphans and children who have become the primary carers in their families, and/or who have some form of disability, but may not be HIV-positive or have TB.

Educators need to be alert to the psycho-social problems that OVCs may experience, especially those who have disabilities, and refer them to relevant health and social services where needed. Research has shown that OVCs in particular suffer more mental health problems than other children. These include depression, post-traumatic stress disorder, suicidal ideation, and peer and behavioural problems.[139] However, it has also been found that problems relating to conduct disorders, delinquency and depression can be effectively if not wholly addressed by ensuring that OVCs are beneficiaries of feeding programmes and no-fee programmes at schools, and that one of their carers is receiving a government support grant.[140] It is essential that schools and educators are made aware of children in these situations in their care, while also maintaining the appropriate levels of privacy and confidentiality as far as possible.

4.7 The Integrated School Health Programme

The Integrated School Health Programme (ISHP) is a key response of the education, health and social sectors to the CSTL Framework, and directly addresses three of the *NSP 2012 – 2016* strategic objectives that deal with prevention, screening and treatment, and care and support services.

School health is an integral part of a national comprehensive package of primary health care services. Although it is primarily an inter-sectoral partnership led by the DBE, the DoH, and the DSD, it must include the participation and cooperation of a wide range of partners and stakeholders, including parents, learners, civil society, universities, the private sector and other appropriate government departments at national, provincial and district levels.

The ISHP takes cognisance of the strengths and weaknesses of earlier policy experiences, for example the School Health Policy and Implementation Guidelines 2003, and several specialised health initiatives such as the Youth and Adolescent Health Policy 2001, Child and Adolescent Mental Health Policy Guidelines 2001, and the Health Promoting Schools Programme 1999 (HPSP). The Programme, while still in its planning stages, builds on the

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138 ELRC. Education supply and demand in the public education system. Integrated report. Cape Town, ELRC, 2005.

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

140 *Ibid*

foundations laid through the continued roll-out of the School Health Screening Programme for grade 1 learners and the conceptual work done to implement the School HIV Counselling and Testing Campaign for learners that was suspended in 2011.

The ISHP is designed to offer an integrated and comprehensive package of health services to all learners through a phased implementation plan beginning with the most disadvantaged school communities and those least likely to access health services. An age and developmentally appropriate health services package is being designed with three main components – health education, health screening and on-site service – that is aligned to the four school phases within primary and secondary education, namely foundation (GR–3), intermediate (G4–6), senior (G7–9) and FET phases (G10–12).[141] The health services package is derived from the current burden-of-disease profile for children and youth, key health barriers to learning, as well as risk factors for future health concerns.

A significant component of the health services package focuses on age-appropriate health education and health promotion. This includes sexual and reproductive health and TB knowledge, that will supplement and consolidate the existing knowledge provided through the Life Skills Programme and the LO learning area. The ambit of health screening has been expanded beyond basic vision, hearing and oral health screening to include screening for TB and psycho-social support needs, among others. On-site services will be limited to immunisation, deworming and treatment of minor ailments, such as skin conditions, where required. Learners that have reached or are past the age of puberty will receive individual counselling on a range of sexual and reproductive health topics, including menstruation, circumcision, abstinence, contraception, how to avoid teenage pregnancy and the importance of knowing their HIV status. Learners requiring additional support on sexual and reproductive health and other health conditions will be referred to local clinics for follow-up services.

Services will be provided by a combination of nurses, health promoters and other health professionals, where available, based on delivery to a cluster of schools. Schools in the poorest areas will receive priority attention, and a strong M&E mechanism will be put in place to assure equity, access and quality of services, and to monitor the impact of the ISHP on the retention and achievement of learners. Finally, it is essential that the ISHP is fully integrated within the CSTL framework and aligned with the re-engineering of primary healthcare services.

[141] Foundation (Grades R–3), Intermediate (Grades 4–6), Senior (Grades 7–9) and FET (Grades 10–12).

5. IMPERATIVES

The education sector responses above have undoubtedly achieved some gains in preventing and mitigating the impact of HIV within the education sector, both at policy and programme level. However, to effectively turn the tide on HIV, AIDS and TB, a comprehensive, integrated and multi-sectoral strategy for HIV, STIs and TB is required. *The DBE Integrated Strategy on HIV, STIs and TB 2012 – 2016* is founded on seven key imperatives. These imperatives underpin the need for a revised and integrated strategy to address the challenges of HIV, STIs and TB in the education sector and have guided the focus and outcomes that this Strategy sets out to achieve.

5.1 Seven Imperatives for a New Integrated Strategy on HIV, STIs and TB in Basic Education

The seven imperatives that form the foundation for the *Integrated Strategy 2012 – 2016* are:

Imperative one	:	Alignment with government's outcomes focused plans
Imperative two	:	The impact of HIV and TB on the education sector and educational outcomes
Imperative three	:	Education as a protective factor – the role of prevention
Imperative four	:	A duty of care in schooling for learners, educators and officials
Imperative five	:	Alignment with the *NSP 2012 – 2016*
Imperative six	:	Lessons from available evidence on effective responses
Imperative seven	:	A sustainable, comprehensive and measured response.

Imperative one: Alignment with government's outcomes focused plans

South Africa has put in place a *South Africa Vision 2025* development plan and along with this a change in government thinking – from inputs and bureaucracy, to outcomes for the nation. This is also articulated in the new sector plan for education, *Schooling 2025*[142] and the Action Plan for achieving 27 associated goals by 2014. The current *Integrated Strategy 2012 – 2016* addresses six of these:

- Goal 10: Ensure that all children remain effectively enrolled in school up to the year in which they turn 15
- Goal 16: Improve the professionalism, teaching skills and subject knowledge of teachers throughout their careers
- Goal 17: Strive for a teacher workforce that is healthy and enjoys a sense of job satisfaction
- Goal 22: Improve parent and community participation in the governance of schools

[142] DBE. *Towards a Basic Education Sector Plan* (working document). Pretoria, 2010.

- Goal 24: Ensure that the physical infrastructure and environment of every school inspires learners to want to come to school and learn, and teachers to teach
- Goal 25: Use the school as a location to promote access amongst children to the full range of public health and poverty reduction interventions.[143]

The Action Plan to 2014 was born out of the national Delivery Agreement 1: Improved Quality of Basic Education,[144] which is one of 12 negotiated charters signed by the Minister of Basic Education and those key partners with direct responsibility for the improvement of basic education (i.e. DoH, Department of Arts and Culture, Department of Science and Technology, Department of Public Works). This agreement stems from one of the 12 key targets set out in the 2009 – 2014 Medium Term Strategic Framework (MTSF) that sets out the strategic mandate of government. The MTSF identifies strategic priorities and targets that serve as the basis for determining government's implementation plans for the period to 2014.

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

Ill health, absenteeism or any other increased stress or vulnerability on the part of school-age children and youth, educators and officials constitutes a threat to the attainment of teaching and learning education outcomes, as defined by the Action Plan to 2014.

The DBE notes that the age group representing in-school youth (15- to 19-year olds) is most likely to be sexually active, with girls and young women (6.5%) having almost three times the HIV prevalence of boys and young men (2.7%). In the 20 to 24 age group prevalence increases overall, but for girls and young women it escalates to over 21%. This suggests, among other possibilities, that prevention programming is failing to provide the sustainable resilience needed by these young people, especially young women, to cope with sexual decision-making after they leave school. Further concern for the DBE is the high HIV prevalence for adults aged 25 to 39 who make up the majority of the teaching cadre. Of these, the highest rates are for those aged 25 to 29 – young teachers who are just entering the teaching profession. For the DBE the implications for human resource management and for mitigation and care are significant.

HIV and TB also place additional strain on households already consumed by poverty. The financial burden of HIV-related illnesses or death on households is an estimated 30% greater than the burden created by deaths from other causes.[145] This depressed financial state can result in payment of school and related fees becoming increasingly difficult which may contribute to lower enrolments and retention in schools of children affected by HIV.[146] Furthermore, children with HIV, or children whose family members are HIV-positive experience discrimination and

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143 DBE. *Action Plan to 2014: Towards the Realisation of Schooling 2025.* Pretoria, 2010.

144 DBE. *Delivery Agreement for Outcome 1: Improved Quality of Basic Education.* Pretoria, 2010.

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

146 UNAIDS Inter Agency Task Team on Education. *HIV and AIDS and education: the role of education in the protection, care and support of orphans and vulnerable children living in a world with HIV and AIDS.* UNICEF, 2004.

stigma which takes various forms, including emotional, verbal and physical abuse and social exclusion and isolation, [147] which can cause these learners to drop out of school. Lack of school infrastructure and capacity to care for HIV-positive learners during times of illness can further encourage school dropout, as can having to care for sick parents or relatives who are HIV-positive.[148,149]

Children contribute significantly to the TB caseload (up to 40%) in high-burden settings such as South Africa (and particularly in high-prevalence provinces)[150] and may suffer severe morbidity and mortality.[151,152] The loss, grief and trauma as a result of TB and HIV is expressed in declining school enrolments, delayed enrolments, erratic attendance, poor attention and performance, and higher dropout rates.[153]

Of children attending school, it is estimated that about 4% have a disability, and although approximately 90% of 7- to 15-year-old disabled children attend school, 10% do not.[154] The likelihood of disabled learners dropping out of school is compounded in school environments that lack the necessary resources and infrastructure.[155] Children and youth with disabilities are particularly vulnerable and in many instances experience stigma and discrimination doubly compounded by an HIV-positive diagnosis or the impact of a close family member or carer becoming ill because of HIV or TB.

Although the above demonstrates some of the immediate and short-term impacts of HIV and TB on the education sector and educational outcomes, the full impact of HIV on the education system may never be precisely measured and attributed, and will likely only be felt in the future. Typical to an HIV epidemic, the initial wave of infection is followed over time by a second wave of death and a third wave of impacts.[156,157] In South Africa, where HIV infection may still not have peaked, the number of orphans may well continue to rise until 2020. This will pose new challenges for the education system that will have to confront a new generation of educationally disenfranchised children that the system has not been able to integrate optimally in the past.[158]

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

148 Mabala R, Anning V, Badcock-Walters P. *Supporting the educational needs of HIV positive learners in Tanzania.* Edusector AIDS Response Trust, Rainson Namibia and Tamasha Tanzania, 2009.

149 Badcock-Walters P, Kvalsvig J, Heard W, Anning V. *Supporting the educational needs of HIV positive learners: Lessons from Namibia and Tanzania.* Edusector AIDS Response Trust, Rainson Namibia and Tamasha Tanzania, 2008.

150 Van Rie A, Beyers N, Gie R., *et al.* Childhood tuberculosis in an urban population in South Africa: burden and risk factor. Arch Dis Child. 1999: 80; pp. 433–437.

151 Marais BJ, Gie RP, Schaaf HS., *et al.* The natural history of childhood intra-thoracic tuberculosis – a critical review of the literature from the pre-chemotherapy era. *Int J Tuberc Lung Dis* 2004: 8; pp. 392–402.

152 Chintu C, Mudenda V, Lucas S, *et al.* Lung diseases at necropsy in African children dying from respiratory illnesses: a descriptive necropsy study. *Lancet.* 2002: 360; pp. 985–990.

153 Cluver, L. Children of the AIDS pandemic. *Nature.* June 2011: 474; pp. 27–29. Coombe C. *HIV/AIDS, poverty and education: The circle of hope and despair.* Pretoria: Faculty of Education, University of Pretoria, 2003.

154 Department of Basic Education. *Report on the 2009 General Household Report: Focus on Schooling.* Pretoria, August 2011.

155 Badcock-Walters P, Kvalsvig J, Heard W, Anning V. *Supporting the educational needs of HIV positive learners: Lessons from Namibia and Tanzania.* Edusector AIDS Response Trust, Rainson Namibia and Tamasha Tanzania, 2008.

156 Starke JR. Resurgence of tuberculosis in children. *Pediatr Pulmonol.* 1995: 11 (Suppl); pp. 16–17; Van Rie A, Beyers N, Gie RP., et al. Childhood tuberculosis in an urban population in South Africa: burden and risk factor. *Arch Dis Child.* 1999; 80: pp. 433–437; Donald PR. Childhood tuberculosis: out of control? *Curr Opin Pulm Med.* 2002: 8; pp. 178–182.

157 Whiteside A. *HIV/AIDS: A very short introduction.* Oxford: Oxford University Press, 2008.

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

The impact of these diseases will be differentiated and borne most profoundly by the poorest and most vulnerable sectors of society.[159] The department, through this strategy, is aligned with government's commitment to act immediately and forcefully to mitigate future impacts.

Imperative three: Education as a protective factor – the role of prevention

The potential impact of HIV and TB on the educational outcomes of youth must be located and understood within the role of the education sector, which can provide a protective influence against the effects of HIV and TB on learners through education itself (Imperative two) and the development of schools as centres for care and support (Imperative three).

The past 12 years have increasingly made clear the centrality of school attendance, outside of sexuality education, in combating the impact of HIV.

UNAIDS, in *A Strategic Approach: HIV & AIDS and Education,* states:

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

UNAIDS further recognises that education has the following positive impacts on the HIV epidemic:

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

[159] Whiteside A. *HIV/AIDS: A very short introduction.* Oxford: Oxford University Press, 2008.

- Education can reduce stigma and discrimination
- Education provides a cost-effective means of HIV prevention.

Youth (15 to 24 years) accounts for approximately 41% of all new HIV infections globally, is considered an especially vulnerable group and represents the most viable opportunity to halt the spread of HIV. Countries that have reported downturns in the HIV epidemic have attributed this to behaviour change among young people.[160]

Education is therefore central to combating the HIV epidemic. If schools are able to increase the number of learners and retain them in the system, then, provided that schools are maintained as safe environments, they will protect against negative reproductive health outcomes such as teenage pregnancy and HIV. The 2003 Reproductive Health and HIV Research Unit (RHRU) survey showed that young women who did not complete their secondary school education were four times more likely to be HIV-positive compared with those who had completed high school. The study concluded that structural factors, such as lack of education, could play a more fundamental role in exacerbating risk for HIV than individual level factors.[161]

The proviso is that schools are only a protective factor with regard to HIV if they are safe spaces for all learners, educators and officials who work and learn within them. In light of the associated TB epidemic, this now includes the introduction of effective airborne infection and cough hygiene protocols for the classroom and school environment. The scope of school safety must also be expanded beyond infrastructure concerns such as fencing and gates to include psychological and emotional safety. A safe school can therefore be defined as:

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

Progress towards the achievement of the outcomes associated with human rights and access to justice (Priority Area 4 of the *NSP 2007 – 2011*) has shown that government initiatives to address issues such as stigma, discrimination and violence in South Africa remain well behind target. Although a significant amount of research has gone into understanding how these issues contribute to HIV transmission in South Africa, the implementation, management and monitoring of interventions to promote human rights and access to justice needs to be bolstered.[162]

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160 UNAIDS. *Report on the global AIDS epidemic.* Geneva: UNAIDS, 2010.

161 Pettifor AE, Levandowski BA, MacPhail C, Padian NS, Cohen MS, Rees HV. (2008). Keep them in school: the importance of education as a protective factor against HIV infection among young South African women. *International Journal of Epidemiology.* 37; pp. 1266–1273, 2008.

162 SANAC. *National Strategic Plan 2007 – 2011: Mid-term review.* Pretoria: SANAC, 2010.

TB is a significant cause of morbidity and mortality in children and young people in South Africa. As such, the school environment offers an opportunity to educate, raise awareness and reduce the risk of TB infection and disease. Educating learners, educators and officials about the symptoms of TB disease will promote early health-seeking behaviour and treatment through the school nurse or local health facilities and will reduce the morbidity and mortality associated with TB. School nurses can also play an important role in supporting adherence to TB treatment (or TB-preventive therapy) and in contact tracing in the event of an outbreak in the school environment.

Imperative four: A duty of care in schooling – for learners, educators and officials

The DBE is responsible for educating young minds, and continually improving the quality and outcomes of the education process. Furthermore, the DBE has a duty to protect the children and youth in its system and prepare them for their roles as productive and responsible citizens. Underpinning all government action and policies is the Constitution of the Republic of South Africa and its Bill of Rights, which delineate a host of rights specifically for children, including the right to basic education – the guarantee of which is unhindered by any reference to 'progressive realisation'. However, the right to education depends on the prior fulfilment of a number of other rights, the attainment of which are influenced by prevailing circumstances such as poverty, HIV, TB and other such factors. In terms of the role of the DBE in the realisation of these rights, there are a number of frameworks and policies that call for schools to become centres through which care and support is facilitated.

The CSTL Programme is one such framework. It recognises the barriers to education for vulnerable children, especially in relation to HIV and related illness, and highlights the important role that schools can play in addressing these barriers, through school-based services and by leveraging other resources from in and around the school community. The CSTL Programme emphasises the various comparative advantages that schools have in fulfilling a care and support function in relation to its learners and educators. Nine priority areas have been identified for programme implementation in South Africa and have been discussed in earlier sections (See Section 4.7). Implementation activities of the CSTL Programme, including the nine priority areas, account for the roles and responsibilities of the DBE outlined in policy frameworks and strategy documents such as the *Policy Framework for Orphans and Other Children made Vulnerable by HIV and AIDS South Africa* and the *NSP 2012 – 2016*.

This duty of care, especially to OVC, is well entrenched in a number of international and regional frameworks (such as the United Nations Convention on the Rights of the Child) to which South Africa is a signatory. These frameworks also stipulate that the duty of care must be fulfilled in a holistic manner through a comprehensive and integrated package of services, care and support. *The Policy Framework for Orphans and Other Children made Vulnerable by HIV and AIDS South Africa*[163] sets out the roles and responsibilities of the DBE to OVC who are accounted for in the CSTL framework and include:

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[163] *op.cit.* DSD, July 2005.

- Educating learners about HIV and AIDS to reduce stigma and discrimination
- Developing mechanisms for school-based support systems
- Providing academic support for orphans and other children made vulnerable by HIV and AIDS
- Developing capacity-building programmes for educators to enable them to respond holistically to the needs of orphans and other children made vulnerable by HIV and AIDS
- Providing Education for All as a priority and a key coordinating mechanism for protecting orphans and other children made vulnerable by HIV and AIDS while promoting opportunities for these children
- Developing referral systems to other relevant service providers (e.g. nurses, social workers) and ensuring that these are in place
- Developing and implementing appropriate life skills programmes for orphans and other children made vulnerable by HIV and AIDS
- Providing primary school nutrition programme and food fortification programmes
- Developing and implementing early childhood development programmes.

A commitment to the above frameworks is driven by a recognition that the education system has several comparative advantages over other services with regard to the care and support of children. These advantages include the following:[164]

- Schools are relatively accessible and often provide a physical infrastructure in communities where other crucial infrastructure is absent. The space and grounds at schools have the potential for expanded use
- Schools represent an existing network of many components, including school staff, learners, their caregivers, school governing bodies (SGBs) and the broader school community. Each component is a potentially valuable resource for care and support
- The way schools are currently clustered creates opportunities for further collaboration and provides educators and middle management with more support
- The school environment is an inclusive environment, which focuses on children and is committed to children's development. The education system reaches over 12 million children,[165] including those most affected by and most at risk of HIV infection. Children spend a large amount of their time at school over many years. It is also an environment where all kinds of vulnerabilities are exposed and therefore has the potential to work against stigma associated with HIV and TB

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

165 *Ibid*

- The school can also reach the younger and most vulnerable age group through school-going children and their families through, for example, child-to-child programmes. Educators see children every day for five days of the week and are therefore ideally placed to track their wellbeing, to notice changes in children, and identify vulnerable children. The National Education Policy Act recognises the pastoral role of educators, and states that the educator will not only develop an attitude that reflects a sense of responsibility to others, but will also develop a supportive and empowering environment for the learner. It is widely acknowledged that within this pastoral role the educator will, to an extent, provide psycho-social support[166]
- In communities with inadequate service provision, schools take on an ever-increasing support role. This might also include schools being used as nodes for the care of OVC.

Educators frequently operate in contexts of chronic poverty, highly limited resources, large classes and a paucity of professional support services. As a result, they are often under great personal and professional pressure. Educator attrition is a growing problem compounded by HIV and TB, and it is imperative that greater attention is given to the psycho-social support of educators, and to the improvement of their working environment and resources.[167] Officials who are both infected and affected by HIV and TB need to be supported in the same way. It is imperative that work place policies and programmes are in place to adequately support officials.

Imperative five: Alignment with the *NSP 2012 – 2016*

There is global recognition that the HIV epidemic "continues to pose serious challenges, undermining broad progress in development and in poverty reduction, threatening basic human rights and seriously affecting the prospects of attaining the MDGs and the EFA goals".[168]

In South Africa, HIV and TB are acknowledged as major developmental challenges, with one percent of the country's population developing active TB each year. TB is now the leading cause of death in people living with HIV. Two of the key markers of the state of development in a country are life expectancy at birth and the under-five mortality rate. In the post-apartheid period of rapid development between 1990 and 2009, life expectancy at birth worsened and the under-five mortality rate remained constant.[169] It is also important to recognise the impact of HIV and TB at the level of the household, where it poses developmental challenges. Situations where, for example, children have to care for sick parents or drop out of school to earn money to support siblings after their parents have died are challenges to our country's development and may cause other significant developmental challenges to emerge.

In view of this, South Africa's response to HIV, STIs and TB according to the *NSP 2012 – 2016* is located within the country's broader development agenda of accelerating progress towards

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166 *National Education Policy Act* No. 27 of 1996.

167 Shisana O, Peltzer K, Zungu-Dirwayi N, Louw J. *The Health of Our Educators: A focus on HIV/AIDS in South African public schools.* HSRC, 2005.

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

169 World Health Organization. World health statistics. Geneva: World Health Organization, 2011.

development goals, including the MDGs.[170] The linkages between the achievement of all the MDGs and HIV interventions are outlined below:[171]

- Goal 1 – to eradicate extreme poverty and hunger (addressing structural drivers of the HIV epidemic such as inequality, unemployment and poverty will reduce risk for HIV)
- Goal 2 – access to universal primary education (instituting care and support programmes for orphans and other children made vulnerable by HIV such as school feeding and no-fee schools will improve enrolment and retention)
- Goal 3 – empowerment of women and promotion of gender equality (unequal gender power relations are considered one of the fundamental factors promoting the feminisation of the epidemic; hence changing social norms on gender equality and equity will lower the risk of infection amongst women)
- Goal 4 – reduction of child mortality (expansion of access to prevention of mother-to-child transmission and paediatric HIV treatment will have a positive impact on infant and child mortality rates)
- Goal 5 – improve maternal health (maternal mortality creates greater numbers of orphans and child-headed households, especially as the prevalence of HIV is greater among young women, and exposes children to greater risks of exploitation and abuse)
- Goal 6 – combat HIV, malaria and other diseases (traditional programmes to address HIV, STIs and TB as well as malaria can mean a reduction in new infections and the ability to stay healthy for longer in a safe and supportive environment)
- Goal 7 – environmental sustainability (HIV adds an extra burden on already struggling societies in Africa by increasing the demand on services while diminishing their supply through the elimination of much needed human and financial resources)
- Goal 8 – innovation and global partnerships (given the scale of the HIV epidemic, a number of sectors of the global community, including governments, civil society and development partners have come together to mount a unified and large-scale response to HIV).

Because its focus is on young people, the South African education sector has been assigned a lead role in prevention and addressing the structural factors in the *NSP 2012 – 2016*. Several of these structural approaches attempt to address deeply entrenched and long standing cultural, socio-economic and behavioural factors which typically require long-term strategies and interventions aimed at addressing socio-economic and developmental goals. Alignment by the DBE with the *NSP 2012 – 2016* is therefore crucial to the achievement of its four main objectives,[172] and will ensure that the *DBE Integrated Strategy on HIV, STIs and*

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170 SANAC. *National Strategic Plan on HIV and AIDS, STIs and TB 2012 – 2016.* Pretoria: South African National AIDS Council, 2011.

171 *Ibid*

172 SANAC. *National Strategic Plan on HIV and AIDS, STIs and TB 2012 – 2016*. Pretoria: South African National AIDS Council, 2011.

TB 2012 – 2016 makes a significant contribution to South Africa's development agenda. In particular, the Department has a direct role in helping achieve a number of sub-objectives:

SO 1) Address Social and Structural Barriers to HIV and TB Prevention, Care and Impact

1.1 Mainstream HIV and TB and its gender and rights-based dimensions into the core mandates of all government departments and all SANAC sectors

1.3 Implement interventions to address gender inequities and gender-based violence as drivers of HIV and STIs

1.4 Mitigate the impact of HIV and TB on orphans, vulnerable children and youth

1.5 Reduce the vulnerability of young people to HIV infection by retaining them in schools and providing post-school education and work opportunities

1.6 Reduce HIV- and TB-related stigma and discrimination

1.7 Support efforts aimed at poverty alleviation and enhancing food security programmes.

SO 2) Prevent new HIV, STI and TB Infections

2.1 Maximise opportunities to ensure that everyone in South Africa tests voluntarily for HIV and is screened for TB at least annually, and is subsequently enrolled in relevant wellness, treatment, care and support programmes

2.2 Make a package of SRH services accessible

2.3 Prevent transmission of HIV by reducing MTCT to two percent at six weeks and to less than five percent at 18 months by 2016

2.6 Prevent TB infection and disease

2.7 Address sexual abuse and improve services for survivors of sexual assault.

SO 3) Sustain Health and Wellness

3.2 Ensure that people living with HIV, STIs and TB remain within the health care system, adhere to treatment and maintain optimal health and wellness.

SO 4) Ensure Protection of Human Rights and Improve Access to Justice

4.3 Reduce HIV and TB discrimination in the workplace.[173]

Imperative six: Lessons from available evidence on effective responses

It is not enough for the DBE Strategy to align itself with the *NSP 2012 – 2016* and the country's developmental agenda. It must also take into account current evidence on effective responses to HIV and TB. We have learned a great deal from both global and regional lessons about what

[173] *Ibid*

works and what does not work in the response to HIV and TB. Supporting learners, educators and officials requires increasing consideration of evidence from a range of sources.[174]

Structural drivers have been under-emphasised in prevention programmes to date, which has limited their potential effect on health and other outcomes. There is also widespread acknowledgement that programmes that focus primarily on increasing knowledge of SRH and HIV prevention will not result in behaviour change.[175] This has enormous implications for school responses that have traditionally relied exclusively on knowledge of HIV, transmitted only via the curriculum as taught in the classroom. The *NSP 2012 – 2016* also acknowledges that it is important to address **social and structural drivers** in order to comprehensively addressing the impact of the dual epidemics.

Coates *et al* advocate three important targets for HIV prevention:[176]

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

(2) ***Combination prevention*** – the strengths of biomedical interventions must be combined with access to treatment, behaviour-change strategies and structural approaches in order to change social and economic conditions that predispose people to engage in unsafe behaviour. Combination approaches to HIV prevention are a key component of the new *NSP on HIV, STIs and TB 2012 – 2016*

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

The DBE acknowledges the need for the focused use of resources according to detailed knowledge of the epidemic. Although DBE programmes require universal implementation in the school setting, they also need to adopt targeted approaches such as focusing on most-at-risk groups, such as OVC and girl learners, and in geographic areas in which risk is concentrated.

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

175 Napierala Mavedzenge SM, Doyle AM, Ross DA. *HIV prevention in young people in sub-Saharan Africa: A systematic review.* London: Infectious Disease Epidemiology Unit, London School of Hygiene and Tropical Medicine, February 2010.

176 Coates TJ, Richter L, Caceres C. Behavioural strategies to reduce HIV transmission: How to make them work better. *The Lancet.* August 2008: 372(9639); pp. 669–684.

Imperative seven: A sustainable, comprehensive and evaluated response

HIV is increasingly being viewed as a chronic disease, much like diabetes and cardiovascular disease, because of its long duration and the increasing availability of treatment. Sustainable, long-term, population-level plans are required to curtail its spread as well as its intergenerational impact. This requires strong and resilient leadership, planning, implementation, financing and human resources for HIV and TB.

To achieve a sustained response to HIV and TB within the education system, mainstreaming an integrated and comprehensive response to both epidemics is required. Firstly, this demands interventions for all role players within the education system – learners, educators and officials. Secondly, strategies must be developed at prevention and treatment, as well as at care and support levels, in line with the rights-based holistic approach adopted by the *NSP 2012 – 2016*. Thirdly, interventions must be mainstreamed across the education system. Although mainstreaming of HIV is currently recognised as a goal, practical implementation at national and provincial levels has been very limited, and a new focus on TB is needed.

This Strategy will be evaluated to monitor progress against its strategic objectives. Evaluation is imperative to ensure effective implementation of the *DBE Integrated Strategy 2012 – 2016* because it holds stakeholders accountable for their contributions towards the achievement of specific indicators.

SECTION TWO: THE STRATEGY

6. THE STRATEGY

Although the Department of Basic Education has been addressing the challenges of HIV through a number of programmes, such as the Life Skills Programme as part of the Life Orientation curricula, this is the first time that the department has attempted to harness the widest range of resources at its disposal in an integrated manner to provide a comprehensive response, and to specifically align the response to the *National Strategic Plan on HIV, STIs and TB 2012 – 2016.*

The Strategy lays the foundation for the subsequent development of detailed implementation plans at national, provincial and district levels, and provides a framework for monitoring and evaluation (M&E) and performance assessment.

6.1 Strategy Alignment

Alignment with DBE core mandate:

The Strategy, like all interventions in the DBE, will contribute towards the achievement of Quality Basic Education, which is government's Outcome 1. The Strategy will also make a contribution to achieving Outcome 2 of government: A long and healthy life for all South Africans, which is led by the Department of Health (DoH).

The Strategy's two impacts are designed to directly support the core mandate of the DBE, underpinned by the following principles:

a. All interventions focused on addressing the challenges of HIV, STIs and TB in support of the NSP will be designed to have simultaneous positive effects on the goals attached to the Delivery Agreement for Outcome 1 – in particular increased learner and educator retention within the education system, and the broad strategic areas of the *Action Plan to 2014: Towards the Realisation of Schooling 2025*

b. Implementation of this Strategy will support and make full use of the Care and Support for Teaching and Learning (CSTL) Programme, particularly with regard to the CSTL's holistic approach to addressing the intrinsic, systemic and societal barriers to teaching and learning

c. The Strategy acknowledges the comparative advantage of the schooling sector in preventing new HIV, STI and TB infections through education of learners, educators and officials. However, given that many learners, educators and officials are infected and affected by HIV, STIs and TB, the Strategy makes provision for access to treatment, care and support programmes. In this regard, schools will be used as centres for enhancing access of young people to services for sexual and reproductive health, including HIV, as well as services for TB

d. Comprehensiveness will ensure that the Strategy constructs interventions to address the range of individual and structural key drivers of HIV and AIDS, STIs and TB among learners, educators and officials in South Africa

e. Interventions will be evidence-based and will rigorously scale-up proven effective responses. In addition, interventions will build on existing programmes and services and never duplicate or waste resources

f. An outcomes-based approach aligns the Strategy with government's new direction and operating paradigms and ensures that all efforts are focused on achieving measurable success

g. Partnerships with key stakeholders within the education, health and social sector fraternities are critical to the successful implementation and M&E of the Strategy. These include all directorates within national, provincial and district education departments; other government departments such as DoH and DSD; teachers' unions; school governing bodies and the parent community at large; learner organisations; non-governmental organisations including community-based and faith-based organisations; development partners; as well as academic and research institutions.

Strategy impact

The Strategy itself will be evaluated against the following **two impacts**:

1. Reduction in new HIV, STI and TB infections among learners, educators and officials.
2. Increased learner, educator and officials' retention within the education system supported.

INDICATORS
HIV prevalence amongst learners aged 15–19 years ► Baseline: Overall 4.4%, Males 2.5%, Females 6.7% (HSRC, 2008) ► Target: Overall 2.2%, Males 2%, Females 4.5%
HIV incidence among educators and officials ► Baseline: To be established 2012/13 ► Target: 10% annual decrease
TB incidence ► Baseline: 981/100 100 population (WHO estimate) ► Target: 490/100 000 population
Percentage learner dropout rate from school ► Baseline: 10% (Grade 9–11) (NIDS, 2008) ► Target: 8% (Grade 9–11)
Number of school-based educators who are medically boarded in the previous academic year ► Baseline: 229/389 329 teachers (PERSAL, 2010) ► Target: <1%

Strategy outcomes

In order to realise the two impacts of the Strategy, the following three outcomes will need to be achieved over the period it covers. Each outcome is elaborated upon below:

1. Increased HIV, STI and TB knowledge and skills among learners, educators and officials

Sound knowledge of HIV is a pre-requisite for the adoption of behaviours that reduce the risk of HIV and TB transmission. The schooling sector plays a leading role in ensuring that young people, and sector employees, have access to accurate and adequate knowledge on HIV and TB transmission.

The Strategy will contribute to increasing the percentage of learners, educators and officials who correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission. The Strategy also aims to contribute to an increase in knowledge on TB prevention and management.

INDICATORS
Percentage of Grade 6 learners and educators who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission ▶ Baseline: 35% Learners (Grade 6); 100% Educators ▶ Target: 10% annual increase among learners; 100% Educators
Percentage of Grade 6 learners and educators who demonstrate knowledge of TB ▶ Baseline: To be established 2012/13 ▶ Target: 10% annual increase

2. Decrease in risky sexual behaviour among learners, educators and officials

The implementation of the Strategy will support the development of the positive attitudes and skills required to reduce risky sexual behaviour among learners, educators and officials, including delaying the age of sexual debut, increasing male and female condom use, reducing the number of sexual partners among those already sexually active, and increasing uptake of prevention and treatment services (health-seeking behaviour). This behavioural change is expected to result in a reduction in risk in HIV infection and pregnancies among learners.

INDICATORS
Percentage of learners who have had sexual intercourse before the age of 15 years ▶ Baseline: Overall 4.5%, Males 11.3%, Females 5.9% (HSRC, 2008) ▶ Target: Overall 2.5%, Males 9.3%, Females 3.9%
Number of female learners who fell pregnant during the previous academic year ▶ Baseline: 45 276 (EMIS DBE, 2010) ▶ Target: 42 000
Percentage of educators who used condoms consistently with one non-regular partner over the past 12 months ▶ Baseline: 56% (HSRC Educators Study, 2005) ▶ Target: 65%
Percentage of 15–19 year old learners who reported the use of a condom with their sexual partner at last sex ▶ Baseline: Overall 86.5%, Males 92.5%, Females 79.8% (HSRC, 2008) ▶ Target: Overall 95%, Males 95%, Females 90%

3. Decreased barriers to retention in schools, in particular for vulnerable learners

Apart from HIV-specific interventions, school retention has been proven to protect against negative reproductive health outcomes like early pregnancy and HIV infection. For this reason, the Strategy includes a comprehensive set of interventions aimed at providing care and support for all learners, particularly the most vulnerable, to enable them to attend school, stay in school and achieve optimally. Schools and education departments will offer safety and protection to learners and employees alike, and be free of stigma and discrimination as well as gender-based violence.

INDICATORS
Current school attendance among orphans and among non-orphans aged 10–14 ► Baseline: Orphans 98%, Non-orphans: 99% (HSRC, 2008, SA UNGASS Report, 2010) ► Target: 100% (NSP target)
Percentage of learners and educators who have experienced stigma and discrimination ► Baseline: TBC ► Target: TBC
Percentage of high school learners who reported being bullied in the past 30 days ► Baseline: Males 35.7%, Females 37% (YRBS MRC, 2008) ► Target: Males 30%, Females 30%

Alignment with *NSP 2012 – 2016*

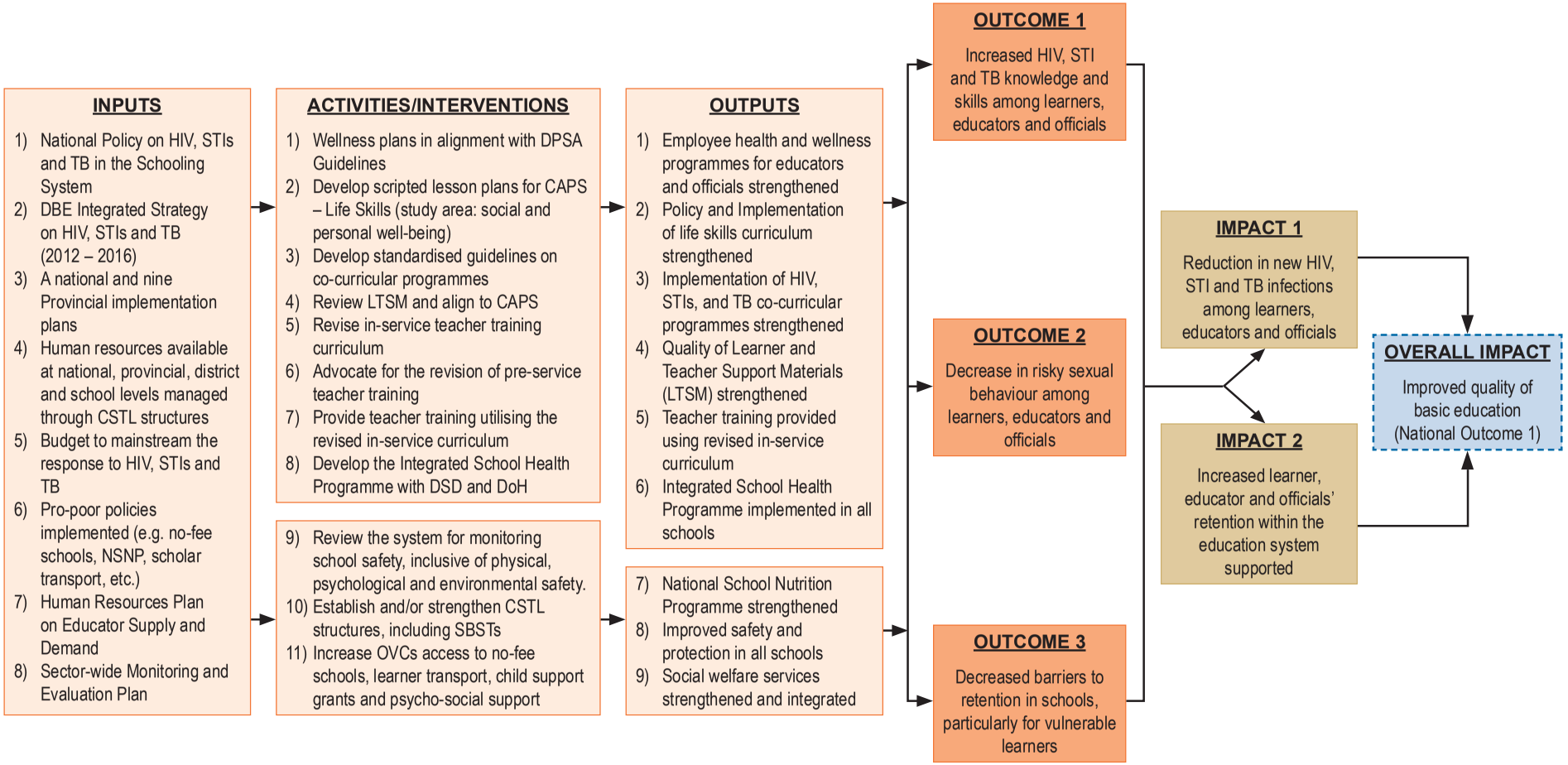
The Strategy's three outcomes have been designed to align as closely as possible with the four strategic objectives of the *NSP 2012 – 2016*, namely to:[177]

1. Address social and structural drivers of HIV and TB prevention, care and impact (Outcome 3)
2. Prevent new HIV, STI and TB infections (Outcomes 1 and 2)
3. Sustain health and wellness (Outcomes 1 and 3)
4. Ensure protection of human rights and increase access to justice (Outcomes 1 and 3).

It must be noted that while prevention, treatment, care and support programmes are not explicitly mentioned in the logic model below, they are mainstreamed in the outputs and outcomes, in particular Outputs 1 and 6 on educator, official and learner health and wellness.

[177] SANAC. *National Strategic Plan on HIV and AIDS, STIs and TB 2012 – 2016*. Pretoria: South African National AIDS Council, 2011.

6.2 Logic Model/Results Framework



7. REQUIREMENTS FOR EFFECTIVE IMPLEMENTATION

In order to create ideal conditions for the successful implementation of the Strategy, a number of key requirements have been identified. If absent or inadequately addressed, these factors will have a negative effect on achieving the strategy's outcomes and goals. These include governance and institutional arrangements; mainstreaming the strategy; effective communication; funding; and monitoring and evaluation. They are explained in detail below.

7.1 Governance and Institutional Arrangements

Good governance and management are important factors in ensuring delivery of the *DBE Integrated Strategy on HIV, STIs and TB 2012 – 2016*. The Strategy speaks to governance in that:

- It offers direction in meeting the core mandates of the schooling system
- It provides a plan for meeting the expectations of the DBE in relation to the NSP and the roles and responsibilities envisaged for education
- It brings together various departmental functions in responding effectively and comprehensively to the impact of HIV, STIs and TB on the education system.

In line with the principles in the *NSP 2012 – 2016*, the governance and management of this Strategy will enable the DBE to coordinate and monitor its implementation. The DBE will further facilitate the development of implementation plans at all levels.

The Strategy will be implemented under the CSTL framework and programme. As such, the existing governance and management structures for CSTL, as defined in White Paper 6 and in the CSTL Conceptual Framework, will be used to link the HIV programme activities with other care and support programmes implemented in and through schools (*see* Section 5 – Imperative four: A duty of care in schooling – for learners and educators).

At the same time, internal DBE structures will participate in the new and redefined SANAC structures at various levels to ensure the inclusion of basic education in the multi-sectoral HIV and TB responses. The National Task Team (NTT) will therefore work closely with the national SANAC structures. Similarly, the Provincial Task Team (PTT) will participate in the Provincial AIDS Council, and the District-based Support Team (DBST) will participate in the District AIDS Council. In this way, local ownership, accountability and coordination will be strengthened and duplication of efforts and resources eliminated. It must be noted that other health and social services workers such as nurses, psychologists and social workers who will play a critical role in the implementation of the Strategy are not precluded by the CSTL structures, but will play a complementary role.

Care and support for teaching and learning in the basic education sector: structures and functions

National Task Team (NTT) – This committee will consist of personnel from the DBE and other key government departments. The team will provide strategic direction and guidance in the overall implementation of the DBE Strategy. This structure will facilitate communication, advocacy, implementation and reporting of HIV and TB programmes in the schooling sector nationally and report to SANAC. The NTT will provide information and guide the process of developing provincial implementation plans.

Provincial Task Teams (PTT) – PTTs will coordinate the implementation of HIV- and TB-related programmes across the provinces with guidance from the NTT. The PTT will guide and assist in the development of the district implementation plans. They will facilitate monitoring and reporting of programmes outlined in the Strategy. These teams will include provincial Department of Education personnel (i.e. specialist learner and teacher support personnel, governance and management experts, and administrative staff and representatives from the school districts in each province). Partners from other government departments and from civil society may be co-opted as required.

District-based Support Teams (DBST) – DBST committees comprise staff from provincial districts and schools. Their primary function is to support schools to develop and implement their implementation plans. DBSTs also have a mandate to develop and coordinate school-based support for educators, officials and learners in responding comprehensively to the twin epidemics by strengthening communication mechanisms and increasing access to information.

School-based Support Teams (SBST) – SBSTs or institution-based support teams operate at a school level to coordinate learner, educator and support staff needs. These teams comprise school governing bodies (SGBs), educators, parents/caregivers and learners, where relevant. They will source expertise from local communities in order to strengthen the school's response to HIV and TB and will be guided by the DBST.[178]

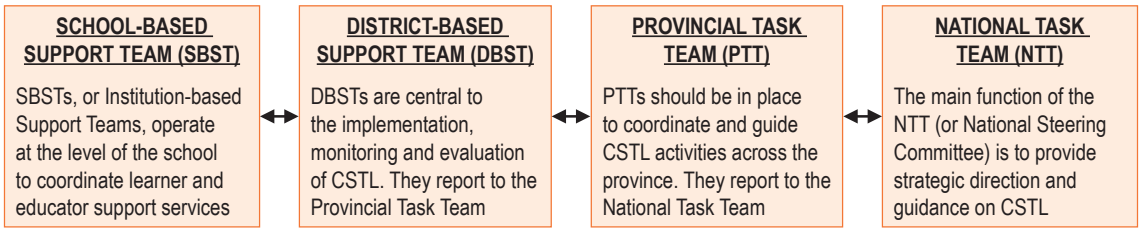


Figure 3: Care and support for teaching and learning in the basic education sector: structures and functions

[178] DBE. CSTL: Action Step: National Model, DBE, 2011.

7.2 Mainstreaming the Strategy

Sub-Objective 1.1 of the NSP mandates all government departments and SANAC sectors to "Mainstream HIV and TB and its gender and rights-based dimensions" into their plans and systems. Components of the DBE's Strategy should therefore be integrated into all national and provincial strategic plans and APPs, and into operational plans, and monitoring, reporting and evaluation systems.

While responses to HIV, STIs and TB have been mainstreamed into a few units of the DBE, others still regard the issues as being outside their immediate areas of responsibility. Even in some of the units where staff have been engaged in activities related to the response to HIV, STIs and TB, this work is generally viewed as assisting the Care and Support in Schools Chief Directorate with its work.

The successful implementation of the Strategy relies heavily on each branch and directorate, at national, provincial, district and school levels, understanding and accepting that the responsibility to respond effectively to HIV, STIs and TB is integral to their diverse portfolios.

Structures to manage the mainstreaming and coordination within the national and provincial departments

A departmental forum on HIV and AIDS has been in existence at the national level since 2008. A nominated representative from each branch sits on the forum. In 2010, the forum was subsumed under the Chief Directors' Forum to strengthen high-level strategic leadership and coordination.

Since there is an emphasis in the new Strategy on mainstreaming, integrating and accelerating the response, it will become increasingly important to have a structure that is capable of aligning and coordinating policy, operational activities, budgetary priorities, staffing and other norms and standards between the DBE and the nine provincial departments of education. In this regard, the establishment of a Heads of Education Departments Committee (HEDCOM) sub-committee on HIV, STIs and TB in basic education will be explored.

7.3 Effective Communication

Each of the NSP strategic objectives will require sustained communication efforts at all levels within the DBE and with the key stakeholders and partners. Ensuring that learners, educators, officials, partners and stakeholders know and understand the key elements of the DBE Strategy is an important first step.

Communication activities should be integrated into all interventions and should be tailored to reach the most vulnerable. People with disabilities should receive focused attention with respect to communication methods to ensure that they can access information and services, paired with appropriate learner-teacher support material. Adequate funding is critical in order to enable this.

Communication must be strengthened between the national and provincial efforts and between sectors to ensure that all efforts are coordinated and focused on achieving the goals of the Strategy.

Beyond the mandate of the DBE and the scope of this Strategy, social and behaviour change communication should be strengthened, as it plays a critical role in shaping and changing risk behaviours and the social conditions that drive the HIV and TB epidemics. Social and behaviour change communication should encompass all levels – individual, community and socio-political – and should include advocacy, media, social/community mobilisation and campaigns, among others.

This necessitates the development of an effective communication plan with a threefold purpose:

1. To provide the departmental, constituency and broader partner environment with new information and knowledge, including information on the DBE's expanded focus
2. To advocate and encourage buy-in at levels which include senior management, provinces and districts to ensure acceptance and active ownership
3. To successfully manage and monitor the Strategy implementation.

Effective communication is an implicit imperative and enabler for the successful implementation, monitoring and evaluation of the DBE's Strategy. This was recognised early in the process of the Strategy's development and time and resources were allocated to communicating the strategy to a range of stakeholders, both within and external to the department. This took place through an extensive consultation process, and through the use of existing mechanisms such as senior management and branch meetings, meetings with SGB formations, and interactions with provincial, district and school structures.

Strategy implementation will also require effective partnerships between government departments and the DBE, most notably the departments of Health, Social Development, and Public Service and Administration. Routine liaison will also take place with other key cooperative governance structures such as the Inter-departmental Coordinating Committee on Disability (ICCD), the Inter-departmental Committee on HIV and AIDS, SANAC, and the National Action Committee for Children Affected by HIV and AIDS (NACCA), amongst others.[179] Assessment is needed to determine whether or not established lines of interdepartmental communication are adequate at the four levels of Strategy implementation, i.e. national, provincial, district and school. The existing communication framework used for the NSP[180] and the CSTL Programme might be sufficient for this purpose, although it might need to be refined to ensure alignment with the management and reporting requirements of the Strategy's monitoring and evaluation framework.

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179 DBE. CSTL: Action Step: National Model, DBE, 2011. pp. 36–43.

180 SANAC. *National Strategic Plan on HIV and AIDS, STIs and TB 2012 – 2016*. Pretoria: South African National AIDS Council, 2011. pp. 54–56.

7.4 Financial Management

The financial implications of a comprehensive and holistic strategy for responding to HIV, STIs and TB in the school system can only be determined with some accuracy once the detailed operational plans have been elaborated on, at both national and provincial levels, and a costing of these has been performed.

Costing the implementation plans

One of the first tasks to be undertaken following approval of this Strategy is to cost the full implementation of all its components. It is foreseen that the amounts allocated from the conditional grant will not be sufficient to make a significant contribution to achieving the Strategy outcomes. The implication of this is that the DBE will have to consider expanding the existing conditional grant in terms of its priorities and activities, and its funding allocation, while sourcing alternative revenue streams (e.g. the equitable share) to finance the priority areas it has identified.

Once the Strategy has made preliminary recommendations on interventions, the priority-setting process, which takes place at a provincial level, will follow, using all the available evidence and best practice, and data from the costing. Monitoring and support at a national level will strive to stay abreast of provincial adaptations and implementation realities as they emerge.

The costing process will require external expertise, coupled with extensive training and support for provincial programme and financial managers in tracking progress against spending, which will ultimately inform future project planning.

Sustainable financing of the Strategy

Sustainable financing of this Strategy is imperative if the stated outcomes are to be achieved. This aspect becomes even more important as the programme is reshaped and expanded through new activities. The DBE needs to ensure that each province is able to plan and implement the key (non-negotiable) interventions necessary to achieve the outcomes and objectives of the country's *NSP 2012 – 2016*.

The conditional grant framework allows for consistent and uniform performance indicators for government to assess the (varied) effectiveness of programmes to inform further programme design and delivery. Sustained monitoring of, and accountability for, the HIV intervention is key to government's agenda and should be coordinated at a national level.

Additional funding will be needed for the increased number of activities, beyond life skills and LO, that are needed to successfully attain the outcomes of the Strategy. In particular, funding should be sought to increase safety and psycho-social support in schools for educators, officials and learners; expand the employee health and wellness programme; and develop strategies to reduce learner drop-out rates and to retain educators.

The alignment of donor aid to the Strategy outcomes is imperative. As set out in the NSP under the Aid Effectiveness Framework (AEF), the DBE will seek to align development partner assistance with education sector processes that will contribute to the achievement of the Strategy outcomes. This includes lobbying SANAC's Resource Mobilisation Committee (RMC) to mobilise funds for the activities specified in the NSP that lie beyond the biomedical components in the health sector, i.e. strengthened interventions to address the structural and behavioural drivers.

7.5 Monitoring and Evaluation

To serve as an effective guide to action, this Strategic Framework will need to be developed into a more detailed set of implementation plans by the divisions of the DBE, which will bear direct responsibility for the implementation of those plans, as well as by the corresponding units in the nine provincial departments of education. This process of elaboration should form part of the annual strategic and operational planning cycle, and should be scheduled to coincide with the preparation of the strategic and operational plans, beginning with the 2012/13 financial year.

Provinces will develop detailed implementation plans of their own within the framework of the national DBE Strategy. The DBE will provide a clear set of parameters for these processes. This process will be assisted by the development and articulation of clear objectives, guidelines on programme activities, SMART (Specific, Measurable, Attainable, Relevant and Timebound) indicators and targets, and the inclusion of these into the templates used for guiding the annual strategic and operational planning and reporting processes. This will require detailed coordination and planning at DBE level before liaison with National Treasury.

Monitoring and evaluation framework

The *DBE Integrated Strategy on HIV, STIs and TB 2012 – 2016* places a strong focus not only on responding comprehensively to HIV in the basic education sector, but also on monitoring and evaluating the effectiveness and efficiency with which this response is being implemented. Monitoring and evaluation (M&E) of the Strategy will help the DBE and its key partners to establish whether Strategy implementation is making a difference and for whom, and whether implementation is on target or if aspects of the Strategy need to be adjusted or replaced. Information gained from the M&E process will also contribute to better decisions about programme investments. The M&E framework will also assist the DBE in reporting periodically and meaningfully on the sector's contribution towards meetings its NSP obligations.

The M&E framework in Annexure B summarises the core set of indicators to be used to monitor and evaluate progress in implementing the Strategy. The DBE has many obligations with regard to monitoring the school environment, learner access, retention and achievement and for this reason has various systems in place to track these indicators (e.g. Education Management Information System [EMIS], Learner Unit Record Information Tracking System [LURITS] and Screening, Identification, Assessment and Support [SIAS]). Where possible, the core indicators

for monitoring the Strategy will be aligned with these existing reporting tools and mechanisms to ensure meaningful reporting and minimise any added burden.

The Strategy's M&E will also rely on other monitoring data collected by key government departments such as the departments of Health, Social Development, and Public Service and Administration, and on data collected by research and academic institutions. A comprehensive M&E plan will be developed, based on a series of baseline data from a variety of sources, with links to the results matrix to assist implementation and measurement and included in regular reporting (see Annexure B).

Finally, a mid-term and end-of-term evaluation of the Strategy will be conducted.

8. CONCLUSION

In responding comprehensively to HIV, STIs and TB in the basic education sector, this Strategy represents a change of pace and a widening of the scope in the response to HIV, STIs and TB, in the DBE and in the provincial departments of education. The Strategy is driven by key national strategic values, and an obligation to protect the nation's youth and its educators, and support its educators and officials.

The Strategy aims to mainstream, integrate, coordinate and accelerate schooling responses. It rests on key strategic components aligned to those of the *National Strategic Plan on HIV, STIs and TB 2012 – 2016* and addresses the context, the history of responses both broadly and specifically in the education sector, as well as the key drivers of the epidemic among youth and evidence on successful responses.

The Strategy builds on the policy adopted in 1999 and aims, in its successful implementation, to comprehensively address HIV-, STI- and TB-related schooling issues, thus contributing significantly to enhanced education outcomes. The Strategy will in turn lay the basis for a new and more comprehensive policy on HIV, STIs and TB for the schooling system.

ANNEXURE A: LIST OF CONSULTATIONS

	ORGANISATION/INSTITUTION	NAME	DATE	NATURE OF INPUT
NATIONAL EVENTS				
1	**DBE Senior Management**	DBE Senior Management Meeting	6 August 2010	Presentation of the Strategy for input and approval
2	**Heads of Education Departments Committee (HEDCOM)**	HEDCOM Meeting	18 October 2010	Presentation of the Strategy for input and approval
3	**Council of Education Ministers (CEM)**	CEM Meeting	18 November 2010	Presentation of the Strategy for input and approval
4	**DBE Seminar Participants:** **Education Officials:** DBE and provincial **Government Departments:** DPSA, DSD, DoH, DHET **Teacher's Unions:** ELRC, SADTU **Development Partners:** UNFPA, UNAIDS, USAID, PEPFAR, CDC, UNICEF, UNESCO **Universities/research:** HEARD, UWC, CEPD, UP, RHRU, HSRC **NGOs:** FPD, SHIPP, Futures Group International, Soul City, LCD, SAT, MIET, loveLife **Private Sector:** Morling and Godden Consultants	Key Speakers: • Mr ME Surty, MP, Deputy Minister, DBE • Dr N Simelela, Chief Executive Officer, SANAC • Mr Maluleke, General Secretary, SADTU • Mr B Shezi, Executive Manager, ELRC/PCTA • Ms K Callaghan, representing National Consultative Forum, SGBs • Dr S Senabe, Chief Director, Employee Health and Wellness, DPSA • Ms C Seabe, High School learner, Princess High School	07 March 2011	Seminar report and presentations
5	**5TH SA AIDS Conference DBE Satellite Session Participants:** **DBE Education Officials:** DBE and provincial **Government Departments:** DoH, DHET **Teachers' Unions:** SADTU, NAPTOSA, ELRC, PEU **Development Partners:** USAID, PEPFAR, CDC, UNICEF, Swedish Embassy **Universities/Research:** HEARD, UWC, CEPD, UP, RHRU, HSRC, Nelson Mandela Metropolitan University, University of Zululand, University of Johannesburg **NGOs:** Right to Care, FPD, SHIPP, Futures Group International, Soul City, PACT SA, MIET, loveLife, One Voice South Africa, World Vision International, Ndlovu Care Group, Heart Beat, Shout-It-Now, AIDS Legal Network, Zoë-Life, MRC	Key Speakers: • Mr ME Surty, MP, Deputy Minister, DBE • Mr PB Soobrayan, Director-General, DBE • Dr D Kirby, International Expert on Sexuality Education • Ms R Rogers-DeSole, Health and PEPFAR Office Chief, USAID	08 June 2011	Satellite report and presentations
6	Care and Support in Schools Chief Directorate	Health Promotion and National School Nutrition Programme Directorates	09 September 2011	Presentation of Strategy to Chief Directorate meeting
7	Research Coordination, M&E Directorate	Dr H Narsee, Director	21 September 2011, 05 October 2011, 01 November 2011	Meetings on M&E framework and indicator development

	ORGANISATION/INSTITUTION	NAME	DATE	NATURE OF INPUT
NATIONAL EVENTS (CONTINUED)				
8	Race and Values in Education Directorate	Dr S Mannah, Director	23 September 2011	Written submission
9	Gender and Equity Directorate	Ms H Mabunda, Director	26 September 2011	Written submission
10	Education Human Resources Management	Ms S Geyer, Chief Director	27 October 2011	Written submission
11	National School Nutrition Programme Directorate (NSNP)	Ms T Magudulela, Deputy Director	29 September 2011	Written submission
PROVINCIAL DEPARTMENTS OF EDUCATION				
12	Mpumalanga Education Consultants	Dr D Edwards-Meyer Dr N Louw	21 July 2011	Written submission
13	Gauteng Provincial Consultation	**Gauteng DoE** – Wellness, HIV and AIDS Life Skills, Employee Assistance Programme, Teacher Development, Curriculum, Nutrition, Principals and Learners, School Governing Bodies, Communications **Government Departments** – DSD, DoH, Ekurhuleni Local Municipality **Teacher Unions** – NEHAWU, SAOU, SADTU, NAPTOSA **Development Partners/NGOs** – Futures Group International, loveLife, Soul Buddies, NIKE, John Hopkins **Universities** – University of Johannesburg	26 July 2011	Presentation, discussion, group work and consultation report
14	Northern Cape Provincial Consultation	**Northern Cape DoE** – Finance, School Enrichment, Wellness, Life Skills, Employee Assistance Programme, Early Childhood Development, Teacher Development, Curriculum, Communications, School Governing Bodies **Government Departments** – DSD, DoH, Local Municipality **Teachers' Unions** – SAOU, NAPTOSA **Development Partners/NGOs** – PEPFAR, Right to Care, Red Cross, Child Welfare, New Start, National Association of People Living with HIV/AIDS, loveLife **Universities** – FET Colleges	10 August 2011	Presentation, discussion, group work and consultation report
15	Free State Provincial Consultation	**Free State DoE** – Inclusive and Special Needs Education, Wellness, Life Skills, Safety, Employee Relations and People Management, Teacher Development, Curriculum, Nutrition, Communications, Principals and Learners, School Governing Bodies **Government Departments** – DSD, DoH, Office of the Premier **Teachers' Unions** – NEHAWU, SAOU, SADTU, NAPTOSA **Learner Organisations** – COSAS **Development Partners/NGOs** – New Start, Grassroot Soccer, Hospice Palliative Care, PEPFAR Partners, loveLife, Reaching a Generation **Universities** – University of the Free State	11 August 2011	Presentation, discussion, group work and consultation report

	ORGANISATION/INSTITUTION	NAME	DATE	NATURE OF INPUT
PROVINCIAL DEPARTMENTS OF EDUCATION (CONTINUED)				
16	Mpumalanga Provincial Consultation	**Mpumalanga DoE** – HIV and AIDS Life Skills, Employee Assistance Programme, Wellness, Teacher Development, Curriculum Enrichment, Nutrition, Governance, School Safety, Communications, Strategic Planning, Scholar Transport, Risk Management, Internal Audit, SGBs, South African National Association for Specialised Education **Government Departments** – DSD, DoH, Office of the Premier, Provincial AIDS Council, Ehlanzeni Municipality, GERT Local Municipality, National Youth Development Agency **Teacher Unions** – NETU, SAOU, SADTU, NAPTOSA **Development Partners/NGOs** – PEPFAR, Right to Care, Futures Group International, USAID, GOLD Peer Education, loveLife, Soul Buddies, Local Council of Churches, House of Traditional Leaders, Link Community Development, Circles of Care, Ligwalagwala, CASNET **Universities** – Tshwane University of Technology	13 September 2011	Presentation, discussion, group work and consultation report
17	Western Cape Provincial Consultation	**Western Cape ED** – Inclusive Education, HIV and AIDS Life Skills, Employee Assistance Programme, Teacher Development, Curriculum, Communications **Government Departments** – DSD, DoH, Office of the Premier **Teacher Unions** – SADTU **Development Partners/NGOs** – Grassroot Soccer, Life Choices, PEPFAR **Universities/Research** – University of Western Cape, Medical Research Council	16 September 2011	Presentation, discussion, group work and consultation report
18	Western Cape Education Department	Mrs R Brink, Psychologist	18 September 2011	Written submission
19	KwaZulu-Natal Provincial Consultation	**KZN DoE** – Youth Arts and Culture, Wellness, Life Skills, Employee Assistance Programme, Teacher Development, Curriculum, Nutrition, Principals and Learners, School Governing Bodies, HIV and AIDS Life Skills **Government Departments** – DSD, DoH **Teacher Unions** – NEHAWU, SAOU, SADTU, NAPTOSA **Development Partners/NGOs** – KZN Christian Council, USAID, Futures Group International, loveLife, NIKE, John Hopkins, HEARD, Soul City, Tabernacle Church **Universities/Research** – University of KwaZulu-Natal/MRC	20 September 2011	Presentation, discussion, group work and consultation report

	ORGANISATION/INSTITUTION	NAME	DATE	NATURE OF INPUT
PROVINCIAL DEPARTMENTS OF EDUCATION (CONTINUED)				
20	Limpopo Provincial Consultation	**Limpopo DoE** – HIV and AIDS Life Skills, Employee Assistance Programme, Teacher Development, Curriculum, Nutrition, Inclusive Education, Gender, School Safety, Institutional Governance, Communications **Government Departments** – DSD, DoH, Vhembe Municipality, Public Protector **Teacher Unions** – PEU, NEHAWU, SADTU **Development Partners/NGOs** – Reaching a Generation, Soul City, Papswa, SAHRC, Faith Based Organisations and Traditional Leaders **Universities** – University of Venda, Vhembe FET College	28 September 2011	Presentation, discussion, group work and consultation report
21	North West Provincial Consultation	**North West DoE** – Inclusive Education, HIV and AIDS Life Skills, Employee Assistance Programme, Strategic Planning, Health Promotion, Teacher Development, Curriculum, Nutrition, Principals and Learners, School Governing Bodies (SENASE, NASGB), Communications **Government Departments** – DSD, DoH, **Development Partners/NGOs** – Soul City, Link Development **Universities** – FET Colleges	04 October 2011	Presentation, discussion, group work and consultation report
22	Eastern Cape Provincial Consultations	**Eastern Cape DoE** – Employee Wellness, Life Skills, Employee Assistance Programme, Teacher Development, Curriculum, Nutrition, School Governing Bodies **Government Departments** – Buffalo City Metro Municipality, DoH, DSD **Teacher Unions** – NEHAWU, SAOU, SADTU, NAPTOSA **Development Partners/NGOs** – Sophumelela Centre, Centre for Social Development, Eastern Cape AIDS Council	11 November 2011 and 14 November 2011	Presentation, discussion, group work and consultation report
UNIONS				
23	Education Labour Relations Council (ELRC)	Prevention Care and Treatment Access Project (PCTA) Provincial Coordinators, National Professional Teachers Organisations of South Africa (NAPTOSA), National Teachers Union (NATU), Professional Educators Union (PEU), American Federation of Teachers (AFT), South African Teachers' Union (SAOU)	12 April 2011	Presentation and dialogue at national meeting
GOVERNMENT DEPARTMENTS				
24	SANAC and Office of the Deputy President	Dr N Simelela – Chief Executive Officer SANAC and Special Advisor to the Deputy President	15 July 2011 11 October 2011	Written submission and presentation at HIV and AIDS life skills inter-provincial meeting

	ORGANISATION/INSTITUTION	NAME	DATE	NATURE OF INPUT
GOVERNMENT DEPARTMENTS (CONTINUED)				
25	Gauteng Department of Health and Social Development	Dr E Floyd, Director, Multi-sectoral AIDS Unit	21 July 2011	Written submission
26	Department of Higher Education, Higher Education HIV and AIDS Programme, Higher Education South Africa	Team led by Mr J Mabelebele, HESA, Operations and Support Director	22 August 2011	Minutes of meeting
27	National Department of Health	Dr TD Mbengashe, Chief Director, HIV and AIDS Dr N Dlamini, Director, HIV Prevention Dr L Mnisi, Director, TB Programme	21 September 2011	Minutes of meeting
28	Department of Social Development	Dr C Kganakga, Chief Director, HIV and AIDS	10 October 2011	Written submission
29	Department of Higher Education and Training	Mr M Mabizela, Chief Director, Policy Development	17 October 2011	Written submission
30	SANAC	SANAC – Treatment, Care and Support Technical Task Team	16 November 2011	Presentation to TTT by Dr F Kumalo, DBE
DEVELOPMENT PARTNERS				
31	Joint United Nations Team on HIV/AIDS (JUNTA)	Dr C Sozi, Country Coordinator, UNAIDS UNESCO, UNFPA, UNDP, UNAIDS, UNICEF, UN Women	05 April 2011 and 23 August 2011	Written submission and minutes of round table meeting
32	UNAIDS	Dr A Reid, Institutional Development Advisor	07 September 2011	Written submission – technical input on TB
33	UNAIDS	Ms E Kiwango, Institutional Development Advisor	20 October 2011	Written submission and technical support for M&E
NON-GOVERNMENTAL ORGANISATIONS				
34	One Voice South Africa	Ms M Van Berne, Communications and Fundraising Manager	22 August 2011	Written submission
35	Shout-It-Now	Dr KE Pahl and Dr DJ Westcott, Directors	30 September 2011	Written submission
36	Ndlovu Care Group	Ms M Slabbert, Chief Operational Officer	07 October 2011	Written submission
37	loveLife	Ms Grace Matlhape, Chief Executive Officer and Mr Scott Burnett, Group Programmes Director	21 October 2011	Written submission
UNIVERSITIES AND RESEARCH INSTITUTIONS				
38	Community Of Practice – HIV and AIDS (COP-HIV)	Higher Education South Africa – Education Faculty	05 April 2011	Presentation by Dr S Panday and dialogue at April conference
39	Health Economics and HIV and AIDS Research Division (HEARD), UKZN	Dr J Hanass-Hancock, Researcher	30 June 2011	Written submission – disability
40	Centre for Education Policy Development (CEPD)	Dr U Amadi-Ihunwo, Researcher	22 July 2011	Written submission
41	Human Sciences Research Council (HSRC)	Dr K Zuma, Research Director	12 August 2011	Minutes of meeting
42	Desmond Tutu Foundation, Stellenbosch University	Prof N Beyers, Director and Dr A Hesseling, Director Paediatric TB Research Program	01 September 2011	Minutes of meeting and written technical input on TB
43	Education, Training and Research Associates	Dr D Kirby, International Expert on Sexuality Education	22 September 2011	Written submission
OTHER				
44	TB Experts	National TB Control and Management meeting	24 May 2013	Presentation by Dr F Kumalo, DBE

ANNEXURE B: MONITORING AND EVALUATION FRAMEWORK

RESULT		NO.	INDICATOR	DISAGGREGATION	BASELINE	TARGET 2016	DATA SOURCE (MOV)	FREQUENCY OF MEASUREMENT	RESPONSIBLE
IMPACT-LEVEL RESULT									
1	Reduction in new HIV, STI and TB infections among learners, educators and officials	1	HIV prevalence amongst learners 15–19 years	Province, sex, age	4.4% Males: 2.5% Females: 6.7% (HSRC 2008)	2.2% Males: 2% Females: 4.5%	Population-based survey	Every three years	Research organisation
		2	HIV incidence among educators and officials	Province, district, sex, age	To be determined (TBD)	10% annual decrease	Special study	Every three years	ELRC Research organisation DBE
		3	TB incidence	Province, district, HIV status	981/100 000 population (WHO estimate 2010)	490/100 000 population	WHO estimates	Annually	DOH STATS SA
2	Increased learner, educator and officials' retention within the education system	4	Percentage of learner dropout rate from school	Province, district, school grade, sex	Overall: 4% Grade 9–11: 10% (NIDS, 2008)	8% (G9–11)	EMIS General Household Survey (GHS)	Annually Every three years	DBE/EMIS Stats SA
		5	Number and percentage of school based educators who are medically boarded in the previous academic year	Province, district, sex	<1% (PERSAL, 2010) 229/389 329 teachers	<1%	PERSAL	Annually	DBE/EHRM
OUTCOME-LEVEL RESULTS									
1	Increased HIV, STI and TB knowledge & skills among learners, educators & officials	6	Percentage of Grade 6 learners who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Province, sex, age	Learners: 35% (SACMEQ, 2008)	10% annual increase	SACMEQ	Every three years	SADC, DBE National Assessment Directorate
		7	Percentage of Grade 6 educators who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Province, sex, age	Educators: 100% (SACMEQ 2008)	100%	SACMEQ	Every three years	SADC, DBE National Assessment Directorate

RESULT		NO.	INDICATOR	DISAGGREGATION	BASELINE	TARGET 2016	DATA SOURCE (MOV)	FREQUENCY OF MEASUREMENT	RESPONSIBLE
OUTCOME-LEVEL RESULTS (CONTINUED)									
1	Increased HIV, STI and TB knowledge & skills among learners, educators & officials	8	Percentage of Grade 6 learners, who demonstrate knowledge of TB	Province, sex, age	TBD 2012/13	10% annual increase	SACMEQ	Every three years	SADC, DBE National Assessment Directorate
		9	Percentage of Grade 6 educators who demonstrate knowledge of TB	Province, district, sex	TBD 2012/13	10% annual increase	SACMEQ	Every three years	SADC, DBE National Assessment Directorate
2	Decrease in risky sexual behaviour among learners, educators and officials	10	Percentage of learners who have had sexual intercourse before the age of 15 years	Province, sex, age	4.5% Males: 11.3% Females: 5.9% (HSRC, 2008)	2.5% Males: 9.3% Females: 3.9%	Population-based HIV survey or any other survey	Every three years	Research organisation
		11	Percentage of female learners who fell pregnant during the past 24 months (15–19 years)	National, sex	25.7% HSRC, 2008	22.7%	Population-based survey	Every three years	Research organisation
		12	Number of female learners who fell pregnant during the previous academic year	Province, district, age	45 276 (EMIS, 2010)	42 000	EMIS Population-based survey	Annually Every three years	DBE Research organisation
		13	Percentage of educators who used condoms consistently with one non-regular partner over the past 12 months	Sex, marital status	54.8% (HSRC, 2005) TBD	65%	Special Study Population-based survey	Every three years Every three years	ELRC Research organisation
		14	Percentage of 15–19 year old learners who reported the use of a condom with their sexual partner at last sex	Province, sex, age	86.5% Male: 92.5% Females: 79.8% (HSRC, 2008)	95% Males: 95% Females: 90%	Population-based survey	Every three years	Research organisation
3	Decreased barriers to retention in schools, particularly for vulnerable learners	15	Current school attendance among orphans and among non-orphans aged 10–14	Province, district, sex, type of orphanhood	Orphans: 98% Non-orphans: 99% (HSRC, 2008)	100%	Population-based survey	Every three years	STATS SA, Research organisation
		16	Percentage of learners who have experienced stigma and discrimination	Province, district, sex	TBD	TBD	Stigma index survey	Every three to five years	SANAC
		17	Percentage of educators who have experienced stigma and discrimination	Province, district, sex	TBD	TBD	Stigma index survey	Every three to five years	SANAC

RESULT		NO.	INDICATOR	DISAGGREGATION	BASELINE	TARGET 2016	DATA SOURCE (MOV)	FREQUENCY OF MEASUREMENT	RESPONSIBLE
OUTCOME-LEVEL RESULTS (CONTINUED)									
3	Decreased barriers to retention in schools, particularly for vulnerable learners	18	Percentage of Grade 6 learners who indicated a negative response to learners infected with HIV continuing to attend school	National, province, district, sex	21.7% (SACMEQ, 2010)	10.7%	SACMEQ	Every three years	SADC, DBE National Assessment Directorate
		19	Percentage of Grade 6 learners who indicated a negative response regarding their attitude toward a friend infected with HIV & AIDS	National, province, district, sex	8.9% (SACMEQ, 2010)	4.4%	SACMEQ	Every three years	SADC, DBE National Assessment Directorate
		20	Percentage of Grade 6 teachers who indicated a negative response to learners infected with HIV continuing to attend school	National, province, district, sex	1% (SACMEQ, 2010)	1%	SACMEQ	Every three years	SADC, DBE National Assessment Directorate
		21	Percentage of Grade 6 learners who indicated a negative response to learners diagnosed with TB continuing to attend school	National, province, district, sex	TBD (SACMEQ, 2014)	2% annual decrease	SACMEQ	Every three years	SADC, DBE National Assessment Directorate
		22	Percentage of Grade 6 learners who indicated a negative response regarding their attitude toward a friend diagnosed with TB	National, province, district, sex	TBD (SACMEQ, 2014)	2% annual decrease	SACMEQ	Every three years	SADC, DBE National Assessment Directorate
		23	Percentage of Grade 6 teachers who indicated a negative response to learners diagnosed with TB continuing to attend school	National, province, district, sex	TBD (SACMEQ, 2014)	2% annual decrease	SACMEQ	Every three years	SADC, DBE National Assessment Directorate
		24	Percentage of high school learners who reported being bullied in the past 30 days	Sex, grade, age, province	Males: 35.7 Female: 37% (YRBS, 2008)	Males: 30% Females: 30%	YRBS	Every three years	DoH Research organisation

RESULT		NO.	INDICATOR	DISAGGREGATION	BASELINE	TARGET 2016	DATA SOURCE (MOV)	FREQUENCY OF MEASUREMENT	RESPONSIBLE
OUTPUT-LEVEL RESULTS									
1	Policy and Implement-ation of life skills curriculum strengthened	25	Improved quality and implementation of life skills curriculum *proxy measures*: - Availability of scripted lesson plans - LO as a subject is examinable - LO as a subject is timetabled as per policy - LO curriculum is being covered as per policy (volume & topics)	Province, type of school (public, independent and special schools)	TBD	100%	Life Skills Quarterly Reports	Quarterly	DBE Directorates: Curriculum and Health Promotion
2	Implement-ation of HIV, STI, and TB co-curricular programmes strengthened	26	Co-curricular programmes standardised	N/A	N/A	100%	HIV, STI and TB co-curricular programmes	N/A	DBE: Health Promotion Directorate
3	Quality of Learner and Teacher Support Materials (LTSM) strengthened	27	Alignment of LTSM with CAPS and UNESCO TGSE standards	N/A	N/A	80% alignment	LTSM	N/A	DBE Directorates: Curriculum and Health Promotion
4	Teacher training provided using revised in-service curriculum	28	Teacher training curriculum revised to include HIV and sexuality education	N/A	N/A	Revised teacher training curriculum	DBE	N/A	DBE Directorates: Continuing Professional Teacher Development (CPTD) and Health Promotion
		29	Number and percentage of LO teachers who have received in-service training based on the revised curriculum	Provincial, district, sex	N/A	To be established	DBE life skills quarterly report	N/A	DBE Directorates: Health Promotion and CPTD
5	Integrated School Health Programme (ISHP) implement-ed in all schools	30	Number and percentage of learners benefiting from the ISHP	Province, district, quintiles, school phases	To be established in 2012	100%	DHIS Health Promotion Directorate quarterly reports	Annually	DoH

RESULT		NO.	INDICATOR	DISAGGREGATION	BASELINE	TARGET 2016	DATA SOURCE (MOV)	FREQUENCY OF MEASUREMENT	RESPONSIBLE
OUTPUT-LEVEL RESULTS									
6	Employee health and wellness programmes for educators and officials strengthened	31	Number and percentage of employees who access the EHWP	Province, sex	To be established 2012	To be established 2012	To be established 2012	Annually	DBE ELRC Teacher Unions
7	National School Nutrition Programme strengthened	32	Number of learners from ordinary public schools that receive school meals through the National School Nutrition Programme	Province, district	8 979 002 (2011/12)	9 000 000 (75% of learners)	NSNP Directorate Database	Annually	DBE, NSNP Directorate
8	Improved safety and protection in schools	33	Number of public ordinary schools that have established and trained school safety committees	Province, district, school	34% (DBE, School Safety, 2011)	66%	Safety Directorate Database	Annually	DBE, School Safety Directorate
9	Social welfare services strengthened and integrated	34	Number and percentage of schools implementing the CSTL Programme	Province, district	225 (DBE, Health Promotion, 2012)	3 600	Database	Annually	DBE, Health Promotion Directorate
		35	Number and percentage of learners from ordinary public schools that attend no-fee schools	Province, district	60% (DBE, EMIS, 2011)	60%	DBE, EMIS	Annually	DBE, Financial Planning and Economic Analysis Directorate
		36	Number and percentage of learners in public ordinary schools that benefit from a Child Support Grant (CSG)	Province, district, sex	TBD	TBD	DBE, EMIS	Annually	DBE, EMIS

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