
As simple as ABC? How rural ABET Centres respond to HIV/AIDS

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Abstract

This article investigates the ways in which two rural Adult Basic Education and Training (ABET) Centres in the Limpopo Province address the challenges of HIV/AIDS. Theories of social capital are used to explain the different responses of the Centres. The communities surrounding both Centres face similar structural problems of poverty, unemployment, migrancy, gender inequality, poor health and low levels of education. In one Centre, educators and learners denied that HIV/AIDS was a serious issue. They had no confidence in the public health service, and no access to information or networks which support HIV/AIDS work. In this centre, no efforts were made by educators or officials to integrate HIV/AIDS in the ABET curriculum. In the second Centre, situated closer to town, the educator responsible for Life Orientation had engaged learners in a variety of social networks which directly or indirectly addressed AIDS. These networks increased the exchange of information among learners, and facilitated collective goals. The paper concludes that developing the social capital of ABET officials, educators and learners plays an important part in efforts to build the capacity of ABET Centres to respond positively to the challenges of HIV/AIDS.

Introduction

In Limpopo Province, where HIV/AIDS prevalence was once the lowest in South Africa (Barnett and Whiteside, 2002), the disease continues to spread at a rapid rate, with devastating effects on individuals, families and communities. AIDS is no longer “an epidemic waiting to happen” (Marks, 2002, p. 13), it has arrived.

Although President Mbeki and the Minister of Health, Dr Manto Tshabalala-Msimang, among others, have been accused of denial and obfuscation with regard to AIDS (van der Vliet, 2004; Crewe, 2000) the Ministry of Education has at least acknowledged the seriousness of the epidemic. Through its National Policy on HIV/AIDS (Department of Education, 1999) it seeks to promote effective awareness and prevention programmes in the public education system, including the system of Adult Basic Education and Training

(ABET). The policy is intended to minimize the social, economic and development consequences of HIV/AIDS for the education system, for all learners, students and educators, and to provide leadership in implementation. The policy, in part, states that:

- The constitutional rights of all learners and educators must be protected equally.
- There should be no compulsory disclosure of HIV/AIDS status.
- The testing of learners as a prerequisite for attendance at an institution, or of an educator as a prerequisite of service, is prohibited.
- No HIV positive learner or educator may be discriminated against, but must be treated in a just, humane and life-affirming way.
- Learners must receive education about HIV/AIDS in the context of life-skills education as part of the integrated curriculum in schools and/or ABET centres (the.
- Educators need more knowledge of, and skills to deal with, HIV/AIDS and should be trained to give education and guidance on HIV/AIDS.

Thus Public Adult Learning Centres (PALCs), the ABET Centres which serve rural communities can, and should, formulate and implement appropriate strategies to address HIV/AIDS in their communities.¹ Currently, educators working in the learning area of Life Orientation (LO) are expected to take the lead in mainstreaming HIV/AIDS education. Although policy does not spell out how this is to be done, strategies might include:

- Using literacy and life skills classes to develop knowledge and awareness of HIV/AIDS among learners, and to address issues such as gender and power relations which contribute to the epidemic.
- Educating and mobilising communities to set up income-generating projects, such as vegetable and poultry farming projects, to support the health and well-being of HIV/AIDS affected families.
- Providing training to community members on home based care and on counselling.
- Networking with other organisations to stay abreast of new developments in HIV/AIDS treatment care and support.

¹ A donor-funded Life Skills Programme for HIV/AIDS in Schools was started in 1995 to provide training and technical assistance to teachers, develop learning and support materials, encourage peer evaluation and conduct advocacy and motivational workshops. During 1997-8 two teachers in every secondary school in the country were trained to implement the Life Skills Programme (Crewe, 2000). However, by 2000 the programme had run out of funds and momentum, and ground to a halt. In any case, the programme was never implemented in primary schools or ABET Centres.

National policy on HIV/AIDS provides a point of departure for this paper. The pronouncements made in the policy are laudable, but so far there has been little, if any, evidence to show whether ABET Centres (or schools for that matter) are giving greater attention to HIV/AIDS education than was the case before the policy was issued. It is the intention of this paper to search out this evidence. Are ABET Centres taking up the challenge of HIV/AIDS education, as required by the Department of Education? What strategies, if any, have they devised and implemented, and with what success? How can divergent responses of individual ABET Centres be explained? In this paper we address these questions by investigating two rural ABET Centres in Limpopo Province which have responded to HIV/AIDS in different ways. We draw on theories of social capital (Coleman, 1994 and 1988; Putnam, 1992) to explain the difference.

We begin the article with background information about the challenges faced by rural communities with respect to HIV/AIDS, and the challenges placed on rural ABET Centres in particular. Case studies of two ABET Centres in Limpopo follow.

Challenges faced by rural communities with respect to HIV/AIDS education

A review of literature on this theme (see, for example, Davidson, 1997; Nelson, 1993) indicates that rural communities worldwide tend to retain traditional values, and are less diverse ethnically and culturally than urban communities. Church, traditional leaders and family generally play a more central role in the daily life of rural people than they do for people who live in cities. Geographic distance and limited resources result in increased reliance on other community members. Social support is often channelled through informal social networks rather than through the formal structures of urban areas. Therefore, new ideas such as the use of condoms, delayed sexual debut, or abstinence, made more public by the AIDS epidemic, may not be easily accommodated in rural communities. Traditional values and beliefs, for example, beliefs in witchcraft and prophecy, may work against an understanding of HIV/AIDS as a preventable, treatable phenomenon.

In South Africa, in rural areas even more than in urban areas, gendered roles based on heterosexual relationships are the norm, and there is stigma and fear attached to homosexuality. Patriarchal values are strongly held. HIV status is often hidden and undisclosed due to fear of isolation and rejection by the community. Denial is evidenced by attitudes which portray HIV/AIDS as an urban issue, or one associated with 'others' (Campbell, 2003; Davidson, 1997;

Meursing, 1996). HIV positive members of rural communities are often invisible, hidden at home by their family members and isolated from support systems. People who suspect that they are infected may be fearful of seeking testing, treatment or support services for fear of public exposure (Francis, 2002). Such fear is also prompted by mistrust of local agencies' ability to maintain confidentiality (Walker, Reid and Cornell, 2004) especially in smaller communities where members of the extended family may be known to those employed in the health services. These factors, combined with initial low sero-prevalence rates in Limpopo Province in the early 1990s, may constitute significant obstacles to HIV/AIDS education which ABET practitioners should take into account when planning and implementing interventions.

Further complicating HIV/AIDS education in rural communities is the lack of resources, both in terms of infrastructure, and in terms of financial and human resources. In South Africa, many rural areas cover large geographic areas. Education and social mobilisation efforts, such as those organised by the *Treatment Action Campaign* and *Love Life*, are thinly spread and often inaccessible. Sometimes, the approaches used to spread messages about HIV/AIDS are not effective in poor communities. For example, people with low levels of literacy may not benefit from pamphlets, posters and other printed media, especially when these are written in English or Afrikaans rather than in indigenous languages. Some AIDS awareness programmes such as *LoveLife* are strongly oriented to youth rather than to adults (Stadler, 2002; Niehaus and Jonsson, 2004).

Rural communities worldwide are characterised by a social system of extended families and traditional systems of leadership (Parker, Dalrymple and Durden, 2000). Although these systems have been eroded in Southern Africa by the migrant labour system and by apartheid (Walker et al, 2004), the role of extended families and traditional leaders remains significant. Without the support of these leaders, AIDS education strategies are unlikely to make much impact. Therefore, a key to successfully mobilizing rural areas by ABET practitioners may lie in recruiting key community leaders as supporters of HIV/AIDS education.

Certain cultural practices², such as polygamy, wife inheritance and male circumcision, actively practised in rural parts of Limpopo province, pose difficulties for HIV/AIDS education. Deference to males, elders and

² We recognise that it is problematic to describe indigenous African cultures and practices (or the cultures dominant in rural areas) as 'traditional' cultures, especially given the diversity of South Africa ethnic groups and the lengthy exposure of indigenous Africans to 'modern' culture. However, it is beyond the scope of this paper to engage in this debate. There are some grounds for drawing the distinction.

authorities, and cultural taboos prevent ‘respectable’ women from speaking about sex and sexually transmitted diseases, even to their children and partners (Walker et al, 2004). Subjects such as gender violence and abuse are believed to be a private problem, ‘nobody else’s business’ (von Kotze, 2003). Even though such practices are changing, they call for sensitivity and resourcefulness on the part of educators so that planned interventions do not offend and alienate learners, or inflict damage to the relationship between the educator and the community.

ABET Centres face particular challenges when it comes to introducing new ideas and practices. Government commitment to Adult Basic Education has waned in the past decade, and there is a dearth of leadership and resources in the field (Aitchison, 2003). In the past decade, the number of Public Adult Learning Centres (PALCs), particularly in rural areas of the country, has dropped from 1440 to 998 (Baatjes, 2003). So, those who need education the most have the least access to it. In addition, there are very few purpose-built ABET Centres. Classes for adult learners usually take place after hours in day schools. Practitioners are often temporary contract employees, ‘surplus’ to the requirements of the day school, who work a maximum of six hours per week, are not paid regularly, and do not have access to a pension, medical aid, or other benefits which government employees, including school teachers, enjoy (Baatjes, 2003). Educators in many ABET Centres are poorly motivated, regarding their appointments as a stop gap while they seek a permanent or temporary post in a day school.³ They rarely receive training or study materials from the Department of Education, and often rely on the learning and support materials used in the day school, which may be inappropriate for adults. It is important to note, however, that despite their imperfections, ABET Centres remain a resource for public adult education, especially in rural areas where there are few alternatives.

Social capital

Capital can be defined as resources that are acquired, accumulate, and are of value in certain situations or markets. Many forms of capital are implicated in health education: human, cultural, social and economic. In the section below, we focus on social capital and explore its links with health and adult education.

³ On finding a vacancy in a day school, a teacher is required to give only 24 hours notice to the ABET Centre.

Social capital, according to Bourdieu (1976, 1997), is a network of power and duty which comes from belonging to a group which provides members with access to collectively owned resources in society. Bourdieu believed that social capital, like cultural capital, could be converted to economic capital. Every member of society has social and cultural capital, but some forms of it are more valuable, and more easily converted into economic capital, than others. So, for example, a housewife in rural Limpopo may have a strong network of neighbours and relatives who provide mutual support in terms of childcare or food security. This form of social capital is less easily converted into economic capital than being a member of the ANC National Executive or the Rand Club where powerful and wealthy people sway the allocation of tenders, contracts and jobs.

While Bourdieu sees social capital as a tool for the reproduction of the dominant class, more recent public and academic interest in social capital has centred on its role and significance in fostering civic engagement and democratic governance. Researchers have investigated the benefits of social capital in a variety of fields such as schooling, community life, criminology and public health.

For Coleman (1988) social capital resides in social networks: the groups, organisations and institutions which make up society. It is the pattern of ties between individuals and networks which facilitate cooperation for mutual benefit. For Putnam (1993) social capital has to do with the way in which social and material resources are exchanged; the level of trust between individuals, and the norms and sanctions which arise from shared obligations and expectations. Seen in this light, social capital is a tool for both social cooperation and social control.

At the community level, social capital involves the nature of people's relations with local institutions, both educational and non-educational, and the extent to which institutions communicate, collaborate or compete with each other (Schuller and Field, 1998, p. 231).

Two forms of social capital are particularly important for this study: 'bonding social capital'- the trusting and cooperative relationships in homogeneous peer groups (for example in groups of women attending a rural ABET Centre) and 'bridging social capital'- the collaboration among diverse groups of agents who might otherwise not have contact. An example of this is an alliance between female sex workers in a mining community and representatives of the powerful mining companies which employ the women's clients (Campbell, 2002, p. 230). The collaboration of these agents increases the likelihood of an HIV/AIDS prevention programme being successful. However, it is important to remember that social capital is relational: participants or stakeholders may

vary widely in the quantity and quality of their knowledge, understanding and commitment to a mutual undertaking.

Concepts such as community participation and stakeholder partnership are articles of faith in HIV prevention policies and interventions worldwide (Campbell, 2003, p. 229). They are also articles of faith in the field of adult education (Vella, 1994; Aitchison, 1987). In South Africa, the ‘empowerment’ of marginalised communities and groups is a major goal of adult education for social transformation in the democratic era.

Campbell (2003, p. 50) argues that people are more likely to be healthy in communities characterised by high levels of social capital, that is, communities in which there are high levels of participation in local networks and organisations in which people feel that their needs and views are respected and valued, and which offer trust, reciprocal help and support as well as a positive community identity. Communities with high levels of social capital are most likely to have high levels of perceived control over their every day lives. People who feel in control of their lives are in general more likely to take control of their health, either through health-enhancing behaviours or by accessing health services in a timely and appropriate way. At the micro level, the emphasis is on the individual’s ability to mobilise resources through local networks, for example community meetings, extended families, churches and community based organisations. The role of educators and health workers is to facilitate access to networks for those who are excluded (by poverty or gender, for example) and to understand, build and strengthen networks which contribute to health and well-being.

There is no accepted way to measure social capital. Putnam’s work on the relationship between social capital and local government in Italy involved indices of newspaper readership, the density of local associations (such as choral societies and football clubs) and confidence in public institutions (in Pronyk, 2002). Many researchers attempt to break the concept down into its component parts- information, networks, trust and collective action. That is what we have attempted to do in this paper: to show how the information sources, networks and trust in two rural communities affect the capacity of ABET Centres to take action to address HIV/AIDS.

The research context

The fieldwork for this study involved non-participant observation as well as interviews with two provincial and district Department of Education officials, two ABET Centre managers and four educators in two rural communities in Venda (Region3, Vhembe District of Limpopo Province). In addition, focus

group discussions were held with groups of learners in each ABET Centre on three separate occasions in 2002 and 2003. This study is part of a larger investigation into the strategies used in rural ABET Centres in Limpopo Province to address HIV/AIDS, conducted by Kiggundu (2005).

The two ABET Centres presented in this study are Makahlule in the Malamulele area, and Mbaleni in the Thohoyandou area. Both centres are located in poor, rural communities in Limpopo Province, but Makahlule is much further from Thohoyandou, the commercial and administrative capital of Venda, than Mbaleni. These particular ABET centres were chosen because they were sites of a community development initiative, the 'Ikhwelo Project', run by Project Literacy, an educational NGO, in partnership with the Departments of Education in the Eastern Cape and Limpopo Province. In 2002, when this research commenced, Ikhwelo Centres were almost the only public ABET Centres still operating in Limpopo Province following a period of harsh cutbacks. Limpopo Province was chosen over the Eastern Cape for this study because Kiggundu, had lived and worked there for several years, and was familiar with the people, languages and geography of Venda.

The Ikhwelo Project (*khwelo*, is taken from the Xhosa word for a call or summons) was conceived as a three year pilot project in which the traditional curriculum offered in ABET Centres would be supplemented by two elective 'learning areas': Applied Agriculture and Agricultural Technology (AAAT), and Small, Medium and Micro-Enterprise (SMME). The goal was to provide adults with skills to improve their livelihoods while earning nationally recognised qualifications in ABET. Of the original 28 sites in the Eastern Cape and 36 sites in Limpopo Province in 1999, only 12 and 13 respectively were still operating in 2002. The project was officially closed in 2003. Surplus project funds were used to build storage and administrative buildings at the sites of participating ABET centres.

We turn now to a brief account of the two ABET Centres selected for study.

Makahlule Adult Learning Centre

Makahlule Centre is located in the Malamulele district, close to the Punda Maria Gate of the Kruger National Park and 80 kilometres from Thohoyandou, at the end of a long, dusty gravel road. The Primary School which houses the ABET Centre is built of brick and fenced with inexpensive wire fencing. There is no electricity or running water, and, on the day of Kiggundu's first visit to the Centre in 2002, there was no one to be found at all. After some time, the Centre Manager was discovered in a distant field with more than 35 learners who were de-bushing and fencing land for a vegetable garden, and digging an irrigation trench from Makuleke Dam to the ABET Centre.

Although Kiggundu counted at least 35 learners in the field, the district office's records showed that 121 learners were registered in the Centre across the four ABET levels⁴ (see Table One, below). The Centre Manager claimed that 89 learners attended classes regularly. The discrepancy was explained by the Centre Manager thus: learners always dropped out during the course of the year but came back at examination time. Learners sometimes went to pick cotton at an irrigation scheme near Makuleke Dam. Others were employed as cleaners in Bed and Breakfast establishments bordering the Kruger National Park. Most learners were unemployed and this was attributed to their poor educational background rather than to a lack of job opportunities. Some women survived on child support grants, others depended on income-generating activities established by the Ikhwelo Project at the ABET Centre.

Table One: Learner registrations at Makahlule Centre, according to District Office records

ABET level	Male	Female	Total
One	2	30	32
Two	1	31	32
Three	0	42	42
Four	0	15	15
Total	3	118	121

As the table shows, the number of male learners registered at the Centre was minuscule. The Centre Manager explained that men “don’t have time to attend literacy classes because they have to provide for their families”.

Six educators were employed at the Centre, four women and two men. Four of the educators held a Primary Teaching Certificate (PTC)⁵, while two held pre-

⁴ In the National Qualifications Framework, ABET Level 1 is equivalent to 3-4 years of formal schooling; ABET Level 2 is equivalent to 5-6 years of schooling; ABET Level 3 equals 7-8 years of schooling (the completion of primary school); and ABET Level 4 represents at least 9 years of schooling (the General Education and Training Certificate).

⁵ In the Apartheid era, the PTC was a two-year qualification open to candidates who had completed a Junior Certificate (Grade 10 in the present education system). Teachers who held a PTC were eligible to teach in schools established by the Department of Education and Training schools for blacks. In 2000 the government published new Norms and Standards for Educators which require a four year, post-matric (Grade 12) qualification.

school certificates. All claimed that they had attended workshops provided by the Department of Education in which they were trained in methods of teaching adults. They taught Tsonga, English and Mathematics at ABET Levels One and Two. Life Orientation, Social Science and Natural Science were added to the curriculum at ABET Levels Three and Four. Agriculture and SMME were offered as elective subjects.

The learners told Kiggundu that as a consequence of the Ikhwelo Project they were running a successful fruit juice business.⁶ They bought concentrated juice which they diluted and bottled for sale to local schools and the community. They also made jam and operated a sewing project. They made sofa covers, cushions and curtains which they sold locally. However, they had only one sewing machine. They had learned how to draw up business plans, and knew how to run a small business. They believed they were equipped with skills which could make them employable. With respect to their ABET classes, learners complained that the time set aside for them was too short. The Centre was open only on three afternoons a week for a few hours when the primary school was closed. It was difficult for learners to participate in the Centre's income-generating activities, attend classes and look after their families in the limited time set aside for ABET.

ABET practitioners also indicated that they could not achieve as much as they and learners desired, but they gave other reasons for this. They complained that they were not paid regularly, and that they did not receive learning and support materials from the Department of Education (or, if materials were received, they came late and there were not enough of them for all the learners). The Centre Manager conceded these problems, adding that there was a general shortage of resources, including funds for furniture and facilities, and suitably qualified staff. All of this, he said, impacted negatively on service delivery. With respect to the Ikhwelo Project, he said he had not received the pump for the irrigation system, and the pipes which had been delivered were the wrong size. Learners had cleared the land and dug the irrigation trenches, but they could not plant crops because there was no water.⁷

Before arriving at Makahlule, the District Coordinator had told Kiggundu about the resources in the district for HIV/AIDS awareness, testing and care.

⁶ This success could not be confirmed, as financial records were not available. Learners may have claimed success thinking that Kiggundu was engaged in an evaluation of the Ikhwelo project which would determine future funding.

⁷ Sadly, even when the pump and pipes were delivered and installed, the water would not run. The hand dug irrigation trench had too many twists and turns which silted up the pipe. A new trench had to be dug, this time using a machine.

There were health centres “in every second village” where pregnant women could get medical advice and support. At Malamulele Hospital, he said, social workers were “doing a great job” of counselling and supporting people with HIV/AIDS. He added that the Department of Education employed nurses to train unemployed teachers about HIV/AIDS. Condoms and pamphlets were readily available in local clinics and the hospital. He singled out for praise the youth of the community who conducted workshops and dramas about AIDS. He concluded that services were quite adequate and accessible to local people.

When asked what the ABET Centres were doing to address HIV/AIDS, the District Coordinator said that HIV/AIDS was not dealt with by practitioners at ABET centres. It was not the practitioners’ field of specialisation and they lacked the knowledge and resources to deal with it. This was later confirmed by the Regional Coordinator who said “We presently have so much on our plate. We have left those HIV/AIDS to the Department of Health and Welfare”. The educators themselves insisted that they were fully occupied with activities such as sewing, making juice and jam, and de-bushing and fencing land, so they didn’t have time for anything else. They were short-staffed; they had not received any training on HIV/AIDS and were afraid to expose their ignorance; it was difficult to teach elderly people; it was insulting for a young person to discuss sex-related issues with someone old enough to be her mother. Moreover, Makahlule was a small community and most people were related to one another. What would their relatives think if they heard that learners and educators were talking about “that thing”?

The District Coordinator and the educators agreed that learners were “shy” and did not talk about HIV/AIDS, even among themselves, because it was frightening and horrible. However, when Kiggundu spoke to learners, she discovered the contrary. They were keen to learn about HIV/AIDS, and begged her to describe the symptoms of AIDS, and how to manage it. When she asked whether they knew anything about the disease, learners said that they had heard about it, but remained unconvinced, since they had never “seen” anyone suffering from it. They said they were unsure of its causes and how to prevent it. On further questioning, learners indicated that people with HIV/AIDS should be kept in isolation to prevent the spread of the disease. They thought that HIV/AIDS could be transmitted by hugging and kissing someone with AIDS, or by sharing a toilet with an infected person.

It was already late in the evening after a long day working in the field. Some of the learners had eaten nothing the whole day. Others announced that they had to leave to prepare dinner for their children, yet they begged Kiggundu to stay for another forty minutes to talk to them about HIV/AIDS. On the question of what caused AIDS, learners were inclined to believe that AIDS was caused by witchcraft. Indeed, many black South Africans, especially those

from rural areas, believe that supernatural forces play a role in causing ill health, with illness resulting from an enemy bewitching the victim, particularly an acquaintance or relative who might be jealous of some good fortune the victim had experienced (Stadler, 2002; Thornton, 2002). However, when asked for their views on whether traditional healers (sangomas) could cure HIV/AIDS, the learners answered in unison “No”.

Learners agreed that it was possible that people in their community were dying of AIDS, but the shame and fear surrounding the disease prevented disclosure, during and even after illness and death. Webb (1997) noted that in rural communities of KwaZulu Natal, where high levels of stigmatisation were apparent, seventy percent of survey respondents wanted to see people with AIDS either killed or isolated. Responses included: “They must get what they deserve”; “Shoot them”; “Give them fatal injection for AIDS”; “Kill the person because he might transmit the disease to other people”; “Shoot them, there is no cure, you can do nothing for them” (Webb, 1997, p. 168). Learners at Makahlule were not as aggressive as those interviewed in Webb’s study, but they also believed that people with AIDS should be isolated from others in the community. As one learner remarked, if you approached an acquaintance with questions about his illness, he might demand “Who told you that I have AIDS? Are you a witch? I will sue you for spreading rumours about me. Drop these untrue allegations or else. ...” .

What sort of networks and partnerships were there to provide awareness and information about HIV/AIDS? The District Coordinator indicated that people from Soul City came “once in a while” and spoke to learners, but these meetings were attended only by women. Men allegedly did not have time for such meetings, and did not regard them as important. Local chiefs occasionally asked nurses to come and give people information about HIV/AIDS during community gatherings known as ‘Vandla’ or ‘Xivijo’ in Tsonga, but HIV/AIDS was not considered a priority issue, and very little time was allocated to it.⁸ AIDS was usually left off the agenda entirely.

A clinic only 100 metres from the ABET Centre had been vandalised by members of the community who suspected that funds earmarked for medicines had been misappropriated by staff. The clinic was not rebuilt in the period of this research, and it was evident that people had lost confidence in the local health service.

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In another ABET Centre which Kiggundu visited, the tribal chief said that he never included HIV/AIDS in the agenda of community meetings which he chaired because he didn’t have time for such “petty things”.

HIV/AIDS affects both men and women (Walker *et al*, 2004), but respondents in Makahlule observed that women were the more vulnerable. The District Coordinator pointed out that poverty and unemployment drove some women to prostitution, which placed them at risk of acquiring HIV. The learners themselves indicated that women's subordination to men made them vulnerable. They were susceptible to infection from their husbands, who had multiple partners, and they were also vulnerable to rape. Women learners implied that there had been an increase in the incidence of rape in their communities, especially of young girls. They attributed this to a belief held by some men that sex with a virgin would cleanse a man of infection.

Asked to indicate how HIV/AIDS affected women in the community, the District Coordinator replied that apart from dealing with the death of peers, women also carried out ritual cleansing of the bodies of family members who had died. Women were responsible for nursing the sick in their families. They also faced the economic burdens of health care, funeral costs and loss of income when the breadwinner became ill. It was women who took on the responsibility for caring for the children of dead relatives, a factor which could increase their desperation, as they did not have the resources to care for additional children. However, neither the District Coordinator, the educators nor learners themselves noted that women were at risk of transmitting HIV to their unborn infants, and that pregnancy, delivery and lactation generated special health care needs for women.

Learners emphasized their limited power to negotiate strategies to reduce their risk of infection. As one woman said, "We do not have control over our bodies. We cannot say 'no' to our husbands. It is a sign of disrespect... Our men do not want to use condoms, yet they sleep with prostitutes in towns.... We can be faithful but we are not certain about our men".⁹ This is in line with Jewkes, Levin and Penn-Kekana (2003) who suggest that between couples, condom use may be seen as tantamount to implying or admitting infidelity, as condoms are associated with prostitution, promiscuity and disease, and are an implicit challenge to the male 'right' to have many partners.

In summary, at this deep rural ABET Centre, the District Coordinator, Centre Manager and practitioners expressed the view that HIV/AIDS was not a serious issue in their community. The Centre did not address HIV/AIDS, either in the ABET curriculum or outside it. Women learners at this Centre

⁹ Walker et al (2004, p. 70) point out that women in rural areas are not simply victims of male promiscuity. In the absence of their partners, they have sexual relations with other men (often in exchange for money or other forms of support) . In Northern KwaZulu-Natal, infection rates of women were higher than those of returning migrants.

lacked sound knowledge regarding HIV/AIDS and did not know (or were uncertain about) how to relate to or care for people with AIDS. Learners expressed a keen interest in learning more about HIV/AIDS, but practitioners lacked incentives and resources to integrate HIV/AIDS into the ABET curriculum. Makahlule Centre is far from Thohoyandou and is poorly resourced. Existing health services and networks for HIV/AIDS are not being used because the community lacks trust in them. Lack of information about HIV/AIDS, denial and stigma, as well as poverty, pose challenges to the development of strategies to address the challenges of HIV/AIDS. These challenges are explored further in the next case study.

Mbaleni ABET Centre

Mbaleni ABET Centre is situated in a peri-urban area, Makwarela, on the outskirts of Thohoyandou. Bus and taxi routes link Makwarela to Thohoyandou, and to the district and regional hospitals, which are within a twenty kilometre radius. Makwarela Clinic, which offers voluntary counselling and testing services, is within walking distance of the Centre. There was running water and electricity at Mbaleni, and, when Kiggundi made her first visit to the Centre in September 2002, new classrooms were under construction. Two educators and the Centre Manager were helping adult learners read and interpret an examination paper. Four other educators were sitting in chairs outdoors, basking in the late afternoon sun.

Once again, the learners at this Centre were predominantly women, but they were somewhat younger than those at Makahlule Centre. As before, men reportedly believed that it was “a waste of time” to study when they had jobs to do and families to support. The Centre Manager estimated that 40% of learners were unemployed. Those who had jobs worked as domestic workers and cleaners, or sold fruit and vegetables in the Thohoyandou open air market.

The Ikhwelo Project had introduced sewing, beadwork and sisal weaving at the Centre, and encouraged learners to sell their goods to tourists from roadside stalls. The women specialised in making ‘Miwenda’ (traditional dresses worn by the Venda) as well as dolls, cushions, curtains, tablecloths, bags and toilet sets. They offered cleaning services to their neighbours: carpets, sofas, new houses and yards were cleaned, especially after funerals. Plans were underway to open a car wash, but there were no facilities for this at Makwarela Primary School.

In the following year, 2003, the ABET Centre took over the premises of Makwarela Community Creche where they had storage space for their study materials, tools and produce, as well as land and borehole water to establish a

vegetable garden. The Centre was open from morning to night, and there were plans to acquire prefabricated units for use as classrooms and for sale to local residents to use as housing. The Centre Manager expressed the hope that such income-generating projects would reduce the rate of absenteeism and dropout.

As was the case at Makahlule Centre, Kiggundu found fewer learners on site than were officially recorded at the District Office. Once again she was told that learners interrupted their studies to take up short-term employment or to attend to family affairs.

Table Two: Learner registrations at Mbaleni Centre

ABET level	Male	Female	Total
One	0	20	20
Two	1	20	21
Three	0	20	20
Four	1	52	53
Total	2	112	114

Eight educators were employed at Mbaleni Centre, all of them female. They all held teaching diplomas, and most of them had completed an ABET certificate at the University of South Africa or the University of Venda. The District Coordinator commented favourably on the educators' commitment to ABET and to the Ikhwelo project, despite the lack of departmental support.

The curriculum offered at Mbaleni was identical to that in Makahlule, except that Venda was taught as the Language of Learning and Communication at ABET levels 1 and 2 rather than Tsonga.

The Centre Manager avoided answering any questions related to HIV/AIDS, referring Kiggundu instead to the educator responsible for teaching Life Orientation (LO). This confident and dynamic young woman acknowledged that HIV/AIDS was a serious problem in the community, and said that learners were aware of it. They had heard about AIDS from the radio and television, from the local clinic and from her. She herself was a member of the Makwarela branch of the ANC Women's League, and she had persuaded some of her learners to do voluntary work at the local hospitals and clinics. It was while they made beds and washed patients that they came to realise that AIDS really existed, and was not something which happened to other people, in other places. The learners returned to class from voluntary service with "shocking stories" to tell their colleagues.

The LO educator had not received any formal training in HIV/AIDS, but had attended several workshops at Tshilidini Training College, the University of Venda and the Technical College of Venda. She had heard about these workshops from her fiancé who worked as a peer educator with the South African Police Service in Thohoyandou. Her interest in HIV/AIDS had also led her to advise learners to take part in a forum organised by the Civic Association, where people with AIDS had been invited to address the community. This level of extra-curricular engagement with HIV/AIDS was not found in Makahlule ABET Centre, where educators avoided the topic altogether.

The educator reported that she discussed HIV/AIDS related issues at length with learners in her LO class. Learners talked openly about AIDS, asking questions about the causes, symptoms and ways to protect themselves from the virus. According to the educator, most learners were single mothers, and those who were married had husbands who worked away from home. These husbands exposed their wives to HIV/AIDS because “they probably had several sexual partners” as they lived far from their families for most of the year. As at Makahlule Centre, women cast themselves as helpless to prevent the spread of AIDS, pleading “How can I convince my husband to use a condom? He is a womaniser but I cannot leave him. ... I do not have a job and I have children. How will I survive?”. Women’s dependency on men, their subordination in patriarchal society, and their vulnerability to infection were stressed by the learners and the LO educator. Men reportedly took the decisions regarding sex practices, and likened using condoms to “eating a sweet with the plastic wrapper on”. They also disparaged the condoms distributed free of charge by the Department of Health, claiming that they would break easily due to exposure to the sun at the distribution points.

The LO educator said that it was not easy to mobilise and support people with AIDS in the wider community because few would admit to being HIV positive. She narrated an incident where she had approached a woman who had recently lost a husband and two-year-old daughter. She encouraged the woman to participate in voluntary counselling and testing for HIV/AIDS, but the woman refused, insisting that a malicious neighbour had bewitched her husband and daughter.

Although the District Coordinator said that there were no reports of people with HIV/AIDS in the district, most learners at Mbaleni Adult Centre knew that HIV/AIDS had penetrated their community. They thought that many people had died of HIV/AIDS, but their relatives generally attributed AIDS deaths to other causes, for example “She died from drinking too much”, or “He died of tuberculosis”. They were against the idea of isolating people with AIDS because they knew that one could not be infected by hugging, kissing,

from the toilet seat, or from sharing food or cutlery with an infected person. They were aware that an infected mother could pass on the virus to an unborn child.

While learners acknowledged the presence of the disease in their community, they conceded that people with AIDS rarely spoke freely about their illness, for fear of being stigmatised. Learners believed that if people with AIDS had access to treatment and support from health services, and groups such as the ANC Women's League, they would be more likely to disclose their status, and receive support. This was in contrast to the view of learners at Makahlule who believed that resources were either unavailable or withheld from them.

The LO educator proposed that a premium should be placed on encouraging people to go for HIV/AIDS tests and counselling. She also expressed the view that the nurses at the nearby Makwarela Clinic were "cruel". They discouraged people from coming for tests because they did not maintain privacy and confidentiality. This mirrors the findings of other researchers in South Africa (Walker et al, 2004) who found that although HIV/AIDS tests are widely available, counselling is rare, and people do not trust health workers to maintain confidentiality.

When asked about the challenges faced by people in the community with respect to HIV/AIDS, the District Coordinator said that the main challenge was people's lack of knowledge. This included learners and educators. A further problem, according to the District Coordinator, was that ABET practitioners did not network with other organisations and individuals. The LO educator at Mbaleni Centre had a different view of the matter. According to her, "people [learners] are aware of HIV/AIDS, they know it kills, yet there is no behavioural change and husbands are resistant to use condoms".

The LO educator had quite a range of contacts through her fiancé in the South African Police Services, her informal studies, her participation in the ANC Women's League and connections with the Civic Association. She drew on her contacts to develop HIV/AIDS awareness among learners at the Centre, and she had further ideas in mind. She suggested, for example, that a forum for couples should be started, since women found it difficult to implement what they had learned about HIV/AIDS without the support of men. She pointed out that poverty and unemployment remained significant challenges in the community, and that young, unemployed women were driven to sell sexual services. She suggested that the Department of Education should organise "a thorough training programme" on HIV/AIDS which would run for more than a week, for both educators and learners. This would ensure that not only the LO educator took responsibility for HIV/AIDS education. She pointed out that Department of Education officials who already "had the knowledge" were the

ones who got the chances to go for training. When they returned to their jobs they were too busy to disseminate the information.

The LO educator used the syllabus for Life Orientation designed for the day school. She was quick to point out that a book meant for primary school learners would not be suitable for adult learners. She adapted and supplemented the syllabus with clippings from newspapers and magazines which she photocopied at her own expense. She had a Project Literacy book, *Positive People, Managing HIV in the Workplace*, which she found useful. She also used Soul City materials (charts, pamphlets and magazines) which were given to the Centre by Project Literacy when the Ikhwelo Project was introduced.¹⁰ She kept them at her home and carried them to the Centre every day, as there were no storage facilities there. There were not enough books for all the learners, so she had to collect them after each class.¹¹ She attempted to integrate HIV/AIDS into learning areas other than LO. For example, she used extracts from the AIDS materials for English comprehension as well as for life orientation. She devised role plays to stimulate dialogue on how women could negotiate condom use with their partners.

When learners were asked what they thought the ABET centre should do to address HIV/AIDS in their community, they responded by saying that other educators at the Centre should join in the campaign launched by the LO educator, and teach women more about how to protect themselves. They suggested that the Centre model itself on the ANC Women's League, which held workshops for women in which they were taught to network, "build each other", stand up to domestic violence, speak out against child abuse and create jobs by forming income generating projects. The League provided start-up capital and training for these projects, and supplied free "books" (pamphlets) and soap. On Women's Day, celebrated nationally on 10 August, women sang and performed HIV/AIDS related songs and dramas on stage. Door to door visits afterwards cemented the messages and swelled the members of the League. Learners felt that they would benefit if more practitioners at the ABET Centre networked with the League, and if educators, too, raised funds to develop income generating projects.

In summary, then, the learners at Mbaleni Centre were aware of HIV/AIDS in their community and believed it was a serious problem which should be

¹⁰ At other Centres which Kiggundu visited, these resources, distributed to Ikhwelo Centres by Project Literacy staff, were kept in store rooms or locked cupboards, and were never used.

¹¹ By the time of Kiggundu's third visit to the Centre, in late 2003, each learner had been given a copy of *Managing your Life, Life Orientation ABET Level 4*. There were still no learning support materials available in indigenous languages, or in English, at ABET levels 1-3.

tackled by ABET practitioners. They had heard about AIDS through the media and from the educator responsible for Life Orientation. Information which they picked up from the media and the classroom was supplemented and confirmed by those who volunteered to provide patient care at local clinics and hospitals under the auspices of the ANC Women's League. Generally, the Centre Manager and ABET practitioners did not concern themselves with HIV/AIDS. They felt it was the responsibility of the LO educator. She used all the resources at her disposal to bring HIV/AIDS into the ABET curriculum. Although she had no formal training, she was keen and had attended several workshops on HIV/AIDS. She had ambitious plans to establish a support group and training in home based care. She believed the biggest obstacle to HIV/AIDS education arose from the stigma attached to people who disclosed HIV-positive status. Little behavioural change had resulted from HIV/AIDS education because of men's perceived persistent promiscuity and resistance to condom use. Women were believed to be especially vulnerable to HIV/AIDS because of their poverty and dependency on men. Solutions suggested by learners and the LO educator were to establish income-generating projects and support groups for women and men so that the weight of poverty, unemployment and exploitation could be countered.

Analysis

The table on the following page summarises the distinctive features of Makhahlule and Mbaleni ABET Centres. The similarities between the Centres rest in the size and gender of their student body, the spread of learners across the four levels of the ABET curriculum, the organisation and content of the ABET curriculum, the lack of Departmental supervision of the Centres and lack of support for practitioners and learners. The learners at both Centres were mostly married women, mothers and grandmothers, whose partners are migrant workers. The women were scarcely educated in youth, and they were unemployed or self-employed, with low and irregular incomes. Men were absent from the home and regarded learning at the ABET Centre as a women's pastime. Women were aware of their vulnerability to HIV/AIDS and blamed men for spreading the disease. Secrecy and stigma surrounded HIV/AIDS in the wider community, discouraging people from going to local health services for testing and counselling.

Table three: Features of Makahlule and Mbaleni Adult Learning Centres

	Makahlule ABET Centre	Mbaleni ABET Centre
Geographical location	In Malamulele district, more than 80 km from Thohoyandou, on a gravel road.	In Makwarela district, 5 km from Thohoyandou, on a tarred road busy with bus and taxi traffic.
Structural/contextual issues	Unemployment, poverty, migrant labour, gender inequality.	Unemployment, poverty, migrant labour, gender inequality.
Learners	118 women, 3 men. Most learners registered in ABET Levels 1-3. Only fifteen learners in ABET level 4. Learners older than at Mbaleni.	112 women, 2 men. 20+ learners registered in each class in ABET Levels 1-3. 53 learners registered in ABET Level 4. Learners younger than at Makahlule.
Educators	6 educators (4 with PTC, 2 with a pre-school certificate).	8 educators (all with PTC and most with an ABET certificate from UNISA or Venda.)
ABET Centre	Makahlule Primary School, solid brick structure, well maintained. No electricity or running water.	Makwarela Primary School, then Makwarela Community Creche where electricity, borehole water, and storage space were available.
HIV/AIDS in the Curriculum	Not addressed at all.	Addressed in LO and English literacy classes by one educator using resources in English provided by Project Literacy and supplemented with photocopied newspaper clippings.
Income generating activities	Fruit juice business, jam production, sewing.	Sewing, beadwork, sisal weaving, cleaning services. Plans to open a car wash and sell prefabricated housing units.
Health services	Nearby clinic vandalised in community action.	Local clinic within walking distance. Two district hospitals within 20 km radius.

Levels of trust	Denial of AIDS and stigma towards people with AIDS expressed by learners and educators. AIDS perceived to be a consequence of witchcraft initiated by jealous neighbours rather than as a sexually transmitted disease. Little faith in 'delivery' of resources by DOE or Prolit. No trust in health services.	Wide acceptance among learners of the existence of AIDS in the community. Information shared among the ABET learner group and LO educator. Confidence expressed in LO educator. Men blamed for the spread of HIV/AIDS. Stigma and blame in the wider community acknowledged as factors which discourage disclosure, testing, treatment and care.
Sources of information about AIDS	Hearsay, radio.	Radio, television, newspapers, witnessing AIDS in local clinics and hospitals, Soul City and Project Literacy resources used by LO educator.
Networks and partnerships	Ikhwelo Project	Ikhwelo Project; ANC Women's League. LO educator was a participant in wider network of information, education and support offered by the SAPS, local Civic Association, UNISA and University of Venda.

Differences between the Centres lie in their distance from sources of information and organs of civil society. Learners and educators at Makahlule Centre, 80 km from Thohoyandou, had relatively little access to the media and to organisations which are active in HIV/AIDS and community development. Department of Education officials (as well as Ikhwelo Project staff, local nurses and others) doubtless visited the Centre less frequently than they did Mbaleni Centre, which is located on the outskirts of Thohoyandou, and is infinitely better served by public transport. Learners at Mbaleni Centre were slightly younger women, and more of them were registered at ABET Level Four, than were learners at Makahlule Centre. The ratio of learners to educators at Mbaleni Centre was more favourable than that at Makahlule Centre, and the educators were better qualified. Several of the Mbaleni educators had completed an ABET Certificate which included a component on HIV/AIDS. This may have given them more knowledge and confidence to address AIDS in the classroom. Above all, the LO educator at Mbaleni Centre was involved in a variety of social networks (educational, professional, political) which directly or indirectly addressed AIDS. These networks helped to situate AIDS as a social issue (and not merely a health issue, or an ABET

learning area) alongside poverty, unemployment, migrancy, gender inequalities, alcoholism, violence and domestic abuse- problems which are interrelated and more effectively addressed at community and societal level, by a variety of agencies, rather than at individual level.

Discussion

The relative success of Mbaleni ABET Centre in facilitating awareness of HIV/AIDS could be seen as a product of social capital developed by the LO educator which brought adult learners together in networks despite widespread community denial, disapproval and discrimination against people with AIDS. The social networks provide information to group members which facilitate a collective goal. Without these social networks, the possibility of exchanging information is extremely limited, as seen at Makahlule Centre.

The quantity of information available to the learners at the two ABET centres was quite different. Learners at Mbaleni Centre had access to a wider range of sources of information, including the media, their LO and English literacy classes, and their own experiential learning at local clinics, when compared with learners at Makahlule Centre. The quantity and quality of information contributed to increased bonding capital (among learners) and bridging capital (between learners and other agencies) in Mbaleni Centre.

Coleman (1990) has argued that the quality of the information exchanged depends on the functionality of the relationships in which people are engaged. How is this functionality reflected these two ABET Centres? In both Centres, learners did not trust the confidentiality of testing and counselling services provided by local clinics. Women did not have confidence that men would act responsibly and competently when it came to sexual relations with other women and condom use. District officials and Centre Managers did not express confidence in the capacity of young educators, especially, to teach older adults about HIV/AIDS. It appears, then, that many of the relationships in which ABET practitioners and learners are engaged are dysfunctional, at least in terms of their ability to contribute positively to HIV/AIDS education. However, learners at Mbaleni Centre expressed a high level of social trust in the ANC Women's League, and it appeared that women who engaged in voluntary activities organised by the League, and in meetings organised by the Civic Association, were more likely to exchange information with others, to act in concert with them, and to suggest initiatives to develop and support the community. Learners at Mbaleni Centre also expressed more confidence in their educators than those at Makahlule Centre, so there were some functional relationships which contributed to the exchange of information, and to learners' sense that it was possible to take charge of some aspects of one's life.

The case studies show that social capital is not always a positive resource. For example, in both ABET Centres, the norm was for 'respectable' women not to talk about sex, sexual relations, or sexually transmitted diseases with older and younger people. It is also a norm for women to respect, and acquiesce to men's decisions regarding sex, including the use of condoms. According to Coleman (1985) norms develop to permit group members some control over the actions of others when those actions have consequences for the group. In this instance, norms uphold the dominance of men in decision-making around sex, and prevent women from exercising control over their sexual health.

Conclusion

Clearly, ABET Centres and the practitioners who work in them are faced with enormous challenges when it comes to dealing with HIV/AIDS in their communities. The Department of Education has added to these challenges by issuing a directive which requires all educational institutions, including ABET Centres, to incorporate HIV/AIDS in the curriculum, without providing guidelines or resources to enable this to happen. Policies can only be implemented on the ground if the capacity and will to do so exist. Capacity includes material, financial, managerial, and bureaucratic resources. Will is greatly increased if positive social norms and expectations are created and sustained through social relationships and networks. The implications of this are that the government should support HIV/AIDS education, and local responsibility for it, by devising enabling policy, providing expertise, infrastructure and finance. Developing the social capital of ABET officials, educators and learners is a significant concomitant to such capacity building.

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