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HIV/AIDS AND TRAUMA AMONG LEARNERS: SEXUAL VIOLENCE AND DEPRIVATION IN SOUTH AFRICA

Outcomes: This chapter will help educators and educators in training to understand

(1) the extent to which South African learners -- and educators -- are infected *and* affected by HIV/AIDS

(2) the culture of sexual violence, abuse and fear, linked to HIV/AIDS, which complicates the lives of female learners and many young children

(3) the culture of deprivation and loss in which AIDS orphans and other vulnerable children live and learn, and

(4) how to mitigate the potentially disastrous long-term consequences of the HIV/AIDS pandemic for learners in difficulty.

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1. THE IMPACT OF HIV/AIDS ON SOUTH AFRICA

South Africa has the fastest-growing HIV/AIDS epidemic in the world: about 10% of those infected world-wide live in South Africa. In May 2001, at least 4.7 million south Africans were reported to be HIV positive, 56% of them women (Centre for the Study of AIDS, University of Pretoria). Infection rates varied by province: 8.7% in Western Cape, 29.3% in Gauteng, and 36.2% in Kwa-Zulu Natal. By 2005 at least six million South Africans are expected to be HIV positive and 2.5 million will have died of AIDS or a related illness. Mortality rates will double by 2010, and life expectancy will drop from a high of 68 years to less than 40 years.

The HIV/AIDS *virus* has been with us in southern Africa since the late 1970s, and our response to it has been biomedical. Our understanding of the universality of the HIV/AIDS *pandemic* on the other hand is more recent: we are only starting to define the complex character and ferocity of this social, economic and cultural disaster. While millions of South Africans are *infected* by the virus, all of us are *affected* by the pandemic as productivity declines, public services cost more, family structures threaten to collapse, child mortality increases and poverty deepens. HIV/AIDS brings reduced opportunities, decreased nurturing support and socialisation and therefore increased petty or violent crime, along with increased morbidity and mortality, and these will mark our society for at least the next century (Coombe & Kelly, 2001).

2. THE CONSEQUENCES OF HIV/AIDS FOR EDUCATION

The HIV/AIDS projection model commonly used in South Africa[1] suggests that from 2000, 4-5% of 15-19 year olds will be newly infected each year, and a further 5% of those who are 20-24 years old. The number orphans, children under 15 who have lost one or both parents, will climb steadily throughout the coming decade, reaching a peak of 2.5 million in South Africa by 2012.

[1] The HIV/AIDS epidemic has progressed more or less in line with model projections during the 1990s. These projections are based on the most recent statistics, using the Metropolitan-Doyle model. The model is continually reviewed in the light of new demographic and population statistics, as well as interventions which may influence the course of the epidemic and result in changing incidence of infection, morbidity and mortality. Such interventions include behavioural changes (increased condom usage, reduced numbers of partners, etc) and medical interventions (improved treatment of STDs, vaccinations, treatment/cure of HIV positive and AIDS sick individuals). Information from Abt Associates South Africa Inc.

Between 20-25% of 10-14 year-olds are expected to be orphaned by 2010, although the proportion will vary from province to province, and from school to school.

Unicef reports that 860,000 children in sub-Saharan Africa lost teachers to AIDS in 1999 with South Africa topping the list with 100,000 teacherless children. Infection levels among South African educators may be as high as 30% by 2010, with local variations in prevalence.

What we can anticipate about the likely impact of HIV/AIDS-related illness and mortality on education in South Africa?

- Fewer children will enrol in school because HIV-positive mothers die young, with fewer progeny; children die of HIV/AIDS complications; and children who are ill, impoverished, orphaned, or carers for younger children, or those who are earners or producers, do not go to school or college. For the same reasons, affected learners will drop out, and retention, transition and completion rates will fall.
- Qualified teachers and officials will be lost to education. Educators are thought to be particularly vulnerable to infection because of their comparatively high incomes, sometimes remote postings, and geographic and social mobility. Other educators will leave the service for better jobs in the private sector which is also losing qualified staff through HIV/AIDS. The capacity of teachers' colleges to keep up with educator attrition will be undermined by their own staff losses. (There are likely anyway to be fewer tertiary students as secondary school output and quality goes down, and as higher education itself declines due to staff attrition.)
- Financial constraints will make it more difficult for provincial education departments to provide formal education of adequate scope and quality. Sick and death benefit costs are already rising, along with additional costs for teacher training. Provinces will come under increasing pressure to switch resources away from education to other social sectors like health and welfare. Contributions from parents and communities to education can be expected to decline, and HIV-affected households may no longer be willing or able to keep children in education, shifting more of the cost back to government.

- What is ultimately incalculable is the trauma which overwhelms individuals and communities. At the very least, in pragmatic rather than humanitarian terms, school performance will inevitably decline where 20-30% of all teachers, officials and learners are ill, and others lack morale and are unable to concentrate on learning and professional matters because their lives too are touched by HIV and AIDS.

It is essential that we begin to comprehend the trauma that teachers and other educators must now confront, the traumas associated with HIV/AIDS that stalk every classroom and every lecture theatre in South Africa. Two conditions in particular, both associated with HIV/AIDS, scar the lives of South Africa's learners: the culture of fear associated with non-negotiable and often violent sex; and the culture of deprivation associated with orphanhood.

3. TRAUMA IN THE CLASSROOM

> *The dominant response [to HIV/AIDS] has been to try and understand the disease within conventional frames of understanding…. AIDS is viewed as a reflection of the status quo, with the epidemic fuelled by poverty, migration, discrimination, powerlessness, and the like. All these factors apply. But they do not complete the circle of understanding we seek. AIDS is also a disease lodged in the behavioural patterns and value systems that become adapted to the presence of the disease* (Marais, 2000: 11)

Why has HIV/AIDS spread so rapidly in southern Africa? Are we confronting a virus which is inherently more virulent than that found elsewhere? The answer is no. HIV/AIDS viral strains in Africa appear to be no more infectious than those found in other regions. What we in southern Africa are confronting is a viral disease transformed into a pandemic driven by social, cultural and political conditions (Gray et al, 2001).

HIV/AIDS is not alone the cause and effect of our troubles. Many of them started long before the virus arrived: the first South African report on the UN Convention on the Rights of the Child (May 1999) described South Africa as a 'racially divided, traumatised, dehumanised and child welfare negligent society' (Smart, 1999). Our attempts to understand what drives HIV/AIDS

force us to shine a torch on long-standing latent social dislocations: inherited and imported cultural norms and standards antithetical to female security; the behavioural sink of inner city poverty and the distress of rural destitution; and the breakdown of family and community values during the apartheid years. These three factors, combined with new kinds of violence and abuse driven by HIV/AIDS, lie at the heart of the pandemic in South Africa.

It is essential for all educators, particularly teacher educators and those training to be teachers or education managers, to understand the fertile ground where HIV/AIDS thrives, which sustains the growing pandemic, and on which trauma flourishes. Teachers are the first line of defence, after medical professionals, in the fight against AIDS. Their task is to teach our children and young people -- starting with twelve million school children -- about safe sexual behaviour and the values consistent with healthy community life. Beyond that, they are mandated to protect the rights of all learners, to provide them with care and counselling, and to create a safe and secure environment in our learning institutions. Educators are also mandated to help mitigate the impact of HIV/AIDS on those they teach and support learners coping with disaster. Education managers, from principals to departmental officials, are responsible for developing and implementing plans to help individual learners and their families, teachers, and the system itself to survive the pandemic's attack (South Africa, Department of Education, 1999, 2000a, 2000b).

3.1 GIRLS AND YOUNG WOMEN: THE CULTURE OF VIOLENCE, ABUSE AND FEAR

The escalating violence against women in South Africa runs in tandem with the spread of HIV/AIDS. Researchers are beginning to suspect that it is not a coincidence that South Africa has among the worst HIV rates and the worst rape statistics on the world, although the causal relationships between these phenomena are not yet evident. Both are independent symptoms of a lack of social cohesion, high rates of social discontent resulting from unemployment, and a highly stratified society (South Africa, National Population Unit, 2000).

The HIV/AIDS pandemic has given impetus to more careful examination of levels of sexual violence worldwide, and South Africa too has come under close scrutiny (Morrell et al, 2001;

CIET Africa, 2000; Human Rights Watch, 2001; see also Leach et al, 2000). Research in South Africa consistently demonstrates a pattern of extensive sexual violence in which children and young people are raped or forced to have sex, young women live in anticipation of harassment, rape or coerced sex, and a miasma of fear permeates sexual relationships between young people.

Adolescent sexuality

The nature of relationships between boys and girls is only one of many elements in South Africa's complex social mix which determine the thrust and spread of HIV/AIDS. But it is one with which all educators must grapple, and one to which the education system must respond.

Many adolescents are sexually active when they are young (some as early as twelve), and boys start earlier than girls. Boys are likely to have more partners, and nearly twice as often have an STD history. Early sexual experience is an esteemed feature of male maturation: sex is considered the most fun you can have (Smart 1999; Morrell et al 2001).

Condom use is commonly low among adolescents because of pressure to engage in early and unprotected intercourse, coercion, pressure to have a child, lack of access to user-friendly health services, negative perceptions about condoms, and low perceptions about personal risk, in addition to lack of privacy and time. Non-penetrative sex is not considered proper sex, and widely believed myths reinforce negative attitudes about safer sex and contraceptive use (Smart, 1999).

While there is an almost universal acknowledgement of the presence of HIV and AIDS, levels of knowledge among young people about ways to avoid infection are low. Some believe there is no way to avoid HIV/AIDS and this is consistent with generally limited knowledge about the aetiology of HIV and AIDS among young people. Nevertheless, decreases in infection rates, pregnancy rates, and STDs among young people suggest safer sex messages may be influencing behaviour.

Adolescents rarely communicate with their parents or other adults about sexual and reproductive health issues, and too many receive conflicting messages about sex and sexuality from various

sources. In fact, most adolescents make decisions about sex in the absence of accurate information, and access to support and services. Young people lack confidence and the skill to negotiate sexual issues, contraception and prevention of infection.

Violence and harassment

Evidence about sexual violence and abuse, bisexuality and same-sex relationships, incest, and intercourse with young children profoundly complicates our understandings of HIV/AIDS as a disease spread by heterosexual consensual sex reflected in our life skills programmes. [2] There are however certain basic understandings which must influence classroom interaction.

Adolescent sexuality is characterised by strongly unequal gender relations, and township masculinity is commonly defined by violence and hostility towards gender equality, particularly in the realm of relationships. Many girls have firsthand experience of rape and sexual assault. Violent and coercive male behaviour, combined with young women's limited understanding of their bodies and of the mechanics of sexual intercourse, directly affects their capacity to protect themselves from unwanted sexual intercourse, from HIV and other STDs, and pregnancy (Smart, 1999: 28; Morrell et al, 2001; Human Rights Watch, 2001).

Communication between partners on sexual issues is often limited or non-existent. Conditions and timing of sex are defined by male partners, giving young women little or no opportunity to discuss or practice safer sex. It is boys who determine when and how sex occurs; girls commonly experience rape, violence and assault, including within relationships.

Some young men seek to justify rape because they perceive young girls have sex with older men for material gain. Adolescent women feel unable to refuse sex or to discuss safe sex with their

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[2] We understand very little about same-sex sexuality in sub-Saharan Africa, and need to know more. See Wanjira Kiama*, Where are Kenya's Homosexuals?* (AIDS Analysis Africa, Feb/Mar 1999, p 9): 'Networks of men who have sex with men can be found across the continent….[There is] a good number of men who are constitutionally homosexual, but socially heterosexual, so as to fit in the society….Men having sex with men is not only common among young people, but fashionable. Just as young men like to wear an earring, they are also opting to try out homosexual practice….The taboos surrounding men who have sex with men have meant that few, if any, attempts have been made to provide AIDS education and support to them.' See also Rex Winsbury, *AIDS in Prisons* in AIDS Analysis Africa, Oct/Nov 1999, p 11: 'The traditional African reluctance to admit or discuss same-sex sexual activity (which of course remains illegal in many African countries) is beginning to break down [as some recent studies have shown]'. See also UNDP, *Botswana Human Development Report: Towards an AIDS-Free Generation*, 2000.

male peers or with older 'sugar daddies' for fear of violence, abandonment or loss of income. Financial or emotional need sustain these relationships.

Misconduct by educators

'*Tolerance of gender-based violence in schools is a serious form of discriminatory treatment that compromises the learning environment and educational opportunities for girls. Girls are disproportionately the victims of physical and sexual abuse at school…. Schools should be safe havens for learning* (Human Rights Watch, 2001).

The South African Medical Research Council reported late in 2000 that one half of all schoolgirls had been forced to have sex against their will -- one third of them by teachers. 'We were shocked by the finding that teachers are the major perpetrators of child rape, but no one experienced in education seems to be surprised.' The Minister of Education reported subsequently to parliament that there were perhaps 6-8 cases involving sexual abuse pending with the South African Council for Educators, and that in most cases the accused were still in the classroom. (Coombe, 2000a).

This suggests that sexual harassment of girls by teachers and other educators is pervasive in our education system. Students report love relationships with teachers, and pregnancies result. Other girls submit to teacher harassment because of fear of discrimination, punishment or failure. Some want the money or other gains (private tuition or leaked examination papers) that might ensue from such a relationship. Hostels are particularly unsafe places for children -- both boys and girls -- as they are reported to be places where teachers can prey at will on the young.

Our society too often condones or overlooks forced sex, at least so long as it does not extend beyond certain legally defined limits (Kelly, 2000b). There is still no rigorous and predictable determination among authorities to deal out discipline where there is misconduct. Many cases are not reported; those that come to the attention of authorities are handled administratively or customarily, by negotiation with parents or elders. Lack of parent-power and a failure of will on the part of school management encourage male teachers to flaunt rules of professional conduct: pay for 'damages' and ask for a transfer. Laws relating to defilement or statutory rape, or

regulations stipulating acceptable levels of professional behaviour are rarely brought into effect in such cases.

The culture of sexual violence, gender inequality, and male prerogative ultimately culminate in a climate of fear. Even in learning institutions, on the sports ground, in hostels, or walking to and from school, girl children and young women cannot be free of fear.

Child abuse

The South African Professional Society on the Abuse of Children (Sapsac) reports (*Pretoria News*, 15 May 2001) that 'one in every three girls, and one in every give boys in south Africa are abused during their childhood'. The *Rapid Appraisal of Children Living with HIV/AIDS in South Africa* (Smart, 1999) highlighted child abuse and its links to HIV/AIDS. A recent study in Gauteng showed that 80% of abused children at one hospital were girls: 7% were under three years old, and 55% under ten. Thirty-eight per cent of perpetrators were biological family members, 66% were family members. Behaviour problems associated with abused children include school problems, unnatural masturbation, 'clingy' behaviour, withdrawal or depression (Smart, 1999: 30). While sexual abuse of children has only relatively recently been identified as a significant problem, figures are rising alarmingly. In KwaZulu-Natal, one hospital treated two sexually abused children in 1989; in 1996, it saw 306 cases.

There are three possible explanations for this increase:

- increased awareness of sexual abuse of children amongst the general public, with a concomitant increase in the number of children presenting for help
- improved services, resulting in numbers of previously undiagnosed cases being accurately assessed at health facilities, and
- the possible relationship between childhood sexual abuse and the HIV/AIDS epidemic.

Three theories link child sexual abuse and HIV/AIDS. The first -- the prevention theory -- is based on the assumption that all sexually active people are likely to be HIV infected and, in order to be 'safe', one must choose a partner who is not yet sexually active. The second -- the cleansing theory -- suggests that having sex with a child will cleanse the infected individual of the virus.

Finally, the retribution theory describes behaviour which deliberately spreads infection to many others.

Anecdotal evidence suggests that disabled children are particularly vulnerable. Those with physical handicaps cannot protect themselves. Some adults believe that deaf children cannot become infected, and such children may therefore be targetted for ‘cleansing’ purposes.

There is much that we do not understand about HIV and sexual behaviour. Whiteside and Sunter (2000) stress that, unfortunately, much of our current understanding of HIV and its links to sexual behaviour is conjectural.

> *It does seem preposterous that we have so little pertinent data about a virus that is such a threat to our society. But then it is related to sex and people do not like talking openly about sex. Taboos and prejudices mar any debate on the matter…. The only way we will get a decent lock on the problem is to have better data. However difficult it is to undertake, we would recommend a proper survey of sexual behaviour in South Africa so that we can identify where the points of leverage are in formulating strategies to stop the spread of AIDS* (Whiteside & Sunter, p 60).

It is time for sociologists, psychologists and others to work with educators to understand the sexual context within which life skills are taught, to collect rigorous data and reliable information, and to apply what is learned to HIV programmes in the education sector.

3.2 ORPHANS AND OTHER VULNERABLE CHILDREN: THE CULTURE OF DEPRIVATION

The numbers of children who have lost one or both parents is increasing dramatically. The trauma of these children -- and of others who suffer deprivation associated with poverty, morbidity and exclusion -- is increasingly evident as the HIV/AIDS pandemic creates a generation of children who are profoundly vulnerable and at risk.

In July 2000, the *Natal Witness* reported that

the Sinosizo home-based care programme helps children aged nine to 14 who are the primary caregivers for parents dying of AIDS and for smaller brothers and sisters. The majority live in households with no incomes, many with parents who have been sent home from hospital -- sometimes comatose -- a day or two before they are expected to die. In the many homes where there are no beds, the children, often malnourished, struggle to lift and turn their parents and to help them to the toilet. Children from some of the 900 families with whom Sinisizo is working told … the [13th International AIDS Conference, Durban, July 2000] about their difficulties. "They say waste disposal is the most difficult thing -- getting rid of soiled dressings and incontinence pads. They also have to find food for their families, cook for and feed their parents and younger siblings. They have to ask for food from the neighbours and it takes hours to get enough for one day. They have to cook on paraffin stoves and open fires while they are carrying smaller children on their backs or hips. They have to fetch water for drinking, cooking, bathing and washing clothes, and a small child can't carry enough." If there is any medication available, the children also dispense that, "but most of the time they can't even get aspirin". So, the children help their parents die; there is no time to mourn, because they must go and seek assistance to arrange a funeral.

Who are these children, and what are their needs? We must ultimately ask what responsibilities we as educators have for alleviating their profound distress.

Physical disadvantage

Loss of parents and family inevitably disrupts a child's normal life. Already more than 30% of African households depend on river water; 16% have no toilet facilities; 40% are headed by women -- and the poverty rate in these households is double the rate in male-headed households. HIV/AIDS compounds the misery. Children who are orphaned are likely to be less well-cared for by a grandmother or other guardian than by their own parents. They may be malnourished, in households stricken by poverty, where too many children are dependent on one adult relative. Poor and damp housing provokes persistent TB, and a lifetime of poor health. Crowded conditions promote abuse and harassment, particularly of young girls. The number of child-

headed households can be expected to increase dramatically in future and these children are thought to be at greatest risk of trauma and lifelong deprivation.

Educational achievement

Children and young people affected by HIV/AIDS are often not able to go to school or continue their education. They may not be able to enrol because they are caring for sick relatives or orphaned siblings, they themselves are sick or undernourished, their labour is needed at home, or there is no money for fees, school funds, books and uniforms (or soap to keep them clean). For similar reasons, if they do enrol, they may be forced to drop out or be regularly absent. For example, girls who are married early or resort to prostitution either attend irregularly or drop out entirely. Enrolment, retention, transition and completion rates at all education levels are expected to fall as a direct result of the pandemic. Because they cannot access education neither can these potential learners access resources that would lead them out of the cycle of poverty, lack of skills, low levels of literacy and numeracy, and dysfunctional behaviours that lead directly back to HIV infection for themselves: '*They will in effect become the next cohort of the HIV infected: a state of affairs which will permit the epidemic to continue and intensify*' (Cohen, 2001).

Discrimination and lack of socialisation,

Pupils and students affected by HIV/AIDS experience stigma and discrimination, teasing by other children, ostracism, and teachers' insensitivity to their loss and emotional deprivation.

Single parenthood and child-headed households are now common in communities throughout the SADC region. Customary mechanisms for socialising the young no longer operate in many places, systems for acculturation do not work, and children tend to become alienated from family and community.

The people who are now falling ill and dying are the adults and role models in society, which means that a generation of children will grow up without much of the care and many of the role models they would normally have had. This means that South Africa could undergo further degradation of its familial and social fabric, already so severely damaged by apartheid. Unless the increase in the prevalence rate is curbed, South Africa will also experience a sudden and

widespread breakdown of the main conduit for transmission of social values, the family (South Africa, National Population Unit, 2000).

Psychosocial trauma

Psychosocial support for young people at risk is 'usually secondary to the provision of material support and other amenities' (Unicef/USAID, 2000).

'HIV undermines and often destroys the fundamental relationships considered essential to healthy family life and child development….Children suffer anxiety and fear during the years of parental illness, then grief and trauma when a parent dies. Less tangible than the violations of other rights that these children suffer, these psychosocial problems are rarely addressed in programmes, and yet can have long-term impact on development' (Unicef, 2001).

For the young, there are many facets to HIV/AIDS-related trauma:

- secrecy and silence about parental illness for fear of being stigmatised, combined with the cultural communication gap between adult and child in this region; denial that the illness is related to HIV/AIDS; no acknowledgement or discussion of the child's fears even though the child is perceptive, and knows by signs and symptoms what is wrong
- grief at witnessing the wasting sickness of a parent or other loved person, often in the most dehumanised circumstances; inability to discuss illness and death prior to the parent's death, to say farewell; and then lack of opportunity to express such grief
- insufficient time to grieve and come to terms with loss, leading to problems with resolution of grief, learning difficulties at school, problems of confiding in people, behavioural changes, loneliness and isolation
- grief after death of a parent or significant other further compounded by continuing silence and denial, breakup of the family home, and separation from siblings, friends and community: *'The grief experience of AIDS orphans is a very silent, secretive and commonly unfulfilled process'* (Devine & Graham, n.d.)
- confusion and distress about family quarrels over disposal of family property

- anxiety about re-starting life in unfamiliar surroundings, in a new location, often in a new school, and about where or how HIV/AIDS will strike the family again.

Children without emotional support may withdraw, resign and isolate themselves. They will have a strong sense of insecurity and instability, a sense that life is empty and that adults are not to be trusted (Kelly, 2000a).

The AIDS-orphaned child is not just another orphan, but a child who suffers from unique pressures and influences which may lead to depression, hopelessness and psychological trauma later in life. Because the concept of 'orphanhood' is relatively new in African communities where children who have lost parents have customarily been incorporated into extended families, we need to know much more about 'orphanhood' and the material, psychological and social deprivation that accompanies it. We need to know more about AIDS orphans in particular, and how educators can work with social and health workers, sociologists and psychologists, and behavioural scientists and managers to comprehend and address their needs.

4. THE RESPONSIBILITY OF EDUCATORS

> *'In the past, educators were counsellors, and used by learners for support. This does not happen now. Educators should become care-givers again'* (Education manager, South Africa).

Schools and colleges are 'normal' places for young people whose home lives are disrupted: they are with friends and teachers, the known and the predictable. For them, school plays a significant role in the socialisation process which may have fractured at home. It is essential that educators provide psychosocial support for children who are in HIV/AIDS-related trauma. Failure to do so will provoke 'second generation' difficulties including alcohol and drug abuse, violent behaviour, suicidal tendencies, unwanted pregnancies and STD/HIV infections.

Experience with life skills programmes, guidance and counselling programmes, peer group support and the evidence from assessments of the impact of HIV on communities and schools in

the region suggest that there are important things that can be done in learning institutions to mitigate the disastrous long-term consequences of the pandemic for learners in difficulty.

(1) Teachers must be knowledgeable about

- HIV as a disease
- the traumas associated with the HIV/AIDS pandemic
- the socio-economic context in which the pandemic is being played out.
- their roles and responsibilities for guarding and guiding children and young people, and creating for them a safe and secure environment in schools and colleges

(2) All educators must have basic knowledge and skills appropriate to counselling and care. A number of trusted mentors will need more specialist skills to help children of HIV/AIDS-affected families, orphans and other children at risk to cope with grief and deprivation. Teachers are in daily contact with children and should be able to identify signs of distress in any child -- social, physical and emotional -- and provide support. They should know too how to create supporting links with appropriate social, health or welfare services.

(3) Every learning institution must be a safe haven all those who learn and teach there. That means zero tolerance for discrimination, violence or abuse. It means that schools and colleges -- and their hostels and residence -- must genuinely offer security and safety for all learners and educators. It is time for a culture of care and respect to be reconstituted in South African institutions of learning.

(4) The education sector must devise more creative responses to meet the complex learning needs of those who are affected by HIV and AIDS. If children and young people are not to be lost to learning altogether, and condemned to a life of extreme deprivation, they must be brought back to learning by

- reviewing and adapting curricula to meet the needs of learners who are out of the formal system, and those who require practical income generating skills
- timetabling and setting calendars more flexibly, while allowing schools, colleges and communities to regulate these in ways that respond to locally experienced needs

- using teaching and learning techniques like distance learning, peer group work, radio and television, that do not require teachers or physical structures
- using interactive radio and appointing itinerant teachers to animate and supervise tutors engaged by community groups
- involving community members in schools, and especially harnessing the energy of women in and around the school.

5. CONCLUSION

HIV/AIDS is changing our perception of reality as we take a long and hard look at the traumas associated with the disease. It is no longer acceptable for educators to be unaware of the conditions in which South Africa's young live and learn, to fail to identify the deep personal anxieties, fears and shame associated with this pandemic, and to respond to their needs for affirmation, solace and care.

We have tried for twenty years to stem this pandemic. We have failed. We must now learn to live with HIV/AIDS in our schools and communities, and bring this generation of children and young people at risk safely through to adulthood.

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