Keeping the Education System Healthy:
Managing the Impact of HIV/AIDS on Education in South Africa

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Introduction

HIV/AIDS not only attacks individuals. It also attacks systems. Until recently, HIV/AIDS has been perceived primarily as a health problem, which can be contained by effective health education programs. But the deadly virus has not been contained and continues to spread so widely that it is now having a profound adverse impact on communities and institutions. Government's health-focused HIV/AIDS plans have failed to consider what must be done when the disease is out of control and state systems are themselves threatened. This article suggests that while working to limit the spread of the disease, it is necessary to recognize and manage the pandemic's impact on the education system.

The Spread of HIV/AIDS in South Africa

South Africa has the fastest-growing HIV/AIDS epidemic in the world, with more people infected than in any other country (UNAIDS, 2000). About half of South Africa's population of 40.6 million are children[1]. Over four million people are HIV positive. It has been predicted that by 2005 6 million South Africans will 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 68 to 40 years (Table 1). Changes in behavior will not alter these projections, as people who are now HIV positive will die (Marais, 2000, p. 5).

It is probable that 50-65 percent of South African 15-year-olds will die of HIV/AIDS-related illnesses within the next thirty years (Kelly, 2000). By 2005, nearly one million children will have lost one or both parents (UNAIDS, 2000; Pretoria News, 28 June 2000). By 2015, when the epidemic peaks, ten percent of South Africa's population--about 3.6 to 4.8 million children--will be orphans (Smart, 1999, p. 22.). Traditional patterns of childcare will be under pressure to accommodate large numbers of children infected and affected by HIV/AIDS (Smart, 1999, p. 28).

Table 1. The Consequences of the Pandemic: Projections to 2010[2]

	1999	**2005**	**2010**
Percentage of SA workforce HIV positive	11.5%	20%	22.5%
Percentage of SA workforce AIDS sick	0.4%	1.65%	2.7%
New AIDS cases per annum	145,256	466,365	625,180
Number of AIDS orphans	153,000	1,000,000	2,000,000
Life expectancy of SA females (years)	54	43	37
Life expectancy of SA males (years)	50	43	38

HIV/AIDS will cause productivity to decline in all sectors because of illness on the job, absenteeism due to personal or family illness, and funeral attendance. Public sector services will cost more, and economic growth will slow as the number of skilled workers

declines and cannot be replaced. Child mortality will increase as poverty deepens. Survivors who are orphaned, unsupervised and inadequately parented are more likely to engage in criminal activities. Ultimately, South Africa is likely to experience a real reversal of development gains. Further development will be more difficult, and development goals, including those set by Government for the education sector, will be unattainable for the foreseeable future.

South Africa's Strategy: Losing the Battle Against the Spread of HIV/AIDS

Taking action

Government and its partners have demonstrated their commitment to combat the pandemic. Health information on HIV/AIDS is systematically collected and reported in South Africa. The Metropolitan Life-Doyle model has been used throughout the 90s to predict the pandemic's course. The first South African HIV/AIDS strategy and implementation plan (Department of Health, 1994) has been succeeded by a new national plan for combating HIV/AIDS launched mid-2000 by the Department of Health. The implementation of the HIV/AIDS/STD strategic plan for South Africa 2000-2005 (Department of Health, 2000) is monitored by the HIV/AIDS and STD Directorate of the National Department of Health and executed by provincial health departments in cooperation with other sectoral departments. Government's HIV/AIDS budgets doubled during the 1990s but were substantially under-spent (Mail and Guardian, 3-9 November 2000).

Government's new strategy is strictly focused on the predisposing factors of HIV/AIDS, preventing or finding a cure, and monitoring health interventions. It does not address the social, development, human rights, economic and infrastructural consequences of HIV/AIDS for vital sectors like labor, education, agriculture, the public service, or the public sector. Government is now under pressure to consider how HIV/AIDS will influence the country's future. The Department of Public Service Administration has commissioned an impact survey. The South African National Defense Force has publicly recognized that the pandemic threatens to reduce or even destroy the capacity of the defense force (Pretoria News, 7 October 2000). Parliamentarians asking questions about HIV/AIDS and economic policy were recently told that Government had no data on which to plan for the impact of the pandemic. Parliamentary committees are now expected to scrutinize Government's response to HIV/AIDS in the context of development (Sunday Independent, 5 November 2000).

Losing the battle to contain the virus

Despite the strategic planning of the Department of Health, and increased resources for fighting the pandemic, South Africa is losing the battle against HIV/AIDS. Prevalence rose from 0.7% in 1990 to over 22% in 2000 (Moore and Kramer, 1999, p. 14). South Africa now has more HIV positive people than any other country in the world. What happened? On one hand, Government's strategic plans have been impeded by a lack of informed political leadership, vision and commitment; concentration of resources on essential post-apartheid transformation during the 90s; mistrust and lack of cooperation among potential partners; program management inadequacy at all levels; and a lack of focus and concentration (Marais, 2000; Coombe, 2000). At the same time, Government is fighting this battle on difficult ground. In taking on HIV/AIDS, it is also taking on the complex legacy of apartheid, the region's migrant labour system which has for decades

disrupted family and community life, high levels of poverty, and profound gender and income inequality. South Africa's excellent transport infrastructure and traditionally high levels of mobility permit the rapid spread of HIV into new communities.

Very high levels of other Sexually Transmitted Diseases (STDs), the low status of women, social norms which accept or encourage high numbers of sexual partners, and resistance to the use of condoms also challenge Government's battle plans (Marais, 2000). The pandemic thrives on sexual violence, male domination, and child abuse in South Africa. HIV/AIDS prevalence rates are highest among young people, especially teenage girls. Many adolescents are sexually active at 12 years old, but few practice safe sex because of pressure to engage in unprotected intercourse, to have a child, or because they lack access to user-friendly health services and are uninformed about condoms and risk (Craig and Richter-Strydom, Flisher et al., Buga et al. cited in Smart, 1999). Over one-quarter of women 16 to 20 years report they have been forced to have sex (Richter cited in Smart, 1999, p. 27). In the face of violent and coercive male behaviour, combined with their own limited understanding of their bodies and the mechanics of sexual intercourse, young women have little chance to negotiate safe sex, including contraception or condom use (Varga and Makubalo cited in Smart, 1999, p. 28).

Abuse of young girls and children within families is on the rise (Smart, 1999, p. 30) highlighting three myths or theories apparently linking child sexual abuse and HIV/AIDS. 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 cleansing theory suggests that having sex with a child will cleanse the infected individual of the virus. Finally, the retribution theory is linked to the deliberate spreading of infection to all sectors of society (McKerrow cited in Smart, 1999, p. 30).

The Impact of HIV/AIDS on the Education System

It is within this context of catastrophe, challenge and loss that South Africa's education departments[3] struggle to maintain their balance. Until Government's impact assessment is completed late in 2000, experience in the region, information from other sectors, demographic analysis, and anecdotal information provide clues about how HIV/AIDS is likely to compromise education quality in South Africa.

Learners: declining and changing demand for education

There are currently just over 12 million learners at school (50.5% female) in South Africa, in about 30,000 primary and secondary schools (Department of Education, 2000a). As HIV/AIDS reduces the number of parents 20 to 40 years old, numbers of orphaned children increase, and poverty deepens, school enrolment rates are expected to decline. Dropouts due to poverty, illness, lack of motivation and trauma are set to increase, along with absenteeism among children who are heads of households, those who help to supplement family income, and those who are ill. There may be greater demand for second-chance, flexible out-of-school education by learners returning to education after absence as care-givers or wage-earners. On the other hand, these demands may be offset by fewer births and more deaths of under-fives, and the fact that family units will have less disposable income for fees, voluntary funds, transport, books and uniforms. Unless

state provisioning changes to meet more complex learning demands, more young people will be functionally illiterate and unqualified.

Educators: reducing supply and quality of education

The education service, the largest occupational group in the country, includes 375,000 teachers, 5,000 inspectors and advisers, and 68,000 managers and support personnel (Department of Education, 2000a, pp. 157-161). At least 12 per cent of all educators are reported to be HIV positive (Abt Associates, 2000). In southern Africa an HIV positive person without access to drugs dies within seven years of infection. That means that over 53,000 educators will die by 2010, or between 88,000 and 133,000 educators if prevalence reaches 20 or 30 per cent. Many others will be ill, absent and dying, or pre-occupied with family crises, and school effectiveness is bound to decline.

Job mobility of educators is likely to increase, and as teachers die or leave the service for better jobs elsewhere, student/teacher ratios will decline. But the supply-demand equation is complicated. Teacher recruitment targets may be lower than at present if enrolments decline or do not grow as expected. Given uncertainty about likely levels of chronic morbidity, mortality and other types of 'wastage,' it is difficult to make teacher requirement projections with any degree of confidence. In any case, new recruits cannot make up for the loss of the education service's most experienced senior teachers, managers, teacher educators, professors, and science and mathematics specialists.

Trauma in classrooms

The HIV/AIDS pandemic will have a traumatic impact on all educators and learners. The work of educators--both those who are HIV positive and those who have developed full-blown AIDS--will be compromised by periods of illness. Once they know they are HIV positive, many are likely to lose interest in continuing professional development. Even among educators who believe they are not infected or do not want to be tested, morale is likely to fall significantly as they cope emotionally and financially with sickness and death among relatives, friends and colleagues, and wrestle with the uncertainty about their own future and that of their dependents. Most educators will have to take on additional teaching and other work-related duties in order to cover for sick colleagues. Although discrimination is illegal, stigmatization of infected learners and educators is a deeply rooted response.

HIV/AIDS will have a traumatic impact on learners. Children are being abused and young women are subject to violence. Many live in families that are overextended and are under pressure to contribute to family incomes as poverty deepens. They are losing parents, siblings, friends and teachers to the disease. Many will have to move long distances to find new homes. For others, there are no homes at all. As a result, learners are increasingly absent from school and distracted.

Management: embattled leadership

Educational management capacity is fragile at national, provincial, district and school levels. The system is finding it difficult to attract skilled managers. Many principals have not yet received sufficient support or training to enable them to be creative about local management of education. The situation will become worse as the pandemic takes hold. In the private sector, some companies are already training replacements for skilled

technical and managerial personnel they expect to lose to HIV/AIDS. Similar strategies are not yet in place in education. In addition to the loss of managers, the system will lose experienced senior teacher-mentors and teacher educators in universities and colleges whose career experience cannot be replaced. Institutions will depend on younger, less experienced educators and the quality of teacher education will decline.

Education Sector Action

The framework for action

Until late in 1999, the Department of Education had no policy on HIV/AIDS. In August 1999, the Department's Corporate Plan, 2000-2004 identified action on HIV/AIDS as one of its five priorities. The Department of Education (1999b, 2000b, 2000c) has highlighted three objectives related to HIV/AIDS: (1) raising awareness about HIV/AIDS among educators and learners, (2) integrating HIV/AIDS into the curriculum, and (3) developing models for analyzing the impact of HIV/AIDS on the system.

The Department of Education's National Policy on HIV/AIDS for Learners and Educators (1999a) takes account of Government's responsibilities for children's rights specified by international agreement (Nineteenth Session of the UN Committee on the Rights of the Child cited in Smart, 1999, p. 58), the Constitution of South Africa (1996), and the law (AIDS Law Project and Lawyers for Human Rights, 1997; South African Law Commission, 1998). Education's HIV/AIDS policy is entirely consistent with the priorities of the Department of Health's strategic plan but goes further to provide guidance on discrimination in schools and institutions, workplace
advocacy and sensitization, and sports safety. It specifies that:

1. The constitutional rights of all learners and educators must be protected equally.

2. There should be no compulsory disclosure of HIV/AIDS status.

3. The testing of learners as a prerequisite for attendance at an institution, or of an educator as a prerequisite of service, is prohibited.

4. No HIV-positive learner or educator may be discriminated against; they must be treated in a just, humane and life-affirming way.

5. No learner may be denied admission to or continued attendance at an institution because of his or her actual or perceived HIV status.

6. No educator may be denied appointment to a post because of his or her actual or perceived HIV status.

7. Learners and educators who are HIV-positive should lead as full a life as possible.

8. Infection control measures must be universally applied to ensure safe institutional environments.

9. Learners must receive education about HIV/AIDS and abstinence in the context of life-skills education as part of the integrated curriculum.

10. Educational institutions will ensure that learners acquire age- and context-appropriate knowledge and skills to enable them to behave in ways that will protect them from infection.

11. Educators need more knowledge of, and skills to deal with, HIV/AIDS and should be trained to give guidance on HIV/AIDS.

The Director-General of Education and Heads of provincial departments of education are responsible for implementing national policy on HIV/AIDS and education. Schools are encouraged to develop their own policies on HIV/AIDS. Principals are responsible for implementing policy in their institutions, and governing bodies are expected to supplement budgetary allocations for health, safety and other equipment.

Confronting HIV/AIDS in education

Education's HIV/AIDS work must be assessed in terms of both health and operational concerns. Health concerns are those which focus on learning about the pathology of the disease, and preventing its spread by better education, advocacy and sensitization. This has been the conventional bureaucratic approach to HIV/AIDS. There are, however, other, equally significant operational concerns which focus on understanding the nature of the pandemic and its influence on the education community as HIV/AIDS continues its inexorable spread, and responding creatively to a much more complex teaching and learning environment in order to maintain education quality.

Understanding means accepting that the pandemic has not been halted or even slowed, that it is not 'business as usual' in education, and that as HIV/AIDS affects the supply, demand and quality of education it must be factored into planning for the future. Responding means seeking ways to protect the education system before it is further compromised by the pandemic, so as to sustain an adequate and acceptable quality and level of education provision. It means stabilizing the system (system self-preservation) to ensure that even under attack by the pandemic, the system works so that teachers are teaching, children are enrolling and staying in school, managers are managing, and personnel, financial and professional development systems are performing adequately. It includes mitigating the pandemic's potential and actual impact (counteracting the pandemic) to ensure that children affected and infected by the pandemic are receiving counseling and care; that there is a culture of care in schools and institutions; and that human rights compromised by HIV/AIDS are protected in learning institutions and education workplaces. And it requires creatively and flexibly responding to it (outwitting the disease) to ensure that the system continues to provide meaningful, relevant educational services to communities of learners in complex and demanding circumstances by finding new times, places and techniques for learning and teaching, and is far more demand- than supply-driven.

Working on health concerns: learning and preventing

The Department's principal focus thus far has been on teaching safe sex and creating an HIV/AIDS-aware environment in schools. The National Coordinating Committee for Life Skills and HIV/AIDS began to design curricula in 1995 (Departments of Health and Education, 1997/1998). Each provincial education department is required to apply the

curriculum and train teachers in its use. All South African educational institutions have also received copies of the Department's HIV/AIDS Emergency: Guidelines for Educators (Department of Education, 2000d) which require that educators exemplify responsible sexual behavior and create a supportive environment for those infected or affected by HIV/AIDS, thereby 'making the school a center of hope and care in the community'. The booklet stresses that male educators have a particular duty of care, and that having sex with learners betrays the trust of the community, is against the law, and is a disciplinary offence (Department of Education, 2000, p. 2).

Some headway is being made in teaching safe sex, and creating a culture of care in schools. But progress is slow. There is evidence (Human Sciences Research Council, 2000) that only 15% of schools have a policy on HIV/AIDS. Male teachers still represent one of the greatest dangers to children and to female educators. The Medical Research Council recently reported (Pretoria News, 5 October 2000) that many young women are forced to have sex by employers and schoolteachers. One-third of all reported rapes of girls younger than 15 were perpetrated by schoolteachers.

Implementation of life skills curricula varies from province to province, but has generally been inefficient. There are about 21,300 primary schools (8.4 million learners), and 5,000 secondary schools, and another 2,500 combined schools (over four million learners). Introducing life skills curricula at primary level alone means re-training 64,000 school educators and 21,000 lay counselors. Apart from the huge numbers to be reached, teaching materials require adjustment, additional master teachers/counselors need regular upgrading training and replacement, and models of peer-group support must be elaborated (Department of Health, 2000).

Life skills content is also suspect. More robust evidence about sexual behaviors, including violence against women and children and male bisexuality, is needed to improve HIV/AIDS teaching, learning and counseling. Not enough is understood yet about how custom and tradition, poverty, family disorientation during the apartheid years, persistent gender inequality, and HIV/AIDS-related myths are linked to each other and to the spread of the disease.

Working on education sector impact concerns: understanding and responding

In its Corporate Plan, 2000-2004, the Department of Education (2000b) has tried to come to grips with the knowledge that HIV/AIDS is threatening to undo South Africa's considerable post-apartheid educational achievements. The Department of Education recognizes that 'the demand, supply and quality of learning and teaching will be affected by the HIV/AIDS epidemic' and that this in turn will 'affect the pattern of human development and economic growth in South Africa' (Department of Education, 2000b).

An analysis of the impact of HIV/AIDS on the education and training system has been commissioned by Government and will be presented to the Department of Education late in 2000. The analysis is taking account of

1. The impact of HIV/AIDS on society and human resource development: changes in skills requirements, the vulnerability of educators to the pandemic, staff attrition and mobility patterns, and changes in household expenditure patterns.

2. How HIV/AIDS affects the supply of education: how many educators by category will be infected, develop AIDS, and die; shifts in rates of educator absenteeism, attrition, recruitment and ill-health retirement, benefit costs, contact time in classes, other aspects of departmental functioning; the extent to which Government policies and practices assist in management of HIV/AIDS-related difficulties.

3. How HIV/AIDS influences the demand for education: projected future numbers of learners, of learners infected and affected by HIV/AIDS, of orphans, of households and schools at risk; effects of the disease on enrolments, wastage and completion rates; the extent to which sector policies and practices help prevent the spread of HIV/AIDS, and meet the needs of learners so they can contribute to society and the economy.

However, the question is whether, with better information on the pandemic's likely impact on the education sector, education departments will in practice be able to respond. There are a number of management hurdles to be cleared. First, despite a sense of urgency in the national Department of Education, there is evidence that as yet provincial departments do not understand that HIV/AIDS is inimical to education quality. This makes it difficult to anticipate whether and how education departments will use the impact assessment findings, and recruit managers who can start being more creative about 'providing an increasing range of learning possibilities, and offering learners greater flexibility in choosing what, where, when, how and at what pace they learn' (White Paper on Education and Training, 1995, p. 21).

Second, innovation in education is difficult under any circumstances because of administrative and procedural constraints, the complexity of the education bureaucracy, and the high cost of personnel. The third problem is how to devise management structures suitable to addressing an issue like HIV/AIDS which cuts across the whole sector in much the same way that 'gender' does. Finally, these difficulties are compounded in South Africa by persistent managerial shortcomings, and the lack of creative management capacity within the sector--the full-time staff capable of fighting this war.

These hurdles are clearly evident in current arrangements in the education sector for combating HIV/AIDS. South Africa's Director-General of Education, and heads of provincial education departments of education, are responsible for implementing HIV/AIDS programs. At national level the Minister's Advisor on HIV/AIDS, and the Chief Director (HIV/AIDS Coordination) are full-time HIV/AIDS-dedicated officials, but have no executive authority. HIV/AIDS-related functions have been parceled out to various departments and directorates. Every provincial education department is required to appoint two HIV/AIDS program managers, as well as a working group to communicate policy, monitor implementation, and advise on progress. HIV/AIDS provincial business plans are designed to make best use of national and international

resources, although officials and cooperating partners have all been frustrated by what they perceive to be complicated procedures for accessing funds.

It will take time before structures and personnel are working effectively. Directorates and individual personnel often lack clear mandates. Officials are under such pressure that there is little time for cooperation. Officials have only part-time to give to HIV/AIDS functions, as they are already overloaded with other competing commitments. Tensions inevitably arise between staff in different departments, different directorates, and at different levels. As a result, structures may get out of phase, and disjunctures and overlaps arise. Overworked officials consequently tend to focus narrowly on a single task or set of tasks which can be carved out of the whole, and for which tangible outcomes can be identified. This results in lack of coherence among initiatives. It also means that as staff come and go, priorities change.

Line management problems are compounded by the shortage of skilled and experienced managers capable of maintaining system performance, and mandated to do so. There is no doubt about the personal commitment of responsible officials, but individually and collectively public officials may not perceive the complex nature of the pandemic, or may lack strategic techniques to counteract it. They are in some cases overcome by inertia because the challenge is too big, resources too dispersed, and their units are understaffed and under pressure. Perhaps they do not understand messages coming from principals, teachers, and district officials. Certainly they do not have support from planners, demographers, economists, sociologists and anthropologists, care workers and others whose advice is now required. If this is a war, it needs generals to fight it.

Some of these problems could be overcome by cultivating stronger links with partners in and out of government. Cooperation problems persist everywhere. The contribution of NGOs, faith-based organizations, unions, international organizations, and communities to the battle against HIV/AIDS in the past has been not just considerable, but fundamental. Protecting the compromised health of the education service will depend in future on how well Government learns to work with other Departments, and with local organizations, and the extent to which it is able fund and support their contributions to the battle against HIV/AIDS.

Mitigating the Consequences of HIV/AIDS for Education

The situation seems to be desperate and getting worse, without a contingency plan to protect the system against HIV/AIDS. But there are things that can be done, however challenged the present and future may look.

A foundation for action

The first step is to recognize that the HIV/AIDS pandemic is not just a health problem, but that it brings psycho-social, economic and other consequences which threaten the efficient operation of the system itself. Making this conceptual break-through makes it possible to redefine the education sector's response to the pandemic, and then to act systematically in fighting it. Taking these practical steps is possible if there is a foundation from which to launch education's counter-offensive. South Africa's past experience suggests some elements of such a foundation for action on HIV/AIDS.

Systematic information

More needs to be known quantitatively about how HIV/AIDS influences teacher and teacher educator attrition (especially in key areas like supervision, management, and science/maths teaching), education costs, education requirements, the complexity of grade cohorts, and wastage and completion rates. How can adequate information be collected and analyzed systematically? Who is responsible for reporting, collecting and collating? Who will analyze it and feed it into the decision-making process? Much information is already available from demographers and sentinel sites at ante-natal clinics. Further data can be extracted regularly from school reporting forms and personnel systems without adding to institutional reporting burdens. It should be possible to deduce a set of 'alarm bells,' or indicators which warn managers when a situation reaches crisis levels in schools, districts and provinces.

Concerns about sustaining the quality of education require more detailed research and analysis. How do existing knowledge and value systems complicate life skills teaching? What should the education system look like in future when a high proportion of learners will be unparented orphans, or part of a child-headed household? What needs to be done to ensure the system meets the needs of children in distress and those who look after them, monitors HIV-affected children's rights, promotes a culture of care in schools, and operates in more flexible, non-formal ways to meet very complex educational needs. What will happen to South Africa's four million AIDS orphans? Who will care for them and how will they be educated? What do we know about 'orphanhood'? What more do we need to know? The education sector urgently requires a research agenda on HIV/AIDS and its impact on the education system, with priorities agreed, academic and other research partners mandated, resources allocated, and research outcomes linked to change.

Collective dedication

The impact assessment commissioned by Government on behalf of the Department of Education will provide a focal point for reaching agreement within education departments, in consultation with partners, about how to stabilize the system and protect education quality. Politicians, planners and practitioners, and development agency partners must now together assert their collective will to understand and deal with the effect of HIV/AIDS on the education system.

Adequate planning and strategic principles

Innovative structures and systems are needed to plan education's response to HIV/AIDS. Some strategic principles have emerged from South Africa's experience during the '90s. First, interventions must be manageable, within the capacity of the system to implement. Second, the grassroots is at work and Government needs to shift from a top-down 'delivery' structure to cooperatively devised support frameworks for local initiatives. Third, peer group support is essential for all pupils, students, teachers, lecturers and other educators. Collectivity, cooperation, collaboration, coordination and consultation, based on trust, are needed to sustain a culture of care in schools. Finally, full-time officials with clear job descriptions need to be mandated to work on HIV/AIDS impact matters. These principles and others need to be fully elaborated as a basis for planning and management.

Streamlined funding
It is essential now to make funding arrangements more efficient, and to make adequate provision for local non-government partners. It is up to the finance and education departments, as well as local and international funding partners, to sort this out as a matter of urgent priority.

Effective partnerships
Cooperation and trust must characterize South Africa's response to HIV/AIDS. That means (1) breaking the current impasse between politicians, government officials, NGO and institutional activists, academics and the media about what to do, and who is responsible; (2) involving communities, parents and local leaders in any campaign through the school governing body, and using the school as the ultimate community-based organization and the nerve-center for local response; (3) listening to what teachers and district officials say about what needs to be done, how it can be done, and what they need to do it; (4) pushing unions to get the message out to their members; and (5) making better arrangements with international development cooperation agencies in support of both Government and local initiatives. Three strong networks exist which can carry messages throughout South Africa: schools, unions, and faith-based organizations. Their potential for leadership at local level as AIDS-focused community-based organizations requires further exploration, along with the role of traditional leaders and South Africa's mothers.

Crisis management capacity
The Department of Education has an obligation to deploy the best managers and leaders it can find to counteract the pandemic. Because so much is at stake, it is essential to recruit dedicated teams of proven, mature senior managers, on contract if necessary. This is not a part-time assignment for individuals dotted around the bureaucracy. Fighting HIV/AIDS, protecting children, teachers and other educators, and shielding the system itself is a full-time professional assignment, at least in the short- to medium-term until the situation stabilizes.

Responsive decision-making
Having a foundation for action in place should make it possible to act creatively to deflect the worst ravages of HIV/AIDS. Difficult decisions will need to be taken about targeting resources where they are most needed (by making provision to replace teachers lost to HIV/AIDS, for example, and meet the needs of the growing orphan population), and avoiding wastage (by building fewer schools where populations are decimated, by creating new learning opportunities for children forced out of school). Educators should be able to identify at-risk schools and learners (female pupils, children who walk a long way to school, those in boarding hostels). With stronger AIDS-dedicated planning and management, education departments and their partners should be able to provide a wide selection of materials to support peer group work among children, teachers, and other care-givers, promote a 'culture of care' in schools and institutions, and start planning for 'randomized' education and training for learners affected by AIDS.

Conclusion

HIV/AIDS is not just a health problem. For twenty years the disease has spread inexorably through southern Africa. All efforts to contain it have failed, and South Africa now has the largest HIV-positive population in the world. The pandemic affects not only the health of individuals, but is attacking the education system itself. Demand for education is dropping and changing, many teachers are ill and dying, and the trauma of loss associated with HIV/AIDS is entrenched in South African classrooms. In South Africa, as in Africa as a whole, we can no longer assume that it is 'business as usual' for education.

The response of South Africa's education departments has so far been practical and multi-faceted. There is both political and official commitment to address operational as well as health difficulties created by the pandemic. An HIV/AIDS-in-education policy and regulatory framework is in place, along with adequate budgetary provision, and practical implementation structures, at least at national level. But management structures now in place are clearly not adequate to handle this crisis, and there are no full-time managers with sufficient skill and executive power to take decisive action to counteract the pandemic's threat.

As the pandemic begins to bite, greater resources and creative energies will be needed to protect the quality of education provision. Education officials and their partners inside and outside government now need to learn how to stabilize the system, devise innovative ways to reduce the impact of HIV/AIDS on the sector, and respond creatively to new management and learning requirements. In an education environment radically altered by HIV/AIDS this will require a foundation for action featuring collective dedication among all stakeholders in education, systematic information collection and analysis, dedicated structures and full-time staff responsible for strategic planning, effective partnerships of all stakeholders, professional crisis management capacity, and streamlined funding.

When closing the 13th International AIDS Conference in Durban in July 2000, Nelson Mandela said that 'we have to rise above our differences and combine our efforts to save our people. History will judge us harshly if we fail to do so now, and right now.' Each day, on the basis of South Africa's experience, much more is known about the adverse consequences of HIV/AIDS for education systems. The time to act is now.

Notes

1. The publication of the SA National Council for Child Welfare, HIV/AIDS and the Care of Children, uses a figure of 19,775,600 children under the age of 18 in 1997.

2. 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 (Moore and Kramer, 1999, p. 14).

3. South Africa has one national and nine provincial departments of education.

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HIV on education sec-tors in Botswana and South Africa; preliminary analysis of data for KwaZulu-Natal province in South Africa by the Health Economics and AIDS Research Division of the University of Natal (HEARD); and the summary of case studies in eight sub-Saharan African countries by Michael Kelly for the Economic Commission for Africa/Africa Development Forum (Crouch.Â In South Africa, the number of potential learners is expected to decline if or-phans and other vulnerable children do not enrol, delay enrolling, or leave school in large numbers. In general, children at risk or orphaned by AIDS, and those in. 6. Global information and education on HIV and AIDS. Donate. Enter your keywords.Â Unprotected sex is the most common route of HIV infection among young people. Low HIV and sexual health knowledge is a key barrier to reducing HIV infections among young people. A â€˜life-cycleâ€™ approach to HIV prevention can help respond to the changing challenges people face at different ages. Explore this page to find out more about young peopleâ€™s vulnerability to HIV, young people and key populations, barriers to effective prevention programmes, treatment and support for young people, and what the future might hold. Young people (10 to 24 years) and adolescents (10 to 19 years), especially y