

The Role of Open, Distance and Flexible Learning (ODFL) in HIV/AIDS Prevention and Mitigation for Affected Youth in South Africa and Mozambique

by Pat Pridmore and Chris Yates

**The Role of Open, Distance
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(ODFL) in HIV/AIDS
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Pat Pridmore and Chris Yates

with

Kate Kuhn and Helina Xerinda

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Acronyms

AET	<i>Africa Educational Trust</i>
AFFC	<i>Africa Facilitators For Change</i>
AIDS	<i>Acquired Immune Deficiency Syndrome</i>
AMODEFA	<i>Mozambican Association for Family Development</i>
ANC	<i>African National Congress</i>
ART	<i>Anti-Retroviral Therapy</i>
ASRH	<i>Adolescent sexual and reproductive health</i>
BBC	<i>British Broadcasting Corporation</i>
BCC	<i>Behaviour Change Communication</i>
BOCODOL	<i>Botswana College of Distance and Open Learning</i>
CBO	<i>Community-Based Organisation</i>
CCATH	<i>Child-Centred Approaches to HIV/AIDS</i>
CCC	<i>Country Coordinating Committee (for the Global Fund to fight HIV/AIDS, tuberculosis and malaria)</i>
CERP	<i>Community Education for Rural People</i>
CHH	<i>Child-Headed Households</i>
CIDAJ	<i>Intersectoral Committee for support for the Development of the Adolescent and Youth</i>
CMJ	<i>National Youth Council</i>
CNCS	<i>National Aids Council (in Mozambique – also known as NAC)</i>
COLLIT	<i>Commonwealth of Learning Literacy Project</i>
DDE	<i>Department of Distance Education</i>
DFID	<i>Department for International Development</i>
DHS	<i>Demographic & Health Services</i>
DOE	<i>Department of Education</i>
DOH	<i>Department of Health</i>
DSW	<i>Department of Social Welfare</i>
EE	<i>Environmental Education</i>
EFA	<i>Education for All</i>
FBO	<i>Faith Based Organisation</i>
FDC	<i>Fund for Community Development</i>
GoK	<i>Government of Kenya</i>
GoM	<i>Government of Mozambique</i>
GoSA	<i>Government of South Africa</i>
HIV	<i>Human Immuno-deficiency Virus</i>
Hivos	<i>Humanistisch Instituut voor Ontwikkelingssamenwerking</i>
HSRC	<i>Human Sciences Research Council</i>
HWW	<i>Hope World-Wide</i>
IAP	<i>Instituto de Aperfeiçoamento de Professores</i>
IATT	<i>Interagency Task Team for Education</i>
IEC	<i>Information, Education and Communication</i>
IBE	<i>International Bureau of Education</i>
ICDL	<i>International Centre for Distance Learning</i>
ICPD	<i>International Conference on Population and Development</i>
ICS	<i>Institute of Social Communication</i>
ICT	<i>Information Communication Technology</i>
IDC	<i>Interdepartmental Committee on AIDS</i>
INDE	<i>National Institute of Educational Development</i>
INJAD	<i>National Enquiry on Youth and Adolescents/Inquerito Nacional Para Jovens e Adolescentes</i>
IPPF	<i>International Planned Parenthood Association</i>
MDG	<i>Millennium Development Goals</i>
MFMC	<i>My Future My Choice</i>
MICOA	<i>Ministry of Coordination and Environmental Affairs</i>
MINED	<i>Ministry of Education</i>
MISAU	<i>Ministry of Health</i>
MONASO	<i>Mozambique National AIDS Service Organisation</i>

MOYS	<i>Ministry of Youth and Sports (MJD in Portuguese)</i>
MSP	<i>Media Support Partnership</i>
MSTP	<i>Management of Schools Training Programme</i>
MTCT	<i>Mother to Child Transmission</i>
MWSA	<i>Ministry of Women and Co-ordination of Social Action (MICAS in Portuguese)</i>
NAC	<i>National Aids Council</i>
NACC	<i>National Aids Control Council</i>
NACOSA	<i>National AIDS Coordinating Committee of South Africa</i>
NAMCOL	<i>Namibian College of Open Learning</i>
NFER	<i>National Foundation for Education Research</i>
NGO	<i>Non Governmental Organisation</i>
NICRO	<i>National Institute for Crime Prevention and Reintegration of Offenders</i>
NIP	<i>National Integrated Plan</i>
NPDE	<i>National Professional Diploma in Education</i>
OCDP	<i>Orphan Care Development Programme</i>
ODFL	<i>Open, Distance and Flexible Learning</i>
OVC	<i>Orphans and Vulnerable Children</i>
PEN	<i>National Strategic Plan to combat STDs/HIV/AIDS</i>
PLWHA	<i>People living with HIV and AIDS</i>
PNCS	<i>National AIDS Council</i>
POSIDA	<i>Integrated programme on HIV/AIDS of the Ministry of Youth and Sport in Mozambique</i>
Pop/FLE	<i>Population and Family Life Education</i>
PSI	<i>Population Services International</i>
PSS	<i>Strategic Plan for the Health Sector</i>
PTSD	<i>Post-traumatic Stress Disorder</i>
REPSSI	<i>Regional Psychosocial Support Initiative (in SADC countries)</i>
SACHED	<i>South African Committee for Higher Education</i>
SADC	<i>Southern African Development Community</i>
SAIDE	<i>South African Institute for Distance Education</i>
SANAC	<i>South Africa National AIDS Council</i>
SANCA	<i>South African National Council on Alcoholism and Drug Dependence</i>
SCF	<i>Save the Children Fund</i>
SEA	<i>Section of School Health and Adolescents</i>
SEDE	<i>Secondary Education through Distance Education</i>
SOMDEL	<i>Somali Distance Education Literacy Programme</i>
SRH	<i>Sexual and Reproductive Health</i>
SSI	<i>Semi-Structured Interview</i>
STD	<i>Sexually Transmitted Diseases</i>
SWAA	<i>Society of Women living affected by AIDS</i>
TB	<i>Tuberculosis</i>
TM	<i>Organisation of Trade Unions</i>
UNCRC	<i>United Nations Convention on the Rights of the Child</i>
UNDP	<i>United Nations Development Programme</i>
UNESCO	<i>United Nations Education, Social and Cultural Organisation</i>
UNFPA	<i>United Nations Family Planning Association</i>
UNGASS	<i>United Nations General Assembly Special Session</i>
UNICEF	<i>United Nations Children's Fund</i>
UNISA	<i>University of South Africa</i>
UNOCHA	<i>United Nations Offices for the Co-ordination of Humanitarian Affairs</i>
USAID	<i>United States Agency for Intersectoral Development</i>
VCT	<i>Voluntary Counselling and Testing</i>
WHO	<i>World Health Organisation</i>
ZIP	<i>Zona de Influencia Pedagogica</i>

Executive Summary

Highlights Summary

This study provides an initial examination of the potential of open, distance and flexible learning (ODFL) to mitigate the affects of HIV and AIDS on young people, through an examination of experiences from Mozambique and South Africa. It analyses national AIDS policy and identifies major ODFL initiatives to translate this policy into practice. It explores the learning needs and favourite ways of learning of young people affected by HIV and AIDS, and suggests ways for ODFL to support and extend the work of existing infrastructures. The central argument in this monograph is that to confront AIDS, and to meet Millennium Development Goals in high HIV prevalence countries, governments must move beyond current efforts to accelerate conventional responses. They must grasp the opportunity to transform the education system, to deliver education more flexibly and to empower young people to participate in moving their communities towards the post-AIDS era. To do this, the full and strategic support of the entire education community, including those with expertise in planning and programming for ODFL, will need to be harnessed.

1. Introduction

The rapid spread of the HIV virus in the Southern African Development Community (SADC) region is a human tragedy. It has been recognised as an emergency, threatening development, social cohesion, political stability, food security, life expectancy and economic growth. Given the extent of the crisis, and the attention currently being paid to accelerating the education sector response to HIV and AIDS in SADC countries, it is surprising that so few educators have tried to find ways that open, distance and flexible learning (ODFL¹) can help to realise national policies on HIV/AIDS. This is a serious gap in current efforts, given that reducing HIV infection rates and meeting Millennium Development Goals (MDGs) and Education for All (EFA) targets will require the full and strategic support of the entire education/ communication community.

This study therefore provides an initial examination of the role of ODFL in reducing or mitigating the effects of HIV and AIDS in South Africa and Mozambique. It is hoped that the lessons learned may be relevant to India, China and other countries where the pandemic is threatening to explode but is less well understood. The study focuses on the growing number of youth who are orphans, living in child-headed households, and carers, many of whom are out-of-school due to the affects of HIV and AIDS. It is hoped that emerging concerns about this particularly vulnerable group may initiate broader momentum to do something for those for whom the formal education system has failed.

The first aim of this study is to examine some of the key ODFL initiatives being undertaken to translate into practice national HIV and AIDS policy in Mozambique and South Africa. The

¹ By open, distance and flexible learning (ODFL) we mean the provision of learning opportunities where attempts are made to reduce the barriers that can often inhibit learning and to enhance access. These barriers may be a result of the physical separation of learners from teachers, or be due to the inability of learners and teachers to meet at mutually convenient times. The main features of ODFL systems usually involve some combination of multimedia packages, learning workshops, counselling and tutorial support, modular courses, flexible timetabling, negotiated curricula and support through guidance. (Hodgson, 1993, pp 85-86).

second aim is to consider how ODFL might be further developed to help meet the learning needs of affected youth in those countries. The study draws on field data collected between January and December 2003, in which a qualitative approach was used to meet the study aims. Policy and strategy documents were analysed, together with agency reports and academic critiques. Data were also collected through semi-structured interviews; informal discussions with key informants involved in policy development and implementation; and focus group and semi-structured interviews with young people, via the organisations who provide ongoing support for them.

The report is organised into six sections. The first section introduces the study, reviews educational responses to HIV and AIDS and considers what ODFL can achieve. The second section reviews literature on the affects of HIV and AIDS on young people. The third section examines national HIV/ AIDS policy in South Africa and Mozambique. The fourth section identifies major ODFL initiatives being undertaken to translate this policy into practice at the national level. This leads to the fifth section, which examines examples of grassroots initiatives to translate policy into practice and explores the learning needs, aspirations and favourite ways of learning of young people. In the sixth and final section the findings are synthesised and discussed and suggestions made for further developing the ODFL provision.

Educational responses to HIV and AIDS

The rapidly increasing body of literature concerned with educational responses to HIV and AIDS offers much good advice on how to continue 'business as usual' in the face of the challenges presented by the epidemic. However, it has been argued that in high prevalence countries, trying to shore up the education system as presently configured is unlikely to succeed, and that this is a lost opportunity to transform ineffective systems for the better (Badcock-Walters et al, 2003). Given the importance of education, which is being hailed as 'the new vaccine for HIV/AIDS', it is of considerable concern to find that young people affected by HIV and AIDS are increasingly missing out on schooling.

What can ODFL achieve?

Since the 1960s, alternative schooling systems have been used to provide opportunities for secondary education in Africa. Such systems have used various combinations of printed materials, mass media (most often broadcast radio) and face-to-face support to provide second-chance education for those who have not had access to conventional secondary schools. This approach has been called 'three-way teaching' by some distance educators (see Young et al, 1991). The study centres model has been the most popular approach in Southern Africa, with sizeable systems developing in Malawi, Zambia and Zimbabwe. More recently, we have seen the establishment of new dedicated 'open school' systems in Namibia and Botswana, again serving thousands of adolescent children at both the upper and lower secondary levels. The largest open schooling systems are, however, found in Latin American and Asia. For example, both Brazil and Mexico have developed large-scale television based systems that enrol hundreds of thousands of students, while in India and Indonesia we find examples of successful large-scale open schools, reaching nationally distributed audiences, using variations of the three-way teaching model.

In health education, ODFL has supported a range of goals:

- increased access and quality of education;
- improved quality of schooling (and thereby child survival and family health);
- raising public consciousness and stimulating popular action in support of national, regional and local health initiatives;
- spreading health information and encouraging people to practice healthy behaviours and avoid unhealthy ones.

Mass media campaigns and radio and television dramas have been widely used to increase health knowledge and influence attitudes and values of individuals and communities. Experience has shown that the possibility of success in mass HIV/AIDS education communications can be increased by drawing on theories of behaviour change that acknowledge the role of social learning, together with a multi-channel mass-media approach and well-facilitated, face-to-face discussions in small groups, linked to ‘youth-friendly’ health service provision. Effective models address the contextual factors that increase vulnerability to HIV infection and target peer networks to help create supportive social norms for individual change. They use a rights based approach and seek to increase employment opportunities through developing livelihood skills. Effective evaluation designs, for use where integrated multi-channel systems are deployed, need to disaggregate the effects of ODFL efforts from other activities, carry out formative research during the development stage, pre-test messages, track local reception patterns and measure programme impacts using both qualitative and quantitative indicators.

2. Major initiatives and actions being taken through ODFL to translate national policy on HIV/AIDS into practice

National policies and strategies on HIV/AIDS

Policy development in Mozambique and South Africa, as elsewhere, has developed within the political landscape of existing policies, strategies, initiatives and programmes at the global, regional and national levels. Both countries have national AIDS strategies and plans that recognise the need for a comprehensive multi-sectoral response. Both countries have also set up high-level bodies to coordinate the implementation of their plans, to be the lead advocates for HIV/AIDS in the national policy arenas and to mainstream HIV/AIDS issues into social and political dialogues. In South Africa, and to a lesser extent in Mozambique, we have seen a shift towards a stronger focus on the provision of anti-retroviral drugs and the promotion of human rights, through increased efforts to counteract stigma and discrimination; and better coordinated education, health and social support programmes, using both formal education and mass media programming. South Africa has a National Integrated Plan for Children Infected and Affected by HIV/AIDS. However, at the time of the study, no such plan was in place in Mozambique.

In both countries, the Ministry/Department of Education’s main concern has been to deliver basic education to children who are in school. The focus has been on the development of an HIV/AIDS curriculum and materials to provide relevant information and life skills, and the training of teachers to deliver such a curriculum. Despite some awareness that young people, especially girls, are increasingly dropping out of school because they are affected by HIV and

AIDS, policies and plans are not yet in place to enable those who cannot attend school regularly to continue with their basic education. There is virtually no provision to enable children to learn at home so that they do not get behind and risk falling out of school, or to help them re-enter school if they have fallen out. In both countries, there is a shortage of strategies that specifically address the needs of young people who are out-of-school and that take into account the very complex contexts within which their sexual and reproductive health decision-making takes place. These are important issues on which the governments need to be strongly challenged in the face of the increasing numbers of dropouts, especially girls, from the system. However, in Mozambique there is little tradition of critical public debate of Government policy comparable to that in South Africa that could mobilise such a challenge.

Key initiatives and actions being taken through ODFL to translate HIV/AIDS policy into practice

Four key ODFL innovations in Sub-Saharan Africa are outlined by way of examples. In South Africa, ODFL efforts have primarily relied on television campaigns, combined with a range of media information strategies. The key media campaign projects – Soul City, loveLife and Khomanani – have been shown to be relatively effective in increasing knowledge and awareness of HIV/AIDS and in influencing attitude change. Some evaluations also report behaviour change. South African universities have developed a number of specialised distance education initiatives to increase training and professional development opportunities for people involved with education, health, counselling and HIV/AIDS care and awareness. There is, however, a lack of easily accessible information on organisations working with children affected by HIV and AIDS in South Africa.

In Mozambique, the two major government programmes that focus on HIV/AIDS – My Future My Choice and Geracao Biz – use mostly face-to-face delivery and train peer educators to reach out-of-school youth. Key lessons learned from these experiences are that young people must be meaningful partners in the design and implementation of activities, and that all sectors of the community must be mobilised to bring about sustainable changes to reduce the spread of HIV. Geracao Biz also uses a range of ODFL materials, including a video with social messages called Yellow Card, and a booklet called Vida Positiva with HIV messages that have a positive psychosocial component and useful nutrition advice.

Another key government initiative for young people in Mozambique is the SEDE Project (Secondary Education through Distance Education). This project is developing a set of ODFL materials designed for use by out-of-school youth (grades 8-10). A distance-learning module on the control of STD/HIV/AIDS has also been developed for primary teacher education by the Instituto de Aperfeiçoamento de Professores (IAP). There is much untapped potential to combat HIV/AIDS in Mozambique using radio, and UNESCO has proposed to facilitate delivery of the new National Primary School Curriculum through local radio stations. This could complement the SEDE project for maximum impact.

3. The learning needs, aspirations and favourite ways of learning of young people affected by HIV and AIDS

To explore these issues, a number of short case studies were developed in consultation with non-governmental organisations (NGOs) working to support young people affected by HIV and AIDS. At the organisational level, the case studies highlight the way in which high profile figures have helped to attract initial resources, and how the church and political activists have helped ensure the continued provision of resources. Although these NGOs have an important role to play in enabling HIV/AIDS affected youth to access support, provision remains relatively uncoordinated and only weakly integrated into whatever state support exists. There appears to be a real need to strengthen links between the government agencies set up to implement policy and the local non-state agencies working on the ground. NGOs show evidence of effective networking for basic service provision, but are often in competition with each other for the available resources. The capacity of communities and schools to support these young people also needs to be strengthened. Some teachers are reported to be disassociating themselves from the affects of HIV and AIDS on their pupils, and there is a need for more awareness raising and training of teachers in how to better support orphans and child heads of household.

At the individual level, focus group discussions with HIV/AIDS affected young people indicated that they need more opportunities to develop literacy skills and to undertake vocational training. Many of these youth aspire to having professional jobs. Interview data also showed that young people affected by HIV/AIDS can most easily be reached through radio, and that they particularly like to learn through music, dramas and stories. These findings are endorsed by large-scale surveys of listening habits.

4. Further development of ODFL to mitigate the effects of HIV/AIDS on young people

Although the research findings suggest that ODFL has a valuable potential role to play, there remains a need for further data and evaluation using effective designs as indicated at the end of section 1 in this summary.

In this section we therefore give voice to our own advocacy for further developing ODFL provision to support and extend the work of existing infrastructures. We argue that ODFL has potential to combat HIV/AIDS in the areas of prevention, psychosocial support and vocational skills. This potential can be realised through interventions at the:

- individual and family/household level;
- school and community level;
- national level.

ODFL interventions at the individual and family/household level

ODFL has the great advantage that learning can be relatively confidential. It can help young heads of household access the wealth of information traditionally provided through the collective knowledge and experience of their own family. For example, a series of handbooks on

skills for everyday living are needed to provide young people with up-to-date and accurate information. Such texts should emulate the strong practical information found in the booklet *Vida Positiva* and be developed with the participation of teenage heads of household and local parents with relevant experiences. This would represent an extension of the memory counselling idea, to develop what we have called the 'family memory information bank' and the 'community memory information bank'. There is also a need for ODFL information targeted at infected parents on how to write a will and plan a cheap funeral. The work of the Story Teller's Group in South Africa could be used here.

There is also scope for well-structured and coordinated programmes of psychosocial support involving mixed media deployment, including appropriately vetted professional Internet websites and email/conferencing services. Simple, individualised and empathetic personal counselling booklets or audio tapes could help to explain what is happening to a young person going through the grief and healing stages of parental loss. Lessons could be drawn from the emerging range of ODFL materials that currently exist in South Africa and elsewhere, but have been targeted at other audiences and levels. Such print materials could be supported through anonymous, toll-free/affordable telephone counselling or via public Internet kiosks. The magazine *Upbeat*, produced by the South African Committee for Higher Education (SACHED) Trust in South Africa, offers an early example of how youth can be successfully targeted with HIV/AIDS messaging via print.

To help vulnerable young people enter the job market, ODFL, including virtual reality, can be used to increase motivation for learning and speed up the time it takes to learn skills. These approaches can be used to teach entrepreneurial skills, such as how to set up and run a small business, and to deliver relevant careers counselling and advice on how to apply for a job and go through an interview. The work of GOAL in Mozambique and of the Alexandra Educational Trust project in South Africa are examples of projects we see as having significant potential here.

ODFL interventions at the community level

We argue that ODFL should be used to develop a more flexible approach to the delivery of the national curriculum, so that young people do not have to fall behind with their lessons when they cannot attend school and can be helped to re-enter if they have already dropped out. In Mozambique, the UNESCO proposal to use Radio Mozambique to deliver the new national primary curriculum has enormous potential to fill a gap here, as do the ODFL secondary curriculum materials being developed through the SEDE project.

Another tried and tested model that could be built on is that of the self-study learner guides developed by the Escuela Nueva programme in Colombia. ODFL curriculum materials could be delivered to and collected from young carers by teachers on home visits, by classmates participating in a 'buddy system', or by home-based care workers. This infrastructure could also be used to deliver ODFL support materials to volunteers in the community, and thereby help to build circles of support around vulnerable young people and develop schools as nodes for multipurpose development and welfare provision.

ODFL can also help create awareness among out-of-school youth that, despite not being in school, there is still a need to consider how to further your education and find a job. In South

Africa, the Department of Health is partnering with loveLife to explore this. Community radio could be particularly useful here. There is also a need to explore how the training manuals, used in the big government programmes such as Geracao Biz and My Life My Choice, might be adapted for training at a distance, and how groups of teenagers could be established to develop more appropriate messaging and supportive information – through the mass media, Internet and more simple print based leaflets and other provision. Experience from the multipurpose community telecommunication and library project in Nakaseke town, Uganda, could be used to help support the development of community-based learning resource centres like those currently being set up in South Africa.

ODFL materials are needed to improve teachers' ability to empathise with young people affected by HIV/AIDS and provide psychosocial, guidance and counselling. Such materials may also be useful for health and welfare workers and volunteer supporters, some of whom are clearly under great strain. There is surely scope for much more transfer and adaptation of existing materials, such as the materials that have been developed in South Africa for home-based care training and teacher training (for example, the UNISA course on 'HIV/AIDS Care and counselling' and the Venda module on 'HIV AIDS and the Educator').

ODFL interventions at the national level

At this level we have indicated a need for developing, coordinating and disseminating the national information base (the institutional memory) on HIV/AIDS. In Mozambique, the Department of Distance Education in the Ministry of Education is exploring the desirability and location of an ODFL Resource Centre that could include ODFL specialist collections on HIV/AIDS. The South African Institute for Distance Education (SAIDE) could also extend the work it has already done in this area for South Africa. These initiatives could link into international HIV materials collections, such as the UNESCO International Bureau of Education (IBE) clearing house on HIV/AIDS, and also further develop national directories for learning materials and organisational databases.

In Mozambique, there is a need to consider how ODFL could strengthen civil society and help develop and nurture a more diverse and vibrant critique of government HIV/AIDS policy and practice, such as that which exists in South Africa. Do the universities in Mozambique need to sponsor more active programmes of research similar to those undertaken at the HIV/AIDS centres in the Universities of Pretoria and Natal?

5. Concluding comments

This study has examined HIV related policy and practice. The depth of the current crisis caused by HIV/AIDS in Mozambique and South Africa, together with recognition that schooling can provide 'an education vaccine' for HIV, means that there is now a real opportunity to change policy, accelerate the educational response and transform and develop ineffective systems for the better. For this to happen, however, education reform must be placed at the forefront of reform processes in a way that it has not been in the past.

This study has also examined the affects of HIV and AIDS on young people. It has shown that young people are facing serious problems now. They are already missing lessons and dropping out of school. They need to run their households and protect themselves from HIV infection or avoid spreading the virus themselves. Dropping out of school not only increases their vulnerability to HIV infection, but also damages their longer term prospects for social and economic development. At the same time, schools are increasingly challenged to meet the educational and emotional needs of the young people who walk through the school door. Many heavily HIV affected communities are reaching the limits of their capacity to cope with the needs of orphans and other vulnerable children. It therefore seems unlikely that, without a radical rethink of how the educational provision can be delivered, schools will be able to reach out to the young people who are not able to attend school regularly.

This study has argued that ODFL should play a much more proactive role in facilitating educational reform, by sharing the burden faced by schools and helping to integrate responses to meet learners' needs more effectively. ODFL can enable the curriculum to be delivered to young people beyond the school gate – not only in relation to HIV prevention education, but also more broadly. ODFL can help children to avoid falling behind and dropping out when they have to miss schooling, to re-enter the system once they have dropped out and to continue their education even when they have left school. ODFL can also help to mitigate the effects of HIV and AIDS on affected young people, by providing materials that give practical advice and emotional support for their everyday lives.

Although the ODFL response to the needs of young people who are out-of-school is growing, it lacks the necessary urgency and remains unfocused and limited in scope. ODFL programming to support educational transformation needs to develop within a broad based educational approach, focused on increasing knowledge and the development of critical thinking and positive group identity and solidarity among the young. It needs to build a sense of empowerment and motivation, strengthen supportive social networks and increase access to services and outside agencies.

Within a broad based educational approach, initiatives are needed at all levels to further develop policy and legislation, mass media and macro-level communications and to support community, interpersonal and participatory initiatives. We need more research on the capacities and potential of the different means of communication (print, radio, television, telephone, Internet). Such work must be located firmly within a poverty reduction, rights based and capability building approach. This approach is necessary to stimulate the type of information rich and dialogue rich environment critical to mitigating the affects of HIV and AIDS and enabling young people to participate in transforming their communities and their wider society.

Placing ODFL in this broad context exposes the futility of focusing narrowly on behaviour change communication, without addressing structural barriers to change and without offering young people real choices in their lives. A stronger deployment of ODFL approaches could do much to overcome such barriers, by helping to raise the critical awareness of young people, meet their needs for basic education and livelihood programmes and offer them wider, life-giving choices.

Chapter 1: The Problem in Context

1.1 Introduction

The rapid spread of the human immuno-deficiency virus (HIV) is one of the most important social issues facing the world today. In SADC countries, the acquired immune deficiency syndrome (AIDS) has been recognised as an emergency that threatens development, social cohesion, political stability, food security, life expectancy and economic growth (UNGASS Declaration, 2001). Hence it is important to place any research study about HIV and its effects in this wider development frame. Current responses recognise the need to address HIV/AIDS within a wider set of agendas that, for example, take account of the continuing significance of malaria and tuberculosis (TB) and the need to have in place appropriate educational and public health infrastructures before substantial achievements can be gained.

The policy and plans drawn up in response to HIV/AIDS often describe the pandemic in militaristic ways – using terms like ‘a battle’, ‘a fight’, ‘to combat’, etc. However, as Crewe (cited in Marais, 2000, p. 57) points out, such language can actually serve to undermine and alienate our understanding, by locating the disease in the realm of the ‘other’, among people who are essentially positioned as outsiders and ultimately blamed for the situation they find themselves in. Further, the language of AIDS can so often become a language of exclusion – an exclusion that can work two ways, in that those with the disease are excluded by those without it and vice versa. That said, the struggle to curb the spread of HIV and to cope with its consequences involves a fight to the death for many, and is surely one that we cannot afford to lose. It has been pointed out there are only two kinds of people in the world – those who are infected and those who are affected by HIV. In that sense, the HIV/AIDS pandemic is something that concerns us all.

At a time when attention is being paid to accelerating the education sector response to HIV/AIDS in SADC countries, it is surprising that so few open, distance and flexible learning (ODFL)² educators have concerned themselves with the epidemic and tried to find ways to help realise national policies on HIV/AIDS. ODFL educators have long sought to use the advances of modern science and technology to extend educational opportunity, and in many countries they have significantly increased access to a steadily improving quality of education of increasing diversity. Given this experience, and a strong commitment to equity, we have to ask why the ODFL community has not yet responded more intensively to the challenge of HIV/AIDS.

Recent DFID-sponsored studies provide guidance on communications and HIV/AIDS (Skuse, 2002) and there has been some general policy and planning work conducted in the region in relation to education systems and the impact of AIDS (see, for example, GoSA/DoE, 1999, 2000b; Coombe, 2000a, 2000b; Coombe and Kelly, 2001; Carr-Hill et al, 2001; Badcock-Walters et al, 2003). However, to our knowledge, there have been no significant studies of the role of ODFL in mitigating the impact of HIV/AIDS in South Africa or Mozambique. A search on the International Centre for Distance Learning (ICDL) database at the UK Open University revealed no studies using the search words ‘open schooling and HIV/AIDS’. This is a serious gap in the literature given that, in the absence of a cure for HIV/AIDS or the widespread availability of anti-retroviral drugs, meeting international and national targets to reduce HIV infection rates requires the full and strategic support of all educationalists.

² See note on page vi

The purpose of this study is therefore to help fill this gap by providing an initial examination of how ODFL might support and extend the work of existing infrastructures to reduce HIV spread and mitigate the impact of HIV and AIDS in South Africa and Mozambique on affected young people. As neighbouring countries at the epicentre of the pandemic, Mozambique and South Africa have very different levels of infrastructure development, but complementary experiences to offer. These experiences may be relevant to India, China and other countries where the pandemic is threatening to explode but is less well understood. The study focuses principally on orphans, children living in child-headed households³ and carers. It is our hope that emerging concerns about this particularly vulnerable group may initiate a broader momentum to do something for those whom the formal education system has failed.

Our experience of meeting and talking with people in South Africa and Mozambique working in this field led us to a great deal of optimism for an initial enquiry such as this. People who work in the area of HIV/AIDS know better than most that the AIDS epidemic is something that we all need to make much more effort to address, if it is not to completely overwhelm us. It has been pointed out that ‘No terrorist attack, no war has ever threatened the lives of over 40 million people worldwide’ (Makinwa, cited in Jackson, 2002: vii) and yet this is precisely what AIDS has done today.

The research group was led by Dr. Pat Pridmore, from the London Institute of Education, and Chris Yates who was at that time working at the International Extension College in Cambridge. To strengthen links, draw on local knowledge and experience and build capacity we collaborated with agencies in South Africa and Mozambique. In South Africa, we worked with the South African Institute for Distance Education (SAIDE), which is the leading agency for policy development in distance education and open learning in that country. One of the staff from SAIDE, Kate Kuhn, joined our research team. In Mozambique, several colleagues from the Department of Distance Education (DDE) at the Ministry of Education (MINED), whose work is currently assisted by DFID, provided support. However, given our focus on HIV/AIDS affected youth, we also networked with other line ministries and agencies. Our research team member in Mozambique, Helena Xerinda, was an employee of MINED/INDE, where she had previously worked in distance education, but was currently deployed to UNFPA.

1.2 HIV/AIDS in South Africa and Mozambique

The need to address the AIDS epidemic among young people in the Southern African region is very clear. This region is home to the eight countries with the highest HIV rates in the world, and almost half of all new infections occur among young people below the age of 24. The countries of the SADC are currently at the epicentre of the pandemic, and AIDS is now the leading cause of death in the region (UNAIDS, 2002a).

South Africa has the second fastest growth rate in new HIV infections in the world, with one in five (20%) of the population predicted to be infected by 2010. A household survey, conducted by the Human Sciences Research Council (HSRC) on behalf of the Nelson Mandela Children’s Fund and the Nelson Mandela Foundation (Shishana, 2002), estimated the overall

³ Households where children live without a resident adult.

infection rate at 11.4%. This means that about 4.9 million people in South Africa are living with HIV. Most of those infected are adults in the 25-39 age group. Among 15-24 year olds, the prevalence rate was found to be 9.3% – with twice as many women as men infected (12% of women compared to 6.1% of men). African youth also carry a higher level of infection than other groups (African 10.2%; White 3.2%; Coloured 6.4%; and Indian 0.3% – though the figures for white and Indian youth need to be interpreted cautiously due to high levels of non-response from these groups). The epidemic is found in all nine provinces, with prevalence rates ranging from 5.6% in Limpopo to 11.8% in Northern Cape. The high levels (20.2%) of infection found among youth residing in urban informal settlements are particularly significant (Shishana, 2002, pp. 47-49).

In Mozambique, the estimated infection rate is 13% for 15-49 year olds (UNAIDS, 2002a) and this rate is projected to increase to 16% by 2007 (GoM/CCC, 2002). HIV prevalence in 15-19 year old girls is nearly double that of boys (16% as against 9%) with the highest rate of infection (19%) found among girls in the 15-24 age group living in the central region (UNFPA, 2003). While prevalence is still lower than in surrounding countries, the epidemic is recognised to have the potential to wipe out all past and current gains in national development (UNFPA, 2003). Furthermore, increased population movement brought about by peace has stimulated interaction with surrounding countries and brought about a rapid increase in HIV infections. Other factors reported to be promoting the spread of HIV include extreme poverty, low levels of education, common commercial and transactional sex, high STD rates, social and economic inequalities experienced by women, and limited access to health services, particularly for marginalised women and adolescents of both sexes (GoM/UNFPA, 2001).

The growing problem of orphans and child-headed households is currently receiving much attention internationally. In both South Africa and Mozambique, AIDS is predicted to have a dramatic impact on the number of children who are orphaned and on the level of child-headed households. (This issue is examined further in Chapter 2.) At a time when governments are striving to reach the Millennium Development Goals, an important gap in the current response of some governments in Sub-Saharan Africa is the lack of adequate provision to bring schooling to vulnerable children and young people, especially girl and orphans, who are unable to attend school regularly. This may be because their parents are sick and they are looking after them and their brothers or younger siblings, or because their parents have died and they need to work to provide for basic needs. It has long been recognised that schooling can be a key protective factor for HIV (Vandemoortele and Delamonica, 2000) and yet alternative modes of delivery to enable children to study at home have not yet been adequately explored. The provision of ODFL could enable young people to catch up on missed work to avoid falling behind and dropping out, or enable them to re-enter the system after dropping out.

The magnitude of this problem is most striking in Mozambique, where more than 70% of youth are out-of-school by the age of 13; only 5% of eligible girls are enrolled in secondary school; and a significant number of young people, especially girls, have never attended school (47% of all females and 26% of all males). Furthermore, the Ministry of Education (known as MINED) has predicted that attendance rates would decrease and dropout rates continue to increase as young people are affected by the epidemic (GoM/MINED, 2002a). MINED has also predicted that young people's ability to learn will be reduced because of the trauma of

living with disease and death and the pressure to look after sick relatives and produce food (GoM/UNFPA, 2001). The National Strategic Plan for HIV/AIDS (GoM/National AIDS Council, 2000) identifies young people who are not attending school as a priority vulnerable group, and states that their needs are not being addressed adequately.

An assessment of the impact of HIV/AIDS on the education sector in Mozambique (GoM/MINED, 2001) acknowledges that ensuring orphaned children have access to schooling requires flexible planning at district and provincial levels. It also recognises that with the large and growing number of orphans, there will not be enough resources available to make direct service delivery the primary type of intervention for affected orphans and vulnerable children (UNAIDS, 2002b).

In South Africa, commentators such as Badcock-Walters at the University of Natal have argued that the effects of the HIV epidemic may well get so bad that they will change the way we configure schooling. With more than half a million children already orphaned, and increasing numbers of child-headed households, there is clearly an urgent need to find new ways to reach out-of-school children and youth. We have to ask how long education sectors can continue to resist major changes in their modes of delivery to make the system more flexible.

There is a general lack of studies on children who are out-of-school. To our knowledge, there are no comprehensive studies to date of the learning needs of young people who are out-of-school because they are affected by HIV/AIDS. Given that these young people are increasingly missing out on the National Curriculum, and facing a barrage of problems in their daily lives, there is a strong moral, socio-cultural and economic basis for focusing resources here to help them.

Much of the informal education provided for out-of-school youth focuses on HIV prevention, without effectively addressing the limits to individual behaviour change imposed by the social and economic context. Access to vocational education or livelihood programmes is limited. When such children have to take on responsibilities that are normally borne by adults, they are challenged by a multitude of tasks for which they have to take full responsibility. AIDS will drive down the age at which adolescent children need to take on adult level responsibilities. The western notion of adolescence (where a young person learns to cope with the expectations of adulthood during a prolonged teenage period from 13 to 19 years of age) has little meaning for young people living in communities severely affected by HIV/AIDS. In their teenage years, these young people are increasingly forced to take on the responsibilities of their lost parents and deal with shifts in social expectation.

In the years ahead, it is likely that increasing numbers of children and older adults will need to learn to cope with the effects of the premature death of the most economically productive members of the community (the 24-49 age group). This will exacerbate the already high levels of poverty, and put young people increasingly at risk of HIV infection. Ebersöhn and Elhoff (2002, p. 78) estimate that about ten million children already live below the poverty line in South Africa. In Mozambique, almost three-quarters of the rural population lives in poverty, and the situation facing young people is predicted to be getting worse as HIV/AIDS further depletes family and community resources and the ability to pay for schooling (GoM/MINED, 2002).

The current lack of services available to support young people affected by HIV/AIDS in Mozambique, and to a much lesser extent in South Africa, is a serious cause for concern. As Ebersöhn and Elhoff (2002) have pointed out, young people affected by HIV/AIDS are likely to be severely traumatised. Current levels of service provision will need to be significantly expanded and reconfigured to cope with the consequences of the epidemic.

1.3 Educational responses to HIV and AIDS

The rapid spread of the HIV virus is a human tragedy. In the countries of the SADC that are at the epicentre of the pandemic, AIDS has for some years been the leading cause of death (UNAIDS, 2002b). In these countries, AIDS has been recognised as an emergency that threatens development, social cohesion, political stability, food security, life expectancy and economic growth (UNGASS, 2001). Experience has shown that young people are affected economically (UNAIDS, 2002b), educationally (Brandt, 2003) and psychosocially (Ebersöhn and Elhoff, 2002). Current educational responses therefore need to address HIV and AIDS, using a wide development frame that recognises the importance of addressing poverty and having in place appropriate educational and public health infrastructures before substantial achievements can be gained.

There is a rapidly increasing body of literature concerned with educational responses to HIV and AIDS, which offers much good advice on how to continue 'business as usual' in the face of the challenges presented by the epidemic (Kelly, 2000; Carr-Hill et al, 2002). However, it has been strongly argued that in high prevalence countries, trying to shore up the education system is unlikely to succeed (Badcock-Walters et al, 2003) and that this is a lost opportunity to transform ineffective systems for the better (Crewe, 2004).

Efforts are now being made to accelerate the education sector response to HIV and AIDS in the SADC region. Studies predict that educational quality will continue to decrease as teacher shortages increase when personnel become sick or take time off to care for sick relatives (Coombe and Kelly, 2001; Carr-Hill, 2001; Badcock-Walters et al, 2003; Bennell, 2003). The accelerated response has also been prompted by studies showing that access to education, and especially schooling, is a key protective factor for HIV (Vandemoortele and Delamonica, 2000; Government of Mozambique/Ministry of Youth and Sport, 2000). Given the importance of education, it is worrying to find that young people affected by HIV and AIDS are increasingly missing out on schooling. In countries such as Mozambique, where 70% of young people drop out of school by the age of 13 (Government of Mozambique/UNFPA, 2001), there is clearly an urgent need to find alternative ways to deliver the so-called 'education vaccine'.

Furthermore, there is evidence that orphaned children are either not enrolling or are dropping out of school at a higher rate than non-orphaned children (World Bank, 2004; Unicef, 2004). Such children are more likely to become infected as they are emotionally vulnerable, socially isolated, financially desperate and hence more likely to be sexually abused or engage in unsafe sex (Foster and Williamson, 2000). This is important because, as previously mentioned, the orphan population is already large, and rapidly increasing, not only in South Africa and Mozambique, but throughout the countries of the SADC region. The UNAIDS, UNICEF and

USAID report, *Children on the Brink* (2004), highlights the enormous gap between what has been done to protect the rights of these children and to meet their needs, and what still needs to be done.

Despite efforts to accelerate the education sector response, the question still remains open on how to best meet the educational needs of affected young people. It is disappointing to find that very few educators have tried to find ways that ODFL can make a contribution. To our knowledge, there have been no significant studies of the role of ODFL in mitigating the impact of HIV and AIDS in South Africa or Mozambique. This is a serious gap in the literature, given that ODFL has a long history of providing education to out-of-school adolescents in most continents of the world and that, in the absence of a cure for HIV and AIDS or the widespread availability of anti-retroviral drugs, meeting international and national targets to reduce HIV infection rates requires the full and strategic support of the entire education and development communication community.

What can ODFL achieve?

Let us briefly return to the meaning of ODFL and consider its pedagogical foundations and what it can achieve. Open, distance and flexible learning form an amalgam of concepts that are being used as shorthand to capture recent trends in education. Of particular importance is the convergence of technology-based learning with the more conventional forms of contiguous, face-to-face education. Openness is a relative term that refers to the removal or reduction of the many barriers that can prevent or hinder learning. These barriers might involve various kinds of institutional or curricular inflexibility, or the fact that the education might only be available at very restricted locations and/or times. Distance education has been defined by Perraton (1982:4) as ‘an educational process in which a significant proportion of the teaching is conducted by someone removed in space and/or time from the learner’. Clearly this does not necessarily mean that all the teaching and learning has to be conducted by teachers who are separate from their students, though in practice it often does. Flexibility in learning might be regarded as referring to the degree of autonomy, independence and control learners have over their learning programme, as a result of the relative openness and ability of the programme design to overcome the various forms of distance and separation (geographic, psychological, pedagogical, economic and social) and its ability to provide appropriate degrees of structure and support to maintain and enhance learning. As mentioned earlier, the main features of ODFL systems usually involve some combination of multimedia packages, learning workshops, counselling and tutorial support, modular courses, flexible timetabling, negotiated curricula and support through guidance (Hodgson, 1993, pp. 85-86).

So what can ODFL achieve? Since the 1960s, embryonic open schooling systems have been tested in Africa, using combinations of printed materials, mass media (most often broadcast radio) and face-to-face support, through an approach known as three-way teaching (Young et al, 1991). The study centres model has been the most popular approach in Southern Africa, with sizeable systems (involving tens of thousands of students) developing in Malawi, Zambia and Zimbabwe (Murphy and Zhiri, 1992; Perraton, 2000). The study centres model consists of a central materials production and coordination unit, based in a Ministry or college, working through a study centre outreach system (often involving the conventional schools network) to provide the learning,

assessment and support services. More recently, we have seen the establishment of new dedicated open school systems in Namibia (Namibian College of Open Learning, NAMCOL) and Botswana (Botswana College of Open and Distance Learning, BOCODOL), again serving thousands of adolescent children at both the upper and lower secondary levels.

The largest systems, however, are found in Latin American and in Asia. Brazil and Mexico have both developed large-scale television-based systems that enrol hundreds of thousands of students. In India and Indonesia, we can find examples of successful large-scale open schools, which reach out to nationally distributed audiences using variations of the three-way teaching model. Although it can be argued that individualised, independent models of distance learning are ill-suited to young children studying at the lower secondary level (12-15 age range), those working at the upper level and in the 16-19 age range are more mature and independent and hence able to cope with the demands of self-learning. However, both groups have been shown to benefit from carefully designed programmes, provided they have adequate levels of support built into them (Yates and Bradley, 2000).

In the health education area (and especially for HIV and AIDS awareness and sexual and reproductive health) ODFL has supported a range of goals. These include:

- increased access to education especially for remote or marginalised groups;
- enriching the quality of schooling and thereby child survival and family health;
- raising public consciousness and stimulating popular action in support of national, regional and local health initiatives;
- spreading health information and encouraging people to practice healthy behaviours and avoid unhealthy ones (Pridmore and Nduba, 2000, p.193).

Mass media public health communication campaigns and radio and television dramas have been widely used to reach youth, both in school and out of school, to increase health knowledge and influence attitudes and values of individuals and communities.

A plethora of models and approaches has been used to inform public health communication campaigns, drawing on the vision encapsulated in the 1986 Ottawa Charter for Health Promotion (WHO, 1986) in seeking to enable people to increase their control over the determinants of health. These behaviour change theories include: the Health Belief Model (Becker, 1984); the Theory of Reasoned Action (Ajzen and Fishbein, 1980); the Stages of Change (or Transtheoretical) model (Prochaska and DiClamente, 1992); and Social Cognitive Theory (Bandura, 1986). These theories identify self-efficacy (the individual's perceived belief that he/she can actually carry out the action) and a supportive social environment as key factors for the reduction of risk behaviours. Successful mass media campaigns have also drawn on Diffusion Theory (Rogers, 1995). This theory helps to explain how behaviour change innovations can be spread through a community by identifying key opinion formers who are respected members of the community, likely to be early adopters of the behaviour change and able to communicate it to others. Once a critical mass of adopters has been reached, the innovation spreads rapidly through the community. Oldenburg et al (1999) have argued that Diffusion Theory can also be used as a vehicle to diffuse other behaviour change models through the community.

Experience has shown that the possibility of success in mass public health communications can be increased by drawing on theories of behaviour change that acknowledge the role of social learning, together with a multi-channel mass-media approach and well-facilitated small group face-to-face discussions linked to ‘youth-friendly’ health service provision (Pridmore and Nduba, 2000; Skuse, 2002). Targeting peer networks can help to create supportive social norms for individual change (Kelly, Parker and Lewis, 2001).

Recent international developments in HIV/AIDS education have provided models of good practice that also need to be taken into account when developing ODFL initiatives. These models recognise the importance of the active involvement of young people in programme design and implementation, and need for an accurate identification of the groups to be served and the need to gain a deep understanding of their cultural values and circumstances (Perraton and Creed, 2002; Warwick and Aggleton, 2002). These models highlight the importance of addressing contextual factors that increase vulnerability to HIV infection though damaging self-esteem, eliminating choices and making it hard for individuals to stand up for themselves. Such factors include social inequality, social exclusion, sexism, racism and homophobia (Aggleton, Chase and Rivers, 2004). To increase the chances of success, behaviour change communications must therefore take account of the local context and be located firmly within a rights-based approach. They must also address poverty through efforts to develop livelihood skills and increase employment opportunities for vulnerable groups.

Given the complexity of broad-based comprehensive ODFL public health programmes, it is difficult to develop effective evaluation designs that enable programme effects to be realistically isolated. Effective designs for use where integrated multi-channel systems are used need to disaggregate the impact of ODFL efforts from other activities such as health service delivery. These designs also need to carry out formative research during the development stage, pre-test messages, track local reception patterns and measure programme effects using both qualitative and quantitative indicators.

1.4 Aims and approach used

There are two main aims for this study. The first aim is to examine some of the key ODFL initiatives being undertaken to translate into practice national HIV and AIDS policy in Mozambique and South Africa. The second aim is to consider how ODFL might be further developed to help meet the learning needs of affected youth who are out-of-school. This examination is carried out by looking at initiatives at:

- the individual and family/ household level;
- the school and community level; and
- the national level.

A qualitative approach has been taken to address these aims. Data were gathered through analyses of policy documents and strategy papers, semi-structured interviews and informal discussions with key informants involved in policy development and in implementation from National Aids Councils, line Ministries, international and bilateral development agencies and

NGOs. Focus group discussions and semi-structured interviews (SSI) were also held with young people affected by HIV/AIDS.

In South Africa, over 20 policy makers and implementers were interviewed, and in Mozambique 55 policy makers and implementers were met. In South Africa, three focus group discussions were held with 21 young people affected by HIV/AIDS, and in Mozambique, four focus group discussions and 31 SSI were undertaken.

Drawing and writing techniques were also used with young people to serve as springboards for group discussion to explore problems and seek solutions. For example, in the River of Life activity, young people were asked to draw a 'river of their life', starting from their birth and projecting five years into the future. The river flows up at good times and down at bad times.

Appendix 1 provides a list of the policy makers and practitioners interviewed and Appendix 2 the guide used to interview young people.

The study was conducted in three stages during 2003. The first stage, from January to March 2003, involved detailed planning, negotiation and acceptance of our plans with the collaborating organisations, collecting policy documents and background literature, and preparing for the field work. The second stage, from April to October 2003, involved continued collection of relevant documents and interviews with policy makers, implementers and affected children. The third stage, from October to December 2003, involved completing the documentary analysis and analysing data from interviews and discussions with policy makers, practitioners and young people. This stage concluded with further discussions and dissemination of the findings, through seminars conducted at INDE in Maputo, SAIDE in Johannesburg and for the Education and HIV/AIDS Working Group in London, which is a group of stakeholders from DFID, the University of London, and NGO agencies. The primary target group for this research is the decision makers responsible for the provision of education to youth who are out-of-school. The secondary target group is the recipients of this education.

Limitations and ethical issues

This preliminary enquiry was of necessity limited by constraints of time and resources. We did not have time to work with agencies and young people outside the capital provinces of Gauteng in South Africa and Maputo in Mozambique. We knew of a number of other agencies working with orphans and vulnerable children, but the distances involved meant we were unable to visit them during the fieldwork period. This is something we would hope to address later if we were able to take the study further.

To find out more about the learning needs of HIV/AIDS affected youth, we needed to collaborate with NGOs and community-based organisations that had developed trusted and ongoing partnerships with them. As we got further into the enquiry, we realised it was going to be difficult to make contact with out-of-school youth, because most agencies seek to keep them in school. It would have taken more time than we had to work through these in-school youth to reach their friends who were out-of-school and to build the trust needed to work with them ourselves.

Gaining the trust of the serving institutions also took considerably longer than we had anticipated. People involved directly with orphans and vulnerable children are, quite understandably, wary of new contacts and of how outsiders might use information gained from interactions.

In the event, we were able to work through a number of organisations in Mozambique to interview a range of youth who considered themselves to be affected by HIV/AIDS. Most of these youth were out-of-school and some had been recruited as peer educators for HIV education programmes. In South Africa, the organisations we worked through all provided support to keep affected young people in school, and therefore we were unable to interview many out-of-school youth. During the focus group discussions and drawing activities, we worked alongside the social workers from the community organisations so that ongoing support for the young people would be assured. Three of these agencies in South Africa asked our field assistant not to mention the words 'HIV' or 'AIDS' at all in the company of the young people themselves.

The focus groups, semi-structured interviews and drawing activities were facilitated by the social workers from the support organisations who were in regular contact with the young people, trusted by them and able to provide any follow-up support needed. Personal disclosure of HIV status was discouraged by asking the young people to share the experiences of their friends and by focusing on their own general needs for everyday living. To help maintain confidentiality, we did not record young people's names, just their age and gender. Discussions were held in the young people's language and later translated by the in-country researchers. Drawing techniques such as the River of Life were used because they have been tried and tested by other researchers and found to provide an effective and ethical channel of communication around sensitive issues. There were some issues of culture in South Africa, where the young people were Africans and the in-country researcher was a white South African, but these interviews were conducted together with an African agency worker.

1.5 Organisation of the report

This report is organised into six chapters. This first chapter has described the problem in context, the rationale for the study, the aims and approach used and provided a brief review of educational responses to HIV/AIDS and what ODFL can achieve. The second chapter reviews literature on the effects of HIV/AIDS on young people. The third chapter, though not intended to be a comprehensive examination of current policy and practice, examines national HIV and AIDS policy in South Africa and Mozambique. The fourth chapter identifies major ODFL initiatives being undertaken to translate this policy into practice at the national level. This leads on to the fifth chapter, which examines examples of grass-roots initiatives to translate policy into practice and explores the learning needs, aspirations and favourite ways of learning of young people. This in turn generates additional questions about current provision. This chapter also provides a brief discussion and synthesis of the findings. The sixth and final chapter concludes the paper with suggestions for further developing ODFL provision to support and extend the work of existing infrastructures, and ends with some concluding comments.

Chapter 2: The Effects of HIV/AIDS on Young People

At this stage of the AIDS epidemic in sub-Saharan Africa, it is well recognised that efforts to prevent the spread of the HIV virus need to be accompanied by efforts to mitigate its effects on those affected as well as those infected. This chapter examines the effects of HIV/AIDS on young people and sets the scene for later consideration of how ODFL might help mitigate these effects in Mozambique and South Africa. We first address issues related to orphanhood, and then move on to examine how young people affected by HIV/AIDS are impacted economically, educationally, psychosocially and in relation to their health and well-being. We aim to show that the effect of HIV/AIDS on young people is such that there is a need for systemic mitigation efforts, which may require radical rethinking of the ways in which educational services are delivered.

2.1 Affected orphans and other vulnerable children

One of the most vulnerable groups to be affected by the AIDS epidemic is young people who have been orphaned by the disease, many of whom are most in need of support, care and assistance. By 2010, the number of children orphaned worldwide by AIDS is expected to exceed 25 million, with eight million in sub-Saharan Africa alone having lost both parents to the disease (UNICEF, 2004).

In Sub-Saharan Africa, the predicted increase in the orphan population represents a human tragedy on a vast scale. By the end of 2001, AIDS was estimated to account for 32-38% of orphans in Sub-Saharan Africa, with approximately 11 million children having already lost one or both parents from AIDS (UNAIDS, 2002a). In many cases this has led to children living in child-headed households. One study found that the older orphan was the primary caregiver for about one in ten orphans in Zambia and Tanzania (Brandt, 2003, p. 44) although this does not necessarily indicate a child-headed household. Other studies have reported the prevalence of child-headed households at 3% in the Rakai district of Uganda, 4% in Zimbabwe and 3% in Tanzania (Foster and Williamson, 2000: p. S279). It has been predicted that by 2010, almost half (48%) of all orphans in most southern and eastern African countries will have lost one or both parents to AIDS (Brandt, 2003, p. 44). According to the Regional Psychosocial Support Initiative in SADC countries (REPSSI) up to one quarter of all children in the region may be orphans by 2010 (UN, 2002, cited in IRIN News, 3 November, 2003).

In South Africa, by the end of 2002, 13% of children between two and 14 years of age were reported to have lost a mother, father or both parents, and 3% of households were headed by children aged between 12 and 18 years (Shishana, 2002). By the end of 2003, 1.1 million children were estimated to have been orphaned due to AIDS, out of a total of 2.2 million children orphaned due to all causes (UNAIDS, 2004; UNICEF, 2005) and community-based programmes in South Africa are increasingly reporting sharp rises in the number of child-headed households. AIDS is predicted to reduce average life expectancy from 60 years in 1998 to 40 years by 2008 (USAIDS, 2004). At the peak of the epidemic, estimated to be 2015, between 9% and 12% of all children in South Africa are predicted to be orphans (UNAIDS/UNICEF/USAID, 2002). Because there is approximately ten years from HIV infection to death, the orphan problem will continue for at least ten years after the epidemic's peak, leading to a significant increase in child-headed households (Foster and Williamson, 2000).

It has been estimated that by the end of 2003, in Mozambique 470,000 children had been orphaned due to AIDS, out of a total of 1,500,000 children orphaned due to all causes (UNAIDS, 2004; UNICEF, 2005). It is predicted that by 2010, the number of orphans will have risen to 1.9 million representing 19% of the child population, and that AIDS will have reduced average life expectancy from 50.3 years to 36.0 years (USAIDS, 2004). The first Mozambican National Strategic Plan for HIV/AIDS (GoM/National AIDS Council, 2000) recognised that women and orphans would be especially affected, because they may lose access to their land, housing, pasture and other resources when the husband/father dies, thereby increasing their poverty and vulnerability. This plan also predicted that affected children would be more likely to turn to street vending, become street children and get involved in prostitution.

These statistics are summarised in Figure 2.1.

Figure 2.1: Estimates/Predictions of the Prevalence of Orphanhood in Sub-Saharan Africa, South Africa and Mozambique

Sub-Saharan Africa	<p><i>2002 estimates:</i> 11 million orphans 32-38% of orphans have been orphaned by AIDS % of households headed by children: 3% in Rakai District of Uganda 4% in Zimbabwe 3% in Tanzania</p> <p><i>2010 predictions:</i> 25-40 million children orphaned by AIDS 48% of all orphans in southern and eastern African countries will have been orphaned by AIDS Up to 25% of all children will be orphans</p>
South Africa	<p><i>2002 estimates:</i> 13% of children 2-14 years of age were orphans 3% of households headed by children aged 12-18 years</p> <p><i>2003 estimates:</i> 1,100,000 children orphaned due to AIDS, out of a total of 2,200,000 orphans</p> <p><i>2015 predictions:</i> 9-12% of all children in South Africa will be orphans</p>
Mozambique	<p><i>2003 estimates:</i> 470,000 children orphaned due to AIDS out of a total of 1,500,000 orphans</p> <p><i>2010 predictions:</i> 1,900,000 children will be orphans (19% of the total child population)</p>

(Sources provided in the text.)

However worrying these statistics may be, they represent only a small fraction of the number of affected children who will be made vulnerable by the impact of AIDS on their lives. These children include both single and double orphans, children who are heads of household, children who are carers of infected others and children who are themselves infected. Experience has shown that such children are more likely to become infected, because they are emotionally vulnerable, socially isolated and financially desperate, and hence more likely to be sexually exploited. A study from Uganda showed that 30% of 12-year-old orphaned girls were already sexually active, although few knew how to protect themselves from HIV/AIDS (Foster and Williamson, 2000, p. S282). A detailed account of the many ways in which children are profoundly affected as their parents fall sick and die is given by UNICEF (2004, p. 9).

For these young people, mitigation can be viewed as playing a role on at least three levels:

- before infection, to prevent becoming infected
- after infection, to increase individuals' abilities to cope with their own or others' infection
- after parental death, to cope with grief, loss and increased poverty.

The definition of an orphan as being a person under 15 years old is problematic, as it may overlook particularly the sexual and economic exploitation of older adolescent girls (Foster and Williamson, 2000, p. S276). Girl orphans and girls with sick relatives are especially likely to be taken out of school to become carers. They may attend school intermittently, or leave if there is no money to pay school fees due to reduced incomes and greater medical expenses (Cohen, 1999; UNAIDS, 2001, p. 19; Foster and Williamson, 2000; Subbarao and Coury, 2004). They may also face sexual abuse from older men, who often hold the belief that younger girls are 'safe'. They may be more vulnerable to rape, or trade sexual favours for money, food, clothes or attention. It is unclear to what extent young men trade sexual favours, although Rivers and Aggleton (1999) argue that it is significant.

There is widespread agreement among national governments and international aid agencies that HIV/AIDS affected children should be maintained in their family or community of origin rather than be put into institutionalised care. There are a number of reasons for this. Orphanages are very expensive, and children raised in orphanages may have difficulties re-entering society and fending for themselves. In addition, orphans greatly benefit from the care, social connection and socialisation that come from the family (UNAIDS/UNICEF/USAID, 2002). Indeed, the extended family remains the predominant caring unit for orphans in African communities with severe HIV/AIDS epidemics. However, the role of the extended family is in flux, due to the breakdown of traditional culture, urbanisation and migration, and some children clearly lose contact with families. Children are more likely to break from the family if their family has little contact with relatives or if the children are older adolescents (Foster and Williamson, 2000).

Although the AIDS orphan population is significant and requires urgent attention, these children should not necessarily be singled out. Destitution has created many other needy children as well as children orphaned for reasons other than AIDS and children whose parents have AIDS or are living in a household that is caring for orphans. If the definition of 'vulnerable' is extended to all poor children in Sub-Saharan Africa, the number living without their most basic needs being met is currently approximately 50 million, but it may rise to 100 million by

2010 (Brandt, 2003, p. 42). It has been argued that orphans create further vulnerable children in poor families where meagre household resources have to be stretched to provide for their care. In addition, there are few estimates of how many children are living with one or two HIV infected parents, and therefore little sense of the social, developmental and health problems these children might face before they are orphaned (Foster and Williamson, 2000).

Targeting orphans who have lost parents due to AIDS in isolation from other vulnerable young people in poor communities also raises ethical concerns related to discrimination and stigma. Such targeting has not been effective in the past, as resources given only to orphan households have caused resentment from destitute neighbours, and some households have adopted orphans so that they could receive assistance. In Botswana, some parents are reported to have registered their children as orphans or sent them to institutions with the aim of giving them increased life chances (Brandt, 2003). There is now wide agreement at all levels that programmes to assist orphans must be rooted in wider community assistance for all vulnerable children. However, for planning purposes, there is an argument to be made for using orphans as the unit of analysis, as they can be more easily identified and counted.

To provide a common global agenda for mounting an effective response to the needs of orphans and vulnerable children, UNAIDS/ UNICEF/USAID (2004) have integrated contributions from a wide range of stakeholders for all sectors of society to develop a joint report, *‘Children on the Brink: Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS’*. This report calls for the expansion of family and community support and increased programme development to meet the needs of older children (12-18 years) to access education, a job, life skills and health care. It represents an important milestone in the increasingly urgent response to the needs and rights of growing numbers of orphans and vulnerable children. The framework is targeted at senior leaders and decision makers around the world who can influence policies, programmes and resources for children made vulnerable by HIV/AIDS. The growing global consensus on protection and support for orphans and vulnerable children could be critical for mobilising and guiding an accelerated response. The key strategies proposed in the framework are to:

- i. strengthen the capacity of families to protect and care for orphans and vulnerable children by prolonging the lives of parents and by providing economic, psychosocial and other support;
- ii. mobilise and support community-based responses;
- iii. ensure access to essential services including education, healthcare, birth registration and others;
- iv. ensure that governments protect the most vulnerable children through policy and legislation and through channelling resources to families and communities;
- v. raise awareness through advocacy and social mobilisation to create a supportive environment for children and families affected by HIV/AIDS.

(UNAIDS/UNICEF/USAID, 2004, p. 5)

In South Africa, the Children’s Institute (at the University of Cape Town) has been commissioned by the Department of Health to develop national policy guidelines on health and

social services for children who have been orphaned or who are at risk of being orphaned. These guidelines are to assist relevant government departments and other role players on an appropriate policy and service response to the needs of these young people. In Kenya, the National Aids Control Council (GoK/NACC, 2002) has already developed the following set of guidelines to assist in the design of programmes to help orphans and vulnerable children:

- i. strengthen the protection and care of orphans and other vulnerable children within their extended families and communities;
- ii. strengthen the economic coping capacities of families and children;
- iii. enhance the capacity of families and communities (including schools) to respond to the psychosocial needs of orphans and vulnerable children and their caregivers;
- iv. link HIV/AIDS prevention activities, care and support for people living with HIV/AIDS and efforts to support orphans and vulnerable children;
- v. focus on the most vulnerable children and communities and not only those orphaned by AIDS;
- vi. ensure the full involvement of young people as part of the solution;
- vii. strengthen schools and ensure access to education and reduce stigma and discrimination;
- viii. accelerate learning and information exchange;
- ix. strengthen partnerships at all levels and build coalitions;
- x. ensure that external support strengthens and does not undermine community initiative and motivation.

These frameworks and principles might usefully be applied to guide the design and implementation of ODFL programming. Some practical suggestions for how ODFL could be used to help implement some of the strategies presented in these two frameworks are given in Chapter 6.

2.2 The family economy

HIV/AIDS affects the family economy in many ways. When a household member becomes sick, finances are diverted to pay for medicine and transport costs to the clinic or hospital (Ebersöhn and Elhoff, 2002). At the same time, any wages will be lost or reduced. When a breadwinner dies, household resources are immediately threatened and the family can move from poverty to destitution very quickly (UNAIDS, 2001; Foster and Williamson, 2000) particularly in the light of funeral expenses (UNAIDS, 2002b). A study in Zambia showed that in two thirds of families where the father died, monthly disposable income fell by more than 80% (UNAIDS, 2002b). A study in rural Zimbabwe in 2002 showed that households with orphans earned 31% less than those not affected by HIV/AIDS (cited in UNICEF, 2003).

Subsistence-farming households are unlikely to have any food or monetary resources to fall back on, and this is the situation for large numbers of families in Africa – for example, 70% of Tanzanians are subsistence farmers (UNAIDS, 2001). HIV/AIDS reduces the labour available for subsistence farming. In Ethiopia, affected households spent between 11.6 and 16.4 hours per week in agricultural work, compared to 33.6 hours in non-AIDS-affected households

(UNAIDS, 2002b). Hence the amount of food produced by AIDS-affected households will be less than in non-affected ones. A qualitative study of the existing needs and provision for children affected by HIV and AIDS, conducted by the Children's Institute at the University of Cape Town in South Africa, has shown that in communities heavily affected by AIDS, children's workloads increased substantially in six provinces (cited in Bray, 2002).

In patriarchal societies, the death of a male breadwinner can mean that the male's family lays claim to any land, property and money, leaving the widow and children destitute and perhaps homeless (UNAIDS, 2001). The absence of a will, which is the norm among people who are not functionally literate, affords the widow no protection. In other situations, the widow is 'inherited' – taken as a second wife by a brother-in-law – or orphans are only taken in by relatives if a bride-price was paid in marriage (Foster and Williamson, 2000). In South Africa, 39% of households are headed by women, and the poverty rate in these households is double the rate in male-headed households (Coombe, 2000b, p.13).

In households that take in orphans, meagre resources are spread even more thinly, thereby affecting a greater number of children. Given the poverty rates for Africa as a whole, having an extra person to feed and clothe will have a deleterious affect on the whole of the foster household, particularly if they are women-headed households. HIV and AIDS affects children, families and communities incrementally, by slowly shrinking resources. Although mechanisms exist for times of crisis (such as drawing on help from relatives, families, the church) these will slowly diminish as they are increasingly taxed.

This level of poverty means that there is a limited capacity for relatives and communities to absorb orphans, as they are just too poor. For example, in 2000 in Botswana, 22% of registered orphan caregivers were unemployed, and 40% were grandparents or elderly relatives (Brandt, 2003, p. 44). Grandparents are caregivers for 32%, 38% and 43% of orphans in Uganda, Zambia and Tanzania respectively (Brandt, 2003, p. 44). When children stay with grandparents, they may end up caring for the grandparents because they are old and become infirm; and the grandparents may have been relying on monthly income from their now-dead child, hence household income can fall drastically. Orphan caregivers are often poor women (UNAIDS /UNICEF /USAID, 2002; Foster and Williamson, 2000). In a survey in a region of Tanzania, households could not meet 'some' or 'most' of the basic needs of 66% of orphans (Brandt, 2003, p. 44). In one study in Uganda, per capita income in orphan households was 15% less than in non-orphan households (Foster and Williamson, 2000, p. S280).

Leach (2002) has argued that in order to mitigate the economic burdens of HIV/AIDS in a family, a young daughter may be married off early – possibly to older men who, as mentioned above, consider young girls 'safe' – and this may be a rational economic decision if a bride-price is paid for the girl. Such actions, however, may lead to child mothers, with increased problems during maternal delivery as well as cutting short their education and holding back social development.

2.3 Education and schooling

Effects on schooling

Access to education, and especially schooling, has been identified as a key protective factor for HIV. Analysis of Demographic and Health Surveys (DHS) across 32 countries found that knowledge about HIV/AIDS increases with higher levels of education. In particular, lack of basic knowledge about HIV/AIDS is about five times higher in women who were illiterate than for women with post-primary school education (Vandemoortele and Delamonica, 2000). Vandemoortele and Delamonica have referred to this effect, among others, as 'the education vaccine'. Of course, knowledge does not necessarily translate into particular behaviours. However, they argue that the 'education vaccine' works in at least three ways:

- through HIV/AIDS and sexual health information at school;
- basic education is important for empowering women and girls to stand up for their beliefs, including safer sexual behaviours, that may conflict with prevailing culture or tradition;
- as an antidote to the silence, shame, stigma and superstition about HIV/AIDS that thrives through illiteracy.

In Mozambique, the protective value of education has been noted by MOYS (GoM/MOYS, 2000) who report that prevalence rates for young people who are out-of-school rise progressively from Maputo to provincial capitals, to district capitals and the rural areas. Most of the vulnerable youth are in the hard-to-reach rural areas, where most live by subsistence agriculture, marry early and have limited access to health, education and social services.

Considering the importance being given to schooling in combating HIV, it is worrying to find that young people affected by the disease are increasingly missing out on schooling. Brandt (2003) surmises that as household resources shrink, young people may be withdrawn from school because of the inability to pay for school fees, uniforms, books and so on. They may attend intermittently if they are caring for sick relatives or younger siblings, or taking on additional domestic chores. This causes them to fall behind in their studies and can lead to them dropping out altogether (Brandt, 2003). If they do continue at school, their concentration may be adversely affected by worries about the health of parents, state of the household finances or by hunger, which are real barriers to effective learning and achievement.

Some children and young people who are orphans or living in foster families are reported to avoid school because of stigmatisation (Foster and Williamson, 2000, p. S282). Brandt (2003) argues that this stigmatisation is generally based on orphan status or destitution status rather than being AIDS related, although HIV status has also been reported as a source of stigma. Furthermore, once children have dropped out, it can be difficult for them to re-enter the schooling system in the absence of any specific re-entry programmes. Early dropout leads to low levels of literacy and decreased life chances. It can also lead to decreased life skills that are acquired through interacting and learning at school (Ebersöhn and Elhoff, 2002). Older children may leave school to find employment to contribute to household income (Commonwealth Secretariat, undated).

Despite the argument for not separating orphans from other vulnerable children, there is evidence to suggest that orphans do drop out of school more than non-orphans, possibly for the reasons cited above. 24% of double orphans in Mozambique go to primary school, versus 68% of children for whom two parents are still alive (Brandt, 2003, p. 50). In Burundi, 40% of children are in primary school, and this drops to 33% with the death of the father and 21% with the death of the mother (Brandt, 2003, p. 50). In Kenya, 52% of orphans and 2% of non-orphans are not in school (UNAIDS/UNICEF/USAID, 2002, p.10). In Uganda, among 15-19 year olds who had lost both parents, 29% continued schooling, 25% lost school time and 45% dropped out. The children who lived with a surviving parent had the most chance of continuing in school, and those who lived with a grandparent had the least (Foster and Williamson, 2000, p. S281). We have not been able to find any comparable figures for South Africa and Mozambique.

Another educational loss created by AIDS is that traditional knowledge and skills die with the parents, often before they have had time to pass them on to their children (UNAIDS, 2001, p. 20). Some recent work on 'memory counselling' is trying to respond to this (see UNOCHA IRIN Plus News, 2003) by encouraging parents to develop memory books or memory boxes for their children to keep.

The importance given to keeping young people in school as a protective factor for HIV has been challenged by those who consider schools can themselves be a risk factor (Cohen, 1999; Leach, 2002). Cohen identifies a conflict between the 'be responsible' AIDS messages and the hierarchical, directive and non-participatory school reality. This is particularly true for young girls, where the prevailing youth and school cultures consider them the legitimate target for boys' and even teachers' attention (Leach, 2002). Leach (2002) argues that in some places, the school culture tolerates gender violence (which is thought of as inevitable, and which is reinforced by gender violence in society generally) and corporal punishment in schools (despite the fact that this is banned in most of Sub-Saharan Africa). This culture perpetuates female low self-concept and under-achievement at school, and women's general dependence on men in society. Teachers who 'come-on' to girls or force them to have sex are rarely reported, because girls lack confidence, fear reprisals or are simply resigned, and in some cases because teachers offer gifts and/or money and are held in high regard in the community (Leach, 2002). This view of schools as a risk factor for HIV is highly controversial and goes against the currently accepted view that schooling is the 'educational vaccine' against HIV, which informs current policy to try to keep young people in school.

Effects on the education sector

Whilst education is viewed as a crucial element in both HIV prevention and mitigation, the ability of the education sector to deliver the education needed has been widely questioned. There has been much controversy over the precise impact HIV and AIDS will have on education sectors in Sub-Saharan Africa, given that teachers and children are dropping out in differing proportions in different countries. On the whole, HIV/AIDS is predicted to decrease the quality of education provided through schools (Bennell, 2003; Coombe, 2000b; GoM/MINED, 2001; Cohen 1999). Where teacher shortages arise as personnel become sick or take time off to care for sick relatives, there will be an increased need for materials that can support self-study and an important role for ODFL.

The other loss that AIDS creates is what has been termed 'organisational memory', which means that replacing personnel is more costly than the simple training budget. This opens up further possibilities for ODFL memory banks to be developed to support policy and infrastructure planning to accommodate changes in life expectancy and population growth. HIV/AIDS will affect attendance at schools, enrolment and dropout rates, repetition rates and the ability of families to pay school fees or levies, buy uniforms and books. In the early stages of an HIV epidemic, many of the effects are not obvious, and provincial directors and district education staff may not be fully aware of the impact of HIV on their ability to provide and deliver education. An annotated bibliography on AIDS and the Education Sector has been compiled by Wafer (2000).

In Mozambique, a study by Carr-Hill et al (2001, pp. iv-vii) on planning to combat HIV/AIDS in the education sector recommended that the Operational Plan should be refocused to give first priority to school teachers, since they are the key resource and have most contact with vulnerable 12-15 year-olds, the so-called 'generation of hope'. The major recommendation was to thoroughly educate all teachers about HIV/AIDS and train selected teachers who have experience in working with adolescents to deliver effective HIV/AIDS education in the classroom. The report stressed the importance of face-to-face delivery of training, at least initially, and close supervision to ensure quality. (One might note here the frequent requests that organisations such as Imfundo receive from Ministries of Education for materials for teachers to enable them to provide quality and appropriate learning opportunities about HIV/AIDS for their students). Attention should also be given to funding NGOs who deliver out-of-school education and work in youth groups etc, bearing in mind the need for strong support from community and religious leaders.

The quality and effectiveness of HIV education

Given the mix of economic, social, cultural, societal and political motivations that encourage or restrict safer sexual behaviour, a set of core principles have now been identified as crucial to the effectiveness of educational programmes to prevent HIV/AIDS. These principles are:

- an accurate identification and understanding of the group(s) of people to be served;
- the active involvement of young people in programme design and implementation;
- the removal of policy barriers to communicating consistent and explicit messages that help young people delay sexual intercourse and protect themselves against HIV infection;
- efforts to help young people acquire understanding and interpersonal (life) skills to resist peer group pressure and adult coercion, delay sexual intercourse and protect themselves against HIV infection, as well as the confidence to use these skills in real-life situations;
- linking information and skills development to service provision;
- action to change service providers' prejudices and attitudes;
- investment in long-enough timeframes and resources to achieve change.

(Adapted from Warwick and Aggleton, 2002)

Recognising the need to shift the focus of HIV/AIDS education/communication interventions from the individual towards the social or community level, we would add to the above principles the need to kick-start a community process of social change, to address social norms and develop a supportive environment for individual behavioural development. In the present

study, a number of our respondents raised the need for parents to understand better what young people are thinking and to recognise more fully the realities of their everyday lives.

As Pridmore (2003) points out, to be successful we need to learn from the experiences of frontline workers how to initiate and sustain a dialogue with young people, parents and community groups to develop a more supportive environment for young people's efforts to combat HIV/AIDS. Such a dialogue is needed to shift negative adult attitudes towards recognition that young people are knowledgeable, competent, innovative and creative individuals who are both allies and agents in working to combat AIDS. Through such dialogue a 'local bill of rights' for young people's participation needs to emerge, so that they can be meaningfully involved in developing programmes to meet their real interests and priorities.

This dialogue also needs to address the common belief that talking openly about sex encourages sexual activity. Grunseit (1997) presents strong evidence to challenge this belief. Several studies have shown that well-designed programmes, including messages about safer sex as well as abstinence, may delay sexual debut as well as increase preventive behaviours among those young people who are already sexually active.

Skuse (2002) provides a clear overview of HIV/AIDS education/communication that locates this work firmly within a poverty reduction and rights based approach. Skuse's work endorses the need for a broad based educational approach, involving initiatives at all levels (policy and legislation, mass media and macro-level communications and community, interpersonal and participatory initiatives). Such initiatives are needed to stimulate the type of information-rich and dialogue-rich environment that is critical to reducing HIV prevalence. Placing HIV/AIDS education/communication in this broad context exposes the futility of focusing narrowly on behaviour change communication (BCC) aimed at the individual, and yet this out-dated approach is remarkably persistent.

There is clearly a need for a broad-based understanding of what is crucial to the quality and effectiveness of HIV/AIDS education to be more widely disseminated and taken up into curricula for initial teacher education. There is also a need for inservice teacher education to be broadened, and there is a role for ODFL to play here. Teachers are key frontline workers in developing the dialogues identified above, and they need to develop new skills in working with young people as partners and in facilitating dialogue between different groups to develop social environments that support the wellbeing of young people.

2.4 Health and wellbeing

Because HIV is sexually transmitted, the probability of both parents being infected is high. As one or both parents fall ill, household income or production falls, and children can become malnourished and more prone to infections and other health problems (Brandt, 2003). This is more acute in rural areas, where health services are scarcer (UNAIDS, 2001), particularly if subsistence farming labour is lost (Ebersöhn and Elhoff, 2002). Young people who are out-of-school may not have the knowledge or skills to make low-cost nutritious meals for themselves and their siblings.

However, according to Foster and Williamson (2000), most studies show that there is no significant difference in the morbidity rates of orphans versus non-orphans. This may be because there is still capacity within the extended families to cope with orphans (Foster and Williamson, 2000, p. S281). In households where there are more demands on resources, there may be less access to health services, even if they are free, because of transport costs, and the target group may fear discrimination or stigmatisation.

Studies of South Africa and Zimbabwe have shown that the dominant views of masculinity encourage boys to have multiple sex partners as a sign of virility. This age group is traditionally not given health information, services and resources, and health services are not designed for young people (Rivers and Aggleton, 1999; Leach, 2002).

Young people affected by AIDS may move to live with a relative, especially a grandmother. With an elderly relative, they may have to assume the more adult roles of cooking, cleaning, caring for younger siblings and undertaking subsistence farm labour. The change in home environment, and perhaps area and community, may cause distress for children, who do not know the neighbours or their way to the shop or school, and this will be felt more acutely if accompanied by declining household resources. Orphans also often report stigmatisation, including at school (UNAIDS, 2001).

The growing number of affected orphans and vulnerable children will also require a shift in the way home-based and community welfare services are delivered in both South Africa and Mozambique. There will be an increased call for fostering. The traditional ways in which South African and Mozambican families have coped with the issue of early parental death will be brought under significant pressure. Furthermore, UNAIDS (2001) argues that family and community safety nets are not sufficient for some children, and that child protection and care interventions are needed if most vulnerable children are to survive. Can ODFL play a role here?

The psychosocial effect of orphanhood is perhaps the most complex issue faced by orphans, and is something that distinguishes them from other vulnerable children. This issue has been recently reviewed in the South African context by Richter (2003), who argues that the impact on large numbers of children of the combined affects of poverty and HIV/AIDS – namely school dropout, child labour abuses and the sexual exploitation and trafficking of children – is likely to cause significant social disruption. Ebersöhn and Elhoff (2002) stress that children who have been orphaned by AIDS are likely to be severely traumatised, and that it is their psychosocial needs that are most often overlooked.

It is much easier for individuals, communities or NGOs to give food and blankets than counselling. But psychosocial needs are crucial: orphanhood can lead to the 'loss of consistent nurture, which can lead to serious development problems, and loss of guidance, which makes it more difficult for the child to reach maturity and to be integrated into society' (UNAIDS, 2001, p. 20). The UN Convention on the Rights of the Child regards having psychosocial needs met to be a child's right (UNAIDS, 2001, p. 13).

For any young person, watching a parent waste away and die is traumatic, particularly in the context of increasing poverty and little access to medicine. Growing economic insecurity in the

household can cause anxiety and fear of abandonment in children (Ebersöhn and Elhoff, 2002). Realising that parents, particularly the mother, are going to die, and with them the child's source of security, comfort, hope and affection, can lead to depression and anxiety. Even if they are not told that the parent is infected, children often pick up on the emotions of the adults (UNAIDS, 2001) and begin to worry. This may cause problems at school, such as lack of concentration or reduced sociability, which teachers might interpret as being 'troublesome' and respond with punishment, thereby reinforcing the isolation and helplessness.

Many parents find it difficult to talk about death with children, and this silence may cause increased worry and a sense of betrayal when the parent later dies. It may also reinforce the idea that it is something they should not talk about or show any emotion over. Under these circumstances, children may believe that the parent is going to die any day, when in fact it might be a few years away. In the situation of ignorance, the death of the parent may come as much more of a shock than if children know that their parent is dying and can start to think about and prepare for their life without their parent (UNAIDS, 2001). Children may also suffer from feelings of hopelessness at poverty, and possibly the overwhelming responsibility for caring for siblings or other family members (some of whom may be sick). Added to this may be the fear (or certainty) that he or she is infected with HIV and facing the same death.

Ebersöhn and Elhoff (2002) suggest that if poverty, malnutrition and poor education stunt children's development, those children will probably also have a reduced ability to form 'coping' and problem-solving strategies. Cultural values and beliefs are key in informing coping strategies, but there is little research on indigenous coping beliefs and practices.

Children with sick parents frequently worry about the future and who is going to look after them, tell them stories, love them and provide for them. During parental illness in Zambia, 82% of carers noted changed behaviour when the parent became ill. The children became worried, sad, helped a lot more in the home, stopped playing to be nearby, and were more likely to become solitary, appear distressed and be fearful of new situations. There were changes in self-esteem reported, but not sociability, indicating an internalised behaviour change rather than an externalised one (Foster and Williamson, 2000, p. S282). This internalisation, or 'swallow(ing) of despair' (Ebersöhn and Elhoff, 2002, p. 84) makes these psychosocial needs very hard to recognise and treat.

Losing a mother has an especially profound effect on the wellbeing of children (Ebersöhn and Elhoff, 2002, p. 78) although the loss of the father may herald increased economic insecurity as well. Coping is defined by Ebersöhn and Elhoff (2002) as adapting to the demands of the environment, answering the question 'what do I do?'. This question is preceded by the questions 'who am I?' (identity formation); 'how and what do I feel?' (emotion regulation); 'how and what do I think?' (cognitive regulation); and 'what are my beliefs?' (normative regulation). Young people form these coping mechanisms as they mature, partly naturally and partly as a response to stressors in the environment.

Coping strategies will be different for each young person (depending on gender, age, self-concept and culture), family (nurture, emotional support, income) and supportive kinship (human, material and environmental support). If identity formation and coping are culturally

specific and learnt through familial and cultural socialisation, what happens to the process if families and communities are lost? Children who lose the support structures on which their coping mechanisms are built may never grow up to be integrated members of society.

Can traumatised children cope in a problem-solving way, and at what age does the required meta-cognition develop? What indigenous or community-specific coping beliefs and practices exist, and how are orphans socialised into them? Do communities support the expression of children's insecurity and sadness, and how do they help children to make sense of their orphanhood? These are just some of the many pressing questions here.

As part of the orthodoxy that relegates children to 'less than adults', children are not encouraged to express grief. Many children are not allowed to go to funerals of parents or relatives. Many children may not understand the situation and thus may be unable to express grief effectively; and even if they want to, there may not be anyone to listen to them. Emotions may be expressed through crying, withdrawing, shouting or playing (UNAIDS, 2001).

Traumatised children are prone to inadequacy, depression and post-traumatic stress disorder (PTSD). In Rwanda, traumatised children became zombie-like and emotionally detached. In Nairobi, unsupported trauma led to a cycle of helplessness, despair at lack of control and an unwillingness to try to manage other situations (Ebersöhn and Elhoff, 2002). In a Ugandan study, most orphans were found to be depressed, with lower expectations about the future. Fewer orphans expected they would find a job, wanted to get married or wanted children than non-orphans (Foster and Williamson, 2000, p. S282). Losing a home – and perhaps siblings, as they are separated to live with different relatives – can be felt as a second or third loss.

To summarise, given the way in which HIV/AIDS is compounding the effects of poverty at all levels, it is not surprising that it is now being recognised as a threat to development, reducing school enrolment, increasing social inequality and instability and pushing more children onto the streets. Although the response to the crisis posed by orphans and vulnerable children (OVC) is growing, UNAIDS/UNICEF/USAID (2004) argue that it lacks the necessary urgency, and remains unfocused and limited in scope. In the next chapter we will examine what is being done to mobilise collective action at the central level in South Africa and Mozambique.

Chapter 3: National Policies on HIV/AIDS in South Africa and Mozambique

This chapter draws on data from interviews with policy makers/advisers and key informants in agencies working in HIV/AIDS (see list of contacts in Appendix 1) and analysis of documents. It tracks the process of policy development and critique in each country, and identifies challenges to policy development and gaps in current provision.

The first AIDS case was reported in Africa in 1982. It was not until the 1990s, however, that the first comprehensive national policies on HIV/AIDS appeared (Stover and Johnson, 1999). Over the last two decades, there have been four main responses. The first response in both South Africa and Mozambique, as elsewhere in Africa, was to treat the disease primarily as a medical problem. Activities focused on screening blood supplies, ensuring safe medical practices and initiating research and surveillance studies to determine the extent and level of infection among the population – initially by anonymously testing pregnant women at antenatal clinics.

As the epidemics progressed, international agencies and governments began to realise that a broader-based approach was needed, involving mass media public awareness campaigns to increase condom use and safer sex practices targeted at high risk groups, along with the provision of improved counselling and support services for those infected and affected. However, even at this stage many difficult issues tended to be dealt with reactively by issuing ad-hoc guidelines or regulations.

Later in the 1990s, as infection rates began to increase alarmingly and the number of AIDS related deaths began to rise, there was an urgent call for a more integrated multi-sectoral response, involving all major arms of government, but also drawing in business interests and civil society. In South Africa, the Metropolitan Life studies, though predominantly stressing the negative effects of the disease on human capital and economic growth, were influential in raising a broader social awareness and in stimulating stronger and more integrated cross-sectoral policy and action from government (loveLife/Abt Associates, 2000). Since 2002, in South Africa and, to a lesser extent, in Mozambique, we have seen a shift to a stronger focus on treatment and human rights (e.g. further efforts to counteract stigma and discrimination and provide anti-retroviral medication) through better-coordinated education and health and support programmes using both formal education and mass media programming.

3.1 South Africa

Historical development

AIDS was first identified in South Africa in 1982 but – not surprisingly, given the preoccupation of the apartheid era with the wider liberation struggle – attention to the AIDS issue proceeded at a slow pace during the 1980s. It was not until 1990, when the ANC held a conference in Maputo and drafted the ‘Maputo Statement on HIV/AIDS’ – where it recognised the potential damage the epidemic could do to South African society in the post-apartheid era – that a focus was gained (Marais, 2000, p. 45).

During the early 1990s, the ANC (while it was still banned), worked cooperatively with the AIDS unit of the Department of Health to establish an AIDS Steering Committee. This had broad representation from across society, including business/chambers of commerce, trade

unions, churches and other members of civil society. This Steering Committee decided on the need for a National AIDS Strategy and Plan and in 1992, held a national conference that established the National AIDS Coordinating Committee of South Africa (NACOSA) to develop the plan. The new Government of National Unity subsequently adopted this plan in 1994. Interestingly, the National Plan and Strategy was developed not by the government in power, but by a coalition of stakeholders from outside government.

However, since 1994 there have been many delays in implementation, due partly to a lack of government experience, the complexity of the issues and a lack of technical and professional capacity in the provinces and districts. Early priorities were concerned with developing support among public and private leaders, developing local capacity, promoting intersectoral action, and with efforts to reduce the stigma associated with HIV/AIDS. More recently, as the epidemic has begun to have increased impact, these priorities have given way to a focus on the issues surrounding treatment and care, including mother-to-child transmission and the use of anti-retroviral therapies for people who are infected (Stover and Johnson, 1999).

HIV/AIDS and South African policy: an overview

South Africa has attempted to address the needs of out-of-school youth through a multi-dimensional response, driven by the Departments of Health, Education and Social Development. The guiding document here is the National Integrated Plan for Children Infected and Affected by HIV/AIDS (1999), which in turn is guided by the broader HIV/AIDS/STD Strategic Plan (2000-2005).

The HIV/AIDS/STD Strategic Plan (2000-2005) (GoSA/DoH, 2000) is South Africa's current national strategy on the HIV epidemic. The plan is the culmination of a number of governmental responses since 1988 (see Marais (2000) for a more detailed discussion of early policy formation and some of the contested issues). The most significant response was the establishment in 1992 of the National AIDS Coordinating Committee of South Africa (NACOSA). NACOSA has been tasked with the development of a national strategy on HIV/AIDS. In 1997 the South African National STD/HIV/AIDS Review instigated the establishment of the Inter-Ministerial Committee on AIDS. This committee has since launched the 'Partnership against AIDS' programme and established the South African AIDS Council (SANAC).

The HIV/AIDS/STD Strategic Plan (2000-2005) identifies four main priority areas: (a) prevention (b) treatment, care and support (c) human and legal rights (d) monitoring, research and surveillance. Four general strategies are emphasised:

- (i) an effective and culturally appropriate information, education and communications strategy;
- (ii) increased access and acceptability to voluntary HIV testing and counselling;
- (iii) improved STD management and promoting increased condom use to reduce STD and HIV transmission;
- (iv) improving the care and treatment of HIV positive persons and persons living with AIDS, to promote a better quality of life and limit the need for hospital care.

The Strategic Plan recognises the AIDS epidemic as an ‘incomprehensible calamity’ that calls for ‘a renewed commitment from all South Africans’ (p. 5). At the core of the government response is a commitment to a multi-sectoral approach to the disease. This marks a significant shift in the government response away from the disease being a health sector responsibility and towards a more collaborative effort between all government sectors at the national, provincial and local levels. The collaboration also extends to non-governmental and civic organisations and HIV/AIDS infected stakeholders.

The intention is that all sectors, both governmental and civic, utilise the HIV/AIDS/STD Strategic Plan to formulate and implement their own strategic and operational plans. Basically, the intention is that this multi-sectoral approach will be achieved across the governmental sectors through the Interdepartmental Committee on AIDS (IDC) and on a broader civic level through the South African National AIDS Council (SANAC).

The South African National AIDS Council (SANAC) has two key tasks: first, to reduce the number of new HIV infections, with special emphasis on youth; and second, to reduce the affects of HIV/AIDS on individuals, families and communities. The 1992 National AIDS Coordinating Committee of South Africa has three tasks:

- to prevent HIV transmission;
- to reduce the personal and social affects of HIV infection;
- to mobilise and unify provincial, international and local resources.

The Strategic Plan is an articulation of policy, in addition to being a framework for developing operational plans with set indicators for monitoring the country’s response. Each priority area (prevention; treatment, care and support; human and legal rights; monitoring, research and surveillance) has objectives, strategies and lead agencies.

The National Integrated Plan (NIP) for Children Infected and Affected by HIV/AIDS (1999)

The overall goal of this plan was to ensure that children have access to integrated prevention and support services that address their basic needs for food, shelter, healthcare, family or alternative care, information, education and protection from abuse and maltreatment (GoSA/DoH, 2000b).

The NIP was conceived at the end of 1999, following the Cabinet’s suggestion for an integrated response by the Departments of Education, Health and Social Development to the epidemic. Although national government conceived the plan, the intention was that an integrated approach should be developed at the provincial level though inter-sectoral and inter-departmental collaboration. Provinces should develop their own implementation plans and programmes, with support and financing to address three main interventions:

- life skills education;
- voluntary counselling and testing programmes;
- home and community-based care and support interventions.

Essentially, the life skills programme formed the core of the plan, and education was given the bulk of the plan's budget of 450 million Rand over the three-year period. Education's mandate was to implement the life skills programme in 20% of schools in year one, a further 40% in year two and the final 40% in year three.

In terms of the voluntary testing and counselling programme, the overall goal was to provide HIV counselling and testing to 25% of the population aged 15-49 within the three years. Priority groups are youth and those who live in rural areas.

The response of the Department of Education

Life skills education

Central to the NIP is the development of life skills education. The goal of this programme is to 'assist youth to acquire knowledge, develop skills and establish values that will enable them to make responsible choices and grow up healthy'. Life skills has been the responsibility of both the Department of Education, for youth attending school, and the Department of Health, for those youth outside of the formal school system. Initially, when life skills education was introduced into schools in 1997, it was mainly coordinated by the Department of Health. However, with the implementation of the Minister of Education's Tirisano strategy, it has now become the responsibility of the education sector.

Master trainers have been trained, resource materials and manuals have been produced to guide teaching and learning in life skills. The life skills programme has targeted out-of-school youth through social mechanisms such as sport, youth organisations and mass media campaigns such as Soul City. (See Chapter 4 for a more detailed analysis of these interventions.)

Human rights

One of the guiding principles of the national HIV/AIDS Strategic Plan is the human rights approach, which underpins all other policies and plans. (For a recent critical review of the rights-based approach to HIV/AIDS in South Africa, and to a lesser extent in Mozambique, see Kisoon, Ceasar and Jithoo, 2002.)

The National Department of Education has developed two critical policy documents:

- The National Policy on HIV/AIDS for Learners and Educators in Public Schools, and Students and Educators in Further Education and Training Institutions;
- HIV/AIDS Emergency: Guidelines for Educators.

These policies focus on the management of HIV and AIDS in schools, namely:

- maintaining a healthy and safe school environment;
- absenteeism of infected learners;
- dealing with discrimination and stigma;
- the prohibition of HIV testing of learners and educators;
- the training of educators as counsellors, and the integration of life skills education with HIV/AIDS education.

The response of the Department of Health

Voluntary Counselling and Testing (VCT)

In terms of the NIP, the overall goal of the voluntary counselling and testing programme was to provide HIV counselling and testing to 25% of the population aged 15-49 within the three years. Priority groups are youth and rural areas. The underpinning philosophy is that once more people become aware of their status, they will undertake more responsible sexual and health behaviour. In order to encourage this, a number of clinics have been established to offer this programme, and media campaigns have been launched to encourage people to use such centres.

Life skills

The Department of Health has been rolling out its life skills programme in schools since 1997. Combined with this there have been extensive mass media campaigns, both print and television, of which the most significant are Soul City, loveLife and Khomanani. The objectives of these campaigns have been to intensify the HIV/AIDS message for youth in particular; to distribute resources and to link youth up to counselling and testing services. Alongside such programmes have been the mass distribution of condoms and the management of STDs.

The response of the Department of Social Development

Community care

A key strategy for supporting infected and affected children has been through a community care model, involving:

- the use of community care workers to support affected families;
- the provision of training to caregivers;
- nutrition and poverty alleviation.

In support of such a model, the Department of Social Development has made provision for child support grants and care dependency grants. We should note, however, that research conducted by the Children's Institute (at the University of Cape Town) has shown that this model of provision has shortcomings. In practice many service providers come into contact with families affected by HIV/AIDS without using this opportunity to identify or support young people who are especially vulnerable (<http://web.uct.ac.za>).

The Department of Health continues to drive HIV/AIDS policy development, although the South Africa National AIDS Council (SANAC) ratifies the policy. Critique is developed through the universities (e.g. Centre for the Study of AIDS in Pretoria), the public media and organisations such as the AIDS Consortium.

3.2 Mozambique

Policy development in Mozambique, as elsewhere, has developed within the context of existing policies, strategies, initiatives and programmes at the global, regional and national levels. For example, policy development has been influenced by the recommendations from the 1994

International Conference on Population and Development (ICPD), the Fourth World Conference on Women in Beijing, and the recommendations from the SADC Youth Conferences held in Maputo in 2000 and in Windhoek, Namibia in 2001. Unfortunately, progress towards realising the recommendations from these conferences has been slow and they are still far from being met. Mozambican adolescents and youth are under-served, and there is still a shortage of strategies addressing the needs of out-of-school youth and the complex contexts within which their sexual and reproductive health decision-making takes place. The commitment of the Government of Mozambique to its youth was demonstrated in 1996 by the development of a National Youth Policy to increase youth involvement in policy development and the decisions that affect them. The policy focuses on the healthy development of young people by promoting programmes that increase their access to information and integrated sexual and reproductive health (SRH) services.

A major government commitment was the development in 1999 of the first National Strategic Plan to combat STDs/HIV/AIDS, known as PEN 1 (GoM/National AIDS Council, 2000). In this plan the government publicly committed itself to improve quality and expand coverage of essential services to combat HIV/AIDS, and identified prevention and impact mitigation activities as of primary importance. The plan guides a multi-dimensional response that has been driven by the Ministries of Education (MINED), Health (MISAU), Youth and Sports (MOYS) and Women and Social Action (MWSA). All ministries and their provincial departments have subsequently prepared operational, sectoral and provincial plans for HIV/AIDS. At the time of the study, there is no National Integrated Plan for Children Infected and Affected by HIV/AIDS in Mozambique like that developed in South Africa.

The government has recognised the need for a high-level body to coordinate the implementation of the PEN, to be the lead advocate for HIV/AIDS by bringing AIDS into the national policy arena, and to mainstream HIV/AIDS issues into social and political dialogue. This body, the National Aids Council (NAC/CNCS), established in May 2000, is led by the Prime Minister and composed of members from the Government and Civil Society. The CNCS has a Secretariat with headquarters in Maputo and a Provincial Nucleus in every province with a five-fold mission to:

- (i) mobilise high-level political and social leadership and commitment;
- (ii) coordinate a multi-sector response involving all members of society;
- (iii) improve the quality and coverage of service delivery;
- (iv) address the HIV/AIDS epidemic in its social, economic, health and development dimensions;
- (v) respond to the special challenges of people living with HIV/AIDS.

(GoM/CNCS, 2003).

The National Strategic Plan to combat STDs/HIV/AIDS (PEN)

The aim of the first PEN (known as PEN 1) was to provide the framework and define broad strategies to be adopted by the government for the period from 2000-2002. The process of policy development was coordinated by MISAU and roughly follows the steps in the planning framework developed by Haddad (1995). This process involved 241 people (representing 66 national and 11 international institutions), participating in seminars and working groups

conducted over a period of six months. A clear, systematic process of development is presented in the Strategic Plan:

- Step 1: Situational analysis. Data were collected to define the magnitude and trends of the epidemic and its impact. At this stage, the most vulnerable groups were also identified. The conclusions from the situational analysis fed into the second step.
- Step 2: Analysis of the national response – relevance, appropriateness, coverage and effectiveness – including identifying constraints and opportunities and appraising options. This analysis showed the national response had been impeded by political, cultural, social, institutional and financial obstacles.
- Step 3: Comparing the findings from steps 1 and 2 – to determine how relevant the present response was. This was done by considering the degree to which the specific determinants for each social group were being covered by the national response activities.
- Step 4: Assessing the adequacy of human and financial resources – in relation to the objectives of programmes and projects.

The situational analysis in the PEN identifies orphans and young people who are out-of-school, especially girls, as particularly vulnerable groups who are currently being under-served. However, only four projects were reported to be directing some of their activities towards young people out-of-school; no NGOs were involved in addressing the needs of orphans; and although the Ministry of Women and Social Action's wish was to address their needs, it had not carried out any activities to date. Consequently, a guiding principle of the PEN was that each project and programme should target a vulnerable group. MINED was tasked with responsibility for young people in school; MOYS with young people not in school; and MWSA with orphans and vulnerable women. MISAU was tasked with improving access to and quality of services to combat HIV/AIDS, with a significant focus on prevention activities among young people.

Priority actions have included:

- implementing essential activities directed at young people, especially girls, to prevent infection;
- effects reduction activities aimed at orphans;
- improving the quality and coverage of youth-to-youth education;
- STD diagnosis and treatment;
- voluntary counselling and testing (VCT).

Priority was also placed on overcoming the most important obstacles (political, social, cultural, institutional and financial) that impeded implementation of the PEN.

The process of revising and updating PEN 1 started in 2003 within a supportive policy environment. The multi-sectoral committee tasked with drafting PEN 2 adopted the UNGASS Declaration (UNGASS, 2001) as its conceptual framework. This declaration recognises that a rights-based approach to AIDS, gender equality and women's empowerment is a prerequisite for stemming the tide of the epidemic, and provides entry points at many levels to implement and monitor progress towards achieving its critical goals and targets. PEN 2 aims to be less

generic, more comprehensive and truly multi-sectoral (integrating, for example, civil society, PLWA, private sector, academics and the mass media) and will say more about how specific strategies can be used. Implementation will be co-financed by the World Bank.

The working draft of PEN 2 (GoM/CNCS, 2003, p. 46) clearly delineates the objectives, tasks and responsibilities of each ministry. The objectives for MINED are to:

- provide education for the prevention of STDs/HIV/AIDS;
- provide education for girls;
- provide support for staff and students with HIV/AIDS;
- reduce the impact of HIV/AIDS in the education sector.

The objective for MWSA is to support children (including orphans) and the most vulnerable families. The objective for MOYS is to coordinate the activities to prevent AIDS aimed at young people, especially girls. Surprisingly, the objectives of MISAU are not included in this document.

Once the objectives, tasks and responsibilities of each ministry have been agreed, the work of developing further policy and strategy will again be taken forward within each ministry. At the time of the study, the responses of individual ministries to PEN 1 were at very different stages of development. This is explored further in the next section.

The response of the Ministry of Education

The initial response was to prepare an Operational Plan and commission a study to assess the impact of HIV/AIDS on the education sector (GoM/MINED, 2001). This study did not present any information on school-aged children who are out-of-school and also the responsibility of MINED, but it did recommend further consideration of how the education sector could respond in an innovative manner to the rapidly growing orphan population, to ensure that they have continued access to education. It did not explore how ODFL might play a role in ensuring access. The study emphasised the need for the education sector to concern itself with teaching children their rights and how to protect themselves from HIV.

Later in the same year, MINED commissioned a study by Carr-Hill et al (2001) to review the current status of planning to combat HIV/AIDS (including an assessment of the impact study) and to suggest how the initial programme in the Operational Plan could be made more concrete and practical. This study strongly recommended refocusing the Operational Plan to give first priority to preparing teachers to deliver Sexual and Reproductive Health (SRH) education through In-Service Teacher Training. Although the study recommended that the majority of information and suggestions on attitude change on HIV/AIDS should be delivered face-to-face, it recognised MINED's low capacity to carry through teacher training activities. The report also recommended prioritising the development of a framework for involving NGOs, and preparing a national strategy for the reduction of the impact of HIV/AIDS in the sector.

The report pointed out that some consideration needed to be given to how to reach out-of-school youth. It raised a number of questions in relation to the design of programmes for reaching this group:

- What are appropriate approaches to the community-based organisations (CBOs) and religious institutions?
- What funding modalities will be accepted?
- How can the impact of such community-based initiatives be evaluated? (p. 16)

The report argued that out-of-school education, youth clubs, etc. must be led by experienced educators trained in adolescent sexual and reproductive health issues, and must have the whole-hearted support of the community and religious organisations. It stressed that mitigating the impact of the epidemic on the education sector will to a very large extent depend on the overall level and effectiveness of assistance that is provided to affected children and their carers outside of school. It argued that divided responsibilities were a major problem in relation to teachers addressing the needs of orphans. Teaching staff believed it was the social workers and not teachers who had the primary responsibility for assisting orphans. Consequently, identification of orphans by teaching staff was generally very poor, and targeted support was patchy and ad hoc.

Building on the findings from these two studies, MINED developed a clearly defined and agreed sectoral Strategic Plan to Combat HIV/AIDS for 2003 to 2005 (GoM/MINED, 2002a). This Strategic Plan is complemented by an Operational Plan that details a list of activities designed to achieve the goals and objectives in the Plan. The Strategic Plan has recently been updated for 2003 to 2008 to include the HIV/AIDS policy (GoM/MINED, 2003). The plan addresses HIV/AIDS prevention, care and mitigation. The plan does not, however, address the issue of how to ensure that those young people who cannot attend school regularly because they are affected by HIV/AIDS can continue with their basic education, so that they do not get behind and drop out.

In addition to developing strategic plans for HIV/AIDS, MINED has addressed HIV/AIDS issues in its main Education Sector Strategic Plan 2004-2008 (GoM/MINED, 2003). Within this plan, additional funding will be available for ‘quick initiatives for education to build capacity’, to develop an action plan for HIV/AIDS and develop schools as centres for information, health service delivery and counselling, not only for students but also for parents and other members of the community⁴. The Strategic Plan also notes the need to develop incentives to increase enrolment and retention of girls in school. It does not, however, make any special provision for young people who are unable to attend school regularly because they are affected by HIV/AIDS.

At the time of the study, HIV/AIDS policy within MINED centred around a restricted group, chaired by the head of the Division of Basic Education and with HIV/AIDS advisers from UNFPA, UNICEF, UNESCO and Danida. This group met weekly. There was also a wider group that included the restricted group and the people who are focal points for AIDS in their departments. (The Department of Distance Education (DDE) was not yet represented here, but

⁴ This notion of schools being developed as nodes of support for children and communities is also being explored in South Africa – by the Children’s Institute at the University of Cape Town.

there was recognition that it needed to be.) This group met monthly. There was also a third group that included all the previous people, plus NGO representatives (such as ActionAid, AMODEFA and MONASO) and the AIDS focal points from each line Ministry as well as from the Fund for Community Development (FDC). This group met quarterly. Another small department within MINED, which is important for combating AIDS but not yet represented on the working group, was the Department of School-Community Links.

A major thrust of MINED's response to the PEN has been within its current major reform of the primary curriculum. The aim of this reform is to increase access to educational opportunities, especially for girls, and to speed up progress towards achieving universal enrolment in primary education. Within the reform process, SRH issues have been integrated throughout the primary curriculum and the teacher-training curriculum, with a view to increasing knowledge and understanding and developing the practical skills needed to take preventive action. A 20% window has also been set aside for the development of local curricula that may include SRH issues. In addition, INDE are collaborating with MINED in providing support for a package of SRH activities in primary, secondary and technical schools (Hainsworth, 2002).

From our discussions, it became clear that meeting the learning needs of 14-18 year old out-of-school youth, especially those affected by HIV/AIDS, did not figure strongly in the mindset of conventional educators within MINED. Outside of the DDE, all policy makers reported that responsibility for meeting the needs of out-of-school youth lies with MOYS and MWSA and not with MINED. The exception was the Department for Adult Education in MINED, where there is a remit to provide vocational education.

This lack of concern for providing basic education to young people who are out-of-school is surprising, given the very high dropout rate of 47% for 10-14 years olds and the fact that rates are increasing, especially for girls (GoM/MINED, 2002).⁵ The lack of concern is even more surprising considering that education, and specifically primary education, is one of the six fundamental areas for action in the National Poverty Reduction Strategy, and that the government is striving to reach the Millennium Development Goals. The MINED (2002) Strategic Plan for the fight against HIV/AIDS acknowledges that 'the education sector has ... responsibilities ... to provide means whereby they (young people out-of-school) may acquire (preventive) information and skills even outside the formal education system' (p. 3). It plan does not, however, refer to any provision for basic education for this group, but identifies a lack of accessible 'social equipment' addressed to the out-of-school group as a barrier to reaching them.

One informant reported that there was some awareness in MINED of the need for more flexible delivery systems for the national curriculum to meet the learning needs of children affected by HIV/AIDS, and that this had been discussed at meetings of the HIV/AIDS working group. It would clearly be useful for the HIV/AIDS working group to have members from DDE who are experts. The Education Sector was already overstretched just trying to bring quality education to children in school, and there was no spare capacity to take on a mandate for reaching out-of-school youth. This gives cause for concern when the very high dropout rates are widely known to be a major problem for achieving EFA. The Head of the

⁵ Other estimates are even higher, with a figure of 70% dropout by age 13 years being given by GoM/UNFPA (2001).

Basic Education Department reported that the 2001 dropout rate of 5% in each grade increased in 2002 to 8% and was running at 9% in 2003. Drought and floods were reported to have contributed to this high figure.

Basic education is free in Mozambique, but there is a social action budget in the schools into which the parents pay at the beginning of the year to help children in need. This fund pays for some books but not for school uniform. We were told that in rural areas it is very difficult to get parents to pay into this fund. Now MINED and MWSA are developing a work plan to help needy children in rural areas so that they can stay in school and contribute to the achievement of EFA. Within MINED, only the Directorate for Adult Education has a specific brief for reaching young people and adults over 15 years of age. However, this does not include delivering the National Curriculum to those who remain beyond the reach of the formal system.

In February 2004, MINED hosted an important seminar to accelerate the education sector response to HIV/AIDS in Mozambique. This seminar was part of a recent initiative from the UNAIDS Interagency Task Team for Education (IATT), which calls for a multi-partner effort from HIV/AIDS affected countries, development partners, civil society and the private sector to promote high-level understanding and leadership, and the development of effective national responses across the education sector.

This initiative had two aims. First, it aimed to promote EFA and the Millennium Development Goals (MDG) to ensure that every girl and boy has access to quality education, despite the impact of HIV/AIDS on the education system. Second, it aimed to strengthen the capacity of the education sector to respond with timely actions to prevent learners and teachers from being infected with HIV. Discussions included the possibility of using interactive radio education to respond to the needs of orphans and other vulnerable children (GoM/MINED, 2004).

The response of the Ministry of Health

Adolescents have traditionally been viewed as healthy individuals, less vulnerable to illnesses than children and adults. Consequently less attention has been paid to them, although they represent 32% of the total population of Mozambique (about 15.3 million young people). However, in recognition of the potential affects of HIV/AIDS on young people, MISAU has established a Section of School Health and Adolescents (SEA) within the Department of Community Health.

Issues linked to adolescent sexual and reproductive health are now integrated into the training of nurses, who are consequently better equipped to respond to the needs of adolescents and youth. At the same time, medical doctors and health technicians have ongoing training on issues of adolescent sexual and reproductive health, including HIV/AIDS, and the ministry is in the process of revising basic medical and nursing training to include these issues.

The main objective of the National Policy on Adolescent Sexual and Reproductive Health developed by MISAU is to improve the physical, mental and social wellbeing of adolescents. To fulfil the objectives of the national policy, MISAU has identified the following strategies:

- creation of a favourable environment for adolescent sexual and reproductive health services and advocacy on sexual and reproductive rights;
- provision to adolescents of Information Education and Communication (IEC) materials for behaviour change;
- improvement of technical capacity and training of service providers;
- provision of quality services;
- involvement of youth in all stages of the process and improvement of their life-saving skills;
- provision of data for monitoring and evaluation of activities with youth in order to improve them.

In 2001, MISAU approved a Strategic Plan for the Health Sector (PSS) 2001-2005-2010 (GoM/MISAU, 2001). The main body of the plan gives only one page to HIV/AIDS, where it highlights the way in which the effect of HIV/AIDS on highly qualified people will have a serious economic affects, increasing the cost of health services and driving up poverty. The plan also includes as an annex the National Strategic Plan to combat STD/HIV/AIDS in Mozambique 2000-2003.

At the time of the study in 2003, MISAU did not yet have any agreed and comprehensive policy on HIV/AIDS. The existing policy was never written in one document, but in two ministerial bulletins related to HIV/AIDS. These are not laws – they are regulations. These two bulletins were on the rights of people with HIV/AIDS and on prevention of mother to child transmission (MTCT).

The HIV/AIDS Strategic Plan of this Ministry was reported to have been adversely affected by the rapid introduction of a series of funding streams, including the Clinton Foundation, World Bank Multi-country HIV/AIDS Programme and the Treatment Acceleration Project. This Strategic Plan was being rewritten and would include scaling up provision of Anti-Retroviral Therapy (ART) from 8,000 people in 2003 to 20,000 in 2006. The controversial issue was about who would have priority access to ART, and it was being mooted in the press that priority would be given to pregnant women and civil servants. There was also a recognised need to link all preventive and curative services into one model. Very high targets for coverage had been set, considering that in 2003 only 40% of the population had access to health services.

MISAU has recognised the importance of adolescent health issues by creating a School and Adolescent Health Section (SEA) within the Community Health Department to extend and improve SRH services in clinics and government schools. A comprehensive National Adolescent Reproductive Health Policy has been developed, aimed as promoting, physical, mental and social wellbeing of adolescents, through programmes that will address adolescent sexual and reproductive health programmes.

Adolescent sexual and reproductive health topics have been integrated into basic nurse training to better equip nurses to address adolescent health needs. An information, education and communication campaign has been started with support from UNFPA. In addition, a National Adolescent Reproductive Health Policy has been developed, which promotes the wellbeing of adolescents through developing adolescent sexual and reproductive health programmes (Hainsworth, 2002).

The response of the Ministry of Women and Social Action

In 2000, the government showed continued commitment to the needs of women, children and the poor by establishing this ministry and creating within it a National Directorate of Women and Gender Issues. MWSA has not yet developed a policy document for HIV/AIDS, but it has a Welfare Policy and an HIV/AIDS Strategic Plan (2000-2002) which focuses on orphans and vulnerable children.

Even though the first National Strategic Plan identified orphans as especially vulnerable groups and singled them out for special attention, at the time of the study there were reportedly no policy documents specifically on orphans, but some guidelines on home-based care and on MTCT (GoM/ National AIDS Council 2002, p.18). There was no integrated orphan strategy or understanding of the long-term needs of orphans. Support for orphans focused on the provision of food, clothing and school fees.

The response of the Ministry of Youth and Sport

MOYS is currently tasked with coordinating the activities to prevent AIDS aimed at young people, especially girls. This ministry has a specific mandate to reach youth who are out-of-school. Given the high levels of school dropout, exacerbated by the HIV/AIDS epidemic, there is a clear need for increased collaboration between MINED and MOYS to develop a joint strategy to help meet the basic education needs of out-of-school youth.

MOYS has developed and approved an outreach strategy for providing out-of-school youth with SRH information (GoM/MOYS, 2002). The strategy defines epidemiological, sociological, socio-demographic, socio-cultural, political and spiritual dimensions to the vulnerability of youth to HIV. It identifies the need to empower youth with knowledge and the capacity to engage in equitable gender relations through developing life-skills. Most importantly, the strategy recognises the need for efforts to be informed by social learning theory and to target not only youth, but also parents, community leaders, traditional healers and initiation rites counsellors, who play a key role in developing a supportive, cohesive social environment for behavioural development. The strategy addresses the need to link vulnerable youth to youth-friendly, gender-sensitive health and social services for counselling, contraception, prevention and treatment of STDs, prevention of HIV/AIDS and livelihood improvement.

MOYS also has an approved Operational Plan. This defines an integrated programme on HIV/AIDS, known as POSIDA, to reach out-of-school youth with a minimum package of essential activities for HIV/AIDS prevention and impact reduction, as defined in the PEN (GoM/MOYS, 2000; Hainsworth, 2002). POSIDA envisaged using the media (mass, small and traditional) to help create a supportive, cohesive social environment for health behavioural development and change among out-of-school youth and their social networks, through

strengthening advocacy and social mobilisation initiatives for gender and HIV/AIDS-related concerns. MOYS is going through a process of trying to define exactly who the out-of-school youth are.

In 1997, the Intersectoral Committee for Support to the Development of the Adolescent and Youth (CIADAJ) was set up under the National Directorate of Youth (DNAJ) within MOYS. This committee included representatives from MISAU, MINED, MWSA, Labour and Environmental Action, as well as from NGOs and religious organisations. CIADAJ's mandate was to develop the Integrated Programme and Plan of Action to Support Adolescents and Youth, and coordinate its implementation. According to Hainsworth (2002), CIADAJ was not able to provide effective coordination for the Plan of Action, owing to rapid turnover of membership, and the coordinating role was later shared between the three ministries involved in the implementation.

At the national level, the National Youth Council (CNJ) and MOYS constitute the principal institutions providing direction to the Youth and Sport Sector. The CNJ is an NGO with small funding sources and a membership of individuals and associations. Their advocacy concerns to date have included discrimination, child soldiers, job creation, out-of-school youth, HIV/AIDS, links between school and employment, street kids, credit opportunities and space for building houses and sports. Over the next few years, the focus will be capacity building and strengthening links with provinces, especially in leadership development, HIV/AIDS, advocacy skills and business development. They are developing a strategic plan to carry this out.

Initiatives of other youth-related sectors

Ministry of Labour

The organisation of Trade Unions (TM) has developed specific initiatives for young workers and is prioritising HIV/AIDS. The unions could be a way of reaching a large group of young people.

Institute of Social Communication (ICS)

Community radio has been instrumental in disseminating information to rural audiences in several provinces. Support from UNFPA has assisted projects to give more attention to targeting young listeners through youth-to-youth broadcasts. ICS has also trained a network of popular correspondents throughout the country, who can cover local youth issues for print and radio and ensure the relevance of the youth-directed programming (GoM/UNFPA, 2001).

Public critique of HIV/AIDS policy

There is no tradition of critical public debate of government policy in Mozambique comparable to that found in South Africa. What critique exists is largely led by the technical advisers of donor agencies. A group of technical advisers for HIV/AIDS has been formed to contribute to the debate. There are also signs that the media are beginning to play a more critical role. Earlier this year, a national newspaper article was strongly critical of the government's proposed policy to prioritise civil servants for ART. The political debate is taking place in the Council of Ministers, and CNCS has created a forum integrating public sector and civil society in order to promote a fruitful debate on national strategies.

3.3 Comparative synthesis and critical commentary

Policy development in Mozambique and South Africa, as elsewhere, has developed within the context of existing policies, strategies, initiatives and programmes at the global, regional and national levels. Both countries have a National AIDS Strategy and Plan that recognises the need for a comprehensive multi-sectoral response. Both countries have set up a high-level body to coordinate the implementation of their plan, to be the lead advocate for HIV/AIDS in the national policy arena, and to mainstream HIV/AIDS issues into social and political dialogues.

In Mozambique, the plan is coordinated by the National AIDS Council, located under the Office of the President, which provides strong leadership and a high national profile. In South Africa, in the early days immediately after the dissolution of apartheid, the government's preoccupation with other issues associated with the dismantling of apartheid meant that the AIDS issue did not receive the level of attention that it might have, and the plan was not located under the Office of the President. The plan is coordinated at the government level by an Inter-departmental Committee, chaired by the Deputy President, and at the sector level by the South African National Aids Council.

In South Africa, the response to HIV/AIDS has been largely driven and coordinated by the Department of Health, since the decision in 1994 to locate the National AIDS Plan primarily within this department under the Directorate of HIV/AIDS and STDs. This decision appears to have restricted the initial conceptualisation of the HIV/AIDS epidemic as primarily a medical/health challenge. As a result, the epidemic was not initially viewed in its wider social frame as the broad based social and development challenge needing the multi-sectoral and integrated response that we have seen emerge throughout the 1990s. The plan was, however, endorsed by the new Cabinet in 1994, and had been widely brokered among the stakeholder community – so there was seemingly a high degree of awareness and ownership.

However, in South Africa, and to a lesser extent in Mozambique, we have recently seen a shift towards a stronger focus on the provision of anti-retroviral drugs and promotion of human rights. This has been through increased efforts to counteract stigma and discrimination, and through better coordinated education, health and social support programmes, using both formal education and mass media programming.

In Mozambique, responsibility for out-of-school youth primarily lies with MOYS, who have developed a detailed outreach strategy with the help of UNFPA and the NGO Pathfinder International. In South Africa, the policy is to try to get all out-of-school youth back into school and reach them through the Life Skills programme (complemented by mass media programming like Soul City). South Africa has a National Integrated Plan for Children Infected and Affected by HIV/AIDS, but at the time of the study, no such plan was yet in place in Mozambique. In both countries, there is still a shortage of strategies that specifically address the needs of out-of-school youth and that take into account the very complex contexts within which their sexual and reproductive health decision-making takes place.

Chapter 4: Key Initiatives using ODFL to Translate National Policy on HIV/AIDS into Practice

4.1 Sub-Saharan Africa

In this chapter we will identify some of the key ODFL innovations that might have potential for adaptation and spread to other countries in the region. Five programmes are briefly outlined by way of examples:

- Somali Distance Education Literacy Programme (SOMDEL);
- Community Education for Rural People – Zambia (CERP);
- the Tanzanian FEMINA Health Information Project (FEMINA HIP);
- the Child-Centred Approaches to HIV/AIDS (CCATH) Project – Kenya and Uganda;
- the Multipurpose Community Telecommunications and Library Project – Uganda.

Somalia: SOMDEL

The SOMDEL Programme (Somali Distance Education Literacy Programme) is a recent collaboration between the UK-based Africa Educational Trust (AET), the British Broadcasting Corporation (BBC) World Service Trust and local education officials in Somaliland and Somalia. The aim is to bring education (literacy, numeracy and life skills) to out-of-school children and adults in Somaliland, Somalia and Puntland.

The programme began in 2002 and has so far reached over 10,000 learners in the region, over 70% of whom are girls and women. The initiative uses a three-way teaching and learning approach, which combines specially prepared printed learner booklets with broadcast radio (via the BBC World Service) and regular local face-to-face study group meetings. Volunteer study group leaders support the study group meetings and are recruited locally. The curriculum covers elements of health education, including HIV/AIDS awareness.

A recent evaluation showed the programme was providing effective access to people who would not normally be reached, and that the health education elements of the curriculum were particularly popular with both learners and tutors. The study group leaders/tutors especially appreciated the input on HIV/AIDS awareness (Fentiman, 2003).

The model illustrates the continued importance and potential effectiveness, even for young children, of the traditional three-way distance learning model. The model seeks to combine appropriately designed printed study materials with carefully researched radio programming and well targeted face-to-face support using local study group leaders. The model has been shown to work well in many settings, provided the financial, logistical and organisational aspects can be effectively designed and implemented.

Zambia: CERP

The CERP (Community Education for Rural People) project was a collaborative research project involving researchers from the UK National Foundation for Education Research (NFER) and academics from the University of Zambia. The project was designed to research, develop and test the effectiveness of basic education materials in health education and farming practices, using conventional audio-radio and paper based print materials along with modern ICT (Web-based and CDROM-based) media in rural Zambia. The basic education programme

was aimed at out-of-school youth and adults. It was offered through three community learning centres located in Kabwe, Katete and Monze in rural Zambia.

The CERP basic education programme included the development of a series of learning materials based on the findings of a detailed local needs assessment. The materials included a Health Education Module that had one unit on 'HIV/AIDS Awareness'. The HIV Awareness unit consisted of five short lessons:

- What are HIV/AIDS and STDs?;
- Modes of transmission;
- Signs and symptoms of HIV/AIDS;
- Preventive measures;
- Cultural beliefs and practices.

The materials included audio and video materials, such as recorded dialogues with young people from local communities. The CERP project built on extensive earlier work done in non-formal community-based education, including the Commonwealth of Learning Six Nations Study – a study of non-formal education in Ghana, Kenya, Uganda, South Africa, Tanzania, and Zambia (see Siaciwena (2001) and the Commonwealth of Learning Literacy Project [COLLIT]). COLLIT was established to test the effectiveness of ICT for basic education in Zambia, India and Bangladesh.) The programme also has a peer support element that offers ideas for future initiatives. Full details of the CERP project can be found in Pye and Stephenson (2003).

Tanzania: FEMINA

In Tanzania, the FEMINA Health Information Project (FEMINA HIP) has produced a glossy, high-quality quarterly magazine since 1999. The magazine targets young people (aged 15-30) with information about sexuality, HIV/AIDS and lifestyles. It is distributed free of charge to schools in rural areas and to NGOs working in HIV prevention. In urban areas, the magazine is sold commercially. Recently, corporations have started buying sets of the magazines for their workforce, and a major goal is to establish partnerships with the corporate sector for cost sharing through sales of advertisements.

There is increasing demand for the magazine, and the current print run of 30,000 copies does not meet the demand. It is estimated that there is an average of 15 readers for each copy. The participatory production process involves consulting and interacting with young people and involving them in the selection of themes and in developing storylines that echo their voices. Helping them to set up clubs and other activities in schools has been important to stimulate interpersonal communication. Youth days and other community outreach events are another regular feature of the project.

The magazine aims to facilitate an open, positive communication about sexuality, intimate relations and healthy lifestyles in private and public settings. Qualitative evaluation studies indicate that the magazine is indeed provoking debate and contributing to more informed decision-making about sex. Many indicators also point to social and behavioural change. During the second phase of the project, the aim is to make sufficient copies of the magazine

available in all secondary schools in the country, to develop photo-only versions to reach those with low levels of literacy and to continue to contribute to the creation of a social movement to fight HIV/AIDS. (For further information, see Fuglesang, 2003).

Kenya/Uganda: CCATH

In Kenya and Uganda, the Child-Centred Approaches to HIV/AIDS (CCATH) project, funded by Comic Relief, aims to help young people and their families cope with the affects of HIV/AIDS. This project has introduced the idea of a memory book, in which parents with HIV record their own and their children's past, celebrating the good, loving memories and helping to prepare for future bereavement. An extension of this idea is the memory box, in which parents and children collect small items of special significance to their family.

Uganda: Multipurpose Community Telecommunications and Library Project

This project, located in Nakaseke town, has delivered virtual reality computer programmes through community-based multipurpose centres. This project involved UNESCO and the British Council, among others. The centre has been so popular that it served as a focal point for community development. A shopping centre and an entrepreneurial community radio project have grown up around the centre, creating jobs, and this model is now spreading by popular demand to nearby towns (Lockwood, 2003, interview data). There is undoubtedly a great deal more going on in this area. Any future work on HIV for out-of school youth should seek to research this thoroughly, particularly in the open schooling and non-formal adult education activities.

4.2 South Africa

ODFL efforts to address HIV/AIDS have primarily relied on television campaigns, combined with a range of media information strategies (printed support materials, billboard advertisements, mobile/taxi adverts, peer training and life skills programmes and workshops, phone-ins, guidance and counselling services, etc). The key media campaign projects in South Africa are Soul City, loveLife and Khomanani.

Soul City

The Soul City Institute for Health and Development Communication is a multimedia initiative focusing on the promotion of health and social change among all age groups. The website is regularly updated and provides a useful insight to the strategy used (see www.soulcity.org.za). With a focus on the edutainment genre, Soul City claims 'to create an enabling environment empowering audiences to make healthy choices, both as individuals and communities'. Created in 1992, the Soul City television series claims to reach 79% of its urban target population and 68% of its rural target population. According to an evaluation conducted in 2001, the series reached a total of twelve million South Africans.

Soul City's approach is based both on the Ottawa Charter of Health Promotion (WHO, 1986) and on a blend of social and behaviour change models such as Social Learning Theory, Social Network Theory, and the Diffusion Innovation Model. It encourages individuals to reflect on their health and social choices and options, through the use of real-life role models in the

programmes. The initiative consists of two projects, namely Soul City, catering for all age groups, and Soul Buddyz, which is geared towards the eight to twelve year old age group.

Soul City uses television, radio and print resources and is currently in its seventh series. Each series is composed of a variety of media:

- 13 one-hour television dramas;
- a daily radio programme of 45 minutes, which is broadcast in nine of the 11 official languages;
- three colour booklets, distributed through local and national newspapers;
- a publicity and advocacy campaign for the purpose of stimulating further debate around selected topics.

The Soul City project has been in operation since 1994, drawing on partnerships forged with business, government, donors, health organisations and the NGO and private sectors. The development process involves extensive expert, stakeholder and audience consultation.

Evaluation is an integral part of the initiative and is conducted independently. The five evaluations commissioned to date have consistently shown that Soul City has influenced attitudes and practices among its target audience. The evaluations have drawn on data from a national survey to assess programme coverage and understand how materials are being used. The most recent evaluation also assessed the affects of the programme on attitudes and social norms towards rape and living positively with HIV. This assessment drew on data on self-reported impact and audience reception from five focus group discussions. The data suggested that Soul City has changed attitudes at the individual and community level, facilitated dialogue about HIV between men and women and between different generations, and probably impacts on behaviour. Soul City is now being adapted and adopted in eight other SADC countries, and components are being used in countries as far afield as Romania and Papua New Guinea (soulcity.org.za).

loveLife

This is a high-budget, sexual health awareness and education initiative. It combines various forms of media, such as billboards, a television series, a nationally distributed youth newspaper, a weekly national radio magazine show and a variety of youth pamphlets and posters. These activities are complemented by outreach and support programmes, including Y-Centres (Youth Centres), a school-based sports programme, a network of peer educators and a toll-free helpline.

Launched in 1999, loveLife is the joint initiative of a consortium of reproductive health NGOs⁶. It obtains its core funding from the Henry J Kaiser Family Foundation and receives additional support from the National Department of Health, the Nelson Mandela Foundation, Bill and Melinda Gates Foundation and the Anglo-American Corporation. Aimed at youth aged 12 to 17 years, loveLife's purpose is to reduce this group's HIV infection rate, through promoting sexual responsibility and healthy living. It aims to encourage youth to delay sexual activity, reduce the number of their sexual partners and use condoms. It relies heavily on

⁶ Such as the Health Systems Trust, Planned Parenthood Association of South Africa, Advocacy Initiatives and the Reproductive Research Unit.

branding, and through its free phone-in line called 'Talk about it', it urges youth to talk about healthy, positive approaches to sex and sexual health, to communicate more openly about sex, sexual rights, contraceptive use and choices and the concept of a positive lifestyle (loveLife/Abt Associates, 2000).

The loveLife campaign had a carefully organised strategy that was conducted in three phases. Phase One began with a series of high-profile billboard teasers/trailers entitled 'Foreplay'. Phase Two consisted of a television youth chat show - loveLife 'JikaJika' – which was complemented by further billboard advertisements and a toll-free telephone phone-in/helpline. In Phase Three the second TV series – 'S'camto' –was launched, accompanied by billboard advertisements designed to shock, and the publication of a national HIV impact analysis, 'The Impending Catastrophe', which focused particularly on the economic impact of the epidemic. The final phase involved a 'love Train' travelling and making stops between Capetown and Durban.

The whole programme was apparently well planned and well orchestrated. However, loveLife has received considerable criticism about its billboards, particularly with regard to meaning and interpretation. Nevertheless, research commissioned by loveLife in 2001 indicated that two-thirds of South African youth recognise the loveLife brand, 89% felt loveLife was a good thing for youth, and 76% felt loveLife made them aware of the risks of unprotected sex (loveLife, 2001).

An external evaluation, commissioned by loveLife in 2004, carried out an audience survey of 11,904 youth (68.2% of all eligible youth aged 15 to 24). It found that 65% reported awareness of at least four loveLife themes and more than one third had participated in loveLife programmes. 82% felt loveLife was a good thing for young people in South Africa and 24% reported doing something as a result of seeing loveLife, including talking about loveLife or seeking information on sex and relationships. (Pettifore et al, 2004)

Khomanani

Khomanani (meaning 'caring together') is the South African government's 92 million rand HIV/AIDS campaign, launched during 2002 and 2003. With a brief to cover all aspects of HIV/AIDS, it is aimed at all citizens to raise awareness about tuberculosis and sexually transmitted infections. Six mini campaigns have been developed. The objectives of each campaign were to encourage safer sexual behaviour, encourage care and support in the community and facilitate openness and acceptance of people living with HIV and AIDS.

Through a variety of small print media, such as pamphlets, and television and radio advertisements, the emphasis is essentially on behaviour change. Each one of the six mini campaigns differed in character, and was closely aligned to the National HIV/AIDS and Sexually-transmitted Infections Strategy. The six campaigns were:

- the Youth Awareness Campaign, with its slogan 'Our time, our choice, our future';
- the Circles of Support campaign, which encourages people to volunteer their assistance to AIDS orphans;
- promoting positive images of people of living with HIV in the Living Positively Campaign;
- three additional campaigns focusing on tuberculosis, sexually transmitted infections and supporting health workers.

In 2004 a National Evaluation Report of the Khomanani Campaign activities between 2002 and 2004 was published. The report draws on data from a national base-line and follow-up audience survey of 2,300 people, along with interviews and focus group discussions conducted in six sentinel sites across South Africa. It concludes that the campaign has been successful in reaching people, increasing knowledge, changing attitudes and social norms, behavioural intentions and, in some cases, self-reported behaviours. (19% of those surveyed spontaneously mentioned Khomanani as an HIV/AIDS campaign; 61% recognised the Khomanani logo; 56% of 15-19 year olds had heard of the Khomanani Youth campaign; and 43% could correctly complete the campaign slogan. People who had been exposed to the campaign messages were more likely than those who had not to identify abstinence, condom use and monogamy as methods of practising safer sex. They also expressed less stigmatising attitudes towards HIV-positive people, were more likely to know ways that HIV-positive people can stay healthy, to report the intention of using abstinence to avoid infection and to report that they had helped needy children.)

Problems and criticisms levelled against the South African mass media programmes

There have been a number of critiques of the government and privately funded media campaigns in South Africa (Coulson, 2002; Stadler, 2001; Halperin and Williams, 2001).

The government programme, Beyond Awareness, has been accused of not having been sufficiently theorised or strongly branded enough, and in some cases of passing unclear or confusing messages. By contrast, Soul City is recognised to have drawn on sound theories of behaviour change communication, to have developed quite strong branding and have been well staged and executed, using a wide range of media.

Coulson has criticised the loveLife campaign for conflating the notion of brand with that of message, and thereby diluting the clarity of the messages and their impact. It also appears that some of the messaging was contradictory and confusing. The latter stages of the loveLife campaign in particular came under strong criticism:

the fun loving, partying and carefree young people seemed to suggest that such a life style places one at risk of acquiring HIV, directly contradicting the overall strategy of the loveLife campaign. It was also seen to imply that people who are HIV positive couldn't have a good time. As with previous phases, the imagery was of black people and suggested HIV is a black disease. The characters portrayed in the advert were also seen to suggest promiscuity and prostitution

(Stadler, 2001 – quoted in Coulson, 2002).

The heavy use of fear, very apparent in the loveLife programme, may also have been inappropriate. Research shows that people respond to the use of fear with feelings of helplessness, denial and even public hysteria, and that positive messages work better (Coulson, 2002). For further details on the mass media situation in South Africa, see Parker, Dalrymple and Durden (1998) Coulson (2002) and also section 1.3 of the HSRC HIV study pp. 6-9 (Shisana, 2002).

ODFL programming

Recently we have seen the emergence of a number of specialised distance education initiatives aimed at improving training and professional development opportunities for people involved with education, health, counselling and HIV/AIDS care and awareness. One example is the UNISA course entitled 'HIV/AIDS Care and Counselling: A Short Course by the UNISA Centre for Applied Psychology (Van Dyk, 2003; Van Dyk, Nel and Nefale, 2003). UNISA also offers a peer-counselling course for HIV/AIDS.

Between 2000 and 2002, the Department of Education, through the Education Labour Relations Council, made available bursaries for under-qualified teachers to participate in a national upgrading programme – the National Professional Diploma in Education (NPDE). Aware of the importance of HIV/AIDS and its impact on schools and teachers, the Department required the 17 providers of the NPDE to make an effort to include in their programmes a component that equipped teachers to deal with HIV and AIDS in schools.

In response to this requirement from the Department, the University of the North and the University of Venda included a compulsory 12-credit module within their NPDE programme on HIV/AIDS and the Educator, based on the workbook entitled 'Courage to Care', published by the Catholic Institute (Winkler and Bodenstein, 2003). They offered this module to 1,780 school teachers, mostly from primary schools, in the Limpopo Province. The module aims to help teachers deal with the affects of HIV/AIDS in schools. It can be used for individual study or group based activities.

A recent evaluation (Bodenstein and Welch, 2003) found exposure to the workbook and involvement in the activities designed for the Limpopo NPDE module increased educators' awareness of HIV/AIDS issues and improved their ability to talk about them more openly. The curriculum approach resonated well with the needs and interests of the teachers. The study suggested that educators in South Africa tended to see HIV/AIDS as something that does not affect them personally but only affects their learners (this phenomenon was also expressed from a different perspective by Djanjdi in the context of the Soweto case study – see below).

The evaluation highlighted the particular importance of establishing a sensitive, non-judgmental climate in which training can facilitate personal sharing. It is also very important to establish the degree of background knowledge trainees have beforehand. Tutors involved with HIV/AIDS awareness need to be especially knowledgeable of the subject and, ideally, have some training in counselling skills if they are to deal effectively with the plethora of sensitive issues raised by the virus. The challenges raised by the course need to be considered in the context of the whole school, rather than staying at the classroom or individual level.

The study found a need to train educators more in the evaluation of open-ended questions and questions that require personal opinion. Teachers also needed to be given more support in research writing skills. On the whole, the course was much appreciated by the teachers. The course book was considered engaging and to be written at a level that identified well with the needs and interests of the target audience (Bodenstein and Welch, 2003, pp. 2-4).

The Rand Afrikaans University (RAU), College for Education and Health, Centre for Distance Education, offers a Certificate in Reproductive Health Nursing. This includes a module on HIV/AIDS, consisting of a study guide, workbook and associated readings. The University of Natal-Pietermaritzburg Centre for Adult Education, in conjunction with St John Ambulance Service (Order of St John Priory of South Africa), offer a Home Care Course, which includes a unit (Unit 17) on 'Caring for People with HIV/AIDS'.

One might suggest that the invisible hand of the market is at work through this early provision from the South African universities. It can be seen that the different providers have each aligned with different government departments. Each has positioned itself to serve clearly differentiated audiences. The University of Natal – Department of Social Welfare/Day Care Community Workers, Rand University – Department of Health/Nurses, and the Universities of Venda and the North are working with the Department of Education to reach primary teachers. The larger operator, UNISA, with its national outreach system and larger scale operation, has gone for more generic provision through its HIV/AIDS Guidance and Counselling course, which is aimed at a broader base of relevant professionals.

However, other educational materials for face-to-face workshop training programmes have been around for longer. These include:

- the Department of Health HIV/AIDS and STD Directorate Beyond Awareness Campaign manual, 'Communicating Beyond AIDS Awareness: A Manual for South Africa', prepared by Warren Parker, Lynn Dalrymple and Emma Durden (1998);
- 'HIV/AIDS and Children: a Training Manual', written by Shelia Drew and Woz'Obona (2000).

Similarly, the Management of Schools Training Programme (MSTP) – a Johannesburg based NGO – offers a training module for teachers, entitled 'HIV/AIDS: Meeting the Challenge' (MSTP, 2002). This consists of a Workshop Facilitators' Guide, a Pre-Reading Booklet and a Participants Manual. While this material is often mediated directly in face-to-face settings, and therefore can only reach limited target audiences, it is nevertheless encouraging to see its appearance. Other older courses like the ASECA programme include limited HIV/AIDS coverage in the integrated science/biology courseware.

There has also been some particularly innovative work done by the 'Storyteller Group' for a range of agencies. This work includes:

- the Johannesburg City Health Department Community Service booklet 'Love and AIDS';
- Old Mutual's Open Talk 'Communicating about Sex' booklets, which deal with sex and AIDS education;
- the South African Girl Child Alliance, which has produced the booklet 'Our Little Secret: Speaking Out against Sexual Harassment and Assault in Schools'.

The booklets are often developed through workshops that draw on the storytelling and illustrative skills of teenagers. Such work is reminiscent of SACHED Trust's early attempts to deal with adolescent issues through its publication 'Upbeat', which carried a number of stories

and articles on AIDS education in the early 1990s. While much of the above material was not written in the distance mode for distance learners, clearly some of it could be resurrected, transferred, critically adapted and translated for use in Mozambique and elsewhere.

Directories

Our research uncovered only one major directory that provides information on organisations working with children affected by HIV/AIDS. This directory 'Child HIV/AIDS Services: A directory of organisations in South Africa', was first published in 2001 by Save the Children and UNICEF. The information is also provided and regularly updated online at www.childaidsservices.org. The 2001 print edition has 908 entries, listing organisations that are actively involved in providing support services to children affected by HIV/AIDS. It would be useful to develop a similar directory of educational materials in the area of HIV/AIDS.

4.3 Mozambique

The two major government programmes that focus on HIV/AIDS prevention in Mozambique are the *My Future My Choice* programme and *Geracao Biz* (Busy Generation – a name chosen by the youth to represent their generation). These programmes have many similarities – they both use face-to-face delivery and train peer educators to reach out to out-of-school youth. In addition to these initiatives, a teacher training module on HIV/AIDS and secondary education materials are both available for learning at a distance. Radio is also a viable option for reaching out-of-school youth.

My Future My Choice (MFMC)

This programme is a joint venture between MOYS and UNICEF. An extracurricular skills training manual has been developed to enable peer educators to deliver and facilitate group sessions for 12-15 year olds who are out-of-school. The programme identifies 15-18 year old peer trainers in school and trains them to lead their peers through ten (two-hour) sessions to increase HIV/AIDS knowledge and build psychosocial life skills.

The manual was originally developed by the Government of Namibia, with support from UNICEF and the University of Maryland, USA, and has been adapted to the Mozambican context. The manual requires a fairly high level of literacy. In rural areas the majority of out-of-school youth are not functionally literate, and therefore most (75%) of the peer educators who have been recruited are in school, and many of their peers who volunteer to participate in the programme are also in school. The programme is coordinated by MOYS. The training manual could usefully be adapted for peer educators with low literacy levels to enable the programme to recruit more peer educators who are out-of-school.

Geracao Biz

This is a very ambitious programme that targets 10-24 year olds living in urban and rural areas and provides adolescent sexual and reproductive health and STI/HIV information services. *Geracao Biz* was first implemented in 1999 as a project executed through MOYS in Maputo city and Zambezia. It then spread to Maputo, Gaza, Tete and Cabo Delgado Provinces, and has

now developed into a multi-sectoral programme, which is on track to be implemented on a national scale. The history and development of *Geraçao Biz* has been well documented by Hainsworth (2002) who draws out some valuable insights from the experiences gained. Hainsworth reports that one key lesson learned is that adolescent sexual and reproductive health issues involve the entire community, and that mobilisation of all sectors is therefore necessary to truly impact change. Young people must be equally involved as partners in the design and implementation of activities.

Geraçao Biz is currently being implemented by three partners – MOYS, MINED and MISAU – and their respective provincial directorates, with technical assistance from UNFPA and Pathfinder International. Being a multi-sectoral programme, it also involves several public sector institutions and two national NGOs – AMODEFA and ARO Juvenil. Through close coordination between the three components (clinical services, school-based and outreach information and counselling) the programme aims to reinforce messages and strengthen links between services and information.

The strategy to implement the out-of-school component involves establishing a network of community activists and building community youth centres. The activists are trained to conduct similar educational activities as the peer educators in schools, and need considerable literacy skills to follow the manual. They provide referrals to health centres and distribute condoms. According to our informants, this programme originally targeted out-of-school youth as activists, but in practice it has needed to recruit among in-school youth as well because of difficulty in finding enough young people out-of-school who had sufficient literacy skills. After training in how to use the manual to facilitate peer education, each activist recruits a number of young people to form a group to work with and takes them through the sessions in the manual.

The strategy also includes establishing links between the activists, youth centres and youth-friendly clinics and launching media and information, education, communication (IEC) campaigns. Although the primary focus of this outreach component is reported to be out-of-school youth, parents, community and religious leaders and faith based organisations are also encouraged to be active partners in addressing sources of risk, and are trained as activists. The behaviour change communication (BCC) material produced includes written materials such as posters and pamphlets, providing health information and messages to be disseminated through local radio stations, theatre, music and sports.

Hainsworth reports that the outreach strategy of MOYS may be overly ambitious and may need to be revised, given its lack of existing operations and structures for introducing and monitoring outreach activities and the weak capacity of NGOs and youth associations. Further challenges identified arise from lack of formal feedback from youth associations, their predominantly male membership, how to develop appropriate approaches for multilingual and multi-ethnic groups and how to target the 'hard-to-reach' groups, especially girls in rural areas.

A further challenge to the outreach strategy, identified by Hainsworth (2002), specifically highlights the fact that many out-of-school youth experience multiple levels of vulnerability due to illiteracy, poverty, migration to transport corridors, broken transport, violence and substance

abuse. As the HIV/AIDS epidemic takes more of a hold in the country, we may also add to this list caring for sick relatives or younger siblings.

Despite recognition of the importance of having an equitable number of boys and girls who voluntarily act in the programme, *Geracao Biz* has experienced low levels of female recruitment, retention and participation. Dropout rates for female activists in community-based programmes are especially high, with an overall rate of 41%, rising to 83% in Gaza Province. More boys than girls are being recruited as leader activists, especially in the 15-19 age group, where only 30% are girls.

A major reason given by female activists for dropping out was lack of monetary incentives after training was completed, when the subsidies given during the training period were replaced by the quarterly incentives paid for working with the peer groups. Of critical importance was also the lack of any introductory programmes for youth into the job market to enable activists to prepare themselves to go forward and gain more secure employment. In some cases, unfulfilled promises of English language and information technology courses also contributed to dropout. Taking these issues on board, one suggestion put forward by Pathfinder International (2003) was for more income generating activities to be developed.

The SEDE Project (Secondary Education through Distance Education)

This is another government initiative that targets young people. It is based in the Department of Distance Education in MINED and is being developed in collaboration with the British Council, South African Institute for Distance Education and the International Extension College in Cambridge, UK. It is funded by DFID.

While most of the educational initiatives that use ODFL approaches are concerned solely with HIV/AIDS education, SEDE is developing a set of ODFL materials designed to help out-of-school grade 8-10 youth access secondary education. At the time of the study, the grade 8 materials were ready to be piloted in Nampula. The curriculum design addresses the issue of HIV/AIDS but, in line with MINED policy, it integrates the content across the curriculum, infusing the messages and BCC strategies throughout the subject courseware. Careful evaluation of this project will be needed to see whether this integrated strategy is effective. Previous studies have shown that HIV/AIDS programmes that are 'integrated' or 'infused' thinly throughout a curriculum, without a discrete, intensive module on HIV/AIDS being taught, have frequently been less effective.

The new National Primary Curriculum

The government of Mozambique, through the National Institute for Education Development (INDE) at the Ministry of Education (MINED), launched a pilot project in 1986 to introduce sex education into the formal education system. The project was sponsored by UNFPA and executed by UNESCO. In the course of the project, INDE decided to extend the aims of the project to introduce Population and Family Life Education (Pop/FLE). Unfortunately, the financial assistance for the project ended. However, the government of Mozambique did not give up its commitment to the institutionalisation of Pop/FLE.

In 1995, the UNFPA approved a new project, not only for Pop/FLE but also for Environmental Education (EE), with financial and technical support from the Ministry of Coordination and Environment Affairs (MICOA). The province chosen for the project implementation was Zambezia, on a pilot basis. The support from UNFPA was firstly to enable the government to institutionalise Pop/FLE/ASRH/HIV/AIDS and EE in the primary school national curriculum and to sensitise decision makers and other key actors including education personnel, traditional leaders and families at local level. Secondly, this support was to train teachers on Pop/FLE ASRH/HIV/AIDS and EE; and to contribute to the improvement of the quality of instruction at primary level by enabling them to use teaching methods that allow learners to participate actively in the learning process. Thirdly, this support was to improve linkages between the education sector and other partners within the programme and to take in-school population/family life education closer to the community needs, including both urban and rural areas in Zambezia province.

The project included activities to stimulate reform of the national curriculum and include revision of learning materials and teaching materials. Revision of the primary school curriculum provided an opportunity to integrate all the content previously identified by UNFPA into science subjects and also some other subjects. Today the new primary school curriculum includes content related to Pop/FLE/ASRH/HIV/AIDS and EE in all subjects.

According to our informants from the UNESCO Media Project, UNESCO has made a proposal to MINED to facilitate the delivery of the primary curriculum through radio stations. This could be a very important step forward and needs to be pursued.

Teacher education through distance learning: the Instituto de Aperfeiçoamento de Professores (IAP) modules

IAP has developed a module on the control of STD/HIV/AIDS for its primary teacher education course. It has also run a two-week training programme (15 days in all in the provinces, including a weekend) for IAP tutors and pedagogical specialists known as the Zona de Influencia Pedagógica (ZIP) coordinators. The ZIP coordinators, who have a lot of influence on the primary teachers, and the IAP tutors were put together for this training. The purpose of the training was to engage IAP tutors and make sure that the STD module was clear. The IAP tutors and ZIP coordinators were then expected to run workshops and study sessions with their primary teachers, drawing on the module materials and guides provided during the training course.

IAP tutors support the lower (EP1) primary teachers doing the distance learning teacher training course 'INSET/IT 7+3'. (These teachers have seven years of primary schooling and the INSE course gives them a three-year school-based distance teacher education programme.) The IAP training of trainers started in 2001 and finished in 2002, reaching 50 participants from each of the 11 provinces. The training for Maputo City took place in January 2003

Radio initiatives

The UNESCO/UNDP Media Development Project

This has been running since 1995 to assist the independence of the media. The full title of the

Project is 'Strengthening Democracy and Governance through Development of Media'. The project team has developed a special package on HIV/AIDS, funded by Swedish SIDA, to train journalists in how to report on HIV/AIDS issues and include women in HIV/AIDS programming. In addition, HIV/AIDS is a common thread in all their training courses.

Through the media project, UNESCO (2002) is supporting eight community radio stations in rural areas. These belong to community-based associations, and UNESCO has a contract with each of them. The project defines a community radio as one that is 'of the community, made by the community and for the community'. The audience survey conducted for this project showed that communities wanted programmes on HIV/AIDS, agriculture, education and health in general. According to our informants, there is a strategy that ensures HIV issues are raised during every programme.

In each radio station, the programmes are produced by a small newsroom, comprising editorial groups that specialise in health, education, democracy and good governance. Each editorial group has eight to ten volunteers, most of whom are secondary school students or teachers. Volunteers are motivated by the training they get and are members of the community association. All those who volunteer are taken up and trained, and there is a policy that lays down the roles and responsibilities of the volunteers. Most volunteers were reported to be 14-18 year olds.

Earlier technical difficulties experienced in setting up the radio stations, getting spare parts and a reliable electricity supply to keep them running were reported to have been to some extent overcome, although their long-term sustainability is not yet ensured. Another problem is how to keep the volunteers in the stations – they stay for two to three years and then move when they leave secondary school. It is difficult to find and train enough new volunteers to keep pace with the turnover.

This project also works with the Institute of Social Communication (ICS) – a government-supported agency. UNESCO has led a seminar to bring together ICS and the Churches to move radio broadcasting forward in Mozambique. The Catholic Church is involved in broadcasting on broadly moral issues, and the more evangelical stations such as Radio Miramar and Radio Incontro were reported to be very critical of the government. The Danish NGO IBIS also has a community radio station that is used to help spread social messages.

Other community radio stations

Although community radio stations in Mozambique are still in their infancy and have low coverage, their potential to help combat HIV/AIDS is rapidly increasing. Our informants reported that in 1999 there were only five community radio stations, but by 2003 there were 41. The developing infrastructure should be accorded further consideration in helping to develop community dialogue to combat AIDS. Although these community radio stations currently have a low reach, there is potential here for working with youth to develop relevant programmes linked to study groups.

In general, the men in the household have the radios, but families listen together in the morning and the evening. Wind-up radios can sometimes be purchased relatively cheaply. At

one time they were on sale in Maputo for as little as £5 – that is the same cost as purchasing two packs of batteries (with four in a pack). (Interview data from Bert Sonneschein, 2003.)

There are strong precedents elsewhere in Africa for the use of radio broadcasts to combat HIV/AIDS. For example, in Malawi they have a long-standing programme called Straight Talk. This is also broadcast in Uganda, but complemented there with a magazine. There is a similar radio programme in Namibia called Take Control.

Radio Mozambique

There is now 100% coverage of the country by Radio Mozambique, but it is difficult to use this medium for social messages because of the costs of buying airtime.

The radio Media Support Partnership (MSP)

This project is a community radio initiative (Radio Quelimane), coordinated through the Ministry of Agriculture and based in Quelimane, Zambezia. The radio programming has included some messages about HIV awareness. The project has completed a detailed audience baseline study, done in collaboration with the University of Northumbria in the UK. The project has potential to target out-of-school youth with health messages.

Distribution of videos with sexual and reproductive health messages

Another interesting initiative is the strategy used by the Danish NGO, IRIS, to overcome the challenge posed by the lack of any national organisation to distribute materials with social messages. IRIS has set up a system whereby it buys the rights to distribute a good quality video film with social messages such as Yellow Card (developed in South Africa and also taken up as a part of the Geracao Biz Programme for youth). IRIS then sells them for US\$ 1 to the Population Services International (PSI) distribution agents, whose job is to distribute national brand (J2) condoms. These agents sell the videos for about US\$ 4 to the owners of the community canteens (grocery shops), who charge local people to watch in the evenings. There are more than 2,000 canteens all over Mozambique and the Population Services International distribution agents visit them regularly. As well as a main film such as Yellow Card, IBIS includes a 20-minute documentary and two advertising blocks in the video programme, and this is how IBIS covers its own costs. (Interview data from Bert Sonneschein, IRIS.)

Vida Positiva

This is a small booklet giving HIV messages for the whole family. It is widely available and can be used by anyone who can read. From studying the way in which the human mental and immune systems function, and talking with people not on ART who have remained healthy many years after infection, Neil Orr and David Patient from South Africa have developed the VIDA Positiva messages to help people infected or affected to have a good quality life. Their messages are not intended to take the place of doctors and medicines, but can be used in parallel to reinforce the body's immune system.

The project is being implemented by ministries and NGOs all over Mozambique. It has reached a very wide audience and is now in its second edition. The information provided is accurate, and there is a strong psychosocial component (e.g. What did you do today that you can be proud of?) and useful nutrition advice (Orr and Patient, undated).

The emergence of meta-level coordinating bodies: MONASO, LINK and NAIMA

In Mozambique, a number of coordinating and networking agencies have grown up in response to the increasing number and diversity of organisations working in the field. For example, the Mozambique National AIDS Service Organisation (MONASO) was established in 1993 as the umbrella organisation for the drive against the HIV/AIDS epidemic in Mozambique. It first received support from a Dutch organization called Hivos (Humanistisch Instituut voor Ontwikkelingssamenwerking) in 1995 to fund its institutional and running costs, and by 1999 there were over 40 member organisations in the network. MONASO's specific objectives are to:

- mobilise and sensitise the NGO community;
- provide incentives among small organisations interested in the exchange of information, human resources and experiences;
- provide a nationwide HIV/AIDS information campaign and dissemination targeted at a wider social and economic forum.

MONASO has developed a database, using ISIS, of over 200 NGOs working in HIV/AIDS prevention and mitigation in Mozambique. It has produced a directory of active organisations, giving details of their activities and contact information (MONASO, 2002). It has also compiled an annotated bibliography of research on HIV/AIDS (MONASO, 2003).

Our informants in MONASO reported that the organisation has been actively involved in campaigns such as the one to get the law in place to outlaw compulsory testing for HIV status. It has also campaigned to increase people's right to confidentiality and outlaw discrimination against workers or job applicants on the basis of HIV status or illness with AIDS. MONASO is lobbying hard for more government attention to AIDS services, from counselling to broader human rights protection for people living with HIV/AIDS.

The MONASO Director stressed the changed attitudes towards AIDS. 'Some time ago the government did not show any interest, but now when government personnel have meetings they always mention HIV prevention, and they are creating more counselling centres in the provinces'. The Director also reported that despite the rapid proliferation of HIV/AIDS organisations in Mozambique, not enough is yet being done to care for orphans. 'They are forgotten, they are not seen. They are becoming heads of households long before they are of age. They need a lot of help.'

The LINK-NGO Forum in Maputo is an umbrella development organisation for Mozambican and international civil society organisations. It does not have a specific focus on HIV/AIDS, but has compiled a directory of donor organisations (LINK, 2002), non-governmental organisations (LINK, 2003a) and its own member organisations (LINK, 2003b) working in Mozambique. NAIMA is a similar organisation that focuses on HIV information networking in Mozambique and is based in Maputo.

Chapter 5: Case Studies of NGOs Working with Affected Youth

5.1 Introduction

The focus for this needs analysis is 13-19 year old youth (teenagers) affected by HIV/AIDS because they are orphans and/or are caring for younger siblings or sick parents. From reviewing the literature, and from our discussions with policy makers in the government departments and staff of donor agencies and NGOs, it is clear that the immediate impact of HIV/AIDS in both Mozambique and South Africa is to further impoverish out-of-school youth who are already poor and marginalised. They have pressing basic needs for food, clothing and shelter and emotional support that must be prioritised. But they also have a right to complete their education and a need to prepare themselves to participate in the social and economic life of their communities.

In this chapter we present a number of short case studies, developed in consultation with agencies working in the area of HIV/ AIDS support for affected young people, especially those who are orphans or child heads of households. Through these case studies we seek to understand more about the background family circumstances, aspirations, learning needs, listening habits and favourite ways of learning of these young people. Such understanding is needed to inform our discussion in the final chapter, where we consider what more needs to be done to reach the potential of ODFL to help mitigate the affects of HIV and AIDS on these young people.

5.2 South Africa

In this section we present four case studies. The case studies first present an outline of the origins, aims, activities and challenges facing the organisations considered. This is complemented in three cases with follow-up focus group discussions with small numbers of affected youth who are being helped by the organisations. The cases explore the range of needs and priorities at both the organisational and individual levels. The case study organisations are:

- Kwaze Kwasa Home-based Care/Day-care Centre;
- Ikageng AIDS Centre;
- The Topsy Foundation;
- Hope World Wide.

Case Study 1: Kwaze Kwasa Home-based Care/Day-care Centre

Introduction

Kwaze Kwasa Katorus Women is a day and home-based care centre, started in 1999 by a group of activist women whose intention is to create a healthy environment in the community and help alleviate poverty. It is located in the Vosloorus township on the East Rand. The main mission of the organisation is to assist those who are sick and bedridden and who are suffering from a variety of ailments including those caused by HIV, TB, cancer and strokes.

Aims

The aims of the organisation are to:

- raise awareness and provide education about HIV/AIDS;
- offer counselling services;
- refer needy people to appropriate specialist organisations;
- offer care and support to orphans and families who are infected and affected by HIV/AIDS.

Background and services

Essentially, the daycare activities have been set up in response to the impact of high levels of HIV and AIDS in the Vosloorus, Katelehong and Thokoza townships. Related to this, the group also seeks to identify orphans and distressed children who are infected and affected by HIV/AIDS and to support them. The organisation has a Board of Governors and ten commissions. The Board is chaired by a Member of Parliament, Mrs Gxowa, and has the support of a number of local councillors. Home-based care is one of the ten commissions.

The centre originally started in a transport container and is coordinated by Grace Seboko, one of its founder members. 23 local women, who all work on a voluntary basis providing daycare and counselling to needy people in the area, currently assist Grace. Grace commented, 'Since we started we are still with the same women – they are very committed. We are well received by the community. Our yard is open. No-one comes in to take things'.

Today, thanks to the support of a number of high profile benefactors, including the UK broadcaster Michael Parkinson (2002) and the New Zealand Rugby player Jomo Somo, the centre now has use of a modest two-room rented house. This serves as an office and is able to run two crèche facilities in the Katlehong and Vosloorus townships. The crèches now serve 100 children aged from 0-6 years.

Most recently, the Metro Mayor linked the Kwaze Kwasa centre to the Airport Company of South Africa, who have donated 450,000 rand towards the building of a full-day crèche facility. Currently the Kwaze Kwasa group is looking for suitable contractors to build the crèche. However, the coordinator's vision does not stop with the daycare and crèche facilities. She commented that 'My vision doesn't only end up at daycare. I see us going beyond daycare. We need to keep the children. We don't have places to sleep, especially for the very sick people who come. Therefore we would like to get a residential facility' (interview, November 2003).

The Kwaze Kwasa centre provides a range of caring and educational services to the community. These include raising awareness of HIV/AIDS through education, providing counselling services and carrying out daily visits to assess client needs and to provide love and support. Day visits involve carers in the provision of a wide range of services including giving bed baths to those who are terminally ill; cleaning mouths; feeding; changing bedding; assistance with toileting; helping people take medications prescribed by doctors; accompanying people to medical facilities; changing dressings; turning bedridden clients; reading to them; the identification of a wide range of related social problems and making appropriate referrals to other professional bodies for help.

Orphans also receive similar levels social support. Carers visit the children to determine needs. They then offer a range of help that may include the provision of school uniforms and other clothing; assistance with school transport needs; help with grant applications and the provision of food parcels where necessary. Others are helped with informal income generating activities and poverty alleviation support such as bead making, fruit and vegetable gardening and through the soup kitchen. The organisation networks with other agencies also working in the field, including the AIDS Consortium, the Anglican Diocese of the High Veld, Khanya Family Centre, Heartbeat and the Executive Youth Forum.

Daily records are kept of all the services rendered and the organisation holds monthly meeting, where volunteer caregivers give regular reports to the Programme Coordinator. The Programme Coordinator in turn provides a monthly submission to the funding bodies and the whole programme is formally evaluated every six months.

Scale of activities

Table 5.1: Summary of the Scale of Activities of the Organisation between October 2002 and September 2003.

Activities	Number
Number of Patients	1,913
Referrals	
Clinic	502
Hospital	229
Hospice	30
Deaths	87 (78 HIV related)
Child-headed households being supported	25
Children living in the child-headed households	95
Grandmother-headed households	120
Children being supported in grandmother-headed households	300

Identifying needs

The acute needs of the community were first identified after door-to-door calls were made during World AIDS Day and Valentine's Day, when it was discovered that many people were suffering and dying in their homes without any external care or support. It seems some people had rejected local clinic based support services due to the poor attitudes of some of the health staff. Today the door-to-door calling is no longer necessary as the local community frequently refer their loved ones to the centre for support.

Training

The centre has recently been able to send some of its volunteers on Department of Health training courses in HIV/AIDS and home-based care, to help them cope with the many distressing circumstances they encounter. Other courses attended have included: Project and Financial Management; Basic HIV/AIDS and HIV/AIDS care; Basic Counselling; Home-based

Care; Orphan Care; and Food Gardening. In a sense the Kwaze Kwasa women's action group serves as a much needed interface to build links between those who are suffering from the trauma of HIV and the state health and social services.

Silence and denial

Making connections between the local community and the state provided services are a vital part of the community sustaining process. Grace Seboko comments, 'One local street near the Kwaze Kwasa centre has become known locally as the 'killer-street'. Nearly all the women who lived in that street are now dead. One of the problems is that the women take too long to realise or admit the disease is in their bodies. They may think they are feeling sick because they are being called to be a sangoma (traditional healer)⁷. People die early because they keep it to themselves'.

The financial affects on the families can be devastating. Burials in particular can be very expensive for poor families. A local burial can cost between 2,800-5,000 rand. Mortuary costs can also be heavy, especially if the family is poor and the deceased has to stay in the mortuary for some time. The longer the body remains in the mortuary, the bigger the debt. Last year 78 people in the community died of HIV- related illness.

Child-headed households (CHH)

One of the consequences of early parental death is the rising incidence of child heads of households. The Kwaze Kwasa centre is currently in contact with 23 families that are headed by children. These 23 families look after some 97 other children. The Anglican Church gives a lot of support to these children, providing food parcels, school uniforms and transport to the schools in the old township areas. Some child heads of household with whom the centre has contact start are as young as 15. Most are in the 15-17 age range. The coordinator commented:

These children don't see life the way we do. One family lost their mother young. They were left with a sister but she died two years later. The sister left a small baby. The elder boy was 18 years and there was another 15 years. The 18 year-old joined local gangsters and got caught by police. Now he is serving several years for stealing people's belongings. These children just face one trauma after another. It can make them very aggressive – they don't see life like we do.

Some of the children find their way to the centre via neighbours. Others have been discovered by door-to-door calling. On World Aids Day, the Department of Health sent volunteers door-to-door calling in the area. Many of the children have been found this way.

The Khanya Family Centre is a local social and community centre that is funded by the Department of Social Welfare. It is the responsibility of the Department to assist the orphaned children and child heads of household. With the funding from the Department of Social Welfare, the Khanya Family Centre provides food parcels, counselling and social support to these children. At the time of the study it had been considering providing school uniforms. It also takes the children on activities like camping and hiking and tries to develop local support groups.

⁷ This phenomenon is also reported in Marais, 2000, p. 50

Heartbeat is another local organisation that tries to meet the social needs of these children by bringing them together and taking them out in groups. However, these facilities are often distant from the children and many cannot benefit from them very often. The coordinator commented forcefully:

What kills people is poverty. There is a high rate of unemployment – unemployment makes poverty. If I'm the breadwinner and I have nothing to give – the kids will go out to survive. Child heads of household can get very desperate. Poverty can cause them to commit serious crimes.

In 2002, one 16-19 year old took the coordinator's bag. However, the police caught him. When Grace Seboko went to the court, she saw another young girl who was a head of household, awaiting trial. The charge sheet said she had stolen at gunpoint. This young person was convicted and sent to prison.

The poverty produces other social maladies. 90% of the young women in the area were household heads. Many resorted to prostitution, 'taking boyfriends just to survive'. Meeting school fees could also be a particular problem for child heads of households and other low-income families like those headed by grandparents. However, the coordinator said the municipal schools were often sympathetic. They don't like it but they respond. At the time of the interview, a mother had died and the family was struggling to bury her. The child cried at school and told the teachers of her plight. The teachers had recently got together to help the child with the burial costs.

Focus group interview with Vosloorus youth

A focus group discussion was held with a total of 12 youth from the Vosloorus township. Of the 12, however, only five actually fitted the profile of infected and affected youth between the ages of 13 and 19. Four were female and one male. Their ages ranged from 15 to 18. All were double orphans and all were currently attending school. One was also a child head of household (CHH). Table 5.2 gives further detail of their background, learning and job aspirations, media learning preferences and an indication of their confidence levels.

The family data obtained accords with the increasing social and economic dependence found in the wider survey literature in South Africa and in other parts of Sub-Saharan Africa, showing that increasing numbers of families are being headed by grandparents, particularly grandmothers (e.g. UNICEF, 2003). The responses also indicate that the children hold high job aspirations. And, perhaps surprisingly, confidence levels are also indicated as being high – particularly with friends. This may suggest that the immediate friendship/peer group may become increasingly important for the provision of psychosocial support in the absence of parents.

Table 5.2: Vosloorus Youth Focus Group – Interview Results

Youth	Age	Sex	Orphan Status	In or out of school	Family situation	Learning aspirations	Media Favourite ways of learning	Job aspiration	Confidence level	
									With friends	With strangers
A	15	F	Double	In	(6 members) respondent + 1G/1U/2B/1S	Life orientation English Sewing	Granny	Fashion designer	Very confident	Shy
B	16	F	Double	In	(3 members) respondent + 1G/1B	Zulu Maths Computers	TV	Doctor	Happy	Shy
C	17	F	Double	In	(6 members) respondent + 1G/1U/2B/1S	Accountancy English/Design	Groups and Books	Accountant	Very high	Shy
D	18	M	Double/ Child-headed household	In	(4 members) respondent + 2B/1S	Science Maths	TV	Engineer	Great	Confident
E	15	F	Double	In	(4 members) respondent + 1G/1B/1S	Technology Environment management Computers	Books	Social work	Very high	Very high

Key: G = Grandmother
U = Uncle
B = Brother
S = Sister

Household situation and 'River of Life' exercise

We asked the teenagers to make drawings of their family/household situation, indicating who brought in income and who bought the food. We also asked them to draw 'River of Life' diagrams to indicate key events in their life history and to indicate their future outlook. Details are given in Table 5.3. This table shows a heavy dependence on aging grandparents for household income and organisation. The children, as the coordinator Grace Seboko indicated above, face one trauma after another and yet remain outwardly optimistic. School-related goals seem to be particularly important in helping to maintain personal self esteem, purpose and stability. And the importance of the daycare centre in the supply of basic needs like food is apparent.

We asked the teenagers about their school situation and the number of days they had been absent. Table 5.4 gives details of their responses. The level of school absence reported at Vosloorus is perhaps surprisingly low. The results may support the view that children try extra hard to attend school in order to project and maintain an 'air of normality'. They use school as a coping strategy to help them with their problems. In such situations, school offers routines that can help children rebuild their 'stability zone' (Toffler, cited in Handy, 1985, pp. 377-78). If children can continue to attend school such attendance may: (a) serve to disguise/hide the pain of their family situation and offer temporary respite from the difficult circumstances they face at home; (b) serve as a predictable part of the day where accepted routines and teachers can be left to take decisions.

Table 5.3: Household Situation and ‘River of Life’ Exercise

Youth	Household diagram (composition, sources of income and food purchase)	‘River of Life’ diagram
A	<p>This 15 year old participant drew six figures, depicting herself, two brothers – one aged six and the other 11 – a sister of 17, an uncle of 41 and a grandmother of 63 years. She identified both her granny and uncle as earning money as well as both buying food.</p>	<p>The first upheaval in this young woman’s life revolved around moving house from Vosloorus to Katlehong, but she was optimistic on entry into school aged seven until her father died during that first year. When she started high school aged 13, her life became relatively normalised, until her mother died when she was 14. She indicates that through ‘finding loving and caring friends’ her life has steadily become happier. She is now 15 years old and in grade 9, and is optimistic: ‘when I pass my matric (grade 12) I’ll be very happy’.</p>
B	<p>This 15 year old girl drew a picture of three figures: herself, her brother of seven and her grandmother, whom she said was 94 years old. Her grandmother provides both food and money from her government pension. Kwaza Kwasa also provides food parcels to this family.</p>	<p>Between the ages of birth and 12, life was stable for this young woman. At the age of 12 she became ill with ‘rehaqwa’, but recovered. At the age of 15 both her parents passed away. She is now 16 and says she feels loved and ‘is very happy’.</p>
C	<p>This 17 year old young woman drew six figures depicting herself, a sister aged 15, two brothers aged 11 and six, an uncle aged 41 and a granny aged 63. Her uncle and granny earn the household money and buy the household food. She did not indicate any additional support from external agencies.</p>	<p>At the age of five, this young woman was burned by boiling water falling on her hand. She is extremely conscious of this and, throughout the focus group, attempted to hide her scars. At the age of nine her father passed away and at the age of 17 her mother passed on. Both of these periods were indicated as dark times in her life. She said she is currently ‘trying to forget’ the recent loss of her mother, and has an optimistic outlook on her future, focusing on passing her matriculation in two years’ time.</p>

D	This 18 year old young man is head of a household, living with two brothers, one seven years old and another 15, and one sister aged 13. He did not identify anyone as holding a job or buying food, and said that the Kwasa Kwaze provided them with their basics such as food.	When he was ten his grandmother died, which was a low time in his life. However, until he was 17 his life was as normal as any other boy of his age, until both his parents died. For the past year his life has been difficult as he is 'now a parent at home'. He has joined a support group established by Kwasa Kwaze, where he is 'learning about different challenges in life'. He feels optimistic about his future.
E	This 15 year old young woman lives with her brother of 15, her sister of ten and her grandmother of 58. Her grandmother brings in a small amount of money, which she obtains from other relatives and ad hoc piece work, but the family depends heavily on the food parcels provided by Kwaza Kwasa.	Until the age of 11, her life functioned normally. Then her father fell ill and a year later her mother fell ill. Both parents died when she was 14 years old. She feels optimistic about her future as 'I still having my grandmother'.

Table 5.4: Schooling and School Absence

Youth	Age	Sex	Number of years in school	Current grade in school	Number of days absent from school last term	Reasons for absence
A	15	F	9	9	4	'I had an appointment with my doctor cause I got an eye problem'
B	16	F	7	7	0	Not absent
C	17	F	10	10	2	'I went for a check-up. I didn't feel good'
D	18	M	9	9	0	Not absent
E	15	F	9	9	2	'There was no money for transport'

Pocket money

We asked the children how they obtained any personal income (pocket money). No participant indicated they received any pocket money. They did suggest, however, that the following were ways in which they might try to make money:

- selling boiled eggs to taxi drivers;
- selling sweets to other children at school;
- selling tins for recycling;
- giving street performances;
- playing soccer for money;
- selling bread.

Additional concerns

One participant raised a concern regarding access to library services. He said that in order to access his closest library he would need to take transport. However, he had no money for this. Participants also commented on the lack of recreational and sporting facilities. Most such facilities are based at schools, with the exception of soccer pitches provided at a public field. Participants said there are no other recreational facilities, apart from libraries.

Case Study 2: Ikageng AIDS Centre, Orlando, Soweto

Introduction

The Ikageng AIDS Centre was founded in 2000 by Carol Djandji, who is the current Director. Carol had earlier nursed a sick friend while undertaking her nursing training. Soon after her friend's death, she came across another sick young mother whose children had not been to school for seven months. As a result of these experiences, and an awareness of the growing plight of children orphaned by AIDS, she became drawn to helping the children who were left behind when their parents died prematurely. To prepare herself further, Carol took a Diploma in Guidance and Counselling offered by UNISA. The programme included a specialist course in HIV/AIDS counselling.

Carol was helped in this work by her friend Rita Tandy, who was acting as the Programme Coordinator. Rita also ran her own organisation, which is involved in local community radio. Both women ran their organisations from the same shared office. Downstairs, three small rooms served as a food store from which volunteers distributed food parcels to the child heads of household on their lists. Upstairs there was a small office for administration. Carol and Rita were assisted by 16 other volunteers who worked to support the outreach service.

At the time of the interview, the centre was looking after 187 children, living in 54 families, mainly of infected women from the Soweto township. The children ranged in the age from 0 to 19 and were scattered among several communities. The main group came from the Protea area. Carol and Rita did not know why so many of the children came from this area, but speculated that it may be because the culture of silence was beginning to break down more in Protea. Certainly in Rita's area – Phefnei in Orlando-West – AIDS was still very much a 'hush-hush' thing. People didn't talk about it, yet they were dying regularly of AIDS related illnesses.

Aims

The main aim of Ikageng AIDS Centre is to work directly with AIDS affected youth – particularly orphans, child heads of household and infected children – to help them cope with the loss of their parents and the effects of HIV. The Ikageng AIDS Centre:

- distributes food to needy families;
- provides home-based care to affected children;
- provides care, support and counselling to referred and needy children;
- develops support groups among the affected children;
- assists children to make grant applications for government support;
- assists children with transport costs to and from school;
- liaises between children and schools around school related issues and problems;
- helps children with the management of the home – e.g. budgeting, paying the electricity and water bills.

Some of the accounts of child suffering were particularly harrowing. Carol told of the case of a 16 year old who goes out to school each day to try to complete her matriculation examinations, leaving her nine year old brother to care for his dying mother. The trauma such children face watching their parents die often causes them to become deeply withdrawn and ashamed. Carol said many of the children also feel betrayed, in that they wonder why their mothers have been unable to tell them the nature of their illness. All too often, the children learn about the cause of their parents' illness from gossip in the street. However, sometimes a different form of silencing occurs. There have been times, for example at funerals, when adults suggest the deaths are a result of witchcraft. For some this causes confusion, and makes the children wonder who in the community hates them so much to want to do such a thing.

Many of the children who have lost parents are still in the grieving stage. There is a great need for grief counselling. The affects on children's behaviour can be absolutely devastating, leading to gross depression, crime and prostitution. Ikageng has fostered relationships with an educational psychologist, NICRO and SANCA, to which these children are referred.

The heavy reliance on voluntarism – a failure of state aid?

The Ikageng AIDS Centre has formed a link with a local group called CARE. This agency has a support group made up of volunteers who visit and counsel the children on Tuesdays. They also have a link with Rotary, who arrange for monthly outings for the children. Rotary also offers a life skills support programme. Some of the girls attend sewing and quilting classes offered at the local Methodist church on Saturdays. There are plans to link with Out Learning, an organisation offering post-matriculation skill programmes.

Ikageng has also spawned a support group of its own. In 2002, a group of professional women calling themselves Concerned Professional Women got together after hearing about the work of the centre. They wanted to do something to help the Ikageng children. One of the women in the group works for Telkom and she managed to persuade the Telkom Foundation to help. As a result, the Telkom Foundation provided funds to ensure the children have uniforms and stationery for schooling.

The Department of Social Welfare has also encouraged Ikageng to link with Hope World-Wide. The centre is also linked to the AIDS Consortium and the Treatment Action Campaign. Carol and Rita have taken up issues through these agencies, but at this level they have not been successful. The AIDS Consortium agenda is not on the same level as that of Ikageng. Getting orphaned children's electricity bills paid is not the same priority as fighting the health minister. Ikageng's agenda is important – but not today.

Relations with some of the state agencies have also been less than successful. To date, Ikageng has received no direct financial help from the Department of Social Welfare (DSW). DSW recently referred Ikageng to the Salvation Army. However, the demands on the Salvation Army are already very great, and there is little they have been able to do to assist. When applications are made to DSW for individual grants for the children, the bureaucracy is slow and demanding. And if personnel change mid-way through the application process, the whole process can go back to the beginning.

The system appears over-dependent on individual relationships. So far, none of the children associated with the Ikageng programme have received any state aid. All the support that has been forthcoming has been from private agencies and volunteers. Further, the systematic provision of support information from the state is unavailable. The aid is just not getting down to the grassroots levels. The people who are close to the community are often just not competent enough to be able deal with state bureaucracy. In some ways, it appears that some parts of the state welfare system are content to leave the burden of children affected by AIDS in the hands of voluntary agencies. However, given the growing scale of the problem, it is not clear how long such agencies will be able to cope.

Problems in schools

In some cases, the schools appear to want to divorce themselves from the children's outside lives. If they are late or absent from school, teachers may remonstrate with the children in front of their classmates. Rarely, however, do teachers look for the reasons behind the absence. People often just don't know how to respond to such children. Their plight is beyond the comprehension of many.

Carol feels schools may not be the best places for such children. She often feels the need to equip the children to cope with the uncaring, detached attitude of some teachers. On the other hand, as we noted above, schooling can offer a semblance of normality for children who are desperately trying to find areas of stability and routine in their lives. Carol feels there is a need to work more with teachers and school governing councils to ensure they are more aware of the consequences of AIDS and the situation around them. The local environments inhabited by such children are not supportive of 'coming out'.

In group discussions, the children said they did not like the labels attached to them – such as 'OVCs' and 'HIV orphans' – on account of the very negative connotations. They have searched for more acceptable and positive terminology for themselves – like being 'challenged'. Such attempts to redefine identities are similar to the way the youth of the so-called 'lost generation' sought to redefine their situation shortly after the demise of apartheid.

Focus group interview with Ikageng youth

A focus group discussion was held with a total of six youth being supported through the Ikageng AIDS centre, fitting our profile of infected and affected youth between the ages of 13 and 19. Of these, two were male and four female. All were currently attending school. All had lost their mothers and two were double orphans. As with the Vosloorus group, all the children were highly dependent on grandparents or uncles for support and stability. They indicated optimism about their future, valued their peer friendships and the opportunity to go to school, and held high job aspirations. The loss of parents resulted in the family group becoming more extended and more diverse, though the new family group was not necessarily larger than the original nuclear form. Interestingly, there was a high level of interest in learning with computers. Table 5.5 gives details of the young people's backgrounds, interests, aspirations and apparent confidence levels.

Table 5.5: Ikageng (Soweto) Youth Focus Group – Interview Results

Youth	Age	Sex	Orphan Status	In or out of school	Family situation	Learning aspirations	Media		Job aspiration	Confidence level	
							Favourite ways of learning			With friends	With strangers
A	16	M	Double	In	(5 members) respondant + IG/1U/1B/1S	Computers	From friends		Pilot	Very confident	OK
B	17	M	Single/Maternal	In	(4 members) respondant + 1A/1FC/1MC	Don't know	Talking to people		Doctor	Confident	OK
C	15	F	Single/Maternal	In	(7 members) respondant + IG/2S/2U/?	Politics	TV		Nurse	Confident	Very confident
D	18	F	Single/Maternal	In	(9 members) respondant + IG/1B/1 brother's girlfriend + brother and girlfriend's child and 2U	Computers	TV		Computer worker	Confident	OK
E	15	F	Single/Maternal	In	(5 members) respondant + IG/1U/1S/1B	Computers	TV		Nurse	Very confident	Shy
F	16	F	Double	In	(4 members) respondant + IG/1S/1B	Computers	Newspapers and friends		Doctor	Confident	OK

Key: G = Grandmother
 U = Uncle
 B = Brother
 S = Sister
 FC = Female Cousin
 MC = Male Cousin

Household situation and 'River of Life' exercise: We asked the teenagers to make drawings of their family/household situation, indicating who brought in income and who bought the food. We also asked them to draw 'River of Life' diagrams to indicate key events in their life history and to indicate their future outlook. Details are given in Table 5.6.

Table 5.6: Household Situation and 'River of Life' Exercise

Youth	Household diagram (composition, sources of income and food purchase)	'River of Life' diagram
A	This participant drew five figures, depicting himself, a brother of six, a sister of 18 and her baby of approximately one year, a granny and an uncle of 25 years. He identified his granny as 'earning money' (on government pension) and buying the household food.	Youth A perceives himself as being a happy child up, until the age of seven when he had to go to school. He explained that he did not like school at first and did not want to be separated from his mother. However, after a year he settled in. His life was good until his father became ill when the youth was 13, and died soon after. Life seemed relatively stable until his mother died when he was 15. He feels that his 'heart is still feeling sore, but my sister and granny help me feel better'. He is optimistic about his future.
B	Youth B is a 17 year old male living at home with his aunt, his female cousin who is 18 and his aunt's child, a seven year old male. His aunt is employed and provides the household food and necessities.	From birth to age 13, this youth claims his life was 'good'. When he was 13 his mother became ill and she died soon after. His father is absent from the household and has, according to this youth, been absent since his mother became ill. While his mother was ill he left to live with his aunt, a place he is currently in. He is optimistic about his future and 'after I've got my matric everything will be alright'.
C	This 15 year old female drew seven figures depicting herself, two sisters aged 12 and 19, two uncles in their 20s and a granny aged 68. One uncle and her granny earn the household money and buy the food.	This young woman described her years from birth to 12 as happy. She had some anxiety at the age of ten as a result of changing schools, but overall her life was stable. At the age of 12 her mother became ill and died. She and her siblings are now being cared for by her granny. Although she 'is still hurting a lot for my mother' she feels optimistic about her future.

D	Youth D is an 18 year old female who is part of a household of eight other people. She lives with her granny, two sisters of eight and 12, one brother in his mid 20s, her brother's girlfriend, who is 19, and their baby who is seven months old. Additionally there are two uncles, aged 36 and 40. One uncle and the granny earn household money and purchase groceries and other necessities.	This young woman's life changed from being 'happy' to 'very sad' at the age of 15 on the death of her mother. Up until her mother's death, she depicts her life as being as normal as any other child of her age. Since the death of her mother she has been sad, but is optimistic about getting her matric and is certain her life will be better.
E	This young woman of 15 years lives with four other family members: a brother of eight, a sister of 22, an uncle of 19 and her grandmother. Her grandmother and sister contribute the household money and groceries.	Until the age of four her life was 'happy' and then she was sent away to live with her father's mother while her mother looked for a job. She stayed with her maternal grandmother until she was nine and describes this phase as 'happy, but I missed my mother'. At nine she moved back to live with her mother and granny, but shortly after her mother became ill and died when the young woman was 12. She is optimistic about her future.
F	This young woman of 15 years lives with three other family members: a sister of 12, a brother of eight and her grandmother, who provides the household money and groceries.	This young woman depicts her life as that of a normal and contented child, experiencing the odd periods of childhood illness, the shock of starting school. At the age of 14 her father became ill and died a few months later. She and her mother and siblings moved in with her granny, but when she was 15 her mother became ill and died. This young woman is optimistic that her life will be happy again and she is grateful that she still has her grandmother as support.

Once again, as for the Vosloorus group, the children suffered psychosocial loss, particularly from the loss of a mother. Once orphaned, they tended to live in more diverse extended family groups and were heavily dependent on grandparents and uncles for income, security and basic needs. They said they particularly valued sibling support and the opportunity to attend school. We also enquired about the number of days absent from school and the reasons for absence. The responses are recorded in Table 5.7

Table 5.7: Schooling and School Absence: Ikageng

Youth	Age	Sex	Number of years inschool	Current grade in school	Number of days absent from school last term	Favourite school subjects	Reasons for absence
A	16	M	9	9	0	English Science	Not absent
B	17	M	10	10	?	Accountancy Maths	'Sick' – Unspecified
C	15	F	10	10	?	Environment management English	'No money for transport'
D	18	F	11	11	0	Zulu Maths	Not absent
E	15	F	9	9	?	Technology Natural science	'I went to the clinic because I was not well'
F	16	F	9	9	?	Technology English	'Sick' – Unspecified

Use of media and recreational time

Participants were asked additional questions to elicit information around careers, other learning interests, favourite ways of learning, recreational activities, use of media, social groups and levels of self esteem. This information is provided in Table 5.8. All participants said they only read school textbooks that they obtained from school.

Pocket money

We asked participants about their access to pocket money. None of the participants received pocket money, and when asked whether they could suggest ways in which they could make money, they were unable to come up with ideas apart from selling sweets and fruit.

Case Study 3: The Topsy Foundation – Mosbe, Mumpumalanga

The Topsy Foundation was set up in 2000. It started with a programme to build a children's home, and their activities began in August 2001. The children's home, Ruford House, currently has 37 children aged 5 months to 16 years, who are looked after in groups by 'care givers' working in 24-hour shifts. They are referred to the home by the Social Services because they are vulnerable and at risk. The care workers are counselling these young people before testing for HIV later.

Adjacent to Ruford House is an area called 'The Village', which has a craft department, a nursery school and a computer room to run courses in computing. The computer courses are for 7-18 year olds and the craft centre offers courses in beadwork, candle making, glasswork, pottery, sewing and cooking. The main aim of these courses is to help students make use of their skills. For example, the Department of Labour will come to train people in cooking skills,

Table 5.8: Use of Media and Recreational Habits

Youth	Favourite radio programme(s)	Favourite TV programme(s)	Sports played	Other recreational/ social groups	No. of hours of engagement per week	Activities when with friends	Newspapers read	Magazines read
A	Music	Take 5 (youth current affairs) Sports	Soccer	Soccer Team	10	Talk, play soccer and watch soccer on TV	City Press	Kick Off (soccer magazine)
B	News	News Sport	Soccer	Soccer Team	8	Play soccer	Daily Sun	Kick Off
C	Music and talk shows	Movies	Netball	Church	8	Window-shopping, talk	Sowetan	True Love
D	Music	Movies	None	Church	3	Talk	Daily Sun	True Love
E	Dramas and talk shows	Generations (local drama)	Netball Dancing	Church	6	Do homework, talk	City Press	True Love, Bona
F	Dramas	Take 5 and variety of local drama	None	None	0	Watch TV, visit other friends	Sowetan	Bona

but 70% of the students must have a job to go to afterwards. Most of the students on the catering course now work in the children's home. Ballroom dancing is also currently on offer, with karate beginning in the next few weeks.

In addition, the Topsy Foundation has an outreach programme called the Orphan, Care Development Programme (OCDP). This supports 44 families in a nearby village. Topsy employs home-based care field workers to go out into the community to identify families in need of support. The children sometimes stay with their family or with their grandmothers. Topsy helps them with food and clothing. The social worker, Elizabeth Moshe, provides one-to-one counselling and group life skills sessions. THE OCDP also promotes home vegetable gardens and employs a gardener to visit the families and supervise garden development. Topsy is also helping with a local Directly Observed Treatment Short-course (DOTS) tuberculosis control programme. They have two nursing sisters and a doctor, and the OCDP works in partnership with the health services (public/private partnership).

Most of the 14-18 year olds are not in school, and although they are literate they need basic schooling as well as skills training and activities to increase their self esteem. There is very little employment in the area, especially for young people. Unemployment rates are generally around 34-40%.

The social worker reported that only about 10% of families in the OCDP have access to radio, and even less have access to TV. Men/boys generally own the radios, except where there is a household with only girls. The social worker also said that 14-18 year olds who are out-of-school listen mostly to Kwaito music and other young people's radio programmes. The optimal time for listening is from 3-6pm. Mingling with these programmes would be a good way to reach this group.

It was suggested that the Siyatamba Health Clinic, based in the township outside of Balfour, would be a good place to reach young people. They have formed a partnership with loveLife, which has provided a TV, video, weekly newspapers and voluntary resource persons, who facilitate group activities such as life skills sessions. These include building assertiveness and self esteem as well as choosing a career. The clinic is open Monday to Friday. Elizabeth Moshe provides life skills sessions (a course consists of eight sessions) there, but feels that such courses are not wholly effective because there is no follow up. Also there is no specific life skills group for the 14-18 year olds. Other needs of this age group include English language skills, as English is the language of business.

Children do not develop a tradition of reading books because there are no libraries in the schools. However, children and young people avidly read the weekly loveLife newspaper – 2,000 copies will be picked up in a single afternoon as soon as they are delivered. Elizabeth said that most of the out-of-school youth leave school because they do not see the need for schooling. They have no sense of having a future. Most of them stay at home. Boys, especially, smoke cannabis. Elizabeth spoke of one youth who helped to milk cows in the morning and evening and spent the rest of the day smoking. The youth like ballroom dancing and soccer. Some youth also do casual farm labour.

If children are given food parcels they sometimes go back to school. Those orphans living alone in child-headed households get a little parenting from the home-based care field workers as well as food parcels. Most grandparents get a pension, but no special allowances for caring for grandchildren – unless they are sick, when they can get a disability allowance. Child-headed households do not get welfare grants – only HIV+ adults can get grants. Youth under 21 years old are still considered to be children by the government – unless they are pregnant, when they are considered to be adults and can get grants.

Teenage pregnancy is a big problem – youth (girls and boys) sell sex for economic reasons. Older men abuse teenage girls for a fee, for food or for looking after their family. Girls are not being sent away into the larger cities to do domestic work – families fear they will get HIV. Young men go away to work and bring back HIV.

It is beginning to be recognised that HIV is a community problem and not just a problem for individual families. The Department of Social Development also provides food parcels and grants as part of the poverty alleviation strategy.

There is a gap in educational provision about young people's rights to social welfare benefits and what is available for orphans. There is also a gap in the provision of psychosocial support (e.g. bereavement counselling for orphans). If the clinic/loveLife programme tried to put together a support group of, say, ten HIV+ persons (as they have done for TB sufferers) this group would get labelled and stigmatised.

Focus group discussion with adolescent children supported by TOPSY

We held a focus group discussion with six youth from the Siyathemba township outside a small peri-urban town called Balfour, located in Mpumalanga province. Youth again engaged in the 'River of Life' activity. They drew the people who were currently living in their household, and answered additional questions focused on their schooling and interests.

All participants were currently in school. However, one young woman expressed the intention to leave school due to difficulties she was having with her teachers. She explained that she regularly goes to school without food in her stomach, which hampers her ability to concentrate. Teachers regarded her lack of concentration as being disinterested. Of the group, two participants were male and four female. Table 5.9 summarises the data we collected:

We also asked the participants whether they knew of others who were not in school, and what their reasons were for being absent. Table 5.10 records the responses.

Household situation and 'River of Life' exercise

Once again we asked the young people to make drawings of their family/household situation, indicating who brought in income and who bought the food. We also asked them to draw 'River of Life' diagrams to indicate key events in their life history and to indicate their future outlook. Details are given in Table 5.11.

Table 5.9: Background Data on Siyathemba Youth

Youth	Age	Sex	Number of years in school	Current grade in school	Number of days absent from school last term	Reasons for absence
A	19	F	14	11	1 month	'Because I'm not focusing on school like now. I'm taking now I don't have a school shoes'
B	16	F	8	7	11 days	[translation] 'My grandmother was very sick and she couldn't do anything, so every time I went to school I would remember the child; and then also my uncle was there and he wasn't working; and the other uncle works sometimes, but did not want to stay with the child, so I had to stay with the child'
C	15	F	8	9	16 days	'When I was absent from school I was very sick. I was suffering from tonsillitis and I try to go to the clinic; and they give me paper to go to the hospital and I was not having money to go to hospital to cut my tonsils because my grandmother is staying far away from us; and I was suffering from flu the past last terms before the school close'
D	18	M	8	8	5 days	[translation] 'I was sick for three days and two days I lost the books'
E	17	M	8	9	6 days	[translation] 'I had to fetch my ID. My sister gave birth, my father died, on the day of writing the test I was sick'
F	15	E	7	8	7 days	'The three days when I was absent from school I was going to the funeral of my mother. The three days I was sick. Then the one day was my uncle's funeral'

Table 5.10: Reasons for Other Young People’s Absence from School

Youth	Response
A	'Because she have a baby and her mother is not a good mother for her because this girl no to school'
B	No response
C	'The are two peoples who are not going to school. The other one is not at school because her parents have no money to take her to school again; maybe next year she will go to school and she is 15. The other one is not at school because she has given birth before she became an adult. She has given birth by the age of 15 when she was in standard 4 but now she is 18'
D	No response
E	[translation] Vusi was a friend of mine from standard 2 to standard 6. When we started secondary school he started smoking dagga and taking pills.
F	'My cousin who is 18 years left school because he think he was old for that class and say he can't repeat a class because he is tall'

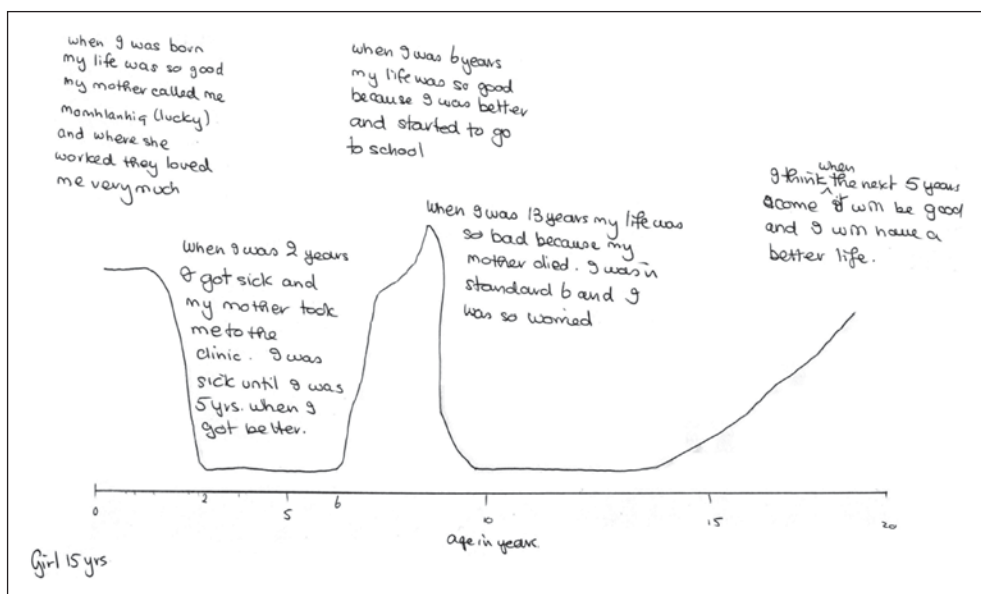
Table 5.11: Household Situation and ‘River of Life’ Exercise

Youth	Household diagram (composition, sources of income and food purchase)	‘River of Life’ diagram
A	This young woman drew three figures depicting herself as eldest (19 years old), her 18 year old brother and her 13 year old sister. She did not identify anyone as holding a job or buying food. During a home visit, we established that her brother had gone to look for casual work on a nearby farm, and that she obtains food parcels from Topsy. In the focus group discussion, this young woman said she wanted to leave school due to teacher attitudes.	When she was 15 she fell pregnant and 'my life was not the same as 5 to 10 years old' (which she indicates as being an upward line). At the age of 16 (1999) her father got sick, and within a month died. Her mother died in 2000. She is now 19 and is not sure of her future.
B	This young woman drew four figures, depicting a brother of three years, two uncles and herself. She indicated that one uncle held a job and also bought the food.	She experienced early difficulties: 'before I was five years I was suffering too much'. Her line continues to indicate difficulty until she turned seven, when 'I started to get to school'. She indicates optimism until the age of 13, when her mother died. She is currently 16 and said 'I think my life will change in this point of time', indicating a positive line.

C	Her drawing indicates five people – her sister aged 21, who holds a job and buys the food; her brother aged 18; herself aged 15; her brother aged nine and another brother aged 11.	This young woman indicated that until she was two her life was good: 'When I was born my life was good and my mother called me N..... because in her work they where loved me very much'. However, when she was two she became sick. Her health improved by the time she was six. Between the ages of six and 13 her life was good. She 'was better and started to go to school when I was seven years old'. However, at the age of 13 'my life was bad because my mother died and I was so worried'. She is now 15 and is optimistic: 'I think the next five years come I will be okay and I will be good and have a better life'. See Fig. 5.1
D	This young man drew six figures, but only labelled three: his granny, himself and his sister. From clothing it appears that there are three females, one being his granny, another his sister and the third unidentified. The remaining two figures are unlabelled and appear to be boys. He has drawn himself and his sister larger than the other figures, which may indicate they are the eldest, with the exception of granny. No figure has been identified as having a job or buying food.	From the age of 0-5 life was going well. At the age of ten he became ill, but does not specify what illness he had. From the age of 10 -15 he indicates his life was not good, and at the age of 15 his mother died. Since the death of his mother he feels his life has been 'bad'. He is currently 18 and hopes by the time he is 25 his life 'will be better'.
E	This young man drew five figures: his grandfather, his grandmother, his sister, his sister's son and himself. No ages are attached to these figures. However, from the size of the figures it appears he is the second youngest member in the household, the youngest being the sister's son. He has identified his sister as the sole breadwinner, in addition to being the one who buys the food.	From the age of 0-5 his life was good. At the age of ten his mother became ill and she died when he was 15. He is currently 17/18 years old and feels optimistic about the future.
F	This young woman has drawn six figures indicating herself, her sister, an uncle, an aunt and two cousins. The uncle is the sole breadwinner and buys the food.	Up until the age of ten 'life was good because I was living with my parents'. However, when she was ten her mother lost her job, and died five years later when the participant was 15. She is currently 15 and she 'thinks the future will hold a better life for me'.

Once again, we can see the importance of the extended family and of grandparents in keeping the children together once parents pass away. Attendance at school offers routine and stability. The children indicate optimism despite the adversity facing them.

Figure 5.1: Example of Drawing from the 'River of Life' Activity



Case Study 4: HOPE World Wide (HWW)

Introduction

The HOPE World Wide Africa support and prevention programmes have been running in South Africa since 1991. The programme was started in 1993/4 by the current South Africa Programme Director, Dr Mark Ottenweller. The central office of Hope World Wide South Africa is located in Johannesburg and is the main administrative and management office of the organisation in South Africa. The organisation has about 80 additional offices located in each of the nine provinces in the country. HWW is a faith based organisation (FBO) that has substantial funding in South Africa from the Nelson Mandela Fund, amongst others. HWW is the National Coordinator for the Regional Psychosocial Initiative known as REPSSI, and the Program Director has represented the AIDS NGO Sector on the South African National AIDS Council (SANAC). The parent organisation – HOPE World Wide, Ltd – is a non-governmental organisation based in Philadelphia, USA (HOPE World Wide, undated). The work done by HWW has also been documented in the latest booklet of the Strategies for Hope series (Williams, 2000) and on the UNAIDS website on best practice – under community care.

Aims and objectives

The main objective of the community programmes is to provide integrated community-based support and prevention services that are self-sustainable and replicable in other geographic areas. According to our informants, HWW is now moving into a new phase, where it aims to act as a mentor to other organisations working in this field. It has been contacted by the

organisation Africa Facilitators For Change (AFFC) to work with them in four sub-Saharan countries.

Strategy

Programming is based on a comprehensive model that is both proactive in its efforts to prevent infection and reactive in providing care and support to those infected. The current focus is on building HIV competence – i.e. the capacity to cope as individuals and communities through community mobilisation, training, support groups, counselling and access to a number of services for positive living for people living with HIV/AIDS (PLWA).

More than 24 HIV/AIDS support groups are maintained in community clinics in urban areas, centres in informal settlements and prisons within Gauteng. Fiks Ntuli oversees these groups, and the idea is that people living with AIDS (PLWA) in these groups also feed back into the work of the clinic. People join these support groups through referral from the clinic, from hospices and Voluntary Counselling and Testing (VCT) centres.

In the clinics, HWW employs support group coordinators to facilitate discussions and activities such as clinic gardens. They have also trained a number of people in home-based care. Services are provided in Soweto, Alexandra, Zandspruit, Diepsloot and Randburg, in partnership with the Department of Health at local clinic level. The childcare and family support programmes are replicated in Cape Town, Umtata, Port Elizabeth and Durban, under the banner of National Family programmes.

HIV/AIDS is recognised in HWW as a development issue. There are now a range of additional programmes such as Siyella (Crossing-Over) to link tertiary care and tertiary services with communities, focusing especially on community mobilisation to support orphans and vulnerable children and young people, many of whom are out-of-school.

They have 30 child support groups and the services provided to these young people mirror those provided to adults. These services provide counselling, nutritional support, primary medical care, home-based care, assistance with accessing government grants, psychosocial support, recreational activities, assistance with the schooling environment, assistance with extended family, VCT, tracking and referrals. HWW is just embarking on a national household survey of issues around orphans and vulnerable children.

Although the significant majority of the support group members were reported to be women and children, HWW also have a 'Men as Partners Programme'. This programme is designed to help men to reflect on the meaning of partnership. At the time of the visit, this programme is run by Mokgethi Tshabalala.

The programme is monitored and evaluated through weekly meetings, at which each community coordinator is given the opportunity to review the progress of their programme with management and peers. The Programme Director receives monthly reports from each programme so that he can be kept abreast on issues. Monthly progress reports and financial statements are available. The evaluation of the community prevention and support programmes is done at regular intervals. (HOPE World Wide, undated) According to our informants further

evaluation tools are being developed, including a baseline survey that will be conducted at their programmes to provide information to improve services. We were asked to suggest questions from our own data collection tool (see Appendix 2) that could be included in this survey. (Hope World Wide, undated.)

5.3 Mozambique

In this section there are four brief case studies, developed with agencies working in Mozambique with adolescent youth affected by HIV/AIDS. As previously stated, the purpose of these case studies is to increase understanding of the background, family circumstances, learning needs, aspirations and listening habits of these young people. The case studies give an outline of the origins, aims, activities and challenges facing these organisations, and explore the range of needs and priorities at both the organisational and individual levels. Findings are also presented from the 'River of Life' exercise and from focus group discussions and individual semi-structured interviews (SSI) with small numbers of affected youth who are being helped by the organisations. The case study organisations are:

- AMODEFA;
- GOAL;
- Kindlimuka;
- SWAA.

The staff we interviewed from these NGOs cited many different reasons why youth had dropped out of school. Some youth had got behind with school work because they had to provide daily care for parents or other members of their family who were sick or take care of younger siblings. Youth who were double orphans and heads of household needed to find casual work to help meet basic needs. Cases were also cited where parents had deserted their children to live with new partners, resulting in increased poverty, inability to pay school fees and the need for youth to find some sort of subsistence.

Another reason given was that teachers were often unaware of the many reasons for affected children underachieving in school, and therefore unsupportive of what they did manage to achieve. Examples of the barriers to learning that were cited included hunger and no electricity for studying at home in the evenings. Depression among affected youth, leading to apathy and lack of motivation to continue with studies, were reported to be on the increase due to lack of psychosocial support.

Case Study 1: AMODEFA (Associação Moçambicana para Desenvolvimento da Família – the National Family Planning Association of Mozambique)

Introduction and aims

AMODEFA is a member of the International Planned Parenthood Association (IPPF). It works with a number of government and non-governmental organisations, from the ministries responsible for health, education, economic planning and social welfare to AIDS organisations, universities, youth and religious organisations.

The association aims to play a supportive role to national family planning programmes:

- by providing education and information programmes for the public;
- through the implementation of innovative service delivery programmes on a pilot basis, so as to improve accessibility and availability of quality services for replication by other agencies.

In addition, the association aims to play a pioneering role by demonstrating adolescent reproductive health education and counselling programmes and advocacy for reproductive health rights for women.

Strategy

This includes improving the capability, capacity and skills of its staff and volunteers in Programme Development and Management, and promoting the empowerment of women through information, education and communication activities related to women's rights. It aims to strengthen the institution in several segments of the society, enhancing development and promoting the publication of the results of study, research and education materials on sexual and reproductive health.

The strategy has focused mainly on teaching people about the virus. 'Sexual education is crucial in the community, especially increasing the awareness of young people so as to reduce, as much as possible, problems of HIV propagation and problems caused by irresponsible sexual activity', says the NGO. AMODEFA has been conducting classes in schools, workplaces and neighbourhoods across the country on the impact of AIDS and STDs. 'We have been carrying out these activities with a view to helping to reduce the HIV/AIDS propagation levels in our country', a member of the association told us.

Activities

AMODEFA has 15 projects, nine of which are funded by IPPE. Examples of the projects are as follows:

- a project being established on reproductive health for teenagers, using discussion meetings amongst adolescents, youths and parents on various subjects including prevention of STD/HIV/AIDS, family planning and counselling, based both in schools and in the communities;
- home care service for people with AIDS. The purpose of this project is to provide assistance and counselling to HIV carriers and AIDS patients at home and in the community in general;
- an education centre for women and girls in Gaza;
- training of activists in the communities on STD/AIDS, family planning and income generating activities. They will promote periodical studies in relation to needs assessment and sexual behaviour;
- AMODEFA aims to improve its institution building and management capacity, including creating and maintaining a public relations technical team for permanent collection and publication of its initiatives and activities, and creating a Human Resources Administration Policy, which includes a rank scale, professional careers, salaries, social package and fringe benefits;

- creating a workplace based family planning project, as a considerable percentage of the urban population works in factories. Some workers were trained as activists to provide information, education and communication to their colleagues on modern family planning methods and the prevention of STD/AIDS. The project did meet some difficulties due to the lack of sensitisation of factory managers, but their sensitisation has now become part of the programme;
- a Primary Health Care information, education and communication (IEC) support activities project, which includes organising workshops, seminars and training sessions to educate health personnel and other leaders on IEC work. In 1997, 45 community activists/educators were trained in the Inhambane, Quelimane and Lichinga cities;
- the AMODEFA reproductive health service centre in Maputo project includes the renovation of the premises, setting up a family planning clinic and youth centre, and providing office accommodation;
- developing a 'hotline' counselling service for youth with phone access (i.e. principally those in urban areas). This project has not yet been funded, but is included in a proposal submitted by the global fund to fight HIV/AIDS, TB and Malaria by the Country Coordinating Committee.

(GoM/CCC, 2000)

(Adapted from http://www.fieldvisits.org/organization_9.html on January 18th 2004, supplemented with interview data.)

Challenges

Our informants identified the following six challenges facing the organisation:

- how to maintain the projects for out-of-school youth, which started in 2003 and are supported by UNFPA;
- how to discuss openly the introduction of anti-retrovirus medication as well as voluntary testing for adolescents at AMODEFA;
- how to support families through mothers who are heads of household, by helping them to start small business with support of Coca Cola;
- how to support youth peer educators, by promoting training at AMODEFA in computer skills and English courses;
- how to create youth centres where the youth associations can work, meet and organise themselves and grow;
- how to create a department of youth with technical capacity to manage projects successfully.

Case Study 2: GOAL

Introduction and aims

Founded in 1977 by its current Chief Executive, John O'Shea, GOAL is an international humanitarian organisation, dedicated to the alleviation of suffering among the poorest of the poor in the developing world. GOAL works towards ensuring that the poorest and most vulnerable in our world, and those affected by humanitarian crises, have access to the fundamental needs and rights of life – food, water, shelter, medical attention and primary education. It is non-denominational, non-governmental and non-political.

GOAL began working with Mozambican refugees in Swaziland in 1987, and registered in Mozambique as an NGO in 1992, enabling the implementation of rehabilitation and development projects inside the country. From 1992 to 1994, GOAL supported a number of community-based projects in the poorest areas of Maputo, through various missionary priests and sisters working there. In November 1994, GOAL opened an office in Maputo and began identifying and implementing rehabilitation and development projects, targeting street children and child mothers.

Activities

GOAL Mozambique aims to address the implications of the HIV/AIDS epidemic within its country programming, through mainstreaming HIV/AIDS activities into all of its programmes countrywide. GOAL has developed programmes in the areas of capacity building, partnerships, HIV/AIDS and operations and currently focuses specifically on projects that benefit vulnerable, marginalised populations.

GOAL's Vulnerable Children's Rights Project, based in Maputo, is a recovery programme to bridge the gap between the United Nations Convention of the Rights of the Child (UNCRC, 1989) and the reality of life for street children. Project workers make weekly visits to about 15 groups of street children who live together. They work towards the identification and registration of children, rehabilitation through life skills education and rights education, and reintegration with family/formal school and vocational training. This programme also provides leisure activities and preventative education for street children, drawing on the communication package on HIV/AIDS called Stepping Stones⁸ and on the booklet *Vida Positiva*.

GOAL's experience of working with vulnerable children has shown the difficulty of engaging female children living on the street in project activities that include male children. This project therefore has a component for boys called 'Child Rights for Life Choices' and a separate component for girls called 'Child Rights for Female Empowerment (Commercial Sex Trade)'. It also reaches out to the children of Maxaquene, a highly impoverished community in Maputo, to help prevent them from ending up on the street.

The children involved in these projects have low levels of education and literacy that can limit their life choices and the realisation of their rights. A popular way to reach out to these children is through photo-voice booklets, which GOAL has developed by asking the children to tell their story. Youth like to learn through photo-booklets, cartoon booklets, music and radio. There are good cartoonists in Maputo.

They also have a vocational training programme – metalwork (bars, fences etc), carpentry, cement work (block-making), sewing clothes (girls). Our informant reported that future work could also include some basic small business skills (how to set up and run a kiosk) and artisan

⁸ The Stepping Stones package – developed by the NGO ActionAid (Welbourn, 1996) for use in non-literate rural communities in Sub-Saharan Africa – has now been widely adapted and used in more than 40 countries in Africa, Asia and beyond. A key to success has been the focus on taking a positive approach to sexual pleasure and sexuality and developing communication and relationship skills. It recognises the need for men and women to spend time with their peers to explore their own needs and concerns about relationships and sexual health and find their own solutions. To be effective, facilitators must be open to new ideas and willing to question their own attitudes about sexuality, gender and equality. ActionAid in Maputo is currently planning to develop a programme called STAR by combining Stepping Stones with a literacy programme called Reflect – an approach to literacy which, like Stepping Stones, uses the approach known as participatory learning and action (PLA).

work (making batiks, paintings and carvings for the tourists). The current programme focus is on working with families because experiences have shown that young people can get into trouble with their parents if you only work with them and ignore the parents.

In response to the need for greater HIV/AIDS intervention in the provinces, GOAL opened an office in Inhambane in central Mozambique in 2001. In Inhambane Province, GOAL is involved in capacity building in the provincial government nucleus for HIV/AIDS linked to MISAU. It is also working with non-governmental organisations to strengthen provincial multi-sectoral responses to slow the spread of HIV. Two separate partnerships have been formed: first, with the provincial arm of the National Aids Council (PNCS); second, with a local association for people living with HIV and AIDS and sympathisers (Utomi). GOAL is planning to replicate the successful lessons learned in the Bandla Inhambane programme by starting a Bandla Maputo City programme.

Since December 2000, GOAL's operation in Mozambique has focused specifically on projects that benefit the most vulnerable, marginalised populations, including street children and people affected by HIV/AIDS. At present, GOAL is working through two offices in Maputo and Inhambane, focusing on rights based approaches to addressing problems of social vulnerability, particularly among children in difficult circumstances and vulnerable families. HIV/AIDS prevention and care is a cross-cutting theme of GOAL's work in Mozambique, and the organisation is working in partnership with government to build the capacity of national organisations, including community-based organisations (CBOs), working to address this critical problem.

In a proposal to the Global Fund on HIV and AIDS prepared by the CCC (2000), GOAL, MNJD, Pathfinder International and CARE have been developing and implementing a multimedia communication strategy with full participation of youth (radio programmes, edutainment through video, print, music and drama, etc.)

Challenges

The following challenges and tasks facing the organisation were reported:

- training of staff in human rights methodology application
- hiring and integration of home-based care facilitators
- ongoing children and youth literacy activities (first/second/third level and formal school preparation)
- updating the registration of students database
- facilitating the new-year school registration process and purchase of educational materials
- purchasing vocational training materials and equipment for youth.

(Interview with Christian Broom, GOAL Project Adviser, Maputo; supplemented with information from the GOAL website (www.goal.ie/atwork/mozambique.shtml) and promotional leaflet).

Case Study 3: Kindlimuka

Introduction and aims

Kindlimuka, which means ‘wake up’ in the Ronga language, is a non-profit association of people living with HIV/AIDS (PLWHA). It was the first PLWHA association founded in Mozambique and has been carrying out prevention, care and advocacy activities since May 1996. Statistics show that today 1.5 million people live with HIV/AIDS in Mozambique. Based on Kindlimuka experience, nine other associations of PLWHA were established in provincial capitals.

The association aims at:

- involving its HIV+ members in prevention and care activities regarding STDs and HIV/AIDS;
- fighting against discrimination, stigmatisation and marginalisation of people affected by HIV/AIDS;
- assisting orphans whose parents have died of AIDS.

Activities

The association's activities include:

- counselling and home-based care for HIV/AIDS affected households;
- sharing testimonials of their members about their sero-status and positive life style. Such testimonials have been an effective tool in reducing stigma and increasing awareness. Sexual education and HIV/AIDS ‘teachers’ are active members of Kindlimuka. The strategy used by Kindlimuka has been adopted by three other associations in the country that are also supported by UNICEF;
- education on HIV/AIDS for young people aged 13-18 years in schools, with UNICEF support. Recognising the need to use participatory methods to encourage the adoption of positive practices, Kindlimuka has begun to use games and debates in its education work. This initiative has been improved every year through monitoring and external evaluations, as well as through documentation of lessons learned. Young people organise themselves to provide peer activities to increase awareness for in-school and out-of-school youth. The number of pupils trained in life skills (mostly HIV prevention) in 2002 was 32,000;
- income generation activities, including the production and sale of clothing and materials for construction.

Kindlimuka also has a network of activists who regularly go out and visit families in need of support. They could be orphan headed households, where the parents have already died of HIV/AIDS related diseases, or households where one or more members of the family are sick. Kindlimuka activists provide moral support, counselling, transport to the hospital and food aid to those in need, with the support of WFP.

The food aid not only improves the patients’ own health, but also supports the family members. Lengthening the survival of heads of households with AIDS can reduce the risk of child malnutrition, which frequently occurs after the early death of a parent, particularly the

mother. The food aid to the chronically ill is integrated into the home-based care services and distributed during house visits by the caregivers.

Challenges

In an interview, Irene Cossa, Deputy President Kindlimuka, acknowledged that the organisation was challenged by the need to develop its own capacity to meet the growing need for support, and also by the long lead-in time taken to build up a relationship of trust and confidence with families and communities.

Case Study 4: SWAA (Society of Women Against AIDS)

Introduction and aims

SWAA is a Pan-African NGO formed in 1988 to promote community responses to HIV/AIDS, and provide a platform for women to take action to reduce the risks of HIV infection for themselves, their families and communities. SWAA has branches in 28 countries, with a regional office in Dakar, Senegal. SWAA Mozambique started in May 2003, with advocacy on behalf of women, children and families in the fight against HIV/AIDS in urban districts, namely Xipamanine and Chamanculo. Then they started working with children, and afterwards found that many women were also in great need and extended their activities to include them.

The aims of the organisation are:

- advocacy and promotion of innovative prevention methods;
- protection of mother and child;
- support to families for care and education of children infected/affected by AIDS;
- integration of STI/AIDS into grassroots programmes;
- male involvement;
- capacity building of women's groups;
- community mobilisation;
- advocacy for access to treatment and ARV drugs.

SWAA seeks to implement a balanced portfolio of activities to achieve the above aims.

Challenges

In interview, our informant identified the following challenges.

- this year the challenge for the organisation is to start a counselling group for women on HIV/AIDS;
- the organisation is aiming to expand its activities. To do so they are mobilising support from the community to help in finding solutions for their problems;
- the other challenge is paying the school matriculation fee, and for uniforms for 21 orphans;
- advocacy activities to mobilise the community to actively participate in the follow up of the children supported by SWAA in the schools.

Household situation and 'River of Life' exercise

This exercise was conducted individually with four boys whose fathers had died of AIDS and

whose mothers were being supported by the NGO Kindlimuka in Polana Canico. Only boys were involved in the exercise because there were no girls in the families visited. We asked the boys to make drawings of their family/household situation, indicating who brought in income and who bought the food. We also asked them to draw 'River of Life' diagrams to indicate key events in their life history and to indicate their future outlook. Details are given in Table 5.12, which demonstrates the importance of support to families who have lost their 'breadwinner' and the optimism of the young people about their future ability to contribute to the family economy.

Table 5.12: Household Situation and 'River of Life' Exercise

Youth	Household diagram (composition, sources of income and food purchase)	'River of Life' diagram
A	This 12 year old boy drew seven figures, identifying himself as one of the youngest; his mother; a brother of 27; a sister of 21; a sister of 12; and a niece of nine. He identified his mother as being the only one working and bringing food home since his father died. The mother is working for Kindlimuka.	He indicated that 'before my father came back from South Africa we were happy because he was bringing food, clothes, and other stuff for us to sell... Before he died we had to work to earn some money for food and after he died our mother started to work for Kindlimuka sewing clothes and now our life improved a lot'. He also stressed that he doesn't know if his life will continue to improve.
B	This boy drew eight figures – his mother, brother, granny, sister-in-law, a sister, a brother and two nieces. He did not indicate the ages of anyone. In the group the only one holding a job is his mother, who works for Kindlimuka since his father died. He also indicated a brother, who does not have a formal job, but is an artist making chairs to help the mother to buy food.	This young boy indicated that until his father got sick they were very happy and that life was good for them. He said that 'my father was buying food, clothes and other things for us, now we are suffering'. He also stated that nowadays his mother is working for Kindlimuka and 'our life is starting to become better ... it has improved a lot now we have food' and he went on to say that 'to continue improving our life I am studying a lot to start working as an artist and help my mother'.
C	This boy drew eight figures indicating himself, his mother, elder brother, two sisters of 20 and 24 years old, a younger brother of 12 and two nieces of two months and another three years old. He indicated his mother as being the only one working and bringing food home, working for Kindlimuka since his father died after being sick.	Until he was 14 his life was good. Then his father came from South Africa sick and after that he died. 'My mother started working for Kindlimuka and our life started to improve.' He went on to say that 'I hope our life will continue improving if I finish to study ... I want to be a journalist and help my mother and nieces'.

D	This boy drew seven people – two sisters of 30 and 23 years; three brothers of 22, 21 and 14 years; himself of 12 years and his mother who is the sole breadwinner and is the one who buys food in the house.	Before he was 12 years old his life was good, because his father was working in South Africa and they had everything. He said that 'now our father died but before he was very sick and my mother used to take care of him while we were working for other families. Then he died and we had nobody to take care of us and my mother went to Kindlimuka and got a job sewing clothes. Now our life is starting to improve because we have food'. He also said that 'my sisters and brother do not find a job and due to that they are at my mother's house doing nothing ... I think that our future is going to be better when I start working when I finish studying'.
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5.4 The learning needs, aspirations and favourite ways of learning of affected youth

Data on learning needs, aspirations and listening habits were gathered through interviews with policy makers, implementers and young people. Data were also gathered from secondary sources through analysis of documents and reports.

The views of out-of-school youth in Maputo

Focus group discussions were held with 25 young people living in especially difficult circumstances. They were aged 10-18 years, out-of-school and attending a workshop for street kids run by the NGO, GOAL. (17 of the young people were aged 14-18, but their responses were not disaggregated from the whole).

The four most frequently recorded reasons cited for never having been to school or for having dropped out of school were:

- peer pressure;
- being badly treated by teachers;
- lack of money for books and other materials, registration and monthly payments;
- indiscipline and fighting leading to exclusion and missing lots of lessons;
- to make a living.

The subjects they would like to learn about in order of priority were how to read and write, drawing and painting, manual skills or a profession. When asked what jobs they would like to prepare themselves for (their aspirations), the responses were an engineer, a business person (entrepreneur), teacher, doctor and pilot. When asked what radio and TV programmes they listen to often, they cited music, dramas and films.

The views of youth peer leaders in Maputo

Four focus group discussions were conducted in Maputo with 29 youth aged 14-18 years, most of whom were living with at least one parent or adult relative who was working. Four single sex focus groups were held – one with five girls, one with six girls, one with 13 boys and another with five boys (each of the young people were also interviewed individually). These young people had all been selected by the NGO, AMODEFA, to be trained as community peer educators. As such they do not represent the aspirations of the majority, but rather those of peer leaders. They were all from Maputo and were selected as being out-of-school and especially affected by HIV/AIDS. However, it transpired during the interviews that a few of them were studying, and only five of them were directly affected by HIV/AIDS, while the others considered themselves to be especially affected because they had a close relative affected. They had between four and 12 years of schooling, with an average of seven years. Most of them had repeated at least one year. Reasons for missing school were given as sickness, and reasons for dropping out of school were cited as peer pressure from friends out-of-school leading to loss of interest, lack of money, sickness and death of parents.

In each focus group, the young people listed the school subjects they would most like to learn about, and these were then sorted into the order of priority. Portuguese and mathematics were top priorities for both boys and girls, followed by biology and languages (English and French). Physics, history and geography were minority interests. The girls' groups reported that the jobs they wanted to prepare themselves for were journalism, medicine, accountancy, economics, a cook, cartoonist and painter. The boys' group identified electrician, teacher, peer educator, doctor, journalist, engineer and telecommunications.

When asked what other things they would like to learn how to do, the girls identified more formal topics – computer skills, informatics, law, environment, how to teach about sexual and reproductive health (including prostitution and abortion and drugs), how to do drama and write songs with positive messages, and how to create space for peer education. They also identified a wide range of further things they wanted to learn – cooking, sewing and embroidery, football, painting, cartoons, drama and how to dress well. In response to this question, the boys also identified more formal topics (informatics, industrial electricity and journalism), topics that related to their work as peer educators (how to deal with the community, how to change, how to make information reach out to where people cannot normally get information), as well as how to prepare for the future, how to better serve the country, scientific knowledge.

All the youth except one said they had access to radio, and some had access to television. The programmes they listened to most were dramas (especially romantic soap operas), music, debates, news and sport. Films on TV were also mentioned. In addition to these topics, the girls reported often listening to women's programmes, students' space, economic issues, security programmes from Brazil, scientific programmes and education programmes like Transtel. The boys also reported often listening to community radio, Radio City, RTK station, Top 10, Brazilian novels, education and information/learning programmes such as historical and medical programmes, an HIV/AIDS programme ('Let's break the silence') and the 'Let's see Mozambique' programme.

When asked about other ways that they learned things, both boys and girls said they learned through teachers, youth associations, magazines and newspapers, friends and other members of their family (for girls this was often their aunts). One girl also said she learned from the Internet, and one boy mentioned books and clubs.

The views of young people living in Xipamanine

Individual, semi-structured interviews were conducted in Xipamanine with seven youth (three girls and four boys) aged nine to 15 years. These young people were being supported by the NGO, SWAA, because they had lost one or both parents to AIDS and were living in especially difficult circumstances. Four were living in child-headed households, and the rest with siblings and a female relative (grandmother or auntie). All the families were receiving food from SWAA, and adult siblings and other relatives helped them when they could. The three girls (two aged 15 and one aged nine years) were all in school, although one had missed some schooling due to malaria. All three girls reported having close friends their own age who were not in school due to lack of money in the family. One of the boys (aged 12) was in school, but the other three (aged nine and ten years) had never been to school, and reported that this was due to lack of money.

The three girls and one boy in school all reported that mathematics and Portuguese were the school subjects they would most like to learn about now, and two of the girls also included science. None of the girls had a specific job in mind, but the boy in school wanted to be a photographer, one of the out-of-school boys wanted to be a doctor, another said he would like to learn any profession, and the third wanted to be a journalist.

When asked what other things they would like to learn, two of the out-of-school boys said they wanted to learn how to repair radios. Of the seven youth interviewed, only two (out-of-school boys) said they had a radio and said they liked to listen to all programmes and learn from them. These two boys also said they had a TV at home, and one of them said he also liked to learn by doing things for himself.

The views of young people supported by Kindlimuka in Maputo

Semi structured interviews were conducted with 12 young people aged eight to 15 years. They were all receiving support from Kindlimuka because they had at least one parent living with AIDS or having died from AIDS, and were living in especially difficult circumstances. One young person was a double orphan and head of household. Kindlimuka was providing food, medicines, clothing and financial support towards school fees. Most of the young people had at least one relative working and, in addition to the food given by Kindlimuka, seven uncles and one grandmother were reported to sometimes bring food into the homes.

All the young people had repeated more than one grade in school, and four said they had friends who had dropped out, in one case one because the mother had died. Two of the boys said they had repeatedly missed classes because they were sick. Portuguese and mathematics, science and history were the school subjects they would most like to learn about now.

Findings from audience surveys on young people's listening habits

Clearly the very limited numbers of young people interviewed in this study cannot be taken as representative of the wider population. However, large-scale audience surveys have also shown that most young people listen to the radio regularly. For example, the survey conducted by the Institute of Statistics (INJAD, 2001), to gather information for planning on young adult (15-24 year old) reproductive health and behavioural risk, endorsed the findings from interviews with young people that radio is the main means of information spread and is accessible to all. In the INJAD survey, 80% of youth boys and 60% of girls were found to be listening to the radio at least once a week.

In an audience survey of 200 respondents – including children, young people and adults – conducted by ARCO-HOMOINE (2003) to help develop community radio, more than 80% of respondents reported listening daily, not only in the early morning and evening but also during the day. The most popular programmes were reported to be women's programmes (3%) followed by the news (21%), children's programmes (12%) magazine (10%) and sport (2.5%). Respondents also reported an interest in 'Open Scene' – a radio theatre programme and a preference for traditional and romantic music. They preferred programmes in Xitswa and in Portuguese. Programmes that some respondents said they did not like were those about dead people, people living in South Africa and sports.

Chapter 6: Mitigating through ODFL the Effects of HIV/AIDS on Young People

6.1 Synthesis and discussion of the main findings of this research

The first aim of this report was to examine some of the key ODFL initiatives being undertaken to translate national HIV/AIDS policy into practice in Mozambique and South Africa. The findings from the study show that at the national level there are some relatively well planned initiatives, which draw on sound theories of behaviour change and diffusion. These programmes have evolved over time to take more account of the need to address the contextual factors that are highlighted in the literature on best practice. These national programmes also follow an evidence based approach to programme development that builds in formative research, monitoring and evaluation from the outset. They appear to be making a useful contribution to social change, especially in South Africa, and have useful experiences to offer for programme development in other countries.

However, in both countries there appears to be an immediate and real need to strengthen and disseminate the national data-base on HIV/AIDS so that the lessons learned can be spread. There also appears to be a need to strengthen links between the government agencies set up to implement policy and the active local agencies working on the ground with affected youth.

The study shows that the capacity of communities to support young people affected by HIV and AIDS needs to be strengthened. Although support agencies are increasingly using participatory community development processes, it takes time for capacity to develop and, given the scale of need, more effective state intervention is also required. It was also worrying to find that some teachers are now reported to be disassociating themselves from the affects of HIV and AIDS on their pupils. This indicates a need for increased awareness raising and training of teachers in how better to support orphans and child heads of households. At the organisational level, the findings highlight the important role of NGOs, through their ability to plug into local state networks and to act as an interface between the individual and the state. However, we conclude that the provision for HIV and AIDS affected youth remains relatively uncoordinated and only weakly integrated into state support. Further, while organisations show evidence of effective networking for basic service provision, they are often in competition with each other for available resources, and many have an urgent need for organisational capacity building.

In relation to the learning needs of young people affected by HIV and AIDS, the findings indicate that there is a serious gap in provision. Many affected young people are unable to access the national curriculum. They are unable to develop basic literacy and numeracy or livelihood skills. They do not have information to support their daily living and help them run a household, or support for their psychosocial health. Many young people are unaware of the factors at the community level that increase their vulnerability to HIV infection. They do not know how to participate in the broader process of social transformation needed to help their communities move towards a post-AIDS era.

The findings also indicate that, in common with other developing regions of the world, radio is the most commonly accessed medium of communication in both countries, although in South Africa television is also widely accessed. Print media are also widely used by out-of-school youth, but there are issues around language access and literacy levels that need to be addressed.

The second aim of this report was to consider how open, distance and flexible learning (ODFL) might be further developed to help meet the learning needs of affected youth who are out-of-school. Although additional situational analyses are needed, the findings indicate that enough is already known to guide some further policy development and start programming to expand the role of ODFL in mitigating the affects of HIV and AIDS on out-of-school youth. The rest of this chapter makes some suggestions as to how this might be done and gives voice to our own advocacy for further developing ODFL provision to support and extend the work of existing infrastructures.

6.2 Mitigating the effects of HIV/AIDS

In identifying potential areas for future ODFL intervention, we have sought to support and extend the work of existing infrastructures and to concur with Glennie (2003) in asking 'In what ways might the appropriate deployment of the principles of open learning help ameliorate the impact and affects of HIV – rather than how might open schools themselves play a role?' (Glennie, 2003, p. 22). We have also borne in mind the framework for the care and protection of orphans and vulnerable children living in a world with HIV and AIDS, developed by UNICEF in collaboration with other development partners (UNICEF, 2004).

At this point it is useful to revisit what we mean by open, distance and flexible learning. In Chapter 1 we defined ODFL as the provision of learning opportunities where attempts are made to reduce the barriers that can often inhibit or prevent learning. We said that these barriers are often a result of the physical separation of learners from teachers, or because of the inability of learners and teachers to meet at mutually convenient times. We argued that such measures essentially attempt to improve access to learning. The main features of ODFL systems usually involve some combination of multimedia packages, learning workshops, counselling and tutorial support, modular courses, flexible timetabling, negotiated curricula, and support through guidance.

A further aspect of open learning is that it should be open in terms of language. In Mozambique, language is an issue because many of the children in the rural areas who drop out of school do not speak Portuguese well. Most of the materials available to support HIV awareness and life skills training are in Portuguese, and hence are not available to the majority.

From our fieldwork, it became clear to us that the educational and welfare services mandated to provide support to teenagers affected by HIV/AIDS are struggling to keep abreast of the need. Increasingly, especially in South Africa, civil society groups such as the churches, as well as neighbours and friends who volunteer to help vulnerable children and families, are providing the vital support that is needed. It is in this context that we seek to identify a role for ODFL to help mitigate the effects.

Factors that influence whether young people's learning needs can be met operate at many different levels throughout society. In recognition of this we have used the following levels to organise the discussion in this section:

- the individual, family and household levels;
- the school and community level;
- the national level.

Mitigating effects at the individual, family and household level

ODFL has the great advantage that learning can be relatively confidential. It can help young heads of household access the wealth of information traditionally provided through the collective knowledge and experience of their own family. Such information could be provided through a series of life skills handbooks that provide up-to-date and accurate information on topics such as:

- You and your rights;
- Getting your welfare payments/food parcels;
- Dealing with your school, Managing your household;
- Caring for younger brothers and sisters;
- Making low cost healthy family meals;
- Community resources to support you.

Such texts should promote positive attitudes and deliver practical information in the way that is found in booklets such as *Vida Positiva*. They should be developed with the participation of teenage heads of household and local parents with relevant experiences. Such information could also be communicated through youth magazines and newspaper supplements, which have been used effectively in places like Brazil. This would represent an extension of the memory counselling idea towards developing the 'family memory information bank' and the 'community memory information bank'.

The memory counselling idea has been rapidly taken up by NGOs in some African countries. In Uganda, for example, PLAN has been working with families to encourage HIV infected parents to write small books, together with their children. The aim of these books is to help them express their thoughts and feelings about each other and record special events in the children's lives, together with photographs and other mementoes of the family, while the parents are still alive. These books have been found to help children through the grieving process and become a most treasured possession.

There is also a need for ODFL information targeted at infected parents on how to write a will and plan an inexpensive funeral. The work of the Story Teller's Group in South Africa could be built on here.

There is also scope for well-structured, carefully coordinated programmes of psychosocial support, involving mixed media deployment, including appropriately vetted professional Internet websites and email and conferencing services. The Hole in the Wall initiative in India

has shown how Minimally Invasive Education (MIE) through public Internet kiosks has worked well with children of all ages. Mitra (2004) argues that this approach should form an integral part of all primary education. Furthermore, simple, individualised and empathetic personal counselling booklets or audio tapes could help to explain what is happening to a young person going through the grief and healing stages of parental loss (through cases and recollections with professional commentary). Lessons could be drawn from the emerging range of ODFL materials that currently exist in South Africa and elsewhere, but which have been targeted at other audiences and levels. Such print materials could be supported through anonymous, toll-free and affordable telephone counselling. The youth magazine *Upbeat*, produced by the South African Committee for Higher Education (SACHED) Trust during the latter apartheid years in South Africa, offers an early successful format that made a notable contribution to non-formal education in South Africa.

To help vulnerable young people enter the job market, ODFL – including virtual reality computer programmes (Lockwood and Day 2003) – can be used to increase motivation for learning and speed up the time it takes to learn skills. Such media can be used to teach entrepreneurial skills, such as how to set up and run a small business and deliver relevant careers counselling. A project being run by the Alexsan Kopano Educational Trust project in Alexandra Township, Johannesburg provides an example to build on. In this project, virtual reality programmes have been successfully used to help young people learn how to apply for a job and go through an interview (see alexankpano.org.za). The work of GOAL Mozambique is also relevant here.

Mitigating effects at the school and community level

In South Africa and Mozambique, the Department/Ministry of Education does not take responsibility for delivering the national curriculum to children who have dropped out (or been pulled out) of school. We ask whether this is an appropriate situation, given the affects of HIV/AIDS on the ability of young people – especially girls – to attend school regularly, when both governments are striving to reach the Millennium Development Goals and EFA targets.

We argue that ODFL should be used to develop a more flexible approach to delivering the national curriculum, so that young people do not have to fall behind with their lessons when they cannot attend school and risk dropping out. ODFL materials are also needed to help them re-enter schooling after dropping out. In Mozambique, the UNESCO proposal to deliver the new national primary curriculum through Radio Mozambique has enormous potential to fill a gap here, as do the ODFL secondary curriculum materials being developed by the SEDE project.

Another tried and tested model that could be built on is that of the self-study learner guides developed by the Escuela Nueva programme in Colombia (Colbert et al, 1993; McEwan and Beneviste, 2001). Independent evaluations have found that Escuela Nueva has improved the academic achievement of participating students, compared with students in traditional rural schools (Psacharopoulos, 1993; McEwan, 1998). A central feature of this programme is the high-quality learner guides that students use for self-study, either individually or in small groups. These learner guides have been adapted and taken up in many other countries, including Uganda.

The findings from the present study suggest that a start might be made in developing learner guides for mathematics and language. Such ODFL curriculum materials could be delivered to and collected from young carers by teachers on home visits, by classmates participating in a ‘buddy system’ or by home-based care workers. This infrastructure, which would essentially be a system of community learning and support webs, could also be used to deliver ODFL support materials to volunteers in the community, and thereby help to build a ‘circle of support’ around vulnerable young people and develop schools to reach out as nodes for multipurpose development and welfare institutions. Further, ODFL techniques could be used to develop and support the emergent peer networks that have been set up to implement programmes like *Geracao Biz*. Without continued skill development and career oriented or vocational training, such networks, however well motivated, are likely to become fragile and transient.

ODFL can help create awareness among out-of-school youth that, despite not being in school, there is a need to consider how to further your education and find a job. In South Africa, the Department of Health is partnering with loveLife to explore this. Community radio could be useful here.

It is particularly encouraging to learn that recently the South African interactive radio education initiative, Open Learning Systems Trust (OLSET), has developed a project to use radio to support out-of-school children affected by HIV/AIDS (OLSET, 2004, p. 14). There is a need to explore how the training manuals used in the big government initiatives, such as *Geracao Biz* and *My Life My Choice*, might be adapted for training at a distance; and how groups of teenagers could be established to develop more appropriate messaging and supportive information – through the mass media, Internet and more simple print based leaflets or other provision. Experience from the multipurpose community telecommunication and library project in Nakaseke town, Uganda, might be used to help support the development of community-based learning resource centres, such as those currently being set up in South Africa (see www.col.org/knowledge/ks_telecentres.htm).

ODFL materials can also be used to raise critical awareness within communities of the way in which society – through actions that damage self esteem, eliminate choices and make it hard for individuals to stand up for themselves – renders some young people more vulnerable to HIV infection than others. This is an emotive issue that requires sensitive handling. The adoption of a more critical, future oriented and outward looking pedagogy in schools could help young people become aware of how society can prevent them from adopting safe behaviours and understand how change at the community and societal level can be positively supportive.

ODFL materials can help to develop critical awareness, through stimulating dialogue and debate and facilitating a process of argument and counter-argument. Developing a capacity for critical thinking and problem solving is one of the first steps in mobilising young people and their communities to take collective action for positive change and enabling them to participate fully in developing a new post-AIDS society.

The work of the Storyteller Group in Johannesburg could be drawn on here. This is an independent group of artists and writers, who have established the first publishing house in South Africa to produce original comic books for adults and young people aimed at AIDS

awareness. The Storyteller Group has carried out groundbreaking work, using comic stories with titles such as *Love and Aids* as a tool to deliver a hard dose of reality, political conscientising and calls to communal action. The Storyteller Group has been approached by the state health department to run school AIDS programmes. The group is also working on sexuality, gender and violence, and exploring interactive story development on a mass scale by involving community radio station listeners in story development (*Id21 Research Highlights*, 2002 – available at www.id21.org).

ODFL materials are also needed to improve teachers' ability to empathise with young people affected by HIV and AIDS and provide psychosocial, guidance and counselling. Such materials may also be useful for health and welfare workers and volunteer supporters, some of whom are clearly under great strain. There is surely scope for much more transfer and adaptation of existing materials, such as those developed in South Africa for home-based care, the UNISA course on 'HIV/AIDS Care and Counselling' and the Venda module on 'HIV/AIDS and the Educator'.

Mitigating effects at the national level

At this level we have indicated a need for developing, coordinating and disseminating the national information base (the institutional memory) on HIV/AIDS. In Mozambique, the Department of Distance Education in the Ministry of Education is exploring the desirability and location of an ODFL resource centre, which could house curriculum development/teaching materials/ODFL specialist collections on HIV/AIDS, to support any future involvement in policy development and programming. Similarly, SAIDE might also build on the work it has already started in this area in South Africa. These centres could link into international HIV materials collections, such as the UNESCO International Bureau of Education (IBE) clearing house, and also further develop national directories and organisational databases.

In South Africa, a diverse and vibrant critique of government HIV/AIDS policy and practice is visible in many sectors – including the academic community, the NGO sector and from the media (journalists and radio and TV producers). By contrast, in Mozambique, this critical capacity and space is less well developed, and there is a need to consider how ODFL might further nurture this, as well as how the two states might learn from each other through joint cooperative ventures. Do the universities in Mozambique need to sponsor more active programmes of research such as those undertaken at the HIV/AIDS centres in the Universities of Pretoria and Natal?

The findings at each level have been summarised in Table 6.1.

Table 6.1: Towards a Comprehensive ODFL Response to the Learning Needs of Young People Affected by HIV/AIDS

Level	Audience	Learning needs/Purpose	Potential areas for future ODFL intervention	Selected samples of ODFL activity /Where we might build
Individual/ family/ household	<ul style="list-style-type: none"> Orphaned and other vulnerable youth (13-19) Child heads of household (13-19) and their peers Potential surrogate parents Extended family relatives Foster parents 	<ul style="list-style-type: none"> To meet physical and psychosocial needs (restore self esteem, overcome grief) Livelihood and income generation skills Entrepreneurial and small business skills 	<p>Youth based ODFL courses in:</p> <ul style="list-style-type: none"> meeting physical and psychosocial needs ('how to' books) practical personal healthcare livelihood and income generation entrepreneurial and small business skills the rights of infected children and child heads of household 	<ul style="list-style-type: none"> The Story Teller Group's work Memory counselling SACHED Trust – Upbeat GOAL's livelihood programmes Alexander Educational Trust project Vida Positiva – Positive Health
School and community	<ul style="list-style-type: none"> Peer group leaders Basic education and secondary school teachers Head teachers/directors Governors Social welfare and community support/liaison officers Community health workers/nurses Community outreach volunteers/daycare support 	<p>Developing circles of support</p>	<ul style="list-style-type: none"> Teacher inservice programmes – HIV/AIDS awareness and sensitisation; guidance and counselling courses (also for health and welfare workers) Children's re-entry cum study maintenance programmes 	<ul style="list-style-type: none"> University of the North and Venda NPDE Module 'HIV/AIDS and the Educator' IAP HIV/AIDS 51st module 7+3 USAID Ghana Basic Education Teacher Training manual on HIV/AIDS UNISA Centre for Applied Psychology 'HIV/AIDS Care and counselling' short course Escuela Nueva SEDE Mass media campaigns e.g. Soul City, Khomenini Multipurpose community telecommunication and library project in Nakaseke town, Uganda University of Peitermaritzberg/Order of St. John Home Day Care course

National	<ul style="list-style-type: none"> National planners and policymakers Curriculum developers 	<ul style="list-style-type: none"> To further develop the national response 	<ul style="list-style-type: none"> Development of national databases, resource centres and clearing houses for HIV/AIDS curriculum development/teaching materials/ ODFL specialist collections – e.g. develop nodes at the SAIDE and MINED/DDE resource centres Development of national directories and organisational databases Audience study of affected youth 	<p>Links to International HIV materials collection centres e.g.:</p> <ul style="list-style-type: none"> UNESCO International Bureau of Education (IBE) clearing house (www.ibe.unesco.org/hivaids) South Africa Save the Children Child HIV/AIDS service www.childaidservice.org MONASO and LINK Mozambique
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6.3 Concluding comments

This study has examined HIV related policy and practice. It is located within the political landscape of South Africa and Mozambique, where AIDS has been declared to be a national emergency that threatens development, peace and stability.

The depth of the current crisis in these countries, together with the recognition that schooling can provide ‘an education vaccine’ for HIV, means that there is now a real opportunity to change policy, accelerate the educational response and transform and develop ineffective systems for the better. For this to happen, however, education reform must be placed at the forefront of change processes in a way that it has not been in the past.

This study has also examined the affects of HIV and AIDS on young people. It has shown that young people are facing problems now. They are already missing lessons and dropping out of school. They need to run their households and protect themselves from HIV infection or from spreading the virus themselves. Dropping out of school not only increases their vulnerability to HIV infection, but also damages their longer term prospects for social and economic development.

At the same time, schools are increasingly challenged to meet the educational and emotional needs of the young people who walk through the school door. Many heavily HIV affected communities are reaching the limits of their capacity to cope with the needs of orphans and other vulnerable children. It therefore seems unlikely that, without a radical rethink of how the educational provision can be delivered, schools will be able to reach out to the young people who are not able to attend school regularly.

ODFL could play a much more proactive role in facilitating educational reform, by sharing the burden faced by schools and helping to integrate responses to meet learners' needs more effectively. ODFL can enable the curriculum to be delivered to young people beyond the school gate – not only in relation to HIV prevention education, but more broadly. ODFL can help children to avoid falling behind and dropping out when they have to miss schooling, help them re-enter the system once they have dropped out and continue their education even when they have left school. ODFL can also help to mitigate the affects of HIV and AIDS on young people, by providing materials that give practical advice and emotional support for their everyday lives.

This study has argued that although the ODFL response to the needs of young people who are out-of-school is growing, it lacks the necessary urgency, remains unfocused and is limited in scope. ODFL programming to support educational transformation needs to develop within a broad based educational approach, focused on increasing knowledge, critical thinking and positive group identity and solidarity amongst the young. It needs to build a sense of empowerment and motivation, strengthen supportive social networks and increase access to services and links to outside agencies.

Within a broad based educational approach, initiatives are needed at all levels to further develop policy and legislation, mass media and macro-level communications and support community,

interpersonal and participatory initiatives. We need more research on the capacities of the different means of communication (print, radio, television, telephone, Internet). Such work must be located firmly within a poverty reduction, rights based and capability building approach. This is necessary to stimulate the type of information rich and dialogue rich environment critical to mitigating the affects of HIV and AIDS and enabling young people to participate in transforming their communities and their wider society.

Placing ODFL in this broad context exposes the futility of focusing narrowly on behaviour change communication without addressing the need to raise the critical awareness of young people so that they can contribute to the process of change. At the same time there is a need to meet young people's need for basic education and for livelihood programmes in order to address structural barriers and provide them with real choices in their lives. A stronger deployment of ODFL approaches could do much to overcome such barriers and offer wider, life-giving choices.

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Appendix 1: List of policy makers/advisers and key informants in organisations working with youth who were interviewed

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Appendix 2: Data collection tools

The following questions were developed to guide the semi-structured interviews with policy makers and implementers at all levels.

- *What are the national policies on HIV/AIDS?*
- Where is HIV/AIDS policy being written?
- What documents (policies, plans etc) have been completed?
- Are any currently being written?
- What is the process of policy development?
- How are policies critiqued?
- What are the challenges to policy development?
- Where are the gaps between policy and practice/implementation?
- How is the impact of the policies being assessed (monitored, measured, evaluated)?

- *What important initiatives are being implemented to translate these policies into practice, and with what effect?*
- What initiatives are currently being developed or are being implemented?
- What initiatives, if any, seek to reach the young people of interest to our study?
- What is the nature of the mass media component?
- What else is included in the package (e.g. STD treatment, condom supplies)?
- What learning/support materials have been produced?
- What are the strengths/challenges of each programme?
- How have any challenges been overcome?
- What plans have been made for spreading out the programme?
- Was a baseline audience survey conducted?
- Are there any evaluation reports?

The following questions were developed to guide the focus group discussions and semi-structured interviews with the young people to assess their learning needs, aspirations and listening habits.

1. Age (in years) and sex.
2. Number of years of schooling.
3. Reasons for leaving school.
4. What school subjects, if any, would you like to learn about now?
5. What job do you want to prepare yourself for?
6. What other things do you want to learn how to do now?
7. What, if any, radio programmes do you listen to often?
8. What, if any, TV programmes do you watch often?

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