loveLife promotes healthy, HIV-free living among South African teenagers. Organised under the auspices of the New loveLife Trust, loveLife combines a sustained high-powered multi-media campaign with nationwide community-level outreach and support programmes for youth. loveLife’s programmes are implemented by a national youth volunteer service corps known as groundBREAKERS and mpintshis in partnership with more than 200 community-based non-government organisations, 5600 schools and 470 government clinics across South Africa. Major funding for loveLife is provided by the South African Government and the Henry J. Kaiser Family Foundation. Additional support is provided by Avis, Barloworld, BMW, DED (German Development Service), Dewey & Le Boeuf, Independent Newspapers, Jumpstart, Mondi Shanduka, Murray & Roberts, Rapport, Royal Bafokeng Holdings, the South African Broadcasting Corporation, SterKinekor, Tone Digital and the Vodacom Foundation.

For more information visit www.lovelife.org.za or call 0800 121 900.
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Introduction
A frank reflection:
loveLife ten years later (1999 – 2009)

PRESENTER: Dr David Harrison
Programme Director: Connected!

The last ten years of loveLife’s existence have been challenging as well as rewarding. We couldn’t have chosen a better time to initiate such a major national HIV/Aids programme in Africa and most certainly Southern Africa. 1999 was the year in which South Africa in particular was experiencing a spike in the mortality phase. While people were dying, the Mbeki administration was reluctant to address the HIV/Aids issue head on. loveLife, however, grabbed the bull by the horns. Against all odds, we are here to share our story – ten years later. Let’s take an evolutionary journey of our strategy and approach to the campaign, including our controversial visual billboard creatives.

1. HOW IT ALL BEGAN

THE STATISTICAL EVIDENCE
Back in 1999, all we had to work with in South Africa was the national ante-natal public clinic surveys. What we saw was that the epidemic prevalence had jumped from 0.7% in 1990 to 22.8% by 1998 in young women (Department of Health, ante-natal surveys). When we broke down this information it became clear that about 55 to 60% of the infections were happening before young women reached the age of 25. The fact that it was happening in a society made up of 40% of young people under the age of 20, created an opportunity for loveLife: we believed that if we could stop the next generation of young people from becoming infected, we could reverse the cause of the epidemic; we had an idea at that stage of what was high-risk behaviour was; we were able to model the risk profile in South Africa, including both high and low risk. The results were straightforward: the majority distribution in the high-risk pool was skewed towards young people. We needed to do something to move these young people out of the high-risk pool – even just a 20% shift could trigger a drop in the infection rate of HIV.

OUR FOCUS
From the numbers we were exposed to, it was clear that HIV was widespread among young people. Because of the youth bubble, the skewed distribution could create a disproportionate effect over a relatively short period of time. Focusing on young people was critical if we were going to crack the epidemic.

UNDERSTANDING THE YOUTH
Getting to young people was a challenge. The first thing we had to do was move beyond academia and really understand young people. Plainly, we needed to understand the following:

- What made them tick?
- Where they were coming from?
- What the influences were in their lives?
- What could potentially change them?
**KEY INSIGHTS**

Between 1994 and 1999, post the democratic elections, the percentage of households that had electricity increased from 45% to 76%; with electricity came greater access to TV. In addition to radio, TV became a huge part of young people's lives. TV brought with it a sense of global proximity, with popular culture splashed in the media. Young people began to experience sudden and fantastic influences that led them to wanting to be part of this global world, yet, at the same time, the world was opening up conflicting concerns for young South Africans. Through surveys we found that young people were concerned about AIDS, TEENAGE PREGNANCY, CRIME, and SEXUAL ABUSE AND VIOLENCE. Their priorities were getting an education, protecting themselves and loved ones from HIV/AIDS, marrying and having a stable family life and finding employment. The youngsters of that time had dreams, priorities and challenges that were very much influenced by the glitz and glamour of the globalising world, informed by electronic media, radio and TV. In creating a campaign and a programme for young people, these were the dilemmas to which loveLife had to respond. In late 1999, a provocative billboard appeared – simply called FOURPLAY. It remained mounted for three months, across the country.

**THE FIRST BILLBOARD: THE BIRTH OF loveLife – DIPSTICK**

The FOURPLAY billboard carried a message that triggered dialogue. People started asking what was going on and why the message was sexually explicit. At the time, discussions of sex and sexuality were far more constrained and much less discussed than today. The billboard therefore caused quite a stir in 1999. This was a precursor to the programme that loveLife has become today.

**CHALLENGE NO. 1:** When we started, our insight was an understanding of young people on the one hand, and recognition that the linkages between sex and HIV had not been made. At best, the ‘Red Ribbon Campaign’ had made the connection between the red ribbon and HIV, but very little connection between HIV and sex.

**CHALLENGE NO. 2:** Getting people to talk about HIV and sex, not solely about sex. It was also about talking about loving, values and ultimately about life. It wasn’t difficult for the pieces to fall in place from there, and come up with the ‘Talk about it’ logo and the power of an aspirational brand for young South Africans.

**OUR GOAL**

Our aspirational goal was to halve HIV/Aids among young people between the ages of 15 and 24, within five years. This was written off as too ambitious, and that we were suggesting we would do it all alone. The epidemic was so big that we had to set ambitious goals otherwise we would not have been able to mobilise the resources to create the impact we wanted. We realised we had to go big and bold. Our plan was to do this by increasing partnerships to make a massive dent in this epidemic, no apologies made.

2. **FIRST PHASE OF THE CAMPAIGN**

The first part of the campaign was to create a climate that would open the discussion, where people were willing to talk. Looking back at these billboards, it is amazing what people were NOT talking about at that stage. The first set of billboards was really just about trying to inculcate a sense of talking/dialogue.

**FIRST SERIES OF BILLBOARDS (LATE 1999)**

- What’s your position?
- Get your point across
- Use your mouth
After the first series of billboards people still didn’t get what loveLife was about. Remember, this was still an attempt to create the need to talk about sex, as these messages had a slight sexual nuance. While people were trying to comprehend what loveLife was about, we hit them hard with the next series of billboards.

SECOND SERIES OF BILLBOARDS
We personified the messages. We used the actual words young people were using around the country. This is what they were telling us:

“I had sex, will I die?” Siphiwe, 14

“My boyfriend is cheating on me – am I going to get the disease?” Bettie, 12

“What if the condom came off when he’s inside of me,” Nomsa, 13

We put the questions that young people were asking into the public sphere. People were horrified. As a result, loveLife had to spend a huge amount of time before the Advertising Standards Authority and the Broadcast Complaints Commission.

OUR RESPONSE: We presented what young people were saying to us, and the questions they were asking. loveLife believed that if we were not prepared to confront and answer them, we were not going far enough in our attempt to combat the epidemic. Having made the connection between the need to talk and young people’s sexual behaviour, we could then bring ‘Talk about it’ and ‘sex’ into the context of HIV. We then addressed the questions which were being asked by the Advertising Standards Authority and the Broadcast Complaints Commission: ‘Why talk about it? Why is it about sex?’

The billboard simply read:
The Future Ain’t What It Used To Be ...+HIV?

Although approximately 85 to 90% of the billboards were very effective in stimulating the discussion, the following did not work:

A billboard of a pregnant teenager – BEFORE ACCIDENTS HAPPEN ...TALK WITH YOUR CHILDREN ABOUT SEX and THE FUTURE AIN’T WHAT IT USED TO BE... TALKING ABOUT SEX DOES NOT CAUSE EARLY SEXUAL ACTIVITY, HIV/AIDS, TEENAGE PREGNANCY.

This was the end of the first phase of the big bang explosion campaign in 2000.

3. SECOND PHASE OF THE CAMPAIGN: LINKING MEDIA WITH SERVICES

WHAT WORKED
By World Aids Day 2000, loveLife was making an impact in terms of sparking dialogue. We had all learnt about sex in such a short period of time through the media campaigns – billboards, print publications, TV, radio, etc. From the outset, however, we understood that the basic essence of behaviour change could not be achieved by media campaigns alone; we needed to create a one-on-one connection. We bridged that with a call centre and provided toll-free helpline services. The young person could read the message in the media, then pick up the phone and be afforded immediate one-on-one response/counselling. The call centres started to attract a million calls per year.

Distribution of calls: The results show that billboards in particular played a huge role in directing
people to services. Although Gauteng represents the density of the population, surprising was the fact that where there was major billboard presence, even in rural Maputaland, parts of Southern KwaZulu-Natal, Eastern Cape and the Free State, a large number of calls came in. On the other hand, the Western Cape, which was less populated with billboards because of environmental constraints, received the lowest number of calls i.e. billboards played an important role in pointing people to further information and services.

4. YOUTH CONNECTING WITH YOUTH: THE HUMAN ELEMENT

As we believed that young people influence behaviour change among other young people, this campaign had to be led by the youth. This belief made youth leadership and mobilisation part of the original construct.

From the outset loveLife wanted to create spaces that were for youth only, so we built Youth Centres (Y-Centres) in four communities. The Y-Centres played a pivotal role in creating political support for loveLife; we could, for instance, take the then deputy president Jacob Zuma to the opening of a Y-Centre. This created support for loveLife which continues to this day. We now have 19 Y-Centres where there is value in these centres, but they are an expensive strategy that requires extensive logistical planning, financing and day-to-day running.

EXPERIENCING THE loveLife lifestyle BRAND

Whether you are in deep rural KwaZulu-Natal or Jozi, you have to experience the same aspirational brand. We try as hard as possible as a growing brand with limited resources to give smart young people who want to know where they are going in life, similar high-quality services irrespective of their geographical location.

Centres and Cyber Ys: For many of these youngsters Y-Centres (and an expansion of the Cyber Ys programmes into a wide network of NGOs), were their first exposure to the Internet and computer technology. We also tried to combine the media and other loveLife services in some of the Y-Centres, so that some had their own radio studios, for example. Young people were involved in the production of programmes that were distributed to radio stations around the country.

Radio: Through our relationship with the public broadcaster, SABC, we managed to have 12 radio programmes per week on multiple stations. We got the voices of the youth from the deepest, most rural parts of the country heard through the use of Outside Broadcast Units.

Clinics and the loveLife love train: We also introduced loveLife into clinics. Typically young people would go to clinics if they had STIs. Turning clinics into places young people where young people wanted to go was an important strategy in terms of strengthening prevention. The next step was to let young people know that the choices they made lay in their hands, so we came out with ‘Choice’ billboards.

5. CHOICE CAMPAIGN

The first billboards in this campaign were about letting the young person know that they had a choice in life; they don’t have to be on a one-stop track to HIV infection. We had a series of billboards featuring young people and graffiti messages about choice/‘Talking about it’. We also used mobile ads by way of taxi side panels to reach even more young people. The main thrust behind these messages was that with choice comes RESPONSIBILITY.

- Your Body – Anybody
- Drop Dead Gorgeous – The Drop
- Climax – Anti-climax
- His and Hers
We then came out with the next set of billboards focused on different aspects of shared responsibility and self-esteem. Choice, responsibility and self-esteem were the successive phases of the campaign.

- FEEL GOOD ABOUT WHO YOU ARE?
- LOVE YOURSELF ENOUGH?
- AT PEACE WITH YOURSELF?
- IS THIS YOUR RELATIONSHIP?

These are what we believed to be some of the building blocks that would equip young people in a climate of discussion to be able to respond to the challenge of HIV/AIDS.

**DIPSTICK RESEARCH**

In 2001 we did our first dipstick research with young people and by that stage 62% (nearly two-thirds) had heard about loveLife. It was encouraging for us because we tried to position loveLife as the new lifestyle for young people. In another study of young people, there were self-reported cases of youngsters saying that loveLife may have contributed to the change of behaviour. What came out from the earlier study was that parents were not talking to the children. Youngsters were saying, ‘We are getting it, but when we go to our parents it is a complete turn off.’

**LETTING PARENTS ‘IN ON IT’**

Even as we were talking to young people we soon recognised the need to direct some of our efforts to parents, as they were willing to talk about HIV but not SEX. They were willing to talk about dreams and aspirations but not about dealing with the pressures to have sex. We then decided that we have to focus on parents too. We had to get parents to understand what loveLife was about. So we started a campaign to encourage parents to open up. The parents’ campaign was one of the most important yardsticks for loveLife. We got senior people from across the country and on the ground to contribute.

**PARENTS CAMPAIGN**

We kick-started the campaign with a billboard:

**LOVE THEM ENOUGH TO TALK ABOUT SEX**

Followed by senior personalities featured on the billboards, saying:

**LOVE THEM ENOUGH TO TALK ABOUT IT**

The then deputy president Zuma was also featured, saying:

**WE NEED TO DO THINGS IN A NEW WAY,**

*Love them enough to talk about sex*

Then Archbishop Desmond Tutu, saying:

**SEX IS A BEAUTIFUL GIFT FROM GOD**

*Love them enough to talk about sex.*

Former president Nelson Mandela:

**WE MUST START WITH OUR OWN CHILDREN**

*Love them enough to talk about sex*
We had to speak frankly about HIV/AIDS because we were facing a catastrophe. We had to start with our own children and try to save their future and their lives by educating them about how to engage in safe sex.

**RESULTS**
- This campaign was successful in that it was even taken up by the Associations of Traditional Leadership.
- It created a willingness to confront issues of sex and sexuality.

**WHAT WE COULD HAVE DONE BETTER…**
In retrospect, we didn’t carry the momentum through enough, but over the years we did develop other aspects of talking to parents.

**BACK TO THE EVOLUTION OF loveLife**
By 2003 we felt that we could now focus more on the issues of sex and sexuality with young people. We could be more direct because we now had them on our side. So we now had very direct questions for young people.

- Which way are you headed?
- Which of your lovers decided your future?
- Since when did ‘no’ mean ‘yes’?

**GETTING EVEN MORE FOCUSED**
Some of what young people were saying during this phase of the campaign:

“I only like it skin-on-skin,” James, 18
“I told James to wrap it or zip it,” Zola, 17
“I wanted to wait, but Abram was inside me before I could say no,” Sandy, 15
“Sshh… did I rape her? Now that we talk I understand that love is not just sex,” Abram, 17

Difficult concepts, but these billboards were up for six months at a time, getting people to engage and start to grapple with the issues that were up for all to see.

And then a very seminal series of billboards was erected:

**NO PRESSURE**

**SEX – WORTH WAITING FOR**

**ONE ROLL-ON ALL WOMEN WANT**

**EVERYONE HE HAS SLEPT WITH IS SLEEPING WITH YOU**

**TOO SMART FOR JUST ANY BODY**

**BILLBOARD CAMPAIGN EVALUATION**
We conducted a survey with a national sample of 4 400 Grade 6 to 12s and asked a number of questions about the billboard campaigns, such as which one they liked most. The answer was the one with the hands: EVERYONE HE HAS SLEPT WITH IS SLEEPING WITH YOU. People also liked TOO
SMART and SEX – WORTH WAITING FOR. These were the most effective; they made people think, act and talk; whereas the ones they liked didn’t necessarily translate to thinking, acting and talking.

THE BALANCING ACT
We had to balance the evocative messages with values. This meant we had to embed our discussion within the context of values and in the communities to ensure they were willing to accept the provocation because they could trust loveLife. The next phase was to back away from the incredible controversy we had created. We wanted to reassert the importance of the values of love, dignity and respect.

2010 CAMPAIGN
In 2003 South Africa decided that it was going to bid for the Fifa World Cup. We decided to take a chance and put up a billboard that said 2010 Love to be there, which went up before we even won the bid. People didn’t get it then, but in May 2004, when South Africa got the winning bid, the penny dropped. This was a very powerful campaign that attracted about 3 million calls on our helpline in 2004.

CHANGE BEHAVIOUR
In a random survey of 12 000 young people from around the country, we wanted to determine whether their behaviour had changed towards HIV.

What we found: Most young people exposed to loveLife were more likely to report behaviour change. The more they participated in face-to-face programmes, the lower the HIV infection.

The statistical analysis: Looking at the more statistical analysis, loveLife was attracting both ‘gangsters’ and the ‘Geeks’ (good people). When you look at the intensity of loveLife, those who participated in one programme versus not, there appeared to be a protective factor and reduced the infection rate by 30%.

The intensity: The higher the intensity of participation in programmes and exposure to information, the lower the odds of HIV infection. Still today, we cannot say for certain that loveLife caused this, but it is important from a strategic point of view that these were the changes we couldn’t see from media exposure alone; rather where there was a combination of media and face-to-face programmes it seemed that something was happening.

Media and face-to-face: For loveLife, this meant not doing away with media, but to intensify our face-to-face interaction. In our construct it was clear that we needed to operate as a campaign as well as a programme, and at a societal level to create provocation and have people talking about it. We also had to strengthen the response of institutions – health, education, social security, sports – to lead to greater change in society. We also needed to continue to work at an individual level, to nurture a sense of motivation, belonging and identity and to do all the things that conventional prevention does when it comes to getting people to understand the risks they have.

NEXT PHASE: 2010
We then honed into the 2010 campaign, which was focused on getting on young people to have aspirations of education, employment, entrepreneurship – thinking about what they were going to do in future and about family life. This encouraged young people to make concrete choices about themselves; that they were going to be part of a different generation to other young people. Unless we could inculcate this kind of attitude in SA’s ‘born-free’ generation, we would have a lost generation.

The evolution: The 2010 campaign became more focused on developing a collective attitude, a loveLife generation of people who are BORN FREE. They had to have the attitude of “you have to take back the future” and adopt an attitude of activism; take up issues of gender inequality that are still so
much part of South Africa, and the willingness to embrace life.

**The roll-out:** As we rolled out the programme, we realised the increasing number of orphans that were part of our programmes and the need to expand the programme to directly support these orphans.

**BORN FREE DIALOGUES**

One of the community project strategies we developed was the BORN FREE DIALOGUES. As loveLife, we sat in noisy auditoriums and listened to what the ‘born frees’ were saying, we put this into programmes that have become a critical part of loveLife. By 2006 there was some evidence (although not enough), that HIV among teenagers and youth between ages 15 and 24 had peaked. There was also research from the Human Science Research Council that there was a decline in prevalence among 15 to 24-year-old men since 2002. But we were getting frustrated. We were not getting the breakthroughs we wanted.

**The frustrations:** The country was frustrated. This was the time of the greatest Aids denialism, so we decided to confront government and society in a much more direct way and came up with a hard-hitting campaign to wake up the country.

**Our response:** Billboards such as HIV FACE IT, HIV LOVES SKIN ON SKIN, HIV LOVES SLEEPING AROUND, HIV LOVES PELEGI GO SUPA BOSADI. The last one got us into huge trouble; it caused a major uproar, mainly in the political ranks and in the communities, so much so that we had to pull it down.

**What young people wanted:** From sitting down and talking to young people in communities, we found that they wanted a sense of identity, purpose, a sense of belonging and possibility. These were triggers we had to instill in all our programmes. While information is the compass, it is not the trigger or impetus for behaviour change. We came up with billboards aimed at giving them a sense of purpose: THE POWER TO DECIDE, not only as individuals, but as a collective – THE BORN FREE GENERATION, THE LOVE LIFE GENERATION. The sense of combining social change with individual change worked remarkably well.

**MAKE YOUR MOVE**

Through research we found that for every three young people who were having sex, one was HIV positive. The outcome of sexual activity varied by age, but what we could show was a sharp decline in condom use from age 16. It wasn’t because young people wanted to have a baby. In fact, they said they were having babies because they weren’t using contraception. They had the information at 16 but they were still taking the risk.

**What was happening:** As we began to better understand the youth who were leaving school without completing it, we began to understand that there was a need for helping young people to navigate the transitions in their lives that we typically associate with aimlessness. There were three factors that affected the sexual outcomes in school leavers:

- Who you think you can be
- Who society thinks you can be
- Who society lets you be (the structural factors)

**How it worked:** We shifted our campaign from just wanting to change sexual behaviour to enabling young people to act on a sense of purpose, identity and belonging. loveLife wanted to help young people to be complete, creative and connect. This gave rise to the shift in our logo to LOVING LOVE, MAKE MY MOVE and continued to build a sense of opportunity for youngsters. This was the Tour de Force of the evolution of loveLife.
HAVE WE MADE A DIFFERENCE?
While it cannot be claimed that loveLife on its own has been responsible for the declines we have seen, it is fair to assume that a campaign as large and sustainable over a period of time has made a significant contribution.

EVIDENCE:
As an evidence-based project, we can show:
- The decline in prevalence among young men (20-24 years old), as older men turn to have sex with younger women.
- The reduction of the prevalence among young women aged 15-24.
- That since 2002 the rate of new infections among teenagers has halved.
- We work with partners on our 800 sites, 5 000 schools, and local community-serving organisations, with loveLife creating an overarching support for local initiatives.

YOUNG PEOPLE MADE IT POSSIBLE
Finally, I have to conclude by going back to the young people behind loveLife, who have energised me. These are the youngsters who have inspired me. They are the young people who give me inspiration of the future not only of South Africa, but of the continent as a whole.
A:

Mapping out the context

THE STATE OF THE HIV EPIDEMIC AMONG YOUNG PEOPLE IN SUB-SAHARAN AFRICA

PRESENTER: Dr Asha Mohamed
ASRH and HIV Advisor: Sub-regional office for East and Southern Africa, UNFPA

When working with the HIV epidemic on the African continent, people on the field have to deal with reality checks that provide context. Africa has a very young population; between 60% to 70% are the age groups are below 30 years. It is these youngsters who face multiple and complex sets of risks and vulnerabilities that ultimately threaten their health and their contribution to socio-economic development.

**STATISTICALLY SPEAKING**

Pregnancies: About 75% of teenage girls between 15 and 19 become mothers, representing 13% of all fertilities.

Child marriages: It is common for girls under the age of 18 years to marry. Take Mozambique, 61.8%; Zambia, 57.4%; Malawi, 55.5%. These figures are even higher in Ethiopia, Niger, Mali, Burundi and others.

Maternal mortality: High maternal mortality during childbirth mostly affects teenage mothers.

HIV: The highest recorded Sexually Transmitted Infections (STIs) and HIV have been among age groups 20-24, followed by 15-19 year olds.

Orphans: SADC has 16 808 000 orphans aged 0-17 years, and 38% due to AIDS, over 50% in some individual countries.

Out of school: 49% children are not in school in some countries, 90% of those with disabilities.

Unemployment: There are huge numbers of young people who are unemployed, in some countries as high as 80%.

Poverty: 70% of people living below poverty live on US$2 per day.

Sex workers: Many sex workers are under age 25; most of them are women but more and more men are beginning to look to sex work as an alternative income generator.

Substance abuse: Serious substance abuse including injecting drug use (IDU).

Marginalised: There are large numbers of marginalised and displaced youth.

**HIV EPIDEMIC IN SUB-SAHARAN AFRICA**
The UNAIDS Research statistics show that of the 2.7 million global new infections, 1.5 million in 2007, were accounted for by the Eastern and Southern Africa regions. Ninety percent of the 1.5 million
were accounted for by eight countries: South Africa with the biggest volumes, Kenya, Mozambique, Tanzania, Zambia, Ethiopia, Malawi and Uganda. These are known as priority countries for HIV prevention. There are countries such as Botswana, Lesotho, Namibia, Swaziland, Zambia and Zimbabwe that need to arrest prevalence while Ethiopia and Angola have rapid increase in HIV infections.

**AIMS:** These countries need a sustained reduction in new infections between 2010 and 2015, using aggressive means informed by HIV prevention strategies. These need to be effectively implemented, monitored and evaluated in priority countries.

**HIV PREVALENCE IN SUB-SAHARAN COUNTRIES (AMONG YOUNG PEOPLE)**

- In 2008, an average of 2.1 million children under 15 were living with HIV.
- Young people account for around 40% of all new adult (15 and above age groups) HIV infections worldwide. Thus, 40% of PLHWAs are youth.
- The number of new HIV infections continues to outstrip the numbers of those getting treatment – for every two people starting treatment, a further five become infected with the virus.
- Young women bear the burden of HIV in the region. They are our “endangered species”!

**FACTS**

- **Disproportionately affected by AIDS:** 61% of all people living with HIV in sub-Saharan Africa are women.
- **Among 15-24 year olds in South Africa:** Women and girls account for more than 90% of new infections.
- **Survival sex:** According to a recent study in Botswana and Swaziland, women who lack sufficient food are 70% less likely to perceive personal control in sexual relationships, 50% more likely to engage in intergenerational sex, 80% more likely to engage in survival sex, and 70% more likely to have unprotected sex than women receiving adequate nutrition.

**Priority:** Structural interventions that increase women’s economic independence and legal reforms to recognise women’s property and inheritance rights should be prioritised.

**TO NOTE:** In adults, South Africa is the leading country with the highest urban HIV rankings among national epidemics, followed by Nigeria.

**BEHAVIOURAL TRENDS AMONG YOUNG PEOPLE**

- **15 to 17-year-old youth:** There is a need to focus on females aged 15-17, where prevalence rates are still relatively low, as this is the group that is just starting to initiate sexual behaviour and are most in need of SRH and HIV information and skills.

- **Not sexual:** The majority of this group is not yet sexually active, but parents, teachers, service providers and community leaders are much more open to this group receiving relevant sexual health and HIV information and risk reduction skills than the younger 10-14 age group.

- **Strategy:** A major – to scale – focus on this group would be possible in most of our countries, especially if the school setting was utilised as the entry point for reaching them. For example, in Malawi there are around 140,000 15 to 17-year-old girls in school. In Lesotho there are around 40,000. Designing and delivering a package of materials into the hands of each and every one of these girls could be possible. We have seen how governments can be mobilised for health weeks and HIV-testing weeks. This response, in partnership with the education sector – as a social movement around protecting ‘vulnerable’ girls – is doable.
Challenge: The old paradigm of risk and vulnerability needs to shift to “advice on evidence-based approaches.” For anyone to be able to apply a differentiated response there is a need to recognise that many young females have agency within sexual relationships, especially those based on transactions for ‘desired needs’.

Age Disparate Sex: In South Africa in 2005, 18% of females between 15-19 and women 25-29 had partners who were over five years older.

Knowledge about Aids
Despite having knowledge about Aids, studies show that young people still engage in risky behaviour. At times it is out of sheer ignorance. Look at Kenya’s situation amongst 15-19 year olds. In a study with teachers in Kenya, 39% of primary and secondary teachers thought that condoms were not effective in HIV prevention. (Horizons/USAID, August 2006)

Assessment
Among 15 to 19-year-old adolescent women using PMTCT services in Kenya, only 6% of the age group knew that limiting the number of partners was a way to prevent HIV infection, and only 7% were able to name all three ABC messages (FHI, 2006).

WHAT HAS BEEN THE RESPONSES IN DIFFERENT COUNTRIES
- Policies and strategies are in place in most countries
- Life skills and Aids education in schools
- Programmes for out-of-school youth
- Media programmes
- Youth-friendly services
Almost all these strategies have worked when implemented well with the right intensity and right programming, but problems of coverage, scale, intensity and targeting of interventions persist.

PROBLEM
The problem is that the coverage, the scale and the intensity of the interventions, may not be addressing all the obstacles and issues young people are facing, which are mostly concentrated on knowledge provision. However, knowledge alone will not address the risk perception.

Because of the large proportion of young people living with Aids in this region, there needs to be an intervention strategy directed at them. There are not enough targeted programmes addressing their needs.

LIGHT AT THE END OF THE TUNNEL: PREVENTION TARGETS BY REGION

We need to ensure that by 2010 at least 95% of young men and women aged 15 to 24 have access to the information, education (including peer education and youth-specific HIV education) and services necessary to develop the life skills required to reduce their vulnerability to HIV infection; all in full partnership with youth, parents, families, educators and health-care providers.

Southern Africa is doing much better in terms of TLC coverage. Condom distribution is higher, with VCT coverage also much higher than Central West Africa, where coverage and distribution remains slow.

BEHAVIOURAL CHANGES
It is not all doom and gloom on the continent as there has been some noticeable change in behaviour. For instance, if we look at the age at which young people used to have their sexual debut, previously
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it used to be largely under 15, but this trend has decreased as a result of the interventions through programmes.

Multi-partnerships have also generally decreased and condom use has increased.

HIV prevalence: Has gone down in Botswana among pregnant young women. In Zambia and Malawi, young people are showing more response to these programmes.

SOLUTION: We need to have more results-orientated programmes based on evidence.

RECOMMENDATION: Focus on targeting out-of-school programmes since we do not have sufficient of these. We need to have age-to-age bands, and not lump young people together and provide age-appropriate programmes in order to meet risks for each group.

EFFECTIVE PREVENTION PROGRAMMES FOR YOUTH

- Pressure for greatly improved efficiencies and effectiveness:
  - Focus on long-term and sustainable planning for youth programmes
  - Ensure availability of data on young people, especially out-of-school youth/sex workers, displaced, disabled, rural, in hotspots, etc.
  - Support mapping of vulnerable youth (numbers/locations)
  - Integrate youth issues in national development frameworks and strategic documents such as PRSPs, Global Fund Proposals/NSPs

- Better identification of effective strategies and interventions for young people:
  - Good quality sex education/SBCC for young people in school and out of school, including at the community levels
  - Analysing complex vulnerabilities, risk factors and drivers among young people
  - Evidence for impact of prevention approaches, with required intensity and quality with right populations in mind
  - Refining combination prevention approaches for out-of-school youth, sexually active young people, those in unions or married, and those who are living with HIV/AIDS. Each one of these groups needs unique interventions – they cannot just be lumped together.

- Ensure access to quality youth-friendly services (public, private and non-traditional settings such as social marketing, kiosks, bars, cross border settings)

- Ensure meaningful youth involvement and leadership movement

RECOMMENDATIONS

Let us educate and empower young people against:

- Early marriage and childbirth
- Unsafe abortion
- New HIV/STI infections
- Coercive sex/rape/incest
- Maternal death
- Fistula/infant death
- Sugar daddies
- Dropping out of school
Judgmental service providers
- FGM/FGC

**IMPORTANCE OF PREVENTION**
Without a cure, the burden of HIV and Aids is determined by incidence and mortality (global estimates for 2007: 2.7 million new HIV infections; 33 million people living with HIV/Aids, only 3 million on ART and 2 million died from AIDS-related deaths).

**WHAT DO WE NEED?**
We need political commitment from:
- EAC and SADC committing to halving new infections by 2015
- Virtual elimination of MTCT by 2015
It is important to look into the prevalence of HIV among young people in South Africa with a focus on self-reported behavioural change and some high-risk behaviour that remains unchanged. However, more concerning is that whatever work we do, we need to understand contextual factors that may be behind the lack of response from high-risk groups, as well as the factors associated with low risk, things that we need to focus on building upon.

Females carry the highest burden, with prevalence much higher among young women. We need to focus on what is working.

**PREVENTION INVESTMENT**

Prevalence of HIV has been steadily decreasing among young people, particularly in young men. We are beginning to see greater returns in the prevention investment. Because of the youth bubble, a very high proportion of the population is under 20, which amounts to 40%. That does translate into the high proportion of the population with lower levels of HIV (HSRC, 2002). If we can sustain the successes, young people are likely to see the trend growing, as they grow up.

**WHAT HAS CHANGED**

At the general level of the population, self-reported condom use has substantially increased since 2002 (Survey by Human Sciences Research Council). In 2008 there were significant gains in condom use. This has improved significantly among young people – especially young men aged between 15 and 24, almost reaching 90%. More work among young women still needs to be done. When it comes to testing, more women are agreeable than men. These are just a few of the things we know we can build on.

**HIGH-RISK BEHAVIOUR THAT HAS NOT CHANGED**

- More than one partner: There has been no change reported among young people aged between 15 and 24 regarding having more than one partner during a one-year period.
- Condom use: People with multiple partners are committed to using condoms and that remains unchanged.
- Age disparity sex: Age disparity sex seem to have not changed where girls as young as 15 may engage in sex with a man five years older. Age disparity sex increases the rate of infection.

**SOME OF THE CONTEXTUAL FACTORS: Behind a lack of response in high-risk groups**

- Urban informal communities in South Africa have the highest prevalence of HIV.

We need to spend time understanding the contextual factors associated with urban informal settlements in SA so that our targeting of these communities will be informed by what circumstances and drive risk among young people in those communities. But that doesn’t mean that we ignore everybody else. We need to be focused and targeted in our approaches.

- Offenders show higher prevalence than national averages.

**FACTORS ASSOCIATED WITH LOW RISK**

We need to understand circumcision and how we can build on it for the benefit of young people in the age groups we are working with as it has been shown to be associated with lower risk. Participation has been shown to lead to self-reported behaviour change and much lower risk.
FACE-TO-FACE
Participation in face-to-face programmes has been shown to lead to behaviour change and much lower risk compared to younger people who do not participate in these programmes.

OUR CHALLENGE
To get to many more young people through programmes so that we can effect behaviour change.

BEING IN SCHOOL
Pupils in school report lower risk sexual behaviour than those not in schools. It is very important from that knowledge to keep young people in school, even though we are faced with a challenge of a very high drop-out rate. School protects them so the focus must also be on taking advantage of that benefit.
Teenage pregnancy has been a subject of debate ever since newspapers blew it out of proportion, to a point where people believe it is still growing. The evidence gathered, however, debunks the myth; teen pregnancy has in fact been on the decline in South Africa. But there is still concern as teenage pregnancy is still relatively high compared to mid-income countries such as Brazil and Argentina.

South Africa’s statistics also reflect that sub-Saharan countries, notwithstanding early marriages in that region, are lower. Highest teen pregnancies in countries where there are early marriages are the norm. Therefore it is important that policy and practice must be informed by an understanding of the conditions under which teen pregnancy occurs. Because it is an emotional issue, we found that most of the proposals of reducing teenage pregnancy have been in our view very misguided. We have established that to put teen pregnancy in context, we need to look at what the trends are regarding fertility in that age group in relation to pregnancy as there is a correlation.

**FERTILITY VS TEEN PREGNANCY**

Overall fertility and teen pregnancy have been declining for the past 50 years in South African women. This means that women are having fewer children than they had previously. However, it is important to throw in the spanner the fact that teenage childbearing has been declining at a slower rate to the overall decline in fertility. Older women are having fewer children than younger ones.

**Perspective:** Teenage fertility has had stalls during certain periods such as late ’80s and ’90s. The contributing factors include the fact that the youth then were the ‘lost generation’. Between 1996 and 2001 fertility had declined by 10% moving from 78 of 1000 to 65 per 1000 teenagers giving birth in a calendar year. By 2007, a further 10% decline had been shown, and childbirth among teenagers had fallen to 54 per thousand. If you compare the figure with industrialised regions we still have relatively high numbers: Europe, 22 per 1000; US, 40 per 1000. Our figures are a bit higher than Western countries but lower than less developed countries.

**Myth:** Another argument is that young people are having children in order to get the support grant. This doesn’t hold true as it was reintroduced in SA in 1998 and we see the decline of pregnancies during the time that the child support grant has been enforced.

**How do you explain it:** Where teen pregnancy is concerned it is relatively unknown how many young people fall pregnant as a number of them terminate immediately. Secondly, termination of pregnancy is not recorded in the private sector. We are only aware of what is happening within the public sector (health facilities).

**BREAKING IT DOWN**

Teenagers who give birth to children are between the ages 17-19 and they account for 90% of teen fertility. The rates are higher among African and coloureds and lower among whites and Indians. A good proportion of that difference can be explained to a large extent by socio-economic differentials between the race groups such as poverty. The poorer the more chance one has of falling pregnant. There is also high fertility shown in relation to poor school performance.

**High risk:** Newspapers have been showing pregnant teenagers in school uniforms to an extent that some people have started to believe that school puts children in higher risk of falling pregnant. Perhaps this can be attributed to improved reporting rather than a real increase.
Introduction

Out of school: We have also found the biggest factor associated with teenagers falling pregnant to be the drop-out factor. They are more at risk of falling pregnant and contracting HIV when they are out of school.

Poorly resourced: We have higher pregnancy rates mostly in poor resourced schools such as those located in informal settlements.

Dysfunctional: Schools that are dysfunctional in whatever respect – age mixing, combined schools – have higher pregnancy rates than those that are separated by age and grades (lower grades stick with their age groups, and higher grades stick with their age groups).

Despite the liberal policy of the Department of Education, many of the girls who fall pregnant never return to school after they give birth.

Resolve: We need the best school-based intervention, that means:
- Keep girls in school as a way to prevent pregnancy.
- Re-enrol once they have dropped out – ensure that those who have children do return to schools so that we reduce the recurrence of pregnancies.
- Ensure prompt return post-pregnancy.

GENERAL CAUSES IN THE REAL DECLINE

Teen fertility results are informed by a complex set of socio-economic factors. Important to mention is that what has led teen pregnancies to decline is access to family planning services with a dramatic use of contraceptives. This in itself has helped in giving teenagers access to reproductive education, thereby leading to the decline in teen pregnancies. Young people with high educational aspirations also do tend to prevent themselves from falling pregnant; they even opt for the termination route if the pregnancy is unwanted.

Still a challenge:
Although we have experienced the decline in fertility and pregnancies in teenagers, the numbers still remain unacceptably high, even with all the knowledge of contraception. Some of the social conditions that teenagers grow up with contribute to this challenge. For instance, chances of a young person growing up in rural or informal settlements, or with absent parents in the home turning out without a child are relatively low. This in turn makes them vulnerable to other factors, particularly infection with HIV.

Vulnerabilities:
- Imbalanced gender relations that often involve coerced or forced sex
- Poverty that results in trade-offs between health and economic security, such as reciprocity of sex in exchange for material goods, remaining in dysfunctional relationships and involvement with multiple partners and older men.

RECOMMENDATIONS

We should have multifaceted interventions that target communities and schools. Promotion of communication between children and parents is also critical.

Communities: Community-based interventions focusing on reproductive health, gender relations and livelihood strategies.

Health: Roll-out of adolescent-friendly services and access to contraception including emergency contraception.

Parents: Promoting open communication, parent-child bonds and setting and enforcing rules.

Mass media: Increase the intensity and coverage of programmes with distinct focus on pregnancy.
HIV and disability is an issue that people don’t often think of. In our research based on a small town in Pietermaritzburg, we show how we can create bridges in order to understand the subject of HIV and disability within context.

**HIV AFFECTS VULNERABLE PEOPLE**

We already know a big component of the HIV/AIDS pandemic is that it affects vulnerable populations; young women between the ages of 15 and 24; older men who have sex with them. But people forget that people with disabilities are also part of the vulnerable populations.

**The facts:** Recent statistics from the HRSC (2008) show that in 458 people with disabilities, 14.1% of those are HIV positive. If you compare this figure to other groups, such as men who have sex with other men, you will notice that this group is only sitting at 9.9%, therefore revealing that people with disabilities have a high risk of HIV.

**Question:** Why are people with disabilities just as vulnerable?

**Answer:** Because they are exposed to similar HIV risk factors just as anyone else, such as poverty, gender stereotyping, access to education, issues of sexuality and access to services.

**POVERTY**

The World Bank states that 20% of the world’s poor are people with disabilities due to lack of access to services, education and employment, all of which are necessary for anyone to get ahead in life. This means they will find alternative ways of generating income, which often involve sex work.

**GENDER**

We already know that women in general are at an increased risk of HIV. We found some startling truths about gender stereotypes with the study we did with numerous focus groups of women with disabilities. Here’s what some of the women said.

**QUOTES:**

“We did use condoms but he (boyfriend) would insult me when I suggested using them. So I would often sleep with him without a condom,” Female with a physical disability, 17

“He (boyfriend) does not see me as his life partner, as someone he intends to marry,” Female with a physical disability, 19

**Multiple partnerships:** What we found is that the issue of multiple concurrent partnerships in females with disabilities is very high, the reason being that they are not seen as life partners; they are seen as sex partners.

**Stereotypes:** There are gender stereotypes, where women are seen as homemakers and bearers of children. Women with disabilities are not seen as being capable of doing those things, but are rather seen as objects of desire. There are many studies that show women with disabilities are three times more likely to be raped.
SEXUALITY
People with disabilities are frequently seen as asexual. We are, however, just as interested in sex as anyone else. But, because of this belief, children with disabilities are not given sex education.

BELIEFS
Mental Illness: There are also beliefs about mental illness. You often find that in Zulu culture, it is believed that the best way to cure mental illness is to have lots of sex. Young people are therefore encouraged to have lots of sex because that will stop them from having a mental illness.

Intellectual disability: Children with intellectual disabilities are very loving and caring. They want to hug and kiss people. They don’t know boundaries between what is right and what is inappropriate touch, and because of this they are often more prone to sexual abuse and the risk of HIV.

EDUCATION
In terms of education we find that many of our HIV/Aids campaigns take this into account. But, how many of the loveLife campaigns are accessible to people with disabilities? How many of the campaigns are in Braille or sign language? It’s a huge gap. It means that those people who are visually impaired/blind or deaf do not get information about HIV. You’ve got these huge campaigns (e.g. ABC, loveLife campaigns), but if you are a child with a disability, you will not hear/see anything that has been said in those messages.

ACCESSIBILITY
Another barrier is the attitude of staff in VCT sites or other HIV service facilities.

Deaf youth: If a deaf child goes to a VCT site because they’ve had unprotected sex, there is usually nobody there who understands how to use sign language. The staff may say, ‘Why don’t you get your teacher to help you in translating’, but where is the confidentiality in that? It is an issue that you should not have to share that with other people.

Rape survivor: We also had an experience of a young woman in a wheelchair who was raped. She was brave enough to go to the local clinic to report it. The nurse at the clinic told her, ‘Thank yourself you are lucky that you had a sexual experience because you will never have one again.’ She was turned away. This is a big concern and is happening all over South Africa.

Peer role models: There is a lack of peer role models for people with disabilities. How many people with disabilities do you see in campaigns that are actively promoting positive living and are HIV positive. They are invisible.

The media: If you think of how disability is portrayed, people with disabilities are depicted as evil or people to be afraid of. You don’t see people with disabilities being in good relationships or being active.

RESEARCH
HIV and Aids National Strategic Plan (NSP): The NSP recognises people with disabilities as a vulnerable group. They say services should not discriminate against anybody. However, there is currently discrimination in services, and the NSPs plans are not being met.

UN Convention of the Rights of Persons with Disabilities: Simply put, the services in South Africa have to be in line with the UN Convention of the Rights of Persons with Disabilities. One article of the Convention states that:

‘State Parties must “provide persons with disabilities the same range, quality and standard of free health care and programmes as provided to other people, including the area of sexual and productive health and population-based programmes.”’
What it means as a country is that we need to make sure that our services are equal for all, including people with disabilities. We are nowhere near that standard at present. We have violated human rights of people with disabilities and youth with disabilities in particular. They are not getting sex education and information about HIV.

**WHAT CAN WE DO TO MEET THIS CHALLENGE?**

The inclusion of youth with disabilities in HIV and Aids outreach efforts cannot wait until everyone else is covered; it is an issue of human rights.

**SUGGESTIONS**

- Monitoring how many people with disabilities go for VCT services using a questionnaire and asking if they have a disability or not. What type of disability? By asking simple questions such as these, we can start collecting data about how many youth with disabilities are HIV positive and how many are coming for services. In this way we can evaluate that if they are not coming forward, why this is the case and what we can do to change the situation.

- Make HIV/Aids prevention messages more accessible to all populations – blind, deaf, intellectually disabled. We need to think of how we can make our campaigns easily accessible to all populations.

- Include VCT counsellors, community and health workers in training so as to understand people with disabilities.

**WHAT CREATE IS DOING**

We have already started with a programme in KZN, where we are going to train the groundBREAKER staff on issues of disabilities to raise their level of awareness. We are also trying to get youth with disabilities to be employed as groundBREAKERS, so that we can have role models for youth in communities with disabilities.

**SOLUTION**

Inclusion is only achievable with proactive engagement. This includes formal and informal partnerships and joint ventures between disability and HIV/Aids sectors to develop and maintain perspective in the respective sectors. As youth with disabilities, we are not asking for special treatment. We want inclusive services; we want to be included in services that already exist.
Question 1: Chris, SURNAME, ORGANIZATION, Botswana
Can treatment be used as an intervention?

Answer 1: Dr Asha Mohamud, UNFPA
When somebody is on treatment, the viral load is less in the body, and the rate of transmission may be lower than when they are not on treatment. There are two times when HIV transmission is highest: when the person is newly infected, because at that time they have the highest level of virus in their blood, and so are more likely to infect somebody; and when the person has Aids, the viral load is also much higher. At both these times, the person is more likely to transmit the virus to their partner. That’s why having multiple partnerships is bad. If someone is on treatment, it goes without question that their viral load will be reduced, therefore the risk of transmission is slightly lower than when someone is not on treatment, but nobody can guarantee you will not get HIV. This can be a very dangerous game, because when someone is on treatment they can get another virus, which is drug resistant. They will then have two viruses: the one you were fighting and a new one. It is not recommended that when you are on treatment, you believe the risks of transmitting are less.

Question 2: From the floor
Seems like where you have sex workers, you have a higher infection rate. Can you expand on this?

Answer 2: Dr Mohamud
HIV is concentrated among the high-risk groups in the African region: primarily men who have sex with other men, truck drivers and sex workers. If we intervene in those risk groups, we are more likely to reduce the infection in the general population. If we intervene with sex workers and promote 100% condom use, services, treatment of STIs, and humane services, then you are more likely to have transmission to the partners of sex workers under control. In countries such as Botswana, Lesotho and Swaziland, a large part of the general population is already infected and many of them are despondent. While we intervene with sex workers, that may not be enough to prevent new infections in the general population i.e. you still need interventions with new infections for ALL people.

Question 3: Brian Loop, ORGANIZATION, Namibia
You speak about East Africa, West Africa and then Southern Africa, but why do we exclude North Africa?

Answer 3: Dr Mohamud
I cannot agree more with you – there is a blunt exclusion. It is a political and geographical exclusion. I think there is also a cultural difference between the North and Southern regions. Most of those countries you are referring to in North Africa are Islamic countries. In those countries, sex outside marriage is taboo; there is also segregation of sexes. Some of the freedoms that people enjoy in the South do not
exist in the north, but this could be adding to the protective factor, as there are no multiple partnerships, older men having sex with younger girls (except in early marriages in some countries). Even if the men have three or four wives in this region, they remain with those wives; they do not go outside the marriage. That could explain why infection is so much lower here.

**Question 4: From the floor**

*You keep youth in schools, and they have lower infection rates. But what about sugar daddies – they don’t care if girls are in school or not. I would like to see the data that proves that when you keep them in schools, they don’t get HIV.*

**Answer 4 (i): Ms Grace Matlhape, loveLife, South Africa**

There is a study that points to young people protecting themselves from infection and practising safe sex being linked to young people being in schools. What this does is that it gets us to focus on life skills that build on that. Firstly, within a school environment young people have someone who asks them for their homework, like a coach who cares for their talent. That kind of environment, along with a number of other factors, makes young people more future focused, more inspired to look towards keeping themselves HIV free. For me this is a very important thing. For instance, if we look at Monde’s presentation, it points to the fact that teenage pregnancy tends to precede school leaving and drop outs, so if we do not do something about having services that are supporting those already pregnant and work on preventing teenage pregnancy more, we are not going to succeed.

**Answer 4 (ii): Dr Mohamud**

There has been a study that was done by the World Bank that shows the higher the education level a young person has achieved, he/she is less likely to be infected with HIV because they can access sexual education at school; the school system has them as a captive audience. The other issue is that the more educated, the better they absorb and digest the information. The educated youth are more likely to better understand educational and media programmes.

**Question 5: From the floor**

*What is it that you do with the boy child and young men in terms of prevention and interventions?*

**Answer 5 (i): Dr Madikwane, organization, country**

It is historically true that men and young boys are overlooked. But there is a shift as there is a new a study that looks at young males who have children at an early age. The concern is generally recognised.

**Answer 5 (ii): Dr Mohamud**

There are many programmes that cater for young men in African countries. We have a lot of youth centres and most of the patrons are boys. There are specific programmes that target young men and that’s why I feel it is important to target young women now because they are the ones who are more vulnerable. Where HIV stats are concerned, they are the ones who have the highest rate of HIV. So I
don’t think that we are neglecting the boys because we reach them in the schools, youth centres and out of school programmes. Boys are more agreeable when it comes to attending programmes than girls are. So while I believe that we can still do more, especially with the out-of-school young men, I do not think they are totally left out.

**Question 6: Mr Paul Oteng Motshome, University of Botswana - Society Against HIV/AIDS**

Prevalence gives us an idea of the disease but not of new infections. If you take Botswana for instance, it has a high prevalence rate. That is due to the good ARV programme. So the prevalence is going to continue to be high because you’ve got a good ARV programme and good management of opportunistic infections. If you look at a country such as Uganda, a lot of people died in the past ... What we need to focus on, is the number of new infections. I would have liked it if you could have talked more on the new infections. Can you comment?

**Answer 6: Dr David Harrison, Connected!, South Africa**

In the South African context and data, the effect of ARVs prolongs life and offsets any declines in prevalence for the next five years, so that even if we achieve 50% reduction in new infections, prevalence will remain the same. So, I think is has important implications for governments in terms of how they measure programmes, because we all become despondent if we see prevalence remaining the same over the next five years, while there may be underlying change. We actually do not have a biological measurement of incidents. But looking at spikes of infection, breaking it down to single-year age bands, maybe focusing it on where the spikes of infection are massive surveys rather than on ‘the everybody’ in the population. Looking at changes in those patterns from year to year will give us a feel for rather than the overall prevalence. For example, I have recommended to the South African government to stop the ante-natal surveys; to do it every three or four years. Because pregnant women have had unprotected sex and if you do the modelling by giving them ARVs you will not see any change in statistics over the next five years. You may see a few nuanced declines when you start breaking it down by age, but nothing that justifies that huge expense when you are not surveying spikes in infections.
YOUTH LEADERSHIP DEVELOPMENT

PRESENTER: Mr. Scott Burnett
Youth Programmes Director: loveLife

We know that from the 1996, 2001 and most recently 2007 data that the youth bubble is not going anywhere. The fact is that South Africa as a society is largely driven by what young people think, do and say – we cannot escape that. The risk profile in terms of how they expose themselves to HIV is of reasonable concern, as there are a number of them in the high-risk category. There are a lot of high-risk behaviours in that category that can be shifted to medium and subsequently to low risk in order to reduce HIV prevalence and incidence.

THE CHALLENGE
Young people always have a fast-paced culture that we do not understand as adults and programme managers. We constantly try to respond to shifts in youth culture. To understand youth culture, you have to track it all the time as a programme designer or programme manager. Often communication is designed not on the basis of where young people are, but where they ought to be or where we wish them to be.

The wish: We wish that young women could control their sexual destiny, would wait to have sex until they are married.

Reality: Youth culture is in a different place than where we would like it to be.

That is largely the challenge in terms of designing a face-to-face behaviour change programme.

DESIGNING A FACE-TO-FACE PROGRAMME
Through this programme we might be able to identify behaviours that drive HIV infections, work out corrective measures, communicate them and then give young people a reason to adopt them. We could scare them into adopting those behaviours, moralise by making them believe they will go to heaven or hell depending on which behaviour they adopt. On a positive side, we could make them excited about a new type of lifestyle, in which such behaviour is integrated. Let’s explore the different models to establish which is most effective.

Conduit Model: PEER EDUCATION OVERSIMPLIFIED
In the Conduit Model, as adults, CEOs, programme designers and anyone else involved, we train young people before sending them out to communicate and train their peers. In essence, we see a peer educator or a youth as a conduit to change what behaviour is driving HIV infections, modelling positive behaviours and giving people the reason to change. They are the channels. We would also do skill development training from which we can develop competencies in terms of knowing the basic physiology of HIV, etc. We basically develop a cadre of young people who can train other youth. There is success in this model in that you are getting the communication and mediation across. This way adult-type training material is translated into youth-friendly material, with a young person used as a conduit to reach other youth as the targets.
The Youth Leadership Model: loveLife CUSTOMISED to youth specifications

The young people, whose stories will be shared, are a result of The Youth Leadership Model. They were already leaders in their communities before loveLife reached out to them.

The loveLife programme didn’t seek to dictate what would be the ideal behaviour. We did surveys that helped us determine how to design the programme inspired by what young people were already doing; what their existing attitudes were that were keeping them HIV free.

That tapped into their sense of optimism – a high sense of self-esteem, of possibility, strong identity and of belonging. We looked at how to support these positive behaviours, how we take existing assets around the HIV-prevention campaign and consolidate them so that everybody rallies around them. That’s the challenge of a youth leadership programme. It is not to dictate to them by showing them that they lack something or that they are ‘silly’, bad children.

We needed to work with young people in order to reinforce that behaviour by supporting them in a more structured way.

**LESSONS LEARNT**

- Listen to young people and where they are at in their lives;
- Find out who the celebrities are they care about and start working with these celebs;
- Find out if there is a sense of activism that can support the campaign such as ‘Take Back The Future’. This will help consolidate, support and reinforce that activism;
- Affirm and support young people, so they can have a far-reaching impact on other youngsters in their community;
- Back up the support and affirmation with training.

**THE IDEA**

The first idea is to identify leaders already working in the community when we partner with the clinics and schools. Even our Youth Centres, one of our flagship programmes, are always based on existing community infrastructure. Our newest programme is the North West province, which is in partnership with the Royal Bafokeng. A youth structure already exists here and we work with young people and consolidate our activities into a structured programme. It is called the Mpintshi Programme.

**Mpintshi Programme**

This is loveLife's main interaction with young people. From those Mpintshis there is a second tear of leadership – the groundBREAKER programme.

**GroundBREAKER Programme**

This is a selection of young people who have worked in the Mpintshi programme for a year and have shown leadership skills, empathy and the qualities of being team leaders, or groundBREAKERs (gB). They then serve as team leaders in a variety of roles in the communities. The gB programme grew from humble beginnings in Youth Centres to a programme that has 1 231 youths, aged between 18 and 25. South Africans in a structured year-long programme. The Mpintshi programme is much more diffused because many of these youths may serve for more than a year; they might serve with loveLife for two or three years. Currently, there are 7 500 youths actively engaged in the Mpintshi programme. These Mpintshis and gBs are based at 800 loveLife sites working with young people across the country.

**RESULTS WITH YOUTH INVOLVEMENT**

As programme designers, let’s make our motivation youth culture. The loveLife programme is not just a national design directly channelled into the community; it is a collaboration between something that is already youth-friendly, that is co-designed with young people.
Why it works: gBs are actively engaged in making the programme work in their communities. They are given leadership responsibility – they have to run sports games/clinics and engage schools. The responsibility placed on them allows them to lead their own programmes at the local level. These programmes are ways to have structured conversations with young people.

The content: The content of these programmes comes from research, not from where we wish young people were. They are non-judgmental in nature.

The programme focus: They focus on a range of activities that are fun and motivational. This is what loveLifestyle programmes have been doing for years.

We have programmes such as:

- Performing arts that are activity driven
- Sexuality education that is theory and class based
- Sports activities
- Born Free Dialogues, Mpintshis programmes/gBs have a large role to play in this regard; these young people are committed to youth-friendly services, including making the clinic services accessible to youths
- They run debating leagues.

THE RESULT
Young people are encouraged to live a LoveLifestyle. The Mpintshis working with young people and gBs have the responsibility to drive the overall strategy. Programmes are designed by/with young people, FOR young people. These young leaders are the vanguards of the loveLife generation or the Born Free Generation.
Through the eyes of the youth: OUR STORIES – THE YOUTH SPEAK

Three young people give us their insight, their activities and the thoughts of the youth.

NAME: Geraldine Kuhlewind, 17, Dordabis, Namibia
PORTFOLIO: Youth activist
SUMMARY: Lack of hope and opportunities, access to education, clinics and information motivated Geraldine and 14 other youngsters to initiate the project, Youth Against Crime (YAC), currently has 17 members.

GERALDINE’S STORY: “I am a founding member of Youth Against Crime (YAC), in Dordabis, a small rural community in Khomas region, mainly surrounded by a small group of farms with a population of 800 people, the majority of whom are young women and men. We only have one primary school that goes up to Grade 7. This has made young people see their future as being very bleak. Our own research shows that young people in our area lack hope and have frustrations such as not being able to advance their education, having no recreation facilities, little support from the government regarding income-generating activities such as poultry farming, gardening and brick making. They also revealed that they felt let down by their parents, some of whom are alcoholics, and/or have little time to discuss their concerns with them. Some of them have become perpetrators of gender-based violence and other crimes.

Youth Against Crime was founded in 2008 by young people. This was in response to the high rate of violence against women and children, among them rape, incest, baby dumping and unemployment. We are also lobbying the Namibian government to provide us with a high school and recreational facilities. Our initiative was supported by the International Community of Women Living with Aids and HIV (ICW) Namibia and IPAS. We are thankful that they trained us in reproductive health, advocacy, information dissemination, methodologies and documentation.

Even though funds are limited, we hope to carry on working to the best of our abilities as peer educators. We are willing to face the challenges head-on while uplifting the quality of life of the youths. There is light at the end of the tunnel.”

YAC’s ACHIEVEMENTS

The police have reported they have seen a slight decrease in crimes related to the abuse of women and girls since YAC started.

Through the existing reproductive health programme and advocacy, emergency contraceptives and PEP services are available in every clinic. This model has been replicated in Katutua, the biggest location in Windhoek. Incidents of abuse reported at the clinics have slightly declined, even though more work has to be done.

We have also encouraged parents to create their own platforms to discuss issues of crime, violence and alcoholism in the community. Out of that, a group called ‘Together We Can Make It’ was formed by two adult women in the church, who responded to our call.
NAME: Junior Bikwa, Orange Farm, South Africa
PORTFOLIO: loveLife ex-gB, currently Drive Time producer at YFM (radio station)
SUMMARY: From attending motivational classes at a Y-Centre to doing his dream job in radio and touching the lives of young people through music and talk.

JUNIOR’S STORY: “I started with loveLife in 2000. I progressed from being one of the students attending motivational classes and moved to debating. I then developed a keen interest in radio. My claim to fame is that as a loveLife radio presenter I interviewed Brat Pitt, a big accomplishment! I then became a gB and had the responsibility of teaching other young people about radio, at which point I had an opportunity to work with the SABC radio stations. A few years later I became the area co-coordinator. Much to my peers’ surprise I announced that I would one day be a famous radio personality. I applied for a job at YFM. A few months later I got a call from the YFM academy and was trained as an intern. Six months later I was appointed as a drive-time producer. All accolades go to the teachings of loveLife, as the programmes I went through thoroughly prepared and equipped me for what would be my first big break in radio.”

NAME: Nonhlanhla Kunene, KwaZulu-Natal, South Africa
PORTFOLIO: loveLife ex-gB, currently a journalist at Sangonet
SUMMARY: Her journey was about self-discovery. In the process she learnt that positive self-esteem was paramount, particularly if you want to impact young people’s lives – moving them from high-risk to low-risk behaviour. loveLife provided the platform and an opportunity for her to interact with other young people.

NONHLANHLA’S STORY: “I am an ex-gB from deep rural KwaZulu-Natal. We had to introduce loveLife to my community in 2000. In my opinion, loveLife gives young people more than a healthy lifestyle, it opens up opportunities for youth. loveLife gave me an opportunity as an aspiring fashion designer at the time. They made me famous by publishing an eight-page story in UNCUT on my designing career. That gave me leverage while working with the youth as a gB. I used it as an advantage when I went to presentations on development in communities.

I now work at Sangonet, a networking organisation that brings together NGOs that work in similar areas. I got this job because of the skills I acquired from loveLife, over and above learning about HIV high-risk behaviour among young people and engaging in programmes that are targeted to turn around their lives for the positive. The life skills I learnt are equal to none. I had studied electrical engineering and wasn’t keen to continue my studies as I believed my talent was to talk. Through loveLife I found the career path that best suits me – journalism.”

NAME: Lerato Patricia Mahoyi, Orange Farm, South Africa
PORTFOLIO: loveLife ex-gB, currently loveLife training assistant
SUMMARY: Having grown up in the dusty streets of Orange Farm, she believes she could have been counted among the millions of youngsters referred to as ‘disadvantaged’. She went through different training programmes, and now works as a material developer and training expert in peer education.

LERATO’S STORY: “Junior Bikwa was my mentor; he made me join loveLife in 2004. I had accompanied a friend from the neighbourhood who wanted to enroll for a free computer skills programme. We were welcomed by very energetic gBs, who showed us around at the Y-Centre. When we bumped into Junior, he was interested in my reasons for the visit and was unimpressed
when I tried to fob him off. After inquiring about my interests, I told him I enjoyed public speaking and poetry. He invited me to a loveLife public speaking event to recite a poem. When I left there I told myself that I wasn’t going back but Junior had other ideas. Junior and his team convinced my mother to persuade me to join. And guess what, I am still here. I have gone through the ranks. I started out just participating in sports, playing netball and basketball. Since I was feeling out of place, I did as much as I could — health and motivational programmes.

I was also part of the Radio Y’s; he mentored me very well. When I completed matric in 2007, with a university entrance exemption, I desperately wanted to study further but my mom couldn’t afford it. Junior helped me again to get into the loveLife call centre at the national office. I was there for three months before David Harrison and other managers recommended that I be one of the three youngsters to go to Cape Town to the South African Institute for Entrepreneurship to develop materials for the new loveLife ‘Take Life Into Your Own Hands’ campaign. I worked with experts in course designing, and was exposed to training facilitation, desktop publishing and layout design of posters and presentations.

The best part about Cape Town was that I got to return to Joburg and train the same people who had trained me to be a gB. That was a major breakthrough for me. I was appointed as the training officer at the national office of loveLife. Having grown up as a disadvantaged youth, I am here and I am what I am because of what loveLife taught me.”

**IN DIALOGUE…**

*with the youth participants (facilitated by Trina DasGupta, Media Director, loveLife)*

**TRINA DASGUPTA:** Do you think that young people know about HIV messaging, or are they tired of hearing it?

**LERATO:** I personally feel like young people are fully aware of HIV. My mom, my three siblings aged between 13 and 18, and myself spoke about condoms. It was surprising how much information my little brother had, much more than my 18-year-old brother had. He also told us that condoms were not 100% safe. These outcomes are mainly because we have the schools programme, which got parents to start talking to their kids about sex.

**JUNIOR:** Young people are fully aware of HIV, but our behaviour is contrary to the information we have. Our approach is still negative.

**TRINA:** What are youth’s approaches to sex? Honest answer please, because if you know you have to stay in school and use a condom, why do young people act differently?

**JUNIOR:** Young people do tend to be excited by sex and have this mentality that ‘HIV won’t happen to me anytime soon’. We are the ‘manje manje’ (now) generation. We live for now and forget about the future. Right now 15 to 17-year-olds are having sex with multiple partners. When you are young you don’t want love because young people think that love is overrated.

**TRINA:** Why is love overrated? For instance, what I have seen young women do is that they will stop using a condom to show the man that they trust him; no one has a conversation about what their HIV status is. Are we together? ‘No, we are just going to stop using condoms because I want you to know that you are my man’. What’s that all about?
JUNIOR: I think that it is about security. Normally young people want to feel secure. You want to show the partner that you’re into them, and he must also prove to be yours. Single parents, mainly women, raise most young women. When she meets a guy the attention she gets can be overwhelming and amazing. You get disillusioned and end up being heart broken. Yet, if you had the love of a father figure, it isn’t easy to be fickle-minded and be swept off your feet by another guy. That is part of the problem – a lack of functional two-parent households.

TRINA: What are young people most concerned about today?

NHLANHLA: Young people are scared of being pregnant more than contracting HIV. When I was a gB I would ask young women why they were using condoms and the answer would be, ‘I don’t want to have a baby’. It was never, ‘I don’t want to get HIV’. There are also myths surrounding HIV. One young woman once told me with a straight face that, if one had sex, all you have to do is stand up to discharge the semen, and thereafter drink Eno or laxatives. That way she would not get HIV nor fall pregnant. The messaging they get from their peers’ plays an important role because when they get home, they can’t ask their parents such questions. I believe parents can play an important role in changing young people’s perceptions. Also, as young people, we have the power to instill in other youngsters the gospel of positive living. In my experience, when we ask young people why they tested, they say they did so because a friend did. I think we must make getting tested the coolest thing that all youngsters want to do so that they know their status.

TRINA: Geraldine, you mentioned peer pressure in your home country of Namibia. What is peer pressure for young people there?

GERALDINE: The peer pressure is mostly about having sex. One girl will tell a friend that if you don’t have sex, you are not part of our group, you will be ‘out’. In addition, they would have sex without a condom, and they know about the consequences of doing so, but they just ignore it.

TRINA: Why the pressure to have sex without a condom? Why is sex cool?

GERALDINE: They believe sex is the ‘in-thing’; you must do it because your friends are doing it and they succumb to peer pressure.

TRINA: We were on one of the loveLife programmes when a 13-year-old girl stood up and said but skin-on-skin feels good. I am trying to present the reality of what goes on with the youth.

LERATO: Having sex is cool for young people; it is like having a pair of Carvella shoes.

TRINA: Don’t they need to work to get the Carvella shoes?

LERATO: No, you need to sleep with a sugar daddy and he is going to pay for all your needs – that’s the thinking.

TRINA: Why is it ok to do that?

LERATO: Because young people want to belong. If I am with my friends and we are going to a party, I am the only one without a pair of Carvella and a pair of Levi jeans; I will be the awkward one. While they know what the benefits of protected sex are, they will go ahead and have unprotected sex, succumbing to peer pressure because they want to belong. Circumstances at home play a very big role. For instance, if your mom can’t afford anything, you end up doing things because your boyfriend buys you airtime;
he pays for your lunch at school. You have sex because you feel you owe that person. This is where women empowerment comes in because young women need to know that ‘I am worth more than that’.

On the baby issue, when you tell them about HIV, they tell you in your face that they are going to die anyway – by a gun shot, TB, etc. They will ask you if you do not want people to be infected with HIV, who should be – dogs? That is the reality.

**TRINA:** What Lerato has just said is huge in terms of programme designing because how do you go ahead and design a programme for someone who really doesn’t care if they will die. How do you deal with that Scott?

**SCOTT BURNETT, loveLife:** We have the Make YOUR Move programme that is intended to encourage young people to recognise the fact they do have opportunities and that changing their destinies is in their hands. What Make YOUR Move does through a variety of tools of assessment, career planning and risk focus is that it allows young people, no matter how cynical, to be able to map out their own lives. We give them real things that they can use now and start focusing their lives towards their destinies.

**GERALDINE:** We encourage each other to have fun, because information delivered in a fun way has more impact than that delivered in a dictatorial way.
YOUTH INTERACTIVE Q&A SESSION 2

**Question 1: From the floor**
Your sugar daddy has now bought you the Levi jeans and a cell phone. Does it stop once you have those things?

**Answer 1(i): LERATO**
No, it becomes a routine, after the Levis; there are Amakipkip T-shirts, then stilettos, and food at home. Then there is partying with my friends, my weave, etc.

**Answer 1(ii): JUNIOR**
Parents do play a role in grooming the psyche of youngsters, as they encourage youngsters not to go into relationships for economic reasons. As a girl, if you wake up and don’t do the dishes, they will scold you and say, “You will get a poor man for a husband”. Automatically, you tell yourself that you need to get someone from a good background. Parents don’t realise that they are pushing young girls towards sugar daddies. “You can’t hangout with a loser – someone who doesn’t take a shower”, they might say. They will draw comparisons with a neighbour’s child who is dating someone driving a fancy car. In the end, it tells a young girl that she needs to get a partner who is loaded.

**Comment 1: TRINA**
It’s also a lot about values.

**Question 2: MICHAEL GOGWANE, American International Health Alliance HIV/AIDS Twinning Center**
With HIV now a socio-economic issue, what would you advise a 13-year-old orphaned girl who has no one to look up to for her survival?

**Answer 2 (i) NHLANHLA**
As groundBREAKERS we are faced with such challenges. We had a girl in similar circumstances. Since we worked closely with child welfare, we got her accommodation in a shelter, and got her into a school where she didn’t have to pay fees. We then encouraged her to stick around loveLife because there were skills she could learn from some of our programmes. She was a brilliant speaker. She is one of the success stories. Angloplat awarded her a scholarship. Today there are many possibilities and no excuses for young people. People blame poverty for everything. Yes, poverty is a reality, but you need determination and to find positive alternatives. There are so many non-profit organisations that can provide communities with necessary skills to get ahead in life. Young people must be aggressive in finding information and use the opportunity. Ask around. Find people who have done it. We are here. We are also from humble beginnings; we are not there yet, but there are so many things that young people can do.

**Answer 2 (ii) TRINA**
It is about access to opportunities. The mindset that ‘there is nothing I can do’ or ‘is anything ever going
to change, and what can I do’, can be turned around. The MYMsta programme, a mobile network which has an entire database of learnerships, volunteerism and other opportunities, is a wealth of resources and it costs you less than 20c to access. We know that 95% of South Africans have cellphones. The idea is to find out what’s out there so that you, as a youth, you can literally Make YOUR Move – small and big.

**Question 3: From the floor**

**How do you address myths that youth have around the causes of HIV, how it to spreads or how it can be cured?**

**Answer 3 (i): SCOTT BURNETT**

There are clear facts of what causes HIV and Aids, and we use available resources to make that information available to young people. Secondly, we have to discuss those myths and causes with the youth. Debating these issues may involve moving away from the structured debates. It is really about encouraging a culture of discussion and a culture of young people getting together to unpack issues and to talk about problem solving among themselves. If you have a combination of information and an opportunity to be involved in discussions, young people feel empowered enough when they have their voice heard and have facts at their disposal.

**Answer 3 (ii): TRINA**

We need to be honest about cultural issues. When we talk about youth culture, these things change all the time. We just got feedback from a study that says having an STI as a young man is something cool. What is important is working towards understanding your audience. Researching to understand whom it is that we are speaking to is critical to getting to the bottom of these issues. I believe it is not how we get the messaging out there, but it is also about addressing the historical underlying facts that are in many ways social and psychological. I want to turn to the panel and find out what they say when youngsters tell you, ‘it is not going to happen to me, I am going to take a shower, and an STI is cool?’

**Answer 3 (iii): JUNIOR**

I am very straight-forward, especially when a young person goes on about how cool it is doing all those things that are high risk. To me, what it says is that you lack self-value. I tell it like it is; that is the only way to deal with it.

**Answer 3 (iv): LERATO**

The truth is, as soon as the facilitator leaves the room, you start reflecting on your future. Youngsters will make jokes about it, but let me tell you that when they see a VCT site, they are the first to go and test because hearing it from their peers drove the message home.

**Comment 3: TRINA**

There’s a lot of, ‘what we say, is not what we do’.
Comment: ZOLIWE ZIKHONA CUTALELE, loveLife
I am an ex-gB; I just wanted to offer a different perspective because most of the young people have gone through the programmes and will go to NGOs or to corporates. I have gone the corporate route and the environment there presents different challenges. So, how do you continue to inspire as that sector requires a different set of skills, and one may be very lonely. How do you support gBs to be part of a community and feel whole after leaving loveLife?

Comment: JUNIOR
After leaving loveLife you are on a totally different journey. At loveLife there are people who are about nurturing and caring; out there it is about the real world. When I am at the radio station I am pumping the music, and when I am DJing at the parties I see youngsters pumping booze, too. Ultimately it is about staying true to your values. No one can give a perfect answer; it is all about self-discovery. loveLife may be a comfort zone, and you go out there and realise the world for what it is, and you need to adjust. At the same time you need to be true to the values you learnt and hope that these values will touch other people.

LERATO: Once a groundBREAKER always a groundBREAKER. It is important for young people to know who they are. It is not about the others; it is always about being at peace with who you are. When I am sitting reading my novel I am fulfilled. Remember to stay true to yourself.
INTRODUCTION
To understand the role played by a father’s presence, or absence thereof, there is a need to look at the complex factors that cause absenteeism fatherhood in South Africa.

These range from high mortality in men to teen or adolescent parenthood, which result in non-long-term relationships, thereby leaving the child in the middle as parents may need to further their studies; sheer irresponsibility resulting from how cultural customs that have created a wedge, affecting relations between fathers and children.

There is a tradition that women have to bond with their new baby while the father is left in the cold. That alone can have an impact on the value placed on women and the ability of men to bond with their children later on.

THE SCENARIO
- Older generation lower in number: It is a reality that older persons constitute 7.2% of the overall population and will increase to 14.2% only in the next 40 years. What this means is that more and more children are brought up by single parents – mostly mothers (see explanation below).
- Low sex ratio: Among older persons there is a low sex ratio – this means there isn’t an even balance between men and women
- Youth bulge: a large portion of the population is between the ages 15 and 24.

The fewer mature people there are, the less the chances of young people spending meaningful time with a father. Let us investigate in depth what causes the distance between generations. Distance may be social or physical in nature, thereby creating a wedge between generations, in particular impacting the father/child relation. According to the recent study Baba, which examines the role of young fathers in their children’s lives, and the role their fathers played in their lives, the following was evident:

WHY ARE FATHERS MISSING?
Social distance causes:
- Silences between generations: Parents and children engage less, if not at all, around issues of reproduction and sexuality.
- Teen fatherhood: Children born to adolescent or teenage parents, are normally left to be looked after by grandparents.
- Leaving parenting too late: Having children later in life does pose a possibility of increased alienation.
- Social epochs: Men who grew up in the apartheid era, which was a rights-based society,
dehumanised people and men were the target. Those were ‘cold’ days, when the approach to parenting was far less emotional, and that was handed down to the next generation. It is highly possible that that social distance may have been passed down to children.

- **Language barriers:** The youth of today speak the language of technology, and/or their culture changes in rapid ways. It is hard for older generation fathers to keep up and so they lose a grip with their young ones.
- **Digital divide:** Young people have better access to technology and are ahead of their parents. In some instances they get so engrossed in this technological world and forget that there are others around them. TV, for instance, doesn’t allow for a healthy social environment in the home.

**Physical distance causes:**
- High male mortality – more males die than women, who often have a higher life expectancy.
- Most children born from within unstable sexual unions.
- Fathers may be migrant labourers, thereby removing them from their immediate family.
- Culture may have an impact on the physical distance since gender stereotypes have had a major role to play. Men were never allowed at the birth of their children, thereby cutting them off from a very important time of bonding with the child early on.
- Women are normally called on for everything where children are concerned, and this may work to cut men off from their young ones.

**WHAT IS MISSING?**
**POSITIVE MESSAGES ABOUT FATHERS**
We need messages of reinforcement for fathers, and media can be a good vehicle to set a national movement towards generations finding each other – in particular fathers and their children.

**Focus:**
- Re-uniting fathers who have never met their children with their offspring
- Give men their purposefulness back in their children’s lives
- Create dialogues (private and national)
- Tap into social movements linking fathers to children
- Reinforce positive images – let us see positive role models in the media of fathers looking after their children
- Men sharing their stories of how rewarding it is to have a relationship with their children
- Invest in children as babies or toddlers – the sooner the better as this will cement the relationship much earlier; this will close any potential for emotional gaps because after age nine, the gap may become too large to deal with
- Programmes for training men on parenting are important to establish and sustain.
One of the interventions that open up conversations between the young and the older generations in order to understand where they both come from are the Born Free Dialogues (BFDs).

These were initiated by loveLife to help communities engage in conversations and dialogue to facilitate intergenerational discussions so that South Africa can bring up a generation of young people who think differently – the generation that believes they have a sense of purpose and that they have the power to decide, not only as individuals but also collectively within the communities they are based, irrespective of their geographical background. These dialogues are based on an integration of social and individual change in search of achieving results.

**What was the rationale?**
loveLife recognises the significant role that parents play in influencing the lives of young people, therefore it continues to build on the need to facilitate communication between parents and children, and to provide a platform for parents’ involvement in the campaign and their children’s lives. Overall, the Born Free Dialogues are a flagship programme of loveLife with the strategy to encourage young people, as part of their communities, to be ‘on the move’.

**WHAT BFDs DO?**
Born Free Dialogues provide a platform for communities to think through and voice their concerns about various situations. They create space for mutual learning and result in new perspectives. They help to redefine relationships and inherent expectations in line with transformed values.

“Knowledge empowers communities to make new and informed decisions and take control.”

**The role of BFDs in communities**
BFDs make young people and the communities at large feel like they are part of the movement. They also:
- Sustain loveLife’s interaction with communities
- Build resilience and the ability to deal with the pressures of life
- Help link young people and parents to opportunities to give back to their communities by creating opportunities for others

1. **IMPLEMENTATION OF BFDs**

All BFDs are underpinned by ‘The Ten Commitments’:
- The commitment to loving life: living life with the joyous, adventurous spirit of youth.
- The commitment to reality: focusing on the facts and keeping your knowledge connected to reality in all matters.
- The commitment to reason: thinking through your life’s challenges logically and imaginatively to find solutions.
- The commitment to independence: taking responsibility for your own thinking and actions, and taking ownership of your life.
- The commitment to purpose: acting always with a specific purpose or end in mind, a specific aim or destination.
- The commitment to productiveness: investing your time to create something of value in a job, or as an entrepreneur or volunteer.
The commitment to honesty: respecting the truth in all matters, and matching your actions to your words.

The commitment to cooperation: looking for opportunities to cooperate with others to achieve win-win solutions.

The commitment to justice: judging others objectively, based on all the facts and without bias or prejudice.

The commitment to individual rights: dealing with others by persuasion and trade – never with the use of force.

2. BFDs are solution-oriented, not just talking platforms

Create knock-on effects through partnerships with other service providers.

3. Experts and Experiences

Invite relevant people who can assist the community to learn how to address their needs, issues and aspirations.

4. Community Action Days

This initiative is facilitated through different stakeholders committing their resources in partnership for the benefit of communities.

5. Creative Corner – BFDs ‘in style’

Create awareness, expose talent, use centre stage and establish networks.

6. Recruitment of participants

The best place we have for finding youngsters is through working with school-governing bodies. Also by using the media, especially local newspapers, community radio stations, events and leaders. We also look at stakeholder meetings and loveLife events, which are convenient to encourage participation from communities.

7. The way dialogues are conducted

These would normally start with a plenary session and then break into commissions running parallel. All participants then engage in a role-play around an issue of concern. When the participants all come together in closing plenary sessions, they thrash out all ideas on the table to produce resolutions.

8. Key drivers of implementation

We have Regional Programme Leaders supported by groundBREAKERS, Mpintshis, Y-Centre coordinators, regional managers and provincial trainers.

9. Reporting and monitoring

The reporting tools that are in place include narrative and monitoring reports, a monthly calendar, attendance registers and a national consolidated report. BFDs are monitored through the data collected from evaluation forms; there are site visits to back that up, mid-year assessments and
random interviews with participants.

10. Growing BFDs

We are planning to work with faith-based organisations as they are permanent institutions with a strong community role. Corporates are places where opportunities can be created for young people, as well as good places where young people can be connected to job opportunities, learnerships, mentoring programmes and financial assistance to further their studies and/or start their own businesses.
Strengthening institutional response to HIV and Aids

Working with school – getting the most out of schools

PRESENTER:  Ms Pumzile Mlambo-Ngcuka
Executive Chairperson:  Umlambo Foundation

Umlambo Foundation is an organisation that works with 17 schools across the SA. We render support for principals to build their management and leadership capacity by providing soft skills – LIFE SKILLS. We believe that investing in the principal yields the highest returns in society: a well-managed school makes the lives of both educators and children better, ultimately benefiting us as a country.

As we engage with principals we often experience challenges in areas where we have no expertise. In such cases we would enlist the support of our partners to intervene. loveLife is one such partner in instances where HIV/Aids has turned to burden the educators and children. Their role is to support students with leadership skills.

WHY SCHOOLS?
We recognise that schools have a captive critical mass and believe if we do not reach young people while they are in school, the result could become dire. So, we need and can make a dramatic impact at that level.

The ideal: Umlambo Foundation seeks to have the various interventions brought into schools become universally accessible; to accommodate children with basic skills of minimum standard education.

How to achieve this: The idea is to have such interventions included in the school curriculum, or, be provided through government-accredited service providers. In that regard, Umlambo Foundation is open to working with life-orientation teachers.

Institutionalisation: When interventions are available within an institution, they become accessible and their impact can be measured in an unbiased and dependable manner.

Changing attitudes of educators: Educators’ attitudes can either encourage or discourage children in school. To help boost the morale of educators, creative measures should be adopted to prevent them from feeling overworked and therefore resentful. Umlambo Foundation believes in integrating these interventions into currently existing subjects such as Life Orientation (LO).

CHALLENGES
New Subject: Life Orientation is virtually a new subject, and we do not have the required capacity as inspectors to implement it, as well as support the educators. Ideally it would be best if the educators remained with the same children and grew with them from grade to grade, to keep track of their
life-orientation development. This is an area Umlambo Foundation seeks to invest in and enjoy the highest returns.

**Working with principals:** While working with principals who seek to produce only good results, we observed that they often would be cautious about engaging in something that may not impact positively on their school results. Therefore, it is also important to make them understand that these so-called soft issues are actually the hardest issues.

**Time intensive:** It has taken time for principals to realise that LO is part of their core duties. At times, and rightfully so, they already have a lot of work or do not have the necessary skills to do the job. That’s when the discussions get into the OBE (Outcome Based Education) and so on, warranting a need to show them their role in LO.

**SWEET REWARDS**
After a discussion between LO teachers and the principals there is generally a mutual understanding on the subject. Although it is early days, our first year to be precise, just the idea that we are already shaping their thinking, is encouraging. Together we have initiated communication and agreed that there is a need for skills and knowledge in order to ensure that HIV-positive people do not infect others and know how to look after themselves, and for those who are negative to remain that way.

**MESSAGE**
You need to look after yourself to prevent HIV infection, because this is ultimately your responsibility. One doesn’t have to be part of an organisation to do this. What needs to be done is to teach young people to make firm decisions and use the services of institutions to their benefit.
There is a dire need to double our efforts to stop HIV, which we have been battling for over twenty-five years now. With the kind of information we have at our disposal, it is time we had an idea of what is working. And we need to implement correctly what is working to enjoy future returns.

The results of our country’s National Strategy that was developed under Ms Mlambo-Ngcuka’s leadership as the deputy president were recently released. Although the document is not yet for public consumption, one of the recommendations it includes is to prioritise prevention because of the slim chances of winning this war at the level of treatment and support. So, a suggestion is to return to the basics, turn off the tap and concentrate on prevention and reductions in our efforts.

INTERVENTIONS
- Focusing on VCT, ARVs, PMC and home-based care are very important, however, prevention must remain a priority.
- According to the HSRC 2008 survey, most young people are HIV negative.
- HIV prevalence in age group 2-14, was at 2.5 %
- HIV prevalence in age group 5-24 years, was just over 8%

The above statistics tell us that in excess of about 91% young people 5-24 years are HIV negative, thus placing a responsibility on all of us that they stay that way.

LIGHT AT THE END OF THE TUNNEL
The survey also pointed out that awareness of HIV was at high levels. Condom use was increasing and prevalence in young people was declining over the three studies that were conducted. It would seem that we must be doing something right and therefore, we need to acknowledge the positive energy and implement it.

Important: Young people are idealistic, exuberant, aspirational and are go-getters. There is also a sense of invincibility (i.e. you can do anything and you can achieve it). It is important that we harness those attributes because therein lies innovation and energy that can be used for the programmes we invent, together with young people, to prevent HIV infections.

THE CHALLENGE
School drop-outs: Although South Africa has an almost universal access to primary education, we also have a 50% drop-out rate. Only half of children who start school will write final Matric exams.

Important: All research shows that staying in school is one of the preventative things society can do. It is therefore crucial for all stakeholders - government and civil society - to ensure that children stay in school. School completion must be both a regional and national agenda that we all fight for and advocate. If a child drops out of school it must be all of society’s responsibility that they are put back into school. Access to secondary education should also be made an imperative; studies indicate that the higher your level of education, the lower your chances of contracting HIV.

PARTNERSHIPS
Schools alone cannot guarantee that children stay in school. It is vital that everybody contributes – NGOs, development partners, funders and the private sector, as well as government and civil society.
**WHAT WE HAVE DONE**

- **Life skills programme in schools**: The intent is to provide life skills education to every child that goes to school and through the LO area. Also, education and information on issues of sexuality and sex should be given at an appropriate age, from the start of school right up to Grade 12. Research done in 2006 reveals a correlation between LO and knowledge. That is, through the life orientation programme, knowledge was increased and attitudes were moved in the right directions. The predicament, however, has been the approach in how schools support LO programmes as there is also the issue of prioritising Maths and Science over LO in our schools.

The question is: **What good is it to have an ‘A’ student and a physicist without life skills?**

**Answer**: LO must get the requisite time and attention. This is a serious battle in getting the education department and organisations such as Umlambo Foundation with whom we work, to support the teaching of LO in schools as an important subject.

- **Out-of-class programmes**: There are programmes that are targeting vulnerable and orphaned children. What the department proposes is to encourage using the school for accessing services – health, social services, etc. The departments concerned are urged to take their places in promoting this idea of using the safety of a school environment to mobilise these resources.

**MESSAGES TO TAKE HOME**

- **Schools protect children**: There should be programmes ensuring access to primary, secondary and tertiary education and providing second chances for those children who drop out of school for reasons such as poverty and teenage pregnancy. This must be a national imperative.

- **Strengthen sex education in schools**: While it is important to impart knowledge on how the virus is contracted, young people need to be skilled with making sound decisions in different areas of their lives. This will help produce well-rounded citizens.

- **Access to health education is paramount**: The Department of Health must play an active role in making access to health services possible to young people.

- **NGOs must continue to push the envelope**: Innovation should be promoted as an effort to push government in the right direction. Also, programmes put on the table need to be evaluated for viability.

- **We need a countrywide communication strategy**: We must get the conversation going with clear messaging talking to the determinants of HIV, addressing societal and cultural issues.

- **Research is vital**: There should be ongoing research to find answers to questions we still don’t know the answers to, as well as to address issues about protective measures in cultural scenarios. Researchers must work with institutions to get the questions so that they can go out and find the solutions.
Having established through research that school protects youth from high-risk behaviour – such as falling pregnant and contracting HIV – it is a good place to start. It forces us to look at those factors that discourage young people from staying in school. More than 95% of 15 year olds are still HIV negative. This provides an opportunity to keep them that way. School leavers between the ages of 18 and 21 seem to be the high-risk group.

Young people should be adequately prepared before they leave school, so that they can anticipate the challenges that are ahead of them. We also recognise a need for programmes for those young people who have completed secondary education. Within loveLife we already have support programmes for teachers that also encourage communities around schools to work hand-in-hand and serve as a reliable network of referrals.

**TEACHER SUPPORT PROGRAMME**

- **Sport or games programme:** We have a teacher support programme that enables teachers to provide young people with sports activities that allow them to focus on healthy living.
- **Motivational programme:** Focuses on teachers themselves.
- **Monthly magazine:** This magazine is distributed to 5600 schools. We would like to reach more, but at the moment we only have a set number of schools that receive the magazine.
- **Face-to-face programmes:** These involve modular programmes that groundBREAKERS and Mpintshis present in the school environment. They are not at all intended to replace Life Orientation; this is meant to be supplementary and extramural in nature.
- **Maths Medium Programme:** Supports Maths teachers.

With school and community inseparable, all these support programmes make clear connections between the school and youth-friendly services within the community. They also keep in mind that schools are part of the communities and that the two cannot be separated.

**SUPPORT SERVICES**

There are also support services through the toll-free helpline and loveLife’s mobile social network. The point is that we already have a comprehensive programme targeting schools. We are, however, nowhere near where we need to be to equip the school with retaining learners and to ensure that they are well-prepared to anticipate the challenges of post-school leaving. We are also challenged with ensuring that the school is equipped with developing leadership skills in terms of the soft, as well as hard skills alluded to by Mlambo-Ngcuka.

**SEGMENTING SCHOOLS**

Starting this year loveLife is segmenting schools even further. In primary schools we focus on disseminating age-appropriate information promoting healthy sexuality. Because loveLife focuses on teenagers, this will target older learners in primary schools. The idea is to inspire a strong sense of identity, belonging and purpose among young people through basic life skills.

**BASIC SKILLS FOR THE FUTURE**

- **loveLifestyle 2010** package of modules takes it a bit further by encouraging activity between modules.
- **Body Ys** focuses on sex and sexuality, gender and relationships, on body changes, issues
around puberty and fitness and linking it with the sports element that we have in schools.
- **Motivation** is about goal setting and having a purpose in life.
- **Debating** is a programme that plays a critical role in enhancing self-esteem. It helps young people to articulate and share their viewpoints effectively while appreciating others’ viewpoints.
- **Cyber Ys** is a computer literacy programme.
- **Born Free Centre Stage** is an art and recreation programme.
- **loveLife Ultimate Dance** is a dance programme for people who prefer moving to the beat rather than sport.

**THE BIG QUESTION:** Why are young people who are knowledgeable about the virus not risk averse?

**THE MAKE YOUR MOVE** programme focuses on getting young people to break down the process of problem-solving and decision-making, and to appreciate the conflict that is sometimes involved in decision-making. They must understand the trade-offs involved in making quick decisions, which may sometimes be subconscious. The programme uses dilemmas, Ten Commitments, goal-setting, and committing to values that they can identify with.

**DISCOVER MY CAREER** allows young people to better understand themselves, what their interests are, what they are able to do, whether they are left or right brained. It emphasises the importance of taking calculated decisions, in particular about the subjects they need to choose in Grade 10. This programme deliberately helps with navigating life, in choosing a subject they want and may very well need to pursue a certain career. The objective is to keep the youth interested in staying in school. We also assist Grade 9s choose subjects and hope that these are retention rewards to keep them motivated until they complete Matric. Through this, we hope to continue to build on identity, purpose and belonging, as well as encourage action and get young people to be more creative in dealing with social pressures.

**loveLife GAMES** are league-based school sports, supported by peer group motivators, groundBREAKERs and Mpintshis. They also provide teacher training and motivation, while integrating the fitness programme into the loveLifestyle programme.

**CLOSING THE GAPS**
- We need to reach more schools in urban and informal settlements.
- Build coping capacity among educators who have to bear the despair of some of the young people.
- The schools-based comprehensive programmes should compliment the mandate of the Department of Education.
- Ensure a sound referral loop between the school and other youth agencies.
- We also need to strengthen teachers personally and professionally.

**WHAT WE CAN ACHIEVE:** It will take an integrated approach by all organisations involved, such as Umlambo Foundation, by focusing on working with the leadership of the school and loveLife focusing on youth leadership. This is necessary to culminate in a schools-based comprehensive programme that strengthens the institution rather than having parachuting programmes.
Skillz interventions in schools

**PRESENTER:** Ms Busiso Ramncwana  
**Assistant Site Coordinator:** Grassroot Soccer Bloemfontein

**PRESENTER:** Mr Taylor Ahlgren  
**Curriculum and Training Manager:** Grassroot Soccer Cape Town

**SUMMARY:** Grassroot Soccer uses the power of soccer in the fight against AIDS by providing youngsters with life skills, knowledge and support — through sport. It was founded in Bulawayo, Zimbabwe, in 2003 by professional soccer players. At the core is a skills-based curriculum that uses soccer as a tool to empower them to understand HIV.

The programme uses three tools to deal with HIV:
- Know your game
- Build your team
- Know your move

Through different evaluation mechanisms it has been proven that soccer can be used as a tool to improve healthy living and public health issues. Grassroot Soccer operates in 18 countries on the continent and it continues to grow. More than 300 000 young people have graduated from Grassroot Soccer and its partners.

**WORKING WITH YOUNG PEOPLE IN SCHOOL**

We train coaches — who may have completed school and are looking for opportunities. They participate in the week-long Training of Coaches (TOC) programme, then qualify as trainers and go to schools to implement the skills they learned. This includes eight core practices that are 45-minutes long and these are implemented during the Life Orientation classes.
- **Skillz tournament — 5-Aside Soccer:** We involve young people in skills tournaments so as to attract members of the community, thereby providing an opportunity to include VCT testing and treatment, followed by referrals. The tournament creates a platform that facilitates access to the community — teachers, children and other members of the community, in a secure environment. The programme lasts a week and is normally held during school holidays.
- **We also have the skills holiday programme,** which takes place for a week.
- **We have magazines and other communication material** that we give out to children, in which we have basic homework questions. The youngsters are also asked to involve their parents in helping them out with homework. We ask questions such as: ‘What are your strengths on and off the field?’ These magazines are also distributed through the Sunday Times and Sowetan.
- **Ambassadors:** In the magazine we have role model soccer stars such as Desiree Ellis of Banyana Banyana as well as Teko Modise of Bafana Bafana, who are the ambassadors for Skillz Grassroot Soccer.

**THE MESSAGE**

Our unique approach moves from board and chalk to coaches getting youngsters to understand that they can protect themselves against HIV. We found that playing games that have a message on HIV and Aids energises the children to participate and understand the message, rather than having them sit behind the desk.

**VITAL CONVERSATIONS**

We have coaches that engage youth in vital conversations that are structured in such a way that they help establish a rapport with the kids. The children share very personal issues with the coaches such as rape, sexual abuse or their first sexual experience.
Introduction

A

Some schools only have periods that run for 30 minutes, thereby requiring an extension on our stay which impacts on the resources.

B

There is sometimes a lack of support from teachers.

C

Our coaches also experience emotional burden, especially concerning the kids’ confessions.

E

Glossary

CHALLENGES

A

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F

G

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There is sometimes a lack of support from teachers.

Our coaches also experience emotional burden, especially concerning the kids’ confessions.

OUTCOME

Learners look forward to the skills period and there is little absenteeism on the day.

Let’s talk about results…

In 2004 we performed a number of evaluations of our unique curriculum-based activities using soccer to deliver powerful life skills education. We were the first development programme to be published in a scientific journal on AIDS and Behaviour in 2006.

RESULTS IN 2009

- 212 coaches trained
- Over 5,407 young people have gone through the AIDS SKILLS PRACTICES in seven provinces.
- There has been significant increase in communication on AIDS and sex among family members and friends.
- Youngsters talk about increased opportunity in life after completing the skills intervention; we use the analogy of bouncing back like a ball as a significant and strong foundation in our curriculum.
- Very interesting with the youngsters knowledge base is that they identify high-risk behaviour in their partners, which was 52% before going through the course and 70% after the course.
- Even though it wasn’t in our content, we found that only 69% did not believe that a shower will cure AIDS. Before training it was 60%.
- Of the 1,269 who tested for HIV, 717 were males.
- Our target group is mainly 12 to 14-year-olds in Grade 7.
- Participants have been confiding in the organisation about their personal matters and we have been referring them to professional help in their communities, as our organisation is not qualified to provide it, be it medical or counselling services.
- No significant change was noted about multiple partnerships. We are looking at possible intervention measures in the future to effect change in that area. We are making adjustments to the curriculum to achieve the desired results in this regard.

NEXT STEPS FOR 2010

- Target is for 26,000 participants this year.
- We are looking for new ways with intervention pilot projects; we have a programme called Red Card.
- Solution in terms of LO periods is a challenge – we are seeking to adjust the curriculum in consultation with the Department of Education. Already we are discussing such a possibility with the Western Cape department at provincial level, with a view to pursue the national agenda.
- We would like to involve teachers in discussions about how to strengthen the curriculum.
The presentation touches on GOLD PEER EDUCATION with a focus on:

- Working with schools for effective peer education
- Reviewing our exploratory outcomes
- Lessons learnt

There are various models of peer education, but GOLD PEER EDUCATION is probably one of the most distinct in that it is a longer-than-usual term programme. Children in Grades 9 or 10 are placed in an intensive programme for 36 months, with the option of the fourth year that could take them up to 48 months to impact their peers.

WHO IS GOLD?
GOLD = Generation of Leaders Discovered. We believe that GOLD is symbolic of Africa’s greatest resource – its young people. Just as it is difficult to get gold out of the ground, it is also difficult to build up a generation of young leaders. We have tried to give them the time that they need.

OUR VISION
We see a generation of young African leaders confronting the fundamental issues of the HIV/AIDS pandemic, through uplifting their communities and imparting vision and purpose to present and future generations. We believe it is possible because we believe in our young people.

OUR MISSION
We seek to support viable community organisations across sub-Saharan Africa with sustainable youth peer education programmes, thereby empowering youth peer leaders to become positive role models and agents of community change. GOLD is represented by 36 community-based organisations and does not operate in schools. The kind of work we do involves capacity building.

STRATEGIC GOALS
- To reduce risky behaviour and new HIV infections among youth
- To mitigate the impact of HIV/AIDS on communities
- To support education in difficult circumstances
- To develop capacity and leadership in strategically selected schools and community organisations

OUR THEORY BASE
We subscribe to what Rogers said in 1983, that people do not change only with information, they change when others around them change [Theory of Diffusion of Innovation, Rogers 1983]. Hence we believe that the message giver is the strongest message.
Effective peer education:
- Harnessing the influence young people have on their peers
- Encouraging youth to make informed choices
- Developing health-enhancing and future-oriented social norms among youth.

It is said that youth think for now but we are hoping to change that with multiple dosages of positive peer pressure.

GOLD’S THEORY OF CHANGE FRAMEWORK
There is a need for change from the evidence that Aids-related deaths are decimating a whole generation of leaders within all social, political and economic spheres.

Our 6 core services of the GOLD Agency are to:
- Build capacity and leadership development
- Skill facilitators and also train, support and equip peer educators
- Peer educators adopt health-enhancing and purpose-driven behaviour
- Peer educators influence their communities positively
- Peers fulfill roles in order to effect change in their peers
- The GOLD programme effects change according to its 23 developmental outcomes

We have a ‘cascade approach’. If you are our programme manager we are always concerned about what you do, no matter when. How many people are in your bed is an issue for us because it all starts with you. We are helping people understand that sexuality has become a citizenship issue. Then it moves down to facilitators and then down to the children. Because we are tired of being dictated to without seeing any results, we make role modeling the heart of what we do.

TEN CORE COMPONENTS OF THE GOLDpe MODEL
1. We have a structured 3-year tracking system: A child who enters track one has to meet all the requirements.
2. Track two is that the biggest one manages to get through the Grade.
3. We always operate on a cluster of 2-6 schools/sites to achieve maximum results.
4. You can’t just go to school unless you ask for permission from the communities and unless you have told them what you are going to be doing.
5. We work through grassroots organisations that understand the language that children use.
6. A facilitator should be someone who is a role model.
7. Youth focus and peer education criteria are more effective to young people.
8. Adaptable, values- and rights-based, school support and curriculum integration.
9. We have a monitoring and evaluation system that will be launched in March 2010; you can even log on using your cell phone.
10. It is quality assured by GOLDpe.

CURRENT FOOTPRINTS
We are supporting education and health services in:
- Three countries: South Africa (the Western Cape, Mpumalanga and KwaZulu-Natal) and in Botswana and Zambia.
- We have 35 community-implementing organisations and 156 secondary schools and community sites. In Zambia we don’t work in schools because most children are out of school – that’s where the community comes in.
- We have 300 facilitators in the system.
- Over 7 400 children – peer educators who are very efficient.
WHY WORKING WITH SCHOOLS PROVIDES FOR EFFECTIVE PEER EDUCATION?

- The school context provides the opportunity to access young people from all walks of life.
- It is a semi-contained community, yet integrated within the wider community.
- Young people provide access to parents, other youth and the community.
- The schools schedule provides opportunity for peer education to take place – we support the LO curriculum; we sometimes run programmes during break times, extra-mural activities, sports, clubs, etc., but most of our clients are contracted to schools through our programme for after-school programmes.

It takes an enabling environment for a peer programme to be sustainable, and we see the need for parents, the community, community service providers, peer educators themselves and government come to work together with GOLDpe, in order to deliver effective peer education.

PEER EDUCATION AS A RESOURCE TO SCHOOLS

We all know that schools are under-resourced and teachers are overburdened. Our aim is to complement and enhance the Life Orientation curriculum and NOT to replace it.

- GOLD works with the education system to provide input and motivation to key learners who in turn motivate those around them.
- We believe that strong linkages are vital. We also believe that our partners should report at least six school linkages, with one of the schools having a principal who can tell them about concerns that are specific to principals.
- Educators should be encouraged to use peer educators.

BENEFITS OF PEER EDUCATORS WORKSHOPS

They receive training sessions and also get mentored. Mentoring means that two facilitators will work with 35 young people. The one thing we are doing right is that we are giving these children eyeball time with adults. We boost their confidence by telling them to believe in themselves and that there is nothing they cannot do. Our curriculum is in six modules that are spread over three tracks at varied levels.

THE CURRICULUM

The young peer educator will be exposed to the following aspects through the six-module curriculum:

- Who I am – self development
- Gender, relationships and rights
- Sexual and reproductive health
- Leadership
- Communication skills – if I want to see change, I will have to communicate to see action and change
- Community action – because that is why I am here.

FOUR ROLES OF A PEER EDUCATOR

1. Young people are encouraged to role model health-enhancing and purpose-driven behaviour.

“Peer education doesn’t tell you what to do differently but changes you as a person, so that you can do things differently. I think it is probably the best approach imaginable when dealing with young people” – Peer educator, Western Cape

“She (peer educator) is a good mentor to me and she is my role model. I wish to be like her. When I have a problem I’m not scared to go and ask her because I know that she is always prepared to give me support.” – Peer, Mpumalanga
2. To educate peers in a structured setting almost always in the presence of an adult; either the LO teacher will be there or the facilitators from our partners. They do it in two ways:

**Lesson deliveries:**
- Structured and planned sessions that are still fun and interactive
- Aim to transfer knowledge to a group of peers and encourage critical thinking and questioning
- Integrated into Life Orientation curriculum outcomes

**Talk groups:**
- Less formal discussion forums on relevant topics
- Debate, discussion and encouraging peers in critical thinking
- Use leading questions or stimulus to spark discussion

“The most change that happened is that I used to have more than two girlfriends. But now I have one because I know how HIV spreads. I used to do unprotected sex.” – Peer KZN

3. The third role is to recognise peers in need of help and refer them for assistance. This is where we need all the of the government tiers to come together at school level.

“After I met a peer educator I went to the clinic to check my HIV status and found that I am negative and now I don’t have unprotected sex.” – Peer, KZN

4. The fourth role is to uplift the community.
- Mobilise peers and community against issues affecting them
- For example, safe and health-promoting schools, advocating youth-friendly services, reporting sexually predatory teachers and learners
- Peer educators act as a bridge between school and community
- GOLD aligning all community upliftment and advocacy activities to the MDGs: providing a common language to co-ordinate and magnify local action

“Peer educators help those in need and make a difference within the community through the information and the support that they offer.” – Peer

**LESSONS LEARNT**

*We have witnessed that:*
- Motivating youth to change their behaviour requires significant investment of time, one-on-one mentorship, programmatic depth and resources within an enabling context.
- The success of peer education depends greatly on the strength of character modeled by all programme participants.
- High-dosage and intense investment into influential young leaders over the long term is critical for sustained behaviour change.
- Partnership with education stakeholders from the local to district to provincial level is key to successful integration in schools:
  - School selection
  - Share best practices and info
  - Hold working agreements
  - Focus on government priority issues and align to policies
Overall perceptions of the GOLD programme, as reported by educators, principals and facilitators:

“The GOLD programme is like a mother and father to our learners.” – Mrs Mthembu, Teacher, ISAAC, KZN

“Teenage pregnancy has dropped by 60% at Vulindlela High because of the GOLD programme.”
– Mr Nkosi, Educator, YFC, Mpumalanga

“Your facilitators have revived the spirit of teachers in this school.” – Miss Mfubi, Educator, Hope2Educate, KZN
Youth-friendly Services

PRESENTER: Dr Sarah Kirby
Executive Clinical Specialist: loveLife

FOSTERING HEALTH AND WELL-BEING THROUGH YOUTH-FRIENDLY SERVICES

We already know that there is a huge youth bubble and often people ask why we need a youth-friendly service not just a good service. We have the biggest bubble population, which is under age 20, and who constitute the majority of patients who come to see a healthcare worker.

As it stands we do not have a good health profile as young people are starting sexual activity at the early ages of 16 or 17. We have also talked about them engaging in risky sexual behaviour and unprotected sex. So how do we find this out? It’s in the evidence…

Statistics:
- **Pregnancy**: By age 19, one in three females has become pregnant. That makes South Africa a global leader in rates of teen pregnancy.
- **STI**: More than 11 million cases of STIs that occur each year in South Africa are in adolescents and youth. That leaves South Africa with a poor health profile as it leaves people very vulnerable to HIV.
- **Physical and psychological trauma**: Young people are at the greatest risk of physical and psychological trauma resulting from sexual abuse, gender-based violence, physical violence and accidents. It is not something to be proud of, we are not sure whether we have a good reporting system or not, or maybe we have the highest reported cases in this age group in the world.

RESPONSE: These are the things we are asking the South African health system to respond to. It is important to address the issue of how a school can be linked to a clinic, the counsellors and nurses. loveLife has a very good intervention with the groundBREAKERS programme, which has been running for the past 10 years. We would rather train the health workers; but the question is what are you driving the end to?

When loveLife was getting ready to put together ideas to come up with a youth-friendly service programme, we came together with the youth, healthcare practitioners and those in charge of the healthcare system. What we found was not the greatest of pictures as young people did not even know about the services offered. We are saying if they (and their teachers) don’t know what’s offered, how are they going to link up with clinics?

YOUTH-FRIENDLY SERVICE INITIATIVE

Research conducted by loveLife and the Department of Health in 2000 established that many public healthcare facilities in South Africa were failing to provide youth-friendly services.

Questions asked: We asked young people many questions and came back with startling answers. Evidence that prompted loveLife and the Department of Health to look into a youth-friendly service in public healthcare facilities; we certainly didn’t want to send the youth running away from these facilities.

Here are some of the questions:
- Are young people being welcomed at our clinics by a friendly face?
- Are they being served by healthcare providers who are sufficiently trained and motivated to tailor services to youngsters’ individual needs?
Are services and treatment options affordable to young people?
Are services available at hours that are convenient to young people (e.g. outside of school hours)? And, are there long waiting times or unnecessarily complicated administrative procedures?
Can a young person be confident that the sensitive issues they discuss will be kept in confidence and that their privacy will not be violated?

THE STATUS QUO AT THE TIME WAS…

Healthcare workers treatment: We heard of a case of a young person who was scorned and chastised when making a choice about their sex life. It was embarrassing to learn a healthcare worker once told a young person who had come knocking at the clinic’s door for help after being raped, that at least she had had sex.

Managing STIs: We also found that nurses were inadequately skilled to manage young people presenting with STI symptoms. Were they able to understand the symptoms, their risks and the services available to help the young people?

Inadequate service: Say the young person finally manages to walk through the door of the clinic hoping to get necessary help and finds out that the nurse is unable to diagnose and treat them, as there is a shortage of equipment or there are no supplies (e.g. drugs have expired). What about young people’s perception of confidentiality or the system being in place to maintain privacy. Can a young person be confident the clinic staff will not judge them for their presenting issue or the choices they make? What about cultural barriers? How about the nurses who have the same barriers as parents when it comes to engaging and facilitating discussion with young people?

The impression for a young person: Engaging with our primary healthcare systems can be an unpleasant experience. If the clinics have a negative reputation, as they do in many countries that we serve, do young people even want to go there for service? When young people spread the word – ‘don’t go because you’ll get yelled at, they don’t know what they are doing, they are not welcoming; and they don’t even have drugs; they won’t do anything for you any way’ – the reputation has a ripple effect on the systems you are putting in place, and that perception needs to be changed.

TURNING THE NEGATIVE REPUTATION AROUND
When we noticed that the healthcare facilities were not providing a supportive environment that promotes the tenets of healthy lifestyles, and proactively addressing the risk factors for illness and disease among young people, loveLife came together with the national Department of Health and initiated a programme to support the sexual and reproductive health of young people, known as The National Adolescent Friendly Clinic Initiative (NAFCI) in 2000.

THE CREATION OF THE NATIONAL ADOLESCENT FRIENDLY CLINIC INITIATIVE
In addition to addressing the issues highlighted by this preliminary research, NAFCI synthesised good practices from both national and international experience in adolescent sexual and reproductive health programming. This culminated in the development of a standards-based quality assurance framework for a multi-sectorial response to young people’s sexual and reproductive health threats.

RESULTS: By the end of 2005, NAFCI had expanded to about 350 primary healthcare facilities across South Africa. Since 2006, loveLife has been supporting the Department of Health’s capacity to sustain and build upon this initial success. NAFCI is well beyond the piloting stage. Moving from a model that was dependent on loveLife to independent leadership, currently we are working with the department to expand the programme to where it becomes an integral part of all primary healthcare facilities.
Equally important is the department’s establishment of mechanisms to ensure that this initiative is implemented with consistency across South Africa and sustained over the long term. As such, NAFCI has been incorporated into the Youth-Friendly Services (YFS) strategy of the department’s 4000 healthcare facilities. So we have a reworked model that has been tweaked, making sure that we are relevant to the department’s operational strategies that could be aligned to the mandate of 2007, 2008 and 2009.

NAFCI was primarily designed to:
- Make health services more accessible and acceptable to adolescents;
- Establish national standards for adolescent healthcare in public clinics throughout the country;
- Strengthen the capacity of healthcare workers to provide high-quality, youth-friendly services.

THE YFS SERVICE PACKAGE
Consultations carried out by the Department of Health, loveLife and other key stakeholders resulted in a standard definition for a core package of services for primary healthcare facilities that aim to improve young people’s sexual and reproductive health. This service package largely focuses on HIV, STIs, pregnancy, and on violence, which is often sexual in nature. It advocates for effective counselling and provision of contraceptives, pregnancy tests and HIV testing at primary-care level, and for continued access to safe abortions. This service package also addresses the issues emanating from research conducted with young people.

THE SERVICE PACKAGE FOR YOUTH-FRIENDLY FACILITIES
1. Information, education and counselling on sexual and reproductive health.
2. Information, counselling and appropriate referral for violence/abuse and mental health problems.
3. Contraceptive information and counselling, provision of methods, including oral contraceptive pills, emergency contraception, injectables and condoms.
4. Pregnancy testing and counselling, antenatal and postnatal care.
5. Pre- and post-TOP counselling and referral.
6. Information on STIs, including information on the effective prevention of STIs and HIV, diagnosis and syndromic management of STIs, including partner notification.
7. HIV information, pre- and post-test counselling, and appropriate referral for voluntary testing if services not available.

CREATING A HIGH-QUALITY SERVICE
A set of service standards has been developed to guide the delivery of the YFS Service Package. These standards provide a practical mechanism for determining the extent to which existing services are youth friendly and for identifying areas for potential improvements.

Furthermore, because providing sexual and reproductive services that are specifically tailored to the needs and interests of young people is a new approach for many clinics. Those involved with YFS need clear guidance on how to adapt their current services, or initiate new services, according to the needs and preferences of their adolescent/youth clientele. It also created a framework to guide healthcare response.

YFS Standards prompt practitioners to consider a series of basic questions that explore where the energy, resources, activities, policies and programmes are being directed within a clinic. In doing so, YFS standards guide clinics to assess their current situation and figure out how to effectively adapt their approaches to be more youth friendly, getting communities to think more broadly and creatively about what is happening in their clinics and what can be done to maximise the clinics’ potential to support young
people’s sexual and reproductive health.

YFS STANDARDS

These standards ensure that:

- Management systems are in place to support the effective provision of health services for young people.
- The facility has policies and processes that specifically support the rights of young people.
- Appropriate health services are widely available and accessible.
- The facility has a physical environment conducive to the provision of youth-friendly health services.
- The facility has the drugs, supplies and equipment necessary to provide the YFS service package.
- Information, educational sessions and other communication services promoting young people’s healthy behaviour is provided.
- Systems are in place to train all staff to provide effective and friendly health services to young people.
- Young people receive adequate psychosocial and physical assessments.
- Youth receive individualised care based on standard case management guidelines/protocols.
- The facility has mechanisms in place that ensure continuity of care for young people.

THE YOUTH-FRIENDLY SERVICE PHILOSOPHY

This takes us to the loveLife philosophy that for Youth-Friendly Services to operate efficiently, “it takes the coordinated efforts of an entire community to empower healthy lifestyles among South African youth.” The responsibility to deliver on health in this context, therefore, is not seen as something that should be shouldered by any one organisation alone, as they require support from other sectors to implement adequate and relevant youth empowerment strategies.

It is important to note that a youth-friendly clinic is not something that is confined to the four walls of a clinic’s structure – it extends beyond the consulting rooms into the broader community and the social construct in which youth exist. By bringing healthcare providers together with young people and a wide range of youth stakeholders (e.g. parents, schools, sport and recreation clubs, community coalitions, local leaders, religious institutions, local businesses, and other government departments), a youth-friendly clinic shares the responsibility to support and enhance young people’s healthy lifestyles. This approach also provides all those involved with a shared vision and a clear purpose in working together to successfully implement services with mutually beneficial outcomes.

This is a community coalition of services that are working together to uplift the spirit and the empowerment of our youth. We have therefore developed non-dictatorial clinics that have moved from ‘thou shalt not do that’ to ‘you may be involved’ – this is a huge paradigm shift and it brings a fresh approach to the health system.
WHAT MAKES THE YFS MODEL EFFECTIVE?

- YFS approaches young people’s sexual and reproductive health from a comprehensive perspective that emphasises systems and processes. It ensures ongoing quality control and continuous improvement in programme implementation and service delivery, while at the same time, focuses on the individual young person and how their health relates to their environment. The YFS model therefore influences both how a clinic is run and how health is achieved.

- YFS doesn’t replace existing programmes or policies, but rather provides a fertile environment for them to grow and be successful. Rather than trying to create parallel systems within existing healthcare services, YFS is integrated into existing programmes and into existing management structures. It builds upon what’s already in place and improves on it to ensure high-quality service delivery and maximum service uptake by young people.

- Through YFS, healthcare facilities provide a focal point to tap into all issues affecting young people’s health, their personal development, their well-being, and their safety. In its comprehensive approach, YFS indirectly becomes so much more than just healthcare – by enabling clinics to have the opportunity to educate, motivate and guide young people.

- Creating more effective and comprehensive solutions to young people’s sexual and reproductive health threats by integrating new programmes into clinics, schools, recreation centres, and community youth initiatives can be very difficult when there is not a vehicle to drive it. By providing a common vision, model and symbol of comprehensive and youthful approaches, YFS integrates existing national policies, programmes and activities and gives them renewed energy and innovation.

- Evidence collected from consultations, focus group discussions and larger scale evaluations demonstrate that clinics, schools, youth organisations and communities who have been involved with YFS experience greater cohesiveness and enthusiasm for the delivery of HIV-prevention services and other youth empowerment programmes. They become invigorated by their progress in creating a holistic response to young people’s sexual and reproductive health threats and are motivated by their success in helping young people to lead healthier lifestyles.

South Africa is a country of incredibly diverse communities – in terms of geography, demographics, health needs, behaviours and resources, etc. Although YFS includes focused guidelines and processes, it is flexible in allowing service providers and communities to follow their own priorities. YFS is also delivered with the support of extensive programme tools, training and mentorship so that those involved are equipped with the necessary skills and focus to deliver high-quality programmes and services. We have training; we provide technical resource support; as well as toolkits for youth and healthcare workers.

CONCLUSION

For the healthcare system, this means that instead of passively waiting to diagnose and treat diseases in our already overburdened emergency rooms, hospitals and clinics, we need to proactively prevent them by focusing on high-quality service delivery and by contributing to raising a generation of South Africans who are equipped with the knowledge, the skills, the motivation and the resources to make healthy lifestyle choices. We can only achieve this with integrated interventions. This programme is the embodiment of an integrated service and this is the NACPI’s aim, to position health as the pillar. Together, we can make this vision a reality.
Question 1: From the floor
In our countries the reality is such that many children are orphaned and then drop out of school. You referred briefly to working with out-of-school youngsters in communities. Do you form linkages with schools when you do those programmes, and what do they entail exactly?

Answer 1: ROSALINE PILLAY, GOLD Peer Education Development Agency
Our commitment to a child who doesn’t have any parents is that they should not be left behind. So our programmes are also extended to them. There is a programme that has been introduced in Zambia, where they use a board and ask the children to write a letter, so you can see the literacy of the person. But, unfortunately at this time, our model is very word based, it may not be as accessible to young people who are illiterate. We received about 80 letters and 35 were selected that represented in and out of school children. And that criterion is helpful. We are talking about children who have nothing going on their lives, in urban areas you have a choice of going to the workshop or not, but in Zambia there is nothing going on and we run the programme on Saturdays and Sundays.

Question 2 (i): From the floor
How long do you work with these kids in terms of capacity building before they graduate?

Question 2 (ii): ROSALINE PILLAY
We seem to be leaving out-of-school youth out of the three-track programme. Is there anything we can do for them?

Answer 2 (i): BUSISO BATHABILE RAMNCWANA, Grassroot Soccer
Grassroot soccer is also about behaviour change and modification. The coaches will go back to have a focus group with the youth to establish what their behaviour towards HIV was before the intervention. If we are lucky enough to have four LO sessions in one week, that would mean we would be there for two weeks, to accommodate eight sessions in total, for a period of 45 minutes in a day.

Answer 2 (ii): Taylor Ahlgren, Grassroot Soccer
We are designing a programme for Skillz graduates but right now they complete the intervention programme, which is designed to build resilience in a short period of time and high alert against HIV-risk behaviour.

Question 3: LOUISE
While doing research on our project, I travelled the width of the country and found that LO is a free subject, but that there was lack of training for educators. It was even worse in rural areas; they did not have any LO ongoing. Next we will bring out the programme in the Western Cape where we working with 100 schools and 3 000 teachers and we will be talking to teachers how to teach. LO is currently two periods a week, so bringing sport in is a big thing.
Comment: TRINA
If I hear you clearly, you would like to look at how LO can be utilised effectively?

Answer 3: DR FAITH KHUMALO, DOE
It is clear that what is intended doesn’t always happen at school. I believe that we need to place important value on the subject and that is what needs strengthening. There have also been attempts to train other educators around HIV/AIDS issues, so that it is integrated in other learning areas in future.
The goGogetter programme is a ray of hope for Orphaned and Vulnerable Children (OVC). It is a support system for OVCs. There are many statistics about the number of OVCs in South Africa, but the bottomline is that, in this country, the number of deaths of adults as a result of HIV/AIDS has trippled in the past decade. As a result we are seeing a rise in the number of orphans. According to the HSRC (2004) there has been close to two million maternal orphans and will be a projected 4.6 million maternal orphans by 2015.

loveLife is about teenagers who are at risk of HIV because of their developmental stage. If you think of OVC and the drivers for the spread of HIV among young people – low self-esteem, pessimism, peer pressure, forming identity, lack of parental communication, consensual sex, low education – you can see children are even more vulnerable. The extended family has always been a key to support the orphan, but unfortunately HIV has been eroding this. We also have other population variables such as migration and urbanisation, which are eroding the extended family’s ability to care for the orphans.

The goGogetter started when the Belinda Gates Foundation put out the challenge of how to deal with the issue of OVC support in a creative way. loveLife’s goGogetter programme’s proposal was accepted. The programme was not originally loveLife’s – it was already happening in communities but we wanted ways we could support the gogos.

WHAT WE AIM TO ACHIEVE
- We hope to illustrate that grandparents and grandmothers support programmes are key to addressing the OVC support problem in South Africa.
- We hope to learn, through the implementation of this programme, the best way of supporting HIV-positive teenagers at a sub-district or municipal level.

PROGRAMME COMPONENTS AND OBJECTIVES
This programme has three levels of intervention: community level; monitoring and research; and the extent to which the community is involved.

COMMUNITY LEVEL INTERVENTION
- **Helping teens:** We have recruited 500 grandmothers. We capacitate and support them and they in turn support 10 to 20 OVCs and help them to access food and rights, and help them stay in school, prevent abuse, etc. This also helps them build a sense of belonging and purpose.
- **Media programme:** Create national awareness and support for the programme in order to galvanise broader mobilisation of gogos/grandparents and society in general in terms of OVC support; as well as politicians and service providers to respond to the issues of OVCs in this country. We also have a strong monitoring and research service.

MONITORING AND RESEARCH
This is very much a pilot project and we want to learn from it. We are trying to learn about the activities and standards that are necessary to prevent HIV focused on teenage orphans and vulnerable children.
DETAILS OF COMMUNITY LEVEL INTERVENTION

What is the role of the goGogetter?

1. An adult ally for teenage orphans and vulnerable children

The goGogetter is an adult friend to the child: she listens to the child and gives advice and guidance from her own wisdom; she checks regularly how the child is doing and engages with the child on a regular basis.

She is a problem-solver for the child. So many problems cannot be solved by children on their own, but, a child whose parent is sick or has died has no one to turn to. With this programme, gogos are able to set in and help them out. On a practical level, the goGogetter identifies the problems and tries to solve them for the child. We have made our model very simple. We say that the gogos must help the child to have a second chance.

2. An activist in her community

She creates awareness in the community around the problems they face and motivates them to address these problems together. She does this by talking to as many people as she can, either individually or as groups. She is really a networker because she brings all these people together.

She involves the community and others in solving the problems of the OVCs – she will have events, and create community dialogues that loveLife helps to organise.

HOW DOES loveLife HELP THE GOGOS?

1. We help out financially:
   - Each gogo is paid a stipend of R300 per month
   - Each gogo gets a travel/telephone allowance of R100 per month
   - Gogos can claim an additional R100 per month for travel to cover their extra travel expenses.

2. We provide support and guidance:
   - We go out and get NGOs and community workers to lead monthly goGogetter support groups, which is an expansion of networking.
   - We provide a toll-free helpline service for gogos allowing them to speak directly to a social worker about their specific OVC-related/personal problems (0800 121 500). They also have a call-back option and we give practical advice to their problems. This service is unique to South Africa.
     - groundBREAKERs assist with the identification of OVCs and ensure they can benefit from our lifestyle programmes. We also link our peer educators with the gogos so that there is a mentorship relationship.
     - Regional teams organise community dialogue events and youth festivals for OVCs on behalf of goGogetters, offering the gogos the opportunity to create awareness, to motivate community members and to form problem-solving networks to improve the life situations of the orphans and vulnerable children in the community.
     - Our goGogetter co-ordinators are ‘problem solvers’ for goGogetters. They assist the gogos to approach local stakeholders and to form and manage relationships with people or organisations that can assist the gogos and the OVCs in any way.
     - Our goGogetter co-ordinators provide human resource/administrative support to the goGogetters.
3. Capacitation and Information

We capacitate and provide information to the gogos. The gogos are very open, some of them sleep with rooms full of children on the floor and they keep taking them in, but we came to help the gogos on which OVCs depend. This is going to be an ongoing process; we have developed some tools to understand the extent of the vulnerability. We rework and translate this information to produce and distribute outputs that are user-friendly for gogos who are often illiterate.

We prepare and facilitate capacitation workshops where the gogos get the opportunity to engage with each other and with subject experts around their general role and specific actions to support OVCs.

4. Coalition building, advocacy and lobbying

At national, provincial and local levels, loveLife staff tries to establish partnerships or secure funding or other means of support for the goGogetters.

- We produce television and radio PSAs (unscripted real documentaries) marketing the programmes and encouraging grandparents in general to support the youth, especially those most vulnerable in our country.
- We collect information and produce reports and learning briefs to inform government and others in terms of the situations and difficulties that OVCs are facing in order to influence policy in this regard.

OVC BASELINE

- Face-to-face interviews with 430 goGogetters (92% of the total number of goGogetters at the time).
- goGogetters interviewed reported that they were supporting 5 257 OVC in total (on average 12 OVCs per goGogetter).
- We collect information on 2 227 of the OVC (43% of the total number of OVC supported).
- 1% of the children come from child-headed households, and 20% come from single-parent homes (info was available in 2 213 cases).

OVC BASELINE FINDINGS

- 38% of 1 939 children missed a meal in the last week due to lack of food.
- 9% of 2 101 OVCs are suspected of being abused.
- 95% of 2 165 OVCs are registered in school. The majority attend school regularly and 4% attend school sporadically.
- 323 OVC (14%) are not eligible to receive any of the grants.
- goGogetters observe that more than 95% of OVCs have positive relationships with friends, caregivers, and family members.

CONCLUSIONS OF BASELINE

1. Findings suggest that overall, the children receiving support from the goGogetters are doing better than expected.
2. Children in poor households, and children living in informal settlements are most affected by orphanhood (Brookes, Shisana and Ricter, 2004).
3. goGogetters need to have a way of prioritising the most vulnerable youth.

CURRENT RESEARCH

We are currently involved with new research to help us understand issues of policy around the OVCs. We want to understand the specific role of the gogos in terms of the policies. We also want to understand how much support the gogos need and how much support loveLife should give the goGogetters. We are excited about the research and expecting the findings quite soon.
SUMMARY (TRINA DASGUPTA)
It is important that we work with institutions and young people; and train and support institutions
to do that. We also saw through the goGogetter programme that a cross-sectional approach is
essential. If you look at these women, they are already doing this and you organise them union-style
to bring their work to force and support it.
YOUTH INTERACTIVE Q&A SESSION 4

Question 1: ROSALINE PILLAY, GOLD Peer Education Development Agency
If we identify an OVC through our programme, how do we connect them with the gogos?

Answer 1: JUDY-MARIE SMITH, Group Programme Director, loveLife, SA
If you do identify them and send them to our site, that will be of great service. We also have groundBREAKERs who are able to identify the out-of-school young people, those are the ones we want on the programme.

Comment 1: ZOLIWE ZIKHONA CUTALELE, loveLife
I was part of the Gogos programme test run and I am aware of the vulnerabilities placed on both gogos and OVCs. One young man was stigmatised at school because a gogo came to see him and it became common knowledge that he was an orphan. As a result he lost his network, which is important in terms of wanting to belong and his social development. And a youngster who had no food and a place to stay, he broke into one gogo’s house. How do you protect them both?

Comment 2: JUDY-MARIE
We are very sensitive about that. When we have an event we don’t call it a goGogetter event; we make it a community festival everybody feels a like part of. We also encourage a personal relationship between groundBREAKERs and OVCs. We don’t want any child to be singled out. In terms of the gogos we are also trying to help them understand the sensitivity around the issues so that they don’t make the youngster feel singled out. That is a real challenge. In terms of protecting the gogos, that is why we created support groups, which we originally didn’t have. This came about in our first year of the programme. The support groups have really helped, as well as social workers or people from the Department of Social Development. Sometimes we rope in retired social workers.

Comment 3: GRACE MATLHAPE, loveLife
It is important to understand what the young person’s acting out means. We do not want to turn gogos into counsellors by any means. With regards to the issue of stigma, the way to deal with it is not to push it under the carpet. We need to engage with it through dialogues that we have created, so that there is constant examining of the issues as we work towards changing behaviour.

Question 2: JEFFREY MKHWANAZI, Southern African Association of Youth Clubs
How does loveLife identify gogos and how do you ensure that the gogo on the programme fits in with your plan?

Answer 2: JUDY-MARIE
Initially, we had gogos who were already taking care of the OVCs, but we are now expanding to target the informal settlements. We are basically using some research that helps us to know about HIV and OVCs to inform our decisions. We monitor management and sometimes we look at the success of the
programme. Management monitoring involves: when is the meeting, who is attending, and how many community dialogues are we getting and we do have systems of monitoring.

In terms of the impact of the programme, that’s why we did the baseline. If the OVCs are registered, we can track them, but the challenge is that sometimes they get lost in the system.

Getting data from the gogos is very challenging, and now it is becoming even more difficult in terms of linking the OVC. That is why we have to continue doing studies, particularly the one we are currently doing. We hope this study will give us a good evaluation tool, considering a whole host of things.

**Question 3: From the floor**
This is a brilliant programme, which we can take to our countries. Are the goGogetters only connected to schools through the loveLife programme?

**Answer 3: JUDY-MARIE**
The goGogetters are not only linked to schools, some work in clinics. They really deal with different social realities. For instance, we have found that some of the out-of-school young people are not in school because they have no uniforms. And gogos normally negotiate with the principals to get this child back into school.
Young people have knowledge about risks, they are self-perceptive, but still go on and take the risks, and this needs to be investigated. A lot of studies emerging out of Africa show that there is generally high knowledge of HIV. These studies show that young people understand risk behaviours better, but still take the risk. Why?

LET’S FIND OUT…
Alcohol dampens the brain. It leads us to act in an uninhibited manner, drives us to do things we would normally not do when sober; we drive cars faster and more recklessly; say things we wouldn’t usually say and don’t use condoms when we have sex.

Statistics from South Africa unrelated to HIV show that alcohol has something to do with homicides and deaths related to domestic violence. It also accounts for 50 to 60% of fatalities. Alcohol is an obvious medium of risk that we haven’t paid enough attention to. Most of these occurrences happen when alcohol binges happen at the weekend.

HIV AND ECONOMIC FACTORS
In South Africa, people who are living in deep rural areas, in homesteads where they have family support, have a very low HIV prevalence. The people who are at risk are those with a bit more money – contract workers, casual labourers or mine workers. Although, the connection between wealth and HIV is not a straight line. It is therefore difficult to show a relationship between HIV and income or wealth. There are several reasons why it is complex. There have been studies in Africa that showed the relationship between money and HIV, but failed to take into account the differences between rural and urban populations. They did not even show that HIV was much higher in moneyed people than in poorer communities.

RELIABLE MEASURE OF SOCIO-ECONOMIC FACTORS
School completion or drop out is a high measure of socio-economic relation to HIV. It is possibly the best measure. Here we have a systematic review of more than 1200 studies that look at education and HIV. It showed that there was a relationship between high HIV infection and education. But, the studies since 1996 show that the lower the education, the higher the risk of HIV infection. There is value in education, in using information better.

Schooling goes a long way as it provides a safe environment. When a person is in school, they have a sense of aspiration and security; they are part of a network of people working towards the same goal. That provides a level of protection that disappears when you leave school. For people who leave school without knowing what the future holds, that is the time of incredible risk.
WE NEED TO UNDERSTAND...
Why are people who are just above the bottom of the pile more likely to put themselves at risk?
Why is crime high in marginalised communities?
Why is alcoholism much higher in those communities?

If we can’t respond to these questions, then we’ve got a blank box between the high HIV prevalence and the factors that cause socio-economic marginalisation. We can’t do much about HIV until we do structural reform. We are stuck in the mentality that nothing can change until it changes at national level. Alternatively, we could say that we are willing to grow economic activity and embed HIV in it. There is nothing in-between; we don’t have any hooks we can use to develop interventions that address some of the intermediate challenges.

WHY STRUTURAL INEQUALITY LEADS TO HIGH-RISK BEHAVIOUR
We have got to start filling in the blanks of why people in marginalised communities engage in high-risk behaviour. This will give us some hooks.

Low risk: The place to start is to understand the profile of HIV. In a study done in 2003 among youths aged between 20 and 24, particularly those who were married (not suggesting that marriage is always protective), the circumcised and those who participated in the face-to-face programmes did not experience high-risk behaviour.

High risk:
- Those who didn’t always use condoms
- Those who have a higher number of lifetime partners
- Age differential between ages 15 and 19, five year age gap
- These are factors that increase the risk of HIV infection

Push from high risk to low risk: There are certain factors that can push one from high risk to low risk.
If we look at chain mediators, people who are not exposed to knowledge are more likely to be exposed to high-risk behaviour.
Cognitive factors: How you respond to the message is often mediated by how you feel about yourself — sense of purpose, belonging, identity, condom use, etc. There is now evidence of the social cognitive factors that contribute to high-risk behaviour.
Classical factors: The predictors of high-risk behaviour include black African women, who are eight times likely to contact HIV than their white counterparts. Most of those affected did not complete high school or are living in informal settlements.

These findings emerged from national surveys. It is very difficult for instance to ask a person who lives in Alexandra Township in Johannesburg why they engage in high-risk sex more than someone who lives in Sandton. All it may mean is that there may be issues associated to social marginalisation. Furthermore, it means that these social and structural issues may affect high-risk distribution.

CIRCUMSTANCES SHAPE COLLECTIVE RISK BEHAVIOUR
In addition to responding to messages, there must be a way in which people respond to circumstances. For instance, in South Africa the blood alcohol limit is 0.05 grams per mills and in Sweden it is 0.00 or very close to that. As South Africans, we are therefore collectively accepting the high risk of deaths; it is a group decision.

If we could understand those social mediators and triggers – both cognitive and circumstance driven – we could possibly be able to reshape risk. This is a dangerous argument, which could suggest that we don’t need structural change. Change to circumstance can only get us so far. We have to find ways to change inequality as we change response to circumstance.
Are there ways in which we can equip young people to respond differently?

That requires a change in society and the individual mindset. Some scientists in the US argue that the way to which society responds to risk is determined by two factors: the degree to which choice is limited in a society and where there is group solidarity, where it doesn’t exist there is a huge problem. This is very interesting because what it says is that we can start to map out where people or groups are. We need to ask how can we build social cohesion and build a model that considers all sociological factors that are risk tolerant. When we build the model, these are the questions that need to be asked.

1. How can we help young people expand their choices in life?
2. How can we find ways to build social cohesion and solidarity?
3. Can we build support systems for young people who are leaving school?

Motivation as opposed to cure messages is important. It is directional and future driven. Young people need to be given reasons to be optimistic about the future. Young people need to have long-term goals but we still have to address their issues in the mean time.

We have to focus on transitions and on school leaving, moving from one place to another creates uncertainty. We do find young people outside existing formal institutions; we’ve got to bridge those gaps. Because young people in those institutions are relatively protected, how do we create processes that follow them wherever they go?

We have got to create footholds on a serious note, which help young people move up or out. A network of those footholds is helpful to disseminate information and knowledge about HIV. These will create new links to communicating with young people. We have to move from only talking about educators and grow trendsetters and leaders from a youth side and empower them to be agents of change in risk behaviour.
Going beyond rational choice theories

PRESENTER: Mr Taylor Ahlgren
Curriculum and training manager: Grassroot Soccer, Cape Town

An evaluation we did in Zimbabwe is going to be helpful in understanding how young people appreciate practical knowledge. We’ve got interesting data from participants who had been with the programme two to five years before filling in a questionnaire in 2008.

We surveyed 246 youth (15-18 years) in Zimbabwe: 106 were past graduates and minimum age was 16. We were very surprised by the data we came back with on risky sexual behaviour. Graduates were six times less likely to report early sexual debut, four times less likely to report sexual activity in the last year and less likely to report to have had more than one sexual partner. Almost 14% of non-graduates reported having sexual activity in the last year, compared to 3.7% of graduates.

WHY THESE RESULTS?
There was no difference in knowledge among the comparison groups and the graduates. This supports previous research that knowledge about HIV transmission and prevention alone are not enough to change sexual behaviour. In a focus group discussion, coaches acknowledged that the relationships they formed with participants might have been as important, if not more important than the knowledge participants gained from the GRS programme. GRS has since developed a new curriculum that aims to build upon these coach-kid relationships to generate ‘deeper’ discussions about the behaviours that put individuals at risk of HIV infection. We also found that the graduates believed that they could avoid getting HIV/Aids.

Rational Choice Theory
Just to explain why youngsters make their choices and decisions are made through a rational process weighing up the costs against benefits. Costs would normally be if you don’t know your status, you get no treatment, you get sick, and you know you will die and benefits would be peace of mind, no worries of stigma and shame.
In South Africa 50% of adults have not tested, and there are many reasons for this reluctance. It is amazing how people frown upon testing – even though once you know what you have, you can work with it.

What rational choices influence our decisions and behaviours?
School and a caring adult relationship are very important. Environment influences the way that you make the decisions.

Theory behind Skillz: Positive role modeling:
Psychologists created this programme and they found that modelling positive behaviour is important. When young people have role models and caring adults they tend to be resilient and want to look after themselves.

Being part of and not a spectator in sport:
Young people are engaged in fun activities that are practical and with the use of soccer language, the coaches are only facilitators of participator-centred dialogues.

Community involvement:
We believe that it takes a village to educate a child. Sexual behaviour is influenced by many factors, therefore the education around sexual behaviour and HIV needs to involve peers, families and the community – all of whom need be committed to creating an enabling and supportive environment for young people.
The coach’s role:

Coaches are trained to be powerful role models for youngsters. The coach understands that the prevention of HIV infection is a priority, and they are encouraged to be that and impart their behaviour to young people. They use three pillars or tools to deal with HIV:

- Know your game
- Build your team
- Know your move

We are in partnership with loveLife in the Make YOUR Move programme to encourage resiliency in young people, so that they have the social support to make decisions, make the move and take action.

RED CARD PROGRAMME

The issuing of a Red Card in football is a universally known gesture, one that indicates that a player has committed an offence resulting in his ejection from the game.

AED Madagascar has initiated The Red Card Project – letting girls call the shots – and sparking conversation between parents and adolescents. We are still negotiating with them to replicate the programme and combine it with a media campaign around influencing peer social norms around HIV risk, especially when it comes to intergenerational sex.

Marketing campaign:

We will print more than five million red cards for men and girls to negotiate issues of sex and HIV. We will use soccer celebrities, such as Teko Modise, on a TV campaign, presenting a red card in a situation of HIV risk. We will also have a community outreach programme. We will have a 45-minute intervention targeted at enabling girls, through role modeling, to manage the issue of sugar daddies and dealing with self-efficacy to use the red card in situations where they might feel at risk. We also are aiming at empowering young men to initiate discussions.

Future:

We plan on taking the Red Card programme beyond South Africa’s borders – to the 2014 Fifa World Cup, and associate the Red Card with HIV prevention.
Risky settings associated with sexual risk among rural adolescents

PRESENTER: Ms Gillian Njika
Study Coordinator: Kemri/ITM

A ‘matanga’ is a Swahili name for a funeral, and today I will discuss funeral discos.

THE REALITY OF SUB-SAHARAN REGION
Adolescent sexual and reproductive health remains a major challenge in sub-Saharan Africa.
- Early sexual initiation, unsafe sexual behaviour: youth have the knowledge about HIV and Aids but they are still engaging in unsafe sexual behaviour.

WHAT WE SEEK TO DO:
Addressing these risk factors is a challenge that requires consideration of contextual facilitators such as community-based leaders and young people themselves.

HIV PREVALENCE IN KENYA BY PROVINCE:
We work in East Kenya in rural Nyanza, an area that has the highest HIV prevalence at 14.9%. We conducted a cross-sectional survey on sexual and reproductive health of youth in a small fishing community in Asembo between 2003 and 2004. The median age was 15 for boys and 16 for girls, and yet about 14% had initiated sex before the age of 13. One in 12 female adolescents between the ages of 15 and 17 was HIV positive, 33.7% of females 20-24 were HIV positive, only 10% males of the same age were HIV positive.

YOUTH INTERVENTION PROGRAMME
Our programme is information based, and its main objective is to intervene early in the lives of young people, with a three key levels approach. With the individual, we encourage healthy choices in two groups, 10-14 years old and those up to 17; we encourage families to educate their children. We teach communication skills in the community and we ensure that young people have youth-friendly services.

Targeted behaviours
- Delaying sexual debut;
- Knowing your HIV status;
- Reducing the number of partners;
- Condom use

Impact
We hope that with the behaviour change, the Youth Intervention Programme will decrease the number of unplanned pregnancies, STIs and HIV prevalence.

Strategy
Our programme strategy is very straightforward: to adapt effective/evidence-based interventions. We did a qualitative study and collected data from Focus Groups Discussions (FGD), from which we concluded:

Six with adolescents in school aged 10-15
Four with adolescents out of school aged 13-17
89 participants: 42 female, 47 male
Median age (years): 13 for males, 14 for females
Findings: Identified risk settings
Young people identified the following areas as risk environments: funerals, (where we have the ‘matangas’ or funeral discos, which is the focus of this presentation), and the night vigils at funerals where they keep the bereaved family company.

Other places where female adolescents find themselves alone:
- Fetching firewood or water
- Going to the market
- Walking home alone or being home alone

Funeral Discos
The funeral discos are generally organised to raise funds and to comfort the bereaved family. The family will pay for the DJ. Young people from the neighbourhood will normally patronise these discos. What happens is that, in the early evening the church choir will come in, and then there will be happy hour with people coming in to comfort the family. Later on, at around 9pm, boys and men who arrive pay an entrance fee; the girls enter for free.

As the music plays, and if a man wants to dance with a girl, he pays a fee to the DJ to play a particular song. If you want to dance with him, you will; it doesn’t have to be your boyfriend. If he doesn’t have money to request a song, you won’t dance with him and there is nothing he can do about it.

Here is what happens:
- There may be a live band or an established DJ or just recorded music playing
- They play local songs with sexual messages and connotations
- People dance in pairs, holding each other tight
- Because this is a rural area the lights are generally dim
- Popular among adolescents
- Parents generally take care of the guests in the house and these adolescents are left unsupervised

Transactional Sex at Matangas
Because everybody is minding their own business, a lot of transactional sex goes on among peers, never cross-generational.
- It starts when boys pay to dance with girls
- The girl has no right to refuse the boy’s sexual advance
- Ideal place to have sex with strangers and other casual partners
- Boys agree in advance to exchange sisters – they bring their siblings for another guy who will do the same with his own sister

Facilitators of Sexual Activity at Disco
- Sexual stimulation through dancing in pairs
- Peer and partner pressure
- Free alcohol and marijuana
- Initiation of smoking and taking alcohol
- Minimal parental/adult involvement
SEXUAL ACTIVITY TO AND FROM THE DISCO

There is a lot of forced sex that takes place on the way to and from the discos.

- Rape by one person or a gang (called a “combi”), is often planned in advance by boys to target specific girls
- Girls who have previously refused their advances are targeted
- Girls whom they paid to dance with but refused to give in to sex.

THE CHALLENGE – OUR PROGRAMME

There are so many funerals in this community, which means a lot of activities for young people. Adolescents and parents are aware of risks associated with funeral discos, but do not take action:

Adolescents:
- Risks not personalised – they think they are going out to have fun
- Few recreational opportunities available for adolescents
- Peer pressure to attend

Parents and community:
- Risks not personalised
- Its socially unacceptable not to attend
- It is difficult to ban discos because they are functional events in the community to raise funds

Lack of condom use:
- Unavailable at the funeral disco
- When under the influence of alcohol and marijuana, there is little time to think ‘condom’
- “Sex in the bush at night” is not conducive for condom use

ADDRESSING RISK SETTINGS

Individual level intervention – healthy choices:
- Homework assignments that help youth identify risky situations and settings such as funeral discos
- In our manual, we have role plays to avoid or to plan ahead of risk situations

We have a SWAT technique of:
- Say NO to unsafe sex
- Why
- Alternatives
- Talk it out

We also have an intervention for them to do the role play for handling peer pressure

At the family level: Families Matter! provides parents with skills to help their children:
- Plan ahead for what they can do if they find themselves in a risky situation (such as a funeral disco)
- We have a four-step plan to cope with peer pressure.

How parents can help their children to:
- Plan ahead
- Recognise signs of potential problems
Think ahead about what to say and do when confronted with a risky setting
Role play to help them deal with the challenge when it arises.

At the community level:
- Youth groups identify risk settings in their community
- Peer educators attend risk settings such as funeral discos
- Give out materials about Sexual and Reproductive Health (SRH)
- One-on-one or small group education and counselling
- Distribute condoms
- Refer to youth-friendly HIV prevention and care services

ULTIMATELY...
Disco matangas are important cultural events in western Kenya. This practice does, however, expose adolescents to sexual risk taking.
But, interventions can be useful in that they focus on risk settings and go beyond individual level risk factors. There is also a need to help parents and adolescents personalise the risk associated with these settings. As it is known that in Africa the whole community raises a child; it is recommended that parents and community leaders play an important role to make these settings safer.
Question 1: LERATO MAHOYI, loveLife
You referred to the SWAT technique. Is there an alternative to that, as it seems to be condoning the status quo?

Answer 1 (i): GILIAN NJIKA, Study Coordinator, Kemri/ITM, Kenya
SWAT is in the curriculum and we teach them to tell their partners or person they are with that they are okay with kissing, hugging and touching, but do not want to go all the way. Our programme also creates some recreational activities such as going to libraries so that they don’t see sex as an extramural activity. What we need to understand is that these young people have limited opportunities for entertainment, and we have to appreciate their socio-economic situation.

Answer 1 (ii): GUY surname, org country
This curriculum is for boys and girls i.e. we engage with both genders. For boys, we also make them understand what it means to force themselves on a girl and that it is not acceptable to have sex with a girl simply because you can.

Question 2: BRIAN KANDINEMO RIRUAKO, Chief Hosea kutako Youth Forum
The question is about the Red Cards, which are more to prevent sugar daddies, but not sugar mommies who date young men.

Answer 2 (i): TAYLOR AHLGREN, Grassroot Soccer
The Red Card doesn’t discriminate against sugar mommy or sugar daddy, but the trend is that there are more sugar daddies than mommies. We are focused on the high risk, and studies show that young women with sugar daddies are at higher risk. The sugar mommy statistics are hardly significant, only 1% of boys had had a partner. There is a huge difference in terms of numbers where girls have had sex with partners five or more years older than them and studies have shown the high risk in young people as a result of being with sugar daddies. The message of our campaign is to take the power into your own hands and to make intelligent decisions that will reduce the risk factor.

Answer 2 (ii): Dr DAVID HARRISON, Connected!, South Africa
The high-risk behaviour that exists actually happens between a teenage girl and a guy, who may be five years older, may be employed and may make a little bit of money. Her mom is okay with the fact that he is giving her daughter things that she cannot afford. They would normally have some casual sex. Mom would push her directly or indirectly to stay with the guy for socio-economic reasons. The case study of Kenya demonstrates the complexity of dealing with these high-risk behaviours. There are subtle economic pressures that are cultural – transactional sex is one of them.
Male circumcision and HIV prevention: from evidence to action in Eastern and Southern Africa

PRESENTER: Chiweni Chimbwete
Associate: MASAZI Development Associates, Malawi

What makes a circumcised penis better than an uncircumcised one in terms of preventing HIV and other STIs?

Biological evidence

Generally an uncircumcised penis has an inner part (inner mucosa), which is just like the inner part of your mouth. One study even says that the inner mucosa of foreskin is rich in HIV-target cells and therefore has a chance of a nine-fold increase in the uptake of HIV, and is prone to cuts because of its sensitivity. Imagine the cuts you endure in the mouth when the cut comes in contact with a foreign substance and the impact thereof? So, when a penis is covered by the outer part of the foreskin, which is normally harder, and can exert tears on the vulnerable softer inner part of the foreskin, especially during the friction of sex, it opens it to all sorts of vulnerabilities.

Ecological evidence

Studies conducted in 1989 about the relationship between HIV and male circumcision, found that countries that have high male circumcision, have lower rates of HIV. By 1999, there was a sense of frustration that this evidence had been shelved for ten years. A variation study was then done to investigate where countries with the highest rate of circumcision were sitting in terms of HIV prevalence. Where circumcision was below 20%, prevalence was higher. For instance, Zimbabwe's prevalence is 25.8% while Guinea, with a higher than 80% circumcision rate, is sitting at 2.1% prevalence.

What were the patterns?

When these different studies were pulled together the data showed that there was a consistent pattern as well as stronger protection among higher risk groups. For example, if a fire starts, do you look at the source or the smoke? You look at the cause of the fire, of course, which is why other researchers realised that there was a need to check if there might be other factors contributing to behavioural risks, such as cultural or religious.

This is what they found...

- Most countries with higher circumcision and lower HIV prevalence rate were West African and Muslim. Muslim religion is known to be conservative and that could be part of the reason.
- Some of the studies showed inconsistent degrees of protective benefit
- All these findings led to one conclusion: randomised trials among circumcised males were needed.

Randomised controlled trials

These trials were conducted in Orange Farm (semi-urban), South Africa, in 2005 (in males aged 18-24) and in 2007 in both Kisumu, Kenya (urban) age group 18-24 and in Rakai, Uganda (rural) 15-49.

Source: WHO/UNAIDS recommendations for policy and programming consultation

RESULTS

These studies, which are relatively new and were done as recently as within the last five years, independently felt that it was unethical to do them, so they were stopped midway. This was also
because it was found that there were other factors that may have contributed to the relationship between HIV prevention and circumcision.

- **How trials were done:** They would take uncircumcised males who were HIV negative, offer circumcision to one and not the other and delay circumcision in the other group. They would get a similar treatment but the differential was the circumcision.

- **Some results:** What was seen was reduction in risk rather than prevention. Some of those men, who were in the circumcision arm, were still infected. Then the question was asked whether it is acceptable for men to circumcise? It was found that in non-circumcising areas, even women encouraged the circumcision of their partners.

**REACTION TO TRIAL RESULTS**

There was generally an increased interest and support for roll-out of male circumcision for HIV prevention since the first trial results were out. Having been part of the WHO/UNAIDS and partners, we believe that we prioritise support to countries with low male circumcision and high HIV rates. This is what we do:

- Issue statements and information packs
- Hold country, regional and global consultation meetings
- Develop guidelines and support national policy
- Build capacity: training of service providers

**Recommendations**

Male circumcision is now an additional important intervention to reduce the risk of heterosexually-acquired HIV infection in men, as a part of a comprehensive HIV prevention package

- Considering that our health systems in most countries are weak, this will be used to help strengthen health services. Systems can be strengthened to increase access to safe male circumcision services
- That male circumcision is provided with full adherence to medical ethics, socio-cultural, human rights principles, as well as informed consent, confidentiality, and absence of coercion.

**CONCLUSION**

Whatever you do, remember that male circumcision is an addition to the existing interventions. We should not throw out others that are working but build on what we know about circumcision to date:

- Countries in the region have started to apply evidence of male circumcision protection for HIV
- Safe male circumcision is being introduced not as a cultural issue but for the prevention of HIV
- There is need to scale up services to meet demand guided by policy and action plans
- Guidance and technical support available from the UN and partners to help countries scale up male circumcision services to reduce HIV transmission
- Government leadership and ownership of male circumcision programming is important
- It's important that there is consultation with various groups: women, youth, people living with HIV
- Countries with high prevalence (more than 15% generalised heterosexual HIV epidemics) and low rates of male circumcision consider urgently scaling up access to male circumcision services
Focusing on self-worth and identity: loveLife communication

PRESENTER:  Ms Trina DasGupta
Media Director:  loveLife

Our communication with young people is evident in the numbers and effectiveness of the messaging. loveLife believes that this is a collaborative effort between us, you and communities.

We have peer educators to the tune of over 8700 by way of groundBREAKERs and Mpintshis as well as 500 gogos in the goGosetter programme. We are in 5600 schools and host 7600 events using the loveLife Games. We have 150 community partnerships and 500 government clinics.

With our direct face-to-face interaction, we reach about 500 000 youth per month. While we have used the media to drive the message, we are not convinced that it alone can be successful. We believe that marryng media with face-to-face interaction would be more effective in achieving desired results.

YOUNG PEOPLE GETTING THE MESSAGE
Young people have got the message. The issue is how they respond to their circumstances. That includes their outlook of day-to-day possibilities – social, educational, economic. What we find is that their context must change and so must their response. In terms of risk, there are three ways it can be reduced, with media fitting into the picture. These are:

- Personal initiative
- Means to negotiate day-to-day pressures and expectations
- Linking young people to new and creative job opportunities

LOVELIFE APPROACH
We have a triangular hierarchy model of reduction and tolerance. Young people have a need to feel connected to something, maybe a movement of sorts. Also, if allowed space to be creative and feel complete, they become receptive to knowledge.

Measuring these factors is a challenge, as they are cognitive. However, there are numerous models that can be used to measure behaviour change. One that I found effective is that of starting from the base. Young people need to be aware of the HIV message and also be equipped with the necessary knowledge. The process continues to a place where they internalise the message and then become motivated to act on it. So, loveLife’s strategy is to capitalise on internalisation and motivation.

YOUTH MAKING THEIR MOVE
Our campaign has always been driven by a can-do attitude. In order to make your move, you must believe that you can, but shifting someone’s mindset from an ‘I can’t’ attitude can be a challenge. No one can make young people do anything if they are not motivated by something. So we thought it important to address challenges of self-worth by coming up with a model of moving young people to a place of having initiative.

Challenge: When a youngster has no hope due to circumstances that may range from poverty to not going to school it becomes a challenge, and thereby increases chances of high-risk tolerance.

Opportunities: When young people anticipate possibilities, they become hopeful, but may, however,
experience roadblocks. For instance, when a young person would like to go where there are opportunities but cannot afford the transportation to get from A to B. That may pose a challenge but hope is something they can, at least, hold on to.

**Inspiration:** It is that SPARK – starting to believe in the possibility that things can change.

**Motivation:** It is the fire that inspires one to believe in oneself.

**Make YOUR Move:** Once you believe in possibilities that’s when you become motivated and that’s when you make the first move. Once you Make YOUR Move there could be new challenges that make you become focused on the way ahead.

**Success:** By the time you achieve your goal, you have developed a coping mechanism and have gone all the way up the ladder.

**HOW THE MEDIA FITS IN**
Who are we talking to? As this is a niche market, we need to talk to young people in general, mostly targeting informal settlements and rural areas. We also need to talk to parents, government, corporate and civil society, all of whom are supportive to young people. How do we do this? Using the media in a targeted manner can bring all the pieces together.

**loveLife MEDIA role:**
- The first thing we want to achieve is creating a larger-than-life brand to drive to programmes
- It also helps to complement programmes for purposes of unpacking specific issues
- Address society
- Provide youth a platform – young people have got loads of ideas that they are willing to share
- Advocate with and for youth
- To drive the programmes

**Media application:**
- **TV** – mostly ad campaigns
- **Radio programmes** – there are 20 community radio stations in the youth centres. Young people are trained to produce radio programmes and some of them have become producers of big shows in South Africa.
- **UNCUT** – in addition, we have our youth magazine, distributed to 500 000 youngsters, through schools and other print publications. It is used to unpack issues discussed in our campaigns and other media platforms
- **Outdoor** – a strategic decision was made in 2008 to pull billboards
- **MyMsta** – is cell phone technology with a global reach. It is designed to have an interactive effect among young people.
From peer education to youth leadership development

**PRESENTER:** Lauren Graham  
**Research and operations manager:** VOSES A

We looked at loveLife’s peer education programme in 2007/2008 and evaluated the groundBREAKER (gB) programme. We also did an evaluation in 2009, so we have come to know loveLife quite well. My presentation will concentrate on the highlights and high-level issues.

**What is the groundBREAKER programme?**
- A community service programme targeting 18 to 25 year olds who show commitment to volunteering in their communities
- Aim of programme to assist young people who display, commitment, leadership qualities and a willingness to be involved in their communities by developing their skills, networking opportunities and leadership potential through community-based voluntary service
- gBs intended to work as peer educators mentoring Mpintshis and other young people who participate in loveLife activities

**groundBREAKER activities**
groundBREAKERS are trained to run a range of activities at loveLife sites, including:
- HIV awareness
- Dance or drama classes
- Radio stations
- Cyber Ys
- Sports programmes
- Life skills training in schools
- Libraries and homework supports
- Environmental awareness programme

**Assessing the impact of the groundBREAKER programme**
In 2007/8 VOSES A conducted a study that aimed to assess the impact of gBs using a self-evaluation survey as a methodology with a representative sample drawn from the total number of gBs who had graduated from the programme between 2001 and 2005. We did not have baseline information to compare the data to, so we did two things: we collected national data on attitudes and such like; we also collected baseline data of similar programmes and drew comparisons.

**The study assessed the following areas:**
- Routes to the groundBREAKER programme
- Opportunities since the gB programme
- Reported impact of the gB programme on
  - Perceptions about life and the future
  - Ability to relate to others
  - Skills acquisition
  - Leadership development
  - Attitudes
  - Behaviour change
- Reported impact on the ability of gBs to influence young people
Introduction

Future prospects
- Nearly 50% of gB graduates now have some level of post-matriculation qualification, compared to only 8% who had such a qualification on entry into the programme.
- Approximately 60% of gB graduates are currently employed; this compares favourably to the national data which shows that 36% of youth with a Matric are employed.
- Unemployment levels among the groundBREAKER graduates (38%) are considerably lower than the national unemployment figures for youth in the same age group and at the same education level (46%).

Skills development
- The majority of participants stated that interaction skills (including public speaking, networking and facilitation) had been the most valuable skills learnt.
- Participants perceive the programme as particularly successful in its ability to develop their sense of confidence and expand their ability to engage social networks.

Citizenship and leadership
This is the area we tend to give special attention, as it is more about volunteering and community involvement. The following is what we found:
- That programme graduates show a commitment to volunteering and civic engagement.
- The findings show that the gB graduates hold positive attitudes towards volunteering and their responses suggest a commitment to responsible and engaged citizenship.
- Graduates display confidence in their own leadership ability, and two-thirds of respondents who are involved in community organisations hold leadership positions, indicating that their leadership abilities are recognised by others.

Stakeholder views on developing young leaders
“We have had some groundBREAKERs stop by. I have been impressed with them. I think they are very knowledgeable out there. They are leaders and role models.” – Eka Williams, Programme Officer, Reproductive Health and Sexuality, Ford Foundation

“There are some wonderful stories of ex-groundBREAKERs who have gone on to do amazing stuff in their communities and really added so much value and continue to do the work long after their contracts expire.” – Stakeholder in the HIV sector who wishes to remain anonymous

“They have been through quite a life-changing experience in terms of their groundBREAKER year and they have certainly shown potential in community leadership. If they are nurtured correctly, they will be the leadership of the future.” – Ms Jennifer Smith, Head of Corporate Social Investment, Barloworld

What does this mean for youth leadership and future priorities in HIV prevention?
A study on youth service (Morrow-Howell and Tang 2007:164) demonstrates that there is a range of positive outcomes for the servers including:
- Increased maturity and personal autonomy
- Become disciplined and reduce risk behaviour
- Promote social, ethnic and cultural interactions and awareness
- Improve understanding of self and community
- Practice and increase skills
- Explore career opportunities
Introduction

- Acquire human capital and educational awards
- Increase civic knowledge and value
- Bring change in civic attitudes and participation
- Increase the likelihood to vote

Building youth leadership
- It works when it is through service and skills development programmes that have positive youth development outcomes

How do these speak to HIV prevention?
- Building autonomy and sense of self as well as confidence may have impacts on how young people:
  - Negotiate sexual relationships
  - Negotiate condom use (especially for young girls)
  - Decide upon risk behaviour

Identity and HIV prevention
Decisions that young people make are tied to their sense of self. We need to be doing more research on how identity impacts on HIV prevention. We believe that loveLife has managed to push the envelope where HIV prevention is concerned. The campaign has to do more to encourage a positive sense of self and positive behaviour in relation to HIV.
Building on existing successes

From peer educator to societal leader – an overview of Connected!

Presenter: Dr David Harrison
CEO: Connected!

Our challenge as loveLife is trying to connect young people. The idea of Connected! is that we invested in a number of incredible young people; now we need to nurture them. We see them today still reaching the glass ceiling – they may be future leaders but they are not contributing to reshape society at this point. We have got to find a way to build them up so that the huge bubble starts creating a national profile, a national influence of young people who are committed to public service and who identify with the commitment to service.

LEADERSHIP WITH OPPORTUNITY FOR PUBLIC INNOVATION

The idea of Connected! is to take 5000 of these young leaders that have been through the loveLife programme and develop their analytical and problem-solving skills so that they can participate actively for change in their communities. We recognise that there are leadership training programmes that are for people who already have jobs, and they enjoy that benefit individually, but because they are not connected to opportunities for personal growth, this development can be a total waste. The critical part of this programme is to create opportunities for each of these 5000 young people in ways that creates purpose.

THE IDEA

SERVICE

It is important to recruit from the already existing group of leaders and connect them to each other; to develop their public profile so that they write in newspapers, they are being interviewed on television and radio; that they became known as the new identity of young people who are connected to public service.

INNOVATION

Ability to understand: They will be developed to have the ability to develop ideas and they understand how to use them with socio-economic and political suss. In addition, to have the capacity to problem solve. We are busy designing a programme that is going to draw from some of the biggest ideas that have crossed the face of the globe, which will be used to shape their arguments on why people behave in a particular way.

Ability to be effective: They will be trained to understand that personal finances and self-discipline are important, and that public speaking and people management skills are at the centre of effective results. They also need to go through project management training and receive some business skills.

Ability to use connections: They must have the ability to use connections for public good. The existing mentor programmes have one goal, to impart knowledge to youth, but most of them fail. We
think that mentors are most useful to create connections to bridge the gap between marginalised communities.

**OPPORTUNITY**

To ensure that these 5000 young people complete their schooling and are able to complete their tertiary studies. More critical is placing young people either in learnership or volunteer programmes. For instance, placing them with the South African Chamber of Commerce to ensure that even if they can’t get paid, they have enough money to be able to get to work. The purpose is to give young people a sense that they can be connected across economic divides.

**COMMITMENT**

All of them will be committed to the Make YOUR Move programme. We will try to identify around 100 of the best leaders per year and link them to academic and/or other technical training units, to give them more advanced skills on problem solving. We will then redirect them to focus on public sector problems in the country, be it dirty water resulting in a lot of children dying of diseases or whatever other issues are at hand, even at national level. This will be supported hopefully by political endorsements in time so that by the next election, there are a whole group of young people with the capacity to be able to hold politicians to account to the public good.

**THE OUTCOMES**

- To create a critical mass of young people across the country, to change the perception of opportunity for young people in marginalised communities. The process will be led by young people themselves.
- Hopefully with the 5000 young people, they will be able to drive the decline in risk tolerance, especially among school leavers.
- Creating a connection to economic opportunity of these 5000 people will hopefully open doors and expand to other youth previously excluded.
- Seek to improve service delivery in our communities.
- To hope that with the training they receive, they are trained activists that can hold people to account.

Connected! as a programme is not going to solve the problem of HIV in South Africa, but loveLife has to ensure that these 5000 young people, who are change agents, are able transform society. As we know for most revolutions to happen, you only need 20 people sitting in a coffee shop and in no time it catches on like wild fire. We need to make a move, to have a movement.
I am here to talk about how to develop partnerships that are creative and yet sustainable; that will have an impact at a low cost. I will share with you the programme that we are working on, and the collaborations thereof. I will share with you some basic ideas that we used and then discuss the way forward. I will also talk about how to engage the media.

**ENGAGING THE MEDIA**

- We are working with media in Botswana and Zambia, and teaming up with the University of Kentucky in the USA. We linked up with them because they have a new programme involving new media, which we have, too. What is interesting about this partnership is that these are all rural communities and therefore, it is difficult to get data. With this link, however, we are able to use technology, which makes life easier.
- Training workshops for journalists: basically, the aim is to improve reporting around HIV/AIDS. We found that we weren’t finding new ways of reporting on the stigma, for instance, as well as media fatigue of journalists, editors, and the general public. So, we challenged journalists to come up with innovative ways of reporting and they are now engaged in critiquing each other’s work to better report on HIV/AIDS.
- Publication of reports by Botswana journalists to inspire HIV/AIDS reporting
- NGO media workshop: dealing with the media and helping to improve HIV/AIDS reporting
- Documentary film on the experience of Botswana journalists reporting on HIV/AIDS
- Development of HIV/AIDS reporting toolkit – an innovative kit with an electronic gadget that loads up information. It is mobile and plays music while also allowing you to quickly fact check information about HIV/AIDS.
- Advertising workshops for journalists.
- Public Service Announcement (PSA) radio placement programme in Zambia. We are now touching people’s lives through this programme, which we do in Zambia. It helps people change their hearts and attitudes.

**WHAT THESE PARTNERSHIPS ACHIEVED**

We were responding to the realisation that the media didn’t know anything about each other or the communities they report on. They were brought together with NGOs in workshops to champion the project. The media showed interest in championing the issues NGOs are dealing with, and a desire to share the information about HIV/AIDS. So, in the workshop, the NGOs gained knowledge and skills, to assist them in dealing with the media, which engaged with the community on specific issues. A very interesting element that came out of the partnership was an understanding that the HIV story is a human story.

**HEART AND MINDS CAMPAIGNS**

People do have the knowledge and they want to treat each other well. We felt that it was best to keep this campaign simple, so we targeted the biggest convention, Africa Conference of journalists at the
University of Grahamstown. T-shirts and soccer balls were given out as part of our branding, which was very simple but effective. There was also a free offer by some musicians to compose a song for the campaign, which is currently used to drive it.

**The following was launched:**
- Debut of video documentary
- HIV/AIDS reporting workshop conducted by partners
- HIV/AIDS Reporting Toolkit distributed
- 350 attendees signed up for the campaign

**HEARTS AND MINDS COMMUNITIES**
We have a community journalism outreach programme called Mafoko Matlhong in Botswana. The country is heavily regulated, which leaves very little option for community broadcast. To deal with that, we have formed a relationship with the Ministry of Local Affairs to allow us to access the community for discussions on HIV/AIDS issues, which are documented and recorded.

- Community radio training in Zambia – there are two large community radio stations in the country.
- Hearts and Minds campaign roll-out in Botswana (Kasane) and Zambia (Lusaka) on November, 2009
- We will launch a website, www.heartsandminds.info, and a Facebook page
- Media Monitoring Training and implementation
- Follow-up training based on monitoring results for journalists, NGOs, editors.

**SCHOOLS AND COMMUNITY INITIATIVES**
- Multi-pronged intervention approach for Kenyan schools – we work with the Catholic church in Kenya but we have also partnered with US artists who are using rap to address the Aids issue, which makes it a more interesting for young people.
- "Making Life's Responsible Choices": School-based abstinence and behaviour-change curriculum.
- Build on HIV-prevention framework of MOE National AIDS Education Syllabus.
- Incorporated messages with traditional religious and African values.
- Delivered in 800 schools, trained over 1500 teachers, and 180 000 pupils participated.
- Identified need to increase family involvement in abstinence and behaviour change.
- "Families Matter!" programme for parents of students participating in school-based programme. Pilot initiated in Machakos Diocese with plans to expand.
- We are also working with radio, creating programmes and messages delivered on Radio Waumini.

**WHAT MAKES PARTNERSHIPS EFFECTIVE?**
Institution-to-institution partnerships, peer-to-peer relationships:

"It has reinforced that peers can often be the best providers not just based on technology or content, but also due to the affinity almost automatically shared by someone in the same position or with similar challenges and responsibilities in the real world as opposed to the drop-in consultant world." – International Twinning and Technical Assistance Projects (NASTAD)

**IMPORTANT**
- When partnering, you want to work with an organisation with the same frame of reference with whom you can make an impact.
- You can also engage in Africa-to-Africa partnerships or exchange information with partners in other countries overseas.
- Working with contacts you meet in workshops outside of the convention.
- Voluntary contributions and leveraging of human and institutional resources: If you do not own
a media company, partner with those people. The partnerships should not be driven by financial gain only, but also professional exchange which contributes to the organisation.

- Non-prescriptive, but rigorous approach to process: You may have people whose salaries are paid, for instance, by universities to help you conduct research.
- Demand driven with significant recipient investment and ownership.

**TIPS**

- **Select effective partners** – there is no point partnering with people ‘just because’. The partnership has to work for all parties involved.
- **Build upon solid foundations** – keep in contact.
- **Cross lines** – you can do something with different partners
- **Do something** – make a splash, then do more – start something that can be beneficial in the long term.
- **Take your time** – it takes time to build relationships; give yourself some time to do it. Do something that resonates with you.
- **Use the calendar** – use the calendar to identify events where you can collaborate with people/organisations. Know your calendar backwards and check out collaborative opportunities.
- **Own it** – Just own it.

**THE PROCESS**

**Identify the need:** Where can the partnership approach help achieve national and PEPFAR goals for target areas and/or institutions?

**Identify the partners:** What local organisation needs technical assistance and what organisation possesses the expertise to help?

**Conduct initial assessment visit:** Partners meet in host countries, begin to build working relationships, conduct site visits, and prepare organisational and needs assessments.

**Exchanges and work plan development:** Host partner visits the donor partner’s institution and community to learn appropriate and new approaches and technologies. Partners jointly develop a work plan in keeping with COP goals and objectives, ensuring maximum coordination with local stakeholders and other implementing organisations.

**Ongoing development:** Based on work plan, partners set a timeline and work together to meet objectives, goals, and targets.

**THE WAY FORWARD**

- Share new programmes ideas. Stop working in silos.
- Twinning for Health is very important for us since we are in this industry.
- Twinning Resources Tab. We define brands and identify opportunities.
- We also have other tools that we are using such as grants and funding databases as well as workplan development. We also implement activities using a monitoring and evaluation toolkit.
- Go to our website: www.TwinningAgainstAIDS.org

Go to our website: www.TwinningAgainstAIDS.org
H.

Group discussions, report backs and action plans

GROUP 1: TARGETING
FACILITATORS: Dr Sarah Kirby (loveLife) and Gillian Adhiambo Njika (KEMRI / ITM)

Our group thought that it was important to simultaneously target young people who are most at risk and those who are infecting them. We needed to identify both the at-risk and the infector(s) groups as a point of departure so as to come up with responses.

At risk:
- 18 to 21-year-old women in informal settlements
- Orphans or children from single households
- Young people who engage in transactional sex
- Young people in prisons
- Engaged or married women
- Young people with disabilities

Infector(s): Are very hard to identify because you need to establish who they are having sex with. Often it would be mature men, sugar daddies who are having sex with the young and the vulnerable; and having multiple concurrent sexual partners.

STRATEGIES:

1. Targeted response for strategies that address multiple concurrent sexual partnerships (MCPs):
   - MCPs among same age youth
   - MCPs among those with a 5 or more year age disparity.


3. Target a response to factors that are sustaining stigma around disclosure
   - Address rights and responsibilities
   - Address fear head on
   - Maintain the sanctity of personal choice.
GROUP 2: CONNECTIONS AND OPPORTUNITY
FACILITATORS: David Harrison (Connected!) AND Zoliwe Zikhona Cutalele (loveLife)

We felt that we needed to approach connections at different levels:
1. Connecting with people
2. Links to educational opportunity
3. Hook up with economic opportunities

1. Connecting with people
   - There is a need to establish adult mentor connectors
   - Connect with support groups
   - Establish alumni networks – both local and national
   - Strengthen networks of intervention participants, including post intervention such as families and parents
   - Link to corporate loyalty cards similar to incentive club participation.

2. Links to educational opportunity
   - Identify scholarships linked to community service
   - Access career guidance at school
   - Creating links to educational opportunities – use MYMSTA and alumni.

3. Hook up with economic opportunities
   - Alumni network is very important in this instance
   - Volunteer placement and job shadowing – funds are needed to facilitate this part
   - Identify entrepreneurship opportunities as well as securing grants for business proposals and mentorships
   - Job opportunities within loveLife

We believe that South Africa needs to offer an enabling environment. For instance, to offer tax concessions to companies that offer jobs to school leavers.
GROUP 3: TRANSITIONS

FACILITATORS: Grace Matlhape (loveLife) and Lerato Mahoyi (loveLife)

We noted that transition comes in shapes and sizes. While some young people are transitioning to go to tertiary institutions, others may be moving into the corporate world, yet others may just be dropping out of school. Any form of transition is a period of uncertainty. This means responding to different groups’ needs with a one-size-fits-all approach. We need structured programmes and interventions for different groups of youth.

There are a number of interventions that may cut across the board:

General
- Volunteerism: Having young people participating in non-government organisations, so they can acquire skills, with incentives of course – we need to give them an allowance.
- Convoying system: This keeps young people in the system. As they venture out to greener pastures, they need to return to share their stories (at their old school, organisation, etc.) and so it rotates.
- Job shadowing: Important to determine whether they really are passionate about the line of work they want to pursue.
- Parental involvement: For those kids who have no immediate parents, a surrogate parent system can be introduced. Every youth should have an adult who cares in their life.
- Career guidance: Essential at a very early age while still in school.

Drop-out focus
- Face-to-face intervention
- Second chance programmes.

Highly mobile communities (geographical transition):
- When a young person moves from a rural to urban area, they should be welcomed with some form of orientation programme to alleviate depression, culture shock and difficulty to settle in. A structured programme would be ideal.

Social mobility
- When someone transitions from a less affluent background to a slightly better economic background, they get more responsibilities and sometimes it can be a challenge to handle the newly found lifestyle. There is a need for a structured social mobility programme.
Any country that does not invest in its youth leadership programme doesn’t think ahead. It is therefore important to mainstream learning inside and outside of the classroom. Involve young males in particular and use creativity to engage these young leaders.

**Identifying leaders**
Leaders are everywhere – in the streets, schools, churches, in communities etc. There are many ways they can be identified, by asking around in communities. Finding those who are already in leadership positions – prefects, youth club leaders, etc.; going to unlikely places – in rural areas, for example.

**Developing leadership**

*Philosophy: “Your country needs your dream”*

- Trust the youth
- Treat them as leaders – give them responsibilities
- Adult support – mentor young people
- Empower them
- Encourage vision
- Develop weekend leadership camps
- Give recognition to the young people.

**Sustained leadership development**

- Link young people to career opportunities through exposing them to career expos
- Train, train, train
- Teach coping skills
- Link up with institutions to get access to leaders so they understand leadership at a different level.

**Strategy**

Involve young people in all stages of the programme – from designing the programme to the fundraising strategy. The more they feel they own the venture, the better participation there will be.

**ACTION PLANS: WORKABLE INTERVENTIONS FOR IN SCHOOL AND OUT OF SCHOOL YOUTH**

**1. ACTION PLAN FOR IN-SCHOOL YOUTH**

- Identify partnership opportunities: Use all existing partnerships effectively or even extend beyond the confines of those already existing relations.
- Country specific: When dealing with young people in different regions of the continent, we need to share best practices and adopt tools to country specific situations.
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2. ACTION PLAN FOR OUT-OF-SCHOOL YOUTH

- Need to better understand this group.
- Need to have structured programmes targeting this group.
- Develop SADC programmes – volunteer exchange.
- Host a YOUTH CONFERENCE to touch base with youths who are in programmes, let them facilitate, do the discussions and plan for the future.
- Partner with government regarding initiating training programmes.
- Have structured programmes around transitions.
- Structure cross training programmes with a SADC-based standard curriculum.

Exchange knowledge

Around big events – partner with big events such as the World Cup.

Develop programmes – with young people in schools rather than for them.

Government – engage government to create youth-friendly schools to ensure that more and more youth remain in school.
### Glossary of acronyms

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<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>AIDS:</td>
<td>Acquired immune deficiency syndrome</td>
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<tr>
<td>ASRH:</td>
<td>Born Free Dialogue</td>
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<td>BFD:</td>
<td>East African Community</td>
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<td>COP:</td>
<td>Female genital circumcision</td>
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<td>EAC:</td>
<td>Focus group discussions</td>
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<td>FGC:</td>
<td>Female genital mutilation</td>
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<td>gB:</td>
<td>groundBREAKER</td>
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<td>GRS:</td>
<td>Human immunodeficiency virus</td>
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<td>HIV:</td>
<td>Human Sciences and Research Council</td>
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<td>ICW:</td>
<td>International Community of Women Living with AIDS and HIV</td>
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<td>IDU:</td>
<td>Injecting drug use</td>
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<td>LO:</td>
<td>Life orientation</td>
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<td>MCP:</td>
<td>Multiple Concurrent Partnership</td>
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<td>MTCT:</td>
<td>Mother to child transmission</td>
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<td>NAFCI:</td>
<td>National Adolescent Friendly Clinic Initiative</td>
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<tr>
<td>NGO:</td>
<td>Non-governmental Organisation</td>
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<td>NSP:</td>
<td>National Strategic Plan</td>
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<td>OVC:</td>
<td>Orphaned and Vulnerable Children</td>
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<td>PEP:</td>
<td>Post-exposure prophylaxis</td>
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<td>PEPFAR:</td>
<td>People living with HIV/AIDS</td>
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<td>PLWHA:</td>
<td>Poverty Reduction Strategy Papers</td>
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<td>SADC:</td>
<td>Southern African Development Community</td>
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<td>SBCC</td>
<td>Sexual and Reproductive Health</td>
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<td>STI:</td>
<td>Sexually Transmitted Infection</td>
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<td>TLC:</td>
<td>Termination of Pregnancy</td>
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<td>TOP:</td>
<td>Voluntary Counselling and Testing</td>
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<td>VCT:</td>
<td>Volunteer and Service Enquiry Southern Africa</td>
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<td>YAC:</td>
<td>Youth Against Crime</td>
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<td>YFS:</td>
<td>Youth-Friendly Services</td>
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