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Phase II Assignments

Assignment Nr. 5

Course Title

**HIV/AIDS and Education: The Hidden Threat to Human
Development**

**ATLANTIC INTERNATIONAL UNIVERSITY
2006**

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1. INTRODUCTION

The purpose of this Assignment is to show the level of the impact of HIV/AIDS in Mozambique in General and in the two abovementioned districts (Morrumbene and Maxixe) in particular. I will explore the perception of different stakeholders, such as, community leaders, traditional healers, teachers, health services providers, Community Based Organizations, Faith Based Organizations and other people and institutions of greater influence in the two districts.

Health as an economic resource

Health is an economic resource like knowledge or machinery. If a society invests in the physical and mental health of its people, it is likely to have a financial pay off (Dr. Alberto Setele, Reverend Bishop of Inhambane Diocese, 2008).

Agricultural, Industrial and commercial production will be efficient with healthy workforce than with an unhealthy one. Studies show that working below par, or having time for sickness are major costs in production. Preventive health is considerably cheaper than curative health (Ministry of Health Annual Report, 2006); therefore, preventive health strategies are excellent social investment strategies.

The issue of investment in health

The issue of investment is complicated when it applies to social goals such as education and health. For states like Mozambique that have to survive in the global market, and therefore to continually structurally adjust their economy, reduction of spending of health is an obvious strategy.

This is done by:

- ✓ Simply cutting health budgets;
- ✓ Efficiency measures such as cutting expenditures on expensive drugs in favor of simpler and cheaper drugs, or
- ✓ Cost recovery methods, such as persuading people to invest in their own health through healthy diets and exercise or, where possible, paying for private medical treatment.

In this way, however, socially disadvantaged groups are deprived of resources that might be made available to them if health care were under public control. In other words, like all resources (consumer, goods, property, money, education), health is stratified by the market and usually needs the state's intervention in the market to distribute health resources equitably.

Structural adjustment and health

Because of global market strategies, debt and structural adjustment, it has become increasingly difficult for the Government of Mozambique to intervene in the health matters especially in rural communities. As a result, NGOs in Mozambique have filled more of the gaps than they used to. GOAL MOZAMBIQUE is one of de NGOs working in Morrumbene and Maxixe specifically in the area of HIV/AIDS. For the purpose of this work, I have

conducted many interviews in collaboration with this NGO, through direct involvement of its activists and Peer Educators trained as sensitizers on HIV/AIDS programs in Inhambane Province.

The objective of the programs carried out by GOAL MOZAMBIQUE in the communities is to slow the spread of HIV/AIDS and mitigate its impact of those infected and affected by reducing HIV infection among young people aged 10 to 24 years and mobile populations in the two districts (Morrumbene and Maxixe) chosen as pilot districts. GOAL MOZAMBIQUE is strengthening existing health systems and is making them more young-friendly and accessible to women. During my work as a PROJECT SENIOR OFFICER in that Organization I have learnt a lot and have used these lessons to strengthen the quality of HIV Prevention Care and Support by privileging direct contact with Groups of People Living with HIV/AIDS in these communities during the phase of data collection for my Final Thesis.

DESCRIPTION

2. AIDS AND ITS IMPACT IN THE RURAL COMMUNITIES OF MAXIXE AND MORRUMBENE – INHAMBANE PROVINCE MOZAMBIQUE

The under mentioned data information have been collected from the following Government and Non-Government Institutions:

- Provincial Hospital of Inhambane
- Provincial Delegation of the RCM (Red Cross of Mozambique) - Inhambane
- Provincial Nucleus of the Combat and Prevention of HIV/AIDS – Inhambane
- District Directorate of Health Morrumbene
- District Directorate of Health – Maxixe
- Forum of Youth in Morrumbene
- Catholic Church in Maxixe
- League of Youth of Morrumbene
- League of Women in Maxixe.

2.1. HIV/AIDS ON EDUCATION: THE HIDDEN THREAT TO HUMAN DEVELOPMENT

2.1. The true scale of the threat

Education plays a fundamental role in broadening people's choices. Educated people are more likely to invest their knowledge effectively and efficiently in creating conditions for leading a long and healthy life, free from want. They are better placed to use their rights and to carry out fully and consciously their duties as members of a community.

The return of peace and economic recovery in Mozambique, together with improvements in access to education, as a result of investments in rebuilding the school network, allow Mozambicans once more to look upon the future with some optimism, particularly as regards broadened opportunities for access to education.

However, the rebirth of hope among Mozambicans unfortunately coincides with a new challenge, with the ingredients of a new curse: **the HIV/AIDS epidemic**, which threatens to overturn all the efforts and resources spent over the last fourteen years of peace in the education sector.

2.2. The characteristics of the pandemic

The fragility of the available data to some extent limits the scope of any assessment of complex phenomenon such as the **impact of the HIV/AIDS pandemic**.

But analysing the impact of HIV/AIDS in Mozambique requires a brief review of the situation of the epidemic in the country, in order to situate better the context in which this analysis unfolds. The challenges presented by the tragedy of HIV/AIDS are not confined merely to Mozambique; long before frightening statistics began to make

headlines in the national press, other countries in the region, under conditions of peace, were already feeling the damaging effects of the so called “plague of the 20th Century”.

Since HIV/AIDS is a global problem, and considering the scarcity of domestic data, comparison with other countries provides a basis for a better understanding of the nature of the emergency, and to impacts of the epidemic.

In Mozambique there is a tendency to view the HIV/AIDS epidemic as less serious than that facing the neighbouring countries. Unfortunately this is not the case. Despite the fragility of the data, arising from the methods and the small number of sentinel sites, the available estimates indicate that the levels of infection in Mozambique are, at best, only a few years behind the most severely affected countries in the region.

By the end of 2000, about 40 million people in sub-Saharan Africa were carriers of HIV/AIDS. A substantial part of this population of HIV-positive people were living in countries located near Mozambique, such as Botswana, Swaziland, Namibia and Zimbabwe, which have prevalence rates among the adult population of 20% or more – the highest rates in the world.

Three of these countries have extensive borders with Mozambique, and it would be pretentious to imagine that the country can maintain its position as a relative oasis for a long time. At worst, 2000 seroprevalence data could point to a maturing epidemic on a par with neighbouring countries. The following table compares the HIV/AIDS situation with that of other countries in Southern and eastern Africa:

Table 1 (please turn to next the Page)

Table 1. Comparative data on HIV/AIDS prevalence and impact

Country	Number of people with HIV/AIDS in 1999			Deaths	Orphans
	Rates of prevalence among adults (%)	Number of people infected (15-49 years)	Number of children infected (0-14 years)	Deaths caused by AIDS	Number of AIDS orphans
Botswana	35.8	280.000	10.000	24.000	66.000
Burundi	11.32	340.000	19.000	39.000	230.000
Ethiopia	10.63	2.900.000	150.000	280.000	1.200.000
Kenya	13.95	2.000.000	78.000	180.000	730.000
Lesotho	23.57	240.000	8.200	16.000	35.000
Malawi	15.96	760.000	40.000	70.000	390.000
Moçambique*	15.4	1.173.878	93.969	83.648	257.981
Namibia	19.54	150.000	6.600	18.000	67.000
Rwanda	11.21	370.000	22.000	40.000	270.000
South Africa	19.94	4.100.000	95.000	250.000	420.000
Swaziland	25.25	120.000	3.800	7.100	12.000
Tanzania	8.09	1.200.000	59.000	140.000	1.100.000
Uganda	8.30	770.000	53.000	110.000	1.700.000
Zambia	19.95	830.000	40.000	99.000	650.000
Zimbabwe	25.03	1.400.000	56.000	160.000	900.000
Total over 15 years old	13.95	16.560.000	692.600	1.531.100	8.080.000
Sub-Saharan Africa	8.57	23.400.000	1.000.000	2.200.000	12.100.000
Global Total	1.07	33.000.000	1.300.000	2.800.000	13.200.000

Source: UNAIDS (2000). HIV/AIDS and Education, Africa Development Forum

* MISAU/MPF/UEM, 2000 Impacto Demografico de HIV em Moçambique, Maputo

Legend: MISAU – Ministry of Health; MPF – Ministry of Plan and Finance;

UEM - University “Eduardo Mondlane”

As table 1 shows, the prevalence rate among adults in Mozambique is somewhat lower than the regional average, but much higher than the average for Sub-Saharan Africa, and about 14 times higher than the world seroprevalence average.

In the 16 years since the first case was diagnosed in 1986, cases of HIV/AIDS in Mozambique have risen at gallop. It is estimated that 1.5 million people in

Mozambique are HIV positive, with an incident in 1999 of about 15.4% for the adult population (those aged between 15 and 49). According to some estimates, everyday there are 700 new infections. The number of people who have already died from AIDS-related illness is estimated at over 100.000, and projections indicate that the cumulative number of deaths will rise rapidly, reaching 1.6 million in 2010.

Prevalence among women is, on average, 1.6% higher than among men, meaning that women are 10.4% more likely to be HIV-positive than men. The age gap among women is particularly worrying. For the year 2000, for example, 35.4% of new HIV infections among women occurred in women under the age of 30, compared to only 13.2% for men. The inference is obvious: women are being infected at a younger age, and are therefore dying at a younger age.

There are major regional differences in HIV prevalence, resulting from the differentiated evolution between the regions (Southern region, Central region and Northern region).

Prevalence is highest in the central provinces of Zambezia, Sofala, Manica and Tete, with an estimated prevalence rate of 20.7% in 2000, compared with 13% in the north (Cabo Delgado, Niassa, Nampula) and 11% in the South (Maputo, Gaza, Inhambane).

This suggests that, in a first phase, the epidemic will have differentiated impact on the various regions, even after it has stabilised. In the central region it is forecast that prevalence will level off at 21.4%, compared to 14.3% in the south and 14.4% in the north, as shown in table 2.

The reasons for assuming that the epidemic will begin levelling off in 2004 are yet clear. This is particularly relevant if we take into account the limitations of the statistics and of the models that are described in the table 1. Furthermore, given the experience of neighbouring countries, this assumption that Mozambique will achieve early stabilisation may be overly optimistic.

Table 2: HIV/AIDS prevalence between 15-49 years

Year	National (%)	Region		
		South (%)	Centre (%)	North (%)
1999	15.4	11.0	20.3	13.0
2000	16.0	12.0	20.7	13.6
2001	16.4	12.8	20.9	13.9
2002	16.7	13.3	21.1	14.1
2003	16.8	13.7	21.2	14.2
2004	17.0	13.9	21.3	14.3
2005	17.0	14.1	21.3	14.3
2006	17.1	14.2	21.4	14.4
2007	17.1	14.2	21.4	14.4
2008	17.1	14.3	21.4	14.4
2009	17.1	14.3	21.4	14.4
2010	17.1	14.3	21.4	14.4

Source: "HIV/SIDA em Moçambique" INE, MISAU, MBF, UEM

Legend: INE – Instituto Nacional de Estatística;

3. An unsustainable burden

One of the specificities of the HIV/AIDS epidemic is that it not only robs the country of many of its most productive individuals, but also imposes many burdens on society. One of these heavy burdens is the sharp increase in the number of orphans. In the 2000, there were about 500.000 orphans in Mozambique; in two-thirds of these cases their parents had died of AIDS. This means that in a scenario without AIDS only 162.000 children would be orphans.

Projections from the National Statistics Institute and from the Health Ministry (2000) show that the worst is still to come.

By the year 2010 there will be about 1.4 million orphans, and in 80% of cases their parents will have died of AIDS. In other words, in addition to a figure of some 280.000 orphans in a scenario without HIV/AIDS, the country will have to establish the conditions to deal with the special needs of a further 1.1 million AIDS orphans – that is four times more (Annual report from the Council of HIV/AIDS, Maputo, 2004).

Table 3: Number of orphans by region, 2000-2010

Year	South		Centre		North		National	
	AIDS	Other Causes	AIDS	Other Causes	AIDS	Other Causes	AIDS	Other Causes
2000	33,034	37,022	229,794	66,855	78,603	58,532	341,431	162,408
2001	47,197	36,934	282,180	71,824	104,298	60,121	433,675	168,878
2002	63,707	36,956	333,417	76,732	131,339	68,048	528,463	181,736
2003	82,153	37,353	382,665	83,314	158,781	75,124	623,599	195,791
2004	101,916	37,935	429,153	89,628	185,774	81,503	716,843	209,066
2005	122,062	38,422	470,402	99,941	210,827	86,640	803,291	225,003
2006	141,994	38,991	506,947	109,267	233,683	91,286	882,574	239,539
2007	161,086	39,445	539,447	116,784	254,421	95,042	954,954	251,271
2008	179,146	41,564	568,003	132,543	272,963	105,292	1,020,112	279,400
2009	196,006	41,988	593,870	139,552	289,819	109,057	1,079,695	290,598
2010	211,580	41,479	617,403	141,250	305,186	109,368	1,134,169	292,097

Source: INE/ Ministry of Health, 2000

3.1. How does HIV/AIDS affect human development?

Life expectancy in Mozambique, estimated at 43.5 years in 1999, is among the lowest in the world. The 1998 Regional Human Development Report (RHDR) estimated that life expectancy in the other 13 member countries of the Southern African Development Community (SADC) in 1995 varied between 72 years in the Seychelles and, at the other extreme, 41 years in Malawi (UNDP-SADC-SARIPS, 1998).

Life expectancy at birth is one of the main indicators used to measure the well being of a population, and is one of the three variables used to determine a country's Human Development Index, alongside per capita income and educational level. HIV/AIDS

attacks all three indicators directly or indirectly. Life expectancy in Mozambique is declining and within ten years it could be cut by a third because of HIV/AIDS.

3.2. Impact of the pandemic

HIV/AIDS results in the demographic, social and economic changes in society, changes that affect the education sector. These include impact in the demand for education, specially enrolment trends, school attendance, drop out and repetition rates, and the growth in number of orphaned children. HIV/AIDS specially affects the education sector in the following ways:

- It has an impact on the demands for education pupils;
- It has an impact on the supply of educators (teachers, administrators and policy makers);
- It has an impact on the quality of education;
- It has implications for costs of the education sector, with rising, and the efficiency of expenditure falling;
- It has an impact on income.

3.3. Impact on the demand for education

For the purpose of this study, demand for education is measured as the number of children likely to seek education over the period 2000-2010. In the Mozambican context this has been measured by determining the number of children within a specific age group likely to be in school.

The age group used conform to those actually in school, and not those who are the correct age for school, since many pupils in Mozambique are, in theory, too old for the grades they are attending due to the repetition rates, late enrolment and other factors. These percentages were then applied to the population projections in the demographic model for the “without AIDS” scenarios. The numbers in school were progressively increased over the projection period, based on the average growth in that particular level of the Mozambican education system over the past eleven years.

There are at present some 2.6 million children in the Mozambican education system. The vast majority (87.9%) of these are in EP1 (the first level of primary school). While the number of children in EP1 will continue to increase, even in the face of the AIDS epidemic, the rate of increase will decline. This results from fewer children being born as a result of the HIV/AIDS epidemic, while those are born already infected with HIV die before they enter school. By 2010 it is estimated that there will be 13% fewer children in EP1 than would be case without AIDS.

While the EP1 projections indicate a decline in the rate of increase in demand for education at this level (that is, demand will flatten), this does not imply that EP1 access objectives outlined in the Education Sector Strategic Plan will be threatened. The reason is that the system has expanded over rapidly over the past five years. Gross enrolment was close to 90% in 2000, which is the 2002 objective. However, as the epidemic progress and the demographic structure of the population changes, this strategic planning objectives relating to access will be threatened.

In Mozambique, where many children are out in school, the understanding of the impact of HIV/AIDS on enrolment is complex. The assumption is the lack of space at EP1 is not the main reason for the non-attendance. Other, more qualitative, economic, social and cultural factors are involved.

Table 4: Evolution of the gross enrolment rate in EP1 by Province and gender (%), 1997-2000).

Province	1997			1998			1999			2000		
	MW	M	W									
C. Delgado	91.1	105.5	76.8	99.2	112.8	85.7	103.7	114.8	92.9	134.7	149.1	120.5
Gaza	96.4	99.2	93.8	106.9	109.2	104.6	116.4	118.0	114.8	118.3	118.4	118.2
Inhambane	94.9	98.8	91.1	98.3	101.1	95.5	110.7	112.7	108.7	116.6	119.4	113.2
Manica	83.5	98.1	69.1	84.6	95.9	73.5	96.7	109.1	84.3	105.7	116.7	94.7
Maputo	108.1	11.5	104.8	101.1	103.1	92.2	112.8	113.7	111.9	121.9	119.8	124.1
Nampula	85.1	99.5	70.5	80.9	91.3	70.3	92.6	101.2	83.9	100.8	108.3	93.3
Sofala	97.6	110.9	84.2	105.2	115.6	94.7	97.2	104.2	90.3	115.0	124.1	105.9
Tete	65.9	81.1	50.8	70.6	86.1	55.0	93.9	109.1	78.7	99.4	112.1	86.6
Zambezia	77.0	85.7	68.4	92.2	100.6	83.8	94.6	129.1	86.9	102.9	109.1	96.7
Maputo City	90.8	104.7	76.8	88.4	100.2	76.5	115.2	102.2	101.1	125.6	137.1	114.0
Total	73.0	74.5	71.5	80.1	81.6	78.7	92.0	91.2	92.9	106.3	104.6	108.0
Total	86.9	98.1	75.7	89.4	98.8	79.9	102.5	111.3	93.6	113.3	121.2	105.4

M – Men; MW – Men and Women; W – Women.

Source: Ministry of Education, 2000

3.4. Impact in income

The impact of the epidemic on the economy has not yet been duly qualified in Mozambique. But preliminary estimates indicate that the aggregate value of Gross Domestic Product (GDP) could be 8-10% lower than the level it would have attained had the epidemic not occurred. This affects another component, income, in a country which, despite the improved performance in recent years, has one of the lowest per capita GDPs in the world.

Estimating the impact of the pandemic on the economy is also based on examples from other countries which faced HIV/AIDS earlier. For instance, it is estimated that the epidemic cost Namibia about 8% of its GNP in 1996. GDP growth in South Africa is forecast to be, on average, 0.3 to 0.4 percentage points below what it would have reached in a scenario without HIV/AIDS during the next decade (Quatteck, 2000). In Kenya, it is estimated that by 2008 the GNP will be 14.5% smaller than if there had been no AIDS (ONAP, 1999).

Overall economic growth has fallen drastically not only in countries with high levels of intensive use of labour in exporting industries (such as Swaziland, Tanzania and Kenya), but also in countries that are highly capital intensive in their exporting industries. Botswana is an eloquent example of this phenomenon.

The diversion of resources to finance medical care, together with the expenditure on combating opportunistic infections in HIV-positive people, as well as reduced opportunities for access to education, and to other social services means that a large proportion of Mozambican households will see their survival opportunities shrink as a result of the epidemic, weakening still further their human development.

As the effects of the epidemic grow, so the ability of households to send their children to school will diminish, at the same time as the capacity of the education sector to carry out its task fully will also be severely affected.

Access to education, which is already very precarious in Mozambique, will be substantially affected. The availability of specialist teachers will decline sharply in a system where the available staff area already insufficient to cope with the needs. It is estimated that there are 43,156 teachers in the country – 38,279 in the two levels of primary education, 2,457 in the levels of secondary education, 998 in elementary education, basic and mid-level technical education, and 1,422 in higher education.(2005 Annual Report of the Ministry of Education - Mozambique).

These teachers are catering for an estimated school population of 2,360,798 pupils.(National Institute of Statistic, 2004).

3.5. HIV/AIDS and Education Sector

The HIV/AIDS pandemic presents multifaceted challenges to the education sector. On the one hand, education must be structured so as to manage the effects of the epidemic in their various forms, from sickness and loss of teachers and the presence of infected children among the pupils, to the preparation of the system and the teachers to attend to the special needs of a growing number of orphans. Furthermore, the sector will be called upon at the same time to play a vanguard role in the efforts to prevent new infections, while also discovering additional resources to sustain, maintain and improve quality, and expand access to seduction. It is gigantic task, a well-nigh impossible mission.

It is undeniable that the education sector can play a key role in stemming the rise in the epidemic. The sector directly targets those who, because of their age, are part of the so-called “*generation of hope*” – those young Mozambicans aged 6-15 who are mostly not yet sexually active, and who are therefore not HIV-positive (with the expectation of those cases in which the virus has not been transmitted sexually).

Education, in its widest sense, is crucial for an effective response to the epidemic. This is an extra burden on the education system and an added responsibility. The situation is worsened by the fact that the education system will have no struggle play this multifaceted in a context where the sector itself is being severely affected by the epidemic.

In order for the education system to respond to the needs of young Mozambicans, the sector must be able to respond to the threats which the epidemic poses to itself.

In recent years education sector professionals and those familiar HIV/AIDS have undertaken research on how to proceed with effective sectoral impact assessments. While the number of such studies is limited, there is a growing understanding of the importance of accounting for HIV/AIDS impacts when planning the way forward for the education sector. (Kelly, Carr-Hill, Kataboro and Catahoire, 2000, and JTK Associates, 1999).

3.6. Impact on the supply of education

The supply of trained educators is perhaps the most critical constraint on the ability of the educational authorities to achieve their objective of universal access to basic primary education and quality improvements, and the longer term goal of universal access to full education. Unfortunately, it is precisely here – the supply of educators – where AIDS will take its toll in Mozambique.

Over the period of 2000-2010, the AIDS epidemic is projected to result in the education sector losing some 17% of its personnel (Annual Report of The National Council for combat HIV/AIDS-Mozambique, 20004).

Across all levels, some 9,200 teachers will die and an estimated 123 Senior Managers, Planners and Administrators will be lost. (Statistic Department-The Ministry of Education-Mozambique, 2003). For each if these educators months of productive work time will be lost before they die (Annual Report of the Ministry of Education/Mozambique, 2003).

Because the central region has the highest of HIV prevalence, it is projected to lose the highest percentage of teachers (23.3%).

(Annual Report of the Ministry of Health/Mozambique). And because this is the region with the highest number of educators in the system, over half of all teachers (53%) who die welcome from the central Provinces of Manica, Tete and Zambezia.

In order to maintain the system at present levels access and quality, trained teachers and senior personnel will need to be replaced. In order to accommodate the loss of trained teachers alone, basic teacher trained will need to expand the number of trainees in the system over the ten year period by 25% solely due to HIV/AIDS. In order to replace teachers with University degrees who die of AIDS, training at this level will need to expand by 28%. It is not clear to what extent the system is structured to absorb these effects, but the fact that there is a reflection is, in itself, a positive sign.

3.7. Impact on the quality of education

The description of the issue above does not take into account the reduction in the demand for education due to the impact of HIV/AIDS at the household and community levels (the results of the specific workshops and meetings held in Morrumbene and Maxixe will be discussed in later stage). ***The discussion above comprises qualitative impacts resulting from the systematic decline in household economic status as AIDS progresses.*** Studies in Uganda, Tanzania and Zambia uniformly conclude that children in households where one or more adults are affected by AIDS, or where the children are orphaned, are the first to lose access to education (UNDP-Mozambique Annual Report – 2000).

While the 16 years civil war provided Mozambique with experience in coping with the problem of orphans, studies elsewhere demonstrate that, at the peak of the epidemic, the expectation that communities and extended families can continue to absorb orphans becomes, in practice, unworkable (Hunter and Williamson, 1997; Hunter, 2000; Rugelema, 1999).

Currently there are around 700.000 orphans in Mozambique, some two-thirds of which are AIDS orphans. (Report from The National Institute for Statistic, 2004).

3.8. Additional Costs Resulting from HIV/AIDS epidemic

The HIV/AIDS epidemic will reduce the efficiency of the education sector and increase the costs throughout the system. Additional costs alone are expected to exceed 1,900 billion Meticaïs (about US\$ 110.5 Million). This represents additional costs to the system of 6.9% just due to HIV/AIDS. This is an underestimate because some costs cannot be quantified based on available data, and because it assumes that the Ministry of Education will bear no costs associated with expanded HIV/AIDS prevention activities by, or within the sector.

A large part of these costs arise from HIV/AIDS-related sickness and death benefits (750 billion Meticaïs), and to a lesser extent from expanded teacher training costs (187 billion Meticaïs). There are also costs associated with increased inefficiencies in the system, most notably increased drop out and repetition rates (936 billion Meticaïs). With education currently receiving 14% of the national budget, *these losses will have a significant impact on the ability of the state to cover these additional expenses.*

4. Possible Solutions

The school system is viewed, not only in its classic role as a vehicle for imparting knowledge, but also as a means for informing children about the dangers of HIV/AIDS, and empowering them to be able to respond effectively to the pandemic, and protect themselves from infection. So that the system may play this role, the challenges posed to it by HIV/AIDS must be considered. The most serious impact for Mozambique will be on supply of trained teachers.

Since, in general, educators are respected people, or are among the few who have any formal academic education in the community, they will be called upon to interact not only with children and parents, but also with the surrounding communities to spread messages on how to prevent HIV infection, and of respect for HIV/AIDS patients. This increases the burden of responsibility on them, particularly because they must also set an example of good social conduct in practice. The school can be an important centre for activities aimed at blocking the spread of the epidemic.

When increasing numbers of people in Mozambique began to experience HIV-related illness in the late 1980s, public health services were overwhelmed and as a result a range of home-based care (HBC) initiatives were developed. Though many programs were initiated by local health workers, they varied both in the way they were organized and in the services that there were provided. At the same time, support programs for *Children Affected by HIV/AIDS and AIDS (CABA)* were developed. These built up the traditional caring and coping practices of families and communities.

The main advantage of integrating CABA initiatives into home-based care is that it increases the ability of organizations to meet the needs and concerns of sick adults, affected children and their cares.

Today, there are many programs in place that cater separately for people needing home-based care, and children affected by HIV and AIDS. Such divisions, however, make little sense for families and communities trying to provide care for both groups. This has led to a growing interest in integrating responses in order to create more holistic and comprehensive programs that address all these people's needs.

Organizations seeking to integrate HBC and CABA services face a number of practical challenges. Central to these is the fact that sick adults and their children may have different needs, problems, and fears that vary over time. Integration can also put serious strain on the skills, time, and resources of cares, and pose significant organizational challenges to community-based organizations (CBOs) and non-government organizations (NGOs).

This study looks in detail at the process necessary to integrate CABA services into HBC. There are a number of options that will be determined by the specific nature of the existing programs, and the aspirations of the organization(s) concerned. Some options for integration are described as:

- ✓ Creating new services for CABA merging existing programs;
- ✓ Radically redesigning HBC and CABA programs or changing them with minimal disruption;
- ✓ Using separate or shared volunteer groups;
- ✓ Crisis interventions or programs that support affected people over a long time frame;
- ✓ Programs with a narrow medical focus or those are more holistic in outlook.

CBO/NGO support providers have a role to play in the integration of HBC and CABA responses. They may catalyze and facilitate integration by supporting their partners in research, planning and training. They may also provide financial support and advocacy for integration. Effective information and advocacy work is also needed at community level, among implementing CBOs/NGOs and at the government and donor levels.

In the past, issues of care, support, prevention, treatment and income-generation were often compartmentalized as “vertical” projects operating in the same community. Now, the need to develop more of a comprehensive response to HIV and AIDS is becoming increasingly clear. This is mainly because an integrated response mirrors a community's natural coping mechanisms and also encourages local participation and ownership. As the pandemic continues to pose the severest challenge to communities across Mozambique, the time has come for all stakeholders to renew their commitment to the development of more comprehensive responses at community level. This publication focuses on one way to make such a response a reality.

4.1. Expected results

The overall objective of the study is to look closely at what people believe to be causes of the increase of new infections in Morrumbene and Maxixe districts, the impact brought by HIV/AIDS in different social sectors in the two communities and the possible solutions.

The second result to be achieved by this study is bound the competence of the two communities to develop and manage effective, appropriate and sustainable responses to HIV and AIDS.

These results will be achieved by focusing the following four components:

- ✓ Strengthening integrated HIV Prevention, Care and Support Services;
- ✓ Promoting positive behavior change amongst youth and mobile populations;
- ✓ Increasing community capacity to respond effectively to the effects of HIV/AIDS;
- ✓ Enhancing advocacy for rights of people infected or affected by HIV/AIDS.

Through the implementation of these four components, my aim is to strengthen the quality of HIV Prevention Care and Support Services at strategic locations of the two districts (bus stations, schools, workplaces, markets and churches) and to improve the access of youth and mobile populations to these services.

A special emphasis will be placed on integrated and linking these health services to maximize efficiency and effectiveness of referrals among the two communities and hospital based services.

The documentary research conducted in order to determine the causes of the progressive increase of new HIV infections in the two communities, its consequences and possible solutions found that an increase or decrease in the number of new HIV infections in a certain period of time was not the main cause of the increase of HIV rates.

Special studies have been undertaken during the course of the research to increase my understanding of key issues. These included studies on Gender and Gender-based Violence (GBV) issues, and on stigma and discrimination of People Living with HIV/AIDS (PLWHAS).

The results of these studies will guide and inform the communities and the elaboration of an advocacy Strategy. In my research, I promoted the adoption of GIPA (Greater Involvement of PLWHA) principles and pursued the application of these principles through its close partnership with Mozambique's Network of PLWHA named RENSIDA.

The preliminary work I have done with these Organizations of PLWHA and their affiliates ensured that the PLWHAS representatives are playing a key role on the HIV/AIDS campaign programs.

My research also raised the awareness and knowledge levels of the key members of society through direct contact with different stakeholders in the communities, such as community leaders, traditional healers, teachers, health service providers, churches and local organizations leaders on HIV/AIDS, youth organizations, gender and human rights issues. This will enhance the effectiveness of the advocacy strategies adopted by the research to protect and promote the rights of those infected or affected by HIV/AIDS.

According to the four major components above described the expected results after its implementation in the two communities will be the following:

Component 1: Activities to strengthen Integrated HIV Prevention, Care and Support services (IPCS) in the two communities:

- ✓ Increased knowledge and skills of IPCS service providers;
- ✓ Improved linkages and referrals between components of IPCS;
- ✓ Increased youth and mobile populations access to quality VCT services;
- ✓ Improved availability and quality of services for treatment of Opportunistic Infections;
- ✓ Increased availability and coverage of Community HBC services;
- ✓ Improved coverage of effective Sexual Transmitted Diseases (STD) services;
- ✓ Increased awareness and capacity of provincial authorities regarding HIV/AIDS, gender and rights of PLWHAS.

Component 2: Activities to promote sensitive health practices amongst youth and mobile populations:

- ✓ Increased number of peer education networks and higher awareness levels;
- ✓ Increased adoption of safer sexual practices by youth and mobile populations;
- ✓ Increased distribution of condoms;

Component 3: Activities to build the organizational and HIV/AIDS technical capacity for local CBOs and faith-based organizations (FBOs) and PLWHA associations;

- ✓ Increased awareness amongst local CBOs and FBOs on HIV/AIDS, gender and human rights;
- ✓ Increased capacity of PLWHA groups in management, leadership and resource mobilization ;
- ✓ Increased number of new PLWHA associations developed and functioning;
- ✓ Increased linkage and networking among PLWHA associations.

Component 4: Activities to enhance advocacy for the rights of people infected or affected by HIV/AIDS

- ✓ Increased awareness among PLWHA, NGOs, CBOs, FBOs on advocacy issues;
- ✓ Increased awareness among policy makers on key advocacy issues, both at provincial and district levels;
- ✓ Development and implementation of advocacy plan.

Integrating Support for Children Affected by HIV/AIDS into Home-Based Care Program can be one of the possible solutions to mitigate the effects of HIV/AIDS in the two Communities. This statement has been given by a group of stakeholders from the two Communities in a meeting held in Morrumbene. The results of the “*brain storming exercises*” performed in the two communities with the participation of community leaders and other stakeholders from the two communities came to conclusion that there are many benefits to integrating HBC and CABA activities. Presented below, are some of the ideas shared with these stakeholders in separate meetings held in each of the districts.

Merging two pre-existing Programs

4.2. Are CABA activities pre-existing or new?

Support for children affected by HIV and AIDS can be integrated into HBC programs in many different ways. The questions presented below are part of many others that can be posed as alternative that could be found in the tentative of mitigating the impact of HIV/AIDS: The questions and possible solutions presented below were shared by me and the community leaders and other stakeholders in Morrumbene and Maxixe (8 groups composed by 30 people each).

An existing HBC program planning to introduce support to children might merge its activities with those of a project already up and running. This is most likely to occur when an organization has its own “separate” HBC and CABA initiatives. In reality, such activities are rarely fully independent of each other and may in fact have several informal overlaps. For example, the different groups of volunteers might already meet on a regular basis to share their experiences. There might also be referral mechanisms between the projects, for example with HBC volunteers notifying CABA volunteers when children are orphaned. Now, however, many such Organizations are seeking to put these links on more formal footing.

If programs are to be merged effectively, it is important that management discussions and decisions within the Organization are informed by consultations with HBC and CABA staff, volunteers, community members and donors. The process of program design will typically involve a needs analysis (to assess the needs of CABA and confirm or revise needs estimates for HBC services), the development (or adaptation) of training materials, training and support for existing volunteers, a reorganization of the workload and supervision arrangements of current volunteers, developing criteria for selecting clients, and developing criteria for selecting clients, and developing monitoring and evaluation tools.

4.3. Questions about alternatives

What might be the benefits?	What might be the challenges?	What might be help?
More equally balanced emphasis on adults and children	HBC and CABA volunteers and staff have different interests and skills	Peers sharing their skills (e.g. CABA volunteers training HBC volunteers)
New program, with stronger skills in both HBC and CABA	The rivalry or “territory” issues between those working on HBC and CABA	Team building activities to develop a common vision

Greater coverage of clients in need	Existing beneficiaries feel their service is diluted	Strong leadership support from managers
Less immediate need to expand the number of volunteers or restrict the target area in order to cope with needs/demands	HBC and CABA activities have different donors, and thus different terms and conditions for staff and volunteers, as well as restrictions that hinder integration	Active consultation with staff and volunteers about merger design Consulting donors to create uniform terms and conditions
	Organizational change is always challenging; Program managers can create uncertainties and fears among staff, volunteers and clients.	Tapping into the shared motivations of volunteers Expanding the merger to clients and stakeholders/or advocating the benefits of more comprehensive responses.

Adding new CABA services to an existing HBC Program

If an Organization does not have an existing CABA program, then rather than establishing an entirely new and “vertical” project, it might chose to integrate new services for children into its existing HBC work.

To add new CABA services into HBC programs effectively it is important to follow similar steps to those outlined above. In addition, organizations may also find it useful to hold community mobilization and awareness-raising workshops about the needs of children affected by HIV/AIDS, as well as proactively and explicitly involving children and their families during program design.

With this option, organizations need to carefully analyze the implications of increased client numbers and increased workload. Unless catchment’s areas are restricted, this option will necessitate the recruitment of new volunteers, and new supervisory and support staff, as well as additional resource mobilization.

What might be the benefits?	What might be the challenges?	What might be help?
A more balanced emphasis on children and adults	HBC volunteers need to develop a new focus, role and skills	Training HBC staff and volunteers in relevant skills, (e.g. child counseling)
Builds on the solid foundations of an existing HBC program	Not all HBC volunteers want to work with CABA	Allowing, or even encouraging, some volunteers to specialize in HBC or CABA
The more explicit recognition of children’s needs is a practical way to increase the quality care and support for	The increased need/demand from wider client group leads to an increased workload for staff, volunteers and managers	Recruitment and training more volunteers and/or restricting the program’s catchment’s area

families		
Can be achieved relatively quickly	Extra resources needed to sustain a more comprehensive response	Mobilizing resources for CABA
Many volunteers will be pleased to meet the needs of CABA more proactively	Policies and materials for working with CABA need to be developed	Involving volunteers, staff and community members in the development of policies and procedures (e.g. criteria for identifying children in greatest need)
Community mobilization and awareness-raising of CABA issues is an important contribution to increasing community support to children.	Donor demands and restricts may be a hindrance.	Explaining the evolution of the program to clients and stakeholders and/or advocating the benefits of more comprehensive responses.

Minimal Disruption

Activities for children can be introduced without any noticeable change to the way that an Organization delivers its HBC. This is more likely to be possible where the HBC programs extensively use community volunteers and already has a fairly broad focus. This is also sometimes the preferred option, particularly when an Organization feels that the upheaval associated with radical redesign would not be worthwhile.

Taking this approach forward typically hinges on CABA-related training for staff and volunteers. It also requires some attention to be paid to revising client selection criteria, volunteer deployment and supervision arrangements, as well as implementing activities to ensure community understanding of the shift in program emphasis.

Does HBC change much as a result of integrating CABA activities?

What might be the benefits?	What might be the challenges?	What might be help?
A more balanced emphasis on children and adults	Problems in existing HBC programs may continue	Careful pre-assessment of the sustainability of an HBC program for the inclusion of CABA services
It builds on the strengths of existing HBC services, including structures and human resources	Activities for CABA may be as less important than core HBC services	Addressing problems gradually
There is minimal disruption to existing HBC services while new CABA activities are introduced.	Staff and volunteers may not want to start activities for CABA.	Holding discussions with staff, volunteers and other stakeholders so as to communicate importance of new activities

		<p>Involving staff and volunteers in planning new activities</p> <p>Advocating the benefits of more comprehensive responses.</p>
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5. The motives for alarm

Although the virus prevalence rate in Mozambique in general and in the two communities in particular is, in relative terms, at what may still be considered moderate levels for sub-Saharan Africa, the specific circumstances of the country ensure that HIV/AIDS epidemic should be seen as a tragedy with damaging consequences for development.

About 60.5% of the Mozambican population is illiterate. The country has 13,156 economically active individuals with higher education courses, of whom only 17% are women (UNDP National Report – Mozambique, 2003). These data reflect the level of vulnerability to the devastating effects of the epidemic in a country with limited resources (Plano Estratégico do ensino Superior, 2004).

The epidemic strikes two blows at the fragile base of education cadres – first through the disappearance of trained and experienced people, and second through the waste of resources spent on their training. This concerns, and with good reason, society at the highest level, because the victims of AIDS include specialists trained with great sacrifice over the 31 years of independency.

In attacking those aged between 15 and 49, the epidemic seriously compromises development efforts, because it concentrates on a significant layer of present and future producers, in a country where this stratum is that of economically active individuals and estimated at only 37% of the population. In other words, one in six Mozambicans regarded as fit for work is infected by the virus (National Council to Combat HIV/AIDS, 2001). The epidemic will force the healthy to bear, directly or indirectly, greater responsibilities and cost.

6. Protecting the “window of hope” and beyond...

The strategy for fighting the epidemic should rest fundamentally on protecting the so-called “window of hope”, that is, the children who are not yet sexually active, who can learn early and better the lessons of abstinence, protection and prevention. This implies targeting the current preventive campaigns on HIV/AIDS at younger age groups, and therefore making appropriate adjustments in the messages of these campaigns. Instead of stressing only the use of condoms or safer sex, for instance, the messages could envisage aspects including changes in sexual behavior and attitudes.

Apart from children of when they are already regarded as sexually active, the campaign should also, and quickly, cover sub-group in the 6 to 15 year olds range.

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