Children, HIV/AIDS and Communication in South Africa

A Literature Review

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Children, HIV/AIDS and Communication in South Africa: A literature review

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Bibliographic Review

This literature review is further supported by a bibliographic review of texts related to children, HIV/AIDS and communication. The bibliographic review is available as an Acrobat document as well as in the form of a searchable database at the Cadre website – www.cadre.org.za.

Contact information

The Centre for AIDS Development, Research and Evaluation (Cadre) is a South African non-profit organisation with offices in Johannesburg, Grahamstown and Cape Town, South Africa. Contact details as well as other reports relating to HIV/AIDS and the media are available on our website at www.cadre.org.za. Comments on or additions to this report can be sent to susan@cadre.org.za.

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Introduction

This review was commissioned by the Center for Communications Programs at Johns Hopkins University to provide insight into issues related to communication of HIV/AIDS to children in the 3-12 year age group, with an emphasis on South Africa.

The overall brief included the following areas of focus:

- to identify key issues related to children and HIV/AIDS, including discrimination, grief, knowledge, attitudes and practices;
- to determine what programmes have been implemented, both media and non-media, with regard to children and HIV/AIDS;
- to provide a comprehensive bibliography of literature in the area;
- on the basis of findings from the literature review conduct supplementary interviews with key stakeholders;
- to develop a review of findings.

The International Convention on the Rights of the Child defines children as all persons under the age of 18. However, this definition largely relates to the legal definition of the age of minority. There are also varied definitions of young people that relate to adolescence and youth. For example, according to the World Health Organisation (WHO), programme on Child and Adolescent Health development children and adolescents are persons under 19 years whilst adolescents are specifically defined as being between 10 and 19 years.[1]

In a review of children and HIV/AIDS in South Africa, Kelly et al[2] argue that the characteristics of childhood and youth are not necessarily bound by age categories, but rather, can be understood in relation to generally accepted indicators such as financial dependence, responsibility and blameworthiness, and emotional need for primary care. In the context of the review, children were defined as prepubescent young people, with the understanding that in most countries, pubescence occurs at the age of 11 to 12 years.

The literature reviewed is often not explicit about the definitions of children, youth or young people. In this analysis however, emphasis has been placed on data that relates primarily to the age category under review – children in the age range 3-12.

Methodology

The initial phase of this review involved electronic searches utilising the following approaches:

- Internet searches using a number of search engines including www.google.com and www.ananzi.co.za (a South African search engine);
- A search of www.aegis.com which includes a range of titles and abstracts including those derived from AIDSLINE, as well as various journal and conference abstracts;
- A search of recent International AIDS Conference CD-ROMs;
- A search of electronic databases available via Rhodes University including Ebscohost, Science Direct, AIDS Search, African Health Anthology, Child Abuse & Neglect, PsycINFO and POPLINE;
- A search of websites that are particularly related to children's issues and children and AIDS. These included: www.unaids.org; www.unicef.org; www.childaidsservices.org; www.pedaids.org; www.childrensrightscentre.co.za; www.childreninadversity.org; www.globalmovementforchildren.org; www.childwatch.uio.no; www.hull.ac.uk/children5to16programme; www.childpolicyintl.org; www.crin.org; www.ohiou.edu/afrchild;

www.uct.ac.za/depts/chu; www.hopeforafricanchildren.org; www.orphans.fxb.org; www.securethefuture.com; www.childrensaidsfund.org; www.avert.org; www.togan.co.za/cindi; www.hst.org.za.

- Keywords and phrases for electronic searches included: child* and (HIV or AIDS); child* and (HIV or AIDS) not (youth or adolescent); Africa; southern Africa, stigma, rights discrimin*; grief, knowledge; attitudes, practice*; communicat*; barrier; intervention; media; program*; 'children in media'; not 'mother-to-child'.
- When searching websites, publication lists were searched first. References in publications were also searched for, if deemed relevant.
- The Cadre resource libraries in Johannesburg and Grahamstown were searched manually and the Rhodes University library catalogues were also searched.

Problems encountered with searches included:

- A lack of consensus on the definition of 'child'. Often programmes or interventions were aimed at young people over the age of 15, but were referred to as 'child' interventions. To counteract this, the words 'youth' and 'adolescent' were excluded from search terms.
- Very little information about how children are dealt with in relation to HIV/AIDS communication. Most media and communications documentation on the subject deals with the direct effects of the media on children, such as violence on television and its effect on the behaviour of children.
- Most information on children and HIV/AIDS is related to orphans and mother-to-child transmission. The latter was excluded from search terms. Other information is generally related to life skills education in schools, but invariably this starts with older children and so the ages between 6 and 10 are usually overlooked.

Nearly 300 texts were identified as relevant for review. The literature was initially entered into Microsoft Excel including abstracts and was then categorised into a number of broad areas including: Background data; Community and family impacts of HIV/AIDS; Community and family responses to HIV/AIDS; HIV/AIDS knowledge and behaviour; Children and communication and; HIV/AIDS communication and children. This allowed for identification of broad trends in the literature and also pointed to areas of emphasis as well as providing insight into gaps. Specific texts were identified as being most relevant and were accessed electronically or as hard copies.

During the review process a range of key informants and stakeholders in South Africa were identified and selected individuals were interviewed telephonically. Organisations included: CINDI, Soul City, Media and Education Trust, Department of Health, SABC, Department of Education, and Clacherty and Associates. This review was however conducted over a relatively short period of time and did not allow for wider consultation. In addition, it must be noted that a large body of information remains within the area of 'grey literature' and is not uniformly made available in the public domain. There is a strong case to be made for systems such as websites and resources centres that actively provide house and promote such literature.

The emerging bibliographic review is available as a separate document and can be downloaded from the Cadre website – www.cadre.org.za. The bibliography is also available, along with related bibliographies, via a searchable database on the website.

FINDINGS

This review is organised under the following broad headings:

- Background data concerning children including policies, rights and statistics;
- Community and family impacts of HIV/AIDS;
- Community and family responses to HIV/AIDS;
- HIV/AIDS knowledge and behaviour;
- Children and communication;
- HIV/AIDS communication and children.

The rights of children

Children's rights are designed to offer a framework for policy and implementation allowing for the enhancement of human and social development of children within a protected environment, and improving the situation of all children. In the context of high prevalence of HIV/AIDS and vulnerabilities posed for children, it is expected that the rights of children as outlined internationally and nationally would serve as guidance for the development of HIV/AIDS strategies.

The UNAIDS International Guidelines on HIV/AIDS and Human Rights state that: 'One essential thing learned in the HIV/AIDS epidemic is that universally recognised human rights standards should guide policy-makers in formulating the direction and content of HIV-related policy and should be an integral part of all aspects of the national and local response to HIV/AIDS'.[3]

For this review, an examination of the rights of children provides a guiding framework in understanding the role and implications of local response to HIV/AIDS on children. As noted by Byrne:[4] 'Response in addressing the HIV/AIDS pandemic has to be rights-based if it is to protect our children and youth'.

HIV/AIDS and children's rights

Strode and Grant[5] provide an overview of rights pertaining to children, some of which are summarised below:

- In October 1997, South Africa ratified the United Nations Conventions on the Rights of the Child (CRC) 1989, which is premised on the survival, development, protection and participation rights of children.
- Article 2 of the CRC sets out the right to non-discrimination and provides children with the right to be protected from all forms of unfair discrimination. Full implementation of Article 2 facilitates the prohibition of discrimination of children based on real or perceived HIV status.
- Article 27 of the United Nations CRC declares that every child has the right to a standard of living adequate for his or her physical, mental, spiritual, moral and social development.
- In January 2000, South Africa ratified the African Charter on the Rights and Welfare of the Child. It is based on the rights of children as stated in the CRC, yet is more reflective of African cultural concerns and considers issues as the position of the girl child, the idea of collective rights and community responsibilities, and the participation of children in armed conflict.
- Article 1 (3) of the African Children's Charter protects against harmful practices. It protects the rights of children and youth from cultural practices and traditions that are harmful to their growth and development, and those that are contrary to

the rights contained in the African Charter. This means that cultural practices and customs that are discriminatory to the child on the basis of sex or other status are prohibited. In the African Charter, cultural practices referred to as harmful to children's growth and development may include child marriages or virginity testing, and other practices that make children and youth vulnerable to HIV/AIDS.

- Article 3 of the African Charter sets out the right to non-discrimination and provides that all children have the right to equal enjoyment of rights and to be protected from unfair discrimination.
- Article 3(1) of the CRC, Article 4 of the African Charter and Section 28(2) of the Constitution of South Africa contain the 'best interests of the child' principle. This states that in all actions concerning children, the best interests of the child 'shall be the primary consideration'. This international standard can be used to ensure that the special needs, circumstances and interests of children and youth infected and affected by HIV/AIDS are considered paramount in all actions concerning them.
- Although the CRC and the African Charter do not specifically refer to HIV/AIDS, the rights contained in them apply to all children, including those infected and affected by HIV/AIDS. Implications for the laws stated in the CRC and the African Charter for HIV/AIDS and children include their application in developing policies and programmes for children and HIV/AIDS. Understanding the impact of HIV/AIDS on the rights of the child is valuable to further guide policies and programmes for children infected and affected with HIV/AIDS.
- In the South African Constitution, the Child Care Act, 74, (1983) contains various provisions related to identifying and providing for children in need of care.
- Sections 11-13 of the Child Care Act contain provisions for identifying and removing children in need of care.
- Chapter 4 of the Child Care Act sets out who may adopt a child, who should consent an adoption (a child over 10 years must also give consent), and valid reasons for rescission of an adoption.
- Section 28 of the Child Care Act states that places of safety must be established to take children into custody for care, treatment, examination and observation. This act can be related to children infected or affected by HIV/AIDS in need of care, for example orphans, or children with ill parents.
- In order to enhance the implementation processes of the revised and adopted laws, the South African government established the National Programme of Action (NPA) in 1996 as a mechanism for coordinating action towards the progressive realisation of children's rights. The NPA provides a holistic framework, which enables all government departments to put children's issues into their agendas and mechanisms for coordinated action between non-governmental organisations (NGOs), government and other relevant entities.[6]

One of the most pressing aspects of children's rights in South Africa relates to the influence of poverty on the contexts within which they live and grow up. According to 1996 census data,[7] there are almost 14 million children under the age of 15. A study by Samson[8] utilising the October Household Survey 1999 data set, estimates that 26.9 million of South Africa's 44.3 million people live below the absolute poverty line (defined as R400 per adult per month). A recent study of child income poverty found that 60% of South Africa's children are poor in the sense that they live in the lower 40% of households.[9] About 30% (5.2 million) of South Africa's children aged under 17 are desperately poor in the sense that they live in households with self-reported hunger.

The World Bank describes poverty as having many dimensions and therefore there is

a need to examine it through a variety of indicators. Such indicators include levels of income and consumption, social indicators, and increasingly vulnerability to risks and of socio-political access.[10] Therefore, factors including parents' unemployment, access to nutrition, shelter, health care, education, mortality risk, are important to examine in seeking to understand the situation of poverty amongst children in South Africa and implications for HIV/AIDS.

The situation of poverty coupled with the high prevalence of HIV/AIDS in the country further impact on the rights of children. Specifically, the right to survival and development is put to question for children living in families affected by HIV/AIDS. Studies have underlined the cycle of poverty that affects most families affected by HIV/AIDS, especially when the breadwinner is infected with HIV, resulting in loss of family income, access to nutrition, education, shelter and health care.[11]

Issues of children affected by HIV/AIDS

Sub-Saharan Africa has a growing population of HIV positive children. UNAIDS estimates that by the end of 2001, the number of children living with HIV in sub-Saharan Africa was 2.4 million. That same year, 800 000 children globally were newly infected with the virus, and 700,000 of these children were from sub-Saharan Africa.[12] The most recent antenatal survey in South Africa,[13] suggests that some 4.7 million people are infected. Pregnant women in their late twenties show the highest infection rate at 30.6%. Projections of the infection rate for the general population suggest that 2.5 million women aged 15-49 years are infected, 2.2 million men aged 15-49 years and over 100 000 babies.

But the rate of infection is not the only factor affecting children with regards to HIV/AIDS. Statistics do shed light on the magnitude of the situation, however, whether or not children are themselves infected, the infection or death of one or both parents, or of siblings or other relatives, directly impacts their lives. According to UNICEF,[14] before HIV/AIDS became widespread, approximately 2% of children in developing countries were orphaned. UNICEF estimated that in 2000 there were just over 14 million children[15] living in South Africa, of which 1.2 million were orphans.[16] Because the epidemic is continuing to grow, and the majority of HIV positive adults in South Africa are still asymptomatic, the number of orphans is expected to increase significantly whilst the number of healthy adults able to care for them will decrease.

HIV infected children

HIV positive children face similar challenges to other children who are directly affected by HIV/AIDS but are not themselves infected. Generally HIV positive children acquire the virus from their mother and usually their father is also infected, leading to challenges at family and community level. These issues are compounded when the child is HIV positive, and consequences include:

- isolation and rejection;
- coping with a chronic disease and the debilitating symptoms that accompany it;
- developing an understanding of a terminal illness;
- frequent periods of illness and hospitalisation;
- pain and grief.

While stigma and discrimination on the basis of HIV status has been linked to HIV/AIDS since the early stages of the epidemic, there has been little research on the extent and exact nature of stigma and discrimination against children infected with or affected by HIV/AIDS in South Africa. Nor has a broad understanding of how this

stigma affects children, their families and caregivers' lives and access to such rights as health care been reached.[17] Strode and Grant,[18] in a study on South African children, argued that children who are either known to be living with HIV or are thought to have the virus, or who begin to exhibit symptoms of HIV, are stigmatised and isolated by their communities. The authors argue that the social attitudes toward infected and affected children show that they are viewed as 'shamefully different'. This attitude reinforces unwillingness of other children and members of the community to associate with infected children.

Family and community impact of HIV/AIDS

Children are affected both emotionally and materially when a parent has HIV or AIDS-related symptoms and is ill for a protracted period of time. Out of necessity, children assume adult roles, such as caring for an ill or dying parent, providing care for siblings and generating income to support the family.[19] The addition of these responsibilities restricts their access to education and children in these circumstances may drop out of school after a period of time. In both the short and long term, loss of education can lead to various negative externalities. Female children of sufficient age whose mothers die are especially vulnerable to dropping out of school, as they may be required to take on domestic chores previously carried out by the mother.

According to UNICEF, in sub-Saharan Africa, three-quarters of the continent's people survive on less than US$2 a day and the HIV/AIDS epidemic is deepening their plight.[20] In the case of an ill breadwinner, family income dwindles, while at the same time, household expenses, especially those related to traditional or clinical treatment seeking, increase. Studies in Cote d'Ivoire show that when a family member has AIDS, average income falls by 52-67%, while expenses related to health care quadruple.[21] Reduced income contributes to poor nutrition in the household and can create a cycle of poverty that the next generation cannot escape.

The extended family, which is a 'network of connections among people extending through varying degrees of relationship including multiple generations, over a wide geographic area and involving reciprocal obligations,' continues to play an important role in supporting HIV/AIDS affected households.[22] The role of the extended family includes caring for the children of other relatives to ease the burden on the family while a parent is sick. In rural contexts this is more feasible as urban dwelling families generally live far from other relatives.

The security net provided by the extended family system has been weakened by HIV/AIDS and is often supplemented by alternative strategies. The expense of the introduction of a relative's children in the household may threaten the financial stability and, as a matter of course, imposes additional financial burdens. Children in this situation may be neglected and, depending on their ages, may be required to make additional contributions to the household tasks, whilst at the same time receiving insufficient attention and care.[23]

Consequences of orphanhood

The definition of the term 'orphan' has been widely debated, and some researchers include children who have lost only their mothers. In this document, an orphan in the context of HIV/AIDS is defined as a child who has lost at least one parent to the disease. The term 'AIDS orphan' contributes to stigmatisation of children and excludes a large population of children whose parent(s) are infected with HIV but are still alive. In this section we refer to children who have lost at least one parent to AIDS as orphans and a broader category of 'children affected by HIV/AIDS' is used to refer to

all children affected or infected.[24]

It is interesting to note that many communities have their own ways of defining an orphan. For example, in a study in Malawi the community regarded children living with a chronically ill person, as well as those who are of age to go to school but do not have any means of looking after themselves, as orphans.[25]

Family members die from various causes, and a study conducted as part of the Bambisanani Project[26] in the Eastern Cape, South Africa, identified the main causes of orphanhood as being due to HIV/AIDS, tuberculosis, crime and violence.

The consequences of the death of a parent differ among children and depend on the circumstances. Such consequences include:

- Some children live in families with one surviving parent with children and remain in the precarious, anxious state.
- The fact of the sexual transmission of HIV/AIDS, in most instances where one parent dies of AIDS, the other partner is HIV positive and will also die within a period of time. Without the support of either parent, the impact of HIV/AIDS becomes even more intense, especially if preparations are not made by parents or other family members.
- In some cases, when a parent has signed a will or alternately pre-determined where the children will go, the transition into orphanhood is easier on the child. However, when preparations are not made, children may face losing their homes and property to other relatives or the community.
- Children without a support system may be forced to try and make ends meet on their own.

While orphanhood is not new to South Africa, the growing number of orphans has overwhelmed existing systems of care and has resulted in evolving family forms. For example, despite attempts to keep the care of orphaned children within the family structure, there is a trend towards orphans caring for themselves. In child-headed households, the eldest child, usually no more than sixteen, tries to keep the siblings together, possibly partaking in low level economic activities, such as selling cigarettes and sweets, to generate income for the family. A study in Malawi identified three reasons for child-headed households: there are no relatives to care for them; relatives are unable or unwilling to care for them for various social and financial reasons and; mistreatment of orphans while in the guardian's household causing orphans to move out and live alone.[27]

In some cases where there is no family to care for the children, they end up living in the street. While the actual number of street children in South Africa itself has never been counted, estimates in sub-Saharan Africa are that there are around one million children living in this way. The majority of these children appear to be boys, possibly because girls have more marketable skills at a younger age, notably, domestic skills. Rather than compete for domestic jobs, boys tend to try and earn money on the street.[28] A 1996 study in Rwanda estimated that one-third of street children were orphans. Researchers also found that 60 000 to 85 000 households were headed by children – three-quarters of who were girls.[29] In 95% of these households the children had no access to health care or education, were frequently exploited and abused sexually and were often denied inheritance rights of land and houses.

The plight of orphans has entered the international spotlight and many organisations and communities have created programmes to address children's issues. In an effort to create projects to assist children, various research studies have attempted to identify their needs. In most studies,[30] children themselves will identify material needs as their most pressing, as demonstrated in a study of South African children[31] who identified as their most urgent needs as food; clothing; bedding; medical care; money;

grants; shelter and; school requirements such as feed, books and uniforms. It is therefore understandable that where basic needs are not being met, programmes tend to focus specifically on providing money for material needs rather than on counselling or other forms of emotional support. While financial aid is critical for the immediate survival of the child, initiatives should not stop there – understanding the impact of death and dying on a child's emotional well-being is also critical.

Psychological impact

Children's emotional well-being is threatened during the course of change in the household, both before and after the parent dies. In the Eastern Cape, orphans identified other less tangible needs that they were missing from their parents, including love, care when they are sick, play time, guidance, friendship and recreation.[32] Generally, children who lose their mothers suffer immense grief over the loss of love and nurturing, whilst the loss of the fathers is more directly related to decline in their standard of living.

In many instances, dying is not talked about with children, so they are left to draw their own conclusions as to what is happening until the time when the parent dies, causing them to lose their sense of security. Where only one parent remains, the child may live in fear that the remaining parent will die as well and uncertainty about the future, where they will go and who will take care of them, can weigh on these children's minds. Because they so often don't readily understand the situation, children cannot express their fears and grief effectively and keep it to themselves. With this sense of inability to affect the situation, children tend to lose hope in the future.

Disclosure

Disclosing one's HIV status means dealing with a number of internal and external obstacles, including stigma and discrimination. For example:

- There is little external support to most parents in this situation, and steps and approaches, if developed at all, are developed in a context of little guidance.
- Some parents feel that disclosure will help their child to understand the virus and the process of the parent's illness, and can help protect the child from contracting the virus at that time as well as in the future.
- Other parents feel that keeping quiet about their HIV status protects the child because knowing the parent is HIV positive means having to deal with the stigma that accompanies the virus, which makes the child's life even harder.
- Eventually, the decision to disclose depends on the individual. It is important to note that whatever is decided, it is necessary for the parent to focus on living positively with the virus rather than on dying.
- It is said that the best way of assisting orphans is to prolong the parent's life, which can be done at the family level through healthy eating and a positive attitude.[33]

While positive living makes the family's present situation easier, the issue of death is not something that can be avoided altogether. Children can see that things are changing at home and while they may not completely understand the implications, it can make them feel anxious, guilty, depressed and misunderstood. They may not want to upset the situation further or may feel overwhelmed and internalise their emotions. Because children are not generally encouraged to talk about themselves and how they feel, when they are given the opportunity they often have trouble verbalising their emotions. Grief that is not expressed can manifest itself in various

ways, including nightmares and anxiety and allowing the child to anticipate the death while the parent is still alive facilitates the process of grieving. [34]

Bereavement

When physical bonds are broken by death, the slow process of grieving begins. During this period, the bereaved person is faced with a turmoil of emotions, life can seem meaningless and there can be a constant feeling of anxiety. Although processes of grief differ for everyone, Kubler Ross'[35] five phases – denial, anger, bargaining, depression and acceptance – offer a useful starting point. But when the death is caused by AIDS, the difficulties experienced can be compounded. Denial of the presence of the virus and the eminence of death is common in families that are affected by HIV/AIDS. Fear and stigma also contribute to denial, which can result in the reluctance to disclose the illness to children or other family members. However, in some aspects, denial can be healthy in that it allows patients to remain focused on life and the tasks of living.[36]

It is widely noted[37] that the age of children determines how they understand death. Before the age of three or four, children are ignorant of the reality of death. Instead, they equate it with abandonment and assume that the dead person will eventually reappear.

- Between the ages of 3 and 7, children personalise events and lack the ability to discriminate reality from fantasy. This is called 'magical thinking' and children may feel guilty because they believe that their own thoughts, wishes and actions are responsible for the death.
- Around the age of 6, children have more concrete thinking and begin to understand that death is final. They think in absolutes, 'good/bad' or 'always/never' and can recognise the permanence of death but feel vulnerable about sharing their grief and uncertainties.

Adults who are unaware of these dynamics may find it odd if a five-year-old continues to play directly after being told of the death or a ten-year-old does not cry. This is not to say these children are not affected by the death, they just deal with it at different levels. In the case of older children, when their emotions are repressed, grief can manifest itself in various ways such as insomnia, headaches and nervousness. Some children may even experience regressive behaviour such as unwillingness to be separated from parents or the desire to be 'babied'.[38] However, when parents or caregivers meet the child's needs of love and support, these regressive behaviours recede.

While adults spread their love among several meaningful relationships, such as a spouse, work, children, friends, children bond closely with their parents and therefore have a difficult time dealing with a parents' absence. The effects of bereavement on individuals vary, but whether or not they appear to be affected, the death of a parent always impacts significantly on the child. Psychological impacts can emerge at any time, even years after a traumatic event, and can greatly reduce a child's ability to integrate into family and social activities. The loss of consistent nurturing from a parent can lead to developmental problems and the loss of guidance makes it more difficult for the child to reach maturity and to be integrated into society.[39]

Bowlby[40] agrees that the ability of children to resolve their losses can be facilitated by involving them during the period of dying and upon bereavement. He gives several factors that enable the child to cope:

- when the child has a secure relationship with the person who is leaving or dies;
- when the child receives prompt and accurate information on the situation from adults;

- when the child is allowed to participate in grieving both publicly and privately and;
- when the child has easy access to a trusted parent or other adult who can be relied on for comfort and a continued relationship.

While each stage of the process of mourning is important to reach, this time can be cut short because of the plethora of people dying in communities. Once death is imminent, discussing it with the child prevents anxiety and distress that builds once the child perceives that something is wrong. Discussion can allow children to prepare for what lies ahead and give them confidence to manage the grief. Allowing the child to say goodbye and exchange wishes and thoughts is healing for the child and leaves less unfinished business to complicate grief. Creating a supportive environment can allow the child to positively begin the grieving process before the actual death. [41]

Children and the community

There are many influences in a child's life, such as family, community, peers, school and culture – all of which are potentially contradictory and confusing for the child. School is important to children in general but because of the difficulties children affected by HIV/AIDS experience at home and the rapid disappearance of support from family, teachers and other students play an even greater role in supporting their self-esteem. Support from others in the community can also lessen the stress of the surviving parent.

When illness invades the household, children's concerns and problems change, and as a result of this, their behaviour towards others can also change.[42] For example:

- They may respond to the additional stress on their lives by crying, becoming withdrawn, shouting or playing.
- Responsibilities at home may directly affect their school lives, contributing to being away from school for short or extended periods of time.
- Worrying about an ill parent can cause a child to be distracted in class or the child can become aggressive when playing with others.
- The absence of a breadwinner can mean that the family cannot afford school fees, and the lack of money for such necessities as soap or shoes may result in the child staying at home for fear of discrimination.

Without a proper understanding of the student's home life, a teacher may identify this behaviour and actions with those of a 'problem child' in need of reprimanding instead of a child acting in response to his or her situation. The more teachers and members of communities are aware of the situation of these children and become involved in activities to support them, the greater the chances of meeting the child's needs. The same need for understanding applies to other students. In many classrooms, the separation between students with parents and orphaned children is obvious. Some orphans even feel physically different from other children with parents.[43]

These factors both at the family and community levels make children's immediate circumstances difficult, but also make them more vulnerable to HIV/AIDS. The extent of this vulnerability depends on many factors, including, whether they are infected themselves; whether they have relatives to foster them; whether these relatives have the means of caring for them; whether they can go to school; how they are treated within the home and community; what degree of psychosocial trauma they have suffered; what responsibilities they are left with. Vulnerability can also extend to family and community members who may physically, materially or sexually abuse the child.

Long-term studies of children in difficult circumstances have shown that they cope in different ways with traumatic stress situations.[44] One study of South African children identified emerging social problems with children in distress – petty criminal acts; rape; teenage pregnancy and promiscuity; and lack of discipline.[45] While some children experience severe impairment in their overall development, others seem to emerge strengthened by difficult circumstances. It is said that the context in which the traumatic experience takes place seems to be more important than the experience itself. If favourable conditions can be created both before and after the parent dies, then chances are that a child will be able to successfully overcome the trauma of separation from a loved one.

Community and family responses to HIV/AIDS

Children are a product of their communities, growing up with the community's norms and values, their interests and those of the community are often the same. Therefore, initiatives targeting children should be community-based, encouraging active support, involvement and participation of members of the community who cooperatively determine the goals and adopt the strategies by which the goals will be pursued, attained and sustained.[46] This said, it was found in an Eastern Cape study that there were few systems set up to facilitate community support.[47] Few non-governmental organisations were identified in the research sites, with those that were identified as doing developmental activities and not specific work with children in distress. Those organisations were found to be lacking in financial, material and human capacity, influencing the sustainability of the organisation. This research determined that there was no referral system, and no systems of follow-up or coordination in place in the region. Government departments were also not directly involved with dealing with children in distress.

There are many initiatives in South Africa targeting different issues relating to children, including hospice care, material support, counselling and welfare support. These include lifeskills in schools, community-based care approaches (Thandanani), networking (CINDI), and the memory box (South Coast Hospice). These are described below.

Lifeskills in schools

While there is an understanding that parents, families and communities, hold significant responsibility to equip young people with necessary life skills,[48] school environments provide an important entry point in the context of an epidemic such as HIV/AIDS. As Walters and Whiteside note:[49] 'Nowhere else does such an opportunity exist to counter the attitudinal and physical threat of the pandemic. It is an opportunity ignored or squandered through lack of knowledge or resources.'

The promotion of lifeskills in South Africa surrounds a rapidly developing culture of youth development initiatives that involve small group and peer group exploration and learning. This has developed amidst wide recognition today that new skills are necessary for young people to respond positively in oppressive and undermining circumstances, thus taking the mass media campaigns a step further in enhancing response to HIV/AIDS information. Kelly et al,[50] note that lifeskills are needed to assist young people to:

- feel positive about and responsible for their sexuality and reproductive health;
- be aware of and counteract the gender dynamics which are part of their social inheritance and which impact on their sexual interactions;

- be able to understand and communicate their needs effectively;
- be able to assert and express themselves amongst other people; and
- stand by their rights as citizens and young people.[51]

The school-based lifeskills programme in South Africa was established by the Department of Health in conjunction with the Department of Education in 2000. A lifeskills and HIV/AIDS teacher-training project was conducted in 1997/98 with over 6 000 teachers in five provinces. Some materials have also been developed for use in schools.[52] However, a Department of Education Report on the implementation of lifeskills training in the provinces and other studies reveals little practical and adequate delivery of lifeskills education in the classroom. Research conducted in 12 schools and six communities across South Africa in 1999 and 2001 showed that education on HIV/AIDS was conducted erratically and that in these contests, lifeskills education is skeletal at best.[53]

There is little data available on national impacts of lifeskills programming. However as already noted, some studies reveal difficulties in the provision of lifeskills education resulting either in inadequate or inappropriate provision or a lack of it altogether. There are significant institutional, political, religious and cultural barriers to the school-based lifeskills education in particular and preventative education in general. Institutional barriers include the incapacities surrounding especially schools in rural and other marginalised areas, with high teacher student ratios, or lower numbers of trained teachers. Lifeskills education in this case is viewed as an additional burden to teachers who struggle to keep up with the examinable curriculum. A lack of resources or finances therefore impact on lifeskills programmes in various schools. Inadequate in-service training for lifeskills programme implementation has also been widely noted as impacting negatively on its implementation across the country.[54]

Kelly et al,[55] highlight difficulties involved in implementing lifeskills education in schools to include:

- problems of prioritising lifeskills programmes, which are perceived to be a teacher intensive activity in an environment where there is much pressure to improve school performance;
- lack of follow-through on the mandate to provide lifeskills education;
- lack of follow-up training of teachers;
- little promotion of the value of the concept of teaching lifeskills amongst teachers; and
- perceptions that it is a soft teaching option which is not highly esteemed amongst teachers.

Other non-institutional barriers exist in provision of preventative education in schools. While talking to children about HIV/AIDS is clearly important, challenges relating to the role of adults in this and their ease at doing it is important to further understand. Farquhar and Kanabus[56] suggest that adults are sometimes scared by the thought of talking with children about HIV. They find it difficult to identify with children's experiences. This may involve talking about things that they don't usually talk about. Yet various authors have noted that children who grow up being able to talk about sex without feeling too embarrassed, may have a better chance of having a safer sexual relationship in the future.

The Thandanani Association, KwaZulu-Natal

Thandanani, which is based in Pietermaritzburg, was formed in 1989 with the aim of moving abandoned children out of state hospitals to community-based forms of care, but has increasingly become involved in assisting in the care of orphans and

HIV infected children. In response to baseline research[57] that indicated that communities wanted to care for children but they lacked material capacity to do so, Thandanani established an AIDS Orphan Project (AOP) to facilitate the development of sustainable community-based care for children in distress, particularly children affected by AIDS, by empowering communities to mobilise their own resources and to lobby state authorities, local organisations and child care professionals. The objectives of the project are to:

- establish a 'Community Child Care Committee' in each participating community;
- identify surrogate families within each participating community;
- liaise with local CBOs and NGOs to access appropriate resources and develop the necessary skills within each community to provide psychosocial support to children and their surrogate families;
- increase the capacity of individuals to care for children in distress in the communities where they live;
- mobilise awareness and resources in and across communities to support individual and community initiatives to meet these needs;
- achieve these goals in a way that both taps into and enhances the varied and rich repertoire of existing individual and community responses to children in need, while being responsive to gaps, shortfalls and the limits of these;
- facilitate and enhance the ability of state, non-governmental and community based service providers to respond to and better meet the specific needs generated by the community outreach project; and
- lobby and mobilise for appropriate policy responses to the growing crisis of survival and care generated at individual, family and community level by the AIDS crisis.[58]

These objectives address issues critical to children's programmes as illustrated in the previous section.

In its early phases, the project was hampered by several factors, which can also serve as lessons for newly established programmes in rural areas, including:

- the project was new and had to establish itself its credibility;
- there were a number of logistical problems, including lack of transportation in rural areas;
- gaining permission to enter the rural communities was difficult for reasons including, political conflict, local government elections and other more urgent community priorities;
- project workers encountered a lack of trust as a result of previous NGOs in the area failing to deliver.

Sharing ideas and experiences through networking: Children in Distress (CINDI) Network, Pietermaritzburg

Created in 1996, CINDI is a network of autonomous, self-funded NGOs and provincial government agencies that seek to respond effectively to the growing numbers of children in Pietermaritzburg and surrounding areas. Four basic social safety-nets were developed as key strategies for caring for large numbers of children in distress, on which CINDI's principles and those of member organisations are based:

- First choice was the extended family of the orphan that may need to be empowered to accept children and raise them effectively;
- The next best safety-net was a neighbour or community-based structure, enabling children to be raised in familiar surroundings;
- The third level was economic empowerment for caregivers;

- The safety-net of last resort was residential care, which includes existing residential facilities, foster parenting and cluster foster care.

Organisations working in the HIV/AIDS field often experience problems working as independent entities. As a network, CINDI has been successful in dealing with children and HIV/AIDS on a number of issues. Networks provide several advantages including:[59]

- strengthening advocacy for children's issues;
- influencing others outside and inside the network;
- broadening the understanding of an issue by bringing together different perspectives;
- reducing duplication of efforts and wasting resources;
- promoting exchange of ideas, insights, experiences and skills;
- providing a sense of solidarity and moral support;
- mobilising financial resources.

Memory box creation: South Coast Hospice, Port Shepstone

Utilising tools for dialogue between parents and children, such as a memory book or a memory box, can help both the child and the parent come to terms with the impending death. Originating in Uganda, the concept started with a memory book that involved a journal of factual information and memories for children who were facing loss or separation from a parent, and can be used in situations including divorce, any terminal illness or adoption. Making a memory book was created to empower both the child and the parent through, as the introduction of the book states, helping 'children to understand the past and move on to a more secure future.'

The memory book has been adapted to fit the South African context by many organisations as a 'memory box'. Because many people living in a peri-urban context live in informal houses, which are often affected by fires, a little metal box is given to the child to hold photographs and other memorabilia. The initiative is run by a hospice organisation but is kept at the grassroots level by involving caregivers or parents in the process of filling the box and hiring someone local to construct the boxes.[60]

This project has been successful because it assists the child and the family to deal with death. It addresses such issues as:

- If the parent is still alive, the memory box helps to alleviate the child's anxiety with the parent's illness by giving an understanding to what is going on.
- Parents can leave behind important memories, guidance and develop a sense of reconciliation with impending death.
- Making plans for the future, discussing who the child will live with and who the child can go to with questions can ease the child's fears of the future. Talking about these decisions ahead of time allows the opportunity to test such choices as where the child would live and see if they would be the correct choice.
- Younger orphans can suffer intense distress when they realise they are forgetting a deceased parent. The memory box is method of keeping the memories of children alive and strengthening their sense of belonging.

International initiatives

While South Africa has many programmes directed at children, it should also be noted that there are many successful programmes elsewhere on the African continent that are relevant to the South African context. Examples include:[61]

Community project clubs: Farm Orphans Support Trust (FOST), Zimbabwe

The commercial farms of Zimbabwe generally function as contained communities. Families of farm workers reside on farm land and their children attend a school on the farm or in a surrounding area. The Farm Orphans Support Trust (FOST) is a national community-based programme that solicits and facilitates support for children in especially difficult circumstances, particularly orphans, on commercial farms in Zimbabwe. The activities of FOST are based on the principle that children's best opportunity for development is within the family and community structure and therefore FOST aims to increase the capacity of farming communities to respond to increasing numbers of orphans. Various organisations in South Africa have based their work on the same principles.

FOST has established Community Project Clubs at a number of farm schools around Harare, with the aim of equipping children with skills and creating awareness about HIV/AIDS, not only in schools but in the communities themselves. Activities of the club include drama performances based on HIV/AIDS issues and gardening projects in which vegetables are grown and sold and the profitused to meet the material needs of orphans at the school.

FOST clubs have been successful for various reasons including:

- The involvement of both students and teachers in learning about HIV/AIDS and other health issues.
- Information they learn as part of the club is then integrated into activities that are then taken into the surrounding communities, such as drama presentations which they perform in neighbouring farm communities. These performances depict issues of HIV/AIDS that are relevant to farm life and therefore are of interest to the community.
- FOST clubs do not focus on orphaned children individually but include all pupils in an effort to destigmatise the virus and normalise being an orphan.
- Each student in a class shares the responsibility of the gardening project and thus an environment of mutual care and support can be engendered.

Learning lifeskills through adventure: Masiye Camp, Zimbabwe

Because of their circumstances at home, most children affected by HIV/AIDS do not have time to play, as other family needs have to be prioritised. The Salvation Army's Masiye Camp in Bulawayo, Zimbabwe, gives orphans the opportunity to learn lifeskills through play. The principle of the camp is the same as that of Outward Bound, which encourages trust and team building through adventure learning. Activities include outdoor recreational activities such as hiking, abseiling and canoeing; aerobics; counselling sessions; craft activities; traditional dancing.

The Masyie Camp has been successful in teaching lifeskills to orphans and addressing their psychosocial needs for various reasons.

- Activities are contextualised as life challenges: they look almost impossible, they challenge the mind and body, but once the children overcome their fears, they can conquer the obstacle and face the challenge feeling confident and strong.

- The objective of the activities at the camp is to build the children's coping capacities and self confidence, so when they leave the camp, they have skills to take back with them and build on in their own communities. Incorporating lifeskills lessons into adventure activities means that children learn while they are having fun. For example, they participate in aerobics and running activities, which emphasize fitness and discipline.
- Counselling sessions create a space for the children to build relationships with children in similar circumstances and foster a sense of mutual identity, as well as learn from older teen counsellors who are usually orphans themselves. The children carry out role plays, draw pictures and use puppets to share their own stories in a safe environment.
- Traditional dancing helps to release tension and performing in front of a group promotes a sense of well-being and encourages self-confidence.
- Once children leave the camp, there is an effective procedure of following-up on them within their own communities so the support becomes constant and long-term.

Putting lifeskills to practice: Vijana Simama Imara (VSI), Tanzania

Another important aspect in developing the ability of children to take care of themselves is empowering them through participation. Whereas orphans generally feel helpless in affecting their situation, allowing them to be part of a decision-making process gives them the courage to affect their situation. This is the philosophy behind HUMULIZA's projects in Tanzania. HUMULIZA operates with two goals: to assist in the development of the coping capacities of children and to preserve their capacity to act in order to influence a situation, and to create an understanding and competent social environment for orphans, which, through supportive measures, possible negative development can be reduced or turned into resilience.[62] HUMULIZA has established activities on various issues involving orphans, including:

- Practical adult courses on themes such as grieving and how to communicate with children
- A 14-week counselling programme for orphans in an after-school setting.
- Vijana Simama Imara (VSI), an orphan-run organisation, whose name means 'adolescents stand firm' in Swahili.

VSI has been successful because it was created and continues to run based on orphan participation. VSI was originally created in response to the voiced needs of orphans in the area and how children thought these needs should be met. The main qualities that orphans said they missed from their parents were guidance and love. The children also said they felt isolated from the community and other children because they were orphans. The objectives of VSI therefore supplement the child's family through providing support, guidance and financial assistance, as well as to teach orphans skills to help them fit into society.

Another example of the orphans' ownership in the project is that they have created their own criteria for membership, including being self motivated and trustworthy, and goals, such as supporting each other during difficult times and to participate in income-generating projects. They also create the activities, which are both supportive and income-generating in nature and include odd jobs for the elderly, assistance with the preparation of meals for funerals of other children's parents, even assistance in building a house when a member had no where to live.

HIV/AIDS knowledge and behaviour of children

In South Africa, as is the case internationally, knowledge, attitudes, beliefs and practices (KABP) oriented research is widely employed to studying HIV risk and prevention behaviour. KABP has often been described as referring to four important elements of response, though variations in the understanding of how these elements combine to produce desired outcomes exist.[63] A large number of KABP or KAP studies have been done to date, with a recent bibliography document providing close to 100 studies specific to South Africa.[64] This literature singles out general trends of KABP studies, and highlights the lack of literature focusing specifically on children and young adolescents; relatively few studies examining KABP in relation to care and support; and a widespread emphasis on studying 'knowledge' as revealed by the various studies.

There is little data that examines HIV/AIDS knowledge, attitudes and practices specifically related to young children and it is thus difficult to provide an understanding of the situation of HIV/AIDS knowledge, attitudes and practices amongst children under 12. The following summary tracks findings in studies dealing with young people over the age of 12, and can be used to provide some insight into younger age groups.

HIV/AIDS knowledge

Kelly et al underline limitations of the concept of knowledge as measured in many of the studies: 'the concept of knowledge, as measured in many of these studies may be more about recognising ideas than having a useful understanding about issues'. This is related to the need for interventions to move more decisively beyond mass media approaches into more interactive styles of communication that foster interpretation of information within local contexts, and which involve mobilisation of social contexts to the point where new forms of empowering understanding can be developed.[65]

- Studies show that young people are generally well informed on the most important facts about HIV prevention. More recent studies have shown high levels of understanding of the main methods of transmission and risk prevention.[66]
- Studies however reveal variations in knowledge levels. Children and young people in urban areas are more likely to have higher knowledge related to HIV/AIDS than their rural counterparts, while those living in informal housing areas further lag behind in HIV/AIDS knowledge.[67]
- Other variables positively related to HIV/AIDS knowledge include, education levels and age. The studies show that younger children are significantly less informed than their older counterparts.[68]
- While knowledge of efficacy of condoms for HIV prevention is high, gaps in knowledge are mostly in knowledge areas where infection risks are not clear-cut or are contingent to other factors. For instance uncertainties about the issue of HIV transmission through oral sex and kissing, and confusion about transmission channels of air, saliva, skin, insect bites and sharing eating utensils exist.[69]
- Children and young people are further reported to hold misconceptions regarding presence of HIV infection and risk of transmission without the infected person being symptomatic. This is specifically education level dependent, and is underlined as an important area for communication campaigns to concentrate on.[70]
- In research related to the Bambisanani Project Kelly[71] included grade 6 students (average age 12.5 years), grade 11 students (average age 18 years) and community members (average age 41 years). Knowledge of HIV/AIDS was found to be poor

amongst children, 57% of children believed that one can get HIV from using the same cup, whilst 16% of youth believed this as did 27% of adults.

- Most studies show that while the sources of HIV/AIDS information for most young people are the mass media, mainly radio and television, most of them learn about sex from their friends.[72]
- A study amongst disabled primary school children in the outskirts of Johannesburg revealed anxieties and self perceived ignorance concerning menstruation, and biological and physical developments as issues of high concern amongst both girl and boy young adolescents between 10 and 14 years. Older children highlighted pregnancy, and expected experiences regarding first sexual encounter as issues of concern.[73]

Attitudes

Studies on attitudes like those on knowledge have concentrated on respondents of age groups above 12 years of age. These studies have mainly examined attitudes towards condom use, attitudes towards people living with HIV/AIDS and attitudes to HIV disclosure.[74] Some of the findings include notions of condom use and diminishing of sexual pleasure; association of condoms with mistrust, variations in levels of prejudice towards PLHAs from high levels of negative attitudes to high self reported positive attitudes; and positive attitudes relating to caring for people living with HIV/AIDS.

- Attitudes of younger children towards PLHAs are reported to tend to be significantly more negative than attitudes of older counterparts.[75] This can be related to the younger children's poorer understanding of HIV/AIDS and less exposure to HIV/AIDS education or messaging than adults or youth. Attitudes of children are also related to confusion amongst children by what they hear about AIDS. Children are exposed to varying messages regarding HIV/AIDS from different sources. The prevalence of community prejudice about PLHAs is also a factor that may influence children's attitudes about PLHAs.
- Prejudice against children infected and affected by HIV/AIDS in schools also exists.[76] Such prejudice is reported as originating either from other parents who may not want their children to mix with HIV positive children or orphans whose parents have passed away due to HIV related illnesses. It is within such environments that negative attitudes of mostly very young children are formed and further portrayed in their relationships with other affected children or in research questions regarding PLHAs.

Practices relating to children and HIV/AIDS

According to Kelly et al, the concept of practice with reference to HIV/AIDS relates to a broad range of activities relating to HIV risk and prevention, care and support. Practices also refer to constituent behaviours that make up targeted behaviours of prevention programmes. For example the practice of using a condom involves many smaller scale processes, such as condom acquisition, talking to a partner about condom use, and the practicalities of using a condom.[77]

- Most studies that examine prevention practices have emphasised condom use. Other practices examined in various studies include sexual debut; sexual consent and coercion,[78] levels of sexual activity,[79] and abstention.[80]
- Boys are reported to experiment with sex earlier, but take longer to become involved in steady relationships. The median age for sexual debut for boys and girls is in mid-teens, with variations in different communities, with some reports

of sexual debut below age 12. It must be noted however, that sexual debut does not consistently predicate continued regular sexual activity. In younger age groups sex is often opportunistic and irregular.[81] Living in rural communities and poverty contributes to earlier sexual debut.

- Ntlabati and Kelly[82] examined adult's descriptions of their sexual debut in a small rural community in the Eastern Cape and noted that sexual socialisation begins as early as eight years and early sexual experiences mostly take place in the context of games such as *Undize* which is a form of hide and seek. As Kelly et al note: 'There are blurred boundaries between childhood sexual games and sexual intercourse in some rural areas in particular, so that many young people have early sexual experiences without a clear decision to become sexually involved'.[83]
- Sexual coercion is an important factor to consider. Studies reviewed include findings that 30 to 40% of girls' first sexual intercourse is coerced.
- Government and media reports suggest high incidences of sexual abuse amongst children in South African schools with teachers included as perpetrators.
- A recent study by the Medical Research Council of South Africa reports that rape of girls, especially in school, is a substantial public health problem in South Africa. The study suggests that one third of rapes of young girls in South Africa are carried out by teachers.[84] The recently introduced laws against sexual relations between pupils and staff in South African schools, is reported as having proven difficult to enforce. Other perpetrators include relatives, strangers and boyfriends. Rape is exacerbated by a lack of coordination between the relevant stakeholders including the police and justice system, social services, school systems and parents, families and communities.
- Disabled children are particularly vulnerable and a recent project with children in a Gauteng school for the blind revealed high rates of sexual abuse.[85]

It is important to note that there has been very little research on abstention trends in South Africa, which makes it very difficult to examine implications of abstention for children and HIV/AIDS.

Kelly et al report that abstinence has generally not been given particular emphasis in HIV/AIDS intervention programmes and campaigns. Promotion of condom use as the primary means of prevention presents an expectation of sexual activity amongst adolescents and young people as a whole.[86]

The emphasis on condom use therefore technically lives out children who are not yet involved in sexual activity as a focus in a large number of HIV/AIDS intervention programmes.

Kelly et al, further report that there is some evidence suggesting adoption of secondary abstinence as a response to risks associated with sex. Various factors are associated to young people making a decision to abstain from sex following previous sexual activity or sexual debut. These include HIV prevention, pregnancy prevention, STD prevention, avoidance of sexual violence or coercion and religious convictions.

Children and communication

South Africa is a signatory to the International Convention on the Rights of the Child, which includes the goal of 'developing the child's personality, talents and mental and physical abilities to the fullest extent. Education shall prepare the child for an active adult life in a free society and foster respect for the child's parents'.[87] These principles are similar to the African Charter on Children's Broadcasting, which states that children's programmes should be of high quality and allow children to develop physically, mentally and socially to their fullest potential. Children's

programmes should 'create opportunities for learning and empowerment to promote and support the child's right to education and development.'[88]

The majority of available literature on children and communication is oriented towards understanding impacts of television, but findings can be understood as relating to other forms of media as well.

Beneficial media influence depends on the manner in which programming is used and perceived. Welch et al[89] illustrate how programmes and advertising can influence children negatively, for example in the case of gender stereotyping. This research illustrates how television advertisements may promote gender roles by emphasising the characteristics of male and female characters differently. This study found that advertisements predominantly depicted women using cosmetics and household products and girls playing with dolls and domestic implements. In contrast, men tended to be depicted more aggressively, in dominant or independent roles and boys playing with vehicles and thriving on competition and war games. The authors argue that messages about authority and dominance are easily implied through features such as the arrangement of characters, visual and body orientation and other cues only indirectly related to the product being advertised. Such messages may be subtly implied so that they are not easily recognisable to the viewer, especially if the viewer is a child. The author shows that this may influence the behaviour and be integrated into the personality of the child.

The thrust of most research regarding children's understanding of mass media information is that children of different ages have different information-processing skills and children's understanding of television is dependent on cognitive development.[90] In preschool years, children's concepts of determining reality depend on the way things appear versus the way they really are, whereas 3 to 4 year olds do not make firm distinctions between appearance and reality. By 11 or 12, children have considerable skill in making distinctions between appearance and reality.

In a study of whether young children see objects on television as physically-present objects or as images of them, it was hypothesised to be an early developmental process. Under-3s probably assume that what they are seeing on TV are real, tangible objects inside the set, whereas 3 year olds learn that TV images don't function like ordinary objects.

Children around the age of 3 realise that they cannot influence events on television and these events do not directly involve them. Four year olds can determine that while TV images represent reality, they can distinguish between the two.

Dorr[91] found that for children between 5 and 12 years old, the probability of television events happening in real life becomes more of a concern. Kelly[92] notes that 7 and 8 year olds unanimously chose Superman as more real than Charlie Brown 'on the basis of the former's superficial verisimilitude to life – that it is filmed rather than animated.' In contrast, research on 9 to 10 year olds shows that they thought the animated cartoon The Simpson's was realistic because 'it was judged to depict characters and situations that were representative of those in real life'.[93]

Soul City[94] has developed programming for children between the ages of 5-12 for various reasons, including:

- children of this age are relatively healthy;
- it is at this time that they start developing health and sexual behaviours that set the standard for both their present and future health practices;
- emotional and health problems can originate or can become embedded during this period, with physical or sexual abuse retarding the development and potential of many children;
- children of this age can grasp abstract concepts and perceive situations from

another person's perspective. This decrease in egocentrism results in an increased sensitivity and awareness of discrimination.

- These children may have parents or siblings who are HIV positive and can provide care and support to them, or they may have had members of their immediate family die of AIDS already.

Media, especially television, is said to play an important role in how a child understands the world. Many researchers argue that television plays a role in helping children to develop concepts of reality and fantasy. Hodge & Tripp[95] conducted a study on children whose ages ranged from 6 to 12 and reported that 'calibrating television against reality is a major concern for children throughout this age group' and other studies suggest that this also applies to even younger viewers.

It is interesting to note that while cartoons are the favourite television genre of the 6 to 8 year olds that Hodge & Tripp studied in Australia, 9 to 12 year olds preferred TV drama. The researchers determined that due to the fantastic nature of cartoons, they are helpful for young children to discriminate between fantasy and reality.

Pike,[96] outlines what adults must know in talking with children about HIV/AIDS. She provides distinction between children of ages 5 to 7; 8 to 10; 11 to 14 and 15 to 18.

- Children 5 to 7 are beginning to understand the difference between real and imaginary. They learn best from experience, and may respond by being fearful when confronted by topics they do not know about or have not experienced.
- In a context of AIDS, children 5 to 7 may ask questions, but may also be afraid to ask questions. They require simple explanations in relation to the disease.
- Between ages 8 and 10, children's fears change from 'monsters' and other imaginary characters to fear that a real person might hurt them.
- At the age of 8 to 10, children are beginning to understand cause and effect, and most of them know that death comes from an injury, illness or accident. At this age, children also talk about fears less openly, and it is important for an adult to look for an opportunity to bring up topics that might be bothering them.
- 8 to 10 year olds have usually heard about AIDS.
- Media emphasis on AIDS might increase children's fear level, but also provides for 'teachable moments'. Children therefore need to be encouraged to talk about their feelings.
- A basic discussion about sex may be needed first before seeking to explain HIV/AIDS.
- Children aged 11 to 14 vary in maturity and adults, specifically parents, should determine how much to say about sexuality and AIDS. The topic of sexuality and AIDS should not be avoided.

Such examples are important as they provide guidelines for addressing HIV/AIDS communication to young children while taking their different needs at different ages into consideration.

The South African media

South Africa has a highly developed mass media communications infrastructure. There are five open broadcast commercial television stations – SABC 1/2/3, E-TV and BOP TV – as well as two subscription-based services – M-Net and DSTV – with the latter providing access to some 50 stations via satellite. There are 38 commercial radio stations, dominated in reach by the African language services of the SABC. There are 70 community radio stations registered with the National Community Radio Forum (NCRF) although levels of operation vary, and some stations are still

under development. There are 16 daily commercial newspapers, one biweekly and 25 weekly.[97]

Broadcast media provide for communication in all South African languages, although television broadcasts are dominated by English. Daily and weekly newspapers are predominantly English, with a few titles in Afrikaans and one in Zulu.

There has been phenomenal growth in television viewership among young South Africans with 95% reporting they watch television, 92% listen to the radio, 82% read magazines and 76% read newspapers. In fact, about two thirds watch television (67%) or listen to the radio (58%) every day. At least two-thirds of youth report that they get at least some information about sex, sexuality and relationships from television (72%), teachers (71%), magazines (67%) and friends (65%). [98]

A number of studies of HIV/AIDS communication have included measures of media access in place of residence. A sentinel site study of six contexts including urban, peri-urban and rural found ranges between sites as follows: Television (45-98%); Radio (80-99%); Daily newspaper (10-79%); Sunday newspaper (2-86%), and Magazines (11-90%).[99] What this demonstrates is severe disparities in media access between urban and rural settings. A more recent study of commuters found media access to be Television (74%); Radio (92%); Newspaper (60%); and Magazine (49%).[100] A study by CASE[101] on youth provides data on preferences and media and media access by race and by province. A survey of youth aged 12-17 by loveLife[102] showed 80% listened to the radio and 69% watched television five times a week or more.

HIV/AIDS communication and children

While there are clear limitations to the role of the media in HIV/AIDS prevention, it must be acknowledged that communication campaigns and programming form an important function in generating individual behavioural and social response to the epidemic.

There have been few television programmes focusing specifically on HIV/AIDS in South Africa, including *Beat It* and *Positive*, which were targeted at young adults. However, while television programmes aren't based solely on HIV/AIDS, several shows have started addressing HIV/AIDS issues. For example, *Take 5* is a talk show targeted at adolescents and frequently hosts special guests who talk on various topics related to HIV/AIDS, sexuality and youth. A number of local soap operas such as *Isidingo*, which is set in a mining town, have incorporated HIV/AIDS issues into their plots. *Isidingo* previously addressed issues around HIV testing when a pregnant character tested falsely positive for HIV. More recently, the show revealed an HIV positive character.

HIV/AIDS initiatives such as *Soul City* and *loveLife* target older audinces and use the multimedia approaches. Using a number of forms of mass media has its advantages, including reaching the same audience in different ways with the same messages; reaching different audiences with the medium that they have access to and; using the strengths of media to communicate messages more effectively – ie. reinforcement.

There are several programmes targeted at children, hosted by children or youth and incorporating cartoons with games, including *Craze* and *Attitude X*. Examples of two educational series are:

What's The Story?

What's The Story is a 13 part series, part game show and part magazine, where contestants dress up, act out stories, follow recipes and write rap songs. This programme is on for one hour a week, targeted at children aged 9 to 12 years old. It

is an entertaining game-show that supports the language, literacy and communication learning area of the curriculum. Each week in *What's The Story*, two teams from different schools battle it out using their reading and writing skills. The aim of the programme is to consolidate vital skills needed to enjoy reading and writing.

Takalani Sesame

Sixteen foreign language adaptations of *Sesame Street* have been broadcast in over 47 countries, including South Africa's *Takalani Sesame*. *Sesame Street's* purpose is to develop the cognitive learning skills of preschool children, teaching them letters, numbers, geometric forms and such valued presocial qualities as kindness and cooperation. A variety of entertainment forms are used, including Muppets, music, animation, live-action films, special effects and celebrity visits. Each segment is short enough to keep a child's attention, usually less then three minutes.[103]

Several lessons have been learned about the entertainment-education communication strategy from *Sesame Street*:[104]

- Entertainment television can be used to educate young viewers without making the educational content subtle, and still attract a large audience.
- Start-up costs for entertainment-education programmes are typically high, and such programmes take a relatively longer time to produce than do strictly entertainment programmes, in part due to the time and costs of formative evaluation research.
- Formative evaluation research is crucial to the success of entertainment-education.
- A balance between artistic creativity and communication research is needed in producing effective entertainment-education programmes.
- The design, production, and evaluation research for an entertainment-education programme can be transferred across national and cultural boundaries, with suitable adaptation to local conditions.
- Entertainment-education television programmes offer tremendous economies of scale in delivering messages to a target audience.
- Television content is strongly shaped by economic and political realities.

Addressing children and HIV/AIDS in the South African media

There is very little programming in South Africa that directly addresses HIV/AIDS issues and children. It should be noted that programming is seasonal and/or once off. Some examples are:[105]

Healthy Me

Healthy Me[106] is a multilingual series about the human body and how it works. The show is produced by SABC Education in partnership with the Department of Education and the Department of Communication and supports the health curriculum for children in grades 1 through 3. The presenters of *Healthy Me* are three children: Boishoko, 14 years old, Adam, 12 years old, and Dineo, 9 years old. The 3 children take viewers on a daily learning journey through their bodies – discovering the heart, the immune system, the digestive system – and everything else in-between. The set for the show is designed to represent the workings of the human body and it's a fun space from which learning is encouraged. The 20 episodes shown five days a week introduce children to how their bodies function, health care services, and the importance of healthy living. There are also School TV Resource Books and Timetables available to educators.

Soul Buddyz

Soul Buddyz[107] is aimed at 8-12 year olds oriented towards health information and behaviours that include HIV/AIDS. Launched in August 2000, *Soul Buddyz* comprises a weekly television series running over 26 weeks, a radio series, a sex education video, a parenting booklet and lifeskills booklets distributed through schools to all Grade 7 pupils nationally. The series deals with issues such as children's rights, HIV/AIDS, youth sexuality, accidents, disability, road safety, gender equality and bullying. It addresses HIV/AIDS and sexuality based on the idea that children of this age are increasingly gaining autonomy and learning to exert control over themselves and are able to understand how to avoid unacceptable risks. Messages include, 'it is important to communicate about AIDS and sex', 'my body is my own' and 'I need to identify my feelings and learn to express them in an appropriate way.'

- The 30 minute television drama centres on a group of South African children who meet after school in a park. They represent children from all walks of life. This group, the *Soul Buddyz*, deal with issues common to children. They help each other, and work for their community, whilst having fun.
- *Soul Buddyz* radio is a pilot project as there is very little radio programming in South Africa for children of this age. Each 30 minute programme includes 10 minutes drama with child protagonists, 10 minutes of documentary information inserts for both adults and children, and a 10 minute interactive phone-in show hosted by a young person. The three collaborating stations were Motsweding, Umhlobo Wenene and Thobela FM.
- As with other *Soul City* series, the electronic media are backed up by print material. The print material is in the form of two booklets (targeting Grade 7s and parents respectively) and posters. The Grade 7 Booklet is made up of modules covering the issues dealt with in *Soul Buddyz*. Each module has a photo comic story relating to the television story, followed by a number of activities and information about the issue. It has a teacher's page in each unit to assist the teacher to use the material. A parenting booklet accompanies the *Soul Buddyz* series. The booklet covers issues such as communication, self-esteem building, discipline, conflict, single parenthood, discussing sexuality and dealing with disability.

Messages from the series emphasise:

- quality and frequency of interpersonal communication or discussion of issues (strongly supported by quantitative and qualitative data);
- destigmatisation and tolerance for diversity (strongly supported by quantitative data);
- youth sexuality (strongly supported by quantitative and qualitative data);
- peer support (more strongly supported by qualitative data).

We Care[108]

'Lets take care of everyone; everyone with AIDS. Here I am together with my family, here I am with all my friends, and here is my body that I take care of'. These are the opening song words of *We Care*, an AIDS education programme that was previously shown for children in primary school. This SABC Education series of ten 5-minute mini-episodes was produced for in Zulu and Afrikaans. The series was aimed at telling 6 to 9 year olds about the HIV/AIDS epidemic and how to develop an attitude of caring for people who live with the disease. *We Care* covered various HIV/AIDS related issues, including 'living positively with HIV/AIDS' and 'our friends with HIV/AIDS are still our friends'. This series was broadcast on SABC starting in October 2001 and was designed to support the Life Skills learning area within Curriculum 2005.

Red Ribbon

The *Red Ribbon*[109] series, launched in August 2001, comprised of 20 mini programmes in Sesotho and English for children between the ages of 6 and 9. The programme was named *Red Ribbon* as research with the age group found that the red ribbon was found to be the easiest and most recognised access point in relation to the epidemic and children responded positively to it. The programme's aim was to assist children to learn about HIV/AIDS and to attach meaning to the red ribbon symbol. Alternating between the two child presenters and inserts, the series raised issues on HIV/AIDS in a lighthearted way. Each insert provided a specific message about HIV/AIDS, which could be read out aloud by teachers and children. The inserts were also designed to assist educators to be aware of their own prejudices as they learn with the children. At the end of each insert the message of the *Red Ribbon* was reinforced, and in this way the themes of respect, caring and friendship are reinforced, as symbolised by the *Red Ribbon*.

Implications for communication programming

Reflecting on the review above, it is clear that there is limited research in the field of HIV/AIDS and communication for children in younger age groups. The following points can be made in relation to communication.

- Addressing issues of children who are affected by HIV/AIDS, including those who are infected and those who are directly or indirectly affected.
- Addressing issues of stigma and discrimination.
- Addressing a broad range of socioeconomic issues including situations of poverty, street children and children in rural contexts.
- Addressing not only children, but older siblings, caregivers, families and communities in relation to children's issues.
- Addressing issues related to dying and bereavement.
- Addressing family and household issues following the death of a parent.
- Addressing orphanhood.
- Promoting frameworks for disclosure of HIV status.
- Developing age appropriate content in relation to death and dying, amongst other HIV/AIDS issues.
- Promoting understanding of emotional responses to HIV/AIDS impacts.
- Addressing issues of prevention in age appropriate ways.
- Drawing on existing programmes for conceptual frameworks in relation to children and HIV/AIDS.
- Promoting child participation in programme development and within programmes.
- Undertaking further research in relation to HIV/AIDS knowledge, attitudes, beliefs and practices amongst younger children.

Footnotes

1 WHO http://www.who.int/child_adolescent-health/over.htm
2 Kelly K, Parker W & Oyosi S, 2002:4
3 Strode and Grant, 2001a: 2
4 Strode and Grant, 2001a: forward
5 Strode and Grant, 2001a
6 Williams and Samuels, 2001
7 Statistics South Africa, 1996 Census data
8 Cassiem et al, 2002
9 Woolard, Ingrid, 2001 study on October Household Survey (OHS) 1999, in Cassiem et al, (2002)
10 http://www.worldbank.org/poverty/mission/up1.htm
11 Fox, 2001; Humuliza, 2000; FOST, 1999
12 UNAIDS Report on the Epidemic, December, 2001
13 National Department of Health, National HIV and Syphilis Sero-Prevalence Survey of women attending Public Antenatal Clinics in South Africa, 2000: 14
14 UNICEF, 2000
15 This refers to children under 15 years of age
16 Orphans are defined by UNICEF as children who have lost one or both parents
17 Strode & Grant, 2001: 15
18 Strode & Grant, 2001: 15
19 Humuliza, 1999; Segu & Wolde-Yohannes, 2000
20 UNICEF, 2000
21 UNICEF, 2000
22 Foster & Williamson, 2000
23 Ali, 1998; Subbarao, 2001
24 Fox, 2001
25 Ali, 1998
26 Bambisanani, 2001
27 Ali, 1998
28 Subbarao, 2001
29 Subbarao et al, 2001
30 Ali, 1998; Gilborn et al, 2001; Segu & Wolde-Yohannes, 2000
31 Bambisanani, 2001
32 Bambisanani, 2001
33 Fox, 2001
34 Ibid
35 Ross, 1969
36 Boyd-Franklin et al, 1995; Bupa, 2001
37 Jewett, 1994; Boyd-Franklin N, 1995; Furman, 1974
38 Boyd-Franklin et al, 1995
39 Fox, 2001
40 Bowlby, 1995
41 Jewett, 1994
42 Humuliza, 2000
43 Fox, 2001; FOST, 1999, Humuliza, 2000
44 Madorin, 2001
45 Bambisanani, 2001
46 Soola, 1991
47 Bambisanani, 2001
48 Parker, 2002:45
49 Walters and Whiteside, 2001: 6
50 Kelly et al.
51 Kelly et al, 2002:45
52 Department of Health lifeskills education materials and teacher and parent guidelines, 1999
53 Kelly and Parker, 2001; Kelly, 2001
54 Farquhar C & Kanabus A 1998 :13
55 Kelly et al, 2002:46
56 Farquhar C & Kanabus A 1998: 14
57 Vishanthie, 2001
58 Thandanani web site: www.thandanani.co.za
59 CINDI, 2001
60 Interviews with South Coast Hospice staff

61 See Fox S, 2001
62 HUMULIZA, 2000
63 Kelly et al, 2002
64 Kelly et al, 2002
65 Kelly et, al, 2002:22
66 Bekskinka &Stadler, 2000; Kelly, 2001; Kelly, 2000; Mathews, 1996; NPPHCN, 1996; Coughlan et al, 1996; du Plessis et al, 1993; Elkonin, 1993; in Kelly et al., 2002
67 Kelly et al, 2002
68 Kelly et al, 2002
69 Kelly et al, 2002
70 Kelly et al, 2002
71 Kelly, 2001
72 Qualitative research notes, Oyosi 2002
73 Oyosi S, 2001, research notes
74 loveLife, 2001a; Kelly, 2000; Killewo and Wall, 1997; Kushlick & Rapholo, 1999; Richter, 1993/94/95/96 in Kelly, et al., 2002
75 Parker et al, 2002; Kelly 2001; Faraquhar, 1998:13
76 Kelly, 2002:25
77 Kelly, 2002:25
78 Jewkes et al, 2001; Wood et al, 1998, 2000; loveLife, 2001a
79 Gouws, 2000; Kelly, 2000, 2001; Kelly and Parker, 2001; Williams et al, 2000; Bekinska and Stadler, 2000; Case, 2001; Buga et al, 1996a, 1996b
80 Varga, 2000; le Clarc Madladla, 2001; Scourgie, 2000) in Kelly et al, 2001
81 Kelly, 2002
82 Ntlabati and Kelly, 2000
83 Kelly et al, 2002: 26
84 MRC News, 2000
85 Kelly et al, 2002
86 Kelly, et al, 2002
87 South African Country Report, 1997
88 African Charter on Children's Broadcasting, 1997
89 Welch et al, 1979, Chandler, 1997
90 Wartella, 1980; Chandler, 1997
91 Dorr, 1983
92 Kelly, 1981
93 Chandler, 1997
94 Soul City website: www.soulcity.co.za
95 Hodge & Tripp, 1986
96 Pike, 1997
97 www.ncbf.co.za
98 loveLife, 2001
99 Kelly, 2000
100 Parker et al, 2002
101 CASE, 2002
102 loveLife, 2001
103 Singhal, 1999
104 Singhal, 1999
105 Information on these programmes is from the SABC website(www.sabceducation.com) or directly from the programme coordinators.
106 www.sabc.co.za
107 www.soulcity.co.za; www.sabc.co.za and Soul Buddyz evaluation
108 www.sabc.co.za
109 ibid

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