MPILONHLE
*a good life*

**SUPPORTING DOCUMENTS FOR: APPLICATION RFA-AFSA-ADV-2019**

**PUBLICATIONS**

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# Documenting Good Practices

## in the Public Health Sector of South Africa

*From Policy to Practice*

## SUGGESTED CITATION

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# DOCUMENTING GOOD PRACTICES IN THE PUBLIC HEALTH SECTOR OF SOUTH AFRICA

## *FROM POLICY TO PRACTICE*

***December 2011 to November 2012***

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The HST team comprised René English (Project Director), Thesandree Padayachee (Senior Researcher), Tamlyn Seunanden (Researcher) and Catherine Ogunmefun (Researcher). The HST team would like to acknowledge the valuable work of two external consultants, Priscilla Morley and Baba Zide, who worked seamlessly with HST to ensure that the project was well executed. We are also thankful to our editors, Barbara English, Ashnie Padarath and Judith King, and our layout artist, Catherine Pagett, for her excellent skills. We appreciate and acknowledge the role of HST's travel support staff under the leadership of Leo Moodley for assisting with the travel arrangements in all nine provinces.

The HST Good Practice Project was brought to life by the clarity of vision demonstrated by Jeanette Hunter (HST Chief Executive Officer, 2012) and René English. The authors are grateful for their steadfast leadership and creative energy throughout various stages of this project.

Finally, this inaugural edition of the HST Good Practice Project is dedicated to all those working in the public health sector, whose collective effort and dedication will ensure sustained progress towards a long and healthy life for all South Africans.

## FOREWORD

It is my pleasure to introduce the inaugural edition of the National Good Practice Project. Published for the first time in 2013, this report presents valuable insights into the range of exciting initiatives currently taking place within the South African public health sector. The publication represents a rare opportunity to actively facilitate understanding about good practice identification and the sharing of knowledge towards improved management and delivery of public healthcare services.

The large geographic area of our country coupled with a high burden of disease, limited resources and the dire need to get services to those in need, keeps our public health workforce busy with the immense task of providing and managing service delivery. Consequently, there is little time or opportunity for sharing knowledge about "what works". Thus, knowledge on the successes, challenges and valuable lessons exists only in people's minds and is inaccessible to others who may benefit from such knowledge.

Health Systems Trust (HST) has taken this problem seriously and has sought to provide guidance on how to use a systems approach in making such information accessible to all working in the public health sector. Using guidance from the World Health Organization, our approach intends to uncover "islands of excellence" and promote the culture of reflective practice in a structured and systematic manner.

The Good Practice Project presents an opportunity for those working in the public health sector to explore the extent of creativity and innovation in South Africa and to share lessons learned. This compendium includes good practices in the area of core health services as well as the all-important support services. All Provincial Departments of Health have contributed to this publication which showcases 16 diverse, creative and constructive initiatives within the public health sector that aim to improve clinical services, quality assurance and corporate governance.

Through this publication, HST aims to inject excitement and encouragement among those working within the challenging context of the South African public health sector, with a hope that it will create momentum towards improved service delivery, fiscal responsibility and corporate governance.

We extend our sincere thanks to all participants for their valuable contributions and commitment to positive change and to the authors, contributors and reviewers who have dedicated their time and expertise to produce this publication. We are also thankful to the National Department of Health with whom we share a common vision to strengthen health systems, for their funding and support of this project. Most importantly though, we acknowledge with gratitude, the men and women who designed and implemented these good practice projects across the provinces of our country. They did not do so to be written about in a publication, but out of caring about, and commitment to, quality health service delivery.

We hope that this publication will mark the beginning of more systematic documentation of good practices within the public health sector and at the same time encourage creative and innovative approaches to current challenges in the public health arena.

Jeanette R. Hunter

**Chief Executive Officer (2012)**
Health Systems Trust

## EXECUTIVE SUMMARY

The documenting and sharing of good practices has been shown globally to stimulate and improve programme design and delivery, based on lessons learned, sustainability, and outreach to a larger pool of beneficiaries, using the minimal available resources.[1,2] In the past decade, there has been an increased demand for the inter-sharing of good practices in several spheres of health care, including HIV and AIDS programming and prevention, care, support, treatment and impact mitigation. However, the documentation of good practices and the extensive sharing of these practices throughout the healthcare community remain limited in the southern African region.[2] While a number of anecdotal accounts exist of successful initiatives within the public health sector, the potential for replication in other settings is hindered by the lack of rigorous documentation, without which there is little room for sharing through experience.

The **Good Practice Project** is an initiative of Health Systems Trust (HST) that seeks to address this need by mobilising Provincial Departments of Health (PDoHs) in South Africa to engage in reflective practice. Through this process, HST hopes to identify, document and build a repository of public health sector good practices, which will serve as a primary source of knowledge on what works within the public health sector.

It was with this vision that the **Good Practice Project** was initiated by HST to identify, document and share good practices throughout the South African public health community. This project marks the beginning of the HST **Good Practice Project**, which will be undertaken biennially to ensure sustained knowledge sharing throughout this community.

Good practice, in the context of this project, was broadly defined as a method that enabled the health service provider to reach or surpass national targets in a particular area or for a specific health indicator, or enabled the health service to improve markedly on previous values for a specific health indicator. The practice did not have to be a novel one, but had to demonstrate successes in the implementation of standard processes as prescribed by provincial or national policy.

The specific objectives were to:

- Develop criteria for the identification of good practices within the public health sector;
- Identify good practices according to stipulated criteria;
- Develop a framework for the systematic documentation of good practices;
- Understand and uncover key successes of the practices;
- Document past and prevailing challenges;
- Document solutions towards improvements; and
- Share lessons learned.

To ensure that all provinces were provided with an equal opportunity to showcase their good practices, all Heads of Departments (HoD) of the nine PDoHs were invited to submit two good practices. A set of criteria, guided by these recommendations, was developed and used to assist PDoHs in their selection of good practices. For a practice to be considered as a good practice it was essential that it fulfilled the following criteria – *effectiveness, efficiency, relevance and sustainability*.

One hundred and twenty key informant interviews and six focus group discussions were conducted over a six-month period. Transcribed interviews were thematically analysed using the World Health Organization (WHO) Building Blocks as the framework, which resulted in a diverse set of 16 Good Practice reports with a range of themes.

It is important to note that this project was not intended to be a rigorous evaluation of each good practice, but was rather meant to facilitate understanding of the process of identifying, documenting and sharing knowledge. This was achieved by providing support during the selection process and assisting provinces to identify and select their successful initiatives.

The project yielded a diverse collection of good practices that described creative and constructive initiatives by people and organisations working within the public health sector of South Africa. The good practices included in this publication have been grouped into three broad categories – clinical services, quality improvements and corporate governance. The majority of contributions focused on efforts to improve service delivery and patient satisfaction.

The compendium of 16 good practices is as follows:

A. Good Practices towards improved clinical services

1. Mpilonhle School Health Programme
2. Community-oriented Primary Health Care Programme
3. A System-wide Response to Reducing Infant and Child Mortality
4. The Batho Pele Health Project
5. Lehurutshe District Educational Campus Project
6. The Reakgona Disabled Club
7. Witbank Hospital Newborn Improvement Care Team
8. Mpumalanga Eye Care Programme

B. Good Practices towards improved service delivery

9. Patient Complaint Response System
10. Advanced Incident Management System
11. Programme to Reduce Patient Waiting Times
12. Hospital Cleanliness Programme
13. Hospital Quality Assurance System
14. Boitumelo Hospital Food Service Management System

C. Good Practices towards improved corporate governance

15. The Approved Post List
16. Management of the Human Resource Development Component of the Eastern Cape Department of Health

All good practices are aligned to **South Africa's policies** to improve health care. The Witbank Hospital Newborn Improvement Care Team sought to promote breastfeeding, aligned with the Tshwane Declaration. The activities of the Reakgona Disabled Club improved the mental health of community members in accordance with the Mental Health Care Act 17 of 2002. Similarly, other good practices address respective policies on patient health, and others that are categorised within corporate governance speak to the integrated financial and human resource policy on staff costs.

*All good practices are aligned to South Africa's policies to improve health care.*

The Community-oriented Primary Health Care programme aligned itself to the community-oriented primary health care approach which focuses on the needs of the community. In addition to this good practice, practices such as the Reakgona Disabled Club, the Batho Pele Health Project and School Health Programme highlighted the **importance of community awareness and the need for community mobilisation** through community meetings and mobile health care respectively.

The good practices used interventions that are responsive to the needs of the clients and the changing context; they can be adapted to suit the target population. These interventions range from the more traditional community mapping approach in the Community-oriented Primary Health Care Programme to use of more **innovative technology** such as the patient report system in the Complaint Response System and the web-based Advanced Incident Management System.

*The good practices used interventions that are responsive to the needs of the clients and the changing context*

The need for interventions that are sustainable became apparent in lessons learned from the good practices. The Community-oriented Primary Health Care programme included a **plan for replication of the model and sustainability** of the intervention and by working with the National Department of Health (NDoH) trained staff to ensure continuity of service delivery. The **value of public-private partnerships** was evident in the Lehurutshe District Educational Campus Project in which partners with a common vision and their respective expertise collaborated to create and subsequently train a new cadre of healthcare workers.

The Hospital Quality Assurance System practice uses audit, survey and review processes to **improve data quality through monitoring and evaluation** of the services delivered at a District Hospital, whilst Mpilonhle School Health Programme uses an innovative data collection system in which every contact with a student is recorded in real time using iPods. The Management of the Human Resource Development Component of the Eastern Cape Department of Health, and use of the Approved Post List system in the Western Cape, aim to improve the **management of human resource constraints** by enhancing the flow and quality of learners and decentralising the prioritisation of vacancies to the district level respectively.

The findings obtained from the compendium of 16 good practices will provide PDoHs and researchers with valuable knowledge informed by successes, challenges and lessons learned on how to improve service delivery. The experiences of both project managers and programme implementers will enable healthcare professionals working in the public health sector to adapt, modify and improve current models of service delivery.

The subsequent round of the **Good Practice Project** will need to take into consideration the fact that some provinces may need additional support during the selection process and may benefit from facilitated workshops. The key limitation of this project is that it was not peer-reviewed. As such, debate about the merits of the documented good practices is expected and should be encouraged.

The following recommendations are made for subsequent Good Practice Project studies; healthcare personnel and decision-makers across from all provinces must invest sufficient time to reflect on their initiatives, as investigator-led facilitation is a valuable approach to evaluating the merits of a proposed good practice. The process for the identification and selection of good practices should include a diverse group of staff including those that work at the coalface of service delivery.

# GOOD PRACTICES TOWARDS IMPROVED CLINICAL SERVICES

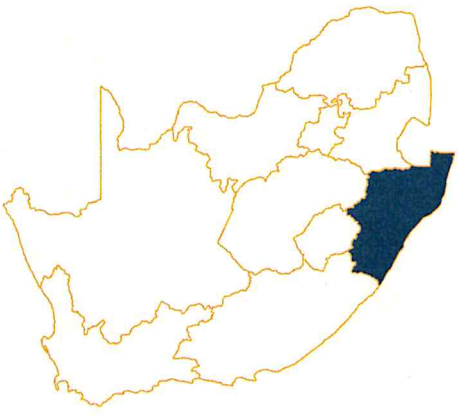
- Mpilonhle School Health Programme
- Community-oriented Primary Health Care Programme
- A System-wide Response to Reducing Infant and Child Mortality
- The Batho Pele Health Project
- Lehurutshe District Educational Campus Project
- The Reakgona Disabled Club
- Witbank Hospital New-born Improvement Care Team
- Mpumalanga Eye Care Programme

# MPILONHLE SCHOOL HEALTH PROGRAMME

*An initiative to improve the health and social development of adolescents and young adults in the uMkhanyakude District*

## BACKGROUND

Mpilonhle, which in isiZulu means "a good life", is a non-governmental organisation (NGO) dedicated to helping some of South Africa's poorest communities in the uMkhanyakude District in northern KwaZulu-Natal (KZN). Mpilonhle was started by Michael Bennish and JP Sevilla in October 2007, its mission being to improve the health and social development of adolescents and young adults in rural KZN, with a focus on HIV prevention. Mpilonhle's vision is for the youth in the uMkhanyakude District to be free of HIV and to lead productive and fulfilling adult lives. Its offices are based at Mtubatuba and it provides services across the district via mobile units.



KWAZULU-NATAL

## STRATEGY

As in most rural areas of KZN, people in uMkhanyakude live in scattered homesteads, with schools often being the only locations in which youth congregate in numbers. Mpilonhle therefore decided to target schools using mobile units, as schools lacked space, and having full-time staff at each school would be cost-prohibitive. By using mobile units in rural areas, Mpilonhle provides services to a larger number of students and community members. Three mobile units take services directly to 30 key schools in the district, where they remain for a week, returning four to five times a year. The mobile units provide health education and HIV prevention services, HIV testing, curative services and computer training. During school holidays, the units run intensive one-week sports/health camps at other schools in the region. Mpilonhle offers the following services and core programmes:

- Health education, screening and treatment and referral;
- Social and psychology services;
- Eyecare services;
- Partnership for Adolescent Support Programme (PALS);
- Teacher training, computer training and career counselling;
- Grassroot soccer "Skillz" programme;
- Home-based care programme;
- Shoe donation programme;
- Circumcision programmes;
- Garden- and food-parcel projects; and
- Sport fields, water and sanitation.

Mpilonhle works in partnership with schools, government, and other not-for-profit organisations to achieve its objectives.

## LINKS TO POLICY

Mpilonhle's work is aligned with the Children's Act 38 of 2005[1], which states that those aged above 12 years should have access to HIV and AIDS testing, contraceptives and reproductive health information. It is also aligned with the government's strategy to re-engineer PHC[2], addressing one of the three main streams of PHC re-engineering, that is – school health services. This stream aims to address basic health issues among school-going children, as well as contraceptive health rights, teenage pregnancy, HIV and AIDS, and drugs and alcohol in schools.

The National Department of Health (NDoH), in collaboration with the Department of Basic Education, revised the National School Health Policy in 2011. The new Integrated School Health Programme[3] recognises that most children spend up to 13 of their formative years in a classroom environment, providing an ideal opportunity for health education and interventions that aim to address the many health- and socio-economic factors that affect children. Mpilonhle has capitalised on this opportunity, as it also calls for establishing effective partnerships between government, trade unions, the private sector, academic institutions, civil society and NGOs to assist in formulating, implementing, and monitoring and evaluating priority areas for school health. Mpilonhle is aligned directly with two objectives of the Integrated School Health Programme:

- To provide preventive and promotive services that address the health needs of school-going children; and
- To facilitate referral to health and other services where required.[3]

Mpilonhle also offers four of the five components of the Integrated School Health Programme's package of services:

- Health promotion/education;
- Individual learner assessment;
- On-site service provision; and
- Referral and follow-up.[3]

### OBJECTIVES

✓ Mpilonhle's main objective is to promote the development of youth through integrated, innovative health and education programmes that prevent HIV, promote general health, and develop the computer-based skills and knowledge necessary to succeed economically.

## SERVICE DELIVERY

### Resource use

Mpilonhle has 60 staff for its core programmes, with each mobile unit staffed by a professional nurse, a social worker, four health counsellors, one health educator, one information technology trainer, 24 home-based carers and a driver who is also the security guard. A mobile unit consists of two caravans, which cost approximately R225 000 each. Each mobile unit carries an Information Technology educator and is equipped with 24 computers that are used by students during the day, after hours and on weekends, as well as during school holidays by those enrolled in the PALS programme. Schools are required to provide a room for the computer training and peer counselling if possible.

### Monitoring and evaluation systems

Mpilonhle has developed an innovative data collection system, in which every contact with a student is recorded in real time using iPods connected wirelessly to a local area network in the mobile unit. This allows the staff, at any time, to know how many people have received services, and to have a complete and secure electronic medical record for every student they care for. The data collection system also allows Mpilonhle to determine how each mobile unit and counsellor is performing, and to assess its overall organisational performance. It monitors a number of key indicators, including the number of health education sessions provided, the number of learners counselled, the acceptance rate of testing for learners, and the HIV positivity rate.

## FUNDING AND PARTNERSHIPS

### Funding

Mpilonhle's funding comes from both private and public sources, including the following: PEPFAR and USAID, Charlize Theron Africa Outreach Project, Oprah's Angel Network, IPAS, National Lottery Distribution Trust Fund, One Sight, South African Sugar Association, and the Los Angeles Futbol Club – Chelsea Foundation.

### Partnerships

Collaboration is very important, and Mpilonhle works closely with government departments and other not-for-profit organisations. It has strong links with the KZN Departments of Health, Education, and Social Development; the South African Catholic Bishops Conference; the Educational Development Center; and Grassroot Soccer.

### Sustainability and possibility of replication

Mpilonhle has been active for five years and its financial sustainability - being a grant-supported programme - makes the future uncertain. While it has diverse sources of funding and appears to have a loyal core of financial supporters, it does not raise a significant percentage of its funding from local sources that could possibly supplement its income. Service provision is also an important aspect of sustainability, and it needs to provide efficient services that meet the needs, priorities and expectations of its constituents. Sustainability also requires a strong public presence, and Mpilonhle enjoys good media coverage and has a solid reputation both locally and internationally. Its sustainability is also dependent on building strong relationships with the schools on which it relies for local support to provide a space for the mobile units, and to make time to allow students to take part in project activities. Teacher- and peer-educator training enhances sustainability, as it builds capacity that benefits the communities. Mpilonhle has developed a viable model of providing computer and health services to isolated rural schools, enabling the programme to be replicated elsewhere.

## CHALLENGES

Mpilonhle has faced a number of challenges. These include:

- Deciding on the package of services to offer and which schools to service. The Executive Director pointed out that an HIV and AIDS-only programme was likely to *"face a lot of stigma and a lot of rejection"*;
- Coordinating project activities with school schedules;
- Providing a package of services to learners who range from 12 to 23 years;
- Accommodating for the fact that all schools are different and require a different approach;
- Ensuring consistent funding;
- Acquiring additional transport needed to provide all services;
- Providing services in a large district with scattered communities;
- Coping with mobile unit staff shortages if staff are off sick;
- Selection of schools to visit to improve the performance of all learners in the district; and
- Inadequate private rooms for peer educators to counsel learners.

## SUCCESSES

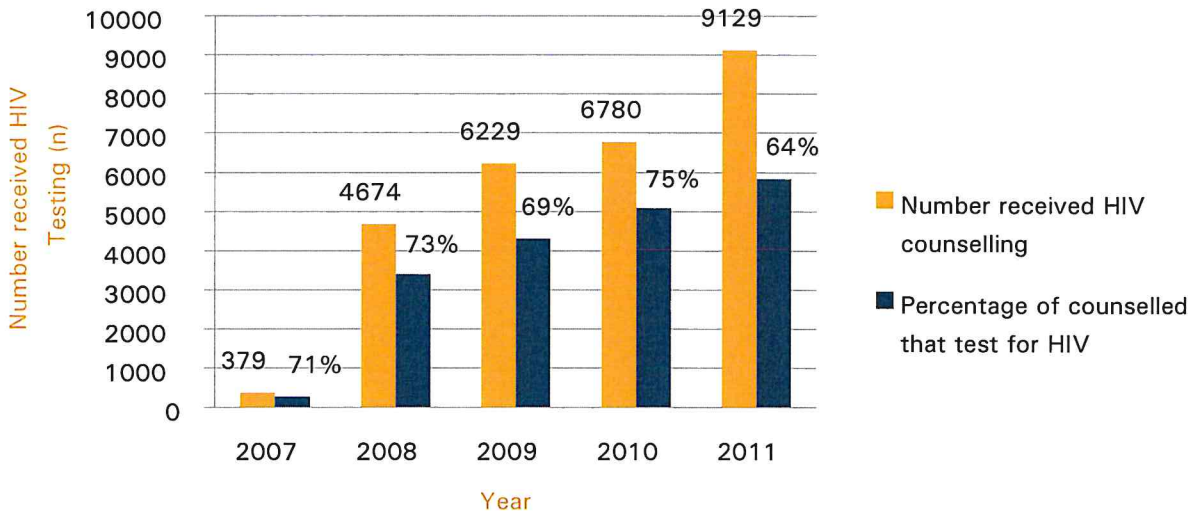
Mpilonhle has reported the following successes:

- A total of 50 852 grade 8 to grade 11 learners and camp participants have attended health education sessions.
- A total of 27 191 grade 8 to grade 11 learners and camp participants received HIV counselling, as depicted in Figure 1 below. The acceptance rate of testing was 75% in 2010. From October to December 2011, Mpilonhle did not test for HIV as per a request from the Department of Basic Education which negatively impacted on the acceptance rate of testing for 2011. From October 2007 to July 2011, the acceptance rate of testing averaged 82%.
- From October 2007 to May 2011, 15 854 learners were seen by the Mpilonhle PHC nurses, mainly for Sexually Transmitted Infection (STI) treatment, family planning, HIV second test, and HIV care and support.
- A total of 3 242 students have received social and psychology services, including identification, referral

and support for those eligible for grants; counselling of HIV-infected leaners; and counselling for sexual or physical abuse (October 2007 to July 2011).

- Just under 31 000 learners from grade 8 to grade 11 and camp participants received computer training.
- Since September 2010, 400 learners have received individual career counselling and 382 received career counselling through workshops.
- Since 2009, approximately 20 000 adolescents have completed eight or more one-hour sessions of Grassroot Soccer "Skillz" training.
- Mpilonhle is collaborating with the Home Field Advantage Project to provide grassed soccer fields with water supply and ablutions, which is currently under construction.
- Food parcel distribution to 40 families started in 2008 and increased to 60 families in February 2011.
- Approximately 50 teachers have attended one-week teacher training sessions.
- Vision screening has been provided to 19 225 people and corrective lenses and glasses to 9 950 people.
- From 1 October 2007 to 30 May 2011, 24 829 community members received health education and 3 659 received computer education.
- Between the period 1 October 2007 to 30 May 2011, 23 632 community members received counselling and the acceptance rate of testing was 64%.

Figure 1: Number of counselled learners, per annum, and proportion of counselled learners that accept testing, October 2011




*Note: Between October 2011 and December 2011 Mpilonhle did not test for HIV in schools as requested by the Department of Education. As of January 2012, Mpilonhle received permission to resume testing for HIV in schools.*

Source: Adapted from Mpilonhle: Four Years of Accomplishments, October 23 2011

## LESSONS LEARNED

Mpilonhle project staff reported that they have learned the following important lessons:

- Staff dedication and commitment are essential to ensure successful project implementation;
- Perseverance, patience, learning from failures and improving services are crucial for improvement.

  > *"There is always room for improvement; you can never say that you are perfect. There is always another step you can take whether it is the quality of your data, cleaning it or reporting on it, from the start to the end but there would always be a room for improving all that."*
  > (Key informant 1)

- The use of innovative techniques such as iPods as data collection tools to solve problems and improve the system.
- The value of team work, good planning and organisational infrastructure.

  > *"Mpilonhle shows how important a team approach is, as well as superb planning and organisation."* (Key informant 2)

- The need for collaboration between government departments.

  > *"We have learnt more about integration, because when you see Mpilonhle, you do not think of only one department, you will meet the Department of Social Development, the Department of Health, and the Department of (Basic) Education, and you will even meet other organisations."* (Key informant 3)

## AWARDS AND RECOGNITION

Mpilonhle has achieved much media recognition, particularly because of its high profile original philanthropists Oprah Winfrey and Charlize Theron. No fewer than nine videos about or mentioning Mpilonhle can be found on the video-sharing website YouTube, and it has also been featured in local and international newspapers, on radio programmes and in magazines.

# Condom Access in South African Schools: Law, Policy, and Practice

Juliana Han*, Michael L. Bennish

In 2007, South Africa's new Children's Act came into effect [1,2], expanding the scope of several existing children's rights and explicitly granting new ones. The Act gives to children 12 years and older a host of rights relating to reproductive health, including access to contraceptives and to information on sexuality and reproduction, and the right of consent to HIV/AIDS testing and treatment [1].

These rights reflect growing concern over the need to prevent HIV in the country's youth. South Africa has the highest number of persons living with HIV in the world [3]. Persons aged 15–24 account for 34% of all new HIV infections and have an HIV prevalence of 10.3% [4,5].

A critical challenge for HIV prevention efforts in adolescents is to ensure that these newly guaranteed reproductive health rights are realized. For youths in South Africa, access to condoms is limited. Barriers to access include substantial travel time and cost of travel to sites of condom distribution [6], the fact that government clinics distributing free condoms are usually closed when students are out of school, the judgmental and often hostile attitude of providers, and the cost of condoms in shops [7].

One way to increase condom access for adolescents is to make condoms available in schools. This is a socially divisive approach. Some believe availability of contraception will encourage sexual activity [8]. Others cite the early age of sexual debut [9,10] and the futility of HIV prevention education that emphasizes condom use without providing sexually active youth with access to condoms [11].

The Policy Forum allows health policy makers around the world to discuss challenges and opportunities for improving health care in their societies.

## Summary Points

- South Africa's recently adopted Children's Act provides children the right to access reproductive health services as a way of addressing the HIV pandemic, but there remains confusion about how socially divisive rights provided for by the Act, such as condom access for youth, will be achieved.
- The Children's Act, together with South African government policies, allows individual schools to decide whether to distribute condoms, but most school staff are unaware of South African policy and regulations governing condom provision in schools.
- Because of confusing and contradictory government policies and public pronouncements regarding provision of condoms in public schools, few schools have undertaken to provide condoms, leaving students, especially in rural areas, with few options for obtaining them.
- PEPFAR regulations potentially conflict with South African law by prohibiting PEPFAR-funded organizations from distributing condoms in schools or providing condom information to youth aged 14 and under.
- The current South African government's policy of leaving the decision of whether to distribute condoms in schools to the School Governing Body of individual schools, rather than enacting a clear national policy, is unlikely to be an effective public health strategy for improving access to condoms for the population of youths at high risk for HIV.

Reflecting these tensions, South African government policy is unclear, and school staff are often unsure if condom distribution in schools is permissible. As a result, most schools hesitate to distribute condoms, and those few that do distribute condoms do so discreetly [12].

Given the continuing high HIV incidence rates in youth, it is important to examine current South African laws and policies governing condom distribution in schools, policies of international donor agencies supporting HIV/AIDS prevention programs in South Africa [13], and community perceptions surrounding condom distribution in schools. We reflect on our experience in developing a policy on condom distribution for Mpilonhle, a nongovernmental organization involved in HIV prevention in schools, focusing on germane South African and PEPFAR (the US President's Emergency Plan for AIDS Relief) policies and on the attitudes of students, school staff, and parents towards condom distribution in schools.

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**Abbreviations:** DOE, Department of Education; DOH, Department of Health; PEPFAR, President's Emergency Plan for AIDS Relief; SGB, School Governing Body

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## Law and Policy

**South African laws and policies.** The overarching legal document governing children's rights to access contraceptives is the Children's Act No. 38 of 2005 ("Children's Act"). The sections of the Children's Act regarding the responsibilities of the national government, such as reproductive health rights and children's courts, were approved by the President in 2006 [1]. Provisions regarding the responsibilities of provincial governments, such as foster care and child-care centers, are contained in the Children's Amendment Act, approved by the President in 2008 [14].

The Children's Act delineates rights not present in the Child Care Act of 1983, many of which are relevant to youth health programs. For instance, every child, regardless of age, has the right to "have access to information on . . . the prevention and treatment of ill-health and disease, sexuality and reproduction" [15]. A 12-year-old child can consent to HIV testing [16], and children under 12 years can also consent if they are of sufficient maturity to understand the benefits, risks, and social implications of a test.

The Children's Act states that no person may refuse to sell condoms to a child 12 years or older, or refuse to provide such a child with condoms on request where such condoms are distributed free of charge [17]. No further regulations are needed to effect these rights [2]. However, whether these rights are appropriate remains the focus of intense debate [18,19].

In addition to the Children's Act, the South African Department of Education (DOE) policies also govern condom distribution in schools. The current DOE policy is a politically pragmatic solution to the national debate: let local schools decide for themselves. In a 1999 policy document (still in force) on HIV and AIDS in public schools, the DOE stated that each school can decide "whether condoms need to be made accessible within a school . . . and if so under what circumstances" [20].

This decentralization reflects the mechanics of policy implementation. The national Minister of Education determines national policy, which drives policy and implementation at the provincial level [21]. Policy updates then trickle down through regional DOE offices, which pass them to local schools. The ultimate governance of every public school is vested in its School Governing Body (SGB), consisting of parents, school staff, and students [22].

In the case of condom distribution in schools, the policy of decentralization has been poorly communicated. Most school staff are unaware of any policies on condom distribution in schools. Perhaps more worrisome, many funding agencies, advocacy groups, and government officials believe that condom distribution in schools is impermissible as a matter of stated policy. This view seems based on statements by senior government officials, including the Minister of Education, suggesting that condom distribution in schools is inappropriate [12,23,24]. Statements to the press, no matter how public, are not official policy. Education policy must be made according to defined procedures, including notice and publication in the Government Gazette [21].

The Children's Act thus preserves the schools' right to choose to distribute condoms, with one modification. If schools do distribute condoms, they must provide them to all students 12 and over. The Act does not impose an obligation on the government to distribute condoms. The condom access clause is a "negative right," which obligates the government to refrain from certain actions. It is not a "positive right," such as the Constitutional right that obligates the government to provide access to health care services [25]. The latter right was the basis for the South African Constitutional Court's decision that drugs to prevent mother-to-child transmission of HIV must be made available to all HIV-infected women giving birth in state health facilities [26].

**Policies of funding agencies.** Restrictions of funding agencies, other than the South African government, that support HIV prevention efforts are also relevant to condom access for adolescents. The United States government is the largest bilateral donor to South Africa's health sector [27]. Through PEPFAR, it allocated US$398 million in US fiscal year 2007 for South African HIV/AIDS programs [28].

PEPFAR's emphasis on abstinence in prevention programs limits condom interventions [29]. PEPFAR global guidelines prohibit use of plan funds for the physical distribution of condoms in schools or the provision of condom information to youth aged 14 and under [29].

This policy conflicts with South African law. It is unclear how health workers supported by PEPFAR who work in South African institutions, such as schools, should act if youngsters under 14 but above 12 years request information or condoms. The Children's Act grants all children the right to access health information and children 12 and older the right to access condoms, but the workers are ostensibly constrained by PEPFAR policies. That PEPFAR's policies may hinder the provision of beneficial condom programs for youth has been noted [30].

## Community Attitudes and Responses

**Discussions with the community on program development and implementation.** To determine how Mpilonhle should, as part of its programs, approach the provision of condoms in schools, we spoke to persons in the communities of four high schools in which Mpilonhle intended to provide services. The schools are located in rural northern KwaZulu-Natal, the province with the highest prevalence of HIV [4]. These schools have student enrollment of 400–900 students aged 12–22 years, and instruction is in English.

Discussions were held at one SGB meeting, which included the principal, one teacher, six parents, and one student representative, and at two parent meetings, each with approximately 100 adults, primarily women, in attendance. Individual interviews were conducted with principals and staff at each of the four schools, including teachers of the Life Orientation subject, which includes HIV/AIDS prevention. At three schools, discussions were held with groups of five to ten students of both sexes from grades 8–12, selected for participation by school staff.

All meetings began with structured questions, including: (1) how schools are addressing HIV/AIDS prevention, including condom education or distribution; (2) how the respondents view condom distribution in schools;

and (3) what specific strategies Mpilonhle could use to increase the efficacy of condom distribution in schools.

Students were asked about condom availability and use. School administrators were asked about their awareness of national policy on condoms in schools and their understanding of education policy implementation.

These questions led to open-ended discussions regarding the impact in schools of HIV/AIDS and other problems, such as teenage pregnancy. Questions were asked in English and, in SGB and parent meetings, translated into Zulu.

These discussions were conducted to enable implementation of a service program. Determining community attitudes was required to ascertain whether Mpilonhle could distribute condoms in the schools in which it intended to work. Because these discussions were conducted for program implementation and not for research purposes, and because no experimentation on humans was involved, institutional review board approval was not obtained.

We do not claim that these responses are representative of South Africa. Rather, these comments were critical in helping Mpilonhle formulate an effective HIV prevention program for local youth. Mpilonhle now provides condoms at the schools it serves in accordance with these findings.

**Community response.** Attitudes about condoms in schools at the community level vary widely. Cultural and moral concerns remain strong among both parents and students, including the preservation of such traditional values as abstinence until marriage. Many parents and some students, but few school staff, felt that condom availability would promote sexual activity and undermine traditional values.

These concerns were balanced by a strong sense of the growing urgency of the HIV/AIDS epidemic. Most people we spoke to indicated that they knew family or friends affected by AIDS and spoke about the emotional impact of burying people from the disease every weekend.

Some community members were also keenly interested in access to condoms to prevent teenage pregnancy, sharing the KwaZulu-Natal government's concern regarding the increase in pregnancies in schools [31]. Others, however, stated that pregnancy prevention will not be a compelling reason for condom use because many adolescent girls want the government's child support grant, even though studies have found no correlation between the grant and teenage fertility [32,33].

**The importance of procedure.** With such diversity of opinion, administrators were not eager to be first movers and insisted on a procedure for ascertaining community support for condom distribution programs. First, schools should consult as many parents and guardians as possible; outside groups such as nongovernmental organizations could help facilitate this discourse. Second, schools should involve the larger community, including traditional (tribal) leadership. Lastly, the SGB should ultimately decide whether to proceed with condom distribution.

Parental support was perceived to be the key factor for program success. Students felt that they could not communicate frankly with their parents about sex. The natural awkwardness between adolescents and parents is reinforced by cultural practices, such as virginity testing, that further stigmatize sexual activity and open discussion [34,35].

Many parents lacked basic knowledge of HIV/AIDS and condoms. Parents questioned the efficacy of condoms and expressed faulty beliefs about HIV transmission, for instance, that a child might get infected by playing with used condoms. Several adults indicated that they themselves did not know how to use a condom. Many parents complained of adults in the community who, accessing condoms in places like shebeens (taverns), would dispose of used condoms indiscriminately. Concerns about wastage and litter were surprisingly common.

School staff also felt it important to consult the greater community, including traditional leaders. This might be accomplished by having a traditional leader present at school meetings. Although the traditional authority has no official role in the operation of schools, condom distribution was seen by some to threaten the moral fiber of the community, areas of concern for traditional leadership [36].

With sufficient parental and community support, school educators, administrators, and governing body members indicated that they would be eager to distribute condoms in schools. Educators also recommended distribution points for school staff; HIV prevalence among teachers in KwaZulu-Natal is estimated at 22% [37].

**Options for condom distribution in schools.** Once a school decides to provide access to condoms, it must decide on the logistics of distribution. The past experiences of two schools in which we work were instructive. At one school, a box of condoms issued by the national Department of Health (DOH) was brought to the school by a nongovernmental organization and placed in the principal's office. In the more than a year that the condoms remained in the office, not a single student approached school authorities to request condoms.

In another school, an educator obtained a box of condoms from a local clinic and placed it in an unlocked cupboard drawer in the school library. Students had to ask for the key to the library, but the educator who had the key said that she never questioned the students' reasons. She reported that the condom box was quickly empty.

Both students and teachers indicated that having an authority figure serve as gatekeeper for the condom supply would deter access in schools, just as it does in clinics. Students fear authority figures discovering that they are sexually active, scolding them for having sex, and asking disapproving questions.

Many students suggested putting unmonitored dispensers in the toilets and classrooms and believed that, with proper education, they would be used appropriately. Other students disagreed, believing that such a setup would encourage litter and misuse—concerns akin to those of their parents. Regardless, if an authority figure is involved, students were adamant that the figure be nonjudgmental. One student described the proper adult role as "control of the condoms, not of the learner."

## Discussion

Despite the high incidence of HIV in adolescents [38] and the efficacy

of condoms in preventing HIV transmission, condom use rates among adolescents remain low, due at least in part to limited access. Especially in rural areas, schools are one of the few sites accessible to large numbers of youth; yet, condom distribution is rarely undertaken in schools.

Although this is a contentious issue, we have found that school staff and students generally support the distribution of condoms in schools but are confused about governmental policy. The national policy, that schools can decide whether condom distribution is beneficial, is one sentence in a national DOE document of which local schools seem unaware. Statements of government officials against condom distribution further obscure actual government policy.

This ambiguity, created by unclear policies and contradictory public statements, has characterized South Africa's approach to other HIV-related issues as well. Both the former Health Minister and the previous President have voiced doubts about the causation and treatment of HIV/AIDS, which at the worst retard national AIDS policy and at the least hinder public understanding of the disease [39].

One rationale for South Africa's decentralized approach to condom distribution in schools is sensitivity to local attitudes. SGBs are arguably in the best position to gauge community views. How exactly to elicit those views, however, is unclear. In parent meetings, men were most outspoken, voicing concerns about the effect of condom distribution on "traditional" values. However, both women and men supported condom distribution more openly in private conversations. School administrators are also unsure what level of consensus would be sufficient to move forward. Should a vote be taken, and if so, should a majority or near unanimity be required? Unfortunately, the latter scenario may always preclude potentially beneficial action.

While decentralization of decision-making on socially divisive issues may be politically expedient, its effectiveness in spurring needed action is questionable. Given the dire risks that still face South African youths, leaving major public health initiatives to local option may be an insufficient governmental response.

The South African government's apparently contradictory actions reflect in part the presence of deeply divergent forces in society. Many in South Africa have supported expanding children's rights to reproductive health services, reflecting the desire in the post-apartheid era to expand individual rights in response not only to injustices of the past, but also to the harsh realities of the present.

The government could be similarly bold in policy implementation and mandate that schools provide condoms. The DOH, which already distributes condoms in public access points [40], could add schools as a distribution site [41]. The DOH, the DOE, and the Department of Social Development (under whose jurisdiction the Children's Act falls) could coordinate more closely, perhaps building on existing programs such as the DOE Life Orientation curriculum and the DOH School Health Policy, to support more effective education on, and access to, condoms.

Together, schools and the government could also increase efforts to educate communities about adolescent condom use. Educators should make clear that provision of condoms is not an endorsement of sexual activity. Empirical research on distribution efforts in South African schools can address fears of increased sexual activity or wastage. At least one study suggests that wastage of condoms distributed from public access points in South Africa is not substantial [42]. In the United States, where social consensus on condoms in schools has also been elusive, studies show that high school distribution of condoms has not resulted in increased sexual activity [43] but has increased condom usage [44].

Community concerns may also be mitigated by tailoring the logistics of condom distribution in schools. The degree of adult supervision over the condom supply may depend on the needed balance between open access and potential misuse.

Access alone is not sufficient. Programs will need to teach proper condom use and address factors contributing to inconsistent use [34], such as a lack of perceived risk of HIV, influence of peer beliefs, and unequal power relations between genders [45,46].

The need to balance sensitivity to local attitudes and urgent national health needs is not unique to the issue of condom access for youths, nor to South Africa, but is part of any policy discussion on socially divisive issues with compelling public health implications. Our experience with South African and PEPFAR policies regarding condom distribution in schools indicates that the present balance disfavors the health of the country's youth and demonstrates a need for clearer and more decisive national action.

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# Write 2 Rise

*"Success is no accident. It is hard work, perseverance, learning, studying, sacrifice and most of all, love of what you are doing or learning to do"*

*- Pele –*

DIFFICULT ROADS OFTEN LEAD TO BEAUTIFUL DESTINATIONS.


*(Pictured above): From Mthatha to Broadway! During her course of training, Sinenhlahla Rawe's vocal and stage talents came shining through, and were too good and vibrant to ignore. It was then arranged that Nomdakazana, the winner of the 2018 Eastern Cape Music Awards' Female Vocalist of the Year, to groom her for better things. The process is ongoing and Sinenhlahla has already written her first song, titled "Rise Up"*

This is the seventh edition of the monthly newsletter, Write 2 Rise, aimed at sharing tools, tips and useful resources with partners implementing the Young Women & Girls (YW&G) Economic Strengthening Programme.

## More success stories!

At Mpilonhle:

- 50 YW&G enrolled in an ABET programme
- 250 YW&G enrolled in employability, whereby 220 successfully completed the Employability programme and 122 beneficiaries have been placed in different companies for internship programmes
- 282 YW&G participated in the Entrepreneurship programme, with 37 businesses being registered and 21 businesses being in full operation
- 89 women were assisted to apply for bursaries online through CAO and NSDAS. Of these, 38 women received acceptance at a higher institution.

**YW&G starting their learnership at NASHUA**

At EOH, 40 of the YW&G started a vegetable farm via the guidance and assistance from their YWG ESP supervisors. They are selling a variety of vegetables such as lettuce, cabbage and cauliflower.

At Future Families, two girls, Bridget Maleke and Lebogang Matshabe, from Tshwane completed a 3-month internship at SABCOHA from July 2017 to September 2017. Bridget Maleke was offered an extended contract at SABCOHA from October 2017 to March 2019. Lebogang was also offered a position but declined. Another two girls, Tisetse Aphane and Dimakatso Majalefa have been employed as TB Mobilisors by SABCOHA for 18 months, ending March 2019.

**A young girl from Mfolozi local municipality who took part in the entrepreneurship programme provided by NYDA**


*(Pictured above): Siphenathi Mapikana, from the Western Cape secured a job as a KPMG Auditor!*

*In addition to this, the Desmond Tutu HIV Foundation and Business Activator, contracted by the Western Cape Department of Health, achieved the following in the YW&G ES programme:*

- *28 participants assisted with ID documents applications*
- *13 participants registered to rewrite Matric*
- *20 participants currently in paid employment*
- *50 participants awarded or soon to be awarded bursaries for various courses*

*(Pictured above): Ms Agrecious Sibuyi, along with other women, grabbed the opportunity and completed forms and attached the required supporting documents. Within a few weeks, Agrecious received positive feedback and was accepted to study at Randfontein Campus, studying Public Management. Ms Agrecious was also funded by NSFAS*

*- Childline Mpumalanga story*

"My name is Thato Lesuyi and this is my story, I was enrolled in a rise club called Doza-Zone last year around September, facilitated by Mahlatse Phala at Atole Village and I attended sessions daily and the sessions helped me a lot, and I enjoyed every session. I always wanted to go to tertiary ever since I completed my matric but due to challenges, I found myself at home. There was a time where I did apply for tertiary, I wanted to be a pilot, I qualified and was admitted but due to financial difficulties I couldn't go, I suppose maybe the reason was because I didn't have the mentoring I've had now in this programme.

**(Pictured above): Positive energy at one of the discussion groups (Future Families)**

It was during the SATE sessions, when my facilitator Mahlatse Phala shared with us that there will be NSFAS online applications assistance for 2019 to beneficiaries that were interested. This would be done by their office in Moroke village Mecklenburg Hospital, and I would be helped by one of the mentors or the management SATE leader from Pretoria. That got my attention and I went there, taking a leap of faith, to see myself in tertiary and when I got there, I found an incredible and very helpful team as they have also managed to register me for online admission in Sekhukhune TVET CN Phatudi. This was a bonus to me because I was expecting to be registered for NSFAS only and as I'm sharing this with you I am successfully studying to be an electrical engineering student at CN Phatudi TVET College.

I would like to say thanks to the programme and most of all Mahlatse Phala for being such a great facilitator by taking us and her job seriously hence she never ceases to encourage us with her multiple calls to check on us and the progress we are having to dream and follow our dreams regardless of our background.

So, I personally would like to encourage other beneficiaries to never lose hope and stay motivated and humble, listen to your facilitator and don't despair, take action trusting God, and you will see things unfolding to your advantage because I am empowered because of the club. All in all, I just wanted to say thank you and continue helping others like me. I'm so grateful and my plan does not end with this. I will forever grow and got so many other plans after my studies/ my electrical engineering diploma I already see myself as an electrician at Eskom I feel so inspired only the sky is my limit and I will forever be grateful; for such great information and mentoring which I received from the club."

Thato Lesuyi's story, an Ikhumiseng success story.

## Knowing me, knowing you

This month's edition of Write 2 Rise introduces fellow YW&G implementation partners, **Nombulelo Musangu** and Future Families team:

**Dimakatso, Ellen, Matjatji, Mapadi and Gosiame**

### Nombulelo Musangu

**Organization:** The Business Activator

**1. What is the most exciting activity that you do on a daily basis in your job?**

Interacting with young women, Facilitating and Transforming lives through training, and sharing real life stories.

*(Pictured above): Photos provided from Childline Mpumalanga of various sessions and happy moments throughout the programme*

2. Describe yourself in three words?

- Confident
- Hard worker
- Helpful

3. What is your favourite part about the YW&G Economic Strengthening Programme?

It is when a young person's life has been transformed, not only the exterior part or materialistic, but the soft skills, behavior changes, so that would be training and mentoring.

4. Name one of your female role-models and why?

Gill Marcus, the first women to work as the governor of the Reserve Bank.

5. If you were to win the Lotto today, what is the first thing you would do?

I Would build more Drug Rehabilitation Centres that are more affordable and accessible to the community.

## Dimakatso, Ellen, Matjatji, Mapadi and Gosiame

Organization: Future Families

1. What is the most exciting activity that you do on a daily basis in your job?

Facilitating the economic stream sessions and to hear the positive response and see the girls participation in the various activities during the sessions. Also hearing the positive feedback from our participants in terms of what has worked from them and how they are now aware of the importance of knowing yourself and planning for the future.

2. Describe yourself in three words?

- Confident: Being able to enhance our facilitation skills
- Energetic: Be active in the group sessions and positive
- Conscientious: Able to do work that is required within a short time/ period

3. What is your favourite part about the YW&G Economic Strengthening Programme?

Changing the perceptions of the girls on how they view life in general. Through our facilitation and discussions the mind-set of girls shifted and changed. They started to believe in themselves and specific issues / things i.e. "there are opportunities for everyone, it's a matter of one having a positive mind-set."

Nurturing and enhancing their skills and developing their low self-esteem, as they used to think of themselves as not having the abilities and necessary skills to break their fear and anxiety. Through the program the girls manage to break down these barriers and seek job opportunities or just change their environment and how they look at things.

4. Name one of your female role-models and why?

Oprah Winfrey, she has changed the lives of many young girls and continuing to making a difference as she has even opened a school for them.

5. If you were to win the Lotto today, what is the first thing you would do?

Open a skills development centre catering for both out of school boys and girls, giving them different skills as per their needs from the assessment tool used. After attending the different programs, participants will be able use the skills acquired to sustain themselves financially and live a productive live in their homes and families

# Tackling education through strong sisterhood

*Story and photos by Wellington Makwakwa*


**The Mangezi RISE club is in Mangezi Reserve in the KwaDlangezwa area in northern KwaZulu-Natal.**

The club was started in March 2017 and the members are between 19 and 25. The community is badly affected by teenage pregnancy, alcoholism, drug abuse and unemployment.

## A strong sisterhood

The main focus of the group is to encourage the community to value education and to identify tertiary educational opportunities for each other.

*"Education is a foundation for a better future. We don't want a community where young women depend on older men to survive,"* said team leader, Ayanda Gumede (26).

The Mangezi RISE club assists young women in tackling various issues such as sex, alcohol and drug abuse.

*"Through discussions, we are able to identify problems and talk about them. Our close sisterhood makes it easy for us to find solutions for many issues, gain self-confidence and support each other as well as our community,"* said Ayanda.

## Making a difference

The Mangezi RISE club members have become an important part of the community through conducting various educational initiatives.

Last year they started fitness and health campaigns. They also started a recycling programme where they taught residents about the importance of the environment. The club members spread a strong environmental message by picking up litter in the streets for recycling. According to the group, their most fulfilling initiatives were their march against the abuse of women and children as well as their ongoing beadwork project.

They teach each other beadworking skills and sell their goods to the community.

## Future plans

They hope to grow the club by recruiting more women. Developing their beadwork project into a lucrative business is also a plan for the future.

# Caregivers with a dream

WOMEN DREAMING AHEAD

**Women Dreaming Ahead RISE club is in eMzingazi Reserve outside Richards Bay. The RISE members meet in a tiny room at Lungelo Youth Development Centre.**

Their community has many challenges such as drug abuse, teenage pregnancy and crime. The RISE young women believe these problems have come about because of high unemployment.

The Women Dreaming Ahead RISE members have targeted unlicensed liquor outlets in the area. Youngsters have easy access to alcohol which makes it very hard for them to stay in school.

## Community caregivers

These young women have become the pillar of strength for their community. They do it all through their strong sisterhood bond. Not only do they support each other but they also look after the frail and elderly.

Through working with other community structures, they conduct community awareness campaigns to

# POSITIVITY

*Story and photos by Wellington Makwakwa*

CRAZY CHARMA GIRLS

**RISE Crazy Charma Girls club is in eCinci area in KwaMthethwa Reserve in KZN. The community is troubled by poverty, HIV infections and lack of educational structures. The Crazy Charma Girls want to be the change they want to see in their community. So they empower their community by providing access to much needed information.**

They have taken responsibility for creating positive community initiatives. With some guidance from their skills coaches, they have managed to develop each other while focusing on educating the community on issues related to health and education.

### Community health and education projects

Their community faces challenges such as teenage pregnancy and an increase in reports of sexual transmitted diseases.

Nonhanhla, a life skills coach, said, *"The community has many orphans due to HIV and most people don't have proper education."*

Through strong partnerships with community-based organisations, such as Mpilonhle, RISE Crazy Charma Girls conducted a massive community campaign in September last year.

They are also promoting self-respect, open communication with peers and identifying educational opportunities. *"Since we started these educational drives, many young people now understand issues related to HIV. The level of school dropouts has decreased as we help them get back to school as well as assist those who completed their matric with tertiary education applications,"* said Nonhlanhla.

The group also has a vegetable garden project and they teach the community about healthy eating.

### Future plans

The Crazy Charma Girls hope to build a multipurpose centre for the youth. Their aim is to have access to the internet and to assist young people with writing their CVs and job applications. The Crazy Charma Girls not only want to open up employment opportunities with their bead project but also want to create a platform for local artists to showcase their art by developing young poets, dancers and musicians, in the hope that they will use their craft to create opportunities for others.

*Educating the community about eating healthy.*

*Showcasing their beadwork.*

ıddress women and children abuse. hey also enjoy art projects and ave a drama club and bead work roject.

### he dream

he Women Dreaming Ahead ISE club hope to expand their ɔmmunity caregiving project. They ope to get sponsors and grow the ead project to ensure financial tability. They also hope to get their wn venue one day which will nsure they are able to sustain their rojects.

### 5.2.2.1 Programme reach and performance

Figure 3 summarises the performance of the districts by comparing the levels of young women that have attended two or three RISE club meetings per quarter as an indication of how well the RISE Programme is running in the various districts. It shows that the attendance of young women has had large variations across time, first occurring at levels lower than 300 young women until the fourth quarter, when it began to rise faster. Only in Gert Sibande were more than 200 young women reached in RISE in the first quarter. By the eighth quarter, King Cetshwayo had the highest levels of girls reached followed by Gert Sibande and Greater Sekhukhune. City of Cape Town Metro consistently had the lowest levels of young women attending the programme over time, followed by the Nelson Mandela Metro. In all cases none of the districts were able to reach the target 1000 young women reached through 2 or 3 meetings in RISE clubs in any of the quarters. The performance of the RISE programme in the City of Cape Town Metro was never above 10% of the target level of performance. In Tshwane the target number of girls for enrolment into RISE was 1600 rather than 1000 which means that SCI were able to reach just under 50% of their target performance level in one quarter only (Quarter 7). In most other quarters their performance fell well below this (Refer to Figure 4).

The handover of RISE clubs to new PRs at the start of the Grant period does not seem to have kick started the implementation of RISE as may have been the original intention. In general, it would appear that the implementation of RISE was from a very low base despite this being the second phase of activity in all of the provinces with the exception of Limpopo.

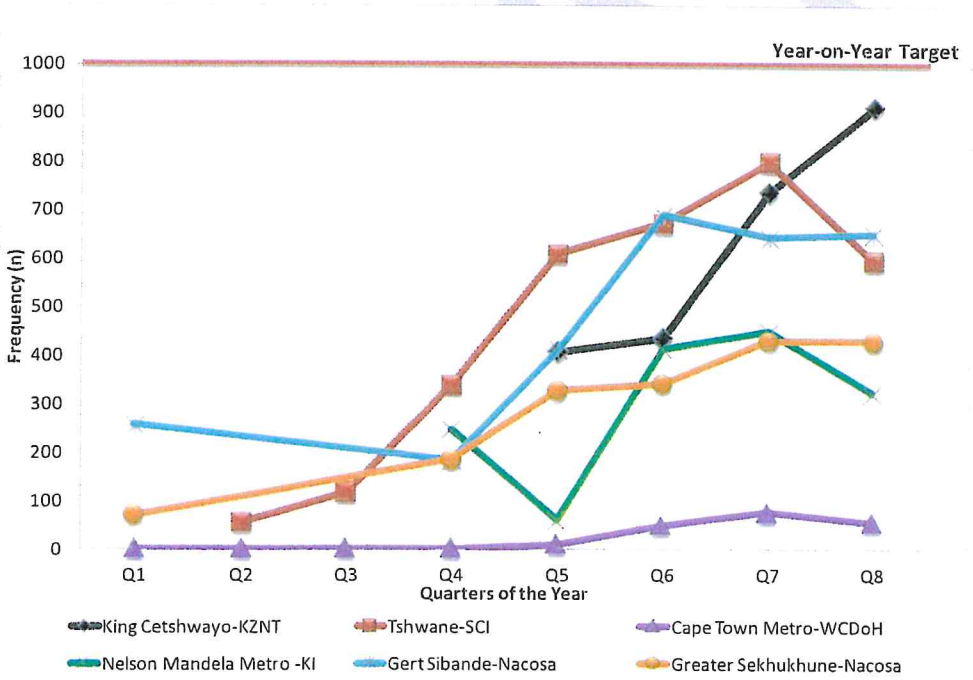


*Figure 3: Numbers of young women attending two or three RISE Club meetings per quarter in Y1 and Y2: April 2016- March 2018*

The above reach data is shown as a percentage of the target number of girls per district across time in Figure 4 below.

# Inhlangano yomphakathi eMtuba iqeqesha amantombazane kwezamabhizinisi

SIZWE SIBIYA

INhlangano eNgenzinzuzo iMpilonhle iqhuba uhlelo olubizwa nge-Economic Empowerment Strengthening Programme lapho abathathe khona amantombazane angu-1000 avela ezindaweni ezakhele uMasipala uMfolozi noMhlathuze aziyisa eMeet Mekaar Resort eseMtubatuba ukuyowaqeqesha, bawakhuthaze baphinde bawacije ngokukhula komqondo.

UNksz. Phumzile Kubheka owengamele lolu hlelo ngaphansi kwalenhlangano uthe lolu hlelo luhlose ukukhuthaza intsha njengoba bethathe amantombazane aphakathi kweminyaka engu-18 kuya ku-24 ubudala.

"Inhloso yalo ukukhuthaza intsha ukuba ibambe iqhaza ekuzithuthukiseni kwezemfundo, ezamakhono, ezamabhizinisi kanye nezamathuba emisebenzi," kusho uKubheka.

UNksz. Kubheka uqhube wathi lolu qeqesho luqale ngoJulayi, luzophela ngomhlaka-17 ku-Agasti. Kanti uthe akusekude phambili ngoba manje sebesele neqembu lamantombazane okugcina angu-57 okumanje aphothula uqeqesho lokucijwa ngokukhula komqondo, ukuziphatha ukuhlumeleliswa kwezimilo kanye nangokwazi ukumelana nezimo ezenzeka empilweni.

Eqhuba uKubheka uthe ukuze bakwazi ukuzimela futhi babambe neqhaza emnothweni wezwe bayafundiswa nangemikhakha abayikhethayo.

Kanti lamantombazane aphinde ahlelelwe i-Career Expo ezoba ngomhlaka-3 kuSepthemba 2018 khona eMeet Mekar Resort, nokulindeleke ukuba kubekhona nabavela eMnyangweni wezeMfundo ePhakeme, abamakolishi angama-TVET kanye naboPhiko lwezokuThuthukiswa kwamaKhono komasipala bobabili abayinxenye yalolu hlelo.

UKubheka uphinde waveza nokuthi kukhona abazohlomula imali yokubhalisa esikhungweni semfundo ephakeme ukuze bakwazi ukubamba indawo ngenkathi besabhalisela isibonelelo sikahulumeni sezemfundo.

Lolu hlelo luxhaswe u-KZN Treasury kanye noGlobal Fund.

Esithombeni : Amantombazane abeyingxenye ye-Economic Empowerment Strengthening Programme eMtubatuba

# Bathi bakhathele ukuhlukunyezwa abantu besifazane EThekwini

SIZWE SIBIYA

Izinkumbi zabantu besifazane abavela ezindaweni eziningi kuleli ngisho nabakwamanye amazwe bahlangane ngazwi linye, bethi bakhathele ukuhlukunyezwa abantu besilisa emashini ebimaphakathi nedolobha leTheku uhlu lwezikhalo zabo khona.

UNksz. Beverly Mothlabani ongomunye wabakade behola le mashi ngaphansi komfelandawonye odume ngele #TotalShutDown ezinkundleni kuloluhlu lwezikhalazo banxusa namaphoyisa ukuba aqaphe izibhamu zawo ngoba izona ezigcina ziba izikhali ezilekelela ekuhlukumezeni abantu besifazane.