

Distance Education as One of the Collaborative Measures Against HIV and AIDS in Swaziland

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Abstract

HIV/AIDS is a threat to national development worldwide. Research has indicated that societies carrying the heaviest burden of HIV/AIDS are the poor developing societies of the world. The link between poverty and HIV/AIDS is well established. HIV/AIDS could only be dealt with if action is carried out on numerous fronts, including the educational front. Unfortunately, Swaziland, a developing kingdom on the South Eastern part of the African continent, only has one university which cannot enrol all qualifying candidates. The limited resources at the University of Swaziland makes Open and Distance Learning the only way forward to educate the Swazis on HIV/AIDS. This paper discusses factors fuelling HIV infection in Swaziland. It shows how multi-sectoral collaboration could be used to solve the problem of HIV/AIDS. This paper further describes the role which Open and Distance Learning could play in combating HIV/AIDS in Swaziland. The sole aim of this description is to create awareness on the potential the Institute of Distance Education (IDE) of the University of Swaziland has in the fight against HIV/AIDS. To achieve the objectives of this paper, the researcher reviewed secondary and primary literature on the prevention and mitigation of the impact of HIV/AIDS in the Southern African Development Community (SADC). Primary sources reviewed, were mainly reports from international and national organizations involved in HIV/AIDS issues like the Department for International Development (DFID), the World Health Organization (WHO) and those from United Nations AIDS (UNAIDS) and the National Emergency Response Council Against HIV/AIDS (NERCHA). These reports contain empirical findings which the researcher used to describe the HIV/AIDS Scenario in Swaziland. In that manner, the researcher was able to come up with a proposal whose emphasis is on the need to use Distance Education as a collaborative strategy in combating HIV/AIDS in Swaziland.

Abstrak

HIV/AIDS adalah ancaman kepada pembangunan nasional seluruh dunia. Kajian telah menunjukkan bahawa masyarakat yang membawa bebanan yang berat daripada HIV/AIDS adalah masyarakat dunia yang miskin berbanding negara membangun. Kaitan antara kemiskinan dan HIV/AIDS telah terbukti. HIV/AIDS boleh diatasi dengan tindakan daripada pelbagai segi termasuk dari segi pendidikan. Walau bagaimanapun Swaziland merupakan negara membangun di Barat Daya Afrika. Terdapat hanya sebuah universiti yang tidak boleh mendaftar kesemua calon yang layak. Sumber yang terhad di Universiti Swaziland menjadikan pembelajaran terbuka dan jarak jauh, satu-satu cara ke hadapan untuk mendidik rakyat Swaziland tentang HIV/AIDS. Kertas kerja ini membincangkan faktor yang menyemarakkan infeksi HIV/AIDS di Swaziland. Ia menunjukkan bagaimana kerjasama pelbagai struktur sektor boleh digunakan untuk menyelesaikan masalah HIV/AIDS. Kertas kerja ini seterusnya menerangkan bagaimana peranan pembelajaran terbuka dan jarak jauh memainkan peranan dalam memerangi HIV/AIDS di Swaziland. Peranan utama adalah untuk mewujudkan kesedaran terhadap keupayaan institut pendidikan jarak jauh di Universiti Swaziland dalam memerangi HIV/AIDS. Untuk mencapai objektif kertas kerja ini, penyelidik telah mengulas literatur primer dan sekunder ke atas halangan dan meringankan impak HIV/AIDS di dalam masyarakat pembangunan Afrika Selatan. Ulasan punca primer kebanyakannya adalah laporan daripada pertubuhan nasional dan antarabangsa yang terlibat dalam isu HIV/AIDS seperti Jabatan Pembangunan Antarabangsa, Pertubuhan Kesihatan Sedunia dan pertubuhan daripada Persekutuan Antarabangsa. Laporan ini mengandungi dapatan empirikal yang digunakan oleh penyelidik untuk mengulas senario HIV/AIDS di Swaziland. Dalam keadaan ini, penyelidik boleh mengemukakan satu cadangan yang menumpukan kepada penekanan terhadap keperluan penggunaan penyelidikan jarak jauh sebagai strategi bersama dalam memerangi HIV/AIDS di Swaziland.

Introduction

Swaziland is a member of the Southern African Development Community (SADC), a region where HIV/AIDS was declared as an emergency which according to the DFID Report of 2006, “Threatens development, social cohesion, political stability, food security, life expectancy and economic growth” (2006: x). In Swaziland most of these effects enumerated in this report are beginning to be felt and seen in almost all spheres of life despite numerous attempts to curb the rapid growth of the pandemic and to reduce

its impact on the nation. The example below shows the gravity of the problem in the country.

“...In one of the homes of people living with HIV/AIDS in Swaziland, AIDS had claimed the lives of three out of a family of five. The only two still alive were a three year old girl and her mother who was intermittently ill and physically unable to find food, cook or bath herself. The three year old girl practically assumed all household chores: the ill bed-ridden mother would tell the child to light the fireplace and move the cooking pot back and forth for her to stir as the child looked on. She would then tell her to wake her up once the food was cooked and bring the food by the bedside...To the mother, the child was the only care giver...To the community worker, taking the child away meant removing the only care giver for the mother and separating the child from her remaining family member...” (Swaziland Government, 2006: 50).

Separating the mother from the child would not change the fact that the mother was about to die of HIV/AIDS. Nothing could be done to remove the virus from the blood of this woman. But a lot had been done to keep Swazis out of danger of contracting the HIV. Despite all the efforts, many families in Swaziland have lost their loved ones to HIV/AIDS. Consequently, ailing family members are left to be looked after by young girl children in whose hands some of them end up dying. The main question raised and answered by this paper is, what remains to be done in this patriarchal kingdom for it to overcome the pandemic?

To paint a clear picture of what Swaziland has been doing to combat HIV/AIDS since 1987, one needs to provide a historical account of Swaziland's response to the HIV/AIDS pandemic. The first HIV case in Swaziland was reported in 1986. In 1987 the first HIV/AIDS victim died. Since then, “...both the Swaziland Government and the Non Governmental Organisations (NGOs) have worked tirelessly to educate the nation in an attempt to combat HIV/AIDS...” (Dlamini, 2003: 34). For instance, in 1987, the Swaziland Government, with the assistance of the World Health Organisation (WHO) established the National AIDS Prevention and Control Programme (NAPCP). This programme was later renamed the Swaziland National AIDS Programme (SNAP). This programme deals with issues of epidemiology, surveillance, education and prevention. In 1992, SNAP carried out the first “...national survey of

women attending Ante-Natal Clinics (ANC), and HIV prevalence in this group was found to be 3.9 percent. In 1994, the prevalence rate was 16.1 percent. Since then, surveys have been carried out every two years...” (National Emergency Response Committee on HIV/AIDS, 2003: 4). A decade later in 2004, the infection rate had gone up to 42.6 percent (9th Sentinel Serosurveillance Report, 2004: 7). This shows that HIV infection is relentlessly growing despite efforts to curb its spread.

In 1998, an HIV policy was developed and approved by cabinet. According to the report by NERCHA and UNAIDS, this policy focuses on the three components which are prevention, care and support and impact mitigation (2003). In February, 1999, His Majesty King Mswati III declared HIV/AIDS a national disaster and he further called upon every member of the Swazi nation to take HIV/AIDS as his or her responsibility. The response to the HIV pandemic goes beyond government. According to Dlamini, “...NGOs involved in this are the Schools Health and Population Education (SHAPE), the Family Life Association of Swaziland (FLAS) and the AIDS Information and Support Centre (TASK)...” (2003: 34). In 2001, the National Emergency Response Committee on HIV/AIDS (NERCHA) was created. Its focus is on prevention, care, research and mitigation.

In 2002, the Government of Swaziland increased her efforts to fight HIV/AIDS when the Ministry of Education (MOE) began to involve itself in educating learners through the Schools Curriculum. This was done in order to complement and enhance the current curriculum in primary and secondary schools by providing basic information on HIV/AIDS that will facilitate behaviour change among the school going youth. This move was a milestone in the prevention of new infections among school going children. Unfortunately, this intervention only catered for school going children who are only a very tiny fraction of the total number of the Swazi youth. Considering all these efforts, it becomes obvious that Swaziland has neither ignored nor underestimated the gravity of HIV/AIDS since the first AIDS related death in 1987. Contrary to this, Swaziland has the highest HIV prevalence in the whole world. The question here is what exactly is the problem with Swaziland? To answer this question, one needs to look at gender relations in this patriarchal kingdom.

The Relationship Between HIV Infection and Gender Relations in the Swazi Socio-Cultural Context

There are a number of factors fuelling the spread of the Human Immuno Virus in Swaziland, but this paper is only focusing on cultural factors. This selection of cultural factors was based on the fact that such factors have a greater contribution to make towards the rapid spread of HIV than others in Swaziland since they are embedded in the Swazi way of life. This implies that Swazis could only overcome the pandemic if they could change their way of life. From the interventions, it is clear that Swaziland has tried the best she possibly could to curb the spread of HIV. Be that as it may, this paper argues that Swaziland has not attempted to use Distance Education (DE) to solve this problem. The existing body of knowledge on HIV and AIDS in Swaziland is silent on the role DE could play in the fight against HIV/AIDS. This paper, therefore, seeks to create awareness on the potential DE in general, and the Institute of Distance Education of the University of Swaziland in particular have in dealing with this problem.

Swaziland is a small kingdom with an area of only 17,363 square kilometres. It is found on the South Eastern part of Africa. This country's population is estimated to 1.6 million (National Census Office, 2006). Of this number, over 68 percent are below 24 years, a clear indication that Swaziland's population is youthful. Swaziland is one of the poor African states with more than 60 percent of the population living below the poverty line. Such an economic scenario has been brought about by an increasing rate of unemployment and the devastating effects of HIV/AIDS.

Swaziland is a patriarchal kingdom. "...In a patriarchal kingdom like Swaziland, the minority status of women, to a large extent regulates the relationship between men and women in general and that between husband and wife in particular..." (Dlamini, 2005: 70). Kanduza, A. (2003) states that "...Patriarchy manifests itself in Swazi society in ordaining the perpetual minority of women...". This perpetual minority contributes towards increasing the vulnerability of Swazi women to HIV infection by hindering women from adopting the ABC approach to HIV prevention. Put differently, "...While clearly there is a role for ABC in HIV prevention, this approach presupposes the ability to exercise rights – a

condition not realized by many girls and young women for whom ABC has turned out to be ineffective...” (Sexual Health Exchange, 2004: 5). Furthermore, Dlamini observed that the institution of patriarchy allows Swazi men to have things their own way both in the public and in the private domains. They even coerce women and girls into sexual activity (2005: 71). This clearly shows that while ABC can contribute immensely in reducing new HIV infections, it is very difficult for girls and women in patriarchal societies to make good use of this strategy.

In Swaziland, like in other African states with very high HIV infection rates:

“... Girls are married off in their teens...Recent studies in Africa indicate that young married women are at high risk of HIV infection than their unmarried peers. Husbands of young married women tend to be older and more sexually experienced, and therefore, more likely to be infected than unmarried or younger male counterparts...” (Sexual Health Exchange, 2004: 5).

In addition to that, poverty in Swaziland forces a number of young women to exchange sex for survival. A soldier interviewed by Hall (2002) concurred with this when he said that soldiers at Matsapha have no difficulty finding people to sleep with because women would come to the barracks after failing to find employment in the Matsapha industrial site. These women come to sleep with the soldiers for dinner (Mamba, 2002).

While a majority of girls and women are unemployed and poor, the male dominance in the country allows men greater access to paid work and material wealth. Thus they control the money and the resultant power. Sexual Health Exchange (2004) reveals that men consider involvement with girls as a demonstration of economic power. Male promiscuity in Swaziland is celebrated as (*bunganwa*), being a stud, while women are expected to be faithful, a test which if they fail could lead to being dumped, divorced or killed. Women are expected to be submissive and accept their promiscuous husbands whose behaviour places them at risk of becoming infected with HIV (The Government of the Kingdom of Swaziland, 2006).

Another cultural practice that increases the risk of contracting HIV among Swazi women is *lilobolo* or the payment of bride wealth. *Lilobolo* is a very

old cultural practice in Swaziland where cattle from the groom's family are transferred to the bride's family for the loss of the bride's presence and her services in her parental home. Booth (1985) adds that it ensures the legitimacy of her children and their lineage. Ndwandwe (1999) gives a clearer function of *lilobolo* when saying, through *lilobolo* a woman was not bought, what was bought were the children a woman reproduced. *Lilobolo* allowed a man to attain ownership of the children the woman produced. Like Ndwandwe (1999), Barnett and Whiteside (2002) noted that in some parts of South Africa, children are what we give *lilobolo* (bride wealth) for. In other words, the payment of *lilobolo* deprives married women the right to decide whether to have children or not. That means that even if a woman knows that she is HIV positive, she is compelled by the institution of *lilobolo* to fall pregnant and put her life at risk and further endanger the life of the unborn child. *Lilobolo* does not only deprive Swazi women of their reproductive rights, it further transforms them into some movable property that can change hands in the event of the death of a husband (Dlamini, 2005). This practice is called wife inheritance. Wife inheritance occurs when a male relative, usually a brother of a deceased husband, takes the widow as a wife often in what amounts to forced marriage. The widow has to become the brother's wife even if her husband may have died of AIDS and she is HIV positive or if the new husband is (Dlamini, 2005).

Collaboration and the Fight Against HIV/AIDS

For a very long time the sole responsibility of making people healthy has rested on the shoulders of medical doctors. But the prevalence of incurable diseases like AIDS has enabled humanity to discover that curative medicine is not the only solution to all our health problems. Talking about this, Khan (1983: 251) argues, "...Society has given the doctor entirely justified praise for having carried out his task with extra-ordinary devotion...". But Khan further wonders if the doctor has succeeded in reducing morbidity and mortality. The prevalence of AIDS shows that he has not. Curative medicine offers a temporary solution if it is not accompanied by preventative measures. Hubley notes, "...The introduction of the concept of primary health care by the World Health Assembly in the Russian city of Alma-Ata in 1978 was a direct result of the failure of curative hospital based systems of health care..." (Khan, 1983: 7).

One of the implications of primary health care is that health is no longer an exclusive preserve of medical doctors and other practitioners in the ministries of health. Health is everybody's business. For instance, communities have to be actively involved in the planning and implementation of their own health care and other development programmes. Unfortunately no community could fully participate in this without being equipped with relevant skills. So community education by skilled and deserving people should be the starting point. In Bidwell's (1988) words:

“...If people in the developing world are to have radically improved lives, it is first of all necessary to teach them to be dissatisfied with the present situation and at the same time make them appreciate how they can work towards a better future....” (Bidwell, 1988: 38)

Unfortunately in most developing nations, health education has not been taken seriously until the beginning of the 1990s when the concept of community health workers began. In Swaziland these are called Rural Health Motivators (RHMs). Their main responsibility in Swaziland is to teach communities on causes of diseases and the importance of hygiene. They are given a three months course in advance in order to enable them to execute their duty. Matrons who are not health educators are responsible for their training and supervision. There are only eight health educators in this country. Of this number, four are in the four different districts of Swaziland. The remaining four are stationed in the health education unit of the Ministry of Health and Social Welfare. The regional health educators, as they are called, only go to communities during times of outbreaks of certain diseases like cholera in the summer season. The major aim of their visits at such times is just to assess the situation and give brief lectures on the causes and prevention of the diseases. This means that the responsibility of health education is left entirely in the hands of ill-trained RHMs.

It is obvious that if the Swaziland government could shift emphasis from curative to preventative measures that include health education; the HIV/AIDS scenario in Swaziland could take a favourable turn to human development. It is this shift from curative hospital based system to community-based systems whose emphasis is on prevention, which makes collaboration the only viable solution especially in poor developing

nations of the world. In this new system, every member of society has a role to play in influencing behaviour change. Professional researchers, for instance, can play a profound role in health promotion and health education through their research. They only need to keep in mind the fact that research for its own sake is a futile exercise. All research endeavours ought to aim at influencing behaviour or policy. This is one concrete outcome of research, which could bring about positive social transformation. In other words, our research should not be done only for academic purposes. We should make sure that it is useful to policy makers and even to the general populace. Research is not only about knowledge creation. It is also about positive social change. So research results need to be disseminated not only to colleagues and students in universities, but also to communities so that community members could use them to improve their lives. Policy makers also need findings from our research to formulate policies that would meet the developmental needs of communities. We should be seen to be exerting pressure on policy makers through research. As researchers, we are advocates of the disadvantaged communities. Therefore, we ought to use our research results to lobby in order to influence policy. For instance, we may need to invite legislators to our conferences, for them to receive research results from the researchers.

Since legislators are the direct representatives of the people who voted them into office, they have a responsibility to address their constituents' needs on the floor of national parliaments (UNAIDS, 2004). In parliament legislators can spearhead laws that reinforce the rights of marginalized people like women and girls who because of lack of rights cannot make good use of the ABC approach. Community members also need to be responsive to the health promotion messages provided by health educators and RHMs.

The HIV/AIDS Collaboration Strategy and Framework in Swaziland

The collaboration strategic framework in HIV/AIDS issues in Swaziland encompasses three goals namely, prevention of new infections, reduction of morbidity and mortality to HIV and AIDS and mitigation of the social and economic impact of the epidemic (The Government of the Kingdom of Swaziland, 2005). To achieve these goals, there are various role players as shown in Figure 1. For instance, School Health and Population Education (SHAPE) is responsible for promoting abstinence among in-

school youth. The AIDS Information and Support Centre (TASC) are responsible for HIV testing. Swaziland Network of People Living with HIV/AIDS (SWANEPHA), Swaziland for positive living (SWAPOL) and Swaziland AIDS Support Organisation (SASO) are responsible for positive living. Hospice at Home is responsible for palliative care. At the centre of this collaboration strategy is the government of Swaziland which collaborates with other stakeholders to ensure that these goals are achieved. The diagram of the collaboration framework below shows how the collaboration is carried out in the country. The reduction of new infections is a behavioral issue which could only be effectively dealt with through education. Emphasising this, the Second National Multi-Sectoral HIV and AIDS Strategic Plan states, "...Behavior change is precipitated by adequate and accurate information..." (Swaziland Government, 2005: 21).

The key factor in the reduction of morbidity and mortality due to HIV/AIDS is the provision of antiretroviral therapy. There is a very high demand of this therapy in Swaziland due to the fact that over 36,500 people are taking them to prolong their lives (Swaziland Government, 2005). Given the high number of Swazis taking antiretroviral therapy, "...The demand for antiretroviral therapy is expected to exceed current national capacity to provide the service to all those who will require it..." (Swaziland Government, 2005: 37). Swaziland only has six hospitals offering antiretroviral therapy services to the public. These hospitals only have 20 laboratory technologist and 24 assistants (Swaziland Government, 2005: 38). "...This number of trained laboratory practitioners is grossly inadequate for present and projected needs for antiretroviral therapy services... Staffing remains a challenge..." (Swaziland Government, 2005: 38). This is where IDE could offer a lasting solution by training laboratory technologists using the distance delivery mode while these workers keep their jobs.

In order for Swaziland to successfully mitigate the social and economic impact of the epidemic she needs to make sure that Swazis at grassroots level are properly educated on issues pertaining to their rights, food and nutrition and others. This is where DE could be used to help educate not only the community leaders but also members of communities who would then pass this message to others. Once this has been done community mobilisation and collaboration against the pandemic would easily take

place. Community mobilisation takes place when local citizens use their talents, time and resources in cooperation with government, business and civil society organisations to work together to creatively solve community problems, tackle issues in order to build on local strengths for a better living. (Pridmore et al., 2006: xi)

Distance Education and the Fight Against HIV/AIDS in Swaziland

This paper has discussed some of the circumstances under which women live and has shown how such circumstances facilitate the spread of HIV infection in Swaziland. The most important problem cited is inequality among sexes. On the other hand, the importance of women in the perpetual existence of states could not be over emphasised. Women are important both for their productive and reproductive capabilities without which national economies could crumble and humanity could cease to exist (Dlamini, 2005: 68). So to deal with the problem of low social status of women in Swaziland, the Institute of Distance Education (IDE) needs to introduce Gender Studies in its Humanities program to address Gender perceptions about the role of women and girls in relation to men and boys. This course could empower female students to be assertive. Male students could learn to respect women and to value their productive and reproductive roles.

Poverty and unemployment are some of the factors facilitating high HIV prevalence in Swaziland. IDE in collaboration with relevant stake-holders could play a role in alleviating poverty by equipping the Swazi youth, especially women, with skills required by the labour market. This could improve women's employment opportunities thus providing them with economic independence and enabling them to make their own decisions without relying on men.

There is limited coverage of HIV and AIDS lessons on life skills education (Swaziland Government, 2006). The information provided in the primary and secondary curricular only caters for the youth in schools. In addition to this, the Ministry of Health educates the nation on HIV issues through the Swaziland Information and Broadcasting Service and selected television programmes. But unfortunately, not all Swazis own radios and television sets. This therefore raises the need for IDE to offer to community leaders, short HIV/AIDS courses that would run for two

weeks to six months. The community leaders would in turn pass on this knowledge to their fellow community members.

Another challenge facing the struggle against HIV/AIDS in Swaziland is the inadequacy of human resource in the health sector. We shall all remember the fact that HIV/AIDS is a new phenomenon in the health circles. That being the case, most of our experienced medical practitioners have not been trained to deal with the pandemic. IDE could extend the frontiers of their knowledge by providing courses which they would take while keeping their jobs. There is a desire among some of them to have access on training on HIV/AIDS issues. This is shown by the increasing number of Swazi nurses who enrol in the Republic of South African universities as part time students in courses such as Disaster Management, Nursing, Nursing Management, Counselling, Gender Studies and many more. Unfortunately, not all practitioners with this desire could afford to enrol in neighboring universities. Those who cannot are obviously looking forward to the University of Swaziland to save their situation. This is a challenge to IDE.

Due to the devastating impact of HIV/AIDS, there is an increasing number in the SADC region of orphaned youth that is out of school and living in child-headed households. Pridmore et al., (2006) observe that “For this vulnerable group, formal education has failed and it is the responsibility of Open and Distance Education to take care of their educational needs” (Pridmore et al., 2006: vi). Swaziland currently has tried to solve this problem by creating a fund known as the Orphan and Vulnerable Children’s’ fund which pays for such children. Unfortunately, corruption is rendering this attempt inactive as this fund ends up benefiting only a few. Distance education could make it possible for Swazi youth who cannot benefit from this fund to enrol in open schools. Swaziland has very good models of such schools in the SADC region to emulate. These are Namibian College of Open Learning (NAMCOL) in Namibia and Botswana College of Open and Distance Learning (BOCODOL) in Botswana which are enrolling thousands of teenagers to do secondary education. Pridmore et al rightly put this when saying that the flexibility of ODL “...can help young heads of households access the wealth of information traditionally provided through the collective knowledge and experience of their own family...” (Pridmore et al., 2006: x). They further argue that “...to help vulnerable young people enter the job market, ODL,

could be used to increase motivation for learning and speed up the time it takes to learn skills. This approach could be used to teach entrepreneurial skills, such as how to set up and run a small business...” (Pridmore et al., 2006: xi).

Challenges and Constraints

The challenges which this paper is concerned with are institutional challenges at the University of Swaziland where IDE is found. The institute of Distance Education of the University of Swaziland is a dual mode institution which offers university programmes using the distance delivery mode. IDE is accorded the status of a faculty within the University of Swaziland. One challenge related to this kind of a structure is that IDE cannot offer courses that are not offered in fulltime programmes. This is one fundamental factor which has arrested progress in IDE in terms of offering courses that are in demand. This shows that there is a need to change the existing structure if the University of Swaziland is serious about using IDE as its extended arm with which to reach the unreachable.

Secondly, distance learners at IDE are not completely removed from their teachers because they still come for face-to-face sessions which amount to a third of the time spent by on-campus students. That in itself is a challenge because it means ensuring that the numbers admitted could be easily accommodated in the available space. The availability of space is a cause for a great concern in IDE because the institute only has one lecture theatre which can only accommodate about 200 people. In the entire university, there are only four lecture theatres. This hinders expansion in IDE since it would be meaningless to mount more programmes if there are no rooms to meet students for face-to-face sessions. But really can't the government of Swaziland, which is responsible for sponsoring educational activities of the University of Swaziland, do something about this?

Conclusion

In conclusion, it should be emphasised that in order for Swaziland to combat HIV/AIDS, there has to be a collaborative action beginning from the grass root level. This collaborative action should include enacting laws that will enhance the social status of Swazi women thus enabling them to make good use of the ABC strategy for HIV prevention. To do this,

legislators rely on research results which academics produce. In addition to that, this collaboration should include the provision of courses designed by IDE to inform the nation on a number of HIV/AIDS related issues, the provision by IDE of courses that will capacitate health practitioners on how best to deal with the HIV pandemic, and the provision of courses that will increase the employment opportunities of the Swazi youth especially female students in order to reduce poverty and put an end to their dependence on men. Distance Education, in general, could also help mitigate the impact of HIV/AIDS by providing open schooling to orphaned youth that is heading homesteads and as a result could not attend formal schools.

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