EFFECTS OF HIV/AIDS ON CHILDREN IN SWAZILAND:

IS THE EXTENDED FAMILY COPING?

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BY

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Abstract

In 2004, Swaziland recorded the highest prevalence of HIV among pregnant women in the world ever at 43%. Around 63,000 children were estimated to have lost at least a parent to AIDS by 2006 and this figure is projected to increase in future to over 80,000 by 2010. About a third of these orphans are double orphans who have lost both parents and are most cared for by grand parents who are too old, weak and poor to provide for them adequately. Most of the orphans who lost one parent lost their fathers and are staying with their mothers, many of whom are sickly and have limited resources to fend for the family. Many of the orphans are sickly, poor, hungry and have limited access to health and education. The traditional safety net for these children is the extended family whose many members are sick, weak and poor and overwhelmed by the orphan crisis. Alternative structures in form of neighbourhood care points, community social centres and chieftainships have been set up to manage the crisis. Does this mean the extended family system has failed to cope?

Introduction

Swaziland is a small landlocked Kingdom in Southern Africa surrounded by the Republic of South Africa on the west, south and northern borders and Mozambique on the eastern side. The country has a land mass of 17, 364 square kilometers and a total population of about one million, 78% of whom live in rural areas. The population of the country is generally young, with children under the age of 15 years and persons who are aged 65 years and above accounting for 46 % and 3% of the total population, respectively. Prior to the mid 1990s, the quality of life of people living in the country had improved significantly from a life expectancy at birth of 44 years in 1966 to 60 years by 1997 with females (63 years) living slightly longer than males (58 years). The Crude Death Rate was on the decline from 18.5 per 1,000 in 1976 to 7.6/1000 in 1997. Infant mortality had dropped to 72 /1000 live births in 1991 compared to 105 in 1986, while Under-five mortality had decreased to 89/1000 live births in 1991 from 139 in 1986.

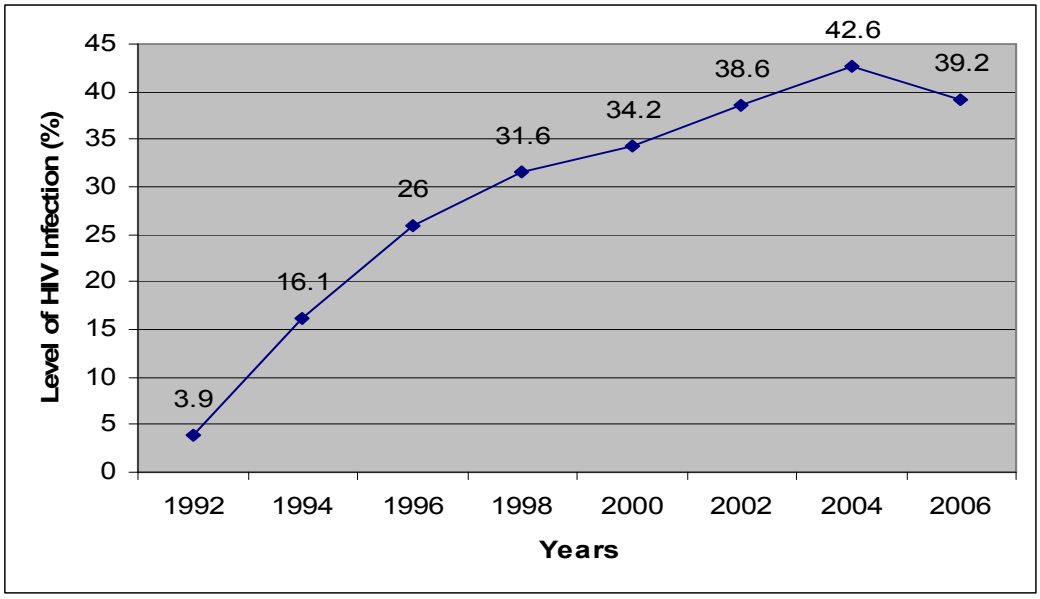
HIV was first diagnosed in Swaziland in 1987. Two decades later the effects of HIV and AIDS epidemic on children are very serious. Fortunately, the country has a strong culture based on monarchy and with extended family system which has tried to provide care and support to HIV/AIDS orphans. This paper aims at presenting the effects of HIV/AIDS on children, evaluates how the extended family system has supported the orphans and examines other options used to mitigate the effects of HIV/AIDS on children.

Effects of HIV/AIDS on Children

Over the last two decades the HIV/AIDS epidemic in Swaziland has been worsening. As Figure 1 shows, HIV prevalence in the country soared from 3.9% in 1992 to 42.6% in 2004 (eleven times over in only 12 years) among the pregnant women attending antenatal clinics, before the trend started coming down to 39.2% in 2006. The Swaziland Demographic and Health Survey (SDHS) of 2006-07 found that 26% of people aged 15 - 49 years were living with HIV/AIDS - 31% for women and 20% for men (CSO 2007). The prevalence observed at this sero-survey among children ranged from 5% for females

and 6% for males between ages 2-4 to 10% for females and 2% for males at age 15-19. These current prevalence rates are the highest recorded by any country in the world. The rates have been increasing across the board, among all age groups, risky sub-populations and regions in the country.

Figure1: Trend in Prevalence of HIV among Antenatal Clients in Swaziland 1992-2006



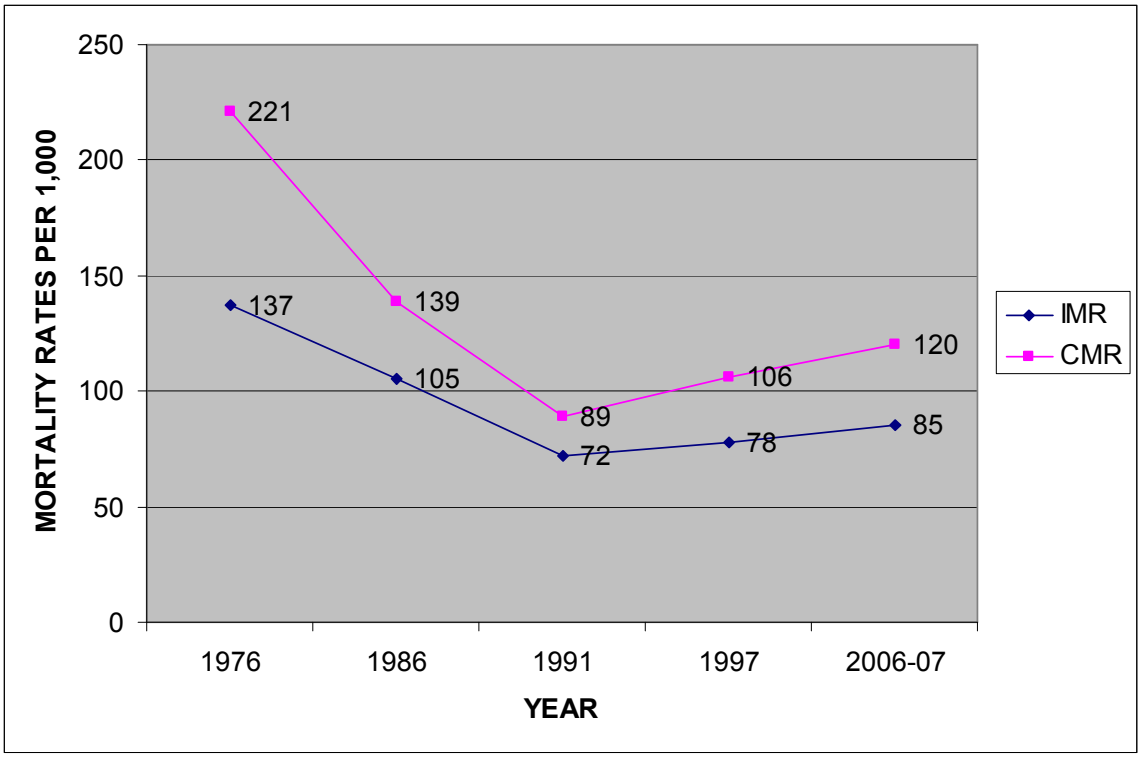
Because of the fast rate HIV/AIDS has spread across the country, a pathetic situation for children in Swaziland has been created. For instance, UNICEF (2006) estimated that of the 95,000 orphans and vulnerable children (OVCs) in Swaziland in 2005, 63,000 (66%) were due to deaths of parents as a result of AIDS related diseases. The UNICEF (2006) study observed that HIV/AIDS orphans form approximately 11% of the total children under age 18 years old. 28,000 children are double orphans who have lost both parents. However, the results of the 2006-07 SDHS found that 23% of the children are orphans and 12% were non-orphaned vulnerable children forming a total of 31% of all the children under age 18 classified as orphans and/or vulnerable (CSO 2007). This later study suggests that the UNICEF study conducted by rapid survey methods under estimated the proportion of the children orphaned and vulnerable. The 2006 survey by the vulnerability assessment committee found that out of 969 households studied a huge 43% were hosting orphans, most of whom were AIDS related orphans (VAC 2006). As seen below, the effects of the epidemic on the children have left them in highly vulnerable situation.

Increased infant and child mortality

In many countries in Southern and Eastern Africa, infant and child mortality has gone up as a result high HIV prevalence. The upward trend of these two important health indicators in Swaziland has been more dramatic than in other countries since the

HIV/AIDS pandemic started. As Figure 2 shows, for every 1,000 live births, both infant and under-five (child) mortality rates that had dropped from 137 and 221 in 1976 to 72 and 89 in 1991, respectively due to high rate of economic development and massive investments in the health sector have been reversed and shot up to 85 and 120 in 2006-07, respectively. Malnutrition of children due to hunger and inadequate nutritious food intake in many areas of the country makes them anaemic, weak and prone to diseases and the HIV/AIDS orphans are the most affected. The 2006-07 SDHS observed that of the children under age 5, 24% were stunted, 7% underweight and 2% wasted. This resulted into the children aged from 6 months to 59 months having anaemia prevalence of 42%, which is high (CSO 2007). Lack of money to pay for essential health services due to abject poverty in more than two-thirds of households, inaccessibility to clean water and deprivation to shelter means exposure to frequent sickness leading to high and increasing mortality of infants and other children as seen in Figure 2.

Figure 2: Increasing Infant and Child Mortality since mid 1990s



Source: VAC (2006) and CSO (2007)

Worsened the health of children

AIDS has greatly weakened the children and many of them go to school hungry, even when they are supposed to eat well as they are on ARVs as the statement from a teacher of an orphan living with HIV and AIDS below shows:

"He was a brilliant boy always jumping around, but his sickness has made him tired and his voice is nothing but a whisper, although his spirit and smile are still strong. We know where he lives with his grandmother near the school and the head teacher is paying his

school fees. Sometimes he comes to school without having eaten anything, the other children contribute something to buy him something to eat" (UNICEF 2004a).

According to the 2006-07 Swaziland Demographic and Health Survey a high proportion of children is living with HIV/AIDS. At 2-4 years old female and male children have a high HIV prevalence of 5% and 6%, respectively. Most of this infection is due to mother-to- child transmission at delivery and during breast feeding. While for the male children aged 15-19 years, the prevalence reduces to 2%, it increases to 10% for girls of the same ages. The reduction among boys with age means that most of those infected died by age 15 and new infection at late ages of childhood is not high. In contrast, while the infected young girls also die off as they grow old reducing the prevalence to 3% between ages 10-14, many other girls are infected and raise the prevalence to the staggering level of 10% between 15-19 years, five times that of boys of same age group.

Denied children of school attendance

Due to lack of school fees and other school necessities, many children have no access to primary education. In 2000, the enrolment in primary school had increased to 81%, but recently it dropped to 71 percent in 2003 (UNICEF 2006). Despite the government bursary schemes for the OVCs, many deserving children do not benefit due to the cumbersome administrative procedures. While 87% of non orphans aged 10-14 years were at school, a lower percentage of 79% of double orphans in the same ages is accessing education, denying 21% access. The girl child is worse off due to higher drop out of school to care for the sick parents and to allow the little money available to be used to send brothers to school.

Children lack psycho-social support

There is limited access to psychological and counseling support for children traumatized by abuse and caring for sick and dying relatives. One orphan who remembers the death of his mother and was traumatized by it narrates his experience:

"I was seven when my mother died. The light was on that night, my mother was crying and she told me she was going to die. She asked me to call my brother and sister who were older than me, they came and she told them. I was scared when she told me she was dying. I did not sleep with her that night and her last words were: go and sleep with your cousins because I am leaving this world. She died at home the next day and grandmother told me. The last time I saw my father was in 1998. He fell sick and I did not know what was wrong with him and nobody told me" (UNICEF 2004a).

In other African countries, such as Uganda and Zimbabwe, it was found that the death of parents due to HIV/AIDS related causes adversely affected a large proportion of orphans psychologically. This was largely attributed to lack of parent care which is always more tender and warmer than from any one else. In Uganda, overall 35% of AIDS related orphans were found to suffer from lack of parental care. Ntozi (1997) reported the psychological stress to be worse with orphans being cared for by NGOs and friends of parents, and least with those under the care of remaining parents, grand parents and other relatives.

HIV/AIDS orphans are heading households
About a third of the orphans have lost both their biological parents. To make it worse some of these double orphans are heading households of children younger than themselves as evidenced by this story of eleven year boy from Lubombo region:

"There aren't any adults around where I live, since my grandmother who was looking after us died. Where I live there are three houses made of stick and mud; one is a kitchen, the other we sleep in and the third has nothing inside. I live in the house with my cousin of three years old, who is a daughter of my mother's sister who died this month. Her father is dead too. My father and mother died when I was an infant. It is scary living all alone, I worry about criminals attacking us at night, I worry about lions, crocodiles and snakes coming to our house. We don't have locks on the door to our house, we use nail that is bent to stop the wind from blowing the door open" (UNICEF 2004a).

Both these children lack psychosocial support from their relatives and they live in one of the large and increasing number of child-headed households created by HIV/AIDS epidemic. A survey of 38 out of 55 local administrative areas known as tinkhundla in 2002 identified 10,616 children living in 2,666 child-headed households (UNICEF 2005), implying close to 4,000 child-headed households covering over 15,400 children nationally. The child in the above story has no capacity to look after his 3 year cousin as he complains:

"I get along well with my cousin, but the problem is when she is sick. She gets flu very often and I do not have money to take her to the clinic. I fear the neighbours may take her away and I would stay alone" (UNICEF 2004a).

Such children are at a high risk of sexual abuse and exploitation. This may create an environment for a second cycle of the epidemic where vulnerability of children fuels further spread of HIV. Unfortunately, Government over relies on the communities, extended families and religious organizations to provide safety nets for OVCs, but these structures lack human and financial resources to assist the orphans adequately.

Orphans are scared when living alone:
The shelters many orphans live in are not good and no one helps to repair their houses:

"The house we live in is falling apart. The rain comes in and the wind blows it hard. I fear mean people may come and push its walls and it would fall down. It needs more thatch which I can't do myself. I have tried to put mud on the cracks, but when it rains the mud just falls off again. We don't have a toilet, but use the bush" (UNICEF 2004a).

Created poverty and hunger
As the prolonged drought pushed up the prices of food and increased abject poverty among the communities and AIDS deaths increased orphans, extended families failed to take on additional children for care. Close to 70% of the population lives below poverty line (US$21 or less than E128 per month). This resulted into child-headed households in

the communities hitherto unknown to the Swazi environment. A third of the households (34%) with orphans are female-headed, unable to provide for them adequately. Many of the orphans are so poor that they do not have money to buy food. Instead they beg for food from neighbours.

Orphans lack other essential items in their lives in addition to food
In addition to food aid given by various agencies, the orphans need a range of other essentials to survive. They need soap, matches, candles, clothes, blankets, money for drugs and school materials. One orphan in this situation says:

"We exchange beans from WFP for soap from neighbours. We don't have clothes and blankets to keep us warm. We sleep on the ground and on grass mats. The wheel barrow we used to fetch water from a river very far was recently stolen by thieves. Bathing is a luxury to us, since we can not fetch much water from the distant river" (UNICEF 2004a).

Discrimination, stigmatization and traumatization of children living with HIV/AIDS
UNAIDS (2006) estimates that 15,000 children in Swaziland aged below 15 years were living with HIV/AIDS by end of 2005, having increased from 12,000 by end of 2003. The 2006-07 estimates about 21,000 children living with HIV/AIDS. Most of these children were infected by their parents. A 14 year boy tells his story of how he was infected.

"I was taken to Good Shepard hospital because I got sick and they drew blood from me. The counselors told me the results. I asked the doctor to tell me where I got it (HIV) from, and he told me I got it from my mother. I didn't cry. I do not know why, perhaps I knew I must be HIV positive. It doesn't bother me. I accept it. I used to sleep with my mother in the same bed" (UNICEF 2004a).

Many children living with HIV and AIDS are traumatized when they get the positive results. Others are discriminated and stigmatized by their relatives who are more interested in the property left by the dead parents.

Some of their relatives who are supposed to care for them do not care. This is illustrated by the same boy whose story continues from above:

"But now that my mother is dead we don't get along with my grandmother (sister to my actual grandmother) and me. My grandmother chased away my sister for good and she wants to chase me, but I don't have any place to go. She said I don't fetch water from the river, I don't cook and don't tend cattle. She knows I am sick, but doesn't care. She doesn't not give me medicine; so I try to remember when it is time to take it and do it myself. She doesn't know the dosage, since it is me that got instructions from the doctor. No body visits me at home to see if I am taking the medicine" (UNICEF 2004a).

Role of extended family in mitigating effects of HIV/AIDS on children
Traditionally in Africa the extended family has played a crucial role in helping its members who are weak, sick, bereaved, poor, distressed and facing other problems. This

role has been studied in many African countries like Uganda, Zimbabwe and Ghana (Ntozi 1997). Similar practice has been used in Swaziland for centuries because of Swazi strong attachment to cultural values, customs and traditions. Traditionally, when rural homesteads in Swazi society experienced an increased pressure on their livelihoods they could rely on the extended family system for help (Whiteside et al, 2006). This was built on a collective way of organizing communities and was often based on the principle of reciprocity (Ibid). In many families and households, orphans have been distributed to members of extended family for care and support when the parents of children have died. In case one of the parents is alive and not too sickly, the orphans have stayed in the original home of their parents being supported by the family members there. Where both parents have died, the orphans have moved out of their parents' homes to their relatives' homes. The family members have treated many of these orphans as if they were their own children by providing them with facilities like shelter, food, clothing, health care and education as well as psycho-social support to help them grow. The aim of psychosocial support is to give children love and support to build resilience for them to be able to cope with life's challenges. Further, it aims at responding to situations that are affecting children adversely (Hensen, 2006).

Unfortunately, the increasing burden of impact from the pandemic has overwhelmed the extended family system, and over time the ability of the social networks to absorb the increasing demand for care will not be sufficient, as dependency ratios increase when more young adults die due to AIDS and leave orphans behind (Whiteside et al, 2006). Whiteside at al. (2006) further report that there is increasing evidence that the extended family and the community are no longer capable of absorbing the shock of escalating numbers of OVCs. Among this is evidence pointing to the rise in numbers of street children and child-headed households (UNICEF, 2003b; UNAIDS, UNICEF, USAID & WFP, 2004 – cited in Whiteside el al (2006).

According to UNICEF (2003), the extended family system in Swaziland managed to take in orphaned children up until 2000, but anecdotal evidence suggests that in 2001-2002 the capacity of the extended family was overwhelmed, and that the number of child-headed households was growing rapidly. The extended family is unable to cope due to these reasons. First, poverty in households is high and increasing. Between mid 1990s and 2000/01 poverty levels increased from 66% in 1994/95 to 69% in 2000/01. This means that an increasing proportion of households can not afford to financially support orphans. The second reason is the long period of drought in many areas of Swaziland resulting in critical shortage of food and hunger in many rural areas. Many rural areas of Swaziland have been lacking rains for long periods in the recent past resulting in poor harvests of food crops especially maize which is the stable food for families in the country. This implies inadequate food for the households to spare for the orphans. Third, there is increasing morbidity of HIV/AIDS related diseases among households, which are chronic and physically crippling. A survey by Vulnerability Assessment Committee (2006) found that 11.6% of households had chronically sick persons unable to work and support their families. This has led to the sick being economically unproductive and hence not able to support the orphans. Fourth, most of the double orphans are looked after by their grandmothers who are frail and too poor and stressed by bereavement of their energetic

children to help the orphans. Fifth, most of the deaths from HIV/AIDS related diseases have been of fathers, the household breadwinners rather than mothers, resulting in more paternal orphans than maternal orphans. In a survey of 70 households in 2006, higher proportion (67.6%) of orphans reported death of their fathers than mothers (53%) (UNICEF 2006). As soon as the fathers die, some relatives grab the properties of widows, which has reduced the capacity of the latter from supporting their children. This has implied that the extended family has not been an effective social safety net for the orphans as expected.

What have been the Alternative Options to Extended Family Support to Orphans
Due to the increasing difficulties of the extended family in coping with the crisis of HIV and AIDS orphans, alternative options have been sought to mitigate the impact of HIV and AIDS on children. Measures to support OVCs are a central component of the national response. The approach taken has been guided by efforts to maintain children within their communities and strengthen the capacity of communities to support them, including:

- Establishment of Neighbourhood Care Points (NCPs) for getting support, food, care and education services to OVCs, led by UNICEF and the Government of Swaziland (GoS). NCPs were first introduced in 2002 and they are fast becoming the mainstay of the quest to find a lasting and sustainable solution to the issue of OVCs in Swaziland (UNICEF, not dated). By the end of 2004, 324 NCPs were part of the infrastructure for this community-based response, reaching almost 30,000 vulnerable children (UNICEF, 2004b).
- Building of kaGogo, or social, centres in each community to promote social responsibility for OVCs, spearheaded by NERCHA in collaboration with, AMICAAL and the Deputy Prime Minister's Office. By the end of 2005, 277 centres were completed (DPM and AMICAAL Quarterly report, 2005).
- Collaboration between NERCHA and MOAC in 2002 to revive the traditional concept of *Indlunkhulu*, or provision of food from the Chief's fields for members of the community that cannot support themselves. In 2005 320 fields were planted (NERCHA, 2006).

Following the problems faced by children orphaned by HIV and AIDS psychosocial support has been viewed as the focal point in **strengthening capacity of families and communities** to be able to take care of their children within familiar networks (Hansen, 2006). This can be achieved by training caregivers on strategies of psychosocial support in areas such as helping children cope with loss and bereavement, helping children to stay in school, gender sensitivity, and protecting children's legal rights to safeguard their future (Ibid).

Children orphaned are left vulnerable to the social ills and all forms of abuse. In 2001 a capacity gap analysis, carried out by UNICEF in coordination with the Deputy Prime Ministers office, highlighted an urgent need to protect children from all forms of abuse, to help communities understand that sexual abuse of children is a major contributing factor in the situation of the HIV epidemic, and to give communities a sense of hope and

empowerment (UNICEF, Ibid). The concept of NCPs has established an innovative initiative to contain the situation, based on the traditional Swazi concept which recognizes orphans and vulnerable children as a responsibility of the community in which they live – *Bantfwana Bendlunkhulu* (children of the community) (Ibid).

By July 2006, there were 438 NCPs which are community driven mitigation intervention for all OVCs who are mostly HIV/AIDS related orphans. The NCPs provide food, basic health care, non-formal education, recreation opportunities and psycho-social support to OVCs. Specifically, the activities of NCPs include mostly providing cooked food to OVCs, helping OVCs to play games by providing the facilities, teaching and story telling, providing psycho-social counseling to the bereaved children and other children with social problems, addressing HIV prevention and behavioural change, provision of clothing and addressing issues of child abuse and protection. These care points have been incorporated in the 2006-2010 National Plan of Action for OVCs targeting to scale up NCPs to every community in the country. Figure 3 is a picture showing one of the NCPs and some of the children benefiting from the support from care givers.

Fig 3: A Neighbourhood Care Point that meets under a tree and supports 62 OVCs, of which 7 have no parents, and 55 have one parent.

Source: UNICEF (2005) RAAAP Report Fig 2. Final draft Report. August 2005.

Education support

The Ministry of Education (MOE) has played an instrumental role in ensuring that OVCs in the country are incorporated and retained in formal schools. In January 2004, the Ministry of Education together with partners (NERCHA and UNICEF) received a World Bank technical support, using lessons learned in the Community Education For All (EFA) initiative, developed a Government supported grant system to expand access to

education for OVCs. This initiative has brought 47,947 school-age OVCs into school in 2005(GOS, 2005).

In addition to supporting participation of orphans and vulnerable children in formal education, there is an informal education program for children who for some reasons can not attend formal schooling. Support for this intervention comes from two main sources, namely Government of Swaziland and the Global Fund. Government contributed E47,000,000 (approx US$6m) to this intervention in 2005 (Government of Swaziland, 2005) while the Global Fund contributed E11,200,000 (approx. US$1.44m) in the same year. A total number of 30,895 OVCs benefited from this Global Fund contribution. In addition, 335 Global Fund supported schools with 145,070 children across the country were supported (Ministry of Education 2006).

While this intervention can be described as promising, there are some challenges in its implementation. These include poor coordination of efforts by different sources of support, unsatisfactory management of the government contribution which is perceived to be characterized by inadequate transparency and accountability on how the funding is being used, unclear beneficiary selection processes including the criteria for inclusion and exclusion of children as well as inadequacy of the amount which is allocated to individual beneficiary children. Benefiting children whose fees have been paid by the intervention are sometimes sent away from school for non payment of other school requirements such as uniforms, contribution to school building projects and books. Children who attend school in the many "non traditional private schools" that are mushrooming around the country do not benefit from the intervention even if they meet the qualifications for inclusion. Furthermore, the country does not have a national register of orphans and vulnerable children which would be an acceptable standard way for identifying genuine needy children.

Food Security

The orphans further were supported by other organizations. These include the World Food Programme which has been delivering food items to NCPs and 174 schools for 74,919 children (WFP 2006) and Alliance of Mayors and Municipal Leaders Initiative for Community Action on AIDS at the Local Level (AMICAAL) which ran 17 kitchens in 2006 to cook and serve food to all OVCs in urban centres. The National Emergency Response Council on HIV/AIDS (NERCHA) has also supported the construction of Kagogo centres (community social centres) which are also used as pre-schools and feeding centres for orphans.

Another intervention to help the orphans is supporting food production by chiefdoms. In Swaziland chiefs, who are the representatives of the King at the grass root level, are responsible for the welfare of disadvantaged members of the community such as orphans and widows. In the past, food for addressing such needs was produced through land set aside by chiefs for all people in the community to voluntarily provide labour for the production of food for the community (lilima). Under this arrangement, the custody of food products rested with the chiefs who then distributed the food to those who needed it. This aspect of past Swazi culture has been revived to fight hunger and has the potential of reducing hunger in the community, especially among the orphans and vulnerable children.

Prevention of Mother to Child Transmission (PMCTC)

Furthermore, in order to reduce the number of children infected by their mothers through delivery and breast feeding, the Government through the Ministry of Health and Social Welfare has been implementing an intervention programme of reducing this transmission route by 50% between 2003 and 2010. The strategy of the programme has been to expand prevention of mother-to-child transmission (PMTCT) services through integration of PMTCT into MCH services; strengthening of community capacity to respond to PMTCT, HIV and AIDS and reduction of stigma and discrimination (Ministry of Health and Social Welfare, 2003). By end of June 2007, PMTCT services were available in 110 out of 184 health facilities (59.8%) in the country. Counseling and testing takes place in antenatal clinics, labor wards and postnatal clinics. The proportion of women who tested after counseling between July 2003 and June 2006 (3 years) was high at 87.2% and they received their results without delay since testing was based on rapid tests which generate results immediately before clients leave the facility. All PMTCT clients, including those who deliver children at home received Nevirapine immediately after testing positive if they were interested (EGPAF, 2006). About two thirds (66.2%) of those who tested positive in antenatal clinic and 70.3% in labour wards in the first half of 2007 were served with ART.

HIV treatment: Survival after 12 months on antiretroviral therapy

The Government of Swaziland further cared for orphans by providing treatment to them. It is reported that by June 2007, 1,776 children were on antiretroviral therapy, accounting for 8.6% of all persons who were on antiretroviral therapy by the end of June 2007.

Other forms of assistance

Through the National Emergency Response Council on HIV/AIDS (NERCHA) which partnered with the World Vision International, 20 houses for OVCs were constructed using funding from African Alliance in 2005. By end of 2006 more 200 houses were constructed for the child headed households by the Red Cross with the support of Government (NERCHA 2006).

Conclusions and Recommendations

The paper has shown that extended families in Swaziland have given their best in helping HIV/AIDS orphans to live, progress and develop. However, the magnitude of HIV/AIDS pandemic has been so overwhelming that the extended families do not have adequate capacity to cope with the orphan crisis. Various partners have had to come to the rescue of the strained families.

Given the inadequate capacity of families, the following recommendations can be made to enhance, compliment and supplement the family to continue playing its role as a safety net of its members especially the orphans. First, there is need to scale-up and sustain support to households and communities where OVCs live in order to improve their lives. Second, the communities need to reduce stigma and discrimination associated with HIV/AIDS orphans. Third, Swaziland institutions need to ensure that OVCs have equal access to basic services and protection from human rights abuses.

Specifically, the country will need to strengthening the capacity of families to protect and care for OVCs, prolonging the lives of parents living with HIV/AIDS and providing economic, psychosocial and other support. Secondly, there is need to mobilize and support community-based responses to supplement and compliment the role of extended families, eg Neighbourhood Care Points (NCP). Thirdly, the Government of Swaziland needs to ensure access for OVCs to essential services and eliminate inequality in the access, including education and health care. Fourthly, Government should protect OVCs through improved policy and legislation and programmes that can channel resources to families and communities. Fifthly, there is need to raise awareness of OVCs problem at all levels through advocacy and social mobilization to increase supportive environment for OVCs and their families affected by HIV/AIDS. Sixthly, Government and development partners need to commit and increase funds needed to support programmes of OVCs and remove the obstacles to access them. Seven, it is important to prevent new infections among children by applying and scaling up proven techniques and interventions. Eight, Government should eliminate school fees and other barriers to education encountered by OVCs. Lastly, there is an urgent need to combat poverty and conflict, which interact with HIV/AIDS to magnify the negative impact on childhood.

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