

School of Population Health, Nutrition & Wellness partners with the School of Architecture to change the lives of orphans and vulnerable children in Eswatini, a country in S. Africa that has one of the highest prevalences of HIV in the world.

SOHO AND HOSA Project: Grand Valley Children's Campus, Hlathikhulu, Shiselweni, Eswatini



ESWATINI: PUBLIC HEALTH NEEDS ASSESSMENT REPORT

Two Non-Governmental Organizations (NGOs) operating in Swaziland, “Saving Orphans through Healthcare and Outreach” (SOHO), and its subsidiary, “Hope Seekers Alliance” (HOSA), have contributed to making a difference in the lives of orphans and vulnerable children (OVC) in Eswatini (formerly Swaziland). These organizations have funded the construction of a children’s campus with a mission to provide a: Holistic environment promoting better living for orphans and vulnerable children and a better life for all. The children’s campus will be located at Grand Valley Farm, Hlathikhulu, Shiselweni, Swaziland. The campus will be constructed in phases and is intended to be self-sufficient, financially supported by a Mountain Vistas Retreat and Lifestyle Centre.

Marcelle Thomas-Richardson, a Master of Public health alumni 2020, from AU under the mentorship of Dr. Padma Uppala and Dr. Andrew Von Mayer conducted a health needs assessment report to determine the needs of orphans and vulnerable children in Swaziland to provide services to meet those needs. For this report, a child is any person under the age of 18 years.

Swaziland, officially renamed Eswatini, is a beautiful mountainous country in Southern Africa. A landlocked country of 17, 364 km² and approximately 1.2 million people, Eswatini, is bordered by South Africa and Mozambique. The official languages of Swaziland are SiSwati and English. Swaziland is ruled by an absolute monarch, King Mswati 111. Traditional Swazi culture is a mixture of local Swazi culture with strong Zulu influences. However, in recent times, Western trends have begun to erode traditional culture due to access to television, the internet, and social media. This influence is seen mostly among younger generations. While traditionally *gogo*'s or grandmothers hold places of honor within the Swazi family structure, more recently they have become principal caregivers to children who are orphaned. Traditional values such as respect for Swazi traditions, the family, elders, male dominance, and polygamy are still prevalent in society. Swazi's are warm, calm, friendly people which find expression in low crime rates.

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Infrastructure in Swaziland remains a challenge. While main access roads are paved, secondary roads are generally unpaved. Public transportation is not provided for the latter. Electricity and running water, though existent in urban areas remain a challenge for many rural areas. Housing is mainly simple concrete dwellings of meager square footage. In many instances, a *rondavel*, a circular hut with a thatched roof, is still evident among many family dwellings. Sanitation and hygiene are also a challenge in Swaziland. Many homes, more so in rural areas, use outdoor plumbing. In both urban and rural areas, there is a need for garbage disposal systems.

Education: Swaziland is experiencing a high number of children who are not or have never been to school as well as children who have dropped out of school for several reasons. According to the Policy, 25% of children, aged 6-12, approximately 55, 000 children, are not enrolled in education, and for the 75% that attend school, the repetition rate, 16%, is four times higher than that of other low-income countries.

Healthcare: In Swaziland, healthcare is seen as a right, however, this is compromised by the lack of access to basic health services which includes primary health care. Non-Governmental Organizations (NGOs), both internal and external, including faith-based organizations, have taken on the responsibility of providing healthcare services to fill the gap where the government has fallen short.

HIV/AIDS: Impact and Consequence: Although Africa is home to about 14.5% of the world's population, it is estimated to be home to 67% of all people living with HIV.

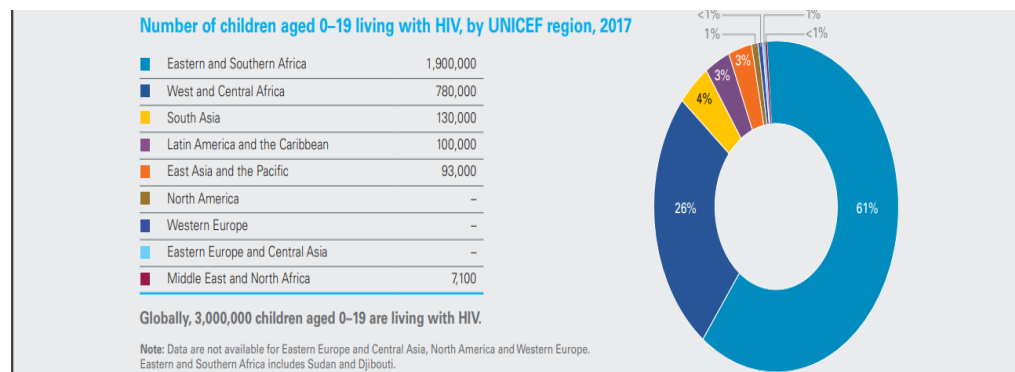


Table Showing the number of children living with HIV by world geographical areas ((UNAIDS 2018 estimates: UNICEF Women: At the Heart of the HIV Response for Children)

Swaziland, a sub-Saharan country has the highest incidence of HIV and TB in the world. According to the Swaziland National Children’s Policy (2009), **26 % of the population is infected with HIV/AIDS**. The Policy states that while the HIV prevalence rate in the broad age category of 15 to 24 years decreased from 39.4% in 2002 to 34,6% in 2006, at the same time it maintained an increase in ages 30 -34 and 35- 39 years. The effect on the country’s children has been devastating. The Policy mentions that HIV and AIDS account for nearly half of the deaths of children under five, that is, 17, 000 children under age five are infected with the disease. There are many contributing factors to the spread of HIV/AIDS in Swaziland. Some of these include; poverty, lack of education, lack of willingness on the part of the nation’s leaders to confront and deal with the pandemic, gender inequality, societal norms, including male dominance, multiple sexual partners, and stigma and discrimination surrounding disclosure

Females and HIV: While HIV/AIDS affects both sexes, females have experienced higher incidences and are the greater victims of the disease. According to an article by UNICEF, Women: At the Heart of the HIV Response for Children (2018), women make up 60% of people living with HIV in sub-Saharan Africa. Across Africa, grandmothers (called gogo’s in Swazi culture) have traditionally played a major role in the care of grandchildren. This, however, has been greatly exacerbated by the HIV/AIDS pandemic where many adults, parents, have died. In Swaziland, because of the high number of orphans, the burden of care has fallen mostly to gogo’s. In cases where no grandmothers are present, child-headed households have often resulted. An unintended vulnerable group that has resulted from the HIV pandemic is adolescent girls. In many instances, due to the death of their parents from HIV, girls have become heads of households and must therefore provide for their younger siblings. This has led to many of them being preyed upon by older males in society while others turn to prostitution. Also, in many societies, including Swaziland, the belief exists among males who are HIV, that having sex with a virgin will cure them of the disease. Many adolescent girls are also forced into marriages, including polygamous marriages. Yet again, many adolescent girls become victims of various forms of abuse, including sexual abuse, at the hands of family members who have taken on the



role of caregivers.

Picture showing a community health mobilizer raising awareness about HIV (UNAIDS 2018 estimates: UNICEF Women: At the Heart of the HIV Response for Children)

Orphans and Vulnerable Children (OVC): HIV/AIDS has ushered in the concept of AIDS orphans. Sadly, in Africa, 25 million children would have been orphaned by HIV/AIDS in 2010. **In Swaziland, it is estimated that 130,000 children, or 31.3% of all children in the country, are orphaned or vulnerable.** This number was expected to grow to 200,000 by 2010. The Children's Policy defines an orphan as a child below the age of 18 years who has lost one or both parents. Vulnerability is defined as a state of being or likely to be in a risky situation, where a person is likely to suffer significant physical, emotional, or mental harm that may result in their human rights not being fulfilled. According to the Policy, the following categories a child as vulnerable. Children who are made vulnerable by HIV and AIDS- especially double, maternal orphans, children who are parents or caretakers of other children. Ndlovu, National Director of Children's Services, Prime Minister's Office, in an interview, (September 2019), shared that the government of Swaziland recommends community-based, kinship, and extended family care for children. He stressed that the economic strengthening of families and communities to provide care for orphans and vulnerable children is the country's approach to care as opposed to institutional care.

The Needs of Orphans and Vulnerable Children: The needs of OVC are varied and multidimensional. Due to the high number of adult deaths from HIV, there is an increased need for care and support services for OVC. As a result of visiting various sites in Swaziland, conducting assessments and interviewing various persons including medical, political, religious personnel and youths, and conducting a systematic review of literature and review of data, the following insights were gained into the needs of OVC in Swaziland.

The Basic Necessities of Life; Food, Clothing, and Shelter: The Swaziland National Children's Policy (2009) asserts that in Swaziland, there is an absence of a conducive environment that enables children to enjoy their rights and basic needs, and that protection from all forms of abuse and neglect need to be addressed as matters of urgency. As previously stated, 69% of children in Swaziland live below the poverty line, and one of the most visible effects of HIV in the country is the increased number of OVC. This has led to an increase in the number of child-headed households. Also, in highlighting the need for the necessities of life by OVC, the problem statement of the National Children's Policy confirms that there are inadequacies in providing shelter for orphans and vulnerable children.

Safety and Security: An environment free from all forms of abuse and violence, including neglect.

Care, Nurture, and Support: Due to their age, socioeconomic status, medical status, and life experiences, OVC need special care, nurture, and support. A National Study on the Drivers of Violence Against Children in Swaziland (2016) reiterates that family members designated as caregivers for orphans may lose interest after all the inheritance resources of the child have been used up. The role of caregivers for OVC demands scrutiny.

Medical Care: Many OVCs have acute and chronic medical needs and include HIV/AIDS and its related complexities, primary health care needs, and psychological needs.

Education: Due to the complexity of their needs, OVC requires an education that is holistic, multidimensional, and comprehensive. The educational needs of OVC should cater to

their physical, mental, social, and spiritual needs. Nsagha et al. (2012) assert that **Education is a key factor to overcoming poverty and AIDS.**

Psychosocial Support: Because of the life experiences of OVC which often includes trauma, there is a need for psychosocial support services. The need for psychosocial support, including mental health services for OVC, cannot be overstated. Education, a variety of social and recreational activities, and mentoring. Some of the topics that should be addressed are HIV disclosure, stigma, and discrimination, loneliness, depression, anxiety, fear, grief, suicide, loss; crime, substance abuse, resilience, self-esteem, self-protection skills, gender equality, equity and sensitivity, sexual and reproductive health: ARV adherence, transactional sex, sexual violence, condom, and other contraceptive use and abstinence.

Legal Support: Because of their vulnerable status, OVC needs legal support and advocacy. Child-headed households and the lack of responsible caregiving and advocacy have led to OVC often being disenfranchised by family members and other caregivers. As previously mentioned, OVC has lost its inheritance because of this. In addition, many do not have basic legal documents and thus cannot access many services. Family disputes and adoption can further be complicated when children do not have legal documents. Canon, do Nascimento, Charyeva, and Foreit (2014) highlight the need for legal documents such as birth registration, certificates, and national ID cards for OVC.

Spiritual Support: Spirituality is an important aspect of humans. Spirituality is known to help persons cope with, be resilient, and recover from adverse life experiences, including diseases (Koenig, 2008). Koenig

Recommended Services for OVC: Grand Valley Children's Campus

All support services for OVC should be provided in keeping with:

- (i) The Convention on the Rights of the Child (CRC) as crafted by the United Nations
- (ii) Holistic, multi-dimensional care
- (iii) Cultural competence and sensitivity
- (iv) The laws, policies, and statutes of the Kingdom of Swaziland.

The following Services are recommended to meet the needs of the orphans and vulnerable children of Swaziland who will use the Grand Valley Children's Campus in the areas of Food, Clothing, and Shelter, Safety and Security; Care, Nurture and Support, Medical Services, Education, Psychosocial Services, Spirituality Care and Support Services, Legal Support Services, Family, Community, and Public Relations, Post-Campus and Reintegration Services

Conclusion: HIV/AIDS has had a devastating effect on countries in sub-Saharan Africa, including Swaziland. While females have been most affected by HIV, children have suffered inordinately as well. The concept of orphans and vulnerable children has arisen as a result of HIV. The death of adults has seen a marked increase in child-headed households. This has resulted in increased abuse of and violence against children. There is much that needs to be done to meet the needs of such children. Our Soho Project will give one of Africa's greatest resources, its children, the chance to live normal successful lives. "Eswatini, together with Switzerland, are the first countries to achieve the '95-95-95' global HIV target. This means that 95% of people living with HIV in Eswatini know their status, that 95% of people who know their HIV-positive status are accessing treatment, and that 95% of people on treatment have

suppressed viral load. The ‘95-95-95’ deadline is 2030, meaning Eswatini reached the target an entire decade in advance.”-Global funds results report 2020.

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