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Exploring the Appropriateness of Institutionalized Care of Orphans and Vulnerable Children (OVCs) in the Era of HIV/AIDS: Examples from South Africa and Botswana

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ABSTRACT The present study aimed to evaluate and discuss the appropriateness of institutions caring for Orphans and Vulnerable Children (OVCs) in the face of HIV/AIDS through a systematic literature review. In the face of HIV/AIDS environment, OVC care institutions: offer a second best home; professionalize their services; provide mothering and attachment figures; and offer HIV/AIDS services. Further, they display the following gaps: The children suffer immense state of stigma; management and funding challenges; experience erratic and unreliable donations/supplies; and their caregivers display knowledge and skills gaps. The present research recommended anti-stigma community mobilization and sensitization; various forms of education starting with on the job training of the caregivers; education on care of children generally, HIV/AIDS testing, early HIV/AIDS diagnosis and disclosure by children, and counseling.

INTRODUCTION

Globally, of the 34 million people living with HIV/AIDS, 3.3 million of these are children under the age of fifteen (AmFAR 2011). Other corroborating global statistics also indicated that there were an estimated 16.6 million children in 2009, who had lost one or both of their parents to HIV. However, 14.9 million of these children were from Sub Saharan Africa (Child Info and UNICEF 2011). South Africa has been at the centre of the epidemic, being the country with the highest number of individuals living with HIV/AIDS globally (Ramphele 2008; South African National AIDS Council (SANAC) 2007). Children have also had a perfidious share of the epidemic. For instance, in 2007, an estimated 370,000 children in South Africa became sero-positive through mother to child transmission (MTCT). This phenomenon has overburdened communities and societies to an extent that these children have to be taken care of in institutions of child care (McDonnell et al. 1994). Incontrovertibly, the role that institutions of care continue to play in caring for vulnerable children in this day and age of HIV/AIDS cannot be overemphasized (Csaky 2009; Meintjes et al. 2007). This is in response to the preponderance and ever burgeoning cases of HIV/AIDS in many contexts, especially of the developing world (Ministry of Local Government 2008). Children's vulnerability in this era of HIV/AIDS has come in various dimensions. Some are born sero-positive and their mothers may be alive or may have succumbed to the virus and, therefore, resulting to children's state of orphanage (Statistics South Africa 2012). If the children are not infected due to the successful implementation of the program of prevention of mother to child transmission program in countries such as Botswana and South Africa (Ministry of Health (MOH) 2005), their parents or guardians may be fighting an uphill and an arduous fight of keeping afloat while living with the virus (Treatment Action Campaign 2007; Clacherty and Associates 2004). This heralds a situation in which the effects of their parents' or guardians' sero-positive statuses negatively influence the environment of children.

Further, the effects of HIV/AIDS to children, whether themselves infected or affected through their parents or guardians living with the virus, could mean an array of things. It could mean a child becomes an orphan that needs to be taken care of; it could mean child poverty where the child cannot get even the most basic needs in accordance with Maslow hierarchy of needs (MLG 2005; Child Info and UNICEF 2011), it could mean child abandonment; child neglect; child prostitution; child engagement in labour to get food; child headed household phenome-

non; and any other situation that makes the child in need of care and help (Kang'ethe 2010a; Musekiwa 2013; Republic of South Africa 2005). It is to this end that care institutions becomes a panacea to such children. The importance of such institutions is that most are able to provide children with the much desirable basic needs. They are a panacea in that they help to relieve society the burden they can no longer hold, or sometimes are not ready to take, whether the finger of responsibility on one hands points at them or otherwise (Kang'ethe and Nyamutinga 2014; Gibbons 2005).

Problem Statement

As global statistics for orphans and vulnerable children continue to burgeon, especially due to the impacts of HIV/AIDS in many countries of the developing world, families and communities in general cannot cope with the burden. The role of care institutions, therefore, becomes a panacea, providing a second home in which children can grow to become citizens of their countries. Since these care institutions are also overwhelmed, it is pertinent that their appropriateness, effectiveness in handling the needs of these children is discussed, debated with the hope of making sustainable and plausible approaches and strategies to address the quagmire. Nowhere is such debates and discussions pertinent as South Africa where statistics in 20007 estimated there were 370,000 children who became sero-positive through mother to child transmission (MTCT).

METHODOLOGY

The study has used a literature review methodology to elicit debates and discourses pitting the role of OVCs against the prevalent HIV/AIDS situations surrounding child care. The study has used government publications such as Child Act Gazette, United Nations based literature and the experiences of these researchers in the field of child care.

Operational Definition

Institutionalized care means the care that takes place in a residential care setting as opposed to a home domicile.

Orphans and vulnerable children are those that have been orphaned by the death of one or both parents, infected and affected by HIV, abandoned**,** living in extreme poverty and living with a disability

THE APPROPRIATENESS OF OVC INSTITUTIONS TO HANDLE OVCS LIVING WITH HIV/AIDS

OVC Institutions Offers a Second Best Home for OVCs

To many OVCs and also in the perspective of those concerned with children's vulnerability, OVC institutions qualify to offer a second best alternative home or a viable solution to these children (Csaky 2009; UNICEF 2004). Literature holds that some babies who may be infected with HIV/AIDS or not are often found in the streets after being abandoned by their parents, while some are abandoned on doorsteps of churches and on the road side (Meintjes et al. 2007). After being taken to the police, they eventually end up in care institutions. As a way of securing a home for these children, the police together with child welfare organization place the child in residential care or in an orphanage (Gibbons 2005). The institutions work together with the state in creating both a first name and a surname for the child. They also give them a birth certificate and a probable date of birth (Gibbons 2005). In this context, these institutions are a panacea for they give these babies a new lease in life.

Professionalization and Institutionalization of Services in OVC Institutions

Compared to community based domiciles of OVC, especially those who are sero-positive, it should be appreciated that institutional care may have some advantages because most of them follow ministry guidelines and timetabling of events as spelt out in the care of orphans and vulnerable children protocol guidelines (MOH 2005). In Botswana, the guidelines were released from the Department of Social Services, Ministry of Local Government, while, in South Africa, such guidelines come from the Department of Social Development, Ministry of Social services (MLG 2008). Of critical concern is that most OVC who are sero-positive may require some individ-

ualized attention. For instance, they may be taking their anti- retroviral drugs that have to be taken in particular time frames. It is hoped that most managers and the caregivers are well prepared to effectuate such services. In community home based domiciles where children are usually at home in the hands of the very elderly, lack of timetabling of events may have their ramifications in that time when a child is supposed to take medication may not be adhered to. Perhaps, that's why Kang'ethe's study in Botswana on community home based programs used conflict theory to inform the difference between communities home based care and formalized institutions. In formalized institutions of care, the timetabling of events ensures that care is given as required and timeframe is also respected and adhered to; while in informal settings, some things are done intuitively or on ad hoc basis (Kang'ethe 2006).

Providing Mothering and Attachment Figures

Though not a perfect replacement of a child's real mother, many OVC institutions have a provision and skills to ensure that the caregivers employed do the task of mothering. This is to try as much as is possible to give the child the love, experiences, trust, and companionship that the real mother would have been giving it. This theoretically, is to increase the attachment of the child to the caregiver as a second mother (Mcleod 2007). Mothering phenomenon is very important for every child's well-being. This is because mothers and their children are bonded by a relationship of trust, love and care (McLeod 2007). In Egypt, it is called surrogate mothering. In this case, children who are in need of parenthood will, therefore, access it through this program. Surrogates mothers are caring and vigilant, and they take their work professionally (Gibbons 2005). They ensure they provide individualized psychosocial and emotional attention to these children. This includes holding, hugging, cracking jokes and fun with them, and touching them passionately. They are employed by the institution on a contract basis that may take about two years (Gibbons 2005). This, therefore, gives children the ability to attach with their caregivers which is a very important aspect in a child's life (Engle 2008). This means that attempts are made by these institutions to ensure that the eight stages of children as given by Eric Erikson as well as the five stages according to Sigmund Freud are complied with. This, it is hoped can prevent these children from becoming social misfits in their future (Eriksson 1968). Sigmund Freud, especially envisioned that children whose childhood growth is not adequately processed with good nurturance find it difficult to adapt to their social milieu when they become adults (Maguire 2002; Freud 1964). However, due to high staff turnover, it becomes a critical problem to ensure consistent emotional and social development of the children (Heron and Charkrabarti 2003). Another setback is that some of these mothers lack training and social skills to work with children, especially from a tender age.

HIV/AIDS Services Offered

Further, to mitigate the effects of HIV/AIDS, some of these institutions cater for only those orphans whose parents succumbed to HIV/AIDS. These centers are usually different from other centers in that ways and procedures of taking care of HIV/AIDS clients are followed. For instance, the centers may be adequately connected to referral clinics and hospitals where such children are given attention (Kang'ethe 2008). However, OVC institutions such as Bona Lesedi Counseling and Moshupa Orphanage centers of the Southern District of Botswana also invite other vulnerable children whose parents may be alive but may be destitute (Government of Botswana 2009). This is usually to surmount the state of stigma associated with HIV/AIDS clients' only centers (Kang'ethe 2010b). Some of these centers offer an array of psychosocial services to these children. For instance, they allow occasional sponsored day trips, hold birthday singing sessions and other recreational based sessions. These are very important aspects of socialization. They cement peer relationship; bolster assertiveness and confidence among the children (Gibbons 2005). In very highly organized centers resource wise, they provide trips and outings especially during summer (Gibbons 2005). Children, for instance, may be taken to the pyramids, beach, zoo, museum and many more places. There is also educational entertainment as the institution access both public and private funding. This, therefore, makes the institutional environment habitable to an extent of calling it a home. Children can celebrate their birthdays and have parties. The home

gives them a chance and sense to develop their identity and define who they are and what they represent in terms of values and the aspirations in the society they live in (Lutenbacher 2005).

INAPPROPRIATENESS OF OVC INSTITUTIONS IN HANDLING HIV/AIDS POSITIVE OVCs

Stigmatization of Children in OVC Institutions

Stigma, in these researchers perspective, is a cancer that stifles prevention, care and support. These researchers candidly agree with the immediate former President of Botswana, Festus Mogae, who said that stigma is the hugest stumbling block impeding successful prevention, care and support of people living with HIV/AIDS (UNDP 2004). Stigmatization of the children in institutional care is not new in the residential care environment. Although the children are stigmatized whether infected by HIV/AIDS or not, HIV infections have exacerbated the state of stigma (Kang'ethe 2010b; UNAIDS 2001; Clacherty and Associates 2004; Smart 2004; Uys and Cameron 2003). This stigma emanates from the societies where these children come from. In these researchers' contention, its the failure to accept the reality of the HIV/AIDS, its impact and how to live with it that make individuals to stigmatize the phenomenon (Kang'ethe 2010b, 2015; UNAIDS 2001). Unfortunately, besides stigma from their peers, children in these institutions are also stigmatized by their caregivers and administrators who should be the ones working to surmount the phenomenon (Meintjes et al. 2007). The state of stigmatization may take an array of dimensions: For instance, female orphans are often stigmatized because they are seen as carrying the potential for demonstrating the loose morals of their mothers. Regardless of gender, schoolmates may bully and hurl the words such as 'bastard child' to an orphan especially in Egyptian societies (Gibbons 2005). Children living with HIV/AIDS are usually bullied at school, called in names as well as treated in a bad way (MLG 2008). However, there are social workers, teachers and psychiatrists who work to ameliorate children's social problems and make sure that their social functioning is enhanced (Nicholas et al. 2010). However, these professionals are usually employed by highly ranked orphanages. This implies that not all the institutions can afford to employ them. If an institution cannot afford a social worker or a psychiatrists, it means that most of the work is done by caregivers. This in turn increases their work load be prone to and have to stress and burn out as they have deal with a lot of problems in such care (Heron and Charkrabarti 2003; Fine 1984; Melgosa 2005). This, therefore, points to the need for a wellness program for such workers so that they can be able to cope with the stress and burn out in their working environment (Addley 2001). Supporting care givers is another pointer to a healthy relationship between children and the staff.

Stigmatized children are not only perceived by others as different, but they appear unmistakably different (Clacherty and Associates 2004). Children infected with HIV are stereotypically stigmatized because they are believed they are a product of their parents' immorality. The unfortunate state of affairs is when stigmatization happens within the extended family and community settings. The situation exacerbates when the same pain of stigma is inflicted to them in care institutions (Clacherty and Associates 2004).

Management and Funding Challenges of OVC Institutions

Although doing an invaluable task of mitigating the effects of HIV/AIDs through taking care of OVCs living with HIV/AIDS and running day care centres, these institutions suffer an array of administrative and management challenges. In Botswana, for instance, where one of the researchers was managing, institution coordinating orphans and vulnerable children, it is saddening to say that most of the managers were people of low socio-economic and literacy levels making an attempt to run these institutions an uphill and an arduous task. Most of the managers are volunteers who are themselves living with HIV/AIDS, or are HIV/AIDS activists/campaigners. Additionally, most of OVc sent Botswana such as Kasane children's centre in Chobe District, Moshupa Orphanage, Olorato children's centre in Southern District of Botswana have for long been relying on well wishers to donate the needs of the children (Government of Botswana 2009). The administrative and management challenge could mean that following the government laid protocols and guidelines

may not be smooth sailing (MLG 2008). However, some countries have cited cases of mismanagement of resources in these institutions. For instance, in a research done in Egypt, a case of mismanaging donations to orphanages was recorded (Gibbons 2005).

Erratic and Unreliable Supplies/Donations

Due to the fact that most of these institutions rely on donations from philanthropic organizations, the supplies of the children's' needs may be erratic. This means that this month children have enough, but the following month a donor may pull out. This poses horrendous effects, especially to children who require special diets due to taking anti retroviral drugs. Hence, some orphanages cannot afford to provide a balanced diet especially to children who are HIV positive (Barnett and Whiteside 2006). The situation also puts the administration of such an institution into disarray (Gibbons 2005). In one of these researchers' experience of Botswana OVC philanthropic terrain, cases of such institutions being given stale and expired food products in Botswana has not been uncommon. In fact some institutions in Botswana have faced closure due to unreliability of donations to run them. Such was the scenario after the pull out of many donors in Botswana when the country was upgraded into a middle income class in the global economic hierarchy. This, unfortunately, painted a wrong picture in that there are very many needy cases in Botswana (Kang'ethe 2010d).

Lack of Knowledge to Caregivers

Handling and taking care of children who are sero-positive requires some kind of expertise. Perhaps that is why Uys and Cameron recommend training of caregivers and clients living with HIV/AIDS (Uys and Cameron 2003). Children living with HIV/AIDS just like the adults become stressed, especially at the point when they become fully aware of their state and its implications. This is especially when other children mock and make them aware that they are sickly. For instance, they could start experiencing shame, despondency, apathy, and a feeling of worthlessness, although not in the same magnitude as the adults (Smart 2003; Clarcherty and Associates 2004). It is therefore, critical that the managers, administrators and especially the caregivers are knowledgeable enough to handle the challenges the children could be experiencing. Unfortunately, most institutions have caregivers who are lacking in knowledge and skills to handle the problems of children living with HIV/AIDS (Lutenbacher 2005). This lack of knowledge to caregivers can be attributed to lack of training, and occupational stress and burnout in these institutions (Heron and Charkrabarti 2003; Fine 1984; Melgosa 2005; Kang'ethe 2010c).

Theoretical Framework

The Systems Theory

The system theory espouses the principle of interdependence between systems and subsystems in the society. For instance, in care institutions, the system theory if applied will inform that different components of care institutions, such as administrative unit, psychosocial unit, testing unit, nutritional unit, recreation unit and educational unit do not work independently to achieve their tasks and mandates but need to mutually relate and help one another so that the care task can succeed (Dale et al. 2006). The systems theory, therefore, is very applicable to care institutions for it would emphasize the need for interrelations and interactions within the institutions. This means different parts or organizations and stakeholders coming together to ensure a holistic functionality of their different tasks. This is to ensure good childhood development (Anderson et al. 1999; Green 2000).

CONCLUSION

The researchers have acknowledged the results of globalization in ensuring the best interests of the child. These include securing basic rights for children to ensure that they are well nurtured in a favorable environment. While the appropriateness of institutional care for OVCs infected with HIV remain a debatable issue, these researchers, therefore, bring out the benefits as well as the problems associated with such care of OVCs. Stigmatization of children, adaptations, effects in psychological, emotional and social wellbeing continue to traumatize children in such care. However, it is difficult to rule out that these institutions offer a second home, parental or at-

tachment figures and professional care. This necessitates the importance of examining the quality of care offered in these institutions with the hope of coming up with interventions that are sustainable

WAY FORWARD

To mitigate the effects of stigma in care institutions, the government through child departments should mainstream anti-stigma education to communities and care managers. Mainstreaming information, education and communication regarding prevention of HIV infection and the spread of other communicable diseases is critical to reduce the state of stigma by community members. These researchers believe that stigma is a recipe of not accepting the diseases and failure to come up with approaches of living with the diseases positively.

Importantly, information about caring for children infected with HIV/AIDS should be mainstreamed to those caring for children in institutions of care. This includes early diagnosis to ensure that all children are tested for HIV/AIDS as they enter into the institutions. This is important to ensure timely access to treatment. It is also critical that the caregivers are adequately trained to handle all the challenges pertaining to children living with HIV/AIDS. For instance information relating to disclosure including telling a child his or her status should be handled with all the professionalism and caution it deserves. If unprofessionally handled, it can cause undue and permanent damage to the child. This is because some children take longer to understand the dynamics of the disease and its immediate or further implications to themselves. Children who are taking medication should not just be assumed. If not explained and handled well, they can as well refuse to take medication, or refuse to cooperate. This can cause a lot of stress and undue pain to the caregiver. It could also be a source of burnout.

Training of the caregivers, therefore, also cannot be overemphasized. If conditions and funding may not allow long term training, it is recommendable that on- the- job training programs and sessions be organized. The on- the-job training should be tailor made to meet the needs of the institutions. Counselling is a very important component of such kind of training sessions. Establishing and educating caregivers on protocols for testing children would also be critical. However, it is important that more training investment is vested on prevention, mainstreaming information education and communication (IEC), implementing universal precautions, information on ARVs, the use of post exposure prophylaxis (PEP) and the prevention of worker to child transmission. Further, it is important to ensure that there are psychosocial and emotional support provided to the children infected and affected by HIV/AIDS.

REFERENCES

Addley K, McQuillan P, Ruddle M 2001.*Creating Healthy Workplaces in Northern Ireland: Evaluation of a Lifestyle and Physical Activity Assessment Programme*. Occupational Medicine: Ireland.

AmFAR 2012. Statistics Worldwide. From <amfar.org/about-hiv-and-aids/facts-and-stats.> (Retrieved on 1 September 2012).

Anderson RE, Carter L, Lowe GR 1999. *Human Behaviour in the Social Environment*. New York: Aldine de Gruyter

Barnett T, Whiteside A 2006. *AIDS in the 21st Century: Disease and Globalization*. New York 10010: Palgrave McMillan.

Child Info, UNICEF 2011. Monitoring the Situation of Children and Women. From <www.childinfo.org/hivaids.html.> (Retrieved on 6 August 2013).

Clacherty and Associates 2004. The Role of Stigma and Discrimination in Increasing the Vulnerability of Children and Youth Affected by HIV/AIDS. *Report on a Series of Workshops*. Arcadia, UK: Save The Children.

Csaky C 2009. Keeping Children Out of Harmful Institutions: Why We Should be Investing in Family Based Care. Save the Children: London. From <www.savethechildren.org.uk//.> (Retrieved on 3 July 2013).

Dale O, Smith R, Chess WA, Norlin J M 2006. *Human Behavior in the Social Environment: A Social Systems Model*. Boston: Allyn and Bacon.

Engle P 2008. National Plans of Action for Orphans and Vulnerable Children in Sub Saharan Africa: Where are the Youngest Children? *Working Paper* Number 50. The Hague Netherlands: Bernard van Foundation.

Erikson EH 1968. *Identity: Youth and Crisis*. New York: Norton Publishers.

Fineman S 1984. *Social Work: Stress and Interventions*. Brookfield: Vt Gower Publishers.

Freud S 1964. New introductory lecturers on psychoanalysis. In: J Stracher (Ed.): *The Standard Edition of the Complete Psychological Works of Sigmud Freud*. Volume 22. London: Hogarth (Original Work Published in 1933).

Government of Botswana (GOB) 2009.*The Second Botswana National Strategic Framework for HIV and AIDS 2010-2016*. Gaborone: Government Printers.

Gibbons AJ 2005. Orphans in Egypt. York University: Canada. From <www.jas.sagepub.com.> (Retrieved on 18 July 2013).

Green RR 2000. *Human Behaviour Theory and Social Work Practice*. Edison NJ: Aldine Transactions.

Heron G, Chakrabarti M 2003. Exploring the Perceptions of Staff Towards Children and Young People Living in Community Based Children's Homes. From <jsw.sagepub.com> At Fort Hare University Library (Retrieved on 27 June 2013).

Kang'ethe SM, Nyamutinga D 2014. The panacea and perfidy associated with Orphaned and Vulnerable Children (OVCs) living in institutionalized care in some countries of the developing world. *Journal of Social Sciences*, 41(2): 117-124.

Kang'ethe SM 2006. *Contribution of Caregivers in Community Home Based Care Programmes*: *The Case of Kanye, Botswana*. PhD Thesis. South Africa: University of North West.

Kang'ethe SM 2008. Challenges that referral system poses to care giving in Botswana. *Maatskaplike Werk*, 44(4): 355-368.

Kang'ethe SM 2010a. The dangers of involving children as family caregivers of palliative care and home based care to advanced HIV/AIDS patients in Botswana. *Indian Journal of Palliative Care*, 16(3): 117-122.

Kang'ethe SM 2010b. The perfidy of stigma experienced by the palliative community home based care (CHBC) caregivers in Botswana. *Indian Journal of Palliative Care*, 16(1): 29-35.

Kang'ethe SM 2010c. Validating that palliative caregiving is a stressful occupation in Botswana care programmes. *SAFP Journal*, 52(6): 1-9.

Kang'ethe SM 2010d. Evaluation of the support to caregiving by local Non Governmental Organizations (NGOs) support in the Kanye care programme, Botswana. *Maatskaplike*, 46(2): 209-223.

Kang'ethe SM 2015. An examination of HIV campaign in South Africa towards eliminating stigmatization. *Journal of Human Ecology*, (In press).

Lutenbacher M, Karp S, Howe D, Williams M 2005. Crossing Community Sectors: Challenges Faced by Families of Children with Special Needs. From <www.jfn.sagepub.com> (Retrieved on 18 July 2013).

Maguire L 2002. *Clinical Social Work: Beyond Generalist Practice with Individuals, Groups and Families.* Australia, Canada, Mexico, Singapore: Brooks/Cole Thomson Learning.

McDonnell S, Brennan M, Burnham G, Tarantola D 1994 Assessing and planning home-based care for persons with AIDS. *Health Policy and Planning*, 9(4): 429- 437.

McLeod SA 2007. *John Bowlby Maternal Deprivation Theory Psychology.* From <http://www. simply psychology.org/bowlby.html> (Retrieved on 27 June 2013).

Meintjes H, Moses S, Berry L, Mampane R 2007. *Home Truths: The Phenomena of Residential Care for Children in a Time of AIDS.* Cape Town: Children's Institute, University of Cape Town and Centre of the Study of AIDS, University of Pretoria.

Melgosa J 2005. *Less Stress.* Madrid. Spain: Editorial Safeliz, Publishers.

Ministry of Health (MOH) 2005. *National Guidelines: Prevention of Mother-To-Child Transmission (PMTCT) of HIV/AIDS.* BOTUSA Project. Gaborone: Republic of Botswana.

Ministry of Local Government (MLG) 2008. *National Monitoring and Evaluation Framework for Orphans and Vulnerable Children*. Department of Social Services, Gaborone, Botswana.

Musekiwa P 2013. *Livelihood Strategies of Female Headed Households in Zimbabwe. The Case of Magaso Village, Mutoko District in Zimbabwe.* Masters Dissertation in Social Work. Faculty of Social Sciences and Humanities. South Africa: University of Fort Hare.

Nicholas L, Rauternbach J, Maistry M 2010. *Introduction to Social Work.* South Africa: Juta Legal and Academic Publishers.

Ramphele M 2008. *Laying Ghosts to Rest. Dilemmas of the Transformation in South Africa*. Cape Town: Tafelberg.

Republic of South Africa 2008. *Children's Act 38 of 2005*. The Government Gazette 2008.

Smart R 2003. Planning for orphans and HIV/AIDS affected children. In: L Uys, S Cameron (Eds.): *Home- based HIV/AIDS Care*. Cape Town, South Africa: Oxford University Press.

South African National AIDS Council 2007. HIV and AIDS and STI Strategic Plan for South Africa 2007-2011 Draft 9, March. From<http://www. womensnet. org.za/sevices/NSP/NSP-2007-2011-Draft9. pdf.> (Retrieved on 13 June 2007).

Statistics South Africa 2012. Countdown to Zero: Elimination of New HIV Infections among Children by 2015 And Keeping Their Mothers Alive. From <hivpmtctfactsheet South Africa. Statistics South Africa.> (Retrieved on 24 July 2013).

TAC (Treatment Action Campaign) 2007. Government Leadership on HIV/AIDS Irrerevocably Defeats Denialism! Implement a New Credible Plan with Clear Targets! From<http://www.tac.org.za/AIDSDEnialismIsDead.html> (Retrieved on 22 February 2007).

UNAIDS 2001. *India: HIV and AIDS-related Discrimination, Stigmatization and Denial*. Geneva Switzerland: August. 2001

UNDP 2004. *Botswana Millennium Development Goals Status Report*. Gaborone. Government Printers.

UNICEF 2004. The Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World With HIV/AIDS. From <http://www.unicef.org.> (Retrieved on 17 May 2013).

Uys L, Cameron S 2003. *Home Based HIV/AIDS Care*. Cape Town: Oxford Press.