A Situation Analysis of Orphan Children in Namibia

OVC

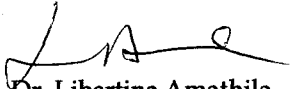# Foreword by the Minister of Health and Social Services

The future of any family, community and nation together with its culture and traditions are its children. Because of the impact of poverty, abuse, violence, disease and armed conflict many African countries have a growing number of orphans and vulnerable children (OVC). Namibia is no stranger to this and because of the impact of HIV and AIDS the number of our OVC population is growing.

As the Ministry responsible for Health and Social Services we have always been aware of this situation and the impact it is having on our country. We have always provided services to OVC but in 1999 we realised that we needed to undertake a national survey on the Needs of Orphans in Namibia. I am proud that my Ministry together with the financial assistance of UNICEF, and the research skills of SIAPAC, are now able to provide this report to you.

As we are reading this report and looking at the projections of OVC in Namibia things look indeed very bleak. The findings of this study have now given us a challenge - a challenge I believe we can overcome. The report provides us with some suggestions on how we can more forward and avert this crisis and I encourage you to take action.

With the move of Child Welfare Services to the Ministry of Women Affairs and Child Welfare they now have taken the main responsibility to ensure that appropriate services are developed. This challenge is however not just the responsibility of that Ministry but a responsibility for all of us. To aid us, we have the Ministry responsible for Child Welfare and the OVC National Steering Committee to develop policies, programmes and services and they are relying on all of us to assist them.

This report is not for our shelves, but it should be our constant companion and a tool that can assist us in ensuring the future of our children in Namibia.

Hon. Dr. Libertina Amathila
Minister – Health and Social Services

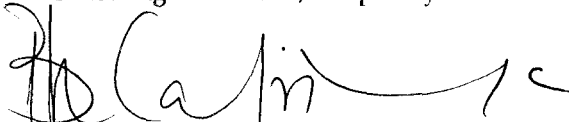# Acknowledgements by the Director of Developmental Social Services

Batseba-Unomuinjo Katjiuongua
Director
Directorate of Developmental Social Welfare Services

Preface by UNICEF

Namibia is classified as one of the most affected countries in the world with an estimated overall HIV/AIDS prevalence of about 22% among sexually active adults. Continuing sentinel surveillance among pregnant women in various parts of the country reveals increases in HIV prevalence over the past 3 years at several sites. HIV/AIDS is the number one cause of death in Namibia and it is also an increasing cause of hospitalization.

This deadly disease is striking down Namibian women and men at their most productive years, leading to more and more children becoming orphans. It is straining the capacity of households, families and communities at large to ensure that the rights of children are protected and fulfilled. Existing higher levels of poverty and income disparities, coupled with an increasing burden on the households to care for increased number of orphaned children, make it difficult for communities and families to fulfill children's rights at all times.

In order to mitigate the situation of orphans and other vulnerable children, a study on orphan children in Namibia was undertaken by the Ministry of Health and Social Services with the support of UNICEF. The purpose of the study was to analyse and provide an understanding of the present situation of orphaned children in the country.

The study report and recommendations will be used by different sectors of the society, including Government, non-governmental organizations, community-based organizations, civil society and others to address issues such as:

- Policy development that needs to address not only material or physical rights but also knowledge and skills as well as psychosocial care;
- Putting support systems in place to help families and communities cope with caring for their orphaned children;
- Ensuring access to basic social services such as education, preventive and curative health services and psychosocial support.

UNICEF is pleased to have contributed to the study, and will continue to support the Government and other partners on programmes that will ensure the protection of orphans and other vulnerable children's rights under the new Government of Namibia/UNICEF Country Programme of Cooperation, 2002-2005.

Khin-Sandi Lwin
UNICEF Country Representative in Namibia

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Executive Summary

Introduction

The Ministry of Health and Social Services (MOHSS) commissioned a situation analysis of orphan children in Namibia, including children orphaned by AIDS. Financed by UNICEF and conducted by SIAPAC, a local social research firm, the study was intended to measure both the quantitative extent of the orphan situation and to qualitatively establish the situations these orphans faced. The purpose of the situation analysis of orphan children in Namibia was to analyse and provide an understanding of the present situation of orphans children in Namibia. The aim was to feed into a process of intervention identification and consideration of the expansion/redirection of existing interventions to better meet the needs of orphans. As the study proceeded parallel progress was made in defining vulnerable children more widely in Namibia. Therefore, this study is to be used by the Ministry of Health and Social Services, and its partners in development, more broadly for vulnerable children programming.

The study was originally commissioned in late 1999, and fieldwork took place in early 2000. However, the report's submission was delayed by Government to await decision-making about AIDS impact modelling parametres and assumptions, to ensure that the findings in the report were consistent with Government-accepted modelling results.

Once the go-ahead was received from Government in mid-2001, SIAPAC modelled the HIV/AIDS epidemic and projected orphan numbers. Projections were made nationally, as well as for the regions of Caprivi and Kavango, the cities of Windhoek, Walvis Bay, Swakopmund, Ongwediva and Oshakati, and the grouped regions of Kunene/rural Erongo, Hardap/Karas, rural Khomas/Otjozondjupa/Omaheke, and Omusati/Oshana/Oshikoto/Ohangwena. These were updated with the obtaining of internal migration data in late 2001, and form the basis for the projections contained herein. Final approval on the report was received in March, 2001.

Scope of the Orphans Problem

As of 2001, an estimated 22.3% of all Namibian adults are HIV positive, or some one-quarter million Namibians, and this will continue to climb to a figure just under 25%. According to the health information system, in 1999 some 2,823 people died of diseases associated with AIDS, representing 26% of all reported deaths and 47% of all deaths in the age group 15-49. However, most AIDS-related deaths have not been recorded in the health information system. Indeed, model projections indicate that some 50,000 Namibians have already died of AIDS, and by the year 2021 there will be a cumulative death total of over one-half million. The total population by 2021 is estimated at 2.7 million, compared to an estimate of 3.6 million without AIDS.

There are numerous problems projecting the number of orphans in the population. Specifically, there are no existing estimates of non-AIDS orphans, and AIDS orphans estimates are only as good as the seroprevalence data they are based on. What is of interest is that the population results yielded by the model differ from the provisional results of the 2001 census by only 16,000 people. Findings therefore suggest that the model is an accurate reflection of reality, and that the seroprevalence data form a good basis for modelling.

A base year number of orphans was estimated by the consultants at 27,493, including only 10 AIDS orphans at the time. For non-AIDS orphans, assuming that all other variables held constant, the numbers were projected at the 'with AIDS' national population growth rate'. Using this approach, as of 2001 there were an estimated 82,671 total orphans, of which over half were AIDS orphans. As the epidemic worsens, AIDS orphans are projected to comprise three-quarters of all orphans from 2006. By the year 2021, there will be an estimated 251,054 orphans, with almost 200,000 of these being AIDS orphans.

Looking at regional variation, some half of the nation's orphans will likely be found in the four north central regions of Omusati, Oshana, Oshikoto and Ohangwena, with many of the remainder found in the two northeastern regions of Kavango and Caprivi, and in Windhoek. However, a number of 'urban orphans' are apparently being moved to rural areas after the death of a parent/parents. Therefore, the four north central regions just mentioned are likely looking after some 60% of the nation's population of orphan children.

Situation Analysis and Possible Intervention Arenas

Key issues for Government and its partners in development to consider for intervention purposes include the following:

<u>Caregiving</u>

- *Situation:* It is evident that the majority of households (but *not* all households) looking after orphan children are suffering financial hardships as a result. In most cases the caregiving household was not able to rely on financial support from the dying parent(s) because either the family was already in poverty, or because they used their resources treating the dying parent(s). Further, many of the caregiving households are already severely poverty-stricken, and the loss of an income-earner (a common circumstance in the case of AIDS) is devastating.

  Possible Intervention Arenas: One possibility is to consider a means-tested financial support package for households looking after orphans. Whether this is a grant meant to supplement other means of supporting the needs of the orphan or to cover all key costs needs to be considered; most estimated the value at some N$200-250 to cover the bulk of the needs. It can also be focused on particular needs (e.g., school fees, uniforms, etc.), or broader needs (e.g., financial support for food purchases). However, the <u>direct</u> costs associated with such a stipend are considerable, while the indirect costs associated with distribution would also be extremely high.

  Of course, registering and means-testing some 30,000-40,000 households would be a considerable task, and the above costs exclude any administrative considerations. Social workers already indicated that they could not cope with existing caseloads, yet the majority of households looking after orphans are not being reached.

  Another alternative is to try and reach all households looking after orphans, without applying a means test (but nevertheless having to ensure that the child is indeed an orphan and that the household is the

caregiving household). In Botswana, for example, there is no means test, and orphans are registered via community development officers, themselves linked to a variety of officers who are involved in orphan registration (including non-governmental organisations). Overall, if there was no means test, the direct costs of reaching the 82,671 orphans estimated to exist in 2001 with N$200 per month would be approximately N$16.5 million, or almost N$200 million for 2001. For 2002, this would rise to N$235 million per annum, for 2010 this would rise to N$500 million, and for 2021 this would rise to N$600 million. Assuming that the stipend were to be increased by 10% per annum from a base in 2003, this would give a figure of N$3.35 billion for the year 2021.

Another alternative would be to help households looking after orphans from incurring certain costs. Waiving of school fees, for example, is one possibility, but this would certainly have costs associated with helping schools overcome financing limitations arising from non-payment of school fees, with associated costs to Government.

Another alternative would be to consider expanding primary level school-feeding programmes so that all children, including orphans and other vulnerable children, receive supplmentary feeding.

Situation: Few households affected by AIDS appear to be able to make provision for their children. Often this is due to the poverty of the household, but there are clearly cases where the money is being spent prior to the death of the parent(s) to care for the sick. There were also cases where the late husband's family took possessions away from the widow's household, while more commonly the husband's extended family is less willing to offer financial support to the wife's family if the latter are taking care of the orphans.

Possible Intervention Arenas: Financial support as noted above. Enforcement of pending legislation protecting widows is needed, as is further strengthening of initiatives derived from the cabinet directive regarding inheritance.

Adjustment and Coping

Situation: Orphan children are generally still living with their siblings. However, the situation is more complex than might have originally been thought, arising from extended family systems that result in siblings often living with other extended family members at varied points in their lives long before they lost a parent/parents. This means that these children are not necessarily moving from one house to another. Further, for those who are moved, the children who have lived together are moved together, meaning that siblings have long been 'split', but not in a manner that caregiving households nor the orphans themselves viewed as inappropriate.

There is an emergent disturbing trend where a few child-headed households come about with the loss of the second parent (or the only parent in single-parent households). This appears to be most common when there are older teenage children in the family (e.g., 15-17) who end up becoming household heads for the few years that they are still considered to be 'children'. The ability of support networks to cope with older children appear to be weaker than for younger children, and the ability of households headed by these older children and youth (even those aged 18 and older) is certainly of concern. Therefore, while there may be few child-headed households at this time in Namibia, there are a number of households headed by young people looking after younger siblings as the households lose the parents. If these households lose assets to relatives of the father, their situation would be significantly worsened.

Possible Intervention Arenas: The tendency is already to keep siblings together, as described above, and for most orphans this pattern will continue. Nevertheless, as the economic ability of caregiving households declines due to an increased orphans burden, it is more likely that siblings will be split, with consequent implications for the emotional adjustment of the orphans.

Further, there will be more and more cases of child- and youth-headed households, with consequent implications for the welfare of the children in the household. This will also likely require further consideration of community-based approaches.

In both cases, it is likely that more attention will need to be given to psycho-social support, in a manner that will be able to reach a wider number of orphans. The Ministry and its partners in development will therefore need to plan for an increased need for counseling services, with reliance on broadened community-based counselling likely to be the only viable alternative.

Further, given the rise in the number of orphans, efforts should be made to expedite formal adoption of orphan children not being looked after by relatives, and to consider channels to expedite adoption by extended family members more generally.

- *Situation:* Because of where Namibia is in the AIDS epidemic (still on the up-slope of a steep curve), because Namibian families have been disrupted by a profound colonial legacy, and become of some cultural practices, caregiving structures have often been in place before the death of a parent/parents. This has tended to make adjustment problems for many of the children less difficult than would otherwise be the case. This does not, of course, mean that adjustment problems do not exist, of course they do, the death of a parent or both parents is traumatic -- some respondents noted that the children became more withdrawn and tended to have emotional problems -- but it appears to have tempered these impacts.

While coping systems designed to weather the hardships of the past are therefore important in responding to the growing number of orphans, this very colonial legacy has meant that many households are more vulnerable to shocks and are less able to cope with additional stress. While households are doing their best to cope, it is likely that their ability to continue to do so in the face of the AIDS epidemic is probably weaker than the overall findings herein suggest. Indeed, case study findings point to a number of cases where coping is already under severe strain.

Possible Intervention Arenas: As noted above, consider a means-tested financial support package for caregiving households, waive school fees, and offer school feeding on a regular basis.

As coping systems become increasingly strained, it is likely that adjustment problems will also intensify, particularly as child-headed households emerge and as extended family and neighbourhood support systems can no longer support the growing number of orphans. Community-based interventions are key to coping with this emergent situation.

- *Situation:* Surprisingly, some of the respondents were quite open that their relatives had died of AIDS, and used the term specifically. They also noted that others knew that it was AIDS. Anecdotal evidence over the past few years suggests that there is a growing acceptance that AIDS is widespread and that 'it is among us'. Nevertheless, given that AIDS is spread through sexual intercourse, and given that there remains considerable confusion over how AIDS is *not* spread -- there is particular concern over the implications of casual contact -- there remains discrimination against those HIV positive. Despite this, the study showed that discrimination against *the children of those who die of AIDS* is minimal.

Possible Intervention Arenas: Continued efforts to destigmatise HIV/AIDS will be particularly important, within the context of overall information, education, and communications activities. Further, the more members of the public 'go public' with their HIV positive status, the more communities will understand the scope of the problem. Finally, political will is already apparent for HIV/AIDS prevention activities, but this will clearly need to be stepped-up in the face of the rising epidemic. The model of HIV incidence, for example, suggests that HIV prevalence will level off around 2004/5, yet it is hard to see why this would actually happen. Instead, the 'Botswana model' of continued high HIV prevalence growth rates may continue. In this case, keeping HIV/AIDS on top of the political agenda will be instrumental to HIV prevention.

<u>Support Networks</u>

- *Situation:* The number of orphan children being supported by any organisations aside from family members appears to be quite low. Instead, most if not all needs are being met by extended family members and close neighbours / friends, with some receiving Government support.

  Possible Intervention Arenas: As noted in the international literature, the first line of 'defence' in responding to the orphans situation is to enable existing support systems to better handle the emergent situation. Financial support as noted above for caregiving households would therefore be an important support mechanism.

  A second would be to build on what already appears to be an educational system that understands the financial limitations many households are facing, and accommodates their needs to a considerable extent (and will need to do so to a greater extent in future). Further investigation is required regarding how systematic such support is, and whether Government policy in this regard needs to be modified to regularise the practice.

  A third issue relates to the 'second line' of defence, beyond the extended family -- community-based interventions. If the study had been carried out in early 2002 rather than early 2000, it is likely that it would show that more households are being reached by NGO networks and CBOs, given the rapid expansion of such services over that period. Growth in outreach is extremely fast, suggesting that no changes are necessary, but rather that expanded support to this growing network is required. The groups themselves are increasingly concerned about their ability to manage such a rapid expansion, suggesting the need for additional support.

  Finally, most of the orphans and caregivers interviewed were not receiving support from Government to help care for the orphans., nor were they linked to outside support agencies in most instances. The few who had made application for financial support often spoke of a lack of feedback on the status of the application, or problems in the application process that had brought the application to a standstill. This suggests that more needs to be done to follow-up on existing applications and to keep lines of communication open with caregiving families and orphans. To the extent possible, the application process should be expedited.

- *Situation:* There is wide variation in terms of the level of activity, and the level of commitment, of the various Regional AIDS Committees. Some have clear co-ordination problems that negate their effective functioning, others have been outstanding in their ability to lead regional efforts.

  Possible Intervention Arenas: Fortunately much has been done in recent years, under the current HIV / AIDS national plan, to improve the functioning of these structures, including co-ordinating bodies. The effects of these innovations need to be considered, and gaps in performance overcome. Further, Government needs to consider whether these structures are capable of serving their facilitative role, and whether they are supportive of innovation in the non-governmental and private sectors.

- *Situation:* The extent to which households looking after orphan children can rely on the wider community was considerably less than anticipated. Nevertheless, findings suggest that households that cannot rely on extended family members were particularly reliant on their close friends and immediate neighbours, apparently because of a lack of alternatives. Extended family linkages were especially strong in the north, while southern and western households appear to rely more on neighbours and friends.

  Possible Intervention Arenas: Broaden community-based interventions in recognition of the dispersed nature of support. Further recognise the importance of informal and extended family social linkages when considering community-based interventions.

- *Situation:* The recently completed Demographic and Health Survey found that only 9% of all women aged 15-49 were currently using condoms, and only one-quarter of all women aged 15-49 had ever used a condom. While it was higher for those aged 15-24, the usage levels are extremely low in comparison with the number of women sexually active. In neighbouring Botswana, for example, usage rates among sexually active 15-24 year olds are over 80%, and consistency of condom use is over 90% (that is, over 90% of 'sexual events' involved a condom; SIAPAC, 2001).

  Possible Intervention Arenas: Given recent rapid expansions in social marketing and condom outreach programmes, continued efforts to regularise condom use is required. The scope of these outreach programmes needs to be reassessed in light of the DHS findings. If condom use is not increased, the rise in HIV infection will likely exceed current model expectations, and the number of orphans will be higher as well.

Education

- *Situation:* Orphan children are being kept in school. Indeed caregiving families are going to great lengths to keep the children in school, and school officials are being flexible in understanding the circumstances facing orphans (as they do with children from poor households). The children also appear to have access to other services in the same way, and at the same level, as other children in the same household.

  Possible Intervention Arenas: Many respondents noted that they were not just having problems meeting school fees and uniform costs and other school-related costs for orphan children, but rather for *all* of their children. They did not feel that it was wise to specifically identify orphan children for such support, suggesting that a more general support package that would allow the household to manage the money for school fees etc. on behalf of the wider household would be more acceptable. The fact that they had an orphan would be the reason they would obtain financial support, but they should have the discretion to cover the needs of other children.

Chapter One: Introduction

"... the [SADC] region has to deal with thousands of orphans and those children born with this deadly disease. The reality ... is that we have ... a traumatic situation where either grandparents or children head households. Increasingly, our governments are required to allocate huge resources to deal with this dilemma, diverting much-needed resources away from productive sectors that are essential to enhance economic growth and development". H.E. President Nujoma (Namibian, 15 August, 2001)

Introduction

In 1999 the Ministry of Health and Social Services (MOHSS) of the Government of the Republic of Namibia (GRN) commissioned a situation analysis of the status of orphan children in Namibia, including children orphaned by the AIDS epidemic. Financed by UNICEF Namibia, the study was intended to measure the *quantitative* extent of the orphan situation in Namibia, and further establish the *qualitative* situations facing orphans, their caregivers (if any), and more broadly their communities. The consultancy was awarded to Social Impact Assessment and Policy Analysis Corporation (SIAPAC-Namibia), a Namibian-based socio-economic research firm.

The **purpose** of the study was to analyse and provide an understanding of the present situation of orphaned children in Namibia. The aim was to identify potential interventions and consider the expansion/redirection of existing interventions to assist the GRN and their partners in development in helping orphans and their caregivers better meet the needs of these vulnerable children. It is important to note that, while the study focuses on orphaned children, Government is

> "Situation analysis is a process of gathering and analysing information to establish a basis for planning a strategy and specific interventions ... It involves gathering information about the epidemic, its consequences, coping responses and relevant policies and programmes. It concludes with analysing the information gathered, identifying geographic priorities and making recommendations, to set the stage for planning and action. It should provide a basis for the hard choices to be made about how and where to direct available resources to benefit the most seriously affected children and families." UNICEF, 1995: 23.

considering the results of the investigation in the context of orphans *and other vulnerable children*. Indeed, the findings from the study point out that the expansion of the orphan population has increased the vulnerability of other children, particularly those living in the same households as the incoming orphans. This is discussed in more detail below.

At the outset it is important to note that, although the scope and nature of the orphan situation is changing dramatically due to the AIDS epidemic, and as will be borne out by the findings presented below, in the early stages of the epidemic most orphans are *not* AIDS orphans. However, in circumstances where other factors artificially increasing orphan numbers (e.g., civil war) no longer affect a country, by the time the AIDS epidemic matures, most orphans will be orphaned due to AIDS deaths.

The quantitative assessment of the number and distribution of AIDS orphans in Namibia was determined using the Spectrum model which specifically projected the number and geographical distribution of AIDS orphans. The estimate for the number of non-AIDS orphans came from specialist studies that tried to

estimate the impacts of AIDS orphans on overall orphan numbers. The qualitative assessment looked in detail at the situations facing orphans, including an investigation of coping strategies (internal to households, extended families and communities, and external to these sources) and the extent to which coping could 'cope'. Equally importantly, the study focused on recommending ways forward, soliciting inputs and insights from the orphans themselves, their caregivers, and the organisations and structures in place designed to assist[1].

At the outset it is important to note that, following start-up of the investigation, significant delays were experienced arising from delays in a decision by Government regarding how to proceed with the modelling of HIV/AIDS impacts. As a result, while fieldwork was conducted in early 2000, an 18 month delay in report preparation was experienced due to delays in obtaining Spectrum projection data. In the end, only 1998 data were received and used for modelling, as 2000 data had not yet been made available to the Consultants for modelling purposes.

Because much of the findings are presented in text format, relying as it does on qualitative information, efforts have been made to 'break up' the presentation using dialogue boxes. These dialogue boxes have been used for three purposes:

> ➤ To quote from a separate study where the information pertains to the current assessment.
> ➤ To summarise key findings in the report.
> ➤ To present case study findings.

Background

Namibia

Namibia covers an area of 825,418 square kilometres with a coastline of 1,572 kilometres. It is located in southern Africa, bordered in the south by South Africa, in the west by the Atlantic Ocean, in the east by Botswana, in the north by Angola and in the northeast by Zambia. There are only five perineal rivers in Namibia, the Orange River forming the southern border with South Africa, the Kunene River forming the northwestern and central border with Angola, the Okavango River that borders Angola in the northeast and thereafter crosses to Botswana, and the Zambezi and Linyanti/Chobe rivers bordering Caprivi Region in the far northeast. A map of Namibia showing its position in Africa

"In its second decade, the global HIV/AIDS pandemic has emerged as one of the most serious threats to survival and well-being of children worldwide. Not only is it an increasing cause of death among adults, infants and young children, it is slowly impoverishing and dismembering families, leaving growing numbers of orphans in its wake." UNICEF, 1995, Children and Families Affected by HIV/AIDS: Guidelines for Action.

follows this page. Namibia is sub-Saharan Africa's driest country, with 92% of the country classified as desert, arid or semi-arid.

Consequently, Namibia is also sparsely settled, with an average of 2.2 people per square kilometre (2001 census findings, rising from 1.7 per square kilometre in 1991). Aside from major settlements in central and

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[1]   Key definitions are offered in Annex A.

coastal Namibia, settlement is densest in the north, where some 60% of the country's population lives. The population of Namibia in 2001 was 1,826,854, based on an annual population growth rate of 2.6% (AIDS-adjusted; compared to an estimated 3.16% per annum growth without AIDS) (preliminary census results, CBS, 2002).

Forty-two percent of the population is under the age of fifteen, while over two-thirds are under the age of thirty (UNFPA, 1998). The severe lack of employment opportunities in rural areas, historical trends and the freedom of movement after independence has led to a dramatic upswing in the urban population, growing at some 5% per annum. By 2010, up to half of the population is expected to be urbanised. Namibia's long history of labour migration has resulted in a high percentage of households being headed by females. Over one-third of all households in Namibia are headed by females, rising to over 40% in rural areas and over 50% in the 'labour exporting' regions of Oshana, Omusati and Ohangwena.

Namibia gained its independence in 1990 after a protracted liberation struggle from South African *apartheid* rule and over a century of colonial occupation. Namibia is guided by a written constitution and a Bill of Rights, the first in sub-Saharan Africa. The constitution outlines the unitary nature of the country's political system, providing for an executive presidency, a two-house legislature (National Council and National Assembly), and an independent judiciary.

Namibia's difficult colonial history has resulted in a legacy of population dislocation, poverty and underdevelopment. In an effort to move away from ethnically-defined homelands and towards the establishment of logical agro-ecological regions after independence in 1990, the country was divided into thirteen regions proclaimed in March 1992 (and revised in 1998), as shown on the map following this page.

Poverty

Namibia was ranked 84th out of 175 countries in terms of Gross Domestic Product (GDP) per capita, with Namibia classified internationally as a 'middle income country'. However, Namibia's difficult history has left the country with the dubious distinction of being the world's most inegalitarian country with a Gini coefficient of income equality of 0.701. As a result, Namibia drops 23 places to 107th in terms of the Human Development Index ranking which includes various measures of quality of life.

> As of 1993, the richest 7,000 Namibians were estimated to spend as much as the poorest 800,000 combined." NPC, 1992.

A related Human Poverty Index developed by the United Nations classified 20% of Namibia's households as in severe poverty, ranging from 10% in Khomas Region (where the capital Windhoek is located) to 32% in the north central Ohangwena Region. Poverty levels are highest in rural areas and in northern regions.

It should be noted that other estimates of poverty in Namibia show considerably higher poverty rates (50% and 67%). In large part the difference is due to the Human Poverty Index inclusion of redistributive measures when considering whether households fall above or below a poverty line. In the case of Namibia, while half to two-thirds of all households may be poverty-stricken from a strictly economic point of view, many of these households are re-classified as not poverty stricken due to outside support offered through monetary and goods remittances and social services (see UNDP, 2000).

Hastings (1999) argues that remittances (both in cash and in kind) have a significant positive impact on alleviating poverty. Indeed, Hastings (1999: 5), referring to other studies on remittances, argues that "... one finds that remittances often target the needy far more effectively than government programs. This can be attributed to the fact that private transfers of income depend upon private networks of knowledge (concerning who is truly needy, and the specific conditions of the need), and operate through human relationships, whereas eligibility for government programs is typically based upon fixed criteria (such as age or formal employment status) which may not correctly reflect the recipient's level of need. Thus, private transfers can respond more quickly and accurately to changes in the circumstances of a poor household than can a large government program."

> "Though they make up only 5.2% of household income nation-wide, cash remittances make up 15.3 percent of the income of those families which receive remittances, and 65 percent of the case income of those families." Hastings, 1999: 40.

While cautioning that calculations are provisional, Hastings argues that remittances show positive distributional effects as follows:

- Rural households - an average 4.5% increase in median household income
- Female-headed households - an average 8.7% increase in median household income
- Households where the head is unemployed - an average 4.1% increase in median household income.

> An orphans plan "... calls for strategic, participatory planning and action involving the governments, international organizations, non-governmental organizations, donors and grassroots groups from affected communities. Its focus is not HIV/AIDS but on understanding and addressing its effects on children and families. Its orientation is, through both policies and programmes, to strengthen the capacity of families and communities to meet the needs of their children. It stresses society's obligations to protect and care for vulnerable children and describes essential action." UNICEF, 1995: 1).

Having said this, Hastings (1999: 36) cautions that, while remittances have positive poverty alleviation effects, and while they tend to lower levels of inequality, the effects on inequality and poverty reduction are reportedly less in Namibia than elsewhere is due to the fact that "... remittances in Namibia flow primarily within ethnic groups, whereas the most severe inequalities in Namibia exist between different ethnic groups".

In 1998 Cabinet approved a Poverty Reduction Strategy for Namibia (NPC, 1998). The policy focused on three areas felt to be central to poverty reduction:

- Fostering a more equitable and efficient delivery of public services, within the context of decentralisation.
- Accelerating equitable agricultural expansion, including an emphasis on food security.
- Expanding options for non-agricultural employment, emphasising the informal and self-employment sectors capable of employing larger numbers of the poor than formal options.

The Strategy contends that the framework for poverty reduction is already in place, no new interventions are required: "... the emphasis has been on identifying which programmes already underway deserve high priority in the fight against poverty; and on suggesting new approaches to how the programmes might be implemented more effectively" (NPC, 1998: 21).

There is little doubt that HIV/AIDS is deepening poverty in Namibia, particularly because the epidemic is hitting people who are often the breadwinners in extended family systems -- absentee males and females -- who due to their very migration are more at risk of infection. It does not, however, suggest that the nation's poorest households are more likely to have infected members.

> The period from 1997 to 1999 showed a loss of development, with the human development index rank falling. While gains were made in terms of health and nutrition, these gains were more than reversed by AIDS. As the 2000 Human Development Report noted (UNDP, 2000: 13), "A significant new feature of the Human Poverty map of Namibia as compared to that of previous reports, is the emergence of HIV/AIDS as a factor shortening the average life span of Namibia. Low survival rates constitute for the first time a critical poverty trap most significantly in Caprivi."

Rather, the issue is as much the *widening* as the deepening of poverty due to HIV/AIDS, with households previously above the poverty line unable to cope as effectively as in the past. This is highlighted by a recent article in The Sunday Independent. An AIDS researcher in South Africa, Hein Marais (The Sunday Independent, 26 November, 2000: 9), notes that "The relationship between poverty and HIV/AIDS is complex. Poverty definitely renders people and households less able to cope with the onset of AIDS-related illnesses. But does sheer poverty predispose a person to HIV infection? If it does, then HIV infection rates should be highest where we find the most severe concentrations of poverty ... The evidence doesn't seem to fit the hypothesis". He thereafter makes reference to the relationship between men having access to money and the spread of HIV and notes that "In South Africa, and the region generally, the epidemic spreads most virulently when the paths of extremely poor women cross those of not-so-poor men. Recall that the majority of South African women are not merely poor; they are impoverished. They are made poor and kept poor by the dominant social, economic and ideological forces that define their lives." This is consistent with emergent findings in AIDS research worldwide. UNAIDS (2000) highlights the shift in research from a focus on individual decision-making to giving due attention to the social and economic context of the daily lives of people, in short, the context within which sexual decisions are made.

Education

At independence in 1990 Namibia inherited a 'balkanised' educational system that systematically mis-allocated resources towards a minority of its citizens. Given these historical disparities, problems such as high levels of repetition and drop-out in the formal school system, high levels of illiteracy among adults, poorly trained teachers and similar problems remain.

Nevertheless, significant improvements have been made. Between 1990 and 1997 the number of schools increased by 21%, the primary school enrolment rate approached 100%, and the secondary school enrolment rate increased threefold. Non-formal education opportunities have expanded dramatically, with many previously uneducated adults (particularly women) having been reached.

Findings from the Namibian Demographic and Health Survey (MOHSS, 2001d) reflect this increase in educational access, with over 90% of women and almost 90% of men aged 15-49 having attended at least some schooling, and over 50% having attended at least some secondary schooling.

<u>Health and Well-Being</u>

In 1990 Namibia adopted a Primary Health Care approach to meeting the health needs of all Namibians, shifting away from a long historical focus on an urban and curative approach. Namibia's allocation of funds to the health sector has been continuously high, one of the highest in sub-Saharan Africa. Access to health care has improved dramatically since independence, while significant gains are expected to have been made with regard to reduced maternal mortality, the lowering of infant and underfive deaths from preventable illnesses through expanded immunisation, improved nutrition, the iodisation of salt, and improved access to essential drugs and supplies.

The summary findings from the 2000 Namibian Demographic and Health Survey (MOHSS, 2001d) give an excellent summary of current health status and health-related issues:

- Virtually all urban households have access to piped water.
- Some two-thirds of rural households have access to water unlikely to be contaminated at the source.
- 90% of all urban households, but only 20% of rural households, have access to an improved form of human waste disposal.
- Two-thirds of the country's population consume iodised salt, with iodine consumption levels at the recommended rate.
- The total fertility rate from the survey was 4.2 children per woman, declining sharply from 5.4 in 1992.
- Two-thirds of all women had ever used a method of contraception, and one-third are currently using contraception. Injections and the pill were most commonly mentioned.
- Only 28.2% of all women had ever used a condom, and only 8.9% were currently using a condom. Condoms were most commonly used by women in their twenties.
- Some 80% of all births were supervised by a doctor or nurse/midwife, with only 5.6% attended by a traditional birth attendant.
- Two-thirds of one year olds had received all immunisations.
- Half of all underfives (6-59 months) had received a high dose of a vitamin A supplement.
- 12% of underfives had had at least one episode of diarrhoea in the two weeks prior to the survey, with rates highest for those aged 6-11 months (2.8%) and 12-23 months (20.3%). Two-thirds had received ORS treatment.
- 12.1% of live births were classified as underweight. This was highest in Omaheke, Ohangwena, and Oshikoto Regions.
- 95% of all newborns were breastfed for at least the first three months, although in the majority of these cases (74%) other supplements were also offered almost immediately. By the age of 7 months, 20% were taken off of breastmilk.
- One-quarter of underfives showed signs of moderate long-term malnutrition, and 7.8% showed signs of severe long-term malnutrition.
- Infant mortality was calculated at 38.1 per 1000 live births. Adding in child mortality, underfive mortality was 62.2 per 1000 live births. These rates show considerable improvement over the 1992 DHS results, with improvements particularly strong in the four northeastern regions of Ohangwena, Oshikoto, Oshana, and Oshikoto.
- One-quarter of women aged 15-49 had been tested to HIV, with urban figures three times rural figures.

Of these findings, the ones on mortality, fertility, and assistance during delivery are of particular relevant to the orphans study, followed by child health measures such as immunisation coverage, breastfeeding, low birth weight, and nutritional status. Findings show marked improvement in child welfare status overall.

However, the findings for mortality were unexpectedly high, with AIDS-projected underfive mortality rates at some 90-95 per 1000 live births. Instead, the 2000 study show a rate at only two-thirds of this, at 62/1,000. Further, the greatest improvement in underfive mortality rates occurred in the north east, where the epidemic has been established for the longest period of time. One reason for this relates to the way in which

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AIDS affects demographic structures, because a number of the children who would have been born with HIV are not born because the infected mother dies. Secondly, in Africa an average of two-thirds of those born to an HIV positive mother do not contract HIV. Nevertheless, both of these should have been accounted for in underfive mortality projections based on the impact of AIDS, and cannot account for the unexpectedly low mortality rates.

Naftali (not his real name) is 14 years old and he is in Grade 8. He lives in Entope in Ohangwena Region. He said that there are six other people in their household, one of which is his brother aged 19, and two of which are his sisters aged 13 and 17. He also has two younger brothers who stay at Ondangwa with his aunt. One is five years old and one is seven, the latter of whom is in school. The two were taken by the aunt when the mother fell ill, and she died while the two youngest children were with the aunt.

Naftali's brother is the head of the household, with the 19 year old brother taking over the household when he was 17. The household tries to make a living out of their arable fields, while their father also put money aside for them, as he was employed with a good job in Walvis Bay. The older brother makes all of the financial decisions for the household.

His father died just before the mother died. After the father died, the father's relatives came and took all of the household's possessions, and his mother therefore died destitute. 'They only left clay pots and old blankets'. The headman then ordered that the children must vacate the house or pay N$400 to stay, so they paid. They do not know why they had to pay this fee.

He said that his older sister took their mother's death hardest. She did not sleep well and she was always crying, and even said that she was going to commit suicide. At one point his older brother took the sister to a neighbour (a close friend of their mother) to counsel the sister, and the church also got involved.

They sometimes do not have food, and when this happens they can rely on the neighbour, 'she always helps us'. They do not have any contacts for 'official' assistance, and they do not have any contacts with social workers.

It may therefore be that other mitigating factors are also affecting mortality rates. First, high levels of supervised births are key to reducing the risk of HIV transmission at the most vulnerable point -- during the birthing process -- and may be one reason why many children in Namibia born of an HIV positive mother are not contracting HIV. Second, high immunisation rates, improving nutritional status, and other child health factors have improved quite considerably over the past decade, and may be mitigating the impacts of AIDS. Third, while breastfeeding is common, many mothers introduced substitutes at a very early age. The literature on HIV transmission via breastfeeding is by no means conclusive, but it does suggest that HIV positive mothers should either exclusively breastfeed the child, or exclusive bottle feed the child. Unfortunately, in Namibia mixed breastfeeding and substitute may increase the risk for HIV transmission.

On an unrelated but important matter, it is likely that few infections have occurred via blood transfusions, given careful screening. Compared to a number of other African countries, therefore, patterns of infection via transfusions is likely to be lower than anticipated. Further, use of disposable needles is universal in Namibia, and intravenous drug use is uncommon in Namibia, suggesting low risk of infection via contaminated needles.

The findings for total fertility rates is not unexpected, with a lowered fertility rate anticipated by the AIDS epidemic.

Nelli (not his real name) is seventeen and is staying with his uncle and aunt and three other children in Khorixas. His parents were separated some time ago. His mother died when he was only eight, and he they went to stay with his father. His father passed away in 1998, he does not know what he died of. While he was alive his father asked his uncle to take care of his son if he were to die. He had always been close to his uncle, so he felt that this made adjustment easier for him. 'The atmosphere here is not really different then from my previous home, and they treat me as their own child'.

The reason why he was not taken in by his mother's relatives was that they were financially weak and could not assist.

He is now living in a hostel because there was no school where his uncle lived. 'There are a lot of orphans at the school', and he has many friends there. He performs well in school, rarely gets sick, and wants to go on to University. He is very active in sports. During holidays and over long weekends he goes to his uncle's house. He has his own room when he is home, as the uncle and aunt are well off.

He said that he was told that his father made financial provision for him in some sort of insurance policies, but up until now he has not received any money and doesn't really know much about it. He did not receive any grant from Government 'because no one applied'.

When considering the health findings in light of the epidemic, it might be concluded that Namibia is not as 'far along' in the epidemic as it might otherwise have been thought. The model that has been developed used a 'year of first case' to establish the starting point of the epidemic, and thereafter an anticipated rate of infection as the virus permeates the wider population of sexually active. In Namibia, migration trends coincide with high rates of infection (e.g., the north central and north east with the urban areas of Windhoek and Walvis Bay), while areas outside of these common migration corridors are significantly lower. It may be that, when combined with the changes in child health status noted above, the complexity of the patterns of HIV infection in Namibia have mitigated its spread.

This does not mean, of course, that infant and underfive mortality rates will *not* reach these higher levels, as modelling findings below suggest. It simply suggests that the epidemic is not as mature as the 'average' epidemic the Spectrum model predicts. Further, this is also likely to have been strongly influenced by two additional factors:

- Population movement was very restricted from 1986 until 1989, immediately prior to independence. The spread of the disease, therefore, would be limited during that period (this also occurred in Mozambique prior to peace in 1992).
- The first case in Namibia was not a Namibian, but rather an expatriate. The first case of a Namibian infected with HIV is not known, but may have occurred later.

HIV/AIDS in Namibia

Despite these gains, there have been significant declines in the overall health status of Namibians due to the AIDS pandemic—Namibia is one of the worst-affected countries in the world, as shown in the following table in comparison to other African countries:

"The Prime Minister [of Namibia] said in his speech that the battle against AIDS is a shared responsibility for all Namibians and all people must take responsibility for orphan children to ensure that the disease that kills their parents does not continue to lay waste to their future." New Era, 11 September, 2000, "New Hope for AIDS Orphans.

Table 1.1: Adult HIV/AIDS Rate by Country in Africa (2000)

Rank	Country	Adult HIV/AIDS Rate (%)
1	Botswana	35.80
2	Swaziland	25.25
3	Zimbabwe	25.06
4	Lesotho	23.57
5	Zambia	19.95
6	South Africa	19.94
7	Namibia	19.54
8	Malawi	15.96
9	Kenya	13.95
10	Central African Republic	13.84
11	Mozambique	13.22
12	Djibouti	11.75
13	Burundi	11.32
14	Rwanda	11.21
15	Ivory Coast	10.76
16	Ethiopia	10.63
17	Uganda	8.30
18	Tanzania	8.09
19	Cameroon	7.73
20	Burkina Faso	6.44
21	Republic of Congo	6.43
22	Togo	5.98
23	Democratic Republic of Congo	5.07
24	Nigeria	5.06
25	Gabon	4.16
26	Ghana	3.60
27	Sierra Leone	2.99
28	Eritrea	2.87
29	Liberia	2.80
30	Angola	2.78
31	Chad	2.69
32	Guinea-Bissau	2.50
33	Benin	2.45
34	Mali	2.03
35	The Gambia	1.95
36	Senegal	1.77
37	Guinea	1.54
38	Niger	1.35
39	Mauritania	0.52
40	Equatorial Guinea	0.51
41	Madagascar	0.15
42	Comoros	0.12
43	Mauritius	0.08
44	Somalia	na

Year 2000 estimate. See UNAIDS, 2000.

Namibia was Africa's seventh worst affected country in Africa, while its ranking also coincided with the world's seventh worst affected country. Subsequent to the publication of the UNAIDS report, the 2000 seroprevalence data indicated that Namibia's seroprevalence rate was actually 22.3%, which would place it as fourth most affected.

The distribution of HIV prevalence across regions is indicated on the following map:

Map 1.2: Rates of HIV Infection in Namibia (1998)

Legend:
- 0 – 4 %
- 5 – 9 %
- 10 – 14 %
- 15 – 19 %
- 20 – 24 %
- 25 – 29 %
- 30 – 34 %
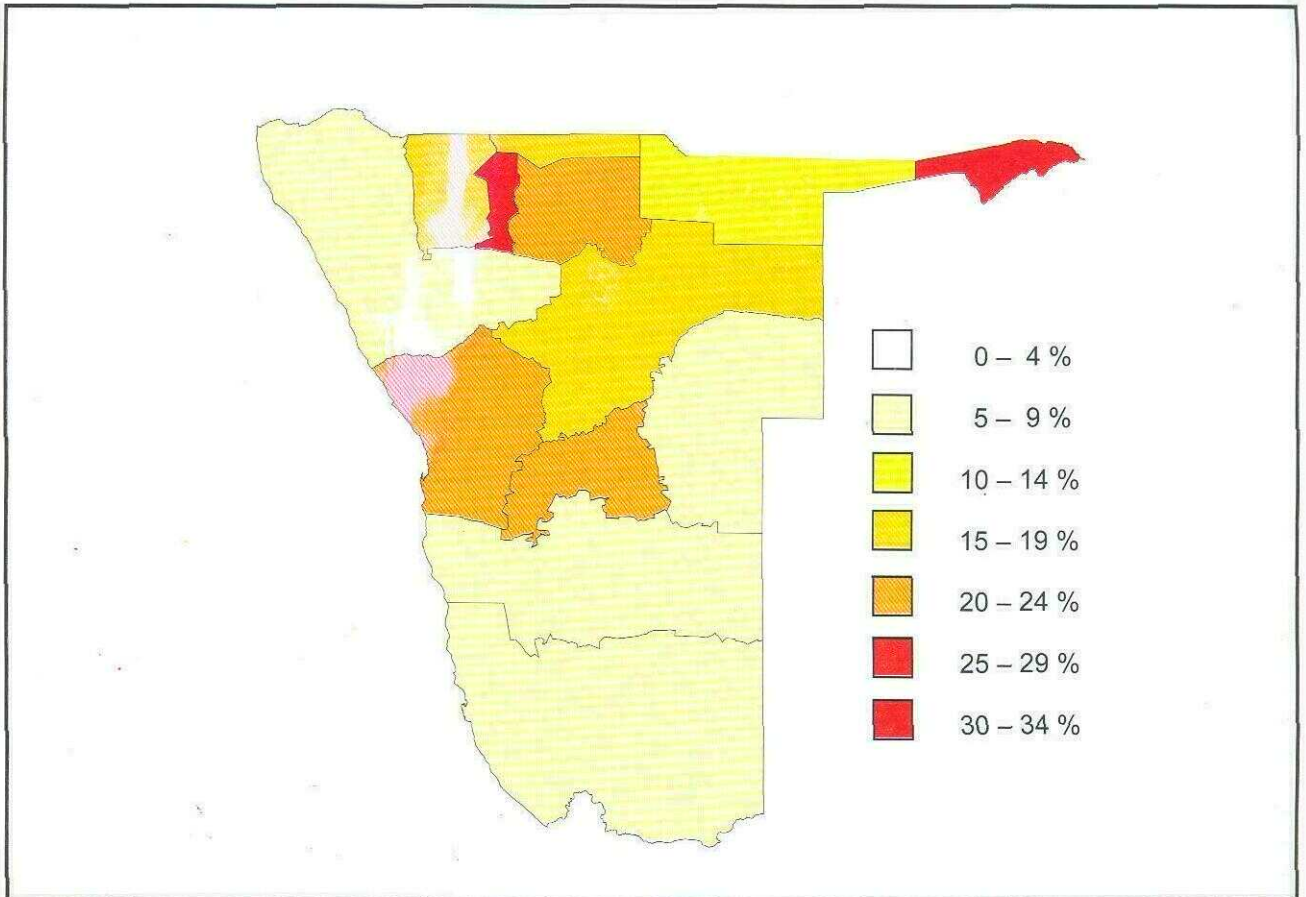
Source: MOHSS, 2000

The 1998 serosurvey of women attending antenatal clinics and sexually transmitted disease patients found a national HIV prevalence rate of 17.4%, ranging from 6% in Opuwo in Kunene Region in the far northwest, 7% in the south in Keetmanshoop and 9% in the east in Gobabis, to a high of 34% in Oshakati in the north central regions, 29% in Walvis Bay in the west, Katima Mulilo in Caprivi Region in the far northeast, and 23% in Windhoek.

Namibia's 1991 population, at 1.4 million, would have been expected to have grown to some 3.5 million by the year 2021. With AIDS, the expected population by the year 2021 would be 2.6 million. The crude death rate for Namibia is expected to triple due to AIDS, rising to 19/1000 in 2006 (and leveling at 15/1000 thereafter), well above the expected level of 5/1000. Infant mortality is expected to be 59% higher with AIDS than without AIDS, while child mortality is expected to be double the 'without AIDS' level. Life expectancy gains which have been made since independence have already been reversed, and is expected to fall from a high of almost 61 years to a low of 40 years by 2005, leveling at 46 years through 2021. According to the projections, the average reduction in life expectancy will average 24 years (The Namibian, 24 May, 2000).

> "The growing number of orphans will have a profound impact on the societies in which they live. Orphans may suffer the loss of their families, depression, increased malnutrition, lack of immunizations or health care, increased demands for labor, lack of schooling, loss of inheritance, forced migration, homelessness, vagrancy, starvation, crime, and exposure to HIV infection. With orphans eventually comprising up to a third of the population under age 15 in some countries, this outgrowth of the HIV/AIDS pandemic may create a lost generation - a large cohort of disadvantaged, undereducated, and less-than-healthy youths." Hunter and Williamson, 1994: 3.

Without AIDS, and assuming some success in family planning interventions, the 'without AIDS' population growth rate of Namibia would be approximately 2.5% per annum by the year 2021. Instead, the growth rate will be almost half this level, at 1.4% by 2021.

The estimated direct and partial indirect costs of HIV/AIDS to Namibia for the period 1996 to 2001 is indicated in the following table (United Nations, 1999: 48):

> The study (MOHSS, 2000: 6) highlighted the impact on Namibia through the following example. "... consider two cohorts of current 14 year olds: 100 boys and 100 girls, all of whom are assumed to be HIV negative on reaching age 15. Under current assumptions and following existing trends, we would expect over half (55%) of the boys to be HIV positive before they reach the age of 50 years, with 38% of them dying from AIDS before their 40th birthday ... Out of an equivalent cohort of 100 girls, 60% will be HIV positive before their 50th birthday, and nearly half (48%) are projected to die of AIDS before their 40th birthday ... a quarter [of all females] will die before their 40th birthday."

Table 1.2: Estimated Direct and Partial Indirect Costs of HIV/AIDS to Namibia (1996-2001) (in constant 1996 N$ million)

Year	Direct Medical Costs	Support to People with AIDS (proposed disability allowance)	Value of Productive Years Foregone	Total Direct and Indirect Costs	Gross Domestic Product	Direct and Indirect Costs as Percent of GDP
1996	21.6	--	407.8	429.4	13,593	3.2%
1997	34.2	14.6	615.8	664.6	14,273	4.6%
1998	47.4	20.1	1016.6	1084.1	14,986	7.2%
1999	64.6	27.7	1415.9	1507.5	15,736	9.6%
2000	89.3	37.7	1903.3	2030.3	16,522	12.3%
2001	127.7	55.4	2648.1	2831.2	17,348	16.3%
TOTAL	384.8	154.8	8007.5	8592.3		

For the period 1996 to 2001, the total loss to the Namibian economy by this year (2001) is estimated at over 8.5 billion Namibian dollars. The report also estimated that 20% of the nation's health budget would be consumed by HIV/AIDS by this year (2001).

Recognising the growing economic burden of HIV/AIDS in terms of orphan numbers, in late 2000 Government announced that it would increase support to orphans and caregiving families. Grants are planned to allow caregiving families to purchase food and provide medical care. The aim is to ensure that at least 60% of orphaned

> "[Prime Minister] Geingob said the HIV/AIDS pandemic is a crisis with grave consequences and should be declared an emergency." New Era, 11 September, 2000, "New Hope for AIDS Orphans.

children would have access to basic education, medical care, counselling and, importantly in the context of traditional laws regarding inheritance in some cultures in Namibia, protection from the loss of property. 80% of orphans and their caregiving families would also be provided with information on their rights and available services. Finally, the aim is also to support access to quality day care for at least half of all orphan children (The Namibian, 8 November, 2000). According to the joint UNICEF/GRN programme of co-operation (UNICEF and GRN, 1997), the objective is to reach these goals by the end of 2001.

The Challenge

The previous section highlights the tremendous challenge facing Namibia due to the HIV/AIDS pandemic. Namibia is *already* severely affected by HIV and AIDS and this is set to worsen, and this has taken place within the context of poverty, high levels of inequality, a high proportion of female-headed households, and

a high percentage of households with members living long distances from each other. Under such conditions, the level of *vulnerability* for many households and communities to the effects of HIV/AIDS is high, and the ability to cope with these effects is under question.

Christina (not her real name) is employed as a cleaner with Government, and lives in a rural area in Kunene Region. She looks after her own children (4) and well as the children of her daughter who died during childbirth (3). She does not remember the age of the children.

She has to take care of all the orphan children by herself, 'no one else helps me'. She makes N$300 per month, and this is not enough. She supplements this with growing a small amount of crops, and she shares her mother's pension when times are difficult. When she runs out of money she sells empty bottles to purchase food for the children. Her husband is not working, and he lives elsewhere, so she does not get any financial support from him.

She was unable to pay school fees and therefore borrowed over N$1000 from friends. She is now worried because she is unable to pay the money back. Nevertheless other neighbours still loan her money when she does not have enough for food. The children perform very well in school.

The children all grew up in her household, even the orphans, so the adjustment problems were not as severe as they could have been. They sometimes fight but she believes that this is because there is a shortage of food in the household.

When the children were small she used to make their clothes. Now she has to lay-bye the school uniforms at Pep. She purchases second-hand shoes from other people for the orphans. She purchases materials and makes traditional clothes and dolls which she sells to tourists.

It is within this context of vulnerability that households, many of whom are in rural areas, have to cope with the rapidly increasing population of orphan children. As noted earlier, it is expected that there will be 190,000 AIDS orphans in the year 2021 (this is *not* a cumulative number, rather this is the number of AIDS orphans who will be living that year). For the year 2000, the Spectrum model estimates that there are some 45,000 AIDS orphans in Namibia. Assuming that AIDS orphans are concentrated in certain households (that is, that they are not spread evenly across all households), some 15,000-25,000 households are already likely to already be looking after AIDS orphan children. If AIDS orphans comprise some 25% of all orphans, some 60-100,000 households may be looking after an orphan child.

Policy and Administrative Context

HIV/AIDS

To meet this challenge, Namibia originally created the National AIDS Control Programme in 1990 at independence. As it

"This [AIDS] policy and other policies, codes and guidelines, should create a supportive environment, in which one can ensure that all Namibians infected and affected by HIV/AIDS will get the best possible care [and] support and that all of us will ensure we keep the virus to ourselves when infected and that those not infected will support the infected ones to be strong, maintain healthy lifestyles and not to spread the virus further', the Minister [of Health and Social Services] said." The Namibian, 30 March, 2000, p. 3.

was increasingly recognised that AIDS was a cross-sectoral issue, this programme was gradually retooled into the National AIDS Co-ordination Programme (NACOP), launched in March 1999. A National AIDS Committee was formed at the same time, chaired by the Ministry of Health and Social Services and co-chaired by the Minister of Regional and Local Government and Housing. It is comprised of all ministers, and serves as the key policymaking body on HIV/AIDS. The National Multisectoral Committee on HIV/AIDS (NAMACOC), chaired by the Permanent Secretary of the Ministry of Health and Social Services, includes all Governors, permanent secretaries from all key ministries, as well as NGOs and representatives from the private sector. Its role focuses more on co-ordinating the implementation of policies and

programmes. The National AIDS Executive Committee (NAEC), chaired by the Under Secretary of the Ministry of Health and Social Services, serves as the key implementing agency.

Regarding orphans, at the national level there is no agency specifically monitoring the status of orphans in Namibia, nor their numbers and locations. Contacts are decentralised to the regions, with social workers at the regional level working with children identified as orphans. In a few cases this required the social worker to assist with placement, whether in a home or with a new family. More frequently, however, social workers were aware of children who had lost their parents and were being cared for by an extended family member, without any formal adoption taking place. Many of these children, however, are not linked to any social workers, as noted in the findings in Chapter 5.

No formal database exists noting all organisations involved in orphans care specifically, or HIV/AIDS prevention more generally. However, many of these organisations are known to various Government actors involved in orphan care and HIV/AIDS, and many are actively working with Government at different levels, including at the national and regional levels. Organisations mentioned included:

- Catholic AIDS Action
- AIDS Care Trust
- AIDS for Action
- AIDS Voluntary Campaign of Namibia
- Bricks Community Project
- Helping Hand
- HIV/AIDS Peer Education Project
- Namibia Catholic Development Commission
- Namibia AIDS Education Group
- True Love Waits
- Women's Action for Development (inc. various regional chapters)
- a number of community action groups such as the Choi Women's Group, Tate Kalunga Mweneka Omukithi, and Katonyala HIV/AIDS Group
- Puppets Against AIDS
- Namibian Network of AIDS Service Organisations
- Michelle McClean's Children Trust
- Church Benevolence Board
- Development Aid from People to People
- The Ark Children's Home in Okahandja
- CCPN Kids Shelter
- Usakos Children's Village
- Namibian Red Cross Society
- Children's education centres in Rehoboth and Tsumeb
- SOS Children's Villages in a number of locations

As a last resort, children who had been identified by social workers or NGOs are placed in children's homes. These are sometimes orphan children, but in other cases also come from homes with significant social problems (e.g., violence, alcohol or drug abuse, etc.) or who had been abandoned by their parents. A number of these children's homes are run by non-governmental organisations without state support, although all are registered with MOHSS. Examples include SOS children's villages, the Namibia Children's Home, Children's Education Centres in Rehoboth and Tsumeb, and the Ark Children's Home in Okahandja. Respondents did not feel that these centres were expanding at a level to keep up with rising numbers of orphans, in part because of the resources required to so expand, but also because of MOHSS's policy of placing children in foster homes or under the care of extended family members. MOHSS was also concerned that its existing social workers could not cope with increasing demands in terms of children in

need, such as orphans, and that already the quality of work was being negatively affected. Volunteers working in home-based care were generally perceived to be of central importance to help reach the growing numbers of orphans, 'as well as the households themselves that are in need of assistance'. Others highlighted the importance of co-operating with NGOs active in the field, because of their ability to reach people.

There was also a concern that Government could not sustainably provide financial support to foster parents now, at N$220 per month for one child and N$60 per month for each additional child, so any attempt to reach more foster families financially would not be possible, despite the rise in the number of children needing assistance. It is estimated that just over 2500 families are reached in this manner. 'Many new cases are coming up and it is impossible, under current circumstances, to increase these grants, either the amount of money given so that it more accurately reflects real needs, or in terms of providing money to new applicants'. In a number of cases where support was needed Social Workers were active in contacting possible organisations for support. These included clubs and private companies.

In interviews with representatives from other ministries, respondents felt that orphans were principally the concern of MOHSS. Few were aware of more than a handful of organisations active in working with orphans, and often referred questions on orphans issued to MOHSS.

Representatives from the Ministry of Basic Education, Sport and Culture (MBESC) raised a concern about the ability of households looking after orphans to be able to meet the costs of keeping these children in school. This extended beyond primary and secondary education, however, with MBESC respondents noting that it was especially important that these children accessed tertiary education to be able to either work for themselves or find employment. MBESC also noted that orphan children were but one group needing special assistance from Government, including San children, ovaHimba children, farmworker children, street children, refugees, etc. A number of MBESC respondents also noted that schools were important venues for outreach.

There are thirteen Regional AIDS Committees (RAC), one in each region. In some of the regions, there are also Constituency AIDS Committees. The RACs are chaired by the regional governors, while the Regional Medical Officer serving on the committee. In some regions, the Constituency AIDS Committee chairs also sat on the RACs and, where relevant, non-governmental organisations. The committees vary considerably in terms of how active they were, with some only having just been formed before the interviews were held, and others that had helped establish a number of Constituency AIDS Committees and were active in a number of fields.

The RACs vary considerably in size and composition. In Oshikoto Region, for example, there are some 40 members, 24 of which were line Ministry representatives, and a number of NGOs active in the region are represented as well. Line Ministry representatives were responsible for co-ordinating condom distribution from various ministry line officers. NGO representatives included drama groups active in HIV/AIDS prevention. In Karas Region members included the Regional HIV/AIDS Co-ordinator from MOHSS, the Regional Pharmacist from MOHSS, one political councilor, a medical officer with the Department of Prisons, a representative of the Namibian police, and a representative from an NGO, Catholic AIDS Action. In

Khomas Region, members included members from the Namibian Red Cross Society, Catholic AIDS Action, and the National Youth Council, as well as members from MOHSS, the Ministry of Women Affairs and Child Welfare, and councilors from a number of constituencies. In Kunene Region, the RAC had only just been formed, and had yet to establish a plan of action. In Hardap Region, members included those active in home-based care, MOHSS social workers, clinic workers, a community-based health care workers, and two representatives from village-level AIDS committees. In Caprivi Region, representatives came from MOHSS as well as the Ministry of Labour, and a number of NGOs active in the region: Catholic AIDS Action, the Social Marketing Association of Namibia, the Director of a theatre group, a trainer from "My future my choice", and the Red Cross.

A draft AIDS policy was circulated in mid-2000 by Government covering confidentiality, notification, reporting and surveillance. The intention of the policy is to 'destigmatise people with HIV/AIDS', and provide an enabling environment for family care, community-based support, and national support. According to the Minister of Health and Social Services (The Namibian, 30 March, 2000: 3), it is time "... for all infected and affected people to exercise their rights to have access to health services and facilities, psychological support, be treated with respect and dignity, be loved and be part of the community and not to be discriminated against because of their HIV/AIDS status".

At the regional level, most of the regions had AIDS plans at the time of the interview. A number of the regions noted that they had received assistance from central government to prepare these plans, attending workshops to this effect. Some reported returning to their regions to further plan, others noted that the plans they had developed with this assistance was as far as things had gone. As an example of the former, Erongo Region took what they had learned at the workshop and spent three months developing the plan. As part of this, they held a regional workshop, set goals and objectives and deadlines. Every member of the RAC was responsible for tasks under the plan, and had to report on progress made to the RAC. As another example, in Hardap Region various actors were asked to come up with what they would want to see in the plan, and thereafter was 'polished' by local health officers. In Caprivi Region, a draft plan was formulated by those specifically involved in HIV/AIDS, and thereafter discussed with line ministries and NGOs. While this took a long time, it led to the development of a plan that many members felt a part of. In some regions, the process of plan development was apparently neither as thorough nor did it involve various actors in the region.

A number of the regions noted problems with the functioning of the RACs and plan implementation. One region, for example, reported that communications with the Constituency AIDS Committees were irregular, and that the RAC itself did not meet on a regular basis. Another region raised a concern about a lack of commitment from RAC members. Kavango Region noted that the outbreak of hostilities along the border had severely hampered implementation of planned activities. Little monitoring of planned interventions was reported, and regular cycles of evaluation were not mentioned. Erongo Region was unusual in noting that it was ahead in terms of planned activities, and that regular feedback occurred with the RAC. Similarly, Khomas Region noted that it was on schedule in terms of planned activities, and that the RAC met regularly to discuss progress and constraints. Some regions noted the overlap between on-going activities, such as STI prevention and treatment, and plan objectives, and a few mentioned that financing for additional

activities was limited. Caprivi Region noted that their plan emphasis was on strengthening patterns of home-based care, but that no system was set up to specifically monitor progress.

When asked how the regional plans may have changed the nature of the response of the region to HIV/AIDS, respondents in regions where the plan had been prepared and discussed tended to feel that it had supported a more multi-sectoral approach towards dealing with the epidemic. However, the degree to which this was perceived to have been effective varied, with most regions arguing that this was still problematic. Having a regional HIV/AIDS co-ordinator was generally felt to be important to the success of RAC interventions.

Orphans

Administratively orphans fall under the purview of the Directorate of Developmental Social Services in the Ministry of Health and Social Services (MOHSS). Social Workers from the directorate are involved in implementing the rules and regulations in children who are classified as orphans or children in need of care but, consistent with Government policy, the first aim is, to the extent possible, to maintain affected children in a positive family environment.

According to key informants in MOHSS, care was taken not to stigmatise orphans from other children who might be in a position of need. This was confirmed by key informant interviews with social workers.

Only in extreme cases are children recommended for adoption or institutionalisation. There is one state-run children's home in Namibia, the Namibia Children's Home previously administered by the Dutch Reformed Church. This home has a capacity for some 120 children, and as of mid-1999 was housing 100 boys and girls between the ages of 2 and 19. Most of these children were removed from

> Lily (not her real name) is looking after six children in Bethanie in the south. Two are orphans from her sister, who she says died of AIDS in 1997, 'because of the way she died it was obvious what she died of to everyone'. The four that are old enough all attend school. They survive on her pension and a few livestock. Her husband died in 1998, but she does not know what he died of.
>
> The orphans were born into her household and therefore they did not have these kinds of adjustment problems. Their mother lived in Oranjemund and Rosh Pinah, so they grew up with Lily anyway and did not often see their mother.
>
> They are always hungry, living almost entirely on porridge, and sometimes have to borrow food to survive. She could not afford school uniforms but the children were able to get old uniforms from other children in school. The children are well accepted in the community, and Lily says that there is no mistreatment of the two because they are orphans.
>
> The kids school fees are not paid, but they are in school. She applied for a foster grant from Government 'but until today I have not heard anything, maybe they don't care anything about the orphans'. 'We need clothing as well as financial assistance so that we can pay school fees'.

their homes because of unsatisfactory family circumstances, while some were problem children beyond the control of their parents (see MOHSS, 1999). There are 6 private institutions registered as children's homes under the Children's Act. There are two SOS children's homes, one in Windhoek and one in Tsumeb, caring for 169 children. Other facilities include the Dutch Reformed Church's Children Home that has 20 children, the Educational Centre in Usakos, the Youth Guidance Centre in Okahandja, the Kids Shelter in Rehoboth, and the Erongo Place of Safety in Swakopmund which offers temporary placement for children. There are two unregistered homes, one in Katutura and another in Grootfontein.

Beyond those directly looking after orphaned or abandoned children, or children who were removed from abusive environments, a number of organisations were identified by key informants as assisting orphan (and other vulnerable) children, including the following:

- AIDS Care Trust
- Puppets Against AIDS
- NANASO
- Michelle McClean Children's Trust
- Catholic AIDS Trust
- Church Benevolence Board
- Development Aid from People to People (DAPP) (used clothes)
- Usakos Children's Village
- Red Cross
- Bricks Community Project
- AIDS Voluntary Campaign of Namibia
- Helping Hand
- HIV/AIDS Peer Education Project
- Namibia Catholic Development Commission
- Namibia AIDS Education Group
- Namibian Food and Allied Workers Union
- Namibia Student Education Movement
- Namibia Students Organisation
- Namibia Transport and Allied Workers Union
- Saamstaan Housing Co-operative
- True Love Waits
- Khomas Women in Development
- Choi Women's Group
- Tate Kalunga Mweneka Omukithi
- Ktaonyala HIV/AIDS Group
- Action Against AIDS

Angelica, who lives in Caprivi Region, is a caregiver for six children, two of whom are orphans from a daughter who had died. There is no wage earner in the household, and they make a living solely by growing crops. When there is no food both the children and the adults go to bed hungry. As food is often in short supply, this is a regular problem.

The two orphans really miss their parents. However, both had been raised in the same household they were now living in, so they adjusted as quickly as one might expect to their new situation. They get along well with the other children in the household, in large part because they grew up together.

While all the children go to school, the household cannot afford to purchase school uniforms, so the children go to school in poor clothes. Sometimes the other children make fun of the fact that the children go to school not in uniforms, but rather in very poor clothes. Beyond this, the children are accepted like anyone else in the community.

'We really need clothes, food, blankets and financial assistance. If we had money, we could be sure that the children remained in school'.

Beyond the number being looked after in institutions, there are no compiled statistics indicating how many vulnerable children (orphans included) are being reached with various services, although individual organisations have their own records. Households lthat are confirmed to be looking after orphans, and who meet clearly stipulated criteria, are entitled to a stipend from Government and, if this reached all eligible households, would serve as an accurate reflection of the number of orphaned children and the number of caregiving household (indeed, this situation currently exists in Botswana, where over 90% of all orphans are understood to be reached via an orphans support programme). However, in Namibia key informants believe that only a fraction of eligible orphans are being reached with state assistance, even in cases where the orphans and their caregiving households are known to social workers who nevertheless provide other forms of assistance (e.g., counselling services, advisory services, humanitarian support).

Of interest, many of the social workers interviewed felt that most orphans in need were being reached, 'because people are always coming to our office'.

According to the report reviewing the UN Rights of the Child (MOHSS, 1999), in terms of the 1960 Children's Act (1960), a child can be declared by a children's court to be a child in need of care if the child has any of the following:

- has been abandoned or lacks visible means of support;
- has no parents or guardians, or parents or guardians who do not, or are unfit to, exercise proper control over the child;
- is in the custody of a person who has committed any of a list of specified offence (such as assault, abduction, or sexual offences) with respect to the child;
- cannot be controlled by the person who has custody of the child;
- is a habitual truant;
- frequents immoral company or lives in circumstances likely to lead to seduction, corruption or prostitution;
- begs or engages in unlawful street trading;
- is being maintained apart from his/her parents or guardians in domestic circumstances which are detrimental to the child's interests; or
- is in a state of physical or mental neglect.

For 1994, 453 children were in need of care as defined under the Children's Act; no more recent data are available. Unfortunately, data collection is now at the regional or local government authority levels, but has not been passed to the national level for compilation for 1995-1999. Where a child is found to be a 'child in need of care', the child can be removed from the custody of his/her parent or guardian and be placed with foster parents or in a children's home, a school of industries or under the control of an approved agency. If the child is not removed from the custody of the parent or guardian, the child may be placed under the supervision of a probation officer or a social worker. Foster parents are usually the preferred alternative for the placement of children in need of care. When a child is placed with a foster family, the goal is always to reintegrate that child into his/her own family, requiring regular review of the family situation on a regular basis. If a foster family cannot be found, children are either sent to a children's home or to a school of industry.

Chapter Two: Methodology and Approach

Introduction

Two approaches were used for the orphans investigation: 1) qualitative data collection; and 2) quantitative modelling of the AIDS pandemic to determine the number and distribution of AIDS orphans. The former included both AIDS and non-AIDS orphans, while the latter focused specifically on AIDS orphans, following which estimates were made of existing orphan populations.

Qualitative Data Collection

A number of approaches were used to solicit insights and opinions of affected parties:

- National Level Key Informant Interviews
- Local Level Key Informant Interviews
- Focus Group Discussions: Caregivers
- Focus Group Discussions: Orphans
- Large Group Discussions: Regional AIDS Committees
- Case Studies With Affected Households and Orphans

National Level Key Informant Interviews

A total of ten key informant interviews were conducted at the national level, including individuals long active in the HIV/AIDS arena in Government and in the non-governmental organisation (NGO) community. More specifically, interviews were conducted with the Directorate of Social Services in the Ministry of Health and Social Services, the Ministry of Basic Education, Sports and Culture, and non-governmental organisations. Questions included the following topics:

- Availability of support services for, and delivery of services to, orphans and caregiving households/institutions.
- Efficiency and outreach in terms of services.
- Monitoring of service delivery, and monitoring of school attendance.
- Home-based care outreach.
- Level of training of service providers, limitations and opportunities arising thereof.
- Social worker activities and workload.
- Street children.
- School-based programmes to reach households with children unable to attend school.
- School-based HIV/AIDS interventions.

Local Level Key Informant Interviews

A total of twenty-nine key informant interviews were conducted in the field at locations where other fieldwork was conducted. Interviewees included headmen, health workers, community development officers, NGO representatives, social workers, church workers, school teachers and principals, and community opinion leaders. Information included the following:

- Involvement in HIV/AIDS.
- HIV-affected and AIDS-affected households (knowledge of, situations facing). A variety of scenarios were presented for comment.
- How people, households and communities cope and do not cope.
- For extension officers, support provided to orphans and caregiving households.
- For extension officers, situations of neglect or abuse of orphans.
- How organisations are involved in strengthening and/or supplementing coping mechanisms.
- Educational issues.
- How to 'tack on' support to existing interventions to support HIV-affected and AIDS-affected households.

Caregiver Focus Groups

Those looking after orphan children were interviewed in small, homogeneous groups of 5-7 people. A structured focus group discussion instrument was administered and took an average of 2.5 hours to complete. Issues discussed included the following:

> "If we are serious about considering communities as partners, then we must understand and value their contributions and innovations." Hunter and Williamson, 1994. Children on the Brink. Strategies to Support Children Isolated by HIV/AIDS, USAID, Washington.

- Structure and 'operations' of the household.
- Socio-economic status of the household and changes taking place.
- Details on orphan child/children.
- Details on other child/children in household.
- Patterns of care, stresses arising thereof.
- Background on how the child came to the household, circumstances arising. Planning, preparations and 'transition' issues.
- Adjustment issues (in the household, in the schooling environment, in the community). Short-term adjustments, over time adjustments.
- Details of economic adjustments (effects of additional children on food security, economic security, etc.). Possible addition of labour for household labour needs.
- Schooling of the orphan(s).
- Receipt of outside assistance.
- Need for outside assistance.
- Potential effects of outside assistance.

> "[Prime Minister] Geingob added that when the caregiver also gets too old or too sick to care for the children, the real emotional trauma and desperation sets in." New Era, 11 September, 2000, "New Hope for AIDS Orphans".

A total of thirty-six such focus groups were conducted.

Orphan Interviews

Beyond interviews with caregivers and other informed parties, direct interviews were conducted with the orphan children themselves. Issues included the following:

- Their current 'average' day.
- Seasonal changes.
- Composition of the households the orphan is living in.
- How their life has changed since coming to the household: daily routines; relationship with siblings; education.
- What their life was like before, and how they feel that their quality of life has changed.

A total of thirty-one focus groups were conducted cover all thirteen regions, with locations indicated on the attached map.

<u>Regional AIDS Committee Interviews</u>

In each of Namibia's thirteen regions, Regional AIDS Committee (RAC) meetings were held. In two cases (Otjozondjupa and Khomas Regions) the meetings were not completed due to the inability of key committee members or a lack of time for committee members to participate in the discussion, but were partially conducted after repeated attempts. Issues covered included the following:

- Introductory questions.
- Discussion of the Regional AIDS Plan for each region and status report.
- Status of the pandemic in their region.
- Knowledge of implications of pandemic on orphan numbers.
- Support mechanisms. 'Tacking on' support to existing programmes.
- Questions for specific RAC members:

  - Provision of services to orphans.
  - Presence of orphanages in the region.
  - Neglect of orphans.
  - Geographical distribution of orphan problem in the region.
  - Educational status of orphans.
  - Monitoring of the status of orphans and caregiving households.
  - Street children.

A total of thirteen RAC interviews were conducted.

<u>Case Study Guide</u>

A total of twenty-six case studies were carried out, two per region. Rather than using an interview format, a case study guide was used rather than a structured data collection instrument, and information was obtained in a more 'flowing', interactive manner. Sample guide queries included the following:

- "Get a sense of how the household has done over time, historically when things have been good and when things have been more difficult. Find out why these have occurred, in other words what led to the good times and what happened to create the bad times. Get a sense, overall, of the 'cycle of the household.'"

- "Tell us, in detail, the 'story' of how the child/children arrived in this household. Get details."

- "After getting a sense of how the child adjusted, determine what adjustment problems the rest of the household had when the orphan(s) first arrived. Include adjustment by other children in the household, their understanding or lack thereof."

- "Look into early adjustment in the community for orphans that have come from elsewhere. How have they been accepted, or not accepted. What about in school? Get a sense of whether the child seems to be 'made welcome' by other kids in the community. For all orphans, find out if they have been ostracised due to problems related to how their mother/parents died. Is there, in effect, an 'AIDS impact' in terms of community acceptance? Problem these issues in detail, as this is key to understanding their circumstances."

- "Consider emotional stresses that would suggest problems with adjustment, such as sleeping problems, crying, fighting, poor performance in school, lack of interest in things, involvement in crime, consistent illnesses that suggest stress and lack of adjustment, and other factors."

- "After getting a clear understanding of what types of assistance they have received from various parties, move to issues of needed assistance. Cover emotional and economic assistance, and anything else in this regard. Be sure to get a good understanding of the context within which such assistance would be most effectively utilised. Further, get a sense of how it would not be effectively utilised, in effect understanding what dysfunctional uses might occur. After discussing these, get a sense of how the household would institute 'remedial actions' to overcome these dysfunctions."

All of the above instruments are included in Annex B.

Quantitative Data Collection

Introduction

Primary quantitative data collection did not take place in the field for the orphans study. Rather, quantitative data collection here refers to the assembling of existing information for purposes of modelling the pandemic and, in so doing, estimating the number of AIDS orphans in Namibia.

While it is obvious that the *total* number of orphans in Namibia exceeds the total number of AIDS orphans alone, no projections of the actual number of non-AIDS orphans are available, not for Namibia, and indeed not reliably for other nations as well. Jackson (2000) had attempted to model likely numbers, and these were used as the basis for this report.

AIDS orphans modelling was conducted by SIAPAC for eleven strata, using the Spectrum System of Policy Models (hereinafter referred to as Spectrum). This model was used by the Government of Namibia for the national model, and is the most commonly used AIDS model. The eleven strata were identified in consultations with the Client, and after consideration of the varied prevalence levels found around Namibia. The strata are as follows:

1. Hardap and Karas (all locations)
2. rural Khomas (excluding Windhoek), Otjozondjupa, and Omaheke
3. Kunene and rural Erongo (excluding Walvis Bay and Swakopmund)
4. Omusati, Oshana, Oshikoto and Ohangwena (excluding Oshakati and Ongwediva)
5. Kavango (all locations)
6. Caprivi (all locations)
7. Oshakati
8. Ongwediva
9. Windhoek
10. Walvis Bay
11. Swakopmund

Spectrum System of Policy Models

Data compilation, as distinct from primary data collection, consisted of securing data needed for the model and data needed so that the impact of the AIDS epidemic on the number of orphans could be estimated. These data were important in improving the rigour of the model and in checking the model's projections against what appears to be going on in the country. It is important to note that models are, by definition, a *representation* of an *aspect* of reality. Models cannot, therefore, fully represent the complexity of real life. If used correctly, however, and if based on reliable data, models are the most effective way of projecting what might be taking place in the population of Namibia and the impacts of orphans. Relevant demographic data of sufficient rigour were therefore collected from Government institutions, including the Ministry of Health and Social Services (MOHSS) and the Central Bureau of Statistics, for use in the model.

The Spectrum System of Policy Models, or Spectrum for short, was used for the project. Two sub-routines, DemProj and the AIDS Impact Model (AIM), were used to develop projections of the HIV/AIDS epidemic in Namibia and its impacts on the population. The Spectrum Models were developed by The Policy Project, a United States Agency for International Development-funded project implemented by The Futures Group International. The Spectrum Models are designed to facilitate planning and policy formation. They were *not* designed to conduct in-depth research into the underlying processes; this was rather the focus of qualitative data collection.

DemProj is the demographic model in Spectrum and is used to create population projections based on the current population, fertility, mortality and migration. AIM is the model used for projecting the impact of the AIDS epidemic.

Base Projection

The first stage in the development of HIV/AIDS projections for Namibia and its regions was to create a base demographic projection using DemProj. This is a demographic projection that does *not* include the impact of AIDS. The demographic projections require data and assumptions related to the population by age and sex for the base year, current and future fertility rates, current and future mortality rates, and international migration.

Base Year Population

This is the population by age and sex for the base year. Figures are usually obtained from census data. It is preferable to select as base year a year which is prior to the time when AIDS began to have a significant impact on the nature of the population, as the base projections run on the assumption of a no-AIDS scenario for comparative purposes.

For the Namibian national and regional projection, the population figures from the 1991 Household Survey were used for the base projection. Although the HIV epidemic had already taken hold by 1991, because of the time delay between infection and death the population figures had not yet been significantly affected by AIDS deaths. This assumption is supported by evidence from the 1992 DHS that suggested an continued increase in life expectancy from the 1981 census (that is, figures suggest that, by 1992, AIDS had not yet significantly affected the population size). The other alternative would have been to use data from the 1996 Intercensal survey. However, the base projection requires figures *without* the impact of AIDS, and one can

> Doni (not her real name), her brother and one of her sisters stayed with their father and his girlfriend and three other household members, all of whom have jobs. Doni is 17 and is in grade 11. Her father is employed as a cleaner with Government, and earns some N$400 per month. They also own livestock. They live in an urban area in Karas Region.
>
> Doni's mother passed away in 1997. She left a huge gap in the family and they all missed her. Doni's father drinks and he creates many conflicts when he is drinking. She had another brother but he left because of their father.
>
> She said that she is not treated any differently than anyone else because she is an orphan.
>
> Despite the fact that a number of people in the house have jobs, they cannot rely on these other people for any financial support. So, when her father was unable to come up with school fees, the children were sent home until the fees were paid. He does encourage them to do well in school. They have no relatives that they can rely on either, 'no one from the family offers us support'.
>
> Doni is determined to finish school, she wants to become a nurse. When she finishes matric she will go on for specialised training.

assume that the 1996 census figures would reflect an impact of AIDS deaths (this is borne out in the findings which follow).

Fertility

Information about current and future levels of fertility, as obtained through measures of Total Fertility Rate (TFR), are required by the model. In addition, the model needs information on the age distribution of fertility.

A TFR of 6.1 was entered for the base year of 1991. This was taken from the estimate made from the 1992 DHS and 6.0 from the 1996 Intercensal survey. For future TFR an assumed decline of 0.1 per annum was used. This was based on empirical data linking the level of socio-economic development and degree of family planning programme efforts with declines in TFR (Parker, Mauldin and Ross, in Stover and Kirmeyer, 1997). The Central Bureau of Statistics made a comparable assumption in their medium scenario for the demographic projections based on the 1991 census, that is, they assumed a decline in TFR of 0.1 per annum. Using the empirical data linking decline in TFR to programme effort and socio-economic development and assuming a moderate programme effort, the assumption of a decline of 0.1 in TFR per annum is considered to be reasonable. It was assumed that this decline would continue until 2021.

Regarding the age distribution of fertility, the estimates generated from the 1991 Household Survey data were used for the base year. The United Nations fertility survey models were then used to predict the age distribution of fertility for the final year (sub-Saharan Africa pattern) and the distribution was interpolated for the intervening years, thereby making use of the measured figures for the base year and the model table for future years.

The male:female sex ratio at birth was assumed to be 103:100 based on figures from the United States Bureau of Census International Database for Namibia.

Mortality

Life expectancy at birth for males and females and a model life table of age-specific mortality rates is required to describe mortality. Life expectancy at birth for males and females was taken from the 1991 Census for the base year and from the Intercensal survey for 1996. Thereafter the United Nations Working Model of Life Expectancy Improvement was used to estimate future life expectancy improvement in the absence of AIDS (Stover and Kirmeyer, 1997). An assumption of a moderate rise in life expectancy was made.

For the model life table, the United Nations General Model provided the closest match to measured Infant Mortality Rates (IMR) and Crude Death Rates (CDR) for 1991. In previous projections elsewhere the Coale-Demeny South model table had been selected (1986 Census). However, this proved not to be a good match for 1991 figures, and was therefore not used.

Migration

In order to account for the effects of international migration on population figures, data on the net number of migrants by sex and year as well as the distribution of migrants by age for males and females is required.

Typically, international and in country migration does not account for a significant proportion of change in populations, however the possible effects do need to be considered particularly in the light of migrant labourers leaving the northern regions. Net migration data provided by the Central Bureau of Statistics in 2001, based on the 1991 census and the inter-censal survey done in 1996 were therefore utilised to consider internal migration, particularly important for regional projections.

HIV / AIDS Projections

The second stage of the projection process is to develop an AIDS projection using AIM. The model takes as its starting point the base population projection and then projects the impact of AIDS on the population given assumptions about HIV prevalence, age-sex distribution, progression of the disease, etc. Health and economic impacts may also be projected if the required input data are available.

Adult HIV Prevalence

The percentage of adults infected with HIV in the base year and estimates of prevalence for subsequent years of the projection are required. An adult is defined as anyone aged 15 or older.

Estimates of HIV prevalence are typically based on figures obtained from antenatal sentinel surveys, which are considered by modellers to be generalisable to the total adult population (this has been checked against population based surveys in a number of African countries and shown to be the case).

This estimate of point prevalence was then used to estimate a likely projection for future adult HIV prevalence using the United Nations methodology for making prevalence projections. As it is uncertain what the shape of the epidemic will be once the endemic stage is reached, for this projection it is assumed that HIV will become endemic and that there will not be a significant decrease in prevalence.

HIV/AIDS Parameters

Several parameters must be specified for the AIM model:

1) *The starting year of the epidemic.* This was assumed to be 1984.

2) *Perinatal transmission rate.* The default value of 35% (that is, 35% of babies born to infected mothers will be infected) was used, as this is the range normally found in sub-Saharan Africa.

3) *Percentage of infants dying within the first year of life.* This value is used to calculate infant mortality rates. The default value of 67% was used, meaning that it was assumed that two out of three HIV-infected infants would die within their first year of life.

4)   *Life expectancy after AIDS diagnosis.* This typically varies from 6-18 months in developing countries. The default value of one and half years was used.

5)   *Percent reduction in fertility for HIV-infected women.* In the absence of country-specific data, the default value of 30% was used.

Incubation Period

The incubation period refers to the amount of time between initial infection and the onset of AIDS. For the current projection, the adult incubation period pattern based on a model constructed by James Chin (1996, in Stover, 1997) was used. This is a medium pattern which has a median time from infection to AIDS of eight and a half years. For the child incubation period a medium pattern was also chosen of two and half years. This is the default option in the Spectrum Model, and is considered to be the best option for sub-Saharan Africa in the absence of country-specific data.

Age and Sex Distribution of New Infections

The male to female ratio was assumed to be 1:1 as Namibia has had a heterosexual epidemic from the outset. No reliable data are available regarding the ratio of male to female infections rates, so a 1:1 sex ratio was considered appropriate. The age distribution based on a 'typical' pattern for eastern and southern Africa was employed, again in the absence of country-specific data.

Information Gaps

As the modelling section suggests, gaps exist in available data. For the modelling, assumptions had to be made that the demographic and infection patterns in Namibia were similar to other Southern African nations. With the exception of minor impacts expected from international migration, however, the modellers believe that the assumptions made are accurate, and that they have not seriously affected the reliability of the projections.

Of course, as noted earlier, no model can get at the nuances of the effects of the epidemic on the country, let alone by region. For this reason, considerable attention was focused on primary data collection to give relevant 'texture' to the demographic findings, and to focus on the situation of orphans in Namibia. Given the extensive nature of primary data collection, the authors do not feel that significant gaps remain in this regard.

Chapter Three: Demographic Impacts of the AIDS Epidemic

Introduction

The Ministry of Health and Social Services modelled the anticipated impact of the AIDS epidemic on the Namibian population. Basic findings are presented in this chapter.

The first case of HIV was reported in Namibia in 1984, an expatriate, while the first case of a Namibian with HIV was documented in 1986. As of 2000 an estimated 22.3% of the population aged fifteen and older were HIV positive, comprising almost a quarter of a million people, mostly in the age range 20-39, the economically and reproductively active age group. Based on the model, an estimated total of 50,400 will have died of AIDS by the end of 2001.

According to the projections, the 2001 population of Namibia based on past trends was approximated at just over two million (2.01). With HIV/AIDS, however, the population was projected at 1.81 million, some 11% below expected levels (due to deaths and lowered numbers of births)[2]. By 2021, the population is now projected to rise to 2.57 million, down from a no-AIDS estimate of 3.41 million, or a drop of one-third in expected population levels.

This chapter presents findings from the demographic projections. To assess the impact of HIV/AIDS, two projections are offered, one covering population growth based on past trends, and another including the impact of the HIV/AIDS epidemic. A number of issues are covered, including | The Namibian population will be 33% lower than previously projected by the year 2021 due to AIDS.

details on adult HIV prevalence, the number of adults alive with HIV, the number of new AIDS cases, projected annual deaths to young adults (15-49) due to AIDS, cumulative AIDS cases, the crude death rate, under-five mortality, and finally projected impacts on the overall population. These estimates are based on the approaches described in the previous chapter.

Adult HIV Prevalence

Adult HIV prevalence, that is, the total number of adults currently infected with HIV, is indicated in the following figure:

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[2] It should be noted that the preliminary results from the 2001 census are extremely close to the 'with AIDS' estimate, with the gap only 17,000 people in a population of almost two million. See CBS, 2002.

Figure 3.1: Adult HIV Prevalence (1991-2021)
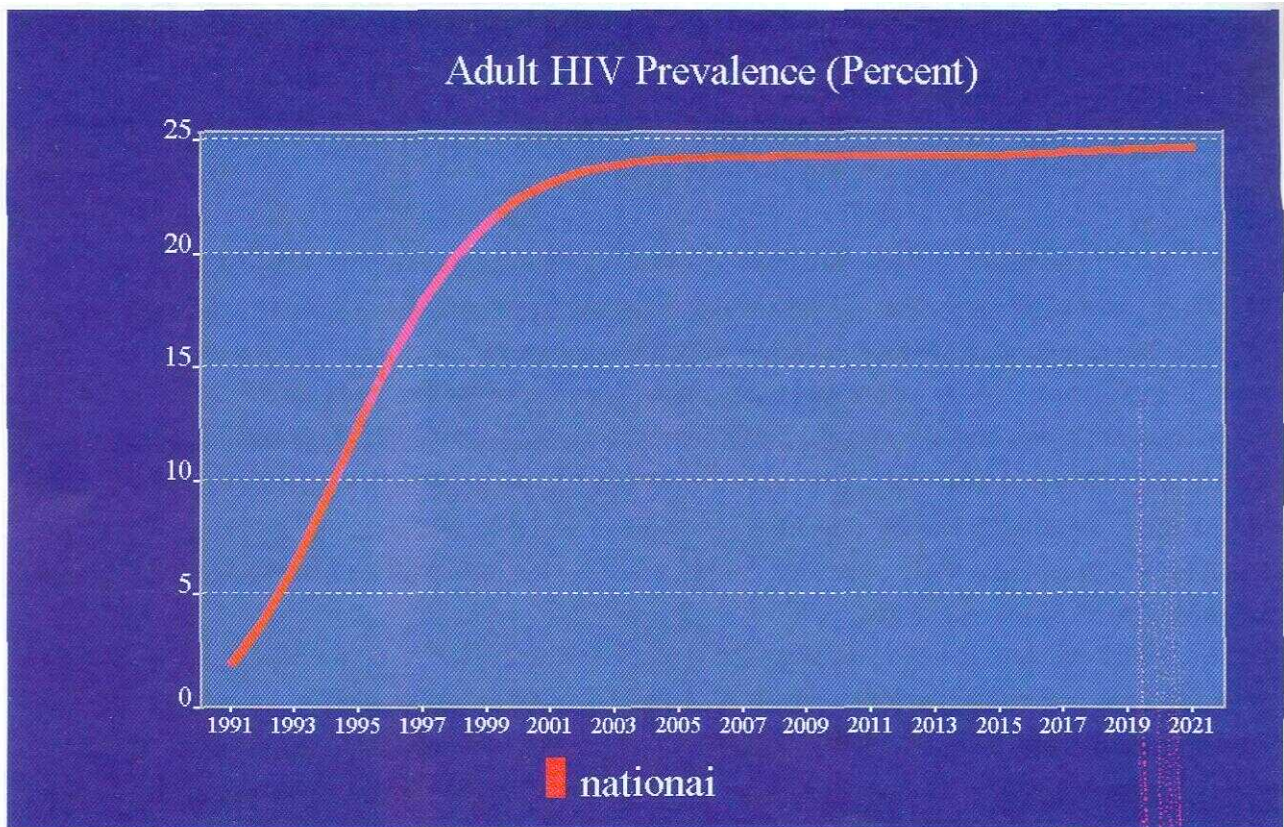
At current rates of increase, HIV prevalence will climb to 24.1% by the year 2006, thereafter maintaining the same level or slightly higher unless the epidemic is brought under control. It is important to note that the rapid increase in HIV-infection seems to be reaching its peak around 2004 - 2007, growing rapidly from 3% in 1991 to almost 20% in 1999 and 23% in 2001.

> Studies "... confirm that sentinel surveillance in pregnant women yields remarkably robust estimates for HIV prevalence in the general population of reproductive age ..." (UNAIDS, 2000: 116).

Without strong interventions, however, the plateau may be substantially higher than the Namibian model suggests. Indeed, both Botswana and Swaziland are plateauing at well above 30% (Zimbabwe is expected to do the same), and there is no reason to believe that Namibia will have a rate lower than these other countries.

The issue of male versus female infection rates is somewhat confusing. While the rate of infection does not vary across males and females in the overall population worldwide, there are differences across males and females in Africa. Further, females tend to be infected at a younger age than males. Among teenagers in eleven African

> "Women described sliding into survival sex as a result of economic crisis. Survival sex exposed women to violence, drug use, sexually transmitted infections, and HIV. Mitigating these risks is a process of awakening in which women reconstruct risk and survival and make changes in their behavior ... researchers found that awakening was a process characterized by new insights, recognition of one's strengths, and adjustments in behavior." "... awakening is particularly important if we consider whether awakening could be artificially induced through intervention programs." Mallory and Stern, 2000, "Awakening as a Change Process Among Women at Risk for HIV Who Engage in Survival Sex", Qualitative Health Research, Vol. 10, No. 5.

countries in a UNAIDS study, female HIV infection rates were five times higher than male HIV infection rates. This declined to a difference of 3:1 for those in their twenties, and reversed for later age groups. In large part the differential infection rates and the differences across age groups relates to age mixing between

young women and older men. Older men tend to have been involved in more sexual activity, and are therefore much more likely to be exposing younger girls to HIV. It is also because infection from male to female is easier than from female to male. Further, once infected, younger people tend to live longer than older infected people, reflected in the higher percentage of infected females. If age mixing among teenager girls and older men did not occur, UNAIDS (2000: 48), teenage girls "would run little risk of becoming infected ... there are few if any HIV infections among boys before the late teens". In Namibia, the 2000 Human Development Report showed a rapid increase in the non-survival of females to the age of 40 compared to males (32.2% for females compared to 26.2% for males), reflecting infection at a younger age.

Number of Adults Alive With HIV

The number of adults who are living with HIV is indicated in the following figure:

Figure 3.2: Number of People Infected with HIV by Year (1991-2021)
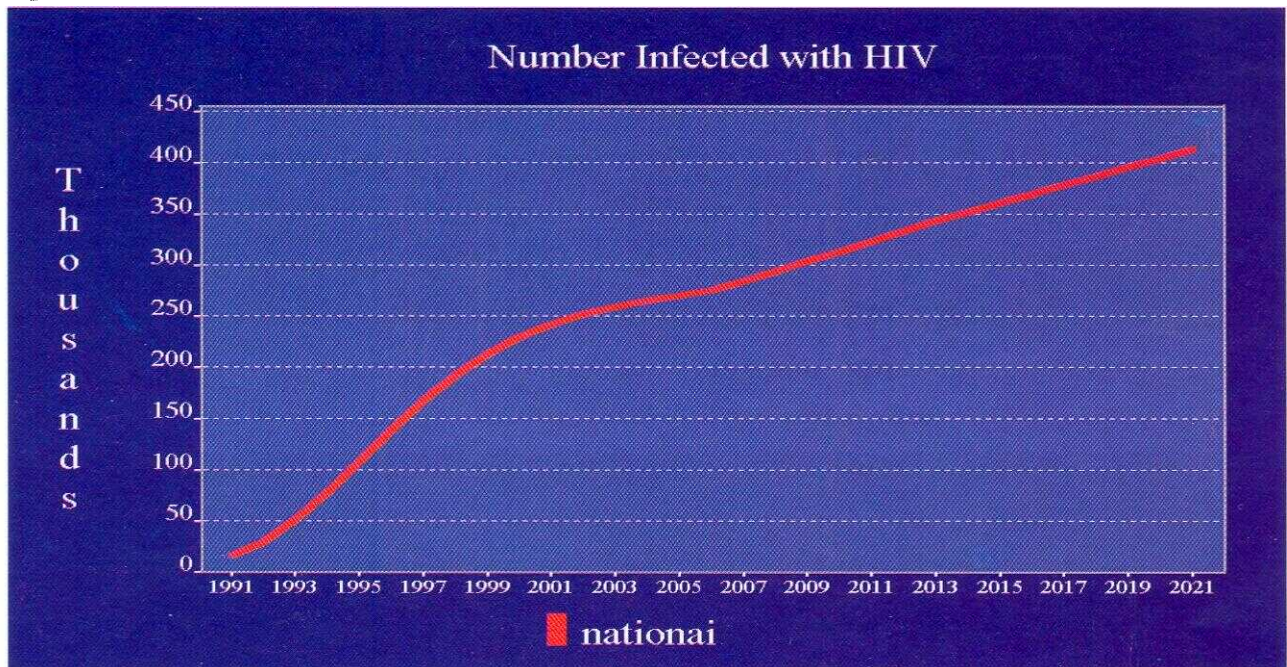
In 1991, some 14,000 Namibians were HIV positive and had not yet died of AIDS. This has risen rapidly to 28,200 in 1992, 50,000 in 1993, 77,400 in 1994, and now tripling to 240,200 by 2001. Rapid growth will level off by the year 2006 at around 273,300, with cases averaging near **367,400** from 2016.

Deaths Due to AIDS

As noted earlier, it is estimated that the average HIV positive person will take eight and a half years from infection before AIDS develops. Therefore, the number of AIDS deaths will lag behind HIV infection by an average ten year period.

Figures for annual and cumulative AIDS deaths are indicated in the following figure:

Figure 3.3: Annual AIDS Deaths
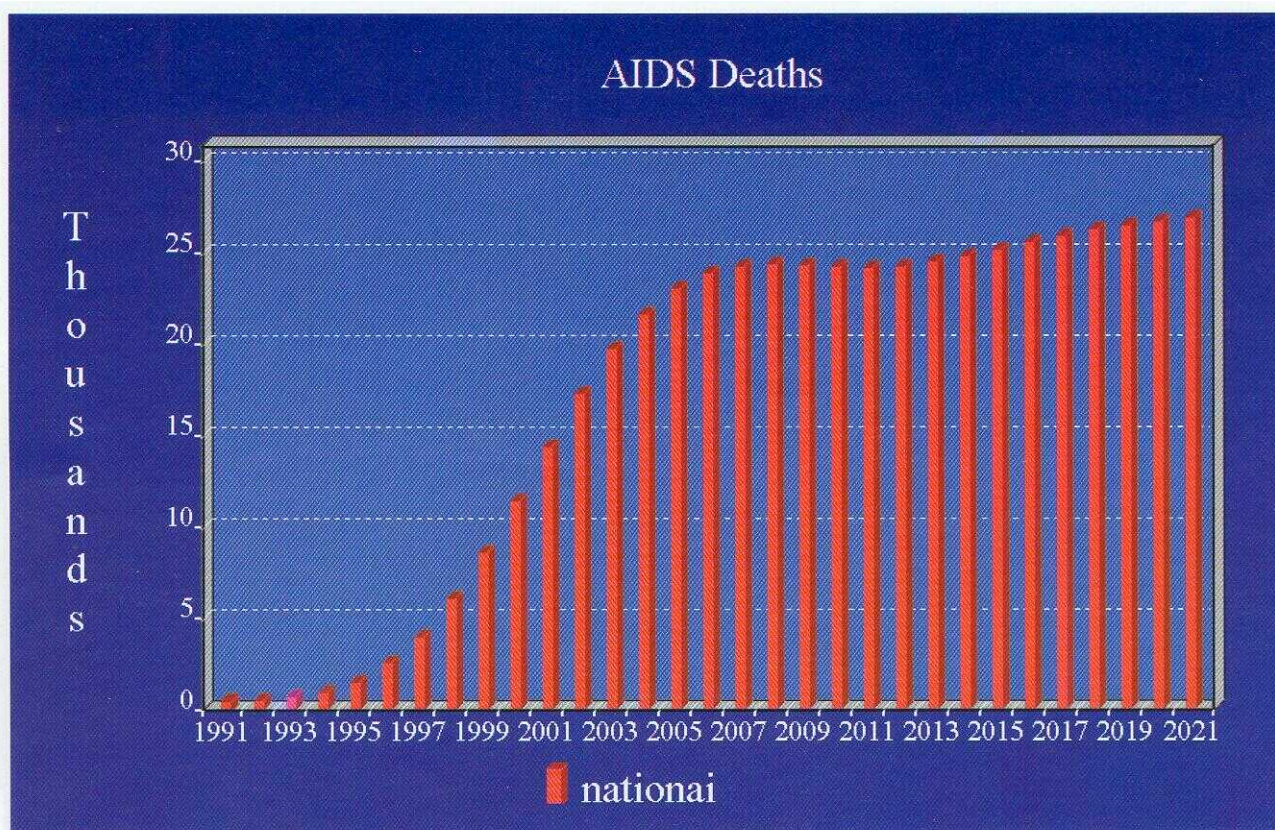
Cumulative AIDS deaths are indicated in the following figure:

Figure 3.4: Cumulative AIDS Deaths
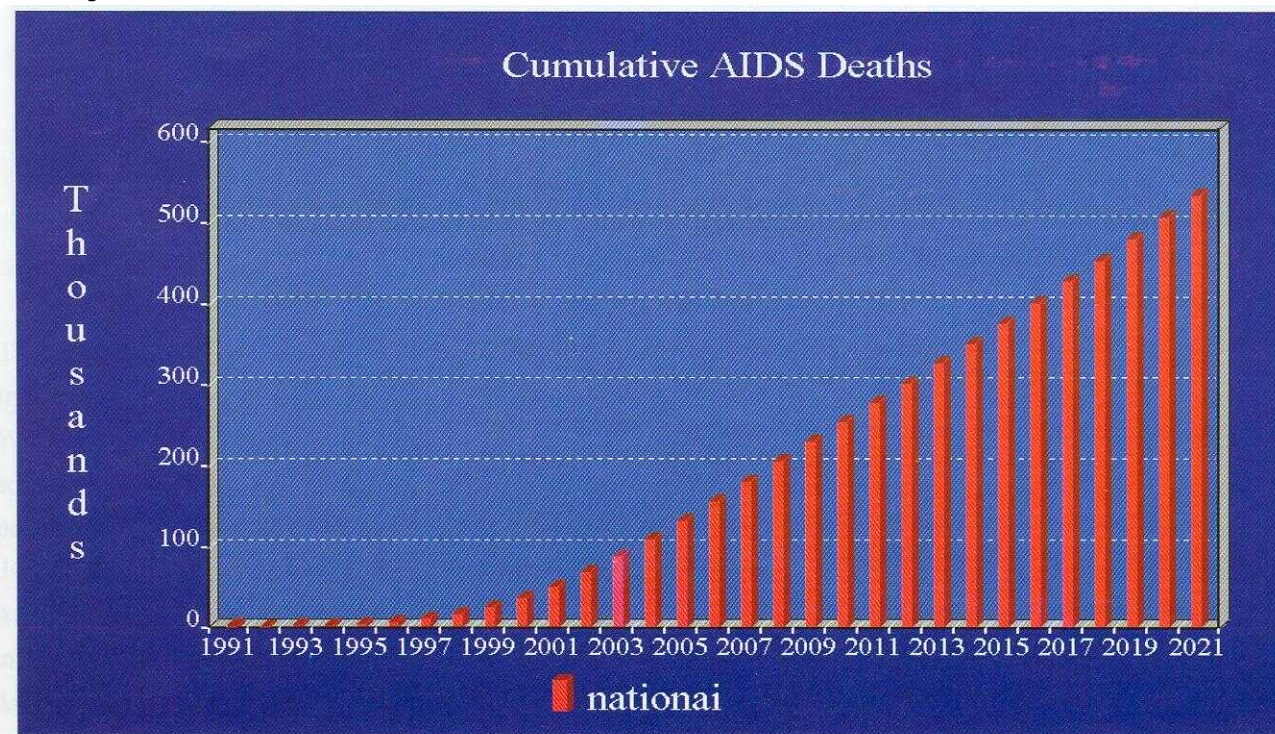
This figure clearly shows the exponential growth in cumulative AIDS deaths, rising to over 500,000 total deaths by the year 2020, while the annual AIDS deaths will begin to flatten by the 2006 based on the current model estimates.

Total Population and the Impact of HIV/AIDS

UNAIDS (2000: 22) summarises the demographic changes arising from AIDS: "The base of the pyramid is less broad. Many HIV-infected women die or become infertile long before the end of their reproductive years, which means that fewer babies are being born; and up to a third of the infants born to HIV-positive mothers will acquire and succumb to the infection. But the dramatic change in the population pyramid comes around 10 or 15 years after the age at which people first become sexually active, when those infected with HIV early in their sexual lives begin to die off. The populations of women above their early 20s and men above their early 30s shrink radically. As only those who have not been infected survive to older ages, the pyramid becomes a chimney." The demographic structure projected for Namibia due to HIV / AIDS is indicated following this page.

The following figures show the total population with and without AIDS, and the population aged 5-18 with and without AIDS, for the projection period.

> Henritta (not her real name) lives in Maltahöhe and is looking after one orphan child, while she also has eight children of her own. She is a pensioner and her husband is always on the look-out for casual jobs to make a living. The orphan child is her daughters child. Her daughter, she says, died of AIDS in 1998 after being sick for a long time. She looked after her daughter herself.
>
> Her daughters child was raised in her household, so the death of her mother did not affect where she lived. The child goes to the same school she always had, and while times have been tough school fees have been made. The child is more shy and withdrawn than she would like, and does not take conflict well.
>
> A policeman also lives at the house, and he always contributes to the entire household financially. However, they only eat on average once a day. Henritta receives a pension and she uses this for school fees.
>
> The orphan child's father is alive and Henritta knows him, but he refuses to provide any support. He claims that the child is not really his anyway.

Figure 3.5: Total Population With and Without AIDS
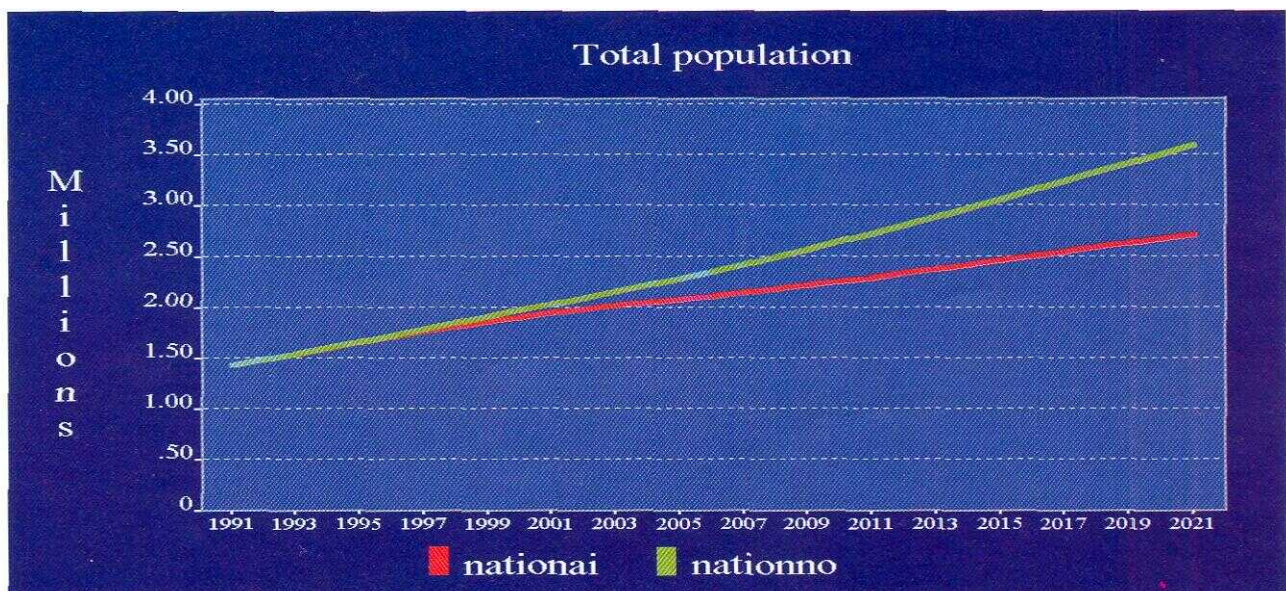
As shown in the figure, the population gap has already started to show, and the variance between the two will begin to show in earnest from 2005 onwards.

Figure 3.6: Population Aged 5-18 With and Without AIDS (1991-2021)
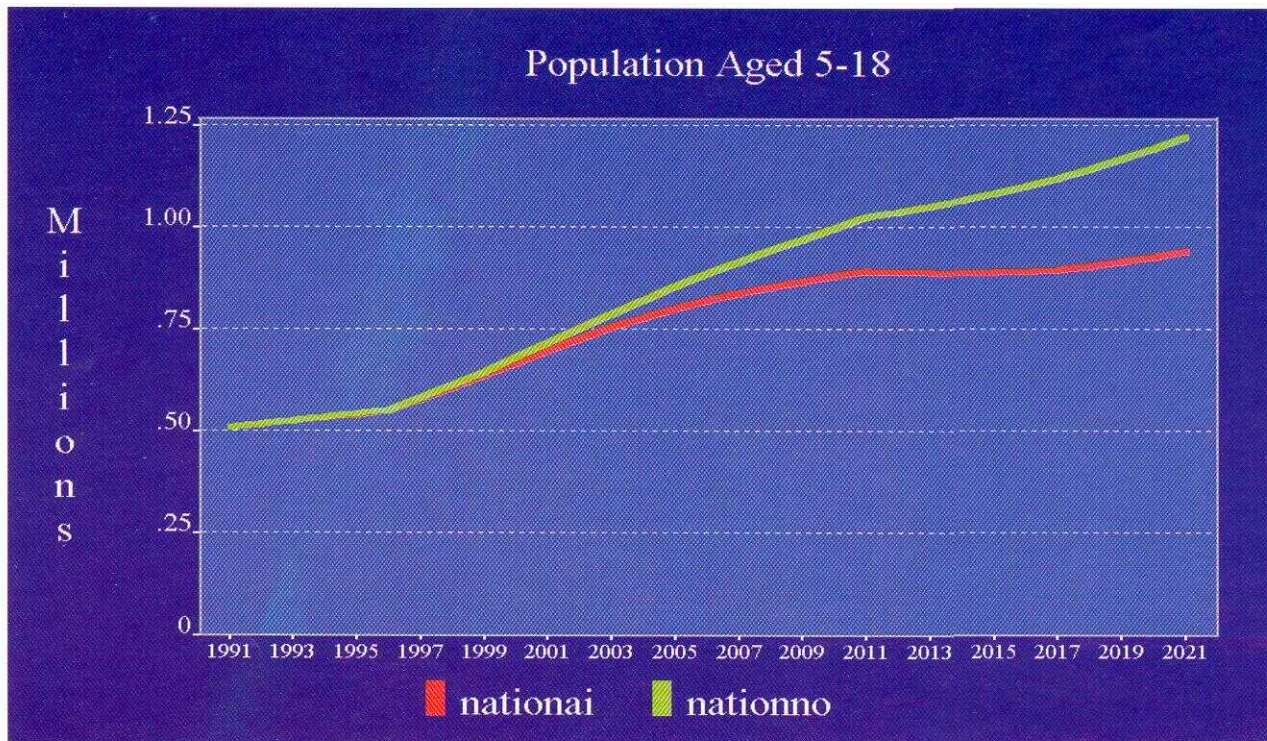
"HIV/AIDS has become a national problem ... this trend in AIDS infection will have serious negative implications for the implementation of the human resource plan of Namibia, as the segment of the population mostly affected by AIDS morbidity and mortality comprises those being trained, or already trained, but whose productive lives will be drastically reduced by the disease." National Planning Commission, 2000, National Human Resource Plan 2000-2010.

For the age group 5-18, deaths from AIDS had little impact until the end of the 1990s, with 1995 showing the first year of decline. Most of this decline is due to children never being born because one or more parent has died of

AIDS, and to a lesser extent due to HIV positive children being born but dying before their fifth birthday.

Chapter Four: Demographic Description of the Orphan Population

Introduction

This chapter presents detailed findings on the size, nature and distribution of orphans in Namibia for the modelling period 2000-2021. Orphans are defined as those who have either lost their mother or both parents and are under the age of fifteen, and include those orphaned by all causes. In Namibia, the definition has been expanded to include those who have lost their fathers. It should be noted that Namibia now defines orphans as part of an overall population of vulnerable children (orphans and other vulnerable children, or OVC). Because the AIDS model does not consider the loss of the father alone, the AIDS orphans figures should be regarded as conservative.

This definition, which is *not* used to project orphan numbers below, is important to consider rather in a policy context: "OVC are childeren up to the age of 18 whose mother, father or both parents have died; who are affected by HIV/AIDS; who are in need of care including those disadvantaged, in conflict with the law, or who are subject to abuse and violence" (personal communication, MOHSS).

Total Orphans

Available evidence suggests that, in countries that are suffering from a generalised HIV/AIDS epidemic, the percentage of all orphans that become orphaned due to AIDS will exceed the number of non-AIDS orphans as a country begins its steep upward slope in AIDS deaths. For 2001 it is estimated that some half of all orphans are AIDS orphans. By 2006 this will rise to 71.3%, by 2011 to over 75.6%. By 2021, the last year in the projections, some 75.5% of all orphans would be orphaned due to AIDS. Combining orphans who are orphaned due to all causes with those orphaned due to AIDS, the total number of orphans in Namibia is shown in the following table:

Table 4.1: Total Estimated Number of Orphans (all causes) in Namibia

Year	Total # of Orphans		# of Non-AIDS Orphans		# of AIDS Orphans	
	#	%	#	%	#	%
1991	27,503	100.0	27,493	100.0	10	0.0
1992	28,499	100.0	28,469	99.9	30	0.1
1993	29,523	100.0	29,443	99.7	80	0.3
1994	31,067	100.0	30,417	97.9	650	2.1
1995	32,886	100.0	31,196	94.9	1,690	5.1
1996	35,976	100.0	31,976	88.9	4,000	11.1
1997	40,881	100.0	32,951	80.6	7,930	19.4
1998	47,882	100.0	33,732	70.4	14,150	29.6
1999	57,111	100.0	34,511	60.4	22,600	39.6
2000	68,711	100.0	35,291	51.4	33,420	48.6
2001	82,671	100.0	36,071	43.6	46,600	56.4
2002	98,230	100.0	36,850	37.5	61,380	62.5
2003	114,556	100.0	37,436	32.7	77,120	67.3
2004	131,120	100.0	38,020	29.0	93,100	71.0
2005	147,270	100.0	38,800	26.3	108,470	73.7
2006	162,175	100.0	39,385	24.3	122,790	75.7
2007	175,152	100.0	39,972	22.8	135,180	77.2
2008	189,150	100.0	43,630	23.1	145,520	76.9
2009	198,338	100.0	44,258	22.3	154,080	77.7
2010	206,074	100.0	45,094	21.9	160,980	78.1
2011	212,351	100.0	45,721	21.5	166,630	78.5
2012	217,798	100.0	46,558	21.4	171,240	78.6
2013	222,521	100.0	47,391	21.3	175,130	78.7
2014	226,755	100.0	48,225	21.3	178,530	78.7
2015	230,710	100.0	49,060	21.3	181,650	78.7
2016	234,574	100.0	49,894	21.3	184,680	78.7
2017	238,012	100.0	50,522	21.2	187,490	78.8
2018	241,476	100.0	51,356	21.3	190,120	78.7
2019	244,843	100.0	52,193	21.3	192,650	78.7
2020	248,088	100.0	53,028	21.4	195,060	78.6
2021	251,054	100.0	53,654	21.4	197,400	78.6

These findings should be treated with extreme care. Unfortunately there is no baseline indicating that the total number of non-AIDS orphans was for the start-year of the epidemic (or for any other year). The Consultants therefore took the Crude Death Rate for adults for the base year (1991) and assumed that one orphan would be created for each death, and also assumed that an equal number of orphans were already in existence. This gives an estimate of 27,493 for 1991. Thereafter the rate was increased as per the natural population growth rate (AIDS adjusted). For AIDS orphans, the Spectrum model was used to project the number of orphans based on AIDS deaths. Therefore, both are estimates, and should be treated as such.

As of 2001, there are an estimated 82,671 orphans in Namibia, just over half AIDS orphans, and just under half non-AIDS orphans. By the year 2021, there will be an estimated 251,054 orphans, of which over three-quarters (197,400) will be AIDS orphans.

Geographical Distribution of the Orphan Population

Further projections were made showing the distribution of the orphan population by each of the eleven strata in the study. Findings are summarised in the following table for the years 2001 and 2021:

Table 4.2: Geographical Distribution of the Orphan Population by Year (2001) and by AIDS Orphans/Non-AIDS Orphans

Strata	Total # Orphans (all causes)	% of Nation's Orphans in Region	# of Orphans (non-AIDS)	# of Orphans (AIDS)
Kavango	6,390	7.73	2,788	3,602
Kunene/rural Erongo	3,571	4.32	1,558	2,013
Hardap/Karas	2,381	2.88	1,039	1,342
rural Khomas/Otjozondjupa/ Omaheke	3,571	4.32	1,558	2,013
Caprivi	12,235	14.80	5,338	6,897
Omusati/Oshana/Oshikoto/ Ohangwena	39,977	48.36	17,442	22,536
Oshakati (urban)	3,100	3.75	1,352	1,748
Ongwediva (urban)	430	0.52	188	242
Swakopmund (urban)	951	1.15	415	536
Walvis Bay (urban)	1,951	2.36	851	1,100
Windhoek (urban)	8,101	9.80	3,535	4,567

Table 4.3: Geographical Distribution of the Orphan Population by Year (2021) and by AIDS Orphans/Non-AIDS Orphans

Strata	Total # Orphans (all causes)	% of Nation's Orphans in Region	# of Orphans (non-AIDS)	# of Orphans (AIDS)
Kavango	21,842	8.70	4,668	17,174
Kunene/rural Erongo	11,297	4.50	2,414	8,883
Hardap/Karas	8,335	3.32	1,781	6,554
rural Khomas/Otjozondjupa/ Omaheke	21,038	8.38	4,496	16,542
Caprivi	22,419	8.93	4,791	17,628
Omusati/Oshana/Oshikoto/ Ohangwena	126,481	50.38	27,031	99,450
Oshakati (urban)	7,632	3.04	1,631	6,001
Ongwediva (urban)	1,105	0.44	236	869
Swakopmund (urban)	2,736	1.09	585	2,152
Walvis Bay (urban)	3,716	1.48	794	2,922
Windhoek (urban)	24,453	9.74	5,226	19,227

It should be remembered that these calculations are based on the prevalence rate in these locations, and do not account for action after (or even before) the death of the parent(s). Indeed, while for example Windhoek shows some 25,000 orphans, qualitative findings presented in Chapter 5 strongly suggest that many of these orphans are elsewhere, mostly in rural locations. Having said this, most orphans will be 'generated' in the north central regions of Omusati, Oshana, Oshikoto and Ohangwena, because of the high percentage of the population of Namibia living there, and because prevalence rates are so high. For 2001, the 'balance' between AIDS orphans and non-AIDS orphans is most distorted in the urban locations, because prevalence rates are so high in these areas.

Looking at the issue differently, for 2001, half (48.36%) of all orphans will be 'generated' in the four north central regions of Omusati, Oshana, Oshikoto and Ohangwena, 7.73% will be generated by Kavango, and 9.8% will be generated by Windhoek. For 2021, this will change 50.38%, 8.7%, and 9.74%, respectively, reflecting the key role these three areas will continue to play in 'generating' AIDS orphans. Assuming that half of the Windhoek and Walvis Bay orphans will return to the north central regions, the four regions of Omusati, Oshana, Oshikoto and Ohangwena may have to cope with some 60% of all orphans in the country.

Chapter Five: Field Study Findings

"The idea of impact is defined making clear that the impact of an epidemic cannot be thought of only as a shock but must also be understood as a series of slow, cumulative events over a long time period". Barnett and Whiteside with Desmond, 2000: 2.

Introduction

One of the key findings of many orphan studies in Africa is the extent to which extended family structures have managed to absorb the orphaned children. Detailed studies have further found that, despite such a remarkable and efficient 'security network', the sheer magnitude of the problem in the context of a mature epidemic may overwhelm the ability of extended family structures to cope. As will be seen in this chapter, Namibia's pattern regarding coping strategies is no exception to this trend.

> "Most problems caused by HIV / AIDS are not unique. But the way this epidemic undermines family and community capacity to deal with them is different, because it primarily infects adults in their most economically productive years, when they are raising their children." UNICEF, 1995: 9.

As noted in Chapter 2, to explore what the impacts have been in Namibia, widespread consultations were held with orphans, caregiving families, and key informants. This chapter presents the findings from the field investigations, and includes, where relevant, references to the broader literature in the field.

Living Circumstances

Orphans participating in focus group discussions were asked to identify whether the households they currently lived in were made up of their mother's family, their father's family, or non-relatives. There was a considerable mix across most regions regarding whether the father's family or the mother's family was looking after the child, but only a few were living with a non-relative. Some were living with their fathers, although this was less common than living with relatives. Examples of living situations is indicated in the following table:

Table 5.1: Family Situation

Location	Household Situation
Kunene	6 participants: 3 with mother's family - 1 with mother's mother (child's grandmother), 1 with mother's sister, 1 with mother's nephew 2 with father's family - 1 with father's mother (child's grandmother), 1 with father's sister 1 with father 4 participants: 2 with mother's families - both with mother's mother (child's grandmother) 1 with sister 1 with non-relative
Omusati	5 participants: 2 with mother's family 3 with father's family 11 participants: 7 with mother's family 2 with father's family 2 with their fathers
Caprivi	6 participants: 4 with mother's family - one with grandmother, one with the grandfather, two with aunts 2 with father's family - one with an uncle, one with the grandfather 8 participants: 2 with mother's family - one with an aunt, one with an uncle 3 with father's family 3 with adult sisters (2 actually with half-sisters, as they had different fathers)
Erongo	5 participants: 0 with mother's family 1 with father's family - grandmother (but currently living in a school hostel) 2 with fathers 1 with brother 1 with step-sister 5 participants: 2 with father 1 with father's family - grandmothers 1 with brother 1 with stepsister (father's side)
Hardap	4 participants: 3 with mother's family - 2 with grandmothers, 1 with an aunt 1 with father's family - both grandmother and grandfather 4 participants: 3 with mother's family - all with their grandmothers 1 with father's family - with the grandmother
Karas	4 participants: 2 with mother's family - one with an aunt, one with the grandmother 1 with father's family - living with the father's sister 1 with father 4 participants: 4 with mother's family - 2 with mother's sister, 1 with mother's brother, 1 with great aunt

Table 5.1: Family Situation (continued)

Location	Household Situation
Kavango	6 participants: 5 with mother's family - 4 with aunts, 1 with grandmother 1 with father's family - grandmother 8 participants: 6 with mother's family - 1 with grandmother 1 with father's family - grandmother 1 with adult brother 4 participants: 3 with mother's family - 1 with an aunt, 1 with the grandmother, 1 with 'distant' relatives 1 with father
Khomas	5 participants: 1 with mother's family - with an aunt 1 with father's family - with an aunt 3 with fathers 7 participants: 5 with mother's family - 2 with aunts, 2 with uncles, 1 with grandmother 1 with father's family - aunt 1 with sister 7 participants: 5 with mother's family - 3 with grandmothers, 1 with aunt, 1 with uncle 1 with father's family - uncle 1 with sister
Ohangwena	8 participants: 5 with mother's family - 2 with grandmothers, 2 with uncles, 1 with an aunt 1 with father's family 2 with fathers 6 participants: all 6 lived with mother's family - 2 with grandfathers, 3 with grandmothers, 1 with an aunt
Omaheke	6 participants: 5 with mother's family - 4 with grandmothers, 1 with great uncle 1 with father 8 participants: 4 with mother's family - 1 with grandmother, 1 with aunt, 1 with uncle, 1 with a cousin 1 with brother 2 with their fathers 1 with sister 5 participants: 2 with mother's family - both aunts 2 with elder sisters 1 with father's family - grandfather

Table 5.1: Family Situation (continued)

Location	Household Situation
Oshana	10 participants: 5 with mother's family - 4 with grandmothers, 1 with an aunt 2 with father's family - 1 with a grandmother, 1 with an aunt 1 living alone 1 with father 1 with non-relatives 8 participants: 2 with father's family 1 with father 4 with mother's family - grandmothers 1 with mother's sister
Oshikoto	5 participants: all 5 with mother's family - grandmothers and aunts 8 participants: 7 with mother's family - 4 with grandmothers, 2 with aunts, 1 with grandfather 1 with father's family - with grandmother
Otjozondjupa	5 participants: 3 with mother's family - all with grandmothers 1 with father's family - with grandmother and grandfather 1 with adult brother 5 participants: 3 with mother's family 1 with father 1 with non-relative (child was abandoned by relatives, taken in by non-relatives)

Of all of the orphans interviewed, only one was living alone, a few were living with non-relatives, and some were living in households with only older siblings (young adults). Most, however, were living with extended family members, usually on the mother's side, but quite a few on the father's side, while some were living with a surviving father. In most cases the caregiver was the grandmother or the aunt (and to a lesser extent an uncle; grandfathers were not commonly mentioned), with only one such situation where the relative was perceived to be 'distant'. No clear regional pattern emerged, with diverse situations observed across various areas of the country. The literature on orphan care is unanimous in the belief that orphans were best off when placed in a family-like structure in a familiar community, headed by a responsible adult (ideally an extended family member), and established within a cohesive community. *The above suggests that this is what is, indeed, happening in Namibia.*

> Child-headed households - "For some children, living on their own in their family home may be the best of a limited number of bad options. The decision of a group of orphaned siblings to remain in their parents' home, rather than moving to live with relatives, may be motivated by the need to protect their right to the house and land. Children in such a situation are extremely vulnerable .... Any child-headed households identified should be a primary focus of community-based monitoring ...". UNICEF, 1995: 97).

The international literature suggests that, if the orphan child had siblings, it was best to keep the siblings together (see, for example, Government of Zambia, 1999). Social workers were therefore asked what tended to happen to orphaned children. Respondents indicated that the children were normally taken in by extended family members, consistent with findings from the orphan FGDs. In the case of orphans going to non-family members, this tended to be the case when no extended family members were available, but where the parent had a close friend who was asked/volunteered to care for the child. Virtually all the social workers interviewed noted that it was best to keep children from the same family together, but that this was not always possible due to the economic circumstances facing caregiving households. Therefore, while it

would be best practice, social workers felt that children were often separated from their siblings. However, interviews with caregivers themselves suggested that, in most cases, more than one child from the same family was taken in by the same household. Indeed, this pattern was repeated over and over. *This appears to be the case in most circumstances in Namibia,* although social workers indicated evidence of some split families.

When asked about child-headed households, most social workers felt that there were few in their regions, if any. There were a few cases in urban areas where social workers indicated that they intervened. Social workers did not feel that most street children were orphans, 'rather they are from irresponsible parents'. Consistent with street children studies, most street children have homes to go to, homes with adults, and social workers felt that orphan children were not the ones working on the streets.

Caregivers in FGDs were asked to describe their circumstances. A subset of situations are summarised as follows:

Case Study - Omusati Region

Marta (not her real name) is 16 and is living in her aunt's house which also houses her grandmother, five other children (all boys) and five other adults.

Her mother passed away in 1999 after a long illness, she did not know what. But, she had not seen her mother for two years because she was living away from home to attend school. Her father is still alive and she sometimes sees him. The father looks after her younger brother, and has for a long time.

In addition to the death of her mother, three of Marta's young siblings also died. 'One had sores in her mouth', but she did not know what they died of.

She misses her mother terribly, she misses the things they used to do together. She feels that her aunt punishes her a lot, and is not fair. She has problems interacting with the other children in the house, and she does not like the adults.

She attends school and helps with chores before and after school. She thinks that money is needed to buy clothing and school accessories.

- Caprivi - 'I stay with my sister's three orphans, and my daughter's child. When my sister died I took them in because there was no one else to look after them. My daughter is alive but I'm also looking after her child. My daughter's child came in 1995, and the three orphans came in 1997'. The children were 17 and 10 and 10 (twins) when they joined the household.

- Caprivi - 'My brother's 16 year old son came to live with us, because both his parents had died'.

- Caprivi - 'I'm staying with three orphans, all from my granddaughter, because my granddaughter and her husband both died'. 'They were 13 and 11 when the came'.

- Erongo - 'I'm staying with four orphans from my sister who died'. 'They have been with me for some time, and they are still in school. The oldest boy is in Grade 12 and the oldest girl in Grade 11. I've had the two of them for many years, the youngest two came to live with me after the mother died. They are younger, at 10 and 5, but they are 14 and 9 now. It really wasn't difficult to look after two more, because I already had the other two'.

- Erongo - 'I'm staying with the orphan children of my own daughter. In fact we had all lived together with my daughter living her, so the children have always lived here'.

- Erongo - 'My sister's two children came to me after she died. First they had gone to their grandmother, but then she died'.

- Hardap - 'I have three orphans. I'm not related to the mother, but the parents were just like family, so after they died I legally adopted them'.

- Karas - 'I'm looking after two orphans from a woman who used to have a house in my backyard. When she died, I already knew them well'.

- Karas - 'I've adopted my daughter's children, this is how we do it in our culture'.

- Karas - 'The children's mother was my husband's sister who used to live in a house in our yard. The father died first. The mother registered for a maintenance grant, and later died. One of the children is disabled'.

- Karas - 'The women who died used to live in a shack in my yard. When she fell sick she went to Owambo with her children, but when she discovered that she would not survive, she sent the children back to Keetmanshoop, and asked that I take care of them and keep them in school'.

> **Case Study - Omusati Region**
>
> Elma (not her real name) looks after ten children. Among the younger children are two, aged 5 and 6, that are from her daughter who died. The daughter had a total of six children, and four of them went with an aunt. The daughter's husband died before the daughter, 'he drank a lot and died of a lung problem'.
>
> The household has no steady income, and depends on running a small business selling bread and cakes to make a living. When the food runs out the children drink *oshikundu*, a traditional mahangu brew.
>
> The two children did not have any adjustment problems when they arrived, there was no fighting, no quarrels, 'because we all have the same traditions and lifestyle'. When they joined the household then enrolled at the local school.
>
> The family sometimes gets assistance from Development Aid from People to People (DAPP), and they discuss things with nurses and the community development officer.
>
> They felt that their immediate needs were food and clothing for the children.

- Kavango - 'I'm looking after my sister's sons, but I've looked after them long before she died'.

- Kavango - 'I'm looking after two daughters from a cousin. When she died, there was no one in Sauyemwa to look after them, so they came here so that I could look after them'.

- Kavango - 'I'm taking care of my son's children, a boy and a girl. When my son and his wife died in a car accident, the children had anyway lived with me a long time'.

- Khomas - 'I'm looking after my cousin's child. After the mother died, the family gather and asked the child who she wanted to life with, and she selected us'.

- Khomas - 'I'm looking after my brother, who was still young when our mother died'.

- Khomas - 'The child we are looking after belonged to my husband's sister. The mother was sick when the child was born, so we took her. When the mother recovered, she asked that the child continue to live with us because she was used to us. Then, the mother died'.

- Kunene - 'I am looking after my sister, she is only two. I'm an adult, and I've applied officially to adopt the child'.

- Kunene - 'I'm looking after the child of my husband's cousin, he was just five months old when his mother died'.

- Kunene - 'My elder sister passed away in 1995 and her children were just left at the hospital (they were 8 months old). At first my niece wanted to adopt them, but then changed her mind. So I adopted them'.

- Kunene - 'The mother died in childbirth, and the woman was my husband's brother. So, I'm taking care of the child because a man cannot look after a child without a woman'.

- Ohangwena - 'I'm caring for my niece's daughter. She lived in another village, and when she died the child was brought here at the age of 2, and she is now 5'.

- Ohangwena - 'I'm the orphan's grandmother, they have always lived in this community'.

- Omaheke - 'I'm looking after three orphans who arrived in 1997. They belonged to my brother, and they came to my household after the mother died'.

- Omaheke - 'The child is my daughter's son, I took him in because I am his grandmother'.

- Omusati - 'I'm looking after four orphans, two from my sister and two from my brother. My brother is alive, but his wife died'.

- Omusati - 'I'm looking after five orphans, all were from my brother, and he and his wife both died'.

- Oshana - 'I'm looking after my two grandchildren. They were only eight months old when their mother died, and now they are 10 years old. They had lived at this household anyway since they were born'.

- Oshikoto - 'I'm looking after my sister-in-law's daughter, she used to live with us but she died when her daughter was young'.

- Oshikoto - 'My brother's child has always stayed with us, when he died the child continued to live with us'.

Sarah (not her real name) is an orphan who came to live with her foster parents, the foster mother being a nurse, when she was six years old. She had met her foster mother when her birth mother was sick in bed at home. The mother had just been discharged from hospital and was near death, having been discharged because the doctor said that there was nothing that could be done, she was in the final stages of AIDS. After being discharged, a nurse came to visit the birth mother and met Sarah. 'I looked at Sarah who was sitting on her grandmother's legs with her arms crossed, she was so thin and looked neglected ... just that moment I could not hold my tears', the foster mother explained.

When Sarah's mother died, the foster mother went to a social worker and discussed the matter. Because the grandmother was old and frail, and because the father's whereabouts was unknown, all agreed and she was fostered to her new mother. They applied for a social foster care grant for the child, and receive the money regularly. She looks after Sarah with the help of her three teenagers. Sarah maintains contact with her grandmother and her other relatives. They are reported to be happy that Sarah is being so well looked after.

At first her husband was against the idea, raising concerns about their ability to afford the child and because of concerns about what the neighbours would think. They took Sarah for an HIV test and, as the mother put it, 'God is always great, it turned out that Sarah was HIV negative'. 'Sarah could therefore go to school without any difficulties or any fear of being rejected. Nevertheless, neighbours and relatives were not prepared to look after the child. 'They were scared because of the fact that the mother died of the feared disease'. Even though she has shown people Sarah's HIV test, they still refuse to be near her. Now, after three years, this has also changed: 'they cannot believe that the child is healthy and alive because most of them thought that she would not make it, we don't have problems with people looking at her or us with suspicion anymore'.

Sarah is now nine years old, and is a happy, well-adjusted Grade 1 student. 'She looks much better now than when she arrived, her health has shown a great improvement during the past three years'. The other children treat her like their sister, 'especially my two daughters are very fond of her, they teach her how to read and write or take her to town'.

What is particularly interesting is the high number of cases where the children came to live with the caregiver a number of years *before* the parent passed away. In this respect, the orphans did not have to get used to a new living environment (although the living *circumstances* changed dramatically due to the death of the parent(s). When asked about changing roles in raising the child, respondents in these circumstances noted that their roles did not change significantly, particularly if the biological parents did not live in the same household.

Also of interest is the fact that the vast majority of caregivers were looking after *more than one orphan child*, and that orphans did not appear to be divided across different households. Indeed, in only two cases were the orphan children divided across two households, and close ties were maintained across these two households (both in Ohangwena Region).

Not unexpectedly, when asked what kind of support caregivers had received in terms of assisting with the care of the orphans, circumstances varied considerably, not by region but rather by circumstance and across urban and rural locations. It appears that households where a single grandparent is looking after the orphans had particular problems: 'there is no one else to care for them, and sometimes they refuse to obey me'. In these circumstances respondents noted that the children were left to look after themselves if the caregiver had to travel. In cases where there were other adults in the household aside from the primary caregiver, respondents noted that the children relied heavily on the primary caregiver, and had problems when they were away: 'the children are always stressed when I'm away'.

Case Study - Omaheke Region

Sake (not his real name) is 10 years old. His mother passed away in 1998 after a long illness. In 1999, his father also died after suffering from what was believed to be TB. Sake and his 15-year-old brother stayed at their dead parents house for a while, on their own, in the squatter camp near Epako. Their father originated from somewhere in the Kavango Region, but they did not know where, and they had little to no contact with him because he was rarely in Gobabis. Eventually Sake and his brother ended up being split between two families, both their mother's relatives.

Sake is staying with his aunt, his mothers biological sister. They live in a two bedroom household in Gobabis. His brother is 'somewhere at a farm' some distance away, perhaps still in Omaheke Region. Sake has not heard from or seen his brother since they were split apart in September 1998, and he feels terribly saddened by this.

Besides Sake and his aunt, there are nine other people living in the house. The household is comprised of three adults, his aunt and uncle and his aunt's mother. The aunt and uncle have four children aged 14, 18, 21 and 24, three boys and a girl, and two grandchildren, aged 6 and 7. There is also a distant relative living there aged 20.

Sake is still in school, in Grade 4, which is correct for his age. Two other teenage children are in school as well, and all are reported to be doing well. Nevertheless, the household finds it difficult to keep the three children in school, and in fact the two grandchildren are not in school at all. Of the three children, the household has only managed to pay the school fees for two, but all three still attend.

The aunt and uncle applied for the Maintenance Grant but did not succeed up to this point. 'We have no idea why the process is taking so long'. They had hoped for drought relief food but they were told to wait, 'but a hungry person cannot wait', she retorted.

The uncle is employed, but earns less than N$1000 per month, and no one else in the household has any income. From this income, they have to purchase food and clothes and pay for services and school fees. Their electricity was cut off almost five years ago due to non-payment. Water alone costs some N$200.

Sometimes the children have to go to bed hungry, and sometimes to school without any food in their bellies. Fortunately, the three that go to school get fed there, and this is important for keeping them going to school. 'When we run out of food, we get food from our neighbours'. But, although the neighbours are supportive, 'they are getting tired of doing us favours'.

Sake has adjusted well and other children in the household treat him like a brother. He has friends in the community and at school. He and the other boys sleep in the overcrowded sitting room.

The aunt said that she is happy to look after Sake because 'he is of my own sister's blood'. She noted, however, that it was a difficult and resource draining thing to do. There are certain days when she felt helpless and powerless and wished that she had never been born '... but what else can I do', she said. She and her family keep their faith in God, '... and only God knows why they are in this situation'.

She estimated that, to meet basic needs, they needed some N$2000 per month. With this money, they could cover school and hospital costs, and meet other expenses such as purchasing clothes and blankets for the children, and basic foodstuffs (rice, sugar, maize meal, potatoes and washing powder). If foodstuffs were to be provided, each month they would need a bag of rice, 2.5 kgs of sugar, one bag of maize meal, and one bag of potatoes.

When asked whether taking on orphan children had affected their lives, almost all respondents noted that it was 'just like having our own children', and generally was not viewed as problematic in these terms. A number noted restrictions on travel, particularly if the children were very young. Only a few indicated that it was the lives of other children in the household that were disrupted, and these disruptions were generally social and related to older children having to look after younger children (including strains on the education of these older children).

In most cases there appear not to have been significant disputes regarding the child/children joining the caregiving household. In cases where a number of relatives were involved in the decision process, there was consensus about who the child/children should stay with. In Caprivi, Erongo, Kavango, Omaheke, Omusati, Oshana, and Otjozondjupa, *all* respondents said that the children were accepted in the first household the dying parent approached, regardless of whether this was the mother's or the father's extended family. In only a few cases (one in Kunene, one in Ohangwena) was a second household approached.

Of interest, whatever the circumstances of the caregivers (that is, from the mother's family, from the father's family), procedures for 'distributing' orphan children were considered to be consistent with traditional norms and practices. This even extended to caregivers who were not biologically related to the orphans. 'Where things are against tradition is where children were not taken in by relatives and instead have to live on their own'. Regional interviews commonly noted the importance of orphans staying within family structures. The problem in many cases is that the father's family may not offer support, sometimes blaming the woman for their son's death. In these cases little to no support is offered to the woman and her children, nor to the children if the mother dies as well. In most cases, orphan children are sent to relatives on the mother's side.

As with a number of other findings, there was no clear variation across regions.

> **Case Study - Oshana Region**
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> Aleta (not her real name) was born at Okatana in Oshakati and she is now 18. She is the head of the household, and looks after her 9 year old brother. She also has a younger sister who stays with a friend of the mother in Ongwediva.
>
> All three children lived with her mother at Okatana, where she was employed as a cleaner at a hospital. 'Our life was good when our mother was alive, because she wanted all of us to have a good education'. The father and mother separated, but they remained close. He sometimes provided support, and used to give the children money. In 1998 the father died, no one know what he died of. Aleta's mother was sick for a long time, but died in late 1998 when Aleta was only 17, and she and her brother still live in the same house. They ran out of money, their services were cut off. They now get their water from a nearby petrol station.
>
> Aleta and her brother receive money from the state, but she is worried that that will run out. Her mother had managed to keep some money aside, but it was running out. She managed to get an exemption from paying school fees but the principal indicated that she must pay the exam fees. She is worried that she might fail her grade 10 exams and does not know what she would do then.
>
> Aleta noted that her parents had had many friends, 'but none come to visit anymore'. She felt that she worried about things all the time, she does not sleep well and does not eat well. She is particularly worried about her younger brother, because she cannot think of who would look after him well.
>
> She met with a social worker when her mother first died to apply for money, but she was turned away saying that, because she was under 18, she must have a guardian that would apply for assistance. She was intending to ask an aunt, but has not do so yet.

Household Coping Mechanisms

> "The burden of responding to the health and welfare problems caused by the epidemic belongs first to families, while communities are the key stakeholders. No other arrangement or structure that government, NGOs, churches or donor agencies have been able to devise comes anywhere near to managing the orphan problem in the way that the extended family succeeds in doing ... In view of this, all policies, strategies and interventions should focus on strengthening the extended family, as an entity in itself and as part of the community, so that it can adequately discharge its protection and care roles". Government of Zambia, 1999: 12.

Overview

There is virtually no disagreement in the literature regarding the central role of the extended family in caring for orphan children. There is a growing recognition that these structures are becoming increasingly burdened, and may be less able to cope with new stresses, but the focus nevertheless remains on extended families. Any support activities should therefore aid these existing coping mechanisms. UNICEF (1995: 3), in a draft 'guidelines' document, notes that "The economic burden of providing for the needs of children whose parents die is generally borne by relatives, often straining already overstretched capacities and affecting their own children." The fact that this responsibility falls to extended family members is, of course, not surprising, as extended families have historically acted to protect the economic and social well-being of its members (see ActionAid, 1993). Indeed, many cultures in Namibia have devised complex risk aversion and opportunity-seeking strategies in response to the many challenges they have historically faced that involve sharing responsibility for the upbringing of children.

As UNICEF (1995: 11) notes, "In a context where extended families are the norm, a pitfall to avoid is seeing households as isolated units where the death of members to HIV/AIDS leads to an inevitable economic decline for the surviving members. Household composition can change as adult relatives more to compensate for reduced adult labour or care for orphans." UNAIDS (2000: 23) notes that "... there is one certainty: a small number of young adults - the group that has traditionally provided care for both children and the elderly - will have to support large numbers of young and old people. Many of these young adults will themselves be debilitated by AIDS and may even require care from their children or elderly parents rather than providing it". How, then, are households coping with these changes?

Situation in Namibia

To consider the 'daily lives' of children, FGD participants were asked to describe their situation. In the FGD with orphans, the orphans were asked to describe their daily routines. The discussions explored what the participants usually did during different times of the day, with particular attention paid to eating patterns, skipped meals, work, child care of siblings, playing and sports, other leisure activities, agricultural activities, and going to school.

> **Case Study - Omaheke Region**
>
> Rosy (not her real name) is a 66 year old widow looking after four grandchildren. She lives in Witvlei in a house made of mud, tins and other informal materials. The house was built with the help of her late daughter who died in 1997, leaving her with the four children, three from her daughter and one from her son. There used to be five, but one who was only a few years old died just two months after the mother's death.
>
> She obtained a housing loan from the Build Together Project to extend the house. The house is half completed, but she has not started paying the loan back. She is surviving from her monthly pension of N$160. The house has no electricity and no water, because both services were cut off 'a long time ago' because she was in serious arrears. She gets her water from a neighbour, and pays N$10 per month.
>
> 'No one is helping me raise these children', she lamented. Her elder son is not employed and does not stay with them. The daughter had worked in a hotel so had an income, but now she is dead. 'Now that my daughter is dead, life is unbearable for all of us. Sometimes I feel like a living corpse'.
>
> Sometimes the household goes 2-3 days without food, although sometimes they get food from a neighbour. 'We only eat pap, which we can't even afford. Everything is not enough in this household', she noted desperately.
>
> Despite having difficulty making ends meet, all four children are in school. The children don't have school uniforms, rather Rosy makes a substitute by hand. She has numerous outstanding debts with the school and she fears that her grandchildren may lose their schooling due to her inability to pay the school fees.
>
> The oldest one is becoming difficult because of the death of her mother, 'she says that if her mother was alive she could get everything they wanted'.
>
> The orphans don't receive any maintenance grant monies. Rosy had the children registered with MOHSS in 1997 after the death of the mother, but has not received any feedback from the Ministry. 'If we receive these grants, this will relieve us from our suffering'. If the grant monies were to arrive, she would use the money for the children's schooling, cover hospital costs, and purchase clothes for the children.
>
> Rosy noted that she had lost touch with extended family members, so 'there is no one else to look after the children. I am the only one, their fathers, and each has a different father, the children have never seen them'.
>
> Rosy does not know why her daughter died, 'but she was sick most of the time'. She believes that she died of pregnancy complications.

In Kunene Region, the one orphan living by herself indicated that she lived alone in a house in Opuwo, looked after herself, and spent the week in school. She was careful to do her homework, and continued to take care of the household and the family's animals. Indeed, the parents appeared to be quite well off, with the girl looking after the family's livestock. However, she indicated that she now only ate one proper meal a day, 'where before we used to eat twice a day'. She indicated that, with school and chores, she was normally busy from sunrise until about 20hrs. Another Kunene Region participant indicated that he had to look after the family's livestock, and therefore did not go to school. Two other participants indicated that they had extensive chores to do in the morning, and did not attend school. All three indicated that the first meal of the day was lunch 'long after we start work', and that all three had to prepare their own lunch, and often lunch for others in the household.

Of interest, when caregivers were asked about the allocation of labour across household members with the arrival of orphan children, virtually all indicated that tasks were shared equally across orphan children and their own children. None felt that there was any additional burden for orphan children, not in their own households, and not in neighbouring households. The only adjustments that were made arose from shifting income sources (e.g., if the orphan's parents were employed and now were no longer sending money).

In another FGD in Kunene Region routines appeared to be similar to most other children, with all the orphans attending school, assisting with some household chores, having time to study (some attended study class in the afternoons at study class), and having adults taking care of the cooking. However, three of the seven participants noted that they had trouble with their schoolwork, 'we have to leave our books at school because we are constantly disturbed at home and not allowed to study there'. For one of the three, the orphan noted that the other children made it impossible to study, while the other two noted that there were expected to take on household chores 'beyond those we normally do'.

Participants in a FGD in Omusati Region mentioned common activities, such as assisting with agriculture, household chores, etc., and most mentioned attending school. Of interest, all mentioned that they only ate two meals a day now 'but we used to eat three'. Responses did not vary despite the participants being in different

> **Case Study - Otjozondjupa Region**
>
> Bev (not her real name) is 16 years old and lives with her aunt. She has been with her aunt for two years. There are 20 people living in the household, all but two related to Bev. Bev was in school at Bulskop and stayed with her father after her mother's death when she was 15: 'She died of cancer in Windhoek after being sick for one year'. She left her father's household after only a short period of time 'because my father and my step-mother were always against me'.
>
> Bev has six other siblings. Three go to school in Omaruru where they stay with an uncle. Two are staying in Windhoek, and one stays on a farm. None receive any support from their common father, 'he does nothing to support us'. Bev's mother used to buy them school uniforms and clothes, but not they get nothing. Bev is now pregnant and there is no one to help her, including the man who got her pregnant. 'We are all just staying alive'.
>
> If support is to be provided, we need food, clothes and cosmetics.

caregiver situations. None of the participants in two FGDs in Caprivi Region had had to drop out of school, and noted that schooling and their studies were central to their daily activities. While all had household chores, none felt that their chores were more onerous now than before, and none felt that these interfered with their studies. Again, responses did not vary despite different caregiving situations.

In Erongo, the one living with her sister had to take care of the household and her sister's child, with took considerable time. However, the sister did the cooking and helped around the house. The girl was still able to attend school, but studies had to be deferred until the evening when the older sister came home.

In the Hardap FGDs, most reported that they did not eat breakfast, but did eat at school. Some ate lunch, but some did not. Most were in school, but a few were not in school and noted that 'we have nothing to do'. One was being looked after by his aunt during the day, and returned to his grandparents at night. A few in Karas Region noted that they only ate one meal a day, dinner, but most ate two meals a day.

Respondents in northern regions tended to note that their non-school time was filled with chores, both agricultural and otherwise, while respondents elsewhere tended to mention involvement in sports. Most respondents stated that they were still in school, and noted that they did homework.

On the weekends almost all respondents noted that they attended church with the relatives they were staying with. Some household chores were more common at the weekend and tended to involve most of the respondents, including washing clothes, looking after siblings, and house cleaning. There was, not surprisingly, a difference across boys and girls, with girls tending to have a heavier workload on both

weekdays and weekends. Boys tended to more commonly note involvement in sports, while only a few noted doing homework on weekends. Again, the orphans in the north tended to note more responsibilities related to agriculture than elsewhere.

Most of the children entered households where other children were present. When asked about their relationship with other children in the households they were staying in, almost all noted that 'we study and play well together', with few noting problems. Barriers to playing together appeared to only relate to age gaps and, with older boys and girls, not wanting to play with the opposite sex. None expressed any concerns about their relationships with their siblings, beyond a few not liking some of them, but none indicated that this was any different than any other family-type situation. Only one respondent, in Omaheke Region, said that he did not get along with his 'new' siblings, noting an age gap, and pointing out that 'they call me and orphan and laugh at me'. None of the rest felt particularly ostracised because of their status as orphans.

A study in Zambia (Government of Zambia, 1999: 19) also found that there was little discrimination against orphan children, noting that there was "... little to distinguish between the plight of orphans and non-orphaned children". The report highlighted the problems facing these 'absorbing' households by arguing that interventions needed to remember that the households caring for orphan children in many cases already faced problems in coping with their socio-economic situation: "The most pressing need experienced by the extended family and community in their efforts to cope with vulnerable children is their day-to-day inability to meet their own needs for food, clothing, shelter, health care, education and other basic requirements" (Government of Zambia, 1999: 20). The same report goes on to advocate differentiating between orphan and non-orphan children only when necessary, arguing that a focus on orphan children is important in terms of psychological support and counselling, but not in terms of basic needs such as food, clothing,

> **Case Study - Oshikoto Region**
>
> Julie (not her real name) is from the Tsumeb area and is 13. She lives with her aunt because her mother passed away in 1998. She does not know why her mother died, 'I was just told that she was very sick'. She does not know where her father is, 'I don't even know who he is'.
>
> She moved in with her aunt before her mother died, some three years before she died. She had joined her aunt in Tsumeb, leaving her mother at the farm, to continue with her schooling when she was ten, just a year before her mother died. 'I was not very close to my mother, but I do miss her a lot at times'. Sometimes she feels that her life would have been very difficult if her father had been present in her life.
>
> She has not received any assistance from anyone or from anywhere. She does not know any social workers.
>
> 'We need money for food and clothing.'

shelter, and access to health care and education (see Monk, 2000). This appears to be consistent with the Namibian findings.

> 'Here in Kunene Region the community is always standing together in times of difficulty, and they assist each other financially. Extended family members are committed to helping their relatives, no matter what.' Social worker, Kunene Region.

When asked who their primary caregiver was, most mentioned the person they identified as the one they lived with if they mentioned a woman (e.g., grandmother, aunt, sister), but rarely a male. In a number of cases, they were looked after by an older sister. Of interest, most respondents were able to identify a second or third adult, or even others, who they argued helped them in one way or another. Some noted support for schooling from family members aside from the household they were living in, from extended family members. Aunts and uncles were commonly mentioned in this regard.

In cases where the orphan was being looked after by a brother or sister, in most cases the person was an adult, although in a few cases the household appeared to have been child-headed. In these latter cases, links with other family members were uncommon, suggesting that these households are quite isolated.

When asked about their best friends, they mentioned both siblings and school mates. None mentioned feeling that they had no friends, and none mentioned problems in terms of socialisation.

Orphan FGD participants were asked how, if at all, their daily routines had changed since they became orphans. While many noted that the 'structure' of their lives had not changed, they argued that they were generally busier and had more chores to do now than before. Some noted that they felt that they were often emotionally upset, 'which was not such a problem before'. The findings are interesting in that they point out that, despite day to day living circumstances not being substantially different, the children's lives were indeed changing, and in so doing were becoming more stressful. While not measured quantitative, roughly two-thirds noted one or more such changes.

Case Study - Otjozondjupa Region

Lizzy (not her real name) is from Tsumeb and is 26 years old, and is looking after three children. She is looking after two of her own children and one child from her biological sister, who died; her sisters other children are living with other family members. The father of her youngest child is paying maintenance, and this is the money they live one. Lizzy used to work at the mine but she is now unemployed. 'Things have been very bad since the mine closed'. She borrows money from friends to purchase food and school fee money.

The child of her sister came to live in her household before her sister passed away. The sister was not taking care of her children, 'she was moving from one place to another with different men'. The children we originally living together with their grandmother, but she could not cope and the children were sent to other households.

'It was not hard for the child to adjust here, she is used to us, we have the same lives, there were not problems with adjustment'. 'She is part of our household, she is accepted here'. 'She doesn't have sleeping problems, she doesn't cry unnecessarily, she does not fight, she performs well in school, and she is interested in things around her'.

With the maintenance money, she is able to make sure that there is sufficient food in the house, but for anything else money has to be borrowed or given to them.

Except for the maintenance support and occasionally borrowing from friends, which is paid back, she does not rely on anyone, and has no links to any social workers.

If money were to be provided, we would pay school fees and to purchase food and school uniforms.

Summary findings are indicated below:

- Four out of five orphans in an FGD in Otjozondjupa Region noted that 'we are heavily-loaded with work that we have to do each day'. The fifth one noted that he was given the choice of doing the work and getting things he wanted, and that this was different than before. 'In the past our mothers used to help us with homework and housework, now we are the ones responsible for these things on our own'.

- In two FGDs in Kavango Region, all the participants felt that they were busier now than before their mother's died. In Kavango, the participants in one FGD felt that they were exploited, having to do more work than other children in the household, or doing work that they thought would normally be the duty of an adult. A few noted that they were beaten if they did not do their work properly, and one noted that he had been chased from the household more than once for 'not doing the chores properly'. In Khomas Region, a few of the participants also highlighted their feeling that the biological children of the caregiver were treated better than they were as orphans: "when I asked my aunt to buy me something she said that she had no money, but then went out and bought things for her children'.

- One participant in Khomas Region noted that, when her mother died in 1991, she was sent to live with her uncle. But, the uncle died in 1997 and her uncle's wife did not want to keep her. The child reported both regular verbal abuse.

- In the two Hardap Region FGDs, most participants noted that they were eating less now than when their mothers were alive, although a few noted that their grandmothers actually increased the amount of food they ate.

- In the two Hardap Region FGDs, most participants noted that 'we now have much work to do, work that we did not have to do before'. This was echoed by participants from Erongo Region.

- Some respondents noted that no one was assisting them with homework now, whereas before they could count on their mothers to assist.

- Many of the respondents across region indicated that they were eating less frequently than before.

- In one FGD in Oshana Region, the participants noted that they household chores had expanded dramatically. 'We used to do some chores, but now we do almost all the work around the house'.

When asked to consider whether any 'new' coping strategies had emerged given the rise in orphan numbers, social workers tended to believe that 'old' coping strategies that focused on a reliance on extended family members continued, and that new strategies were not underway. What was of concern was the sheer magnitude of the problem of HIV/AIDS that needed to be coped with, and complications arising particularly with the father's family in the case of AIDS deaths.

<u>Outside Support</u>

Overview

Foster (2000), in a study of AIDS orphans, noted eleven community-based activity areas that were being supported by NGOs in Zimbabwe that were believed to be central to the health and well-being of orphan children:

1) Identifying and monitoring the most vulnerable children.
2) Supporting community coping mechanisms.
3) Keeping children in school.
4) Income-generating activities.
5) Practical help and household training.
6) Crèche, child-minding facilities and recreation.
7) Community foster homes.
8) HIV prevention activities.
9) Volunteer training and motivation.
10) Registration and monitoring.
11) Child Welfare Forum establishment.

> "In most programmes [in Zimbabwe], the motivation of volunteers to provide care for children affected by AIDS is high and dropout rates are low, even in those programmes that provide no material incentives. The recognition by community members of the value of what volunteers are doing, very often linked with the volunteers' own sense of service to God, are strong motivating factors." Foster, 2000: 4.

Two common threads run through these eleven activities: *volunteerism* and *community-focused coping*. In the Zimbabwean study mentioned above (Foster, 2000), emphasis is placed on community-based support for infected and affected households. Noting that households and communities have applied historical coping mechanisms to deal with the AIDS pandemic, Foster suggests that emphasis should be focused on strengthening coping mechanisms where people already have experience, and providing 'safety net' support where coping cannot cope. Community-level coping mechanisms have included labour exchange

mechanisms, the provision of free labour in times of great need (e.g., planting season), seasonal agricultural loans or grants (cash or in-kind), child care, household maintenance, etc. These mechanisms have apparently been growing and expanding in scope because of the extreme challenges arising from the AIDS pandemic. Foster notes the rapid expansion of child-minding services, an extension of services that were offered when there are labour shortage, but also the extension of these child-minding services into the sporting and cultural arenas, including soccer, netball, traditional dancing and singing for orphan children.

Case Study - Oshana Region

Katie (not her real name) is from Onaanda village, and now lives in Okaukamasheshe with her husband and kids. There are 13 people in this household, one an orphan. Only three are adults, two females and one male, and are the remainder are children. All children of school-going age are in school.

They live on her husband's retirement money, he worked for Namdeb, as well as income from a small cuca shop where they sell sugar, bread and cigarettes. They also have an agricultural field and livestock to meet some of the household's needs. Now most of the retirement money has run out, and they generally live from income from the shop.

The orphan child is from a non-relative. The child was vary young when she arrived. When she first arrived she cried all the time and asked for her mother. The child was malnourished, so she had to spend a great deal of time helping the child to get her strength back. The child did some to adjust to her new lifestyle, and that did not take a long time. Sleepless nights, fighting, etc., 'these were not problems'. She gets along well with other children in the house and in the community.

The child has not, to her knowledge, been mis-treated or stigmatised by other children, 'we treat each other well here'. Children are well behaved. The child has the same responsibilities as all the other children commesurate with her age. She helps to collect water, crush mahangu, etc.

The orphan child is the best in school of all the children in the household. She has not missed any years in school, and is now twelve and in Grade 6.

Katie has not received any assistance for the orphan child. The mother of the child was still alive when the family took her, but not any more; no one knows about the father. When the mother was alive she visited the child, but as her TB got worse and worse this stopped. 'When she died no one else came to us and said that they would take care of the child, because the child was already staying here.'

'If Government is to assist, we need money for education, other basic needs, and shelter'.

Referring to experience to date in terms of outside support for local initiatives, Foster (2000: 3) notes that "Community-based orphan support initiatives have a demonstrable ability to target small amounts of material support to large numbers of orphan households in greatest need. Support may include school fees, food, clothing, blankets or agricultural inputs. To avoid creating dependency, many programme volunteers are instructed to avoid making promises of material support too early."

Foster does note the serious problems surrounding outside support in terms of income generating activities, and suggests that other exchange mechanisms are better placed to meet the needs of infected and affected households.

FGD caregivers were asked whether their households received any assistance -- moral, financial or otherwise -- from non-family members in their communities, or the communities in general, to assist with the orphans. Of interest, *none* indicated that they received assistance from other households, none mentioned the church or other community-based organisations/institutions, and none mentioned non-governmental organisations. Indeed, respondents did not even have any *expectations* of such assistance. Given the clearly perceived importance of such initiatives in the literature, the lack of such community networks to cope with HIV/AIDS in Namibia may be surprising.

Despite the importance of community support indicated in the international literature, the issue of helping to take care of orphans an the potential suspicion that the orphans were AIDS orphans appears to have led to unexpected dynamics in Namibia. How Namibia might, or might not, adopt community-based interventions as the second 'fall back' mechanism after

> "... for the carers in this study, the finding of meaning was a powerful way in which to redress the balance of the costs of caregiving with personal rewards. This study supports other work that has noted the involvement of lay carers in volunteer work following their caregiving role in the home. It extends our understanding of this by offering an explanation of how one group of caregivers perceives the function of their roles as volunteers in related organizations, such as hospices and HIV/AIDS agencies. This role is not purely to use the skills they have acquired but also to receive positive feedback for their efforts and to gain unconditional acceptance and acknowledgment in thee HIV field, something many of them could not do while they were an informal caregiver in the home due to their fear of being stigmatized." Carlisle, 2000. "The Search for Meaning in HIV and AIDS: The Carers' Experience", Qualitative Health Research, Vol. 10, No. 6.

reliance on extended families will certainly need careful consideration. Hunter and Williamson (1994: 24-25) highlight the need to achieve a balance between spontaneous community-based responses and outside encouragement for effective community-based interventions: "Such efforts may involve helping communities identify problems among vulnerable children and families and ways to support them, encouraging leaders to protect the property and inheritance rights of widows and orphans, organizing cooperative child care or labor support, training community members to assess needs and provide support, organizing orphan-visiting programs, or providing material or financial resources." They specifically list six key factors aimed as 'stimulating and strengthening community-based responses':

1)   respect community decision-making;
2)   enhance the community's ability to support vulnerable families
3)   organize orphan-visiting programs
4)   protect women's and children's property rights;
5)   provide training; and
6)   organize cooperative day care and labor support.

Elsewhere UNICEF/Mozambique (1999) advocate broad-based support for community-based interventions by outside agencies, including Government, donors, NGOs and private implementing agencies in cases where community resources are limited:

1)   income support to poor households with people living with HIV and AIDS or orphans;
2)   increased funding for public assistance programmes;
3)   tax credits to individuals, households, and businesses providing care;
4)   organisational support and inputs to community-based organisations;
5)   training and paying semi-professional caregivers and community workers;
6)   involving men in prevention and care-giving activities.

As part of key informant interviews, social workers were asked a series of questions about outside support, including community support, and where they as social workers fit into assisting these support networks. When asked what would help families and communities better cope with orphans, social workers gave mixed responses. Some felt that, because of high levels of poverty, most communities could not cope with the increase in orphans, and therefore 'the Government should budget for social relief'. Others argued that, as even Government could not provide sufficient support, donations from individuals and organisations were required. This required knowing who was looking after orphans and what their needs were, and social workers could not handle such a huge task on their own. Limitations on outside support were commonly mentioned by regional interviewees as well.

Social workers highlighted the fact that they alone could not handle all orphans in their regions, given that they were involved in many, varied activities, including counselling on marriage, rape, domestic violence, child abuse, drug abuse, as well as orphans issues across many communities. In fact, given heavy workloads, it was sometimes difficult to provide outreach, and this resulted in them only being able to effectively serve those who came to them for help. As a group of regional interviewees in Karas Region noted, 'we are only three social workers, yet we have to cover Keetmanshoop, Bethanie and Namaland'. Social workers did note that they worked with others in terms of referrals, and that those who did reach out to community members (e.g., community health workers) assisted in this regard. None, however, mentioned line ministry extension officers (e.g., agriculture), although these line ministries are felt to be key to improving outreach related to HIV/AIDS prevention and counselling.

When asked about outside support, most respondents indicated that no support had been received that assisted them with orphans, although things such as pension monies were certainly used. A few mentioned maintenance grants, but most did not.

Findings suggested varied levels of involvement of social workers in the HIV/AIDS arena, and with regard to orphan children. One social worker from Oshikoto Region noted that orphans were orphans, whatever the cause, and the circumstances facing orphans from varied causes and from various communities were more similar than dissimilar. A

> 'Most people that are HIV positive are shocked to hear about their status. We spend much time counseling people for just this, so that they will understand what it means, so that they will not go out and infect others, either through ignorance or on purpose'. Social Worker, central region.

number of social workers indicated that they did not work specifically in the HIV/AID arena 'as there are educators who specialise in this area', whether hospital or community-based. There was, however, significant variation across region, with Erongo Region and Khomas Region social workers apparently especially active in the HIV/AIDS arena. Over half of the respondents indicated that they did not know the extent to which there were HIV positive people in the community (a few felt that there weren't any).

One social worker who specifically handled counselling of people before and after HIV testing highlighted the importance of such counselling. She noted that, with few exceptions, all those who tested HIV positive were shocked by their results, and did not fully see how they could have been infected. She further noted that it was particularly problematic to help people adjust to live after finding out that they were HIV

positive. Because of secrecy around the issue, those tested were unwilling to discuss it with sexual partners, and therefore continued to risk infecting others.

Tumba (not her real name) is 51 years old and lives with her husband and 11 orphan children in a squatter campe in Rundu. She had three daughters, but all three died, one in 1995, another in 1998, and the third in 2000. The first daughter died of 'a disease she got from her husband', the second died after a short illness, and the third died of malaria after being sick for some time. In addition to her and her husband and 11 orphan children, there are five others living in the household. Three are unemployed males aged 26-28, one is an unemployed female with a one-year old. The orphans range in age from one to sixteen.

The house consists of five huts of which three are thatched all round, one is made of mud, and the other is made of corrugated iron. The girls and boys sleep in separate areas.

Her husband is the only one in the household with work, at a construction company, and he makes between N$100-200 per month depending on my much work there is. He also gets an old age pension of N$160 per months. Tumba sometimes brews traditional beer as well, to supplement their income. They regularly go to bed hungry.

She complains that Rundu is not a community, and that there is no help from others: 'the whole community and even our neighbours are indifferent to our suffering. This is not like it is in rural areas, where we are close to each other'.

Only 5 of the 11 orphans are in school, all of whom are in lower grades. The older ones have had to drop out because school expenses are too high.

Tumba reports that, when the daughters were alive, times were tough, but now 'it is beyond our ability to look after them'. She is concerned that she is getting too old. 'It is worse because some of the younger orphans are always sick, and we cannot afford to take them to hospital. Two of the younger ones have wounds that will not heal.

Tumba and her husband decided to look after the orphans because they were biologically their grandparents, and felt obliged to do so. One of the daughter's husbands sold all of the household possessions and abandoned them, while othe other two live nearby but offer no support. Indeed, the younger children do not even know their fathers at all because they were very young.

Tumba had some of the orphans registered for the maintenance grant 'a long time ago', but to date nothing had come of it. I was told that the forms were incomplete and that I needed to provide certain documents to prove things. I was sent from one office to another without any success'.

A number of social workers did not feel that those in need of support were receiving such support, because of the lack of openness about HIV status. When they became ill, they were cared for, but if there was suspicion about AIDS, support from neighbours was felt to be more problematic. However, little was known about whether such support was offered within the community, and most social workers indicated that they were unaware of any such support channels.

Social workers were asked what happens in cases where the husband dies, leaving the wife looking after the children. While not classified as 'orphans' in the international literature, Namibia has defined paternal orphans as orphans. What situations might such households face? A number of the respondents indicated that such a situation was one of the reasons that people were not open about AIDS, because if a widow expected continued support from the family and friends, she could not mention AIDS. Respondents in the north central regions highlighted the potential loss of possessions and housing 'if the wife is chased out of the house together with the children'. In the northeast and south, inheritance patterns were different, and these problems were felt to less of a concern. While overall negative patterns of inheritance was felt to be less of a problem now than before, it still occurred.

Caregiver FGD participants were asked to indicate the types of priority assistance they required to look after the orphan children. Of interest, some of the respondents argued that the best means of support would be prevention of the problem.

A number of respondents felt that, given the AIDS epidemic, more attention should be paid to AIDS prevention, and that people need to know why they

> For children who cannot be cared for by family members or the broader community, "They need a third line of response. Under national law and the United Nations Convention on the Rights of the Child, national governments have the ultimate responsibility to ensure that children are protected and cared for if they are on their own or if those with whom they live are unable or unwilling to care for them adequately." Hunter and Williamson, 1994. <u>Children on the Brink. Strategies to Support Children Isolated by HIV/AIDS</u>, USAID, Washington.

need to be careful in deciding about sex. 'Some people still do not think that AIDS exists, we need to see videos'.

In terms of practical assistance, common responses included the following:

Most Commonly Mentioned

- Payment of school fees for orphans.
- Assistance with the purchase of school uniform.
- Food assistance to ensure that the child is properly nourished.
- Payment of a monthly stipend for orphans ('it could be distributed with old age pensions').
- Clothes ('even second hand clothes are okay').
- Blankets.

> "In Namibia ... remittances are especially important due to the country's specific geographical, historical and economic context. Namibia's population and natural resources are distributed such that the majority of the people live far away from the major sources of formal sector employment. During the colonial era, a widespread system of migrant labour was established, the effects of which are still present today. Add to the picture a highly dualistic economy, where wages in the formal sector are much higher than in the informal sector, and a cultural context which places a high priority on the extended family, and it is clear that remittances will continue to function as an important mechanism of economic redistribution and social stability far into Namibia's future." (Hastings, 1999: 1)

Also Mentioned

- Free treatment of orphans at Government clinics or hospitals.
- Counselling so that the children adjust ('we need to be counselled as well').
- Special attention to disabled orphans.
- School books.
- Bursaries to cover all costs.
- Tractor support services.
- Shoes for the orphans.
- Assistance with shelter for the orphans.

Regional interviewees highlighted the importance of linking orphans with support services, particularly linking caregivers with those able to counsel them.

When asked to give a value that such assistance, respondents suggested the following:

- Caprivi Region - Group 1 N$500; Group 2 N$500; Group 3 N$500
- Erongo Region - Group 1 N$200-500; Group 2 N$500-1000
- Hardap Region - Group 1 N$200-300; Group 2 N$300-500
- Karas Region - Group 1 N$250-500; Group 2 N$150-300; Group 3 N$150-500
- Kavango Region - Group 1 N$300-400
- Khomas Region - Group 1 N$200-500

- Kunene Region - Group 1 N$200-300; Group 2 N$260-400
- Ohangwena Region - Group 1 N$200; Group 2 N$500-1000
- Omaheke Region - Group 1 N$250-500; Group 2 N$300; Group 3 N$200-300; Group 4 N$200
- Omusati Region - Group 1 N$150-400
- Oshana Region - Group 1 N$100; Group 2 N$100; Group 3 N$250-300
- Oshikoto Region - Group 1 N$200; Group 2 N$300
- Otjozondjupa Region - Group 1 N$200; Group 2 N$250-300; Group 3 N$200

> "Providing support to children affected by AIDS ... is not simply a humanitarian necessity: meeting the basic needs of growing numbers of children is a developmental necessity too." (Foster, 2000: 2)

If money or non-monetary resources were to be provided, respondents were asked how the support could be provided so that it best reached children, orphans and others. With few exceptions, respondents were surprised that someone could believe that the money would be mis-used, as the need for the money for orphan support was, in their minds, very clear. Respondents did not think that the money would be 'diverted' to other uses, but did note that, to avoid confusion, it should not simply be linked to an increase in the pension. Rather, it should be a separate stipend. This was particularly important, given that many households looking after orphans were not headed by pensioners, and did not necessarily all contain pensioners. If the money were added to pensions, there needed to be controls in place to make sure that the purpose of the money was properly understood, and that it use should be overseen.

To meet the longer-term interests of the orphan children, virtually all of the respondents suggested that savings accounts could be opened in the children's names. It could be drawn upon for studies.

For *non-monetary support*, answers were more diverse. Many suggested the involvement of social workers, together with local authorities, to ensure that the items were properly distributed. Suggestions included headmen and church elders. The key was that the process should be transparent and fair.

When asked if the distribution of monetary and non-monetary resources would stigmatise families looking after orphans, most felt that this would not be a problem but, even if it was, the need was so great that the households were willing to live with any such stigmatisation.

When asked whether there should be any sort of 'needs test' before support was offered, most respondents felt that such a means test would be fair. However, the situation of households would have to be assessed over time, in case their circumstances changed. Further, if the support could be 'stretched' to cover all households looking after orphans, it should do so. When asked what would be the basis for such a 'means test', all focus groups except two had the exact same ranking:

1. Absence of wage earner.
2. Household with many children.
3. Non ownership of livestock.
4. Household without other means of financial support.
5. Household with a wage earner who was employed casually.

For the two that did not rank the five the same way, the only difference was that responses one and two were reversed.

If a figure of N$200 were adopted, and given an estimated 89,000 orphans as of 2001 and 250,000 orphans projected for 2015, this would imply N$18 million per month and over N$200 million per annum for 2001 and N$50 million per month and N$600 million for 2015 for *direct* subventions (*excluding* administrative costs, which may double the costs). Assuming an inflationary adjustment of 10% per annum from 2001 to 2015, the monthly figure would be over N$800 per month by 2015, giving an astonishing revised annual figure of N$2.4 billion for 2015.

However, if a means tested subvention were to be offered, and assuming that one-quarter of the caregiving households would meet the relevant criteria, flat costs would be some N$17 million in 2001 and N$150 million for 2015. Further, assuming that the *household* were to receive a total of N$200 for *all* orphan children, and assuming that there were an average of two orphans per caregiving household in 2001 and three in 2015,

> Kundya (not her real name) is 30 years old and lives at Kaisosi in Kavango Region. Her sister and her sister's husband died last year after ailing for a long time. She things her sister died of liver-related illness. When they died, they left behind two boys aged 9 and 13 and two girls aged 1 and 11. The 1 year old soon died after her parents however, 'because she was not getting enough food'.
>
> The three orphans now live with her and her husband and her three own children, aged 1, 4 and 5. They live in a one-bedroom shack.
>
> Both she and her husband are involved in selling at the open market in Rundu, and also have a field. However, harvests are often poor.
>
> Kundya feels that the three orphans are a heavy burden on her and her husband as 'we don't get much support from the rest of the family'. Her husband's mother gives them some money from her pension, and this helps. The orphans' biological family does nothing to support them 'because they believe that my sister bewitched her husband'. Kundya finds this especially upsetting because her sister's husband's family inherited all of the households goods and property.
>
> All three orphans are in school, although they are too old for the grades they are in. The children have adjusted well and are making progress in school. However, she has not been able to meet school fee expenses, and reports having received a letter from the school informing her that, should the children not come in uniforms and should school fees not be paid, the children will not be readmitted next year.
>
> The older male orphan says that Kundya is 'just like our mother, I am very happy that we are staying with her. She is looking after us well'. He is very upset with his father's family, noting 'I want to know why they don't want to give us money, our father used to give money to them when he was alive'.
>
> Kundya could not register the children for the Maintenance Grant because she could not produce the parents' death certificates because these were apparently lost. She was advised to obtain new certificates from the court, but this was also refused and she does not know why. 'I don't know what to do'.

this would give the following costs: 2001 - **N$8.5 million** per annum; 2015 - **N$75** million per annum (with no inflationary increment nor any other adjustment), again *excluding* administrative costs.

Psychological Issues

Overview

As UNICEF (1995: 99) notes, there has been a tendency to focus on what are perceived to be the more tangible aspects of orphanhood--the economic stresses, problems related to social service access, risk behaviours, social impacts. In recent years there has been a growing appreciation of the need to counsel in particular infected households, and to a lesser degree affected households, but it is uncertain the extent to which this has reached the affected children themselves. Findings from the fieldwork suggest that most of the orphaned children had little to no say in determining their own future, and often expressed a sense of helplessness. They often felt that their concerns and anxieties were not adequately recognised nor

responded to. UNICEF (1995: 99) have identified programmatic elements for psychological support as including "... helping infected parents fulfill their normal roles; enabling children to express their fears and concerns about a parent's illness and what will happen to them; and helping extended families and communities provide consistent support for children." Later in the same report UNICEF (1995: 102) argued that "Before a parent dies it is essential to deal constructively with children's fears about how and where they will live and with whom and about how they will stay in school ... Religious and traditional practices for dealing with grief and mourning permit the expression and release of intense emotions, which helps survivors recover".

> "Children affected by HIV / AIDS suffer anxiety and fear during the years of parental illness, then grief and trauma with the death of a parent. Less tangible than the material problems children suffer, these psychosocial problems have only rarely been addressed in programmes in the developing world, although they are frequently of concern to staff and can have serious long-term impacts on children."
> UNICEF, 1995: 99.

The traumas facing children in households where someone is HIV positive are well summarised in ActionAid (1993: 8-9): "Since most people with AIDS die at home, children also have to cope with the anguish of seeing a mother or father, or both, dying in great physical and emotional distress. Even before developing the clinical symptoms of AIDS, adults infected with HIV typically suffer from bouts of severe illness for four or five years, when they require frequent medical care and nursing. During the terminal stage of the illness, which usually lasts at least 12 months and sometimes longer, the person with AIDS is likely to be bedridden, may be physically disfigured and may also suffer from incontinence. Mental or emotional disturbances are also common. At the same time, many children will also experience the death of a younger brother or sister from AIDS after one or two years of illness".[3]

Situation in Namibia

Caregivers were asked about any emotional adjustment problems orphan children had with the death of their parent(s) and 'joining' the caregiving household. Many of the respondents felt that such adjustment problems were minimised by the fact that the children were already in, or were entering into, a caring environment. 'Members of the family did not say anything bad about their being orphans'. In cases where orphan children and the biological children of caregivers had lived together for some time, adjustment problems were felt to be minimal. 'The children are not new to our households, and anyway we have the same culture'.

However, despite a minimum adjustment to new households for most of the orphans, the death of the parent certainly had an emotional impact. Some respondents noted that the children's studies suffered, others said that the children were 'difficult to handle emotionally', but these problems were relatively uncommon. Where children were taken in by households that differed markedly from those they came from, adjustments were reported to be more problematic. One household in Omusati Region, for example, was taking care of children who came from Windhoek. 'They are used to high life, they are now refusing to

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[3] Psycho-social impacts are detailed in a document by Madorin (1999), "Manual. Psycho-Social Support of Children Affected by AIDS", published by terre des hommes Switzerland and Novartis Foundation for Sustainable Development". The report points out that many of the effects are not easily discernable to observers, even caregivers, nor the children themselves, and do not necessarily present themselves as behavioural problems. The questions to caregivers and orphans, therefore, refer to impacts as perceived by these affected parties themselves, and may miss more deep-seated problems.

eat their food here. And, they are difficult in not wanting to play with my children, one is a bully and he beats my children'.

Another noted that 'these orphan children are used to a fancy life. Whenever there are no apples, simba chips, or sweets in the lunch boxes, they refuse to go to school. They would just cry for the whole day and ask for their mother'. These problems tended to go away over time as these 'outside' children adjusted to their new lives, but 'some never adjust to life here'. Mostly, however, that reported initial emotional adjustment problems indicated that these 'disappeared soon after the children arrived, the crying and fighting soon ended, and the children adapted'.

Practical coping issues did require some adjustment when the orphan children from outside first arrived, but was not problematic for those children already 'used to' the caregiver's household. FGD participants in Caprivi, for example, noted that there was a shortage of blankets and sleeping areas, and sometimes these things were fought over. Food was sometimes a problem, because at some points in the year it was in short supply, and the arrival of the orphans make a bad problem worse. Clothing was mentioned, albeit less frequently. There were also complications sometimes arising from older boys and older girls and sleeping arrangements.

As noted above, household-level adjustment was generally not a long-term or serious problem. Caregivers were also asked whether the orphans were able to adjust to live in the community. For those who had always lived there, no such adjustment was necessary. For 'outside' orphans, virtually *none* noted any such adjustment problems.

Impacts on Education

Overview

HIV/AIDS affects the education sector in three key ways: 1) if affects the *supply* of education because of educator illness and death; 2) if affects *demand* for education as fewer children are born and orphan children are increasingly unable to attend; and 3) it affects the quality of education as educational resources are increasingly stretched and class sizes grow (see Verde Azul, 2001, for a study on the impact of HIV/AIDS on the education sector in Mozambique, and JTK, 2000 for a study on the impact of HIV/AIDS on the education sector in Swaziland, in both cases assisted by SIAPAC; a study by the Ministry of Basic Education and Culture in Namibia is current (mid-2001) underway, with results expected out in 2002).

One of the most commonly-noted impacts of AIDS on young children is the withdrawal of children in affected households from school. Studies in Uganda showed that, following the death of one or both parents, the chance of the child attending school halved. Even those who attended school spent less time there than they did formerly. Impacts occur well before the death of one or both parents, as resources are diverted to the care of a terminally ill household member, as additional home-based or agricultural labour is required, as children need to look for income-earning opportunities, and as the emotional trauma of a parent dying takes it toll. Studies in Zimbabwe and Kenya note that even those children who manage to stay in school are more likely to repeat classes or enter schooling late (UNAIDS, 2000).

In a study of the impact of HIV/AIDS on the education sector in Swaziland (JTK, 2000), respondents noted that it was increasingly difficult for households affected by AIDS to keep children in school. Many schools had, in response, tried to accommodate these children through school fee waivers, but other responses (such as flexible school hours, after-school lessons, etc.) were extremely uncommon. Further, agricultural and home-based labour demands on school-aged children were noted to have risen as dying parents had to withdraw their labour. When parents died and children went to the households of extended family member, they often ended up in households already short of labour (particularly in households with elderly heads), or joined families where expenditure on education for their own children was already stretched.

The issue of school fee waivers for orphans is by no means non-controversial. Lack of affordability is not a new problem, and is not unique to orphans. Increasingly programmes to support continued attendance of orphan children in school focus on *needy* children, rather than on orphan children. In Zambia, for example, schools fees for needy children can take place through the Public Welfare Assistance Scheme. Although under-funded and little known by affected households, the scheme is considered to be an effective basis for building such an intervention. Such an intervention would be seen, however, as a *supplement* to community-based bursary schools that raise finances locally, which the Zambian study found to be more effective and efficient in targeting needy households (Government of Zambia, 1999).

The impact of their emergent status on the educational opportunities facing orphan children is often one of the key concerns raised both by policymakers and by affected households. What is less commonly known is how early the educational status of children in infected households are affected by the pandemic. UNICEF (1995: 13) notes that the stresses facing children who are coming to terms with the death of a parent (or both parents) can have a direct impact on schooling, with these stresses causing "... difficulty concentrating in school and behavioral problems. Teachers have identified such effects as a sudden drop in academic performance, becoming detached or sullen, ill health and truancy."

Situation in Namibia

Orphan FGD participants were asked about the impact of their orphan status on education. While most were *currently* in school, some feared for the completion of their education. However, most felt that their caregivers were serious about their education, and felt that this would help ensure that they would continue in school and have careers. Situations included the following:

- Otjozondjupa - All five participants had doubts that they would ever complete their schooling due to financial problems. 'Even now we have to beg for money to pay for school fees'. One noted that 'I do not know if I will complete my education because my uncle's wife, who pays for my school fees, does not like me and always complains when she has to pay the fees'. Another noted that her caregiver 'always complains that there is no money', and that 'the school fees are taking money away from more immediate expenses'. Another noted that her brother, who used to pay her school fees, had lost his job and no could no longer afford the fees. Another noted that they only managed to pay half the school fees, but that the school had taken her anyway.

- Otjozondjupa - The other FGD participants were less concerned about completing their education. From better off families, they felt that affordability would not be a problem.

- Kavango - Participants from two FGDs were concerned about completing their education. 'Money for school is always difficult to find'. For those living with grandmothers, they mentioned that 'our grannies are getting old, and then there is no one'. Participants in a third FGD from relatively well-off households raised concerns about ability to pay at the high school level, because 'expenses are much more at this level'.

- Erongo - Some participants had managed to negotiate that their children stay in school even if no school fees could be found. The caregivers did worry that if they could not find the funds the school would throw the children out. One interesting problem was raised about hostel fees in cases where caregivers could not afford to keep the children at the school. As a result, the children had to live with the caregivers and move back and forth to distant schools each day. In a number of cases, the children would miss days of school.

- Hardap, Erongo and Khomas - Most participants generally felt that they would be able to continue their schooling, and did not feel that their orphan status was a particular problem. Many of these felt that their relatives supported them both financially and morally in school. Some had very specific career goals, and did not perceive these goals to be hindered by their orphan status. This also held for participants from Caprivi Region.

- Across regions, many participants gave examples of how their caregivers had 'gone to lengths' to cover school fees and make sure that the orphans continued in school, despite stresses. This often involved calling upon the resources of extended family members, particularly employed relatives in urban areas.

Despite most of the orphan children still being sent to school, when asked about the economic 'burden' of looking after the orphans, caregivers commonly mentioned school-related expenditures, in particular school uniforms. This held across region.

> Only a few orphans noted that other children in school made fun of them because of their orphan status.

Impacts on Rural Livelihoods

Overview

It is perhaps in the area of small-scale arable agriculture that the negative effects of AIDS on household livelihoods has been most pronounced (see AIDS Brief, 1999), and to a much lesser extent in other rural livelihoods (e.g., small enterprises, trade, etc.). In an extremely detailed investigation of a community in northwestern Tanzania, Rugalema (1999) outlines in detail the varied effects AIDS illnesses and deaths have on households, specifically household agriculture (arable and livestock). Elsewhere UNAIDS (2000:32) notes that "the effect of AIDS is devastating at family level. As an infected farmer becomes increasingly ill, he and the family members looking after him spend less and less time working on his family's crops. The family begins to lose income from unmarketed or incompletely tended cash crops, has to buy food it normally grows for itself, and may even have to sell off farm equipment or household goods to survive". Many arable smallholder farming households in Namibia already suffer severe labour shortages due to high out-migration of able-bodied men and women to seek wage employment where returns on investment are considerably higher. These shortages are intensified by the nature of the rainy season in Namibia, where considerable labour is required for short 'windows of opportunity'. If these brief window periods are missed, arable production can be dramatically reduced, making smallholder arable production in Namibia particularly vulnerable to HIV/AIDS (see AIDS Brief, 1999).

In a study in Thailand, there was a clear relationship between the loss of household labour due to AIDS and reduced agricultural output. In households that were already short of labour before AIDS illness and death, agricultural output dropped by half. In Ivory Coast, food consumption went down an average of 41% per

capita in AIDS-affected households (UNAIDS, 2000). In these circumstances, the importance of accelerating adoption of labour-saving technology is seen as key (Mutangadura, Rugalema, Jackson and Mukurazita, 1998).

Situation in Namibia

There have been a few studies on the impacts AIDS and agriculture in Namibia (FAO, 1999 and MAWRD, 1999; see also SAfAIDS, 2001). Although the information is largely anecdotal, projections carried out by the Food and Agricultural Organisation of the United Nations (FAO) suggests that "Namibia will be the worst hit among the most affected countries in Africa" (The Namibia, 15 May, 2001: 3). The FAO noted that the impact was largely in terms of the loss of able-bodied adults and seasonal labour, both on communal and commercial farms. In the latter case, there was concern about the impacts of labour shortages on export market commitments. Briefly, impacts on agriculture can be divided into five arenas for Namibia:

- Impacts on smallholder farming (livestock, arable, mixed).
- Impacts on commercial and commercialised agriculture.
- Impacts on irrigated agriculture.
- Impacts on specialised crop production for export markets.
- Impacts on the *supply* of services by Government and other delivery agencies.

The FAO study (1999) looked at the varied impacts on smallholder households in northern Namibia. What is important to consider with regard to orphans is the 'downstream' impacts on these children arising from reduced food security due to the loss of labour and the sale of

"Over 50 percent of the communities reported sale of livestock as the means of covering direct costs caused by sickness and death. This diverts critical crop production resources (draft power and manure), essential animal food products (meat and milk) and the returns in cash or kind from the mobile bank away from the household's normal use ... Besides siphoning off physical and material production resources, HIV / AIDS morbidity and mortality also reduce the labour available in the household for both on-farm and off-farm work. Households which were previously worker-sufficient become worker-deficient, and those already worker-deficient become severely worker-deficient. Worker-deficient households are know to cultivate smaller areas, own less livestock, earn less off-farm income, and have less total household welfare compared with worker sufficient households." (FAO: 2000: iii)

productive assets. As HIV / AIDS has a negative effect on labour availability, labour substitution of younger children may occur. Field findings suggest that this is, indeed, the case in the north where labour allocation is required for arable production, but to a lesser extent for livestock.

However, the issue is not necessarily this straightforward. It is interesting to note that many households investigated in the FAO study (1999) were *already* worker deficient priority to illness and death. This is not surprising, given that the return on investment of labour is generally higher in other economic sectors than in agriculture (reflected in high out-migration to seek formal sector work and off-farm investments). The labour of children is often, therefore, already allocated to agriculture, particularly during peek demand. It is therefore not surprising that FGD participants noted that the orphan children contributed towards agricultural production 'just like our own children'.

The burden was highest in the crop growing regions, particularly during peak seasonal demand, but virtually none of the respondents felt that they burdened the orphan children any more than their own with agricultural chores. Of interest, in most cases the death of the parents of the orphans did not appear to affect

the agricultural production of the caregiving household, as their labour tended to be allocated elsewhere, and not in agriculture.

In crop-growing regions where the parent contributed during high labour demand times, there was an impact, but the orphans themselves tended to substitute for this labour as much as possible (but only the older ones). Some reported looking after livestock, but most did not have livestock-related responsibilities. This did not vary across crop-growing and non-crop growing regions.

Most of the caregivers noted that the parents of the orphans did not make provision for the economic well-being of their children before the parents died. The problem was not one of intent, rather it was an inability to afford to do so due to a lack of employment. In a few cases provision was made through insurance companies for those in good employment in urban areas, but this was not common.

What tended to be more important was 'networking' among extended family members, pointing out that caregiving households tended to receive support from other extended family households. Most caregiving households highlighted

> **Case Study - Omaheke Region**
>
> Linde (not her real name) is from a San family in the Rietfontein area where she lives with her boyfriend as well as two orphan children.
>
> The mother of the children was her daughter, and she died in 1997 of cancer. The father is still alive, and he works on a farm, and he still assists sometimes.
>
> She does not know the precise age of the children, but both are of school-going age but are not in school. They survive economically on odd jobs that the boyfriend does, and her pension. They tried to grow crops, but could not because they are on a commercial farm.
>
> After the death the police brought the children to their grandmother because 'there was no one else'. The children were very young when they arrived, and there was no time to prepare for their arrival. They did not have any beds or blankets, so they made blankets out of maizemeal bags. They had problems adjusting as well, and cried a lot.
>
> They often borrowed food from neighbours, because they do not receive any assistance from social workers or non-relatives.
>
> The children were not ostracised due to their orphan status, they were well accepted in the community.
>
> She wanted to be visited by the social workers so that they could get help. She would really appreciate assistance from social workers.

the importance of this support, given the negative economic impacts the arrival of multiple orphans has on households that, in many cases, are already poor, and who have now lost one source of income/transfers/remittances. Indeed, a majority of FGDs noted a negative economic impact arising from the children's arrival, particularly those with few income sources and a high reliance on pensions. In other households, where the children were already living there, the problem was only encountered if the parent had been contributing economically to the household, and this was not always the case. As noted above, school-related expenditures were viewed as particularly problematic.

Annex A: Definitions and Clarifications

AIDS

Acquired Immune Deficiency Syndrome (AIDS), a collection of symptomatic conditions caused by the Human Immunodeficiency Virus. AIDS develops once HIV has weakened the immune system to such an extent that illnesses easily and regularly attack the body. Although there are a number of other symptoms, when three 'symptoms' present themselves, it is generally acknowledged that AIDS has set in: 1) weight loss of 10% or more (for infants, could also included abnormally slow growth); 2) chronic diarrhoea lasting one month or more; and 3) prolonged fever lasting longer than one month.

The 'A' stands for acquired, meaning that the virus is not spread through casual or inadvertent contact, such as flues do. In order to be infected, they have to be directly exposed to the virus. 'I' and 'D' stand for immunodeficiency. The virus attacks a person's immune system and makes the system less capable of fighting infections, making the immune system deficient. 'S' is for syndrome, because AIDS is not just one disease, rather it presents itself as a number of diseases that set in as the immune system fails.

Measuring AIDS is problematic. In areas where CD4 counts and viral loads can be measured, AIDS is defined as having set in for people who have CD4 counts below 200. Where measures of CD4 counts and viral loads are not possible, AIDS is usually defined clinically, that is, by examining the patient and making an assessment of their condition.

AIDS Orphan

A child aged 0-15 who has lost her/his mother, or who has lost both parents to AIDS.

Asymptomatic HIV
  Infection

The stage of HIV infection prior to the development of illness or clinical signs and symptoms.

Base Year

Year upon which projections are based.

Counselling

Dialogue between a person in need and a care provider with the aim of reducing the stressful impact of HIV/AIDS on the individual and family and preventing transmission of HIV infection. Information, education and psychological support are given in a way which allows the individual and the family to make decisions that facilitate preventive behaviours.

Epidemic

A situation where a disease is prevalent over an entire area or an entire country.

Epidemiology

The study of the incidence, distribution and determinants of an infection, disease or other health-related event in a population. Epidemiology can be thought of in terms of who, where, when, what and why. That is, who has the infection/disease, where are they located geographically, and in relation to each other, when is the infection/disease occurring, what is the cause, and why did it occur.

Focus Group Discussion

A discussion held among a small group of people (usually 5-9) on a specific set of issues. Usually comprised of people who are in a similar situation, or are alike in another way.

Gender

Family Care Internationally (1999), in a pamphlet on 'sexual and reproductive health', define gender as follows: "Gender refers to the socially defined roles and responsibilities of men and women and boys and girls. *Male and female gender roles are learned from families and communities and vary by culture and generation. Gender equality* means the absence of discrimination, on the basis of a person's sex, in opportunities, in the allocation of resources or benefits, or in access to services. *Gender equity*

	means fairness and justice in the distribution of benefits and responsibilities between women and men, and often requires women-specific projects and programmes to end existing inequalities."
Heterosexual Sex	Sex between men and women.
HIV	Human immunodeficiency virus (HIV) is a virus which attacks the body's immune system. HIV slowly destroys the immune system reducing the body's ability to flight off illness. When the immune systems weakens, a person becomes vulnerable to illnesses which normally would not have affected her/him.
	There are two basic types of HIV, with HIV 1 being most common in Southern Africa and HIV 2 which is most common in West Africa. HIV 1 is more easily transmitted than HIV 2 and the period between initial infection and illness is shorter for HIV 1; these two factors may account for the difference in the spread of HIV between Southern and West Africa. There are some nine subtypes of HIV-1.
HIV Infection	HIV is primarily a sexually transmitted infection, passed on through unprotected penetrative sex. The virus can also be transmitted through blood transfusions, the use of unsterilised injection equipment or cutting instruments and from an infected woman to her fetus or nursing infant. While some individuals experience mild HIV-related diseases soon after initial infection, nearly all then remain well for years (see Asymptomatic HIV Infection). Then, as the virus gradually damages their immune system, they begin to develop illness of increasing severity, characterised by various combinations of symptoms and diseases, such as diarrhoea, fever, wasting, fungal infections, tuberculosis, pneumonia, lymphoma, failure to thrive and Kaposi's sarcoma.
HIV Sentinel Survey	The systematic collection and testing of blood from selected populations at specific sites for the purpose of identifying trends in HIV prevalence over time and location.
HIV to AIDS	Loewenson and Whiteside in Whiteside (1998: 13-14) explain what happens during the 'transition' period between HIV and AIDS as follows: "As the body's defense system weakens symptoms appear, alone or severally. They include: chronic fatigue or weakness, diarrhoea, minor skin infections, respiratory problems, sustained weight loss, persistent swelling of the lymph nodes, deterioration of the central nervous system. As the immune system weakens more severe diseases manifest themselves, such as cryptococcal meningitis, thuberculisis, pneumocystic pneumonia and cancers ... This more severe phase can continue for up to two years before death, with progressively longer periods of illness that may be inter-spersed with periods of remission. The median time from infection to development of AIDS in industrialised countries is 10-11 years, while in sub-Saharan Africa it is estimated to be 5-10 years. Most infected children will die before their fifth birthdays."
	Whiteside and Sunter (2000: 2) noted that "... the new advanced drug therapies make it possible for people to move back from a state of AIDS, when they are very sick, to being HIV positive and leading normal lives again".
Immunodeficiency	The inability of the immune system to satisfactorily protect the body, which results in an increased susceptibility to various cancers and opportunistic infections.
Incidence	The frequency of new infections during a designated time period expressed as a proportion of the population at risk of the infection, disease or other health-related event.

Incubation Period	The time interval between HIV infection and the onset of AIDS.

Infectiousness   The relative ease with which a disease is transmitted. According to Whiteside and Sunter (2000: 10), "... each HIV-positive person is likely to infect five others during his or her lifetime". If it drops to 1:1 or lower, infection rates will fall.

The degree of infectiousness of HIV varies over the course of the incubation period, and is probably highest when people are first infected (prior to development of antibodies) and when they are symptomatic. Whiteside and Sunter (2000: 8) describes the process as follows: "During the early stages of infection, the antibodies to the virus (which we usually test for) may not be identifiable. This is called the 'window period'. An infected person will be very infectious during this phase. Equally, at this time a person may experience a short bout of illness. The cause is a rapid multiplication of the virus and a correspondingly rapid response from the body. A cattle commences between the virus and the immune system, described as the incubation period. During this stage, the viruses and the cells which they attack are reproducing rapidly and being destroyed as quickly by each other. Eventually, the virus is able to destroy the immune cells more quickly than they can be replaced and slowly the number of CD4 cells falls. In a healthy person, there are 1,200 CD4 cells per microlitre of blood. As the infection progresses, the number will fall to about 200 or less. At this point, new opportunistic infections begin to occur and a person is said to have AIDS. The infections will increase in frequency, severity and duration until the person dies. It is therefore the opportunistic infections that cause the syndrome referred to as AIDS."

UNDP/BIDPA (2000: 9-11), in a study in Botswana, overview issues surrounding risk of transmission of HIV, summarised in the following table:

Mode of Transmission	Probability of Infection per 100 Exposures	Global Percentage of Infection
Sexual Transmission	0.033-0.2	70-80%
Mother to Child	13-48	5-10%
Sharing of Injection Equipment	na	5-10%
Blood Transfusion	90-100	5-10%
Accidental Needle Stick Injuries	0.3	less than 0.01%

Sexual Transmission - "The vast majority of HIV infections are the result of sexual transmission resulting from unprotected vaginal sex. Male to female sexual transmission of HIV is more efficient than female to male transmission, the risk to women may be up to four times higher than to men. The major factors responsible for this are the larger mucosal surface area exposed to the virus in women, and the greater viral concentration present in semen compared with vaginal secretions."

STIs - "The presence of sexually transmitted infections (STIs) will greatly increase the change of HIV infection, because there is more chance of the skin, or membranes being broken and allowing the virus to enter the body. Furthermore the cells the virus is seeking to infect will be concentrated at the site of the STI - because these cells are fighting infection."

Age - "An early onset of sexual activity has implications for HIV risk because it is often associated with a higher likelihood of casual sex activity ... Such practices increase the risk of STD and HIV acquisition in both men and women before they marry. The common practice of older men having sex with young women also increases the risk that women will acquire HIV at an early age."

"Mother-to-Child Transmission (MTCT) - "The child can be infected with HIV before birth, or during delivery, or through breastfeeding. A number of factors influence the risk of infection, particularly the viral load of the mother at birth - the higher the load the higher the risk. A low CD4 count is

also associated with increased risk. Anti-retroviral drugs may decrease the viral load and therefore decrease the risk of MTCT."

Intervention	A set of activities through which a strategy is implemented. For example, promoting safer sexual behaviours is one intervention to reduce sexual transmission of HIV.
Key Informant Interview	One-on-one interviews with those who, by their position or through their influence, are considered to be knowledgeable or influential with regard to an issue or set of issues.
Model	A model is a construct that is developed in an attempt to represent the real world. Models are usually expressed in the form of a mathematical equation or set of equations that represent an object or a system.
Morbidity Rates	The percentage ill over a particular span of time.
Mortality Rates	The percentage who die during a particular span of time.
Opportunistic Infections	Infections that are caused by microorganisms which the body's immune system is normally able to fight off. When the immune system is weakened or destroyed, as in HIV infection, opportunistic infections can then take hold.
Person Living with HIV	An individual infected with HIV, also called a person who is HIV positive or a person who is HIV seropositive. As soon as an individual becomes infected, s/he is capable of infecting others through sex, blood and perinatally. HIV infection is lifelong.
Prevalence	The proportion of a defined population with the infection, disease, or other health-related event of interest at a given point or period of time.
Preventive Measures	Measured aimed at stopping the sexual, blood borne and perinatal transmission of HIV.
Primary Data Collection	The collection of data which did not previously exist, usually carried out using structured data collection instruments. Collected via one-on-one or group interviews.
Projection	Estimate of future characteristic based on past trends, information known, and experience.
Qualitative Data	Data which are not statistically generalisable to a larger population. Tends to provide more depth than quantitative data.
Quantitative Data	Data generalisable to a larger population based on following careful sampling procedures, detailed question and questionnaire construction, and consistent implementation.
Reproductive Health	Family Care Internationally (1999), in a pamphlet on 'sexual and reproductive health', define reproductive health as follows: "Reproductive health is complete physical, mental and social well-being in all matters related to the reproductive system. This implies that people are able to have a satisfying and safe sex life and that they have the capacity to have children and the freedom to decide if, when and how often to do so." *Reproductive health care* includes, at a minimum:

- family planning services, counseling and information
- prenatal, postnatal and delivery care
- health care for infants
- treatment for reproductive tract infections and sexually transmitted diseases
- safe abortion services, where legal, and management of abortion-related complications
- prevention of and appropriate treatment for infertility

	• information, education and counseling on human sexuality, reproductive health and responsible parenthood, and discouragement of harmful practices like female genital mutilation.
Risk Factors	Conditions or behaviours which make it more likely that a person will become infected with HIV. These factors might include: involvement in any sexual relationship other than one which has been mutually exclusive and HIV negative for a sustained period of time; presence of an STD; injecting drug use; history of blood transfusions, skin-piercing, invasive, surgical or dental procedures that were done under possibly unsterile conditions or with contaminated blood or blood products; and sexual intercourse with a partner who has any of these risks listed.
Secondary Data Collection	Data obtained from existing published materials or available from existing databases and sources.
Seroprevalence (HIV, STI)	The percentage of a population from whom blood has been collected that is found, on the basis of serology, to be positive for HIV or other STIs at any given time.
Sexual Health	Family Care Internationally (1999), in a pamphlet on 'sexual and reproductive health', define sexual health as follows: "Sexual health is a part of reproductive health and includes: healthy sexual development; equitable and responsible relationships and sexual fulfillment; and freedom from illness, disease, disability, violence and other harmful practices related to sexuality."
Sexually Transmitted Infections	STIs comprise a variety of infections that are transmitted through sexual intercourse. They include HIV, as well as other sexual diseases such as gonorrhoea, although HIV is often discussed separately from other STIs because it cannot be cured.
Social Marketing	Application of private sector marketing techniques to the sale of products, such as condoms, that fulfill a social objective. Marketing refers to having the right product at an accessible place at an affordable price with appropriate promotion to one or more targeting audiences.
Socio-Economic	Refers to the investigation of both social and economic aspects of an issue. Tends to be broken down into 'macro', larger investigations, for example at the national or regional level, and 'micro' level, referring to an individual, a household, neighbourhood, or community.
Susceptibility	Whiteside (1998: 79-80) defined susceptibility as follows: "Susceptibility is used to describe those factors which determine the rate at which the epidemic is propagated. It may be considered in part to reflect the 'riskiness' of the environment. Such factors may be physical (as in the case of the development of a new road), environmental (such as a drought which results in unusual population movements), cultural (a particular sexual practice), economic (increased maldistribution of income) or social (the operation of labour and associated housing markets in urban areas)."

Symptoms	Major signs of AIDS:

(a) weight loss greater than 10% of body weight
(b) chronic diarrhoea for more than one month
(c) prolonged fever for more than one month (intermittent or constant)

The presence of generalised Kaposi's sarcoma or cryptococcal meningitis is sufficient, in itself, as a clinical diagonsis of AIDS.

Minor signs of AIDS:

(a) persistent cough for more than one month
(b) generalised pruritic dermatitis
(c) recurrent herpes zoster
(d) oropharyngeal candidiasis
(e) chronic progressive and disseminated herpex simplex infection
(f) generalised lymphadenopathy

Transmission

Whiteside and Sunter (2000: 7-8) describe infection as follows: "In order for infection to occur, the virus has to enter the body and attach itself to host cells. HIV attacks a particular set of cells in the human immune system known as CD4 cells, which organise the body's overall immune response to foreign bodies and infections. These T-helper cells are the prime target of HIV. HIV also attacks immune cells called macrophages which engulf foreign invaders and ensure that the body's immune system will recognise such invaders in future." "Once the virus has attached to the cell's surface ... it penetrates the wall. Thereafter it is safe from the body's immune system and cannot be destroyed by the body's defense mechanisms. Inside the cell, it copies its RNA into DNA in order for the door into the cell's nucleus to be opened. There the copied DNA integrates easily into the company of the host's genes and by manipulating the proceedings of the nucleus causes the cell to churn out new HIV virual proteins. These are reassembled into viruses which break out of the cell. In the process, the cell is destroyed and the viremia go on to infect more CD4 cells. Thus, the immune systems of infected people are gradually weakened until they fall prey to a host of diseases which they would normally fight off".

Virus

One of a group of minute infectious agents not visible using an ordinary light microscope. They are characterised by a lack of independent metabolism and by the ability to replicate only within living host cells. Viruses are customarily separated into three sub-groups on the basis of host specificity, namely bacterial viruses, animal viruses, and plant viruses.

Vulnerability

Whiteside (1998: 80) defined vulnerability as follows: "Vulnerability describes those features of a social or economic entity that make it more or less likely that excess morbidity and mortality associated with disease will have deleterious impacts upon that unit." He goes on to note that it has three basic parts: "It refers to features which make it likely that raised morbidity and mortality will have adverse effects." "It refers to those features which make it more or less likely that a unit will be able to respond or cope effectively with raised mortality or morbidity and for how long." "Relative susceptibility will affect the gradient and the peak of the epidemic while relative vulnerability will describe the effects of age-specific impact."

Annex B: Field Instruments

Orphan Children Guide
Focus Group Discussion Instrument: (Draft 6 -- Final) – 26 March, 2000

A Situation Analysis of Orphan Children in Namibia

Prepared and Administered by SIAPAC for
the Ministry of Health and Social Services and UNICEF

FGD Leader	
FGD Assistant	
FGD Notetaker	
Other:	

Start Time: _____ Finish Time: _____ Total Time: _____

Date: _____

1) Focus Group Discussion participants: _____ boys _____ girls

2) Region:
   _____ - 1 Caprivi   _____ - 8 Otjozondjupa
   _____ - 2 Kavango   _____ - 9 Erongo
   _____ - 3 Ohangwena   _____ - 10 Khomas
   _____ - 4 Oshikoto   _____ - 11 Omaheke
   _____ - 5 Omusati   _____ - 12 Hardap
   _____ - 6 Oshana   _____ - 13 Karas
   _____ - 7 Kunene

3) Strata:
   _____ - 1 Caprivi   _____ - 5 Karas/Hardap
   _____ - 2 Kavango   _____ - 6 Windhoek/urban Erongo
   _____ - 3 4 'O' Regions   _____ - 7 Otjozondjupa/Omaheke/rural Khomas
   _____ - 4 Kunene/rural Erongo

4) Location:
   _____ - 1 urban   _____ - 2 peri-urban   _____ - 3 rural

Introduction

[Int: Explain project briefly] The Government of the Republic of Namibia, including the Ministry of Health and Social Services, the Ministry of Local and Regional Government and Housing, and the Ministry of Basic Education and Culture, as well as the United Nations through UNICEF have commissioned SIAPAC, an independent, Namibian social research firm to do a situational analysis of households looking after children that have lost their mothers or both mothers and fathers. They wish to understand how households that have taken on the responsibility of caring for these children are getting along. They would like to know how these households cope with this additional responsibility and what difficulties such households experience. It is for this reason that we are meeting with you today. The information you provide will be treated confidentially. We ask that you co-operate and respond to questions honestly so that we can understand your situation accurately, and tell Government and UNICEF accordingly what needs to be done.

Introductory Question

We would like to begin by asking a few questions about you and the household you live in. Please tell us a few things about yourself. [Int: first name, age, where they are from, how long they have been living in their current community, and anything else they want to add]

Background Information on the Orphans

We want to begin by understanding a bit more about you and the households you live in.

5) Is this household made up of your mother's family, your father's family, or non-relatives? [Int: Get a sense of which side of the family 'took them in'. Find out whether they were taken in by relatives, or by, for example, neighbouring households.]

6) Tell us a bit about your average day during the week. What do you do, for example, when you first get up? What do you do for the morning? What about in the afternoon? And during the evenings? [Int: Use a daily calendar to get a sense of how the group spends their weekday. Use time groupings such as morning, afternoon, evening. Get a sense of their daily routine. Find out about eating patterns, skipped meals, involvement in preparation of foodstuffs, looking after siblings, playing, sports, other leisure activities, working in the fields, looking after livestock, going to school, homework, story-telling, etc. Be sure to get a sense of variation across boys and girls.]

　6a) Are weekends different that this? [Int: Use a daily calendar to get a sense of how the group spends their weekday. Use time groupings such as morning, afternoon, evening. Get a sense of their daily routine. Find out about eating patterns, skipped meals, involvement in preparation of foodstuffs, looking after siblings, playing, sports, working in the fields, looking after livestock, going to school, homework, story-telling, etc. Be sure to get a sense of variation across boys and girls.]

7) What about when its time to do important seasonal things, such as during planting, during weeding, or during harvest, or when the livestock need to be looked after or moved. How are you involved? [Int: We are interested in understanding how the child's labour is used]

8) Tell us about other children in the household you are living in. Who are they? Are they related to you? Are they older or younger than you, or the same age? Do you sometimes play together? Do you sometimes study together? [Int: We want to understand whether the children 'fit in' with the other children in the household.]

9) Tell us about the adults in the household you are living in. Who would you say looks after you the most among the adults? Who else helps them? Is there an older child who helps look after you? [Int: We want to know the relative role of male and female caregivers, younger and older caregivers (in particular grandmothers), and older children.]

　9a) Who would you consider to be your best friends? [On answered, ask the following] Are any of these best friends living in the household you are living in?

Changes in the Orphans' Lives

We would now like to ask you to consider how your lives have changed since you came to be looked after by this household.

10) We spoke earlier about your daily routines, during the week and at the weekends. We know that you were younger when you came here, but consider how you daily routines may have changed because you have moved here. [Int: Look at the daily calendar they had created earlier. Find out about important differences, with particular regard to labour allocation, eating patterns, leisure time, time allocated to school, time allocated to homework, etc. We are trying to get a sense of whether there has been a shift towards more labour allocation, interrupted eating patterns, and less time for school and homework. Further, get a sense of possible changes in seasonal labour allocation.]

11) We asked you about other children living in the households you are living in. How many are your brothers/sisters from your original household, and how many belong to this household otherwise? Overall, would you consider them all to be 'friends', or do you sometimes have serious troubles getting along with them? [Int: Get a sense of whether there are 'adjustment' issues with these other children, jealousies, suspicions, etc.]

12) Tell us a little about your education situation. Are you currently in school? If some of you have not, had you ever been in school? What are your schooling plans, or our schooling hopes? [Int: We need to understand the following: 1) has their new orphan situation resulted in them dropping out of school, not entering school, or having problems in school; 2) what was their education situation, or at least likely situation, had they not become orphans; 3) how do they 'value' education in the context of their orphan status; and 4) how to they think their caregivers 'value' the orphan's situation. Focus considerable attention on point (4).]

The Process of Becoming Orphans

We now understand a bit about you and your current situation. We will now turn to some questions that, frankly, may be difficult for you to talk about. We know and understand this, but we nevertheless need to hear from you. We want to start by understanding what your life was like before your mother/parents passed away. Please, therefore, answer our questions no matter how difficult this may be for you.

13) First, tell us a bit about what your family 'looked like' before your situation changed. Did you live with your mother and father, aunt and uncle, or just your mother, aunt or grandmother or what? Who was around? What about brothers and sisters and cousins? [Int: We want to know how the household looked, whether they were *already* in a situation, such as being looked after by the grandmother only, whether they were in a stressed situation, or whether their situation was more along the lines of what would be expected in their culture. In short, to be able to 'judge' how their circumstances might have changed for the worse, we need to be better understand what this situation was.]

14) Where did you live? How long did you live there? Where did you live before that? [Int: We want to know if they had lived in their situation for a relatively long period of time, or whether they had moved across households and/or locations before their most recent move. Did they live in the town/village/farm they are living in now before they ended up in this household?]

Closing Question

15) Do you have any other comments before we close?

A Situation Analysis of Orphan Children in Namibia

**Prepared and Administered by SIAPAC for
the Ministry of Health and Social Services and UNICEF**

FGD Leader	
FGD Assistant	
FGD Notetaker	
Other:	

Start Time: _____ Finish Time: _____ Total Time: _____

Date: _____

1) Focus Group Discussion participants: _____ males _____ females

2) Region:
    ____ - 1 Caprivi   ____ - 8 Otjozondjupa
    ____ - 2 Kavango   ____ - 9 Erongo
    ____ - 3 Ohangwena   ____ - 10 Khomas
    ____ - 4 Oshikoto   ____ - 11 Omaheke
    ____ - 5 Omusati   ____ - 12 Hardap
    ____ - 6 Oshana   ____ - 13 Karas
    ____ - 7 Kunene

3) Strata:
    ____ - 1 Caprivi   ____ - 5 Karas/Hardap
    ____ - 2 Kavango   ____ - 6 Windhoek/urban Erongo
    ____ - 3 4 'O' Regions   ____ - 7 Otjozondjupa/Omaheke/rural Khomas
    ____ - 4 Kunene/rural Erongo

4) Location:
    ____ - 1 urban   ____ - 2 peri-urban   ____ - 3 rural

Introduction

[Int: Explain project briefly] The Government of the Republic of Namibia, including the Ministry of Health and Social Services, the Ministry of Local and Regional Government and Housing, and the Ministry of Basic Education and Culture, as well as the United Nations through UNICEF have commissioned SIAPAC, an independent, Namibian social research firm to do a situational analysis of households looking after children that have lost their mothers or both mothers and fathers. They wish to understand how households that have taken on the responsibility of caring for these children are getting along. They would like to know how these households cope with this additional responsibility and what difficulties such households experience. It is for this reason that we are meeting with you today. The information you provide will be treated confidentially. We ask that you co-operate and respond to questions honestly so that we can understand your situation accurately, and tell Government and UNICEF accordingly what needs to be done.

Introductory Question [Ask ALL focus groups]

We would like to begin by asking a few questions about you and the household you live in. Please tell us a few things about yourself. [Int: first name, occupation, whether they are married (polygamous or monogamous) or single, and anything else they want to add]

Background Information on the Household [Ask ALL focus groups]

We want to begin by understanding a bit more about the households you live in. Please consider the following.

5)   How many people currently live on a regular basis in your household. By this we mean all those who are resident here, as well as all of those who live elsewhere by whom you feel belong to this household, and will be eventually coming back to live here (e.g., migrants). We are interested both in adults (aged 16+) and children and infants (aged 15 and under). [Int: Find out how many live here year round, how many belong to the household but live elsewhere, and what they are doing elsewhere. Find out who the head of the household is and whether this person usually lives here or away. Get the AGE of the household head and the main caregiver.]

6)   Tell us a little about how your household makes a living. For example, does the household raise any crops (rainfed or irrigation), do household members look after the household's livestock, do any work in casual labour, do any work in informal businesses, do any run their own shops or small businesses, do any work in regular wage labour, those who are in school, those who are of age but are unable to attend school, etc. [Int: We do not need exact details for each household and each person. Rather, what we are looking for is a 'risk profile' of the household, for example households lacking someone in wage labour, households where young people are not in school, etc. Once this is done, do your own quick classification of households at 'higher risk' and 'lower risk'. Do NOT ask households to rate their own risk.]

7)   How have things been over the past year or so, say since January 1999? Do you feel like this has been a particularly 'hard' year, or do you feel that things have gone well, or at least okay? [Int: We want to get a better understanding of the stresses and strains facing the households overall, or whether they are 'cushioned' against problems because they are doing okay. This is largely an economic ranking, but the economics of the household could clearly be affected by, for example, the loss of work by a household member, the death of a family member, the long-term illness of a key household member (e.g., household head, caregiver), the arrival of an additional child to look after, etc.]

Background Information on the Orphans [Ask only ONE focus group per region]

We want to now try and get a better understanding about the child/children you are looking after. Please consider the following.

8)   Tell us a little about the young child/children you are now looking after, and how you came to be looking after her/him/them. [Int: Get **DETAILS, this question will take some time.** We want to know whether the child/children are biologically related to the caregiver (via mother or father?) or another household member (explain), how long ago the child/children arrived, how old the child was upon arrival and what the child's/children's current age is, whether the child/children is male or female, and specifically how this movement of the child/children into this household was consistent with cultural norms. For this last point, get a better sense of what these norms are before asking for clarification on the specifics for the child/children who were orphans] [Int: Remember, if they are looking after two or more children, they could be from different mothers/fathers, and could have 'arrived' in very different circumstances]

9)   Who in the household is involved in caring for these new children, aside from yourselves? [Int: probe for the various roles of the different family members. Include adults AND children and their respective responsibilities.]

   9a)   In your absence, who else in the household takes on your tasks for caregiving, if anyone? [Int: probe for stresses this may create, including worry on the part of the caregiver, emotional stress on the part of the orphan(s), and stresses on other household members.]

9b) Have you been unable to do things you wanted to do, such as (for example) going to funerals outside of this community, going to weddings outside of this community, attending church as often as desired, visiting relatives, etc.

9c) Have others in this household not be able to do things they wanted to do because of these additional responsibilities? [Int: Probe for social issues such as the above, but also attending school, doing homework, etc.]

10) Tell us a little about how the child/children actually came to you. By this, we would like to better understand the decision-making process that led the child to join your household. [Int: How long was the 'negotiation' process (if any), was the arrival of the child/children expected, whether the child had gone elsewhere after the loss of the mother/parents before coming to this household, whether the child/children were part of the decision about where to go, whether the child/children was already with the caregiver before the death of the mother/parents, whether you and your household had any choice about the arrival, etc.] [Int: Remember, if they are looking after two or more children, they could be from different mothers/fathers, and could have 'arrived' in very different circumstances]

10a) Was there a refusal by another household that was approached first to look after this child/these children? [Int: If you are talking to a relative of the mother, get a sense of whether the father's parents or relatives were approached to take on the child, and why they did not do so. Get a sense of 'blame' for the death/illness of the father, and what role this might have played. Has the children/have the children, in effect, been 'rejected' by the father's relatives. If you are talking to a relative of the father, probe into the same issues.]

11) Did the death of the mother/parents leave more than one child needing to be looked after, including her/their own children but also children they were looking after? If yes, please tell us about the child/children other than the one(s) you are looking after. [Int: Find out where these other children went to any why. After getting background information, move to asking questions about their contact, or lack thereof, with these siblings/other children. Next, find out whether there was ever any negotiations to have any of these children come to this household, and why they are not there.]

11a) Did any of these children come to your household before they got to their present household for some time? If yes, please tell us why they are no longer with you. [Int: Probe for issues related to unaffordability, problems with being able to look after the child/children, behavioural problems with the child her/himself, etc., as well as basic issues such as movement to secure education.]

The Situation of Orphans in Their Households
[Ask only ONE focus group per region, differen that the above one]

We would now like to discuss with you a bit about how the child/children 'fit into' your household.

12) When the child/children first arrived, what would you describe to be the main emotional 'adjustment problems' that occurred, if any? [Int: Cover the emotional adjustment of the orphan(s) in some detail. What were the signs of emotional distress. ALSO cover the adjustment problems of other children in the household, by ages (in relation to the age of the orphan(s), as well as adults. GET DETAILS.]

13) In some respects a member of your extended family has joined your household. In this regard, have there been any emotional 'pluses' of the child's/children's arrival? [Int: Includes pluses felt by other children in the household who have a new friend. PROBE into how the arrival of this child has 'fit into' the cultural context of caregiving, as discussed above, and ask whether this has made emotional adjustment easier.]

14) When the child/children first arrived, what would you describe to be the main adjustments in terms of the following:

14a) sleeping arrangements, eating arrangements, etc.

14b) allocation of labour within the household [Int: Probe for the orphan(s)' taking on tasks that were previously handled by other household members, including other children, as 'replacement' labour. Get this information distinct from the orphan simply 'does his/her share' as the work burden has increased due to the orphan's arrival.]

14c) additional tasks falling to you as the caregiver [Int: Probe by the age of the orphan, given that tasks will vary.]

14d) additional tasks on other children in the household

14e) additional economic burden to wage earners belonging to the household

14f) conflicts arising between other household members

14g) conflicts arising between household members and the new arrivals [Int: probe for reasons, including rejection of the child because the mother/parents died, as well as fear over what they had died of.]

15) Over time, how have these emotional stresses changed, if at all? [Int: Base this discussion on their response to the above]

16) What about adjustment in the community? How have the children done in terms of adjusting within the community? [Int: Probe for their involvement in sports, community events, playing with other children, etc. If the children are from the community, focus on problems they may have encountered because of the deaths of their mothers/parents.]

17) Tell us a little about how the situation of children who had lost their mother/parents in this community is governed by traditional laws and norms. First of all, how, historically, would these children be treated? What about now as things have changed, given that, for example, many children are looked after by grandparents, or given that there are now more motherless/parentless children?

18) What sort of provision, if any, did the mother and/or father make for the child/children before they were sent to you? [Int: Probe in particular for economic provision, but also 'easing' the transition for the child/children to the new household by talking to the child/children, discussing things with the new household, etc. What, in sum, did the mother/parents do to help the child or children make the adjustment more easily. If NOTHING, probe as to why no provision was made.]

Economic Status of the Household and Impacts
[Ask only ONE focus group per region, differen that the above ones]

Earlier we touched on a few economic issues. We would now like to probe these issues in more detail.

19) You described a bit about the economic situation of your households earlier. This current situation, of course, includes possible impacts from you having to take in new children. Could you tell us what your households' economic situation would have been had you not had this new responsibility. Would the situation have been no different, would things have been easier/better, or would things perhaps have been worse off? [Int: Probe for specific examples. Probe based on main sources of income of the household, and discuss the specific issue of reliance on pension money.]

20) We would like to know whether the need to look after these additional children has worsened your economic situation in any way. Please consider the following:

20a) Many households have problems in having enough food all year long. Historically, have your households had any 'food insecurity' problems, even seasonally? If yes, please give examples of what this has meant in terms of eating patterns, seasonal shortages, and other means to get food. [Int: Once they are done, ask a few basic questions, such as how often children or adults or both go to bed hungry, whether anyone has substituted alcohol for food because of the lack of food, etc.]

20b) What about your households' ability to purchase clothes, school uniforms, and other items such as this. Has this changed?

20c) What about your households' ability to pay bills, for example, for charcoal/electricity, water [for locations where billing occurs], telephone [inc. public phone use], loan accounts, etc.

20d) What about the ability of you and other household members to allocate labour to home production, to your small businesses, and to other economic activities?

21) The arrival of older children may have made more labour available to at least some of your households. Is this true? If yes, has this labour 'offset' the negative economic impacts, at least to some extent? If yes, please 'weigh up' the negative economic impacts versus the additional labour and consider what the overall impact has been.

Over Time Adjustment
[Ask ONLY if there is sufficient time]

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22) Would you say these new children have adjusted well to their new circumstances, or are they still facing adjustment problems? By adjustments, we are referring to emotional adjustment, adjustment to living in a new community, adjustment to a new household, adjustment to a new school, adjustment to new friends, etc.

22a) In terms of 'over time' adjustment, have the children had any of the following problems and, if so, please describe:

trouble sleeping

crying a lot

fighting/argumentative

poor performance at school

involved in crime

other

22b) [If any had these problems] Have these problems come about recently, or did they exist when the children first came?

23) Have these new children been ill more than you would have expected? If yes, what kinds of problems have they had? Do you think any of these are due to the stress of adjustment?

23a) If yes, has this stressed the household budget in any way? If yes, how?

24) Are these new children able to attend school? If yes, how is this paid for? If no, why not? [Int: Probe in detail for lack of affordability issues, but ALSO these children being seen as 'less important' to be educated. Find out if they have been able to attend because of special things, such as school fees being waived or reduced, special fees being waived, no requirement to wear a school uniform, etc.]

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We have spoken about how the household itself has adjusted, and some things about how this adjustment has been made within your community. As a final set of questions, we would like to ask you about support that comes from outside your household, and what support is not forthcoming but is needed.

Previous Assistance

25) Has your household received any assistance from non-family member households in this community, either in-kind or in-cash, to assist you with looking after these new children? [Int: Probe for who this was, and under what circumstances. Get examples.]

    25a) If yes, has this changed over time? [Int: Probe for initial help that has dropped off. If reduced over time, find out why and what impacts this has had on the household.]

26) Has your household received any assistance from churches or any other community organisations, either in-kind or in-cash, to assist you with looking after these new children? [Int: Probe for who this was, and under what circumstances. Get examples.]

    26a) If yes, has this changed over time? [Int: Probe for initial help that has dropped off. If reduced over time, find out why and what impacts this has had on the household.]

27) Has your household received any assistance from any non-governmental organisations, either in-kind or in-cash, to assist you with looking after these new children? [Int: Probe for who this was, and under what circumstances. Get examples.]

    27a) If yes, has this changed over time? [Int: Probe for initial help that has dropped off. If reduced over time, find out why and what impacts this has had on the household.]

28) Has your household received any assistance from any Government departments, either in-kind or in-cash, to assist you with looking after these new children? [Int: Probe for who this was, and under what circumstances. Try to set an idea of which Government department the assistance came from, such as a community development officer, a social worker, etc. Get examples.]

    28a) If yes, has this changed over time? [Int: Probe for initial help that has dropped off. If reduced over time, find out why and what impacts this has had on the household.]

29) Has your household received any assistance from any other organisation, such as a donor, either in-kind or in-cash, to assist you with looking after these new children? [Int: Probe for who this was, and under what circumstances. Get examples.]

    29a) If yes, has this changed over time? [Int: Probe for initial help that has dropped off. If reduced over time, find out why and what impacts this has had on the household.]

30) Is anyone belonging to your household currently receiving any support from Government such as a pension, a child maintenance grant, emergency food relief, emergency feeding, labour-based public works employment, etc?

31) We have spoken about what assistance your households have received, or have not received. Now we would like to ask you what type of assistance your households need. Consider the following:

31a) Earlier you mentioned how your households were coping with the arrival of the new children. Where there were shortfalls in this regard, what would need to be 'made up' so that you did not have these problems? [Int: Probe for foodstuffs, clothing, school fees, sweets, etc. Also, probe carefully for the need for emotional support, counselling, an improved understanding of AIDS within the community, etc.]

31b) If you had to give a monetary value to these needs on a monthly basis, how much do you think you would require to have your households the same economically as they were before the arrival of the new children? [Int: Probe for REALISTIC values. If numbers are high, discuss this further. Get a <u>consensus</u> of the minimum amount of support required. Once this is done, use the money sketches to represent units of money, and put these needs under the specific areas of support required (e.g., food, schooling, clothes, etc. Once done, reproduce the figure on a sheet of paper.]

32) Consider how <u>money</u> is allocated across household members and across uses. If cash assistance were to come into the household, how would it need to come to most directly support the needs of the household's children, including (or specifically referring to) the new children? [Int: This may require some probing with regard to how money would be spent for purposes other than support for the children/orphans.]

32a) If financial support were to be added to pension monies for eligible household, would this help to reach the intended target children? [Int: Once they respond, begin with negative probes. Consider the following: Wouldn't the household head make the decision to look after their own family members, rather than these new family members? Wouldn't the money be used for things like livestock purchases that would not benefit the child/children? Etc.]

32b) How could such money be 'put aside' for the longer-term interests of these children? [Int: Probe into issues such as putting the money into education for the child, putting together a savings account for the future, etc.]

33) Consider how <u>non-monetary resources</u> are allocated across household members and across uses. If such resources were to come into the household, how would they need to come to most directly support the needs of the household's children, including (or specifically referring to) the new children?

34) Would such assistance, designed specifically for looking after children that had lost their mothers or parents, stigmatise households receiving such assistance? If yes, how could this be avoided?

35) As you may know, more and more households in your community and throughout Namibia are encountering the same problems as we've discussed today. Within such a context, such Government assistance as we've just described may not be available to all who need it. Given this worsening situation, what criteria would Government need to use to decide who should receive these scarce resources and who should not, and how much? [Int: Probe for issues of equity, and criteria that could be used to decide who should be eligible and who should not.]

35a) What about households that can rely on their relatives. Should they be excluded because they have other means, as assistance could not reach all?

35b) What about households that can rely on community organisations? Should they be excluded because they have other means, as assistance could not reach all?

36) If you had to 'rank order' those households with these new children most in need and least in need, how would you do so? Consider the following: [Int: Use cards to create a profile of households least in need and most in need.]

presence or absence of wage earners

household with more adults compared to children versus households with more children to adults

ownership or non-ownership of livestock

households receiving outside financial support versus those with no such support

households with a wage earner who is employed 'casually', rather than on a regular basis

other

Closing Question [Ask ALL]

37) Do you have any other comments before we close?

Case Study Guide
(Draft 8 -- Final) – 26 March, 2000

A Situation Analysis of Orphan Children in Namibia

Prepared and Administered by SIAPAC for
the Ministry of Health and Social Services and UNICEF

Case Study Leader	
Case Study Assistant	
Case Study Notetaker	
Other:	

Date of first visit: _____

Date of second visit (if any): _____

1) Region:
    _____ - 1 Caprivi   _____ - 8 Otjozondjupa
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3) Location:
    _____ - 1 urban
    _____ - 2 peri-urban
    _____ - 3 rural

Introduction

The case study is designed to give information on how households who care for orphaned children live, how they cope and how they don't. It involves getting to know the household well, fitting into their routines. It involves listening to their stories, their examples, their interactions with others.

This instrument should be used only as a guide to lead the person, who is being interviewed, to volunteer and share the kind of information that is required. It should not merely consist of a series of questions and answers, but should take the form of the household and the caregivers, and the orphan her/himself, 'telling a story'. The case study officer should listen carefully and ensure that the household members feel that their opinions have been heard. In this regard you are more of an observer than an interviewer, meaning that your prompts and questions should be subtle, and you should let the respondent 'weave their story'. Put yourself in their position. You have had something dramatic happen to your household. You are being asked to share this. What would the person need to do to make you want to tell them your situation?

The aim of the case study is to gain an in-depth understanding of how having to care for an orphan(s) has affected the household, while at the same time learning about the household in which the orphan is being raised. It is therefore important that we understand how circumstances in the household have changed since the orphan(s) arrived. One must gain insights into the changes that arose from the arrival of the new child/children and those that would have happened in any event, as there may be a tendency to *overstate* actual impacts.

We are of course interested in the economic impacts, but we are equally interested in the social, cultural, and emotional impacts. It is likely, for example, that a number of households are coping quite well, and are fully able to handle their new situation in all of these respects. However, even when a household can handle the financial requirements, they may not be able to handle the emotional impacts. Further, for example, a rural household may end up with a child from an urban background, or a child that has language differences, or a child that has a different cultural background. How, in short, are they all coping with these changes.

In dealing with these questions, please be sure to bring the orphan(s) him/herself into the discussion if they are old enough (this is not necessary just based on the child's age, but rather the child's ability to express him/herself, the child's maturity, etc).

REMEMBER to tell us who is saying what when you record your information!

Context Questions

4)   To start off with, have the respondents give you an idea of **who is who** in the household. Find out who lives there, and who doesn't live there but 'belong to' the household. We need to know adults and children (defined as those under sixteen). For children of school-going age, are they in school or not? Are they overage for their grade? Be sure to specifically find out how the orphans fit into this as well.

5)   Once you know who is who, find out how the household makes a living. Who is doing what? Does the household raise livestock? Do they grow crops? Do they have members in employment? Do they run businesses?

6)   Get a sense of how the household has done over time, historically when things have been good and when things have been more difficult. Find out why these have occurred, in other words what led to the good times and what happened to create the bad times. Get a sense, overall, of the 'cycle' of the household.

Details of the Orphans

7)   Before going further, ensure that you got details about the orphan child/children. What is the biological and social relationship between the orphaned child/children and the caregiving household?

8)   Tell us, in detail, the 'story' of how the child/children arrived in this household. GET DETAILS!

9)   Tell us about where the orphan child/children did not go, if this applies. For example, was another household approached, perhaps before coming to this one, or perhaps after?

10)   With regard to the period around the immediate arrival of the orphan child, what types of emotional 'adjustment problems' had occurred. This may be a good question for the child her/himself, as they can talk about how they missed their mother/parents, how they felt about moving to a new area, etc. You can also ask the caregiver how the child seemed to adjust, or did not adjust.

11)   After getting a sense of how the child adjusted, determine what adjustment problems the rest of the household had when the orphan(s) first arrived. Include adjustment by other children in the household, their understand or lack thereof.

      Get details of adjustments, from sleeping and eating arrangements, to labour allocation, to conflicts, to fights, or whatever.

12)   Now, deal with these same issues over time. How have things changed, if at all, since the child/children first arrived?

      Importantly, how were adjustment problems overcome over time, if they were? If they were not, what has this meant for the household?

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13) Look into early adjustment in the community for orphans that have come from elsewhere. How have they been accepted, or not accepted. What about in school? Get a sense of whether the child seems to be 'made welcome' by other kids in the community.

For all orphans, find out if they have been ostracised due to problems related to how their mother/parents died. Is there, in effect, an 'AIDS impact' in terms of community acceptance? PROBE THESE ISSUES IN DETAIL, AS THIS IS A KEY TO UNDERSTANDING THEIR CIRCUMSTANCES.

Economic Adjustments and Impacts

14) Here we want to know the specifics of how the arrival of the orphan(s) affected the household's economic circumstances. It might be best to have them describe, in some detail, their current economic situation, followed by having them indicate what they think might be the difference due to the arrival of the orphan(s).

15) After a general discussion of the various economic issues, move to more specific issues, such as:

15a) food security - eating patterns, seasonal shortages, shortages arising from a lack of money, etc.

15b) ability to purchase clothes, school uniforms, and other such items.

15c) ability to pay bills

15d) need to draw on savings

15e) having to borrow money (formal or informal)

15f) having to borrow foodstuffs

15g) having to sell labour that would not have occurred otherwise

15h) having to 'trade' labour that would not have occurred otherwise

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Emotional and Social Adjustment

16) Now, look at the situation over time. Over this time, has the child adjusted well to the new circumstances, or are they still facing numerous adjustment problems? You need to discuss this in some detail with the caregivers and the orphan(s).

17) Consider emotional stresses that would suggest problems with adjustment, such as sleeping problems, crying, fighting, poor performance in school, lack of interest in things, involvement in crime, consistent illnesses that suggest stress and lack of adjustment, and other factors.

18) Look into over-time adjustment in the community for orphans that have come from elsewhere. How have then been accepted, or not acceptable. What about in school? Get a sense of whether the child seems to be 'made welcome' by other kids in the community.

For all orphans, find out if they have been ostracised due to problems related to how their mother/parents died. Is there, in effect, an 'AIDS impact' in terms of community acceptance? PROBE THESE ISSUES IN DETAIL, AS THIS IS A KEY TO UNDERSTANDING THEIR CIRCUMSTANCES.

19) Given that many orphans are in these circumstances due to the mother/parents dying of AIDS, blame will most likely be assigned. For example, perhaps the family of the son who dies of AIDS 'blames' the wife or girlfriend and, by extension, her family. What are the implications of this? What is the emotional stress that arises? What about financial stress in this regard?

20) We need to first establish what types of support the household is currently receiving, and what it is being used for. As this is a case study, we need to get specifics, get details. Look at assistance from extended family members, non-family members such as neighbours, churches and other community-based organisations, and from outside the community. From outside, look at the support they receive from non-governmental organisations, Government ministries, donors, etc.

   Don't forget to look at what support the household gets in terms of, for example, Government pensions, private pensions, child maintenance grant, emergency relief, etc.

21) If the household has links with Government's social workers, get details of their interactions with these social workers. Get a sense of what the nature of support has been, emotional, economic, or whatever.

22) After getting a clear understanding of what types of assistance they have received from various parties, move to issues of needed assistance. Cover emotional and economic assistance, and anything else in this regard. Be sure to get a good understanding of the context within which such assistance would be most effectively utilised. Further, get a sense of how it would <u>not</u> be effectively utilised, in effect understanding what dysfunctional uses might occur. After discussing these, get a sense of how the household would institute 'remedial actions' to overcome these dysfunctions.

Large Group Interview Instrument
Regional AIDS Committee (Draft 7 -- Final) – 26 March, 2000

A Situation Analysis of Orphan Children in Namibia

Prepared and Administered by SIAPAC for
the Ministry of Health and Social Services and UNICEF

Situation Analysis of Orphan Children in Namibia Prepared and Administered by SIAPAC for the Ministry of Health and Social Services and UNICEF

Int. Leader self Check: Date: _____   Signature: _____

Compilation of Int.: Date: _____   Signature: _____

Other check: Date: _____   Signature: _____

Date NUD*IST Entered: _____   Signature: _____

Date NUD*IST Entered: _____   Signature: _____

First Names of Participants:	Position of Participants in the Regional AIDS Committee

Information	Contact Details for the CHAIRPERSON of the Committee
First Name	
Surname	
Name of Location	
Title (Mr., Mrs., Ms., Dr., Rev., etc.)	
Position outside Committee	
Postal Address	
Name of Organisation	
Telephone	
Fax	
E-Mail	
Other Information	
Interviewer Name	
Interviewer Check: [Initials and Date]	
Assistant Name	
Start Time: _____ Finish Time: _____	Total Time: _____
NUD*IST Entry	Print Surname: _____ Date: _____
NUD*IST Validation	Print Surname: _____ Date: _____

Introduction to Project

My name is _____ and I work for SIAPAC. SIAPAC is a Namibian research firm that has been contracted by Government, through the Ministry of Health and Social Services, the Ministry of Local and Regional Government and Housing and the Ministry of Basic Education and Culture, as well as the United Nations (UNICEF) to do a Situational Analysis of Orphan Children in Namibia. We are meeting with you today to explore the potential consequences of the increasing number of AIDS Orphans in our country, and what specifically is going on in this Region. The information you provide will be treated confidentially.

As members of the Regional AIDS Committee, your views are particularly important.

Interviewer: As this group is larger than a standard focus group, you will need to spend additional time ensuring that you hear from the various participants. Try to get at the commonality of responses you often find in focus groups, you will need to spend more time ensuring that various 'sets' of opinions are heard. If such 'sets' of opinions are indeed the case for some questions, you will need to explore whether this will affect the ability of the Committee to play an active, positive role in the ODC. **Remember as well that this is a Committee, and therefore has committee rules to follow in its proceedings.**

1) First, we would like to know a little bit about you. Could you please tell us your first names, your positions in the Regional AIDS Committee, and anything else you would like to say?

2) Please tell us a bit about your involvement in the Regional AIDS Committee [Int: Probe for how they became a member of regional AIDS Committee and a summary of roles and activities they are involved in with regard to the fight against AIDS.]

3) What are the purposes of the Regional AIDS Committees? What is the Committee's specific mandate? [Probe into why these committees were established and the extent to which they serve this purpose]

Regional AIDS Plan

4) We have received copies of your regional AIDS plan. Please consider the following [Int: Take plan out and discuss the following **FOR EACH POINT**]:

   4a) How was the plan developed? [Int: Get a sense of the role of the various committee members, the extent to which it was well 'grounded' in an understanding of the region, how long it took, and anything else they want to tell you.]

   4b) How were the various tasks identified and why?

   4c) How was the timeframe established?

   4d) Where does the region now stand with regard to its implementation?

   4e) What monitoring and evaluation activities are there with regard to the plan, its various component parts?

5) Of those on the Regional AIDS Committee, which officers would you say are the most active in HIV/AIDS related activities. [Int: Note this for follow-up interviews as well.]

HIV/AIDS in the Region

6) How serious is the HIV/AIDS epidemic in your region? By 'serious', we mean HIV incidence, AIDS deaths, an unwillingness of people to confront the epidemic, a lack of knowledge and understanding on the part of people regarding the problem, and problematic attitudes.

   6a) Where in your region would you say the problem is worst? Why?

7) What about the national Government's response to the epidemic, how has this affected the epidemic in your region?

8) What about the region's response, prior to the current plan?

9) What are the implications of the epidemic on the number of orphans in your region? [Int: Includes 'exporting' the orphans to other regions]

10) How, in the predominant culture(s) in this region, are orphans handled? Consider this under the various scenarios that might occur: a) mother passes away, father is living elsewhere; b) mother passes away, father still alive; c) mother and father both pass away, child has to leave household; d) child living away from parents, mother passes away; and e) child living away from parents, parents pass away.

10a) Communities in your region, as with other communities in Namibia, have ways of coping with difficult as well as emergency situations, as do households, extended families, etc. How would you say the HIV/AIDS epidemic has been responded to via these coping mechanisms, with particular reference to the situation of orphans.

10b) Given the response of the community, households, extended families, etc. to the epidemic and the rise in the number of orphans, how do your plans at the regional level 'fit into' how coping occurs.

10c) What coping mechanisms have not arisen that really need to be there to help cope with the situation, and how do your regional plans fit in?

Mechanisms of Support

11) Given the scope of the orphan problem, and given the scope of the HIV/AIDS epidemic, the amount of resources required to deal with the increasing problem will likely exceed the ability of existing services to deal with them. This is likely to occur within extended families, within communities, within regions, and within the country. We spoke about some of these stresses above.

One possibility that donors and Government are thinking about is how to 'tack on' support to these households so that services can be most efficiently delivered. Please consider the following:

11a) What existing Government or non-governmental organisation interventions could support for households 'ride on' to reach these households?

11b) How could these best target households in need that are looking after orphans?

11c) How could these best target the specific needs of the orphans themselves?

11d) What expenditures on other things could best be 'diverted' to support for these orphans?

11e) How does this 'fit in', or not fit in, with your Regional Planning activities?

12) Where there is not scope to 'tack on' support in this manner, what new, additional support programmes would be required to mobilise to support orphans and their caregiving households? [Int: Get detailed ideas. Also, get a sense of whether they think that such services could realistically be provided and, if so, HOW.]

13) Overall, what would be the single most important intervention that would improve the lives of the orphans themselves and the households that are looking after them? What would be second most important? Third most important?

Questions for Specific Members, Following Group Interview
Must Interview Social Workers, Health Workers and Whoever Else is Listed as Key

14) Tell us a little about the office you work for/the organisation you work in. What issues does it cover? What geographical area is it responsible for?

15) To what extent, if at all, is your organisation involved in providing services to orphans, caregiving households, and others that would have to adjust to the new situation. What is your specific involvement?

15a) To what extent does your organisation reach all of those in need?

15b) What needs are you helping them to reach, and which ones is your organisation not able to respond to?

15c) How do you go about identifying orphan households (or, more generally, households of this type 'in need')?

15d) How do households go about applying for assistance with your organisation? How efficient is this? Are most of these applications approved, or are some turned down?

15e) How has the presence of orphans in the community affected 'case loads'? If heavy, are there systems of prioritising cases?

16) Are there orphanages in this Region? If yes, where, how many are resident there, and how many children cannot be kept in the orphanages due to the lack of space.

17) Are you encountering situations of neglect of orphan children? By neglect, we are referring to any or all of the following areas: emotional; financial; schooling; other.

17a) What about situations of abuse. Have you encountered such situations? If yes, how are these dealt with? Are situations of abuse mental, physical, sexual, or all? In what circumstances does abuse seem to be the main problems?

17b) What about situations of malnutrition? Have you encountered such situations? What do they arise from? How are they dealt with?

17c) Do orphan children suffer from stigmatism in the community or in their 'adopting' households arising from their status, particularly because of the fact that their mother/father/parents died of AIDS? If yes, what have been the implications of this?

18) In general, would you say that households looking after orphans (including those who have not sought your services) are well aware of the availability of outside assistance?

19) Given the areas you cover, where is the orphan problem most serious? Where is it least serious? Why does it differ? How has your organisation responded to these situations?

20) To what extent would you say your organisation has responded to the orphan situation? In other words, have you been able to cope with the rise in the number of orphans, or has it exceeded the ability of your organisation to cope?

20a) What resources are required, not presently available, that would help your organisation better cope with the orphans situation? [Int: This refers to a variety of resources, including training needs, human resources, counselling skills, etc.]

21) We spoke a little about how coping occurs, and how this has been affected by the AIDS epidemic. How can what your organisation does be used to strengthen these coping mechanism? In other words, how can we build on what people and communities are already doing, bringing your organisation's resources to bear in this regard?

22) We've spoken a little about the needs of orphans and the households looking after them. Please rank order what you believe these needs are in order of importance:

counselling support for the caregivers

counselling support for the orphans

support to ensure that the orphans remain in school

direct financial support (e.g., support to pensions) to meet basic needs

access to relief employment for food

access to employment opportunities

child care opportunities

other

23) [Ask educationalist only] To what extent is the number of orphan children attending school monitored in this region? Are data passed along to the national level?

24) [Ask educationalists only] Are there any orphan children attending schools in this region? Are there orphan children in the region who have not been able to attend school because of problems of affordability, acceptability to the other schoolchildren, fear over how their parent(s) died, etc?

25) [Ask educationalists only] For orphans attending school, do they perform in school about the same as other children, or do they have more problems? Do they tend to miss more school that other children?

26) [Ask educationalists only] Have there been any situations where school fees have been waived or made up by someone else, perhaps someone at the school, for orphan children who could not have attended school otherwise? What are the financial implications for the Ministry in this region for waiving fees for orphan children, particularly given the likely number of these children?

27) [Ask educationalists only] What about school uniforms. Have there been problems with affordability of school uniforms for orphans? If yes, what has been done, if anything, to overcome this? How does this relate to national policy regarding school uniforms?

28) [Ask educationalist only] What is the status of HIV/AIDS education, both curriculum based as well as additional interventions, in this region?

29) [Ask educationalist only] What sorts of school-based programmes are going on in this region, if any, to help orphan children and their caregiving households? What about wider programmes that reach orphans, but are targeted to a wider group?

30) [Ask principals only, or ask principals via the teachers you are interviewing] How many children in this school are exempted from paying school enrolment fees? Are many of these orphans? What about other fees? Is specific provision made for orphan households with regard to other financial demands from schooling?

31) [Ask educationalists only] Have health authorities, social workers, or others worked with you to specifically deal with the needs of educationalists?

32) [Ask social workers and community development officers only] What mechanisms exist that monitor social service delivery to orphans and their caregiving households?

33) [Ask social workers and community development officers only] Are there any databases or registers of organisations in the region or nationally that provide services to orphans and their caregiving households? These can be Governmental, non-governmental, or otherwise.

34) [Ask social workers and community development officers only] Are there formal institutions such as orphanages in this region? If yes, what is their role in dealing with orphans identified by yourselves, including young children who are HIV positive? [Int: Get details of the number and location of these orphanages, how many children are being looked after, how many are turned away, what support these organisations receive from outside, etc.]

35) [Ask social workers and community development officers only] Are there any private, voluntary organisations providing support to orphans and caregiving households? These could include churches, companies, etc.

36) [Ask social workers and community development officers only] Regarding national policies in the area of orphans, are policies communicated to the regional and local levels effectively, or is there a great deal of uncertainty with regard to what these policies are? Are these policies consistent with the actual needs in your region?

37) [Ask social workers and community development officers only] What initiatives, if any, currently exist or are planned at the regional level designed to empower communities to deal with the emergent orphan situation?

38) [Ask social workers and community development officers only] Tell us a little about social worker client ratios, and what effect case loads have on the effectiveness of work. Are there alternative approaches to the case approach that would allow you to reach more people in need?

38a) [Ask social workers and community development officers only] There has been a proposal mooted to create community centres where people in need could come to receive services. At such centres, orphans and their caregivers could approach a variety of different service provides from within and outside Government. How would this affect the case load of social workers in your region, and the efficiency of service delivery?

39) [Ask social workers and community development officers only] Are there any programmes in this region that empower community-based organisations, non-governmental organisations, and other voluntary organisations to provide care and support for orphan children?

40) [Ask social workers and community development officers only] What about grants to families who care for orphans. Are there any? Are they reaching caregiving households? Would they be affordable to Government if they reached all who were in need?

40a) [Ask social workers and community development officers only] What about foster care grants. Are there any? Are they reaching caregiving households? Would they be affordable to Government if they reached all who were in need?

41) [Ask social workers and community development officers only] Is there a problem of street children in this region? If yes, please tell me a little about this? [Int: Get details, numbers, boys, girls, types of problems they suffer, where these children live when they are not on the streets, etc.]

42) [Ask social workers and community development officers only] Overall, what are your resource needs to effectively reach the orphans in need, as well as their caregiving households?

Regional Health Officers - To Be Asked After the Group Interview

43) Tell us a little about the office you work for/the organisation you work in. What issues does it cover? What geographical area is it responsible for?

44) To what extent, if at all, is your organisation involved in providing services to orphans, caregiving households, and others that would have to adjust to the new situation. What is your specific involvement?

44a) To what extent does your organisation reach all of those in need?

44b) What needs are you helping them to reach, and which ones is your organisation not able to respond to?

44c) How do you go about identifying orphan households (or, more generally, households of this type 'in need')?

44d) How do households go about applying for assistance with your organisation? How efficient is this? Are most of these applications approved, or are some turned down?

44e) How has the presence of orphans in the community affected 'case loads'? If heavy, are there systems of prioritising cases?

45) Are you encountering situations of neglect of orphan children? By neglect, we are referring to any or all of the following areas: emotional; financial; schooling; other.

45a) What about situations of abuse. Have you encountered such situations? If yes, how are these dealt with? Are situations of abuse mental, physical, sexual, or all? In what circumstances does abuse seem to be the main problems?

45b) What about situations of malnutrition? Have you encountered such situations? What do they arise from? How are they dealt with?

45c) Do orphan children suffer from stigmatism in the community or in their 'adopting' households arising from their status, particularly because of the fact that their mother/father/parents died of AIDS? If yes, what have been the implications of this?

46)   Do orphan children have different health needs and health problems than children who are not orphans? If yes, please tell us a little about how these differ, and what could be done to ensure that health authorities could better meet the needs of these orphans? What about helping via caregiving households?

47)   Are non-health workers, specifically referring to other extension officers, aware of the extent and nature of the HIVAIDS epidemic in this area? If not, why not? What have you done specifically to deal with their lack of knowledge, which this has been a problem, if anything?

48)   In general, would you say that households looking after orphans (including those who have not sought your services) are well aware of the availability of outside assistance?

49)   Given the areas you cover, where is the orphan problem most serious? Where is it least serious? Why does it differ? How has your organisation responded to these situations?

50)   To what extent would you say your organisation has responded to the orphan situation? In other words, have you been able to cope with the rise in the number of orphans, or has it exceeded the ability of your organisation to cope?

       50a)   What resources are required, not presently available, that would help your organisation better cope with the orphans situation? [Int: This refers to a variety of resources, including training needs, human resources, counselling skills, etc.]

51)   We spoke a little about how coping occurs, and how this has been affected by the AIDS epidemic. How can what your organisation does be used to strengthen these coping mechanism? In other words, how can we build on what people and communities are already doing, bringing your organisation's resources to bear in this regard?

52)   We've spoken a little about the needs of orphans and the households looking after them. Please rank order what you believe these needs are in order of importance:

counselling support for the caregivers

counselling support for the orphans

support to ensure that the orphans remain in school

direct financial support (e.g., support to pensions) to meet basic needs

access to relief employment for food

access to employment opportunities

child care opportunities

other

Closing Question

53)   Do you have any other comments before we close?

Local Level Key Informants
Key Informant Interview Instrument (Draft 7 -- Final) – 26 March, 2000

A Situation Analysis of Orphan Children in Namibia

Prepared and Administered by SIAPAC for
the Ministry of Health and Social Services and UNICEF

Situation Analysis of Orphan Children in Namibia Prepared and Administered by SIAPAC for the Ministry of Health and Social Services and UNICEF

Information	Contact Details
First Name	
Interviewee Category	_____ - 1 headman _____ - 2 health worker _____ - 3 community development officer _____ - 4 other Government extension officer _____ - 5 NGO representative _____ - 6 social worker _____ - 7 church worker _____ - 8 community 'opinion' leader (specify: _____) _____ - 9 school teacher _____ - 10 school principal _____ - ## other _____
Interviewer Organisation (if any)	
Position	
Other Information	
Interviewer Name	
Interviewer Check: [Sign and Date]	
Start Time: _____ Finish Time: _____	Total Time: _____
NUD*IST Entry	Print Surname: _____ Date: _____
NUD*IST Validation	Print Surname: _____ Date: _____

[Int: Explain project briefly] The Government of the Republic of Namibia, including the Ministry of Health and Social Services, the Ministry of Local and Regional Government and Housing, and the Ministry of Basic Education and Culture, as well as the United Nations through UNICEF have commissioned SIAPAC, an independent, Namibian social research firm to do a situational analysis of households looking after children that have lost their mothers or both mothers and fathers. They wish to understand how households that have taken on the responsibility of caring for these children are getting along. They would like to know how these households cope with this additional responsibility and what difficulties such households experience. It is for this reason that we are meeting with you today. The information you provide will be treated confidentially. We ask that you co-operate and respond to questions honestly so that we can understand your situation accurately, and tell Government and UNICEF accordingly what needs to be done.

1) Region:
    ____ - 1 Caprivi   ____ - 8 Otjozondjupa
    ____ - 2 Kavango   ____ - 9 Erongo
    ____ - 3 Ohangwena   ____ - 10 Khomas
    ____ - 4 Oshikoto   ____ - 11 Omaheke
    ____ - 5 Omusati   ____ - 12 Hardap
    ____ - 6 Oshana   ____ - 13 Karas
    ____ - 7 Kunene

2) Strata:
    ____ - 1 Caprivi   ____ - 5 Karas/Hardap
    ____ - 2 Kavango   ____ - 6 Windhoek/urban Erongo
    ____ - 3 4 'O' Regions   ____ - 7 Otjozondjupa/Omaheke/rural Khomas
    ____ - 4 Kunene/rural Erongo

3) Location:
    ____ - 1 urban
    ____ - 2 peri-urban
    ____ - 3 rural

All

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4) Please tell us a little about yourself. How long have you lived in this area? Where were you before that? How long have you been doing what you are currently doing? How old are you? [Int: We want to get a sense of who we are talking to. Also, we want to know how they got to their current situation.]

5) In your position, have you had any involvement in any HIV/AIDS related issues? By this we mean things such as involvement in education activities (in school, at the clinic, outside, etc., covering all types of education), information dissemination, counselling, problem-solving with households that have been affected by HIV illnesses or AIDS deaths, publicising the problem, community speeches, etc. [Int: Probe for DETAILS. We want to know whether HIV/AIDS 'touches' their lives as leaders in their communities. Equally importantly, we want to know how it may have NOT touched their lives, but you would have expected it to do so (e.g., teachers that have never done any sexual counselling, health workers who did not discuss HIV/AIDS with sexually transmitted disease patients, headmen who are unaware of HIV/AIDS, or what it is doing to their communities, etc.]

6) Tell us a little about what you know about HIV-affected as well as AIDS-affected households in this community/area/neighbourhood. Are there a number of these households in this community/area/neighbourhood? How are HIV-affected and AIDS-affected households affected by their status? [Int: Cover these issues in DETAIL. We want to know about community adjustment issues, households being shunned, households fighting more, etc. We also want to know about how these households might be suffering socially and economically, etc. Again, get DETAILS, how is the community reacting to these households? Denial? Blame? Hatred? Are there fears, for example, of witchcraft? Probe the witchcraft issue in detail. If, for example, a husband dies, is the wife blamed for his death by witchcraft?]

    6a) Are these households receiving any types of support from other households, from extended family members, from the community, and from outside?

    6b) What types of support are available that they are not receiving?

7) What about households where the husband may have died of AIDS and the wife lives on with the children. What has happened to these households, culturally, socially, and economically? What, specifically, happened with the husband's family?

8) What about households where the children have become orphans, and have had to move into another household (relative or non-relative). What has happened to these households culturally, socially, and economically? For those staying with non-relatives, what happened with their relatives (why didn't they take the children in)?

8a)   Have the children that have become orphaned been split up to different relatives/non-relatives? If yes, what impacts has this had? Would it be better for the children to have been kept together?

8b)   Are 'child-headed' households emerging in this community/area/neighbourhood?

8c)   [Urban and peri-urban areas only] What about children who are actually living on the streets in your area. Are there any? If yes, are they 'AIDS orphans'? What are there circumstances? What is their situation, particularly in comparison to AIDS orphans that have been 'adopted' by other households? Are they, in short, worse off, more vulnerable, etc?

9)   Your community, as with other communities, has ways of coping with difficult as well as emergency situations, as do households, extended families, etc. Please tell us a little about how people, households and communities cope.

9a)   How have these coping mechanisms been used to help people, households and communities cope? Have they come under strain? Have some weakened so much that coping has become very difficult for these households, and for the community as a whole? [Int: Probe in detail. Cover issues such as formal and informal transfers, labour exchanges, etc.]

9b)   Have new coping mechanisms arisen in response to the new situation? If yes, please explain. [Int: This can include outside interventions]

9c)   What coping mechanisms have not arisen that really need to be there to help cope with the situation? [Int: This is basically THE KEY GENERAL QUESTION to the key informants. What, specifically, can be done in the community, at the regional level, at the national level, with donor support, with Government support, etc.]

Social Workers and Welfare Practitioners , Other Extension Officers Offering Support, and Educationalists (Governmental and Non-Governmental)

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10)   Tell us a little about the office you work for/the organisation you work in. What issues does it cover? What geographical area is it responsible for?

11)   To what extent, if at all, is your organisation involved in providing services to orphans, caregiving households, and others that would have to adjust to the new situation. What is your specific involvement?

11a)   To what extent does your organisation reach all of those in need?

11b)   What needs are you helping them to reach, and which ones is your organisation not able to respond to?

11c)   How do you go about identifying orphan households (or, more generally, households of this type 'in need')?

11d)   How do households go about applying for assistance with your organisation? How efficient is this? Are most of these applications approved, or are some turned down?

11e)   How has the presence of orphans in the community affected 'case loads'? If heavy, are there systems of prioritising cases?

12)   Are you encountering situations of neglect of orphan children? By neglect, we are referring to any or all of the following areas: emotional; financial; schooling; other.

12a)   What about situations of abuse. Have you encountered such situations? If yes, how are these dealt with? Are situations of abuse mental, physical, sexual, or all? In what circumstances does abuse seem to be the main problems?

12b)   What about situations of malnutrition? Have you encountered such situations? What do they arise from? How are they dealt with?

12c) Do orphan children suffer from stigmatism in the community or in their 'adopting' households arising from their status, particularly because of the fact that their mother/father/parents died of AIDS? If yes, what have been the implications of this?

13) In general, would you say that households looking after orphans (including those who have not sought your services) are well aware of the availability of outside assistance?

14) Given the areas you cover, where is the orphan problem most serious? Where is it least serious? Why does it differ? How has your organisation responded to these situations?

15) To what extent would you say your organisation has responded to the orphan situation? In other words, have you been able to cope with the rise in the number of orphans, or has it exceeded the ability of your organisation to cope?

15a) What resources are required, not presently available, that would help your organisation better cope with the orphans situation? [Int: This refers to a variety of resources, including training needs, human resources, counselling skills, etc.]

16) We spoke a little about how coping occurs, and how this has been affected by the AIDS epidemic. How can what your organisation does be used to strengthen these coping mechanism? In other words, how can we build on what people and communities are already doing, bringing your organisation's resources to bear in this regard?

17) We've spoken a little about the needs of orphans and the households looking after them. Please rank order what you believe these needs are in order of importance:

counselling support for the caregivers

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18) [Ask educationalists only] Are there any orphan children attending this school? Are there orphan children in the community who have not been able to attend school because of problems of affordability, acceptability to the other schoolchildren, fear over how their parent(s) died, etc?

19) [Ask educationalists only] For orphans attending school, do they perform in school about the same as other children, or do they have more problems? Do they tend to miss more school that other children?

20) [Ask educationalists only] Have there been any situations where school fees have been waived or made up by someone else, perhaps someone at the school, for orphan children who could not have attended school otherwise?

21) [Ask educationalists only] What about school uniforms. Have there been problems with affordability of school uniforms for orphans? If yes, what has been done, if anything, to overcome this?

22) [Ask principals only, or ask principals via the teachers you are interviewing] How many children in this school are exempted from paying school enrolment fees? Are many of these orphans? What about other fees? Is specific provision made for orphan households with regard to other financial demands from schooling?

23) [Ask educationalists only] Have health authorities, social workers, or others worked with you to specifically deal with the needs of educationalists?

Health Workers

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24) Tell us a little about the office you work for/the organisation you work in. What issues does it cover? What geographical area is it responsible for?

25) To what extent, if at all, is your organisation involved in providing services to orphans, caregiving households, and others that would have to adjust to the new situation. What is your specific involvement?

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27) Do orphan children have different health needs and health problems than children who are not orphans? If yes, please tell us a little about how these differ, and what could be done to ensure that health authorities could better meet the needs of these orphans? What about helping via caregiving households?

28) Are non-health workers, specifically referring to other extension officers, aware of the extent and nature of the HIVAIDS epidemic in this area? If not, why not? What have you done specifically to deal with their lack of knowledge, which this has been a problem, if anything?

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Community Development Officers

34) What mechanisms exist that monitor social service delivery to orphans and their caregiving households?

35) Are there any databases or registers of organisations in the region or nationally that provide services to orphans and their caregiving households, that you use locally? These can be Governmental, non-governmental, or otherwise.

36) Are there formal institutions such as orphanages in this area? If yes, what is their role in dealing with orphans identified by yourselves, including young children who are HIV positive? [Int: Get details of the number and location of these orphanages, how many children are being looked after, how many are turned away, what support these organisations receive from outside, etc.]

37) Are there any private, voluntary organisations providing support to orphans and caregiving households in this area? These could include churches, companies, etc.

38) Regarding national policies in the area of orphans, are policies communicated to your level effectively, or is there a great deal of uncertainty with regard to what these policies are? Are these policies consistent with the actual needs in your area?

39) What initiatives, if any, currently exist or are planned at the regional level designed to empower communities to deal with the emergent orphan situation? [Int: Check this against the findings from the regional interviews]

40) Are there any programmes in this area that empower community-based organisations, non-governmental organisations, and other voluntary organisations to provide care and support for orphan children?

41) What about grants to families who care for orphans. Are there any? Are they reaching caregiving households? Would they be affordable to Government if they reached all who were in need?

41a) What about foster care grants. Are there any? Are they reaching caregiving households?

42) Is there a problem of street children in this area? If yes, please tell me a little about this? [Int: Get details, numbers, boys, girls, types of problems they suffer, where these children live when they are not on the streets, etc.]

43) Overall, what are your resource needs to effectively reach the orphans in need, as well as their caregiving households?

Community Leaders (Traditional and Opinion Leaders, CBO Activists)

44) Tell us a little about your community and its strengths and problems.

45) To what extent, if at all, are organisations and individuals in your community involved in providing services to orphans, caregiving households, and others that would have to adjust to the new situation. What is your specific involvement, if any?

    45a) To what extent do individuals and organisations in your community reach all of those in need? [Int: Also refers to their specific involvement.]

    45b) What needs are they helping them to reach, and which ones is your organisation not able to respond to? [Int: Also refers to their specific involvement.]

    45c) How do they go about identifying orphan households (or, more generally, households of this type 'in need')? [Int: Also refers to their specific involvement.]

    45d) Do you think that households looking after orphans are aware of how to go about getting assistance, both formal and informal, that might help them?

46) Are you encountering situations of neglect of orphan children? By neglect, we are referring to any or all of the following areas: emotional; financial; schooling; other.

    46a) What about situations of abuse. Have you encountered such situations? If yes, how are these dealt with? Are situations of abuse mental, physical, sexual, or all? In what circumstances does abuse seem to be the main problems?

    46b) What about situations of malnutrition? Have you encountered such situations? What do they arise from? How are they dealt with?

    46c) Do orphan children suffer from stigmatism in the community or in their 'adopting' households arising from their status, particularly because of the fact that their mother/father/parents died of AIDS? If yes, what have been the implications of this?

47) In general, would you say that households looking after orphans (including those who have not sought your services) are well aware of the availability of outside assistance?

48) Given the areas you cover, where is the orphan problem most serious? Where is it least serious? Why does it differ?

49) To what extent would you say your community/area/neighbourhood has responded to the orphan situation? In other words, have you been able to cope with the rise in the number of orphans, or has it exceeded the ability of your organisation to cope?

    49a) What resources are required, not presently available, that would help your community/area/neighbourhood better cope with the orphans situation? [Int: This refers to a variety of resources, including an understanding of HIV/AIDS and what it is doing to the community and country, training needs, human resources, counselling skills, etc.]

50) We spoke a little about how coping occurs, and how this has been affected by the AIDS epidemic. How can what people and organisations in your community/area/neighbourhood does be used to strengthen these coping mechanism? In other words, how can we build on what people and communities are already doing, bringing your organisation's resources to bear in this regard?

51) We've spoken a little about the needs of orphans and the households looking after them. Please rank order what you believe these needs are in order of importance:

counselling support for the caregivers

counselling support for the orphans

support to ensure that the orphans remain in school

direct financial support (e.g., support to pensions) to meet basic needs

access to relief employment for food

access to employment opportunities

child care opportunities

other

All

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52) Given the scope of the orphan problem, and given the scope of the HIV/AIDS epidemic, the amount of resources required to deal with the increasing problem will likely exceed the ability of existing services to deal with them. This is likely to occur within extended families, within communities, within regions, and within the country. We spoke about some of these stresses above.

One possibility that donors and Government are thinking about is how to 'tack on' support to these households so that services can be most efficiently delivered. Please consider the following:

52a) What existing Government or non-governmental organisation interventions could support for households 'ride on' to reach these households?

52b) How could these best target households in need that are looking after orphans?

52c) How could these best target the specific needs of the orphans themselves?

52d) What expenditures on other things could best be 'diverted' to support for these orphans?

53) Where there is not scope to 'tack on' support in this manner, what new, additional support programmes would be required to mobilise to support orphans and their caregiving households? [Int: Get detailed ideas. Also, get a sense of whether they think that such services could realistically be provided and, if so, HOW.]

54) Overall, what would be the single most important intervention that would improve the lives of the orphans themselves and the households that are looking after them? What would be second most important? Third most important?

Closing Question

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55) Do you have any other comments before we close?

A Situation Analysis of Orphan Children in Namibia

Prepared and Administered by SIAPAC for
the Ministry of Health and Social Services and UNICEF

Situation Analysis of Orphan Children in Namibia Prepared and Administered by SIAPAC for the Ministry of Health and Social Services and UNICEF

Information	Contact Details
First Name	
Surname	
Name of Location	
Title (Mr., Mrs., Ms., Dr., Rev., etc.)	
Position	
Postal Address	
Name of Organisation	
Telephone	
Fax	
E-Mail	
Other Information	
Interviewer Name	
Interviewer Check: [Initials and Date]	
Start Time: _____ Finish Time: _____	Total Time: _____
NUD*IST Entry	Print Surname: _____ Date: _____
NUD*IST Validation	Print Surname: _____ Date: _____

Introduction to Project
My name is _____ and I work for SIAPAC. SIAPAC is a Namibian research firm that has been contracted by Government, through the Ministry of Health and Social Services, the Ministry of Local and Regional Government and Housing and the Ministry of Basic Education and Culture, as well as the United Nations (UNICEF) to do a Situational Analysis of Orphan Children in Namibia. We are meeting with you today to explore the potential consequences of the increasing number of AIDS Orphans in our country, and what specifically is going on in this Region. The information you provide will be treated confidentially. Given your position and the organisation you work for, your views are particularly important.

1) Ask about mechanisms that monitor social service delivery to orphan caregiving households.

2) Find out whether any database or register of organisations, including non-governmental organisations, which provide services to orphan caregiving households exists.

3) Ask about formal institutions such as orphanages and their perceived role in dealing with orphans, including young children who are HIV positive.

4) Get details on the number of orphanages and the subsidies received by them.

5) Ask about additional support/resources for orphanages based on the growing orphan population.

6) Ask about voluntary organisations providing various types of support.

7) Ask about home-based care outreach to orphan caregiving households?

8) Ask about programmes/strategies that encourage voluntary and community based care. Ask about policies on home-based care of orphans.

9) Ask about current AND planned initiatives at national level designed to empower communities to deal with the emergent orphan situation.

10) Ask about communication of policies from a national to regional and local levels. Are national policies implemented at the regional and local levels with regard to orphans and the situations they face?

11) Ask about the training of welfare practitioners, and what limitations and opportunities this might create.

12) Ask about social worker- client ratios/case-loads.

13) Ask about programmes which empower CBOs, NGOs and voluntary organisations to provide care/support for orphan children.

14) Ask about grants to families who care for orphans. Ask about what these are, and whether they reach orphan caregiving households, and indeed whether if they did they would be affordable to Government.

15) Ask about foster care grants. Ask about what these are, and whether they reach orphan caregiving households, and indeed whether if they did they would be affordable to Government.

16) Ask about policies on street children/strategies to deal with this consequence of the growing orphan population.

17) Ask about the efficiency of processing various requests for assistance.

18) Ask about the Government's capacity to provide grants to all who are eligible.

19) More generally, ask how Government/Directorate of Social Services could improve on the way it is addressing the orphan problem.

20) Ask about resources needed to improve service delivery.

Non-Governmental Organisations

21-40) [Int: Take the issues raised for the Directorate of Social Services above, including the Directorate's responses to these questions, and reformulate these for the NGOs.]

41-60)   [Int: Take the issues raised for the Directorate of Social Services above, including the Directorate's responses to these questions, and reformulate these for MBEC.   Then, ask the following:]

61)   Extent to which the number of orphans attending school is monitored.

62)   Ask about school based programmes to reach poverty stricken children, and specifically can reach orphan caregiving households.

63)   The implications of exempting all eligible orphans from paying school funds and hostel fees.

64)   Policy on school uniforms and exemptions thereof.

65)   HIV/AIDS education - in school interventions.

Bibliography

Achieng, J. (1998, February 1995). Uganda's Winning the Aids Battle [23 paragraphs]. Electronic Mail & Guardian. Available: http://www.mg.co.za/mg/ africa archive.html

ActionAid (1993). AIDS Orphans. A Community Perspective From Tanzania, ActionAid, London.

AIDS in Zimbabwe [21 paragraphs]. (1998, October 19). Available: http://www.woza.co.za/news/oct978/zimholocaust.htm

Amupadhi, T. (1999, April 22). MP's Urged to Support AIDS move [11 paragraphs]. The Namibian- Africa News online. Available: http://www.africanews.org

Assistance to AIDS Orphans Within the Family Kinship System and Local Institutions: A Programme for East Africa. [12 paragraphs]. HIV Insite – Gateway to AIDS information [online article]. Available: http://kali.ucsf.ed/topics /children/2098.2db5.html

Barnett, T. and A. Whiteside with C. Desmond (2000). The Social and Economic Impact of HIV/AIDS in Poor Countries: A Review of Studies and Lessons, (mimeo), Durban, South Africa.

BIDPA (2000). Macroeconomic Impacts of HIV/AIDS Epidemic in Botswana, Botswana Institute for Development Policy Analysis, Gaborone.

Bisseker, C. (1997, July 25). AIDS Costs Multiply [38 paragraphs]. National AIDS Review [article online]

Blackden, C.M and C. Bhanu (1999). Gender, Growth and Poverty Reduction: Special Program of Assistance for Africa, 1998 Status Report on Poverty in Sub-Saharan Africa, World Bank Technical Paper No. 428, The World Bank, Washington.

Blackie, R. and P. Tarr (1999). Government Policies on Sustainable Development in Namibia, Research Discussion Paper No. 28, Directorate of Environmental Affairs, Ministry of Environment and Tourism, Windhoek.

Briggs, C. (1999, January). Children Affected and Orphaned by HIV/AIDS: A Global Perspective [19 paragraphs]. Fact Sheets [online article]. Available: http://www.pedhivaids.org/fact/infant fact g.html

Carlisle, C. (2000). "The Search for Meaning in HIV and AIDS: The Carers' Experience", Qualitative Health Research, Vol. 10, No. 6.

CSO (1994a). 1991 Population and Housing Census, CSO, National Planning Commission, Windhoek.

CSO (1994b). Provisional Population Projections 1991-2011 Namibia, Central Statistics Office, National Planning Commission, Windhoek.

CSO (1996). Living Conditions in Namibia: Basic Description With Highlights. The 1993/1994 Namibia Household Income and Expenditure Survey: Main Report, Central Statistics Office, Windhoek.

CSO (1998). Provisional Population Projections:1991-2011, National Planning Commission, Windhoek.

CBS (2002). "Census Preliminary Results in Brief", Central Bureau of Statistics, National Planning Commission, Windhoek.

Damases, S., P. Bruhns and J. Sindano (1999). Sexual Exploitation of Children in Namibia: A report for terre des hommes, Germany and Network against Sexual Exploitation of Children (NASE), Windhoek.

Department of Women's Affairs (1997). National Gender Policy, Office of the President, Windhoek.

Devereux, S. and T. Naeraa (1993). <u>Drought and Entitlement Decline in Namibian Agriculture, 1992</u>, SSD Discussion Paper No. 3, SSD, MDRC, UNAM, Windhoek.

Family Care International (1999). "Sexual and Reproductive Health Briefing Cards", Family Care International, New York.

FAO (2000). <u>The Impact of HIV/AIDS on Farming Communities in Namibia</u>, report prepared by Mr. E.J. Matanyaire in collaboration with Ms. E. Timpo, Food and Agricultural Organization of the United Nations, Windhoek.

Forsyth, S. (1999). Cost-effectiveness of HIV/AIDS Interventions: Why don't Policy Makers Listen? <u>SAfAIDS</u> 7(3) 10,11,15.

Foster, G., T, T. Nyaruwa and L. Muchaneta. (1999). Increased Scope and Decreased Costs of Home Care. <u>SAfAIDS</u> 7 (3), 6,7,9.

Foster, G. (2000). "Responses in Zimbabwe to Children Affected by AIDS", <u>SAfAIDS News</u>, Vol. 8, No. 1.

Gregson, Nyamukapa and Mlilo (2000). "Are Women or Men More Affected by HIV in Southern Africa? Insights from Studies in Rural Zimbabwe", SAfAIDSS, December 2000, Vol. 8, No. 4.

GRN (1999). <u>A Commitment to Our Children. Namibia's Country Report Under the United Nations Convention on the Rights fo the Child</u>, prepared by Cactus Consult and SIAPAC on behalf of the Government of the Republic of Namibia and UNICEF, Windhoek.

Hastings. T. (1999). <u>The Role of Remittances in the Namibian Economy</u>, NEPRUOccasional Paper No. 15, NEPRU, Windhoek.

Heywood, M. (1999) SADC Moves Towards Making AIDS and HIV Notifiable. <u>SAfAIDS</u> 7(3), 14-15.

Holt, C. (1997, December 9). Zambia's Orphans of AIDS [15 paragraphs]. <u>Electronic Mail & Guardian.</u> Available: <u>http://www.mg.co.za/mg/news/97dec1/9dec-zambia aids.html</u>

Hubbard, D. (1991). <u>Women and Children in Namibia: The Legal Context.</u> The Namibian Institute for Social and Economic Research, University of Namibia, Windhoek.

Hunter, S. and J. Williamson (1994). <u>Children on the Brink. Strategies to Support Children Isolated by HIV/AIDS</u>, USAID, Washington.

Iken, A., M. Maaasdorp and C Solomon (1994). <u>Socio-Economic Conditions of Female-Headed Households and Single Mothers in the Southern Communal Areas of Namibia.</u> Social Sciences Division, University of Namibia, Windhoek.

Jackson, H. (1998). World AIDS Conference: Bridging the Gap. <u>SAfAIDS</u> 6 (3), 2-8.

Jackson, H. (2000). "AIDS 2000 Break the Silence", SAfAIDS, September, 2000, Vol. 8, No. 3.

JTK Associates (2000). <u>The Impact of HIV/AIDS on the Education Sector in Swaziland</u>, prepared by JTK Associates with assistance from SIAPAC for the Ministry of Education and UNICEF, Mbabane, Swaziland.

Livuza, A. (1997, July 19). Malawi's AIDS Orphans Turn to Begging or Drugs [21 paragraphs]. <u>Electronic Mail & Guardian.</u> Available: <u>http://www.mg.co.za/mg/news/97ju-malawi aids.html</u>

Long, C. (1999, December 14). Children Orphaned by AIDS: A Ticking Time Bomb in Africa [21 paragraphs]. Disasterrelief.org [online article]. Available: <u>http://www.disaterrelief.org/Disaters/991214AIDSorphans</u>

Madorin, K. (1999). <u>Manual. Psycho-Social Support of Children Affected by AIDS</u>", terres des hommes Switzerland and the HUMULIZA Project, Basel, Switzerland and Kagera, Tanzania.

Mallory, C. and P.N. Stern (2000). "Awakening as a Change Process Among Women at Risk for HIV Who Engage in Survival Sex", Qualitative Health Research, Vol. 10, No. 5.Mataure, P. (2000). "Volutary Counselling and Testing", SAfAIDS News, September 2000, Vol. 8, No. 3.

MAWRD (1999). The Impact of HIV/AIDS on Gender Burdens and Household Incomes in Kavango: Technology and Policy Implications, discussion paper no 4, Division of Agricultural Planning, Directorate of Planning, Department of Agriculture and Rural Development, Windhoek.

Meldrum, A. (1997, August 5). Land of the Orphan Armies [17 paragraphs]. Electronic Mail & Guardian. Available: http://www.mg/news/97aug1/5aug-uganda7.html

MLHRD (1996). National Code on HIV/AIDS and Employment, Ministry of Labour and Human Resources Development, compiled in co-operation with the Labour Advisory Council, Windhoek.

MLHRD (1997). National Employment Policies, Directorate of Employment, Ministry of Labour and Human Resources Development, Windhoek.

MLHRD (1998). The Namibia Labour Force Survey 1997: An Interim Report of Analysis, Ministry of Labour and Human Resource Development, Windhoek, Namibia.

MLHRD (2000). Namibia Child Activities Survey 1999: Report of Analysis, Ministry of Labour, Windhoek.

MOHSS (1993). Namibia Demographic and Health Survey 1992, P. Katjiuanjo, S. Titus, M. Zauana and J. Boerma, Ministry of Health and Social Services and Macro International, Windhoek.

MOHSS (1999a). The National Strategic Plan on HIV/AIDS (Medium Term Plan II) 1999-2004, Ministry of Health and Social Services, Windhoek.

MOHSS (1999b). Report of the 1998 HIV Sentinel Sero Survey, MOHSS, Windhoek.

MOHSS (1999c). Epidemiological Report on HIV/AIDS for the Year 1999, National AIDS Co-ordination Programme, Windhoek.

MOHSS (2000a). "AIDS Projections", MOHSS, mimeo, Windhoek.

MOHSS (2000b). Projecting the Impact of HIV/AIDS in Namibia. A report on Work in Progress to Establish National Consensus on HIV/AIDS Impact Projections for Namibia, prepared by the MOHSS Working Group on HIV/AIDS Impact Modelling, Directorate of Policy, Planning and Human Resources Development, Ministry of Health and Social Services, Windhoek.

MOHSS (2001a). Report of the 2000 HIV Sentinel Sero Survey, Directorate of Primary Health Care and Nursing Services, National AIDS Co-ordination Programme, Ministry of Health and Social Services, Windhoek.

MOHSS (2001b). For the Love of Children: Namibia's Growing Population of Orphans and Vulnerable Children, Background Information for the First National Conference on Orphans and Other Vulnerable Children, Windhoek, Namibia, 8-10 May 2001, Windhoek.

MOHSS (2001c). First National Conference on Orphans and Other Vulnerable Children, Windhoek, Namibia, 8-10 May 2001, Summary Report, organised by the Directorate of Developmental Social Welfare Services, Ministry of Health and Social Services, Windhoek.

MOHSS (2001d). Namibia Demographic and Health Survey 2000: Preliminary Report, Ministry of Health and Social Services, with assistance from SIAPAC and UNAM, Windhoek.

MOHSS/UNICEF (1998). More than a Loss of a Parent: Namibia's First Study of Orphan Children. UNICEF, Namibia, Windhoek.

Monitoring the AIDS Pandemic. ('undated') The Status and Trends of the HIV/AIDS Epidemics in the World. Available: http://wwwfhi.org/en/aids/impact/mapgva.html

Monk, N. (2000). <u>Orphans of the HIV/AIDS Pandemic. A Study of Orphaned Children and Their Households in Luweero District, Uganda</u>, Switzerland.

Muchena, O. (1998). AIDS and AFRICA Smallholder Agriculture. <u>SAfAIDS</u> 6 (3), 10-11.

Mutangadura and Webb, D. (1998). The Socio-Economic Impact of Adult Mortality and Morbidity on Households in Urban Zambia. <u>SAfAIDS</u> 6 (3), 14-15.

Naeraa, T. <u>et al</u>. (1993). <u>Coping with Drought in Namibia, Informal Social Security Systems in Caprivi and Erongo</u>. Namibian Institute for Social and Economic Research, NISER Research Report 12, Windhoek.

The Namibian (3 March, 2000). "The orphan generation and employment creation", <u>The Namibian</u>, Friday, 3 March, 2000, p. B5.

The Namibian (30 March 2000). "AIDS policy 'a first for Africa'", <u>The Namibian</u> 30 March, 2000, p. 3.

The Namibian (24 May 2000). "AIDS Cuts Life Expectancy by 16 Years", <u>The Namibian</u>, 24 May, 2000, p. 5.

The Namibian (8 November, 2000). "Govt to up support for AIDS orphans", p. 8.

The Namibian (17 November 2000). "Namibia's Child Death Rate Rises: HIV/AIDS Linked to Increase", pp. 1-2.

The Namibian (4 December, 2000). "Impact of AIDS on Africa's Workforce 'Far Worse'", p. 11.

The Namibian (16 March, 2001). "AIDS orphans to skyrocket", <u>The Namibian</u>, 16 March, 2001, pp. 1-2.

The Namibian (9 May, 2001). "Support for AIDS Orphans", <u>The Namibian</u>, 9 May, 2001, p. 3.

The Namibian (12 May, 2000). "A Child in the Frontline", <u>The Namibian</u>, 12 May, 2000, Page 7.

The Namibian (15 May, 2001). "Farming sector faces AIDS devastation", <u>The Namibian</u>, 15 May, 2001, p. 3.

The Namibian (21 May, 2001). "Caregivers struggle to look after AIDS orphans", <u>The Namibian</u>, 21 May, 2001, p. 3.

The Namibian (15 August, 2001). "Region faces huge fall-out from AIDS", <u>The Namibian</u>, 15 August, 2001, p. 5.

Namibia Acturial Services (2000). "AIDS in Namibia Workshop 22 February 2000", Namibia Acturial Services, (mimeo), Windhoek.

Namibian HIV&AIDS Media Campaign (2001). "Take Control", bulletin 4, mimeo, Windhoek.

Narayan, D. with R. Patel, K. Schafft, A. Rademacher and S. Koch-Schulte (2000). <u>Voices of the Poor: Can Anyone Hear Us?</u>, World Bank, Washington.

National Planning Commission (1995). <u>First National Development Plan (NDP1). 1995/1996 - 1999/2000</u>, National Planning Commission, Windhoek.

National Planning Commission (1997). <u>National Population Policy for Sustainable Human Development</u>, NPC, Windhoek.

National Planning Commission (1998). <u>Poverty Reduction Strategy for Namibia</u>, NPC, Windhoek.

National Planning Commission (2000a). <u>Mid-Term Review of First National Development Plan (NDP1) Report. Volume 1, 1995-1996 - 1997-1998</u>, National Planning Commission, Windhoek.

National Planning Commission (2000b). <u>National Human Resource Plan 2000-2010</u>, NPC, Windhoek.

National Planning Commission (2000c). <u>Intercensal Demographic Survey Incorporating Mid-Decade Goal Survey</u> (draft), Central Bureau of Statistics, National Planning Commission, Windhoek.

National TB Control Programme (1999). "National TB Control Programme, MOHSS, Report 1998/1999", Ministry of Health and Social Services, Windhoek.

New Era (11 September, 2000). "New Hope for AIDS Orphans", Windhoek.

Ngonji, R. (1997, November 3). Tanzania's All-Female Marriages an AIDS Risk [15 paragraphs]. Electronic Mail and Guardian. Available: http://mg.co.za/mg/news/97nov1/3nov-tanzania.html

NISER (1993). "Phase I of Educationally Marginalised Children's Project: Baseline Desk Study", prepared by D. LeBeau, NISER for MEC.

Pulley, L., A. McAlister, L. Kay, and K. O'Reilly (1996). "Prevention Campaigns for Hard-to-Reach Populations at Risk for HIV Infection: Theory and Implementation", Health Education Quarterly, Vol. 23, No. 4.

Reeves, P., S Merriam and B Courtenay (1999). "Adaptation to HIV Infection: The Development of Coping Strategies Over Time", Qualitative Health Research, Vol. 9, No. 3.

Republic of Zambia (1999). Situation Analysis of Orphans in Zambia 1999, Government of the Republic of Zambia.

Rugalema, G. (1999). Adult Mortality as Entitlement Failure: AIDS and the Crisis of Rural Livelihoods in a Tanzanian Village, a Ph.D. Thesis Submitted to the Institute of Social Studies, The Hague, The Netherlands.

Sanderson, W., B. Fuller, M. Hellmuth and K. Strzepek (2001). Namibia's Future. Modeling Population and Sustainable Development Challenges in the Era of HIV/AIDS, International Institute for Applied Systems Analysis, Lazenburg, Austria.

SAfAIDS (June 2000). "OAU Strategies to Support Orphans and Vulnerable Children", Vol. 8, No. 2.

SAfAIDS (2001). "The threat to food security in Zimbabwe", SAfAIDS, March, 2001, Vol. 9, No. 1.

Save the Children (1999). Children Living with HIV/AIDS in South Africa - A Rapid Appraisal, Save the Children Fund (UK) South Africa, Johannesburg, South Africa.

SIAPAC (1998). Trends in Youth Sexual Knowledge, Attitudes and Practices: 1995 to 1997, prepared by SIAPAC for READ, NANASO and the Namibian-German AIDS Control Project, Windhoek.

SIAPAC (1999). Food Security and Nutrition Assessment Report - 1999, Prepared by SIAPAC for the Food Security Secretariat, Ministry of Agriculture, Water and Rural Development, Windhoek.

SIAPAC (2001). Baseline Study on Knowledge, Attitudes, Behaviours and Practices of Adolescents and Youth on Sexual and Reproductive Health, prepared by SIAPAC for the Government of Botswana, UNICEF/Botswana, the African Youth Alliance of Botswana, UNAIDS, and PSI Botswana, Gaborone, Botswana.

SSD (1996a). Namibia Poverty Profile: A Report for SIDA, Social Science Division, Multi-Disciplinary Research Centre, University of Namibia, Windhoek.

Stegling, Christine (1998). Community Home-based Care of People Affected by HIV/AIDS in Botswana: A Human Rights Perspective, MSc Dissertation for Development Studies, School of Oriental and African Studies, University of London, London.

The Sunday Independent (26 November, 2000). "Macabre interplay of poverty and sexual habits adds fuel to the HIV/AIDS furnace", prepared by Hein Marais, South Africa, p. 9.

Totemeyer G., V. Tonchi and R. du Pisani (1997). Namibia Regional Resource Manual, Fredriech Ebert Stiftung, Windhoek.

UNAIDS (1999). "ABC's of HIV/AIDS", UNAIDS internet download.

UNAIDS (2000). Report on the Global HIV/AIDS Epidemic, UNAIDS, New York.

UNDP (1997a). Development Cooperation Report: Namibia, United Nations Development Programme, Windhoek.

UNDP (1997b). Human Development Report 1997, United Nations Development Programme, New York.

UNDP (1998a). Development Cooperation Namibia: 1997 Report, United Nations Development Programme, Windhoek.

UNDP (1998b). Human Development Report 1998, United Nations Development Programme, Oxford Press, New York, USA.

UNDP (1999). Human Development Report 1998, United Nations Development Programme, Namibia, Windhoek

UNDP (2000). Namibia: Human Development Report, UNDP with UN Country Team, Windhoek.

UNDP/UNAIDS (1997). Human Development Report 1997, Oxford Press, New York, USA

UNICEF (1995). Children and Families Affected by HIV/AIDS: Guidelines for Action, draft prepared by UNICEF, New York.

UNICEF (1998a). State of the World's Children 1998, United Nations Children's Fund, Oxford Press, London, England.

UNICEF (1998b). Report of the United Nations System in Namibia on Namibia's Follow-Up to the United Nations Global Conferences, UNICEF, WHO, FAO, UNDP, and UNFPA, Windhoek, 1998.

UNICEF (1999a). The Progress of Nations, UNICEF, New York.

UNICEF (1999b). Report of an Assessment of the Situation of the HIV/AIDS Epidemic and its Consequences for Families and Children, Focussing on Orphans, Children and HIV/AIDS, Government and Community Response in a Multisectoral Context, UNICEF/Swaziland, Mbabane.

UNICEF (2001). The State of the World's Children 2001, UNICEF, New York.

UNICEF/Mozambique (1999). Orphan Programming in Mozambique: Combining Opportunities for Development with Prevention and Care, Report of an Assessment of Programming in Mozambique for Families and Children Affected by HIV/AIDS, UNICEF/Mozambique, Maputo. Draft Report. Main consultant was Susan Hunter.

United Nations (1999). Common Country Assessment of Namibia, United Nations, Windhoek.

Verde Azul (2000). The Impact of HIV/AIDS on the Education Sector, Verde Azul Consult Lda in co-operation with AfriDev Associates and SIAPAC, prepared for the Ministry of Education (MINED), Maputo, Mozambique.

Warwick, R.I. (1999). CHILDREACH Cites AIDS Orphans as Greatest Risk to Africa's Future [5 paragraphs]. CHILDREACH [online article]. Available: http://www.childreach.org/headlines/aidsorphans.html

Whiteside, A. (ed.) (1998). Implications of AIDS for Demography and Policy in Southern Africa, University of Natal Press, Pietermaritzburg, South Africa.

Whiteside, A. and C. Sunter (2000). AIDS. The Challenge for South Africa, Human and Rousseau Tafelberg, Cape Town.

WHO (2000). The World Health Report 2000. Health Systems: Improving Performance, World Health Organisation, Geneva, Switzerland.

World Bank (1997). Confronting AIDS: Public Priorities in a Global Epidemic. New York: Oxford University Press.

World Bank (1999). Intensifying Action Against HIV/AIDS in Africa. Responding to a Development Crisis, Africa Region, The World Bank, Washington, United States.

World Bank (2001). World Development Report 2000/2001: Attacking Poverty, World Bank, Washington.

Zimba, R. and M. Mostert (1993). "The Namibian Secondary School Students' Cognitive, Attitudinal and Behavioural Risks That May Promote HIV Infection and the Spread of AIDS", in K. Prah (ed.), Social Science Research Priorities for Namibia, University of Namibia and the Council for the Development of Economic and Social Research in Africa, Cape Town.