ORPHANS AND OTHER ULNERABLE CHILDREN IN NAMIBIA - - THEIR RIGHT TO EDUCATION AND HOLISTIC SUPPORT AND DEVELOPMENT

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INTRODUCTION AND BACKGROUND

People everywhere, but particularly in developing countries, are struggling with similar daunting problems: hunger, homelessness, rapid population growth, unemployment, violent crime, poor health, the preventable deaths of millions of children, widespread environmental degradation, and education systems inadequate for countries' needs and people's aspirations.

But the world is at the threshold of a new century, with all its promise and possibilities, with the cumulative experience of reform, and innovation. In the case of children, a number of international events affecting children have marked the past few years:

1. The Jomotien World Conference on Education for All, held in Thailand in March, 1990. One thousand five hundred delegates from hundreds of nations and organisations gathered to assess conditions and develop plans to improve education around the world. The World Conference generated an action plan and launched the Education for All movement to meet the basic learning needs of all children, youth and adults in all countries of the world;
2. The World summit for children in September 1990, which was attended by seventy Heads of State;
3. The Child-to-Child movement was started in 1978, shortly after the Alma Ata Conference which launched the world-wide commitment to spreading the concept of Primary Health Care (PHC), in preparation for the International Year of the Child (IYC) in 1979;
4. The emergence of the HIV/AIDS epidemic which has had a negative impact on development and particularly on children in Africa.

We expand some of these points before describing our exploratory studies on children's rights in Namibia and the services provided to children affected and infected by HIV/AIDS and making some recommendations on the need for education and provision of support for their holistic development.

1. EDUCATION FOR ALL (EFA): THE EXPANDED VISION; AND MILLENIUM DEVELOPMENT GOALS

At the World Conference on Education for All (Jomtien, Thailand, March 1990), the international community reaffirmed its commitment to ensuring the right to education for every man, woman, and child. The conference also committed to ensuring that serving the basic learning needs of all implied more than just commitment to education as it now exists. What is needed is an "expanded vision" that surpasses present resource levels, institutional structures, curricula, and conventional delivery systems.

Commitment is embodied in the *World Declaration on Education for All,* and its accompanying *Framework for Action to Meet Basic Learning Needs,* which outlines a global strategy to be undertaken through the 1990s in line with the principles contained in the *World Declaration.* Subsequently, a secretariat was established based at UNESCO's headquarters in Paris. The objective was to promote cooperation in basic education and monitor progress toward the provision of basic education for all.

The World Declaration on Education for All, and the Framework to Meet Basic Learning needs was adopted and signed by 155 governments present at the conference. Through these two texts, the world community renewed its commitment to ensuring the Right to Education, and effectively broadened the scope of basic education to include early childhood development (ECD), primary education, non-formal education (including literacy) for youths and adults; and learning conveyed through the media and social action.

The conference also specified that follow-up action at the international level should serve national follow-up action and support it effectively. Such follow-up action should seek to maintain the spirit of cooperation amongst countries, multilateral and bilateral agencies, as well as NGOs (which had been the hallmark of the conference). The Mid-Decade Review of Progress towards June 1996 which was preceded by regional assessments of the state of basic education in Africa, Latin America, and Asia. In preparation for the Global

end-of decade assessment, the Africa regional preparatory conference took place in December 1999 in South Africa.

The assessments are intended to help provide analyses of the state of basic education in both quantitative and qualitative terms covering the areas of **Early Childhood Care and Development** (including expansion of ECD programs, family and community involvement, attention to disadvantaged children, and ECD policy, regulations and management; **Primary Education** (including strategies for providing access to out-of-school children; parental attitudes; conditions of schools; quality of schooling; and direct, indirect and opportunity costs of schooling to families), **Learning Achievement and Outcomes** (including strategies to measuring achievement outside the school system; quality of teaching-learning process), **Adult Literacy** (including types and range of literacy programs, mechanisms for monitoring women's literacy programs; policy, management and financing), **Training in Essential Skills** (including policy, the nature of skills programs; population/target groups served; and quality and effectiveness); and **Education for Better Living** (including types of electronic and print media used for education; social mobilization campaigns leading to awareness; policy, management and funding; and quality and effectiveness).

Early in the year 2000, a global summit, the World Education Forum, was held in Dakar, Senegal, from 26 – 28 April. The summit completed the global assessment. Representatives from all the regions of the world agreed upon priority policy and programme actions that target educational opportunities for those – young and old – who have been under-served or not reached at all during the 1990s. For those who have been reached within this decade, policy directions were set for ensuring quality lifelong education. All of these actins are now popularly referred to as the Education for All (EFA) goals (Box 1).

Box 1: EFA Goals as stated in the Dakar Framework for Action

Goal 1
Expand early childhood care and education. Expand and improve comprehensive childhood care and education, especially for the most vulnerable and disadvantaged children.

Goal 2
Free and compulsory education of good quality. Ensure that by 2015 all children, particularly girls, children in difficult circumstances and those belonging to ethnic minorities, have access to and are able to complete primary education that is free, compulsory and of good quality.

Goal 3
Promote the acquisitions of life skills by adolescents and youth. Ensure that the learning needs of all young people and adults are met through equitable access to appropriate learning and life skills programme.

Goal 4
Expand adult literacy. Achieve a 50% improvement in levels of adult literacy by 2015, especially for women, and equitable access to basic and continuing education for all adults.

Goal 5
Eliminate gender disparities in primary and secondary education by 2005, and achieve gender equality in education by 2015, with a focus on ensuring girls' full and equal access to and achievement in basic education of good quality.

Goal 6
Enhance educational quality. Improve all aspects of the quality of education and ensure excellence so that recognized and measurable learning outcomes are achieved by all, especially in literacy, numeracy and essential life skills.

The EFA goals were supplemented and complemented by the Millennium Development Goals (Box 2)

Box 2: The Millennium Development Goals

The Millenium Development Goals are a set of development targets internationally agreed upon by the member states of the United Nations. They commit governments to reduce poverty by 2015 and to accelerate the pace of economic, social and human development.

Goal 1: Eradicate extreme poverty and hunger

- Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day.
- Halve, between 1990 and 2015, the proportion of people who suffer from hunger.

Goal 2: Achieve universal primary education

- Ensure, that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary education.

Goal 3: Promote gender equality and empower women

- Eliminate gender disparity in primary and secondary education, preferably by 2005 and to all levels of education no later than 2015.

Goal 4: Reduce child mortality

- Reduce by two thirds, between 1990 and 2015, the under five mortality rate.

Goal 5: Improve maternal health

- Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio.

Goal 6: Combat HIV/AIDS, malaria and other diseases

- Have halted by 2015, and begun to reverse the spread of HIV/AIDS.
- Have halted by 2015, and begun to reverse the incidence of malaria and other major diseases.

Goal 7: Ensure environmental sustainability

- Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources.
- Halve, by 2015, the proportion of people without sustainable access to safe drinking water.
- By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers.

Goal 8: Develop a global partnership for development

- Develop further an open, rule-based, predictable, non-discriminatory trading and financial system. (Includes a commitment to good governance, development, and poverty reduction – both nationally and internationally).
- Address the Special Needs of the Least Developed Countries (Includes: tariff and quota free access for least developed countries' exports; enhanced programme of debt relief for HIPC and cancellation of official bilateral debt; and more generous ODA for countries committed to poverty reduction).
- Address the special needs of landlocked countries and small island developing states (Through the Programme of Action for Sustainable Development of Small Island Developing States and the outcome of the twenty-second special session of the General Assembly).
- Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the

long term.
- In cooperation with developing countries, develop and implement strategies for decent and productive work for youth.
- In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries.
- In cooperation with the private sector, make available the benefits of new technologies, especially information and communication.

2. THE UN CONVENTION ON THE RIGHTS OF THE CHILD

The UN Convention on the Rights of the Child (CRC) recognizes that the particular status of children engenders specific forms of vulnerability, and particular interests and entitlements. It sets out the inherent rights and entitlements needed to guarantee a child's right to survival, development and an adequate standard of living. These rights encompass entitlements to basic standards in health, education, food, shelter, welfare and protection from exploitation and violence.

Securing the right to adequate healthcare is paramount to ensuring the survival and development of children. Every year, more than 10 million children die before the age of five. Nearly half of these deaths occur within the first month of life.

Child survival figures reveal stark inequalities. The poorest 20% of the world's children are ten times more likely to die before the age of 14 than the wealthiest 20%. In sub-Saharan Africa, 172 out of every 1000 children do not survive to their fifth birthday. This compares with six out of every 1000 children in industrialised countries. The factors affecting children's health include access to quality healthcare, nutrition, household income, parental (particularly maternal) education and access to safe water and sanitation.

The CRC places a responsibility on states to ensure that adequate measures are taken to combat disease and malnutrition, through the application of readily available technology, including ensuring that children receive adequate nutritious foods and clean drinking water and the highest attainable standard of healthcare.

Education is vital to both a child's physical and intellectual development. It enables a child to develop skills and knowledge, which will improve their livelihood and earning potential during later stages of their lives. Education also contributes significantly to improvements in health. One study in Africa found that a 10% increase in female education led to a 10% decline in child mortality. The CRC entitles all children to access to free primary education. It also outlines the responsibility of states to ensure the provision of secondary, higher and vocational education. The quality of education provided should allow the child to develop its personality, talents, and mental and physical abilities to their fullest potential.

A child's ability to survive and develop can be hampered or scarred due to violence and exploitation, both inside and outside the family. These include hidden, hazardous and unregulated forms of labour, sexual abuse and exploitation, and the direct and indirect consequences of conflict. The CRC outlines the responsibility of the state to protect children from abuse, neglect, violence, exploitative labour and conflict.

Finally, the CRC places the responsibility on the family to secure, within their abilities and financial capabilities, the conditions of living necessary for the child's development. The state is given the responsibility to assist parents in this task.

The CRC provides inspiration and a framework for the development of child poverty eradication policies. These need to be developed in the context of national circumstances, and shaped to address the specific needs of children in each case – but within the overarching framework of the recognition of the universality of the rights of the child.

3. CHILD-TO-CHILD APPROACHES

Child-to-Child started as an international programme designed to teach and encourage older children, especially school children, to concern themselves with the health and general development of their younger brothers and sisters and of younger children in their own communities. The programme has grown

from a few health messages to be spread by children into a world-wide movement in which children are considered as responsible citizens who, like their parents and other community members, can actively participate in the community and in the developmental affairs of the community.

The approach emphasizes that children need to be accepted as partners to promote and implement the idea of health and well-being of each other, of families, and of communities. In so accepting them, you help them to develop, and the approach enhances their own worth both in their own eyes, and in those of adults. Hence there is a strong link with the idea of children's rights. You respect partners and you work with them.

The parallel between Child-to-Child and the **Convention on the Rights of the Child** may not be immediately obvious, but the philosophy and work of Child-to-Child is in fact a practical expression of the **Convention's** many provisions which seek to make children **subjects** rather than objects of efforts to ensure their survival, protection and development. Articles 5 and 14 of the Convention speak of the evolving capacities of children; Article 12 refers to children's right to express views freely in all matters which affect them; Article 24 obligates governments to "ensure that all segments of society, in particular parents and children, are informed, have access to education, and are supported in the use of basic knowledge of child health and nutrition, the advantages of breast-feeding, hygiene, and environmental sanitation, and prevention of accidents". These extracts from the **Convention** read like guidelines for a Child-to-Child project.

In Namibia Child-to-Child was formerly introduced towards the end of the first year of independence (Mostert and Zimba, 1990), at a major workshop held in Windhoek.

4. SCOPE OF HIV/AIDS AND ORPHANS IN AFRICA

In Africa there are an alarmingly high numbers of children homeless and living on the street. The plight of these children has been a matter of great concern to UNESCO which focuses in part on combating the exclusion of children from

any given society. The street children crisis has been deepened by the HIV/AIDS pandemic, which is a formidable challenge and obstacle, not only to the economies of several countries, but also to families and communities in the South African Development Community (SADC) region.

GLOBAL HIV EPIDEMIC

- Since its first documented appearance 20 years ago, HIV has infected more than 60 million people worldwide.
- Globally, there are an estimated 40 million people living with HIV.
- About one-third of those currently living with HIV/AIDS are between 15 – 24 years.

REGIONAL HIV EPIDEMIC

- Sub-Saharan Africa is the region most severely affected by HIV/AIDS:
  - 3.4 million new infections in 2001
  - 28.1 million people are living with HIV/AIDS regionally
- HIV prevalence rates have risen to alarming level in Southern Africa
- Recent antenatal clinic data show that several parts of Southern Africa have prevalence rates among pregnant women exceeding 30%.

Source: AIDS Epidemic Update: UNAIDS/WHO, December, 2001

Sub-Saharan Africa is said to be amongst the most severely affected regions by the HIV/AIDS pandemic. This has contributed to an increase in the number of children living on the street, children living in families with inadequate care and support, and children resorting to high-risk behaviour for their own survival and that of their siblings, such as commercial sex and child labour. As a result, more and more children in the sub-region are being affected by and becoming infected with, HIV/AIDS. This threatens both their health and social acceptability. The chances of these children entering and remaining in school to attain a basic education are thus severely reduced.

	Total Children living with HIV/AIDS	**Children who have lost one or both parents to HIV/AIDS**	**Estimated AIDS Deaths**
Botswana	10 000	66 000	24 000
Lesotho	8 200	35 000	16 000
Malawi	40 000	390 000	70 000
Namibia	6 600	67 000	18 000
Swaziland	3 800	12 000	7 100
Zambia	40 000	650 000	99 000
Zimbabwe	56 000	900 000	160 000

Source: Report on the Global AIDS epidemic: UNAIDS/WHO, June 2000

In the hardest hit countries, HIV/AIDS has wiped out four decades of development progress. In 2001, 580,000 children under the age of 15 died from HIV/AIDS. A further 2.7 million children under the age of 15 are now living with the virus. Coping with HIV/AIDS is hardest for the poor. Unless HIV/AIDS is rapidly addressed, it will perpetuate the intergenerational transmission of poverty and prevent the attainment of the Millennium Development Goals.

Children are affected by HIV/AIDS in numerous ways. They can be directly infected through their mothers in the womb, at birth, or through breastfeeding. They can also contract HIV/AIDS as a result of unsafe or unwanted sex with an infected partner, or by sharing needles with someone who is infected with the virus. Even if they are not directly infected, children and young people are afflicted by HIV/AIDS as it impacts upon their families and communities.

HIV/AIDS has a profound effect on responsibilities in the home. As parents become ill, children struggle to take over adult responsibilities for housework or family care. They may miss school as a result. Some children are left as orphans, sometimes with responsibilities for their siblings. Alternatively their kin, and grandparents in particular, may take them in, but often in difficult circumstances. The loss of care and security experienced by children in HIV/AIDS afflicted families is accompanied by feelings of sadness, loneliness, and falling self-esteem.

HIV/AIDS can also have a drastic effect on the family's income. Those affected are eventually unable to work, and face increasing health care costs. The search for a cure and funeral expenses can also place a heavy burden on family funds. There may be no money available to pay for food for children's school fees. Children in child-headed households are particularly vulnerable – with average monthly incomes in Zimbabwe, for example, of only $8 compared to $21 amongst non-orphaned neighbours.

Children and their families might receive some assistance from the community. Neighbours and women's groups may give children support in

carrying out household tasks and may also help out with food on a short-term basis. Hospitals and NGOs might also offer homecare, free medication and material support to the family. Support with emotional needs may be sought from wider kin and neighbours in the first instance. The capability of the community to assist, however, will often depend on the extent of the epidemic. The provision of health and education services may suffer as nurses and teachers fall victim to HIV/AIDS. Teacher deaths due to AIDS in Zambia in 1998, for example, were equivalent to two-thirds of the number of newly qualified teachers.

One insidious effect of the HIV/AIDS is the unholy trinity of "shame, discrimination, stigmatisation" an elaboration of which we now turn.

Challenge of "Shame, Discrimination, Stigma" (SDS)

In Namibia's Constitution discrimination on the grounds of colour, religion, sex, place and origin and state of health are prohibited. Many officials preach against discrimination and stigma. Yet, on a daily basis, there are several reports in school, in communities, and in places of work, where people are being discriminated and stigmatized on the basis of their being affected and infected with HIV/AIDS. AIDS orphans, particularly, have borne the brunt of this "shame, discrimination and stigma" (SDS). Yet in traditional African customs and practices, orphans and other vulnerable children used to be well taken care of, and grew up in a spirit of acceptance.

The most effective health interventions are worthless if they are not used. What is it about our cultures that compels us to overlook a major barrier to improved healthcare: the entwined issues of stigma, discrimination, and shame (hereafter, SDS)?

SDS is such a powerful force that, if there is a chance their conditions would be revealed, people would rather suffer and die, and have their children suffer and die, rather than access treatment that could improve their quality of life and save their lives. Currently, those with any number of illnesses are stigmatised and rejected, as are family members if those illnesses are made

public. People also hide their medical conditions because they fear, oftentimes justifiably, that they will lose friends, jobs, housing, educational and other opportunities, if their conditions are publicly known. The many conditions affected by SDS include forms of cancer, Hansen's Disease, mental illness, mental retardation, tuberculosis, domestic violence, substance abuse and dependence, sexual dysfunction, and sexually transmitted diseases, now most notably HIV disease.

Repeatedly and loudly and for decades, experts at the international level and service providers at local levels have described the powerful forces of SDS. No less a personage than the late Jonathan Mann, then Director of the WHO Global Programme on AIDS, warned the world about SDS in regards to HIV. In 1987, speaking informally to the UN General Assembly, he "identified three phases of the HIV/AIDS epidemic: the epidemic of HIV, the epidemic of AIDS, and the epidemic of Stigma, discrimination and denial". He noted that the third phase is 'as central to the global AIDS challenge as the disease itself' (cited in Parker et al, 2002).

"Each year, more and more people die from the (HIV) disease and it is the stigma and misinformation around HIV that is killing people," Juan Manuel Suarez de Toro, President of the International Federation of Red Cross and Red Crescent Societies, said in a recent World Red Cross Day message. "people place themselves at high risk from infection or refuse to access treatment rather than face the consequences of social stigma, such as losing their homes, businesses and even their families," he said (Olafsdottir, 2003).

Given this background we briefly turn to the situation on the ground in Namibia in terms of the preliminary studies dealing with children's rights; and services provided to children infected and affected by HIV/AIDS.

5. CHILDREN'S RIGHT

In a 1995 study Zimba and Otaala, among other things, examined Nama childrearing practices associated with selected articles of the Convention on the Rights of the Child, and tried to draw up programmatic implications of these practices.

We observed, firstly that there seemed to be conceptions of children's rights that were consistent with universal understanding. Children's rights to education and good health were, for example, valued by Nama parents in ways similar to those expressed by concerned parents all over the world. However, the Nama families faced considerable hardships in providing for their children's education and medical care. Unemployment, lack of stable incomes and lack of affordable medical schemes were used to explain the hardships. Income generation activities and general community development initiatives appear to present possible solutions to the problems.

Secondly, there appeared to exist conceptions of children's rights that were inconsistent with current global formulations. Nama parent's conceptions of corporal punishment present a good example here. From a non-Nama perspective, it would seem that the endorsement of the use of corporal punishment in the home and at school violates children's freedom from physical and emotional abuse. According to the Nama, this interpretation would be inappropriate. To them, corporal punishment is one of the tools available to parents for socializing children into honest, well-behaved, self-disciplined, obedient and reflective individuals. In addition, it helps to produce out of children persons who fear and respect authority. To the Nama, this is important for the maintenance of regulated and ordered social relationships. Our judgement is that this concept conceptualization should be taken into account when championing the cause against child abuse. Obviously, most Nama parents do not perceive any abuse when corporal punishment is intended to create out of children responsible human beings with some realistic understanding of social and emotional connotations of right, wrong, unfair, fair and just actions.

Thirdly, our data revealed contextualized conceptions of children's rights. These were displayed when the consideration of the freedom to make their own choices and decisions regarding entertainment, spending money, friends, schools and churches to attend did not only implicate the social–cognitive developmental needs and welfare of the children but in addition involved matters of safety, security, protection from harm, custom, tradition and social relations with peers and adults. For example, whereas more than half of the respondents thought that adolescents were old enough to exercise the freedom of choosing their own friends, more than a third of them considered this to be in error because to protect them from alcohol and drug abuse, forming anti-social behaviour, bad influence and the misuse of sex, the youth required advice, counselling and guidance from their parents and other adult family members. It appears from this understanding that according to the Nama the exercise of children's rights to free choice and decision making should take into account their **contextualized best interests**. These interests should reflect Nama custom, tradition and contemporary social-cultural, social-economic and community development realities. (Zimba and Otaala, 1995, pp. VIII – IX).

SERVICES AVAIALBLE FOR CHILDREN AFFECTED AND INFECTED BY HIV/AIDS

Our preliminary study revealed that a range of services and programs were available in the Windhoek region. In the study we gathered information about the child and caregivers and the setting; about programmes and services which directly affect the setting, caregiver and the child; about the larger context including community attitudes, policy directions and strategies which influence service planning and delivery.

Program available

The programs currently operating in the study region included:

Survival programs

- Needs assessment by community volunteers (followed by distribution of goods and services to identified needy families and/or community groups);
- Safe homes: OVCs can live here temporarily. Officially registered safe homes receive N$10 per day per child. Monitoring is informal (i.e. neighbours may report incidences. There is no formal process for de-registration);
- Home based visiting;
- Soup kitchens: lunches for school children;
- Emergency and temporary accommodation for children;
- Special 'Fete' days when families can receive donated goods (3 times per year);
- Fostering of babies when they have nowhere else to go.

Health programs

- Vouchers for purchasing anti-retroviral and other medications;
- Health services;
- Support with maintaining medication schedules;
- Nutrition programs;
- Exercise and massages;
- Accessibility and support for HIV/AIDS testing, including counselling, and other support services for those found to be HIV positive;
- Dissemination of documents to access health and medical services.

Programs aimed at well-being, psychosocial development, family and community connections

- Home based visits;
- Counselling for 0-18 year old OVCs including a weekly support group (NOTE: Children aged 0-8 years do not access support groups. Instead they attend the mother support group with their mothers.);
- Support groups for infected adults and caregivers;
- Support for residential (relative) care in the community;
- Opportunity to meet and interact with others in an informal way;
- Promotion of adoption for orphans;
- Counselling for pregnant women.

Formal education and training programs

- Training for community volunteers;
- Training for home based visitors;
- Day-care preschool program, providing food and medicine;
- Camps for older children;
- After school tutoring;
- Training for caregivers (including workshops on *Building Resilience In Children Affected By HIV/AIDS; Home Based Family Care In Namibia; How To Start A Support Group);*
- School fee vouchers;
- Provision of school uniforms

Freedom of expression, choice and movement

- Income generating projects for infected mothers (Young children often accompany the mothers, but no activities are organised for the children);
- Bursaries for exceptional children to attend secondary school;
- Raising awareness about HIV/AIDS including advocacy for acceptance of HIV positive children and their mothers.

- Children in residential settings who had access to day programs such as school lunch program and day care program, which serves meals were not experiencing these deficiencies.

How children access services and programs

Information about services available to OVCs is disseminated through community agents such as Churches, schools and NGOs, government departments, support groups, community volunteers, door-to-door visits, and general public awareness (radio, posters, brochures) and by word of mouth.

In one case the centre became known when it set up in a community and was able to take in children who appeared at the door. Now it is full and provides services according to priority criteria determined by the organisation: Many children who would benefit remain unable to access this service. The centre is currently looking for ways to expand its delivery to accommodate the numbers presenting themselves.

The belief that there may be many OVCs who are not known, not registered or not accessing services was reported by all respondents.

One of the small organisations reported that they are aware of the needs of the 0-8 yeas old population in their own (small) geographical location.

We think we know about them all…went door to door in this area – had community meeting

Director of small organisation

Monitoring and quality of service provision and delivery

No formal monitoring of quality of service provision was identified during this study. Organisations reported that informal monitoring took place and/or that remarks by neighbours would sometimes alert them to distressful situations for their children.

Researchers used observations and interview data to assess the extent to which services were meeting established criteria for effective early childhood programs (see Box 2 above) These are described as follows:

1) Programs are community driven and highly participatory

Organisations and centres appeared to be community driven: That is, they were based on needs identified in and from the community, were situated where needs were prevalent and were run by or included staff and volunteers from the community and from the client population.

In Centre B the impetus and management of the service had emanated from a source outside the community (an international organisation). Management and staff did not include community representatives.

2) Programs emphasise a wide diversity of areas concerning children's health and well-being

Centre a was a small organisation which ran multi service programs including home based visiting, support groups for mothers, income generation (in planning stages) and links with several other organisations. Children in the centre interacted in their community but were branded as being 'from the AIDS house'. It was reported that some neighbourhood children has been told not to play with the centre children because of this stigma. A four-year-old had been barred from the local kindergarten because of his HIV positive status.

Centre B focussed primarily on providing an 'educational' program for 3-6 year olds. This was supplemented by serving nutritious meals, organising for health checks, occasional visits by doctors, and distribution of prescribed medicines for the children. This organisation did not focus on family support or related services nor was it linked to schools or other community services at the time of the study.

Centre C was based within the community. Children attended community schools. There appeared to be linkages with other social service providers.

Volunteers from NGOs came on an adhoc basis to interact with children. A large organisation had an association with this centre, including referrals and placement of children. Monitoring was not observed but a representative from the large organisation reported that they would respond if complaints were made. (The centre reported having more than the allotted capacity of children, because the children had no-where else to go.) School aged children at this centre appeared to mingle with non-OVCs in the community.

Centre D had contacts with schools, training programs and health services. The Centre contained homes within a large compound, behind a security gate. Children did not mingle with non-OVCs in the neighbourhood.

Centre E is a decentralised large organisation which runs many programs. Children in residential homes associated with Centre E were integrated in their neighbourhoods and communities and were accessing health and nutrition programs through the large organisation.

3) Programs emphasis strategic communications for awareness rising

The large organisations were highly committed to this activity. Numerous brochures and posters were produced and disseminated widely. Workshops and training packages were developed for diverse participants. Books were published and distributed through a variety of outlets. Income generation projects served double purposes of raising awareness and raising funds (for example the production of beaded AIDS brooches and story books for children).

Centre A played and active role in raising awareness about the needs of infected and affected individuals and children. Radio and print media were used to promote positive messages about these issues. Community meetings were held to discuss the importance of not rejecting HIV positive people and families. Centre B reported on their success with *'flag days'* whereby people celebrate the anniversary of the day they become aware of their HIV positive status and vow to live positively with the disease. They also engage in small scale awareness raising:

We…sensitised people in the area. We had community meetings. We even went from door-to-door. That's why we never have a burglary, because (everyone) knows we are the "AIDS-house". Blankets can be outside for a week.

Director, small organisation

Centre B, Centre C, Centre D and the residential houses did not appear to engage in awareness raising activities. Centre E is very active and has a strong infrastructure which supports awareness raising about all facets of HIV/AIDS.

4) Programs have links to community programs including schools

One large organisation reported having exceptionally close relations with health and educational agents and was thus able to provide services for its registered clients in an effective and efficient manner. All organisations expressed a desire to increase inter-agency linkages and to develop vehicles for information-sharing and referrals, but time and coordination needed for this was not deemed to be a priority in light of service-oriented needs.

One safe house identified links with schools. All safe houses reported linkages with health and social service providers.

Many caregivers in residential houses were receiving assistance from Centre E. However, many caregivers reported feeling unconnected. Some were in conflict with community services such as municipalities and schools who were making funding claims upon them. Many respondents in residential houses reported that they could not access adequate health services and/or did not appear to know where to seek assistance for the children in their care.

The school is always threatening with letters to pay the school fees otherwise the children will be out of school. The municipality is also threatening with the payment of the house, water and electricity.

Caregiver in residential house (rh)

need school fees and schoolbooks because they are threatening from the school

Caregiver in rh

She is not well informed … she does not know where to seek help, who to talk to and how to find solutions to her problems.

RA comments on caregiver in rh

5) Programs provide training opportunities for sustainability

The stability of infrastructure to ensure sustainability of current levels of service delivery and to facilitate the development of new programs as needs emerge was not evident in all situations.

At one Centre, a sustainable infrastructure was in place. This service had been operating for several decades. The infrastructure would protect service continuity beyond the presence of anyone individual such as the Head/Director.

An another Centre, the commitment of one individual was the driving force behind service development and delivery. The absence of this individual could result in program closure.

The majority of caregivers in residential houses (all but 2) reported having no backup should they become ill or unable to care for the child (ren) in their care. This was a source of grave concern to may caregivers.

As long as I am alive everything will go well, but what will happen to them if I pass away one day?

Elderly caregivers in rh

Training

One large organisation reported a training (and advancement) program for their staff. Most respondents in this study were not engaging in professional development activities. Caregivers in safe houses were aware that organisations were offering workshops/training in relevant topics, but only one respondent reported having attended any such program. In one safe house, turnover of caregivers was rapid. Caregivers seemed to have no experience or preferred background for the position. Training did not seem to be accessible due to lack of awareness, lack of time and/or lack of interest/commitment by some workers at this safehouse.

WHAT CHILDREN AND CAREGIVERS SAY

J came when he was only 1 year old. He lost his mom during childbirth. He was brought by the social workers and we've heard nothing about his relatives since.

Caregiver is sh re child aged 4

F came from hospital. He was 5 months. He was born in Katima. His mother was positive. He came as Baby F; no mother's name, nothing. No details of family. Only this year did we find out his surname.

Caregivers is sh re child aged 2½.

Narratives by children often revealed a sense of confusion and/or rejection:
They put my father in a big hole and now I live here.

Child in sh

Do you now who brought you here? No

Child in sh, aged 6

He changed houses in the compound a short while ago. It seems as if he does not remember anything before that.

RA about child aged 5

He says he is 3 years, his friend says he is 5. The caregiver says he is 5.

RA

I believe he is not well informed about himself. He does not know his own age.

RA re child in sh

Some children obviously believed that something wrong with them had resulted in their current predicament and/or they held other simplistic views about their situation:
My mother is in Owamboland. She doesn't want me to live there. (Why not?)
I don't know

Child in sh

My mother does not want me anymore.

Child in sh

Why are you here? *I am sick.*

Child in sh, aged 5

Other children had a grasp of their situation:
My mother and father died because they have AIDS.

Child in sh

"Aunty" brought me with my mother and my sister. Where are they now?
They are in Rehoboth.

Child in sh

I want to become a soldier…because a soldier took Jesus and put him on the cross.

I want to become a policeman and shoot the children (sic) and drive away.

I want to work with shovels and cleaning the house when people die.
I will clean the yard, shovelling.

Children

A number of children have visions of material wealth for themselves.

I want to work and earn a lot of money to be rich and buy a lot of things and many things to eat … buy a lot of furniture and a big house.

I want to buy clothes.
I want to work for company and buy myself a big house and a lot of FOOD.
I want to buy a house and stay with my children.
I want a BMW…a big one!

Children

POSITIVE EXPEREINCES OF CHILDREN

While many deprivations were noted, nearly all caregivers believed that the children were currently in the best situation possible under the circumstances.

A number of encouraging statements were made about children by caregivers in all situations:

When they came here they seemed to have no hope – you did not believe that they would wake up in the morning – but now most of them are well – they are fine. They put a smile on my face.

I thought we were going to bury M (child age 6 months) but there she is – I think that her mother's death gave her motivations!

We cannot replace family but we give them love and care.

At least they are healthy under this difficult situation. And they have a room.

The children come from difficult circumstances. Now they have their own bed. They sit at the table with a Mummy. They have shelter.

The children they have a place to sleep and eat, they have a home.

Some of these children have nothing, nobody…They are better off here.

I think they get everything….I take them to the swimming pool. We buy toys.

STIGMA AND DISCRIMINATION

Despite existing laws and regulations, children and caregivers in this study were subject to stigma and discrimination in several ways.

Caregivers reported that relatives had deserted/neglected children who were known or suspected to be HIV positive. Some children were 'blamed' for a parental death. In at least one case, a child was barred from kindergarten because his HIV positive status was known.

Everybody was blaming my baby for my sickness. They did not want to touch him because he was positive. They really don't like him and I was thinking of giving him up for adoption.

Caregiver in rh

When I started getting sick and weak my mom suggested that they (father's family) may look after the child for a while but they didn't want to. It hurt me.

Caregiver in rh

Some of their mothers passed away, and their fathers are not interested in them anymore.

Caregiver in sh

We don't tell the other children that he has HIV. But we told the others that when he is bleeding; don't touch it as he has a disease in his blood.

Caregiver in sh

The other boys on the street won't play with S. (because of his HIV+ status)… He goes out anyway and starts kicking the ball…He has taught me so much about courage.

Caregiver in sh

…some were never visited by any parent or relative. Do you want us to send these children to die of hunger? To be told they are HIV positive and rejected?

Caregiver in sh

I cannot play with other children because my blood is bad

Child who is HIV positive

Large organisations and at least one small organisation were active in raising awareness to counter stigma and discrimination:

We advocate. When the need arises I take up issues. We also do radio stations programs. Like now, I am going to UNAM for a call-in program. We try our best to be a mouthpiece for our children.

Caregiver in sh

However there was no evidence in the study region of a centralised plan for a public awareness campaign to counter stigma and discrimination:

A second form of stigma was reported by caregivers in a non-community based setting. They stated that children did not like to be branded as 'orphans'.

They don't want to be told that they are in an orphanage…
When the children complete matric they feel insecure. Because they do not know what the future looks like. Where they should go.

Caregiver in sh

RECOMMENDATIONS FROM OUR SURVEY

Psychological assessments, therapies and memory making

There is need to:

1. Develop procedures for assessing the state of health and well-being of OVCs and their caregivers.
2. Make available counselling services, support groups and therapy for post-traumatic stress disorder for children and caregivers who will benefit from these services.
3. Develop record keeping procedures that will ensure children (and caregivers) have information about their backgrounds, including information about their parents and relatives.

Programs

There is need to:

4. Review and enhance services and programs which are specifically targeted at children aged 0-8 yeas of age.
5. Develop and make widely available day programs for young children. These should include an early care and development focus along with the provision of nutritious meals and health services such as health checks and distribution of medicines.
   (a) Day programs should include opportunities for providing information and support to caregivers of young children through group meetings, workshops, home visiting and similar programs.
6. Increase programs which support educational and health services to older children including school lunch and after school tutoring programs, school fee vouchers, school uniforms, and donations of clothes, blankets and other goods.
7. Provide incentives for volunteer programs. Volunteers can be trained and supported to assist with child related activities and provide respite to caregivers. Activities could include excursions, outings, facilitating involvement in sports and other community oriented activities.

Caregiver support

Training, workshops and support groups for caregivers

There is need to:

8. Provide information about and access to resources for all types of caregivers which address ways to stimulate cognitive, emotional and psychosocial development in young children.
   (a) Facilitate the development of support groups for caregivers.

There is need to:

9. Provide training and support for caregivers who wish to develop or enhance income generation projects.

Infrastructure and backup

There is need to:

10. Provide a system of ‘backup’ or emergency care for caregivers in residential settings and safe houses who become ill or are unable to care for the child(ren) in their care for other reasons.
11. Develop an infrastructure for the recruitment, selection, training and support to caregivers in safe houses.

Leadership

There is need to:

12. Find ways to develop and reward advocates who take on leadership positions in safe houses and other situations which support young OVCs.

Community and organisation support

There is need to:

13. Provide incentives for enhanced community involvement to address the needs of OVCs, including those who are infected or affected by HIV/AIDS.

Coordination, linkages and support for organisations and service providers

There is need to:

14. Provide incentives or other means for allowing time and resources which will facilitate collaboration, networking and linkages amongst organisations, centres, and other service providers who target similar populations of children and families.

Policy development and funding issues

Equity issues

There is need to:

15. Establish a centralized database and to review service delivery which is available to all regions.

Standards and monitoring

There is need to:

16. Develop a system for identification and monitoring of OVCs, including those aged 0-8 years including information on accessible and needed services for each child.
    (a) Establish a process for updating data on individual children
    (b) Establish a system for collaboration with all relevant agencies to ensure that data is comprehensive and that duplication does not occur.

17. Develop standards, monitoring processes and code of conduct for caregivers in safe houses.

    There is need to:
    (a) Establish standards for working hours, duties and salaries.
    (b) Monitor the number of children and age/sex combinations to ensure healthy relationships can be established in the home.

Funding

There is need to:

18. Investigate current funding policies from the Ministry and to monitor current use of this funding source.

19. Review criteria and assess procedures for support to organisations and caregivers from the Ministry and other donors;
    (a) Investigate the potential for increased support from government sources and other agencies for identified needs of the target population.

20. Coordinate funding and other support from Ministries and other reliable, long-term sources as a means to increase access to existing sources, reduce duplication of funding and identify targets for new or redirected funds.

21. Investigate the potential for accessing corporate sponsorship;
    (a) Provide assistance to organisations to learn about diverse fund raising techniques.

Sustaining existing programs and developing new programs

There is need to:

22. Develop an infrastructure (collaborative network amongst policy decision makers and service providers) which will allow for consistent assessment of service delivery and of changing needs, and
    (a) Make use of the infrastructure to plan and develop new programs as needs emerge.

23. Provide seed grants and/or other supports to facilitate the development and implementation of sustainable income generation projects for caregivers.

24. Enhance and develop new programs aimed at recruiting foster families, reunifying families and relatives with children and, where appropriate, adoption of children.

Reducing stigma and discrimination

There is need to:

25. Provide incentives for programs of public education awareness raising aimed at decreasing discrimination for children and adults who are HIV+.

26. Review and ensure compliance with anti discrimination laws and policies for children and adults who are known to be HIV+.

27. Find ways to further integrate children in non-community based settings to counter branding as orphans, and other sources of stigma.

Data gathering and research directions

There is need to:

28. Assess the situation of young OVCs and their caregivers through studies which include qualitative data, as well as quantitative measures, including descriptions of the experiences of caregivers and narratives which incorporate children's perspectives

Zimba, R.F. (2003) **Community Support for the Education of Orphans and Other Vulnerable Children.**

Orphan-hood and vulnerability

“an OVC in Namibia is child under the age of 10 whose mother, father or both parents or primary caregiver has died, and/or is in need of care and protection”.

Need of orphans in Namibian Schools:

1. Basic Needs

   These include toiletries, bedding, plates, cups, cutlery, clothes, shoes, school supplies, pocket money, uniforms, school fees, as well as “the school development fund”.

2. Safety and Security Needs

   It was reported that stealing, fighting, quarrelling, use of insults, drunkenness and bullying were common in hostels. Also sexual relationships.

3. Need for protection against neglect, abuse and the risk of HIV infection

   Although programmes were provided to fulfil this need; the community activities, including drunkenness and sex undermined those programmes.

4. Need for protection against discrimination and stigmatization

   In some communities San children were discriminated against.

5. Need for psychosocial support

   Several OVCs were depressed, anxious and worried, and needed support.

Strategies on community support

Need for

1. mobilization of resources
2. involvement in activities organized in support of OVCs
3. raising awareness about the needs of OVCs

4. building capacity to be used in support of OVCs

5. CONCLUDING REMARKS

Given what has been said above about the challenges that face us, someone might easily conclude that we have ended with a “paralysis of analysis”. I should therefore hasten to echo James Thurber’s words; “let us not look back in anger or forward in fear; but around in awareness”. In concluding, I want to draw our attention to two key areas, attention to children, and attention to the critical role of education, to which we must pay attention.

Let us remind ourselves of the UNICEF position paper for the World Conference on Human Rights, held in Vienna in June 1993:

> “The best interest of the child are universal. They include the right to survival, to healthy development and protection from abuse. These rights are agreed. They are international standards. But what value do they have in a world which turns its back on hunger and want, on torture, rape, and exploitation of children?
>
> Children’s lives cannot be put on hold while adult society mulls over its obligations towards them. Public commitments have been made. Treaties have been written and ratified. The time to act is now!”

Also, as I have had occasion to say many time before, in different for a, the survival and protection of children is the responsibility of all of us, individually and collectively, including us the participants at this very important conference, because as Leon Chestang (1974) has aptly observed:

“And so I ask, who, if not us, will nurture our children?
Who, if not us, will protect them?
And who, if not us, will assure them of their birthright? Who?”

On education one can say that it holds the key to development, to receptiveness to others, to population control and to the preservation of the

environment. Education is what will enable us in Africa especially, to move from a culture of war, which unhappily we know too well, to a culture of peace, whose benefits we are only just beginning to sense. We are prepared to deal with the threats of the past but we are still helpless when confronting the threats of today and tomorrow.

There should be a consensus that time has come to move from discussion to decision, and from decision to implementation. Further delay in tackling the education crisis particularly in teacher education as it exists in each country or region and globally will have a very high cost in both financial and human resource terms.

Dean Acheson, one of the great and witty Secretaries of state in the USA tells about a bright young diplomat who came to him once and outlined a brilliant strategy. The young man ended his presentation by saying, “And with the help of God, we shall carry this through.” To this the Secretary responded: “Unfortunately, young man, God doesn’t work for the State Department!”

God may not work for African children either: I would hope and pray, however, that **HE** has a watchful eye on their healthy growth and development, under the Convention the Rights of Children, and other provisions, meant to protect our most precious resource, and the future of humanity.

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APPENDIX 1

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	25.6
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.	Guina-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 seroprevalance rate was actually 22.3% which would place it as fourth most affected.