INFORMATION TO USERS

This manuscript has been reproduced from the microfilm master. UMI films the text directly from the original or copy submitted. Thus, some thesis and dissertation copies are in typewriter face, while others may be from any type of computer printer.

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleedthrough, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps.

Photographs included in the original manuscript have been reproduced xerographically in this copy. Higher quality 6" x 9" black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.

Bell & Howell Information and Learning
300 North Zeeb Road, Ann Arbor, MI 48106-1346 USA
800-521-0600

UMI®

THE SOCIAL ECOLOGY OF MALAWI ORPHANS

"Seven people die of AIDS every hour in Malawi, leaving behind tens of thousand of orphans" (Livuza 1997 p.3).

UNIVERSITY OF VICTORIA

THE SOCIAL ECOLOGY OF MALAWI ORPHANS

by

Christopher Okumu
B.Com., The National University of Lesotho 1991

A Thesis Submitted in Partial Fulfilment of the
Requirements for the Degree of

MASTER OF ARTS (MA)
(Policy and Practice in Health and Social Services)

The School of Child and Youth Care, University of Victoria

DEDICATION

This study is dedicated to the children: Norbert, Newton, Abitimo, Onen, and Lawrence, Harriet, Proscovia, and Brenda, Annette, Brian, Marion, and Sharon and Odoch, Whitney, Will, and Bruno, Akemkwene, and Mpeng, plus Senate. Guys, you gave me the impetus to push on when the world felt lonely and alien. I hope my ability as a role model, uncle, and father meets your expectations.

This study is also dedicated to the sweetest lady in the world, Dr. Lisa Veres, who provided me with tempestuous, momentous, and non-ethereal support, and helped sustain my sanity and my confidence in my ability during the lean and insane period of this project.

AKNOWLEDGEMENT

I want to acknowledge the support of my Thesis Committee Members who provided the wisdom and direction during the evolution of this thesis. Dr. Philip Cook, thank you for sticking it out with me to the end. Dr. Michael Prince, thank you for the hilarity. Your jocosity made this onerous task enjoyable and a little lighter. Dr. Frances Ricks, thank you for the support.

I also want to acknowledge Richard Mitchell and Michael Burnette for their collegial support. Comrades, aluta continua.

Supervisor: Dr. Philip Cook

ABSTRACT

This is a study of HIV/AIDS orphans in Malawi. Malawi is one of the poorest countries in the world but with one of the highest HIV seroprevalence. Peace Corps (1998) approximates that 13% of the Malawi population are infected with HIV/AIDS. All Africa News Agency (AANA) states that as of June 1998 there were over 600,000 orphans in Malawi. This is a doubling in three years of the 300,000 number reported in 1995. This study used a descriptive research design to outline the social environment of Malawi orphans using Bronfenbrenner's (1979) Socio-ecological Perspective and Erikson's (1997) Life Cycle frameworks. The study used archival data from the Malawi project "Starting from Strengths" 1996-1998. The research methodology for the study was Content Analysis within the critical social science paradigm. The question in this research is "Who are the prominent individuals and institutions in the "social ecology" (Bronfenbrenner 1979) of orphans in Malawi and what is their impact on the development of these orphan-children?" The unveiling of the identity of individuals and institutions active in the social environment of Malawi orphans exposed the orphan-care social network and the key problems affecting orphan care in Malawi today. Orphans in patrilineal Malawi were found to be more "at risk" than those in the matrilineal cultural setting due to the differences in: the ages of care providers, the access to inheritance, and the prevalence of polygamy in the patrilineal cultural setting. Advocacy work for Malawi orphans grounded on the United Nations Convention on the Rights of the Child (1989) is one intervention strategy that can empower orphan-families to take ownership of the fight against the HIV/AIDS carnage. This study provides the leadership that is urgently needed

in the fight to mitigate the plight of HIV/AIDS orphans in Malawi and elsewhere, and provides the stepping stone from which to launch future ecological studies.

CONTENT

MAPS

TABLES

FIGURES

CHAPTER I

THE SOCIAL ECOLOGY OF MALAWI ORPHANS

HIV/AIDS AND THE CHILDREN

> The ecology of human development involves the scientific study of the progressive, mutual accommodation between an active, growing human being and the changing properties of the immediate settings in which the developing person lives, as this process is affected by relations between these settings, and by the larger contexts in which the settings are embedded (Bronfenbrenner 1979 p.21).

This is a research study of orphans in Malawi. The study has the primary goal of aiding the development of a structural psychosocial support system for the increasing number of children whose parents are being killed by the HIV virus. This study will use a descriptive research design to describe the social environment of the Malawi orphan child using Bronfenbrenner's (1979) social ecological perspective and Erikson's (1997) life cycle frameworks. The study will use archival data from the Malawi research project **"Starting from Strengths: Working with Communities to Care for AIDS Orphans"**, to try to understand and put into perspective the social ecology of the Malawi orphan child. Chapter One will start by giving an overview of the HIV/AIDS epidemic globally, followed by a picture of the disease in continental Africa and then in Malawi. A background of Malawi the country with an emphasis on the socio-economic status will be discussed to provide a context for the study. The last part of Chapter One will discuss child development in the context of African culture, the social ecology of human development, and the study's research question.

Chapter Two will discuss the research methodology used and the details of the research

participants, the data collection procedure, the sampling strategy, and the data analysis procedure. Chapter Three will discuss the results of the study and will present them in a statistical format. Chapter Four will be an interpretation of the results and will include the examination and qualification of the results in the process of drawing inferences. Chapter Five will look at some advocacy strategies that can inform and empower orphans and families and enable them to be active participants in the discourse of Malawi's social engineering.

This research will define a child in accordance to the 1989 United Nations Convention on the Rights of the Child, Article 1 where "a child means every human being below the age of eighteen years unless, under the law applicable to the child majority is attained earlier" (p.3). In Malawi, majority is attained at the age of eighteen. An orphan will be defined using the Malawi UNICEF definition, which is a child who has either lost its biological mother, or biological father or both biological parents.

AIDS The Global Epidemic

The Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome (HIV/AIDS) epidemic has inflicted an untold amount of misery on humanity since its first recognition in 1981. The United Nations AIDS (UNAIDS) and World Health Organisation (WHO) December 1996 estimates paint a very sad global picture of the effect of the virus to-date. About 30 million people have been infected with the HIV virus. In 1996 alone 3.1 million people contracted the deadly virus and about 1.5 million people died of HIV/AIDS related diseases. About 23 million people were estimated to be

living with HIV infection or AIDS in 1996. Of these 22.2 million were adults and 830,000 were children. Women made up approximately 42% of the HIV/AIDS infected adults and this proportion is reported to be increasing (UNAIDS and WHO, 1996).

	1996	Cumulative
World wide HIV Infection	3.1 million	29.4 million
World wide HIV/AIDS associated deaths	1.5 million	6.4 million

Source: UNAIDS and WHO December 1996.

AIDS and Africa

About 63% of the world's HIV/AIDS population live in sub-Saharan Africa where 14 million persons are infected with the HIV virus. At the end of 1994, HIV seroprevalence was at more than 10% among adults in several sub-Saharan African countries. In Botswana the rate of HIV among adults was 18%, 17% in Zimbabwe and Zambia, 15% in Uganda and 13% in Malawi. Projections indicate that child mortality rates may increase threefold by the year 2010 in certain sub-Saharan regions due to HIV/AIDS. Of all the children infected with HIV in-utero, 85% has been in sub-Saharan Africa (UNAIDS and WHO, 1996).

The impact of the HIV/AIDS epidemic on children goes far beyond the infected children to the millions of children that are left orphaned. The social tragedy starts at the time when the parents, because of poor health, are unable to provide adequate parental care to their children. Since the beginning of the HIV/AIDS epidemic, over 9 million children

under the age of 15 years have lost their mothers to the disease. Sub-Saharan Africa accounts for 90% of these orphans and one out of three children orphaned by HIV/AIDS is younger than five years (UNAIDS and WHO 1996).

AIDS and Malawi

The first HIV/AIDS case in Malawi was reported in 1985, and a 1992 surveillance reported HIV seroprevalence at 23% in urban areas and 8% in rural areas of all 15-49 years old age group (United Nations and Malawi Government, 1993). The Peace Corps (1998) approximates that about one million Malawians are infected with HIV/AIDS, which translates into about 13% of the national population. "Seven people die of AIDS every hour in Malawi, leaving behind tens of thousand of orphans" (Livuza, 1997 p.3). Livuza continues that most of the AIDS victims in Malawi are in the active 24 to 40 years age group and the heavy HIV/AIDS death toll on the population has resulted into a large number of orphaned children. Some orphans are taken into care by extended families while the rest are left to fend for themselves. All Africa News Agency (AANA) states that as of June 1998 there were over 600,000 orphans in Malawi. This is a doubling in three years of the 300,000 number reported in 1995.

The severity of poverty in Malawi and the increasing number of orphans has already strained and broken some traditional extended family structures. Livuza (1997), writes that government statistics show that at least a quarter of the orphans adopted by the extended family are left to fend for themselves when the extended family finds the burden too heavy to shoulder. The prognosis of the wellbeing of children without adult

guidance and supervision is extremely bleak. There is the general tendency for children to gravitate to delinquency in the absence of parental or adult guidance.

The high rate of HIV/AIDS in Malawi has even affected Malawians abroad. Between 1988 and 1992, about 13,000 Malawian mine workers were forced out of South Africa, and the official reasons given was that 200 Malawians working in South African mines had tested HIV positive the previous year. The Malawi government was requested to screen all prospective migrant workers before entering South Africa (Chirwa, 1998).

Background

Malawi was formerly the British Protectorate of Nyasaland. Nyasaland gained independence, as Malawi, on 6th of July 1964. The Republic of Malawi is a tropical land-locked country in south central Africa with a total area of 118,484 square kilometres (45,747 square miles) including 24,208 square kilometre (9,347 square miles) of inland water. Malawi is bordered by Zambia to the west, Mozambique to the south and east, and Tanzania to the north. Lake Malawi covers most of the eastern boundary. English is the official language and Chichewa is the national language. Seventy five percent of Malawians profess Christianity, 10% follow African traditional beliefs and another 10% largely Asians are Muslims (The Europa World Year Book, 1997).

The 1987 Census recorded the population of Malawi at 7.99 million and UNICEF (1998) put the Malawi population at 9.8 million in 1996. About 49% of Malawi's population are male and 51% are female. The Malawi population under 15 years of age constitutes 46%

of the total population implying a very high dependency ratio (The CIA Report on Malawi, 1997). The population density in Malawi is estimated at 100 persons per square kilometre, making it one of the most densely populated countries on the African continent. Malawi's population growth rate is estimated at 1.57% per annum, projecting the population to over 12 million by the year 2000. Population pressure on land and natural resources is emerging as a serious problem in Malawi. The competition for arable land has been underscored by the incorporation of customary land into the estate sector. Over half of the smallholders cultivate less than one hectare of land, which is considered insufficient to meet the household food requirements. Increasing land fragmentation among family members, coupled with the general environmental degradation, has resulted into forced continuous cropping, the depletion of soil fertility, and declining land productivity (Malawi Government and United Nations 1993).

According to the World Bank (1996) Malawi is among the world's 12 poorest countries. The Malawi population living below the absolute poverty level ranges from about 10% in the urban area to about 85% in the rural population. Malawi's GNP between the years 1993 and 1995 was US$ 1,620 million translating to US$ 170 per head, and the GDP in 1994 was US$ 1,302 millions. Agriculture, including forestry and fishing, is the most important sector of the economy accounting for about 35.9% of the GDP in 1995.

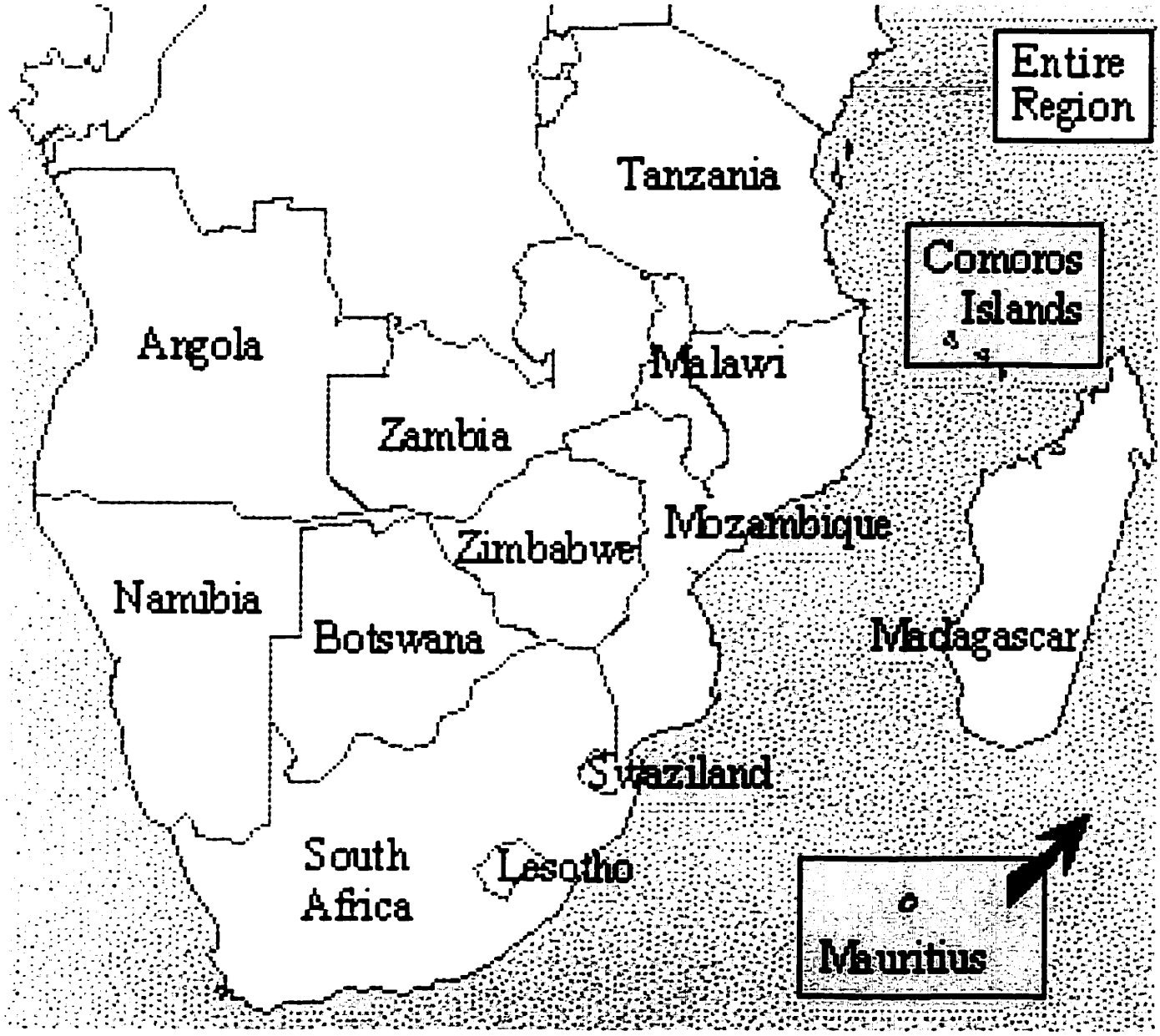
There is widespread household food insecurity in Malawi as reflected by the high levels of child malnutrition in the country. Between the years 1990 and 1997, 48% of all Malawi children under five years of age suffered from stunted growth, and 7% were

wasting as result of malnutrition. In 1995 the national literacy rate in Malawi was at 56 percent. Literacy rate among males was at 72% while among females it was at 42% (UNICEF 1998).

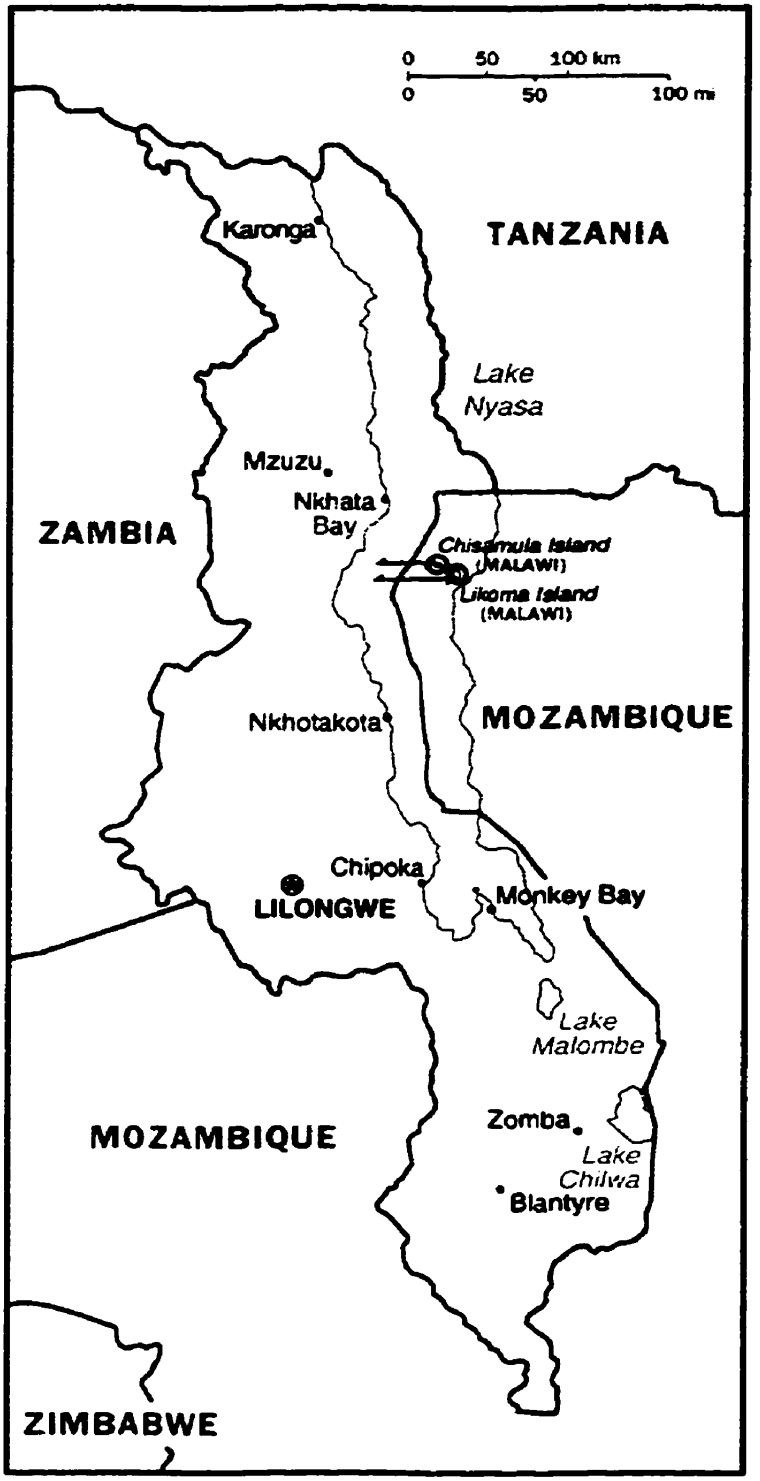
HIV/AIDS related deaths, birth outside wedlock, and male migratory labour has resulted in the proliferation of single female-headed households in Malawi today. United Nations and Malawi Government (1993) estimate that the average Malawian household consists of 4.3 persons, and that about 30% of Malawian households are headed by women. A significant proportion of these female-headed households are among the poorest Malawi population both in the rural and urban areas. Their only assets are small parcels of land which may further diminish with mounting population pressure.

New developments in modern economy have also encouraged the expansion in female labour participation in the wage-earning sector. Female labour participation has increasingly left more young children at home, poorly attended to in the fields, or in the charge of their older siblings. The demise of the extended families structures, a function of "modernisation", denies families the traditional childcare support. In Malawi, like elsewhere in sub Saharan Africa, there are no social welfare safety nets as found in the industrialised countries. The only available social safety net is the family and kinship within the extended families.

The map of Southern Africa



The Map of Malawi



THE STAGES OF CHILD DEVELOPMENT

Among many African cultures there exists what anthropologists refer to as "age sets", "age grades ", or " age classes". This is a demographical dichotomy that separates the children, the adults, and the elders from each other. These age classes are essential parts of the socio-cultural structures because they are tied to special prerogatives and specific tasks (Bernardi, 1985). Bernardi also states that "the formal institutionalisation of age classes takes place through the celebration of rites of passage of the candidates on the basis of two principles: either the public recognition of the candidates' physiological maturation with the celebration of postpubertal initiation or the determination of the generational distance between each candidate and his father" (p. 4).

African child development literature (Bernardi, 1985; Raising, 1985; and Vansina, 1980.) suggests three main child development stages namely; infancy, childhood and puberty.

1. **Infancy** (birth to three years)

These are the years when the child experiences the world directly through the senses and is primarily dependent on the maternal person. For this study infancy will be extended to the third year of life instead of the two year cut-off period used in industrialised countries (Crain, 1992) because of the widespread household food insecurity in Malawi discussed earlier. Poor maternal nutrition and the resultant low birth weight, exacerbated by the subsequent inadequate infant nourishment translate into delayed child development (Foster, 1992).

2. Childhood (Above three to 12 years)

These are ages when children have attained some level of autonomy. They can walk, run,

talk, and feed themselves. In most African cultures the care of this age group falls under the responsibility of older siblings. The playground for this age group gradually expands to include the whole village.

Table 1

Psychosocial Development Phases

Stages	Psychosocial Crises	Radius of Significant Relations
1. Infancy (up to three years)	Basic trust and Autonomy Vs. Mistrust, Shame and Doubt	Parental persons
2. Childhood (above 3 to 12 years)	Initiative and Industry Vs. Guilt and Inferiority	Basic family, extended family and village
3. Puberty (above 12 to 18 years)	Identity and repudiation Vs. Identity diffusion	Peer groups and adults

Adopted from Erikson (1997)

3. **Puberty** (above 12 to 18 years)

This is the age when children in most African cultures attain majority, manhood and womanhood. The transition into adulthood is marked by ritual rites which confer on the initiates knowledge and rights which underline and justify an increase in public status. Raising (1995) in her study of the Bemba (a Bantu tribe in neighbouring Zambia, and

closely related to the tribes in Malawi) found that womanhood is attained by girls through the puberty rituals, which takes place at the time of menarche. Raising continues that another tribe the Gisa in Central Africa also perform the initiation rite to womanhood at the onset of menstruation. According to Foster (1992) menarche is reached at different ages by different populations around the world depending on the level of caloric intake. This is because the female sex hormone oestrogen is produced from cholesterol a fat related compound. The higher the caloric intake level the more oestrogen a woman is likely to produce and the earlier the age of menarche. Foster (1992) cites menarche ages ranging from 12.3 years in Santiago Chile to 18.4 years in Lumi New Guinea.

Among the Wagenia (a Bantu tribe like the tribes in Malawi) in Kisangani Zaire, circumcision initiation rites takes place once every ten years and the ages of the initiates vary from 7 to 19 years. Non circumcised boys are not considered adults irrespective of their ages and are not allowed to participate in the doings of the initiated (Vansina, 1980).

THE SOCIO-ECOLOGICAL PERSPECTIVE

The orphan child lives in a family that is a unit in the village structure. The relationship within the family among family members and the interaction of the family with the immediate and larger community is a very complicated network. Bronfenbrenner (1979) groups these complex relationships into four categories, namely the microsystem, mesosystem, exosystem, and the macrosystem.

(i) The Microsystem is the formal and informal immediate face to face relationship with individuals and institutions emanating from a child

to its immediate ecology. The microsystem include among others the relationship with peers and playmates, family members, school, and church groups.

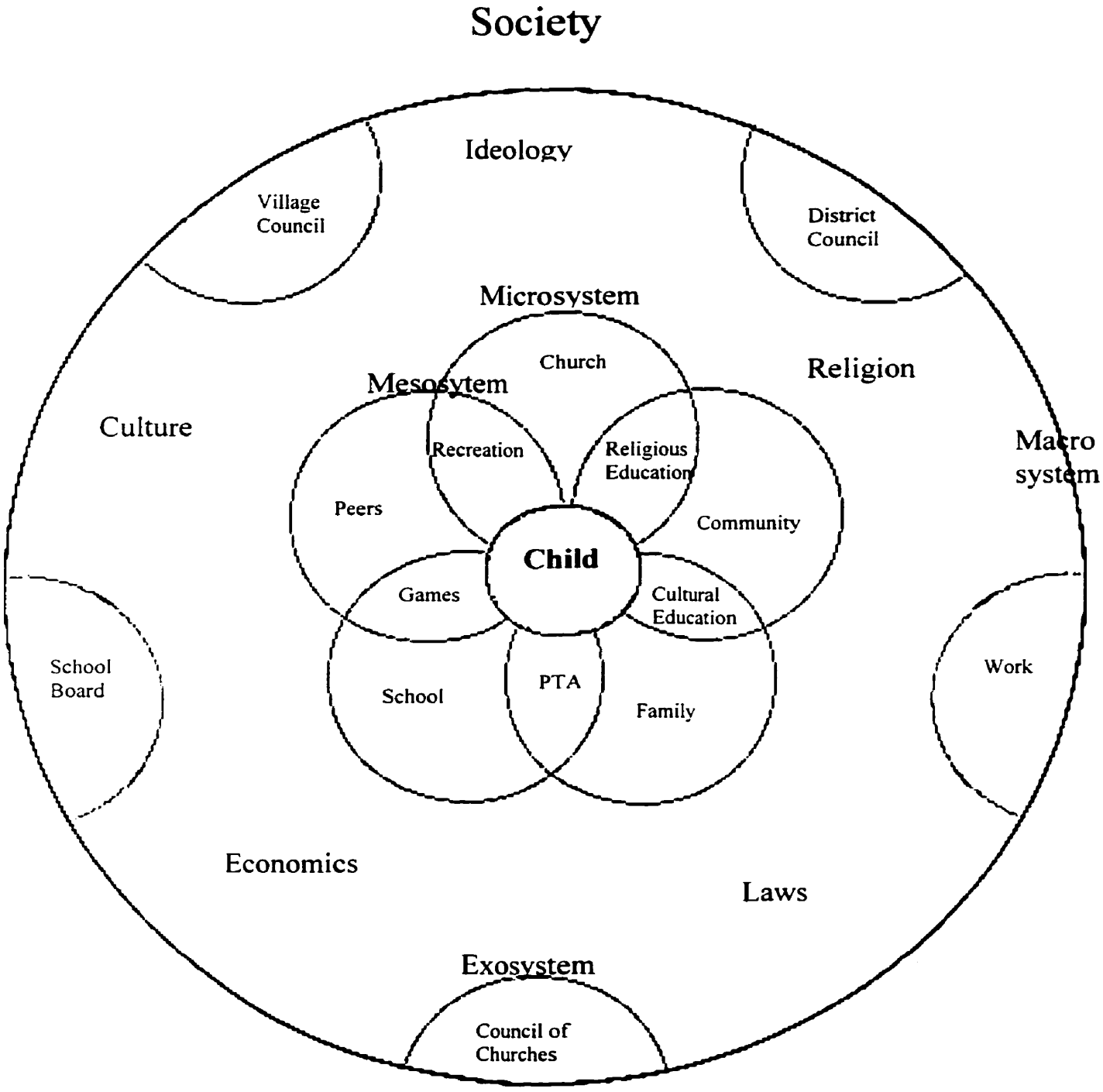
(ii) The Mesosystem is the interactions between the microsystems of a child. Examples of the mesosystem are playmates visiting the family, teachers meeting with parents, and the church working with the school system.

(iii) The exosystem is the group of individuals and institutions with which the child does not interact directly but whose actions have an impact on the child's life. The plantation owner who employs the parents of the child, the council of churches that controls local church activities, and the school board that runs the school system, are good examples of the exosystem.

(iv) The Macrosystem is the broad socio-cultural institution within which are embedded the exosystem, mesosystem and the microsystem. The Macrosystem defines the characteristics of the society at large. The culture of raising children in Malawi, the status of the Malawi economy, Malawi family laws, and the spiritual discourse of the Malawi nation, together form the macrosystem of the Malawi orphan child.

Figure 1

An Ecological model of Human Development



Source: Adopted from Berns (1993)

This study will attempt to comprehend the social structures uncovered by the "Starting from Strengths" research project with the orphan as the focal point, using Bronfenbrenner's socio-ecological framework, at the developmental stages of infancy, childhood, and adolescence. Mitigating the carnage of the HIV/AIDS pandemic has taken on many different faces. In Canada, there are the "safe sex" and "positively living with HIV" approaches. This research will be looking at ways of ameliorating the HIV/AIDS carnage through the understanding of the social environment of Malawi orphans. toward the development of a psychosocial support infrastructure.

The use of the psychosocial and ecological frameworks together is of great importance as both deal with the ecology of human development. Erikson refers to the social ecology as the "radius of significant relation" while Bronfenbrenner labels it "systems". Using the psychosocial or ecological perspective frameworks separately, given the definitions of a child and an orphan, would fail to provide a focus and or identify the individuals and institutions in the orphans' ecology. The comprehension of the psychosocial needs of children outside the socio-ecological framework would fail to identify the individuals and institutions that can fulfil these psychosocial needs. The social ecology of a child, defined as every human below the age of 18 years, would be too vague a parameter given the differentiation within childhood. The strength of using the psychosocial and ecological perspective together is the ability to one; focus and understand the specific needs of orphans at a specific stage of child development, and two; to identify the prominent individuals and institutions at a specific psychosocial development stage simultaneously.

Interventions can then be developed for and targeted at the most "at risk" development stage.

The extended family

The construct "extended families" prevalent in Africa is frequently romanticised in the West. The African proverb "It takes a village to raise a child" was one of the central rhetorical themes used by the Democratic Party during the 1996 USA presidential election. The reality of the extended family dynamics to the Malawi orphan child, however, appear to be different in the absence of the parent/s as evidenced by the difficulty faced by orphans, and the lack of support available for orphans in Malawi today.

There are several orphanages funded by foreign donors in Malawi today. Industrialising the orphanages to take in the increasingly large number of orphans is not a feasible option. No donor would be willing to fund these orphanages indefinitely, and Malawi as a nation does not have the political will or the resources to sustain such an undertaking. The current orphan support structure appears to be poorly organised and inadequate to meet the community needs. There are however some non-governmental organisations in Malawi that provide orphan care within the extended family structure (Livuza, 1997). Community based orphan care allows children to grow up within the extended family structure, an environment with which these children can identify with all through their life. A community based orphan care that addresses the social, psychological, and

economic needs of orphans requires less funding, can produce a dramatic impact on the lives of orphans, and can be comparatively easy to sustain.

The "Starting from Strengths" project achieved the following. One, it exposed the community-structure starting at the village level upwards to the district and national governments, and downwards to the extended families and household level. Two, the project laid open the physical and socio-economic environment of the community participants. Land scarcity, poor farming technology, lack of public transportation, unemployment, and poverty among others were explicated. Three, the project captured the social structure surrounding orphan care in both the matrilineal and patrilineal cultural settings. The effects of non-governmental organisations (NGOs) activity on orphan-care, the level of participation of the various levels of governments in orphan-care, and the quality of orphan-care at the micro level of the widow-headed or orphan-headed household were all exposed. The health care structure stretching from the biomedical side of dispensaries and hospitals to the traditional healers in the forms of herbalists and witchdoctors was also unveiled. Four, the study uncovered the current policies around orphan-care from the national level to the village level.

THE RESEARCH QUESTION

Community based orphan care appears to be the best feasible option available for supporting the orphan child. To develop effective community based orphan care programs, however, it is essential that the relationship of the orphan child with the social environment is properly understood. The research question of this study is "**Who are the**

prominent individuals and institutions in the "social ecology" (Bronfenbrenner 1979) of the orphans in Malawi and what is their impact on the development of these orphan children?" This question strives to explicate the instrumental persons and organisations, within the local and larger social communities in the development of the orphaned children.

Objectives

This research has three major objectives:

1. To delineate the key persons and institutions influencing orphan child development in Malawi. These individuals and institutions are very important entry points that can be capitalised on in the design of orphan intervention programs.
2. To assess and understand the quality of the relationships the orphan child has with the immediate environment, and with individuals and institutions influencing child development at the various levels of the social ecology.
3. To explain the presence or absence of essential support structures for the development of the orphan child in Malawi society. The missing structures might then be developed through structural adjustments in one or all of the various levels of governments, and or through the implementation of community based intervention initiatives.

CHAPTER II

METHODOLOGY

This study used archival data from the Malawi project "Starting from Strengths", and the methodology section therefore will have two parts. The first part will discuss the research methodology used in this present study. The last part will briefly present the methodology used by the Starting from Strengths project in the data collection phase. The research proposal and the interview guidelines used in the data collection phase are attached in appendix I and II respectively

Research Design

This study utilised a descriptive research design in an attempt to describe the social environment of the Malawi orphan child using Bronfenbrenner's (1979) social ecological perspective and Erikson's (1997) life cycle frameworks. A descriptive design was appropriate for this study because there is already available a fair amount of literature on Malawi orphans. Studies done by the Peace Corps, UNAIDS, WHO, and UNICEF, among others, make the task of explicating the social map of orphans in Malawi feasible.

Method

The methodology used in this research is **Content Analysis** within the **critical social science** paradigm. Content analysis is a research methodology used in transforming recorded qualitative, and unsystematic documents into quantitative and systematic format (Monette, Sullivan, and DeJong. 1994). The research question "**who are the prominent individuals and institutions in the social ecology of Malawi orphans, and what is**

their impact on the development of these orphan children?" seeks to unveil the identities of individuals, and institutions and the type of care these individuals and institutions provide for orphan children within Malawi culture. Content analysis is appropriate for this research question because the methodology as a research tool can be used to "reveal the focus of individual, group, institution, or social attention", and to "reflect cultural patterns of groups, institutions, or societies" (Weber, 1990 p.9). The understanding of the cultural patterns, and the focus of a community (the strengths of content analysis methodology) on the prominent individuals and institutions in the orphan's social ecology (the research question) informs Bronfenbrenner's four ecological levels of the microsystem, the mesosystem, the exosystem, and the macrosystem (the analysis framework). This is the link between the research question, the research methodology, and the research analysis framework of this study.

Lawrence Neuman (1994) defines **critical social science** research "as a critical social inquiry that goes beyond surface illusions to uncover the real structures in the material world in order to help people change conditions and build a better world for themselves" (p. 67). Lawrence Neuman continues to state that critical social science sees social reality as dynamic, and deceptive on the surface, and propelled by hidden forces. Critical social research is therefore aimed at uncovering these hidden forces that shape social relations and to empower the powerless. Empowerment implies the entitlement to an equitable share of the resources of society, and owning the ability to participate in the decision making, and resource exploitation and allocation processes (Holcombe, 1995). Under the critical social science paradigm, the researcher also acts as an advocate and instigator.

Critical social science takes the position that interpretive social science approach, as in ethnography and phenomenology, is benign as it does not take a value stand, or help open the eyes of people to understand the illusionary constructs that surround them in order to empower and improve their lives. The situation of the orphans in Malawi is very precarious and calls for immediate intervention. A research that stops at the comprehension of the social order would be ethically irresponsible and insensitive to the plight of the Malawi orphans.

The Data

This study will use the data of nine villages from the Malawi project Starting from Strengths. In Malawi, like in many other traditional societies, the village is the basic social unit and is organised under customary law with authority vested in the traditional headman "Nyakwawa", who is assisted by village elders or clansmen. Traditional authority is respected and plays a central role in the lives of most Malawi citizens (UN and Malawi Government, 1993). The nine villages are Kabudula, Kabuthu, and Mtema in Lilongwe district in central Malawi, and in southern Malawi there are the villages Kabuthu and Ntiza-Dzenje in Mulanje district, the village of Namwera-Malekano in Mangochi district, and the villages of Balakasi, Domasi, and Mkwopatira in Zomba district. The decision to use the nine villages was based on the following reasons: One, the nine villages adequately represent both the matrilineal and patrilineal family cultural structures in Malawi. Two, the nine villages represent village settings with both the presence and absence of non-governmental organisation (NGOs) activities; Three,

detailed and elaborate data of the nine villages were readily available here in the University of Victoria.

The Starting from Strengths data is appropriate for this research because of the followings:

- The data are current and from a study that is still going on. The findings of this research therefore will be relevant to contemporary social issues.
- The data collection instrument (Appendix II, Guidelines for Interviewing Key Informants developed by the International Children's Centre in Paris) deals with the psychosocial needs of the child, and the composition and structure of the communities, which are the focal points of this research.
- The Starting from Strengths project was a participatory action research study hence appropriate for this critical social science paradigm based study.
- Distance, time, and fiscal constraints make it impossible for this research study to physically collect empirical data directly from Malawi.

Analysis

The analysis stage will primarily employ Content Analysis's tool of theme identification within a context (Weber 1990). Themes around orphan-care will be identified and then used to make inferences on Malawi cultural practices using the villages as the unit of analysis.

The analysis of the data will be done using the following themes:

1. The identification of the orphan age demographic in Malawi. This is very important as knowledge of the age groups provide an understanding of the psychosocial development needs.

2. A detailed comprehension of the problems faced by orphans. This study was initiated because of the current developmental hardships faced by the bursting orphan population in Malawi. Understanding the problems faced by orphans provides the foundation needed to design effective intervention programmes.

3. The identification of the individuals and institutions who provide primary care to the orphans in Malawi today. Orphan-care intervention programmes that capitalise on existing care infrastructure require less funding and are easily sustainable in the long run.

4. The identification and the comprehension of the orphans' relationship with their social environment. Understanding the ecology of the orphan provides community development planners with entry points to influence child development.

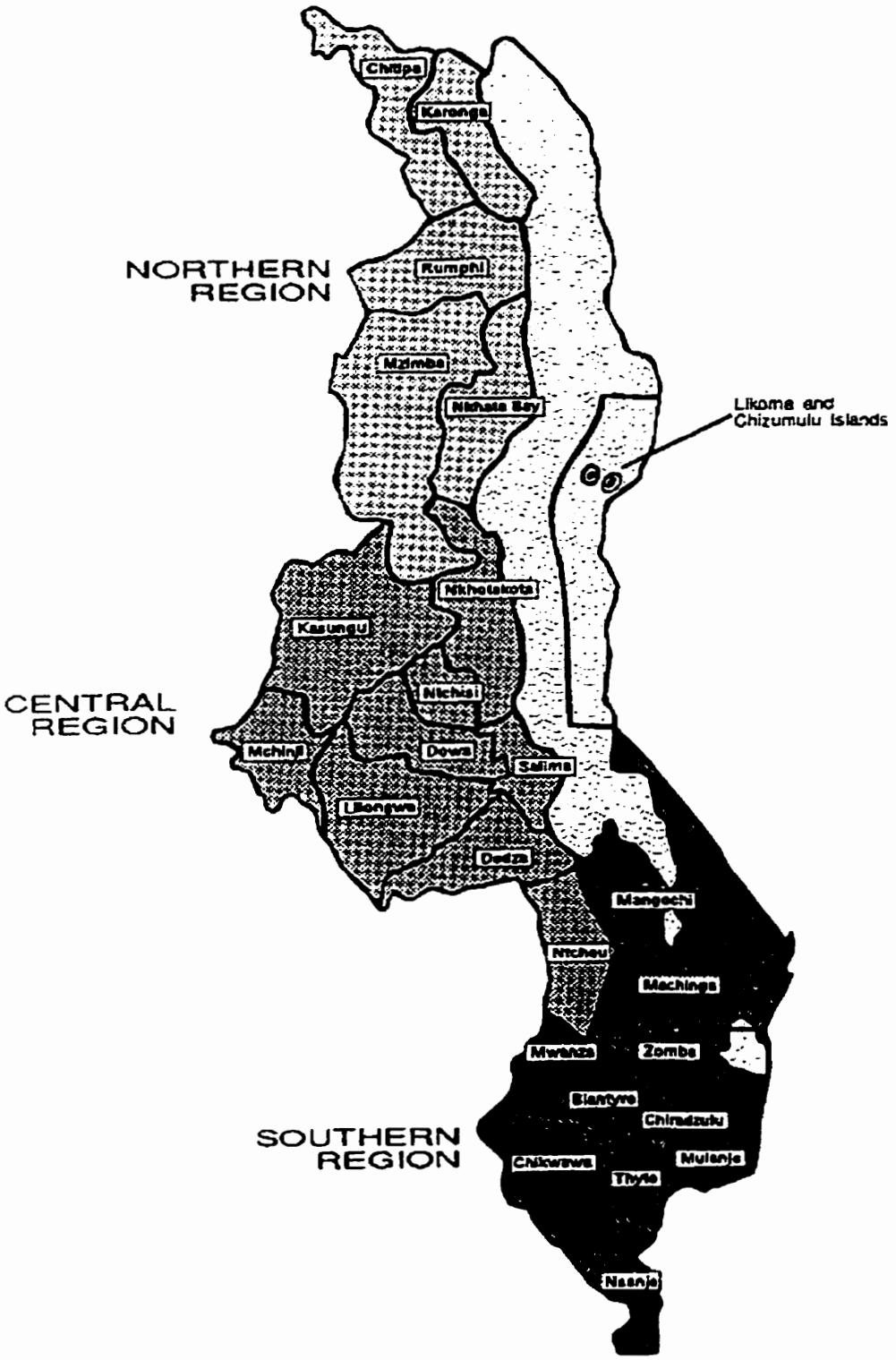
5. The identification of the structures that support orphan-care both locally and nationally. This would provide to the local communities the ability to access available resources, and to community development planners the awareness of potential allies in the course of social engineering.

STARTING FROM STRENGTHS

The Starting from Strengths project also referred to as the Malawi project was conducted in Malawi between 1996 and 1998. The project involved seven administrative districts. The districts of Karonga and Mzimba in the north, the districts of Deza and Lilongwe in central Malawi, and the districts of Mulanje, Mangochi, and Zomba in the south.

Malawi

ADMINISTRATIVE REGIONS AND DISTRICTS



The sites of the data collection were chosen to capture the cultural disposition and the effect of the presence or absence of non-governmental organisations (NGOs) working with the community on orphan-care. The cultural disposition of the northern districts of Karonga and Mzimba and that of the central districts of Dedza and Lilongwe is patrilineal. The three southern districts of Mulanje, Mangochi and Zomba are all culturally matrilineal. In the patrilineal family system, the wife moves to the husband's village. The husband and his male relatives are the centre of family life and decision making. The males own and control land and land ownership is passed down the father-son line. Here the levirate custom is practised and the wife is expected to marry the brother of her husband if her husband dies. If both parents are dead, it is the responsibility of the paternal relatives to take care of the children. Under the matrilineal family system, the husband lives in the wife's village, and has very limited say in the raising of his children. The children inherit from their mother's parents. In the event of the death of the wife, the husband generally moves back to his village. The children remain in their mother's village and are taken care of by their maternal relatives.

The Starting from Strengths project was a collaborative scheme that involved many international development agencies and local institutions in Malawi. The United Nations Children Emergency Fund Malawi (UNICEF Malawi), The International Development Research Centre (IDRC), World Vision International (WVI), Save the Children Federation USA (SCF), the University of Victoria Canada, Chancellor College Malawi, and the Malawi Government were all involved in the research project.

The University of Victoria Canada was responsible for the overall administration of the project. The University of Victoria Canada, together with Chancellor College Malawi were jointly responsible for training and supervising the research assistants, the analysis of the data collected, and the dissemination of the research findings. The international agencies UNICEF, SCF, WVI and IDRC were primarily responsible for funding the project. These four agencies were also responsible for the supervision and transportation of the research assistants during fieldwork, and the linking of the research assistants with the project co-ordination office at Chancellor College Malawi.

The Malawi project used participatory action oriented research method. Community members who participated in the research were involved in the setting of research objectives, collecting data, and in the process of data analysis. The Malawi data are qualitative in nature and were collected through focussed group discussion, key informant interview, case study, and observation, using the guidelines in Appendix II. Focussed group discussions were carried out with traditional leaders (village chief, headmen, counsellors and clansmen), religious leaders, school-teachers, village orphan care committees, and orphan guardians. Key informant interviews were conducted with orphans, village headmen, foster parents, priests, and church counsellors. There were some case studies of orphan-headed households, and community based orphan care support projects.

The data were collected using questions from the following four categories: the composition and the organisation of the community, the care and the support structures

available in the community, the diseases and causes of death prevalent in the community, and the psychosocial needs of the orphan children. Data from all four questions' categories will be used in this current study because the community's organisational infrastructure, care infrastructure, death and grief infrastructure, and the psychosocial need fulfilling infrastructure all inform the various ecological levels of system's theory.

CHAPTER III

RESULTS

CHILD REARING IN MALAWI

The Cultural Lineage

The data of nine villages from the Malawi project Starting from Strengths were used in this study. The nine villages are located in four administrative districts, with one district in the central region of Malawi and three districts in the southern region of the country. The Villages of Kabudula, Kabuthu, and Mtema in Lilongwe district are culturally patrilineal, while the villages of Kabuthu and Ntiza-Djenze in Mulanje district, Nawera-Malekano in Mangochi district and Balakasi, Domasi, and Mkwopatira in Zomba district are all culturally matrilineal.

Table 2:

Cultural Lineage in Malawi

Region	District	Villages	Lineage
Central	Lilongwe	Kabudula	Patrilineal
		Kabuthu	
		Mtema	
South	Mulanje	Kabuthu	Matrilineal
		Ntiza-Djenze	
	Mangochi	Namwera-Malekano	Matrilineal
	Zomba	Balakasi	Matrilineal
		Domasi	
		Mkwopatira	

Age sets

The Malawi project involved 1375 orphans both directly and implicitly. Some orphans participated directly as key informants, and others participated implicitly through foster parents and through orphan statistics provided by participants. Of the 1375 orphans that were involved in the Malawi project, there were only 106 orphans (8%) whose ages could be determined. This is primarily because of the qualitative nature and open endedness of the data collection instrument used in the Starting from Strengths project. Of the 106, three orphans (3%) were between the ages of 0 – 3 years, 73 orphans (69%) were between the ages of 3 – 12 years, and 30 orphans (28%) were between the ages of 12 – 18 years.

Table 3

Orphan age demographic

Age set	Number of male	Number of female	Total # of orphans	Percentage %
0 -3 years	3	0	3	3%
3-12 years	36	37	73	69%
12-18 years	14	16	30	28%
Total	53	53	106	100%

Primary caregiver

Again because of the essence of the data collection instrument, only 118 orphans (9%) of the 1375 orphan total had their primary caregiver identified. The caregivers included

grandparents, aunts, and uncles from both the mother's and father's side, biological mothers and fathers, sisters, older siblings, and adopted parents. Of the 118 orphans grandmothers provided primary care to 27%, biological mothers to 44%, sisters to 11%, aunts to 2.5%, grandfathers to 5%, fathers to 2.5%, and uncles to 2%. Female relatives provided care to 100 orphans (85%), males to 10 orphans (8%), older siblings to 6 orphans (5%), and adopted parents to 2 orphans (2%).

Table 4

	Primary care provider				
Primary Caregiver	**Number of orphans**	**%**	**Gender of caregiver**	**Total # of orphans**	**%**
Grandmother	32	27%	F		
Mother	52	44%	F	100	**85%**
Sister	13	11%	F		
Aunt	3	2.5%	F		
Grandfather	6	5%	M		
Father	3	2.5%	M	10	**8%**
Uncle	1	1%	M		
Older siblings	6	2%	OS	6	**5%**
Adopted parents	2	5%	F/M	2	**2%**
Total	**118**	**100%**		**118**	**100%**
Key					
F	Female				
M	Male				
M/F	Two parents female and male				

PROBLEMS FACED BY ORPHANS IN MALAWI

Orphanhood is not a new concept to the Malawi culture. The extended families in the persons of grandparents, uncles, aunts, and other relatives have always stepped in to take on the duties of a diseased parent. The HIV/AIDS era however has raised the scale of orphanhood to levels beyond the coping capacity of most extended families. A key informant from Djenze village encapsulated the situation when he stated that "*there are more orphan these days and people cannot keep up with their needs as they used to in the past.*"

Today, Malawi orphans face many problems. Research participants cited the problems of poor or inadequate adult care and guidance, truancy and school dropout, food insecurity and inadequate sanitary water supply, the difficulty in accessing healthcare services, material needs, and psychosocial needs, problems with inheritance, the absence of children's playground, and the lack of government support to orphan-care.

1. Poor / Inadequate adult care and guidance

Mistreatment of orphans by foster parent/s, and poor or inadequate adult care and guidance for orphans are prevalent in the community. Focus group discussants (FGD) from Kabuthu village reported the prevalence of the maltreatment of orphans by foster parents in their community. A key informant from the village of Mamwera-Malekano stated that "*there is a kind of segregation where the foster parents favour their own children*". Another key informant from Balakasi village stated that "*some families are cruel and orphans are given more work such as washing clothes, washing dishes and*

digging". A Catholic priest also from Balakasi village stated that "*Guardians care more about their own children than the orphans. This is very hard on the orphans who depend on these guardians*". The data from Djenze village indicate that there are several orphan-headed household in their community with very limited adult guidance.

Focussed group discussants from Kabuthu-Lilongwe stated that "*the orphans lack manners because they do not have someone to guide them*". The group continued to state that the lack of adult care has resulted into the following. "*[Boys] just wander around, learn to steal and get diseases, smoke chamba, [marijuana] drink alcohol and become drunkards*," and "*[girls go] to bars, start prostitution, [enter the sex trade business] contract diseases because of promiscuity, marry before time to whoever wants to marry them*". Poor or inadequate adult care is reported here as one of the primary causes of delinquency among Malawi orphans.

2. Truancy and school dropout

Parental illness, parental death, the lack of school accessories like uniforms and school supplies, and the change in social roles, were cited by the Malawi data as causes of truancy and school dropout among the orphans. Statistics of orphan school enrolment in Namwera, Table 4, shows that more than one half (51%) of orphans are not enrolled in school. Namwera is the third largest town in Mangochi district and its geographical health catchment area includes 83 villages and a population of about 23,000 people.

Teachers from the village of Namwera-Malekano who participated in the research

reported that many children miss school due to parental illness and death but the school administration or teachers are unfortunately not always informed of these circumstances. The teachers also stated that "*orphan children look miserable and are not active in both classroom and outdoor activities*". The teachers feel that there is not much they can do, as they have not been trained to counsel orphans let alone notice the behavioural changes. Other research participants reported the followings: "*children do not continue with school ... because their mother wants the children to help her with house chores. Children are also forced to leave school due to changes of household and social roles. That is, male children become the household bread winners, female children are forced into early marriages for self support*" (FGD Namwera Malekano).

Table 5

NAMWERA ORPHAN SCHOOL ENROLLMENT STATUS OF 16 VILLAGES AS AT 1996			
Villages	**Number of orphans in school**	**Number of orphans not in school**	**Total number of orphans in the village**
Balakasi	93	72	165
chiutula	33	74	107
Chiwina	42	70	112
Kabuthu	34	36	70
Kwipitu	20	44	64
Makumba Nasato	19	12	31
Malamya	6	3	9
Mbalame	35	23	58
Mmnyanga	17	19	36
Namwera	96	61	157
Ngalande	2	6	8
Ngawo	26	66	92
Nyombi	42	49	91
Simbiri	66	54	120
Somba	5	9	14
Sumaili	47	20	67
Total	**583**	**618**	**1201**
Percentage	**49%**	**51%**	**100%**
Note			
1. Of the 1201 orphans, 56% (667) were males while 44% (534) were females			

"Most of them [orphans] go to school because it is free. But many of them drop out later because they cannot look like the other children that come to school" (KI Dzenje). *"The eldest [boy in an orphan-headed household] has left home and is now working on Minimini Estate in Mulanje... He is presently moulding some bricks which he hopes to build another house for them. The other sister stays at home to cook and look after the family"* (KI Dzenje).

3. Food insecurity

There is reported a severe food shortage in the village of Kabuthu where families are not able to store food all year round. A key informant from Djenze village reported that an orphan-headed household recently lost their baby sister because of malnutrition. Another key informant from Balakasi village also stated that there was sufficient food in the village only during the harvest season. "*There is not enough food for a year, only at harvest time. Some families store the food for at least four months*" (KI Balakasi). "*There is food shortage in the households with orphans because the number of orphans is increasing*" (KI Dzenje). The causes of food insecurity in the villages of Balakasi and Mkwopatira were stated as the lack of farm land, poor soil quality, unemployment, and overpopulation.

4. Difficulty in accessing healthcare services

A high prevalence of whooping cough, diarrhoea, tuberculosis, malaria, pneumonia, bilharzia, and sexually transmitted diseases including HIV/AIDS was cited in all the nine villages.

Participants from the villages of Kabuthu and Djenze complaint of the long distance to the health centres and the lack of a transportation system to service the villages. "*When someone is very ill, transport is a very big problem, and the hospital is very far. However, often, the community provide a stretcher for the sick person and they carry them to the hospital*" (KI Dzenje). Focus group discussants from Balakasi village accentuated the problems of transportation to the health centres, the lack of

pharmaceuticals in the health centres making the access to prescribed medication beyond the reach of many families, and the lack of adequate sanitary water supply. Balakasi is serviced by two boreholes situated a couple of miles away from the village. Another key informant from Mkwopatira village informed the research that a bridge linking Thondwe market and Mkwopatira village was washed away during the rainy season and that most drugs available in the private sector were beyond their expiry dates.

5. Difficulty in accessing material needs

Research participants from all the nine villages reported that the orphans urgently need clothes, bedding, shelter, game equipment, soap, school supplies, and financial support. *"[The] children need clothes, bedding, good food, shelter, and proper parental care"* (FGD Kabuthu Mulanje). *"[The children need] clothes ... games to play during their free time and blankets"* (KI Dzenje). *"[The children need] financial assistance and food, clothes and blankets"* (KI Balakasi). Poverty, a function of the national economic status, the high rate of unemployment, the limited availability of farm land, and poor infrastructure, makes the access to many basic material needs an impossible feat to most Malawi families.

6. Psychosocial needs

Malawi orphans do experience trauma during parental sickness and after parental death but unfortunately do not have access to any counselling in their struggle to grapple with the reality of grief and death as evidenced by the following excerpts. "*These children are withdrawn and tend to keep to themselves. They are not open. ("Amakhala*

momangika")" (KI Dezenje and Kabuthu Mulanje). "*Children's grief is perceived before, during and after [parental] death. They [the orphans] express it through withdrawal, refusal to eat, crying, fainting, suicide, dropping themselves in the grave, and worry*" (Case study Kabudula). "*After the funeral... the children notice the minimal care they are receiving and cannot cope. They remember their parents and the good things that they used to do for them. They look sad and are withdrawn*" (KI Kabudula). When their parents die, "*Children are grieved after their mother or father's death. In the case where a father dies, this grief continues until the mother remarries*" (FGD Namwera-Malekano). "*When they [the orphans] are alone, tears just role down their cheeks; They sit very sad and lonely on their own and may wish that their parents were still alive*" (FGD Domasi). "*The children are often very quiet for the first few weeks after the death of their parents and often need to be encouraged to go and play with their peers; Orphans are not active both inside and outside school activities. They can sometimes seem to be alone; Teachers also notice that a lot of pupils drop out of school shortly after their parent(s) death*" (FGD Teachers Namwera Malekano). "*The control of their father is missed [by the orphans]. One boy has a big psychological problem because of the [parents'] death*" as he does not want to accept the foster mother as his parent. (Foster mother Balakasi). There is no structured psychosocial support available for orphans in Malawi today. Orphans generally go through their grieving process haphazardly and without any adult guidance.

The data also show that Malawi families address the difficulties experienced by orphans through avoidance and the withholding of information about the parents, as captured by

the following extracts. "*When the parent is critically ill, the children are moved into another house and told that their parent is ill, but not of the disease*" (FGD Namwera-malekano). "*They do not know that their parents are dead and they say that they will come back. She feels that way the children feel no grief*" (KI Foster mother Balakasi). "*The grandmother feels the grief of the children but does not speak about this grief. She can also see grief in them, but they do not speak about it either*" (KI Foster grandmother Balakasi). Death in Malawi culture appears to be a taboo topic that adults do not discuss with children as seen in the following quotes. "*Children do not talk about death*" (KI Balakasi). "*If the children are younger..., they are not told anything [about the death of their father] but they bother their mother to see their father, but the mother just looks and does not say anything; They talk among their peers they do not talk with adults, even in the event of death* " (FGD Domasi).

The data show that Malawi families do want a change in the process of handling orphans with psychosocial problems as current cultural practice appears to have failed to effectively contain the situation. "*When they are playing with other children, they are told that they do not have a mother or father or both, then the child gets upset, then they come and ask you the guardian about it, and they are depressed; When they come with these questions, or when we see that they are sad, we try and bribe them with little treat, and ask them to go and play with their friends.* " (FGD Domasi). The orphans need "*Access to information of an illness and death of a parent; Love from peers and foster parents and religious groups.*" (FGD Namwera-Malekano). "*Withdrawn behaviour is evident in foster homes in those children who have not been allowed to mourn the death*

of their parent(s) and when their friends refer to their parents. This also is true if they are not told why they are being placed in a foster home as is sometimes the case." (FGD Namwera-Malekano). Teachers agree that a lot of orphans have psychosocial problems, "*However, the teachers feel there is not much they can do as they have not been trained to handle such situations, [grief counselling] and if they were, maybe they could also be more aware of the behaviour change that occurs.*" (FGD Teachers Namwera-Malekano). The general feeling among adults, like foster parents and teachers, working with orphans is that of inadequacy at providing the urgently needed psychosocial support for the traumatised orphans.

7. Inheritance Problems

The cultural norm in both matrilineal and patrilineal Malawi is that the property of the man belongs to his relatives and not to his wife or her relatives. In Namwera-Malekano (a culturally matrilineal setting), "The widow has no say on the deceased's property; [and] The deceased's property sharing begins after "alubaini" (forty day mourning period). The property sharing is handled by the "ankhoswe" (marriage counsellor of the deceased) in the presence of the village headman; All the husbands items such as trousers, bicycle, and radio are taken by the relatives. This attitude of property grabbing is done primarily because of poverty, sour relations with the wife's family, and illiteracy". *(FGD Namwera-Malekano). A key informant from Balakasi stated that the relatives of the dead man usually come and take away all the property and* "Mothers end up with children in empty houses". "*If the deceased was a polygamist, all [the] household items from both the houses are brought to one house for sharing amongst the*

deceased's relatives. Sometimes children from both families may be given a few items." (FGD Namwera-Malekano). *"In [the] event of polygamy, the first wife may claim the property from the second wife"* (FGD Kabuthu). Many orphans are not even aware of the distribution of their parents' property. *"None of these orphans know something about inheritance of deceased [their parents] property. The overall answer I got from them was "Kaya sindidziwa amene anatenga kutundu wa ababa." "Ndimakhala ndi anganga kuny umba." ("I don't know who took my fathers property") I stay with my granny at home".* (KI orphans Nawera-Malekano).

The cultural practice of paying dowry for a wife, and the sharing of ones fortune with the extended families is given as the rationale behind the sharing of the deceased's property among the relatives. *"The practice [of] property grabbing appears to be traditionally / culturally accepted"* because of the following two reasons. One, *"Here [patrilineal setting], the men pay for the women, therefore all the property belongs to his family or at least that is what they say; Another reason [is] that when these parents / deceased are alive, they do not 'remember' those they left in the village until they are sick. So it is only right and proper that the relatives take what is theirs then."* (FGD Kabuthu)

Today, some Malawians feel that the cultural practice of sharing the deceased's property among the relatives does not serve the interests of the orphans well, as captured in the following excerpts. *"Some say that the property belongs to the children, but some men take it all even the herds [of cattle]. This is a problem and the children are left with nothing"*. (FGD Domasi). *"The Koran says that the property is for children; The*

Catholic church does not intervene with inheritance, but feel that the property left behind is for the children" (FGD Religious leaders Namwera-Malekano)

Some Malawians feel that the inheritance problem could be solved by the sick parent(s) taking a more pro-active role as seen in these excerpts. "*Husbands and wives [should] call the relatives in the presence of a witness and their children and point out what s/he wishes to leave to their children and anyone else while they are still alive. The wishes of a dying man is always respected*" (KI Roman Catholic counsellor Kabudula). "*The deceased should share out the property before they die, so no one takes what is not theirs*" (FGD Kabuthu-Lilongwe).

8. Generation gap

In all the nine villages involved in the research many orphans are in the care of their grandparents. Table 4: Primary Care Provider; shows that grandparents are the primary care providers for 27% of the orphan sample. Participants discussing orphans at risk stated that one of the most vulnerable group of orphans are "*Those children [orphans] staying with elderly guardian*"(FGD Kabuthu Lilongwe) because "*There is no one to give them advice or wisdom because sometimes, ...they live with their grandparents who are too old to provide advice, [and] energy to accommodate a child's curiosity*" (FGD Kabudula).

9. The lack of a children's centre

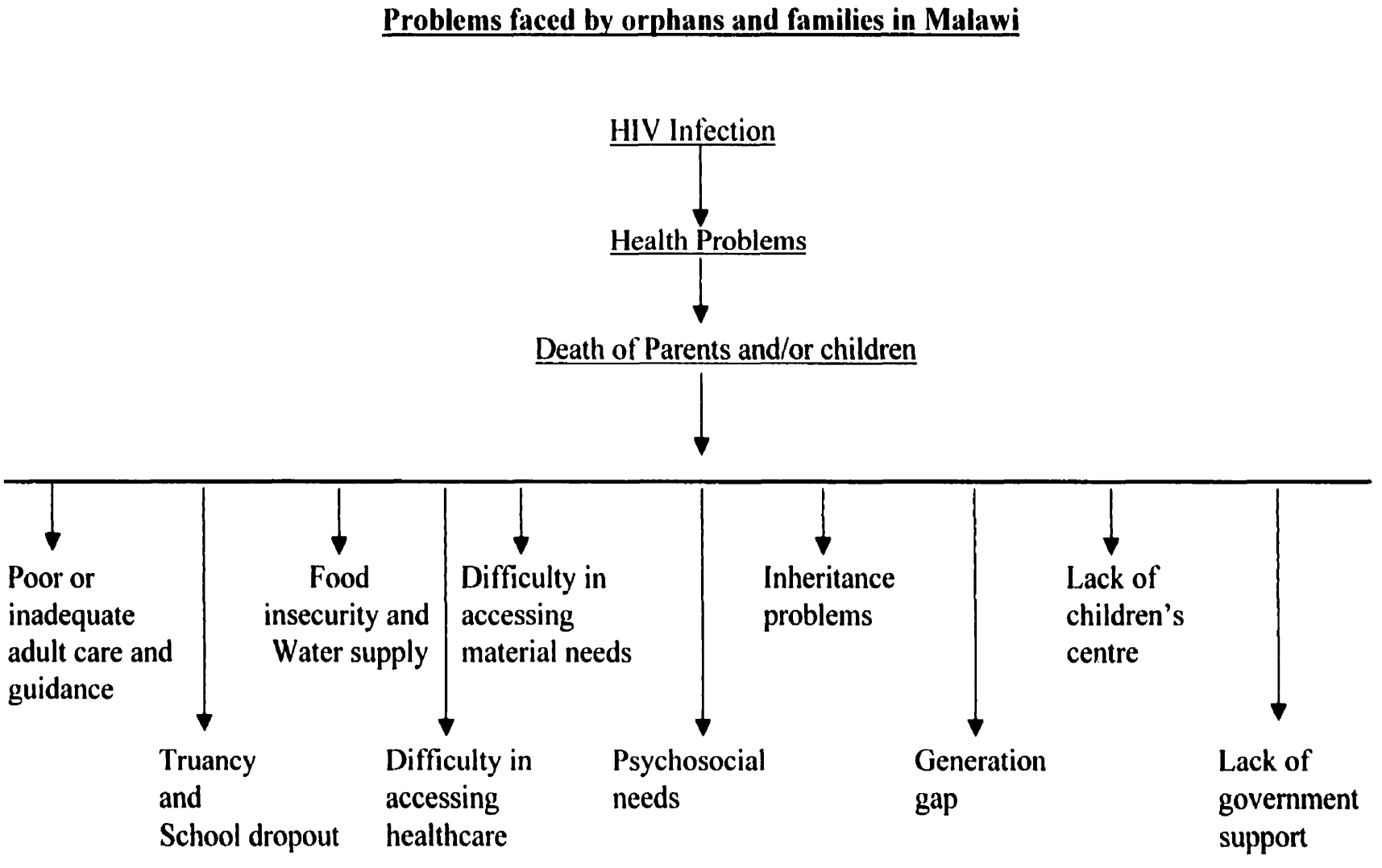
The Malawi data show that there is the lack of children's centres to meet the needs of recreation and social interaction. A key informant from Balakasi village stated that the

village does not have any recreational centre were children can meet, play and entertained themselves. Another key informant from Mkwopatira village stated that there was only one small inadequate football ground for the entire village.

9. Lack of government support

While there is expectation for support from the government by orphan care providers, the government is not providing any. A key informant from the village of Balakasi stated that "*They (the constituents) ask their MP [Member of Parliament] for help, but he rarely hold meetings, and when he does he promises support, but no support is coming*". The participant continued to state that "*Orphans have been registered twice. First by the chief for the government, and then by the Community Aids Committee (CAC) for the social welfare office, but there has not been any support from anywhere*". A foster family member, participating as a key informant also from the village of Balakasi, stated that the district commissioner was informed of their foster work but they still have to see any support from the government.

Figure 2


Problems faced by orphans and families in Malawi
HIV Infection
Health Problems
Death of Parents and/or children
Poor or inadequate adult care and guidance
Truancy and School dropout
Food insecurity and Water supply
Difficulty in accessing healthcare
Difficulty in accessing material needs
Psychosocial needs
Inheritance problems
Generation gap
Lack of children's centre
Lack of government support

All the nine villages reported that the lack of adequate adult care and guidance, the difficulty in accessing material needs, and the difficulty with the inheritance of parental property were some of the major problems faced by orphans in their communities. Eight villages reported food insecurity, healthcare access difficulty and psychosocial needs as problems faced by orphans. School dropout and the generation gap between the grandparents and grandchildren were cited as problems to orphans by three villages. Two villages pointed to the lack of government support to orphan-care, the absence of children's playground in the communities, and the lack of adequate sanitary water supply as some of the key problems faced by orphans.

Table 6

Problems faced by orphans in Malawi

Variables	Mkwopatira	Balakasi	Malekano	Kabuthu Mulanje	Dzenje	Domasi	Kabuthu Lilongwe	Kabadula	Mtema	total # of villages	%
Lineage	M	M	M	M	M	M	P	P	P		
Adult guidance	Y	Y	Y	Y	Y	Y	Y	Y	Y	9	100%
School dropout	-	-	Y	-	Y	-	-	Y	-	3	33%
Food insecurity	Y	Y	Y	Y	Y	Y	Y	Y	Y	9	100%
Healthcare access	Y	Y	-	Y	Y	Y	Y	Y	Y	8	89%
Material needs	Y	Y	Y	Y	Y	Y	Y	Y	Y	9	100%
Psychosocial needs	-	Y	Y	Y	Y	Y	Y	Y	Y	8	89%
Inheritance	Y	Y	Y	Y	Y	Y	Y	Y	Y	9	100%
Generation gap	-	-	-	-	-	-	Y	Y	Y	3	33%
Lack of govt. support	Y	Y	-	-	-	-	-	-	-	2	22%
Children playground	Y	Y	-	-	-	-	-	-	-	2	22%
Safe Water supply	Y	Y	-	-	-	-	-	-	-	2	22%
N=9	Key										
	M	Matrilineal									
	P	Patrilineal									
	Y	The issue was stated as prevalent in the village									
	-	The issue was not mentioned									

The most vulnerable orphans

The most vulnerable orphans in Malawi according to the data are those orphans fighting for survival, which is "the process of seeking a healthy state at birth and in the early months and years of life" (Myers 1992 p.37), those who do not have adult care, or have inadequate adult care and guidance, and those with pathological problems, as evidenced by the following extracts. The most vulnerable orphans are: "*those who are breastfeeding and those between two and five are the most vulnerable*" (KI Kabudula); "*Those [orphans] who have lost both parents*" (KI Kabudula); "*Those children [orphans] staying with elderly guardians*"(FGD Kabuthu Lilongwe). "*There is no one to give them advice or wisdom because sometimes, ...they live with their grandparents who are too old to provide advice, energy to accommodate a child's curiosity*" (FGD Kabudula); "*Those children [orphans] who have one parent or guardian who is unable to cater for their needs*" (FGD Kabuthu Lilongwe), *[and]* "*The orphans who look after themselves*" (i.e those who do not have foster parents) (KI Dzenje).

THE ORPHANS' ECOLOGICAL SYSTEM

The orphans' immediate relationship

The data show that orphans regularly interact with their primary caregivers, older siblings, the church, health centres, traditional healers, schools, peers, and the village chief. All the nine villages reported the interaction of orphans with their primary caregivers, the health centres, traditional healers, schools, and peers. Six villages reported the interaction with the church and older siblings, while two villages reported that orphans do interact with the village chief.

The orphans' relationships with the immediate environment is captured by the following excerpts. "*In elder children, they go to the chief, uncles or other relatives with their problems*" (FGD Kabuthu Mulanje). "*They [orphans] talk among their peers, they do not talk with adults even in the event of death*" (FGD Domasi). The churches (Roman Catholic (RC), and Church of Central African Presbyterian (CCAP)) "*offer advice to young children about eight years old on how to pray and encourage them to respect their parents and all adults. Youth awaiting marriage (16 – 20 years old) (RC) and those recently married (CCAP) are counselled somewhat along the same lines*" (KI Kabudula). "*Most of them [orphans] go to school because it is free*" (KI Dzenje).

Table 7

Malawi Orphans' Immediate Relationships; The Microsystem

Village	Lineage	Primary caregiver	Older siblings	Church	Hospital	Traditional healer & TBA	School	Peers	Chief
Mkwopatira	**M**	Y	-	Y	Y	Y	Y	Y	-
Balakasi	**M**	Y	Y	Y	Y	Y	Y	Y	-
Malekano	**M**	Y	Y	Y	Y	Y	Y	Y	Y
Kabuthu Mulanje	**M**	Y	-	Y	Y	Y	Y	Y	Y
Dzenje	**M**	Y	Y	Y	Y	Y	Y	Y	-
Domasi	**M**	Y	-	-	Y	Y	Y	Y	-
Kabuthu Lilongwe	**P**	Y	Y	-	Y	Y	Y	Y	-
Kabudula	**P**	Y	Y	Y	Y	Y	Y	Y	-
Mtema	**P**	Y	Y	-	Y	Y	Y	Y	-
FREQUENCY		9	6	6	9	9	9	9	2
PERCENTAGE % N=9		100%	67%	**67%**	**100%**	**100%**	**100%**	**100%**	**22%**

Key

M Matrilineal
P Patrilineal
Y Data show the presence of a relationship
- Data does not mention the existence of a relationship
TBA Tradional Birth Attendant

Orphan care supportive structures

The data show that non-governmental organisations (NGOs), the village bureaucracy in the persons of the chief and the headman, party leaders, relatives, community development assistants (CDA), health surveillance assistants (H S A), and the church, are the main structures that provide support to orphan-care in the village setting.

All the nine villages cited relatives as a supportive institution. Eight villages reported the village bureaucracy in the persons of the chief and the headman, and the church as supportive structures to orphan care. NGOs, party leaders, and H S A, were cited by six villages as structures providing support to orphan care. Four villages cited the CDA as a supportive structure for orphan care in the villages. The Malawi data show that the villages in the patrilineal cultural setting have generally more supportive structures than the villages in the matrilineal setting. All the three villages in the patrilineal setting reported the presence of all the seven highlighted supportive structures in their communities, while the presence of these supportive structures ranged from one to six in the matrilineal setting.

Table 8

The Malawi Orphan-care Supportive Structures; The Exosystem

Variables	Mkwopatira	Balakasi	Malekano	Kabuthu Mulanje	Dzenje	Domasi	Kabuthu Lilongwe	Kabadula	Mtema	Total	%
Lineage	**M**	**M**	**M**	**M**	**M**	**M**	**P**	**P**	**P**		
NGO	N	N	Y	Y	Y	N	Y	Y	Y	6	67%
Chief and Headman	Y	Y	Y	Y	Y	-	Y	Y	Y	8	89%
Party Leaders	-	Y	-	Y	Y	-	Y	Y	Y	6	67%
Relatives	Y	Y	Y	Y	Y	Y	Y	Y	Y	9	100%
CDA	-	-	Y	-	-	-	Y	Y	Y	4	44%
H S A	-	-	Y	Y	Y	-	Y	Y	Y	6	67%
Church	Y	Y	Y	Y	Y	-	Y	Y	Y	8	89%
TOTAL	3	4	6	6	6	1	7	7	7		
PERCENTAGE %	**43%**	**57%**	**86%**	**86%**	**86%**	**14%**	**100%**	**100%**	**100%**		
N=9	**Key**										
	M	Matrilineal									
	P	Patrilineal									
	Y	Exosystem entity present in the village									
	N	Exosystem entity NOT present in the village									
	-	The presence or absence of the supportive structure was not mentioned									
	NGO	Non-governmental organisations									
	CDA	Community Development Assistant									
	H S A	Health Surveillance Assistant									

Orphan care

Provision of care through counselling is provided by peers, uncles, chiefs, guardians, relatives, village elders and church elders. Three villages cited peers as people orphans talk to in their times of distress. All the three patrilineal villages reported that relatives, village elders, and church elders were the persons orphans talk to when their parents are sick or dead. Two villages reported that uncles were the persons orphans talk to at times of grief. One village each cited the chiefs and the guardians as the persons orphans talk to when their parents are ill or dead.

Relatives, the church, and the community are the institutions that provide care to children when their parents are sick. Three villages stated that relatives were the people that provide care for orphans when their parents were sick. Two villages cited mother's relatives as the people who provide care for orphans during parental sickness. All the patrilineal villages cited grandparents as the people who care for children when their parents are sick. Two of the patrilineal villages also cited the church, while one included the community as the institutions that take care of orphans when their parents are sick.

Mother's relatives, grandparents or other relatives, were according to the Malawi data, the people providing care to orphans after the death of their parents. All the six matrilineal villages reported that orphans were cared for by the mother's relatives after the death of their parents. The data from all three patrilineal villages show that orphans are cared for by grandparents or relatives after the death of the parents.

Table 9

	Orphan Care Relationship								
	Mkwopatira	**Balakasi**	**Malekano**	**Kabuthu Mulanje**	**Dzenje**	**Domasi**	**Kabuthu Lilongwe**	**Kabadula**	**Mtema**
Lineage	**M**	**M**	**M**	**M**	**M**	**M**	**P**	**P**	**P**
Who do orphans talk to when parents are sick or dead	N/R	Peers	N/R	Peers Uncles Chiefs	Uncles Guardian	Peers	Relatives Village & Church elders	Relatives Village & Church elders	Relatives Village & Church elders
Care of children during parental sickness	N/R	Relatives	Mother's relatives	Relatives	Relatives	Mother's relatives	Grandparents Church members or community	Grandparents Church	Grandparents
Care of children after parental death	mother's relatives	mother's relatives	mother's relatives	mother's relatives	mother's relatives	mother's relatives	Grandparents or relatives	Grandparents or relatives	Grandparents or relatives
	Key								
	M	Matrilineal							
	P	Patrilineal							
	N/R	No Response							

CHAPTER IV

DISCUSSION

PSYCHOSOCIAL SUPPORT

Earlier in chapter one it was stated that this study's primary goal is to aid the development of a psychosocial infrastructure. The term psychosocial is very contentious and yet frequently used in the human development discourse. Ms. Sandra Ali of Chancellor College Malawi, who was a facilitator in the Starting from Strengths project, stated in her workshop report for training research assistants that the term psychosocial is regularly used interchangeably with psychological and yet they do not have the same meaning. Myers (1992) breaks the term psychosocial development into the three components of cognitive, emotional, and social development. The operationalization of these components is essential for the proper comprehension of the term psychosocial.

The list of problems faced by Malawi orphans cited earlier, could all be grouped into three categories. The categories of nutritional need, psychosocial need, and health need.

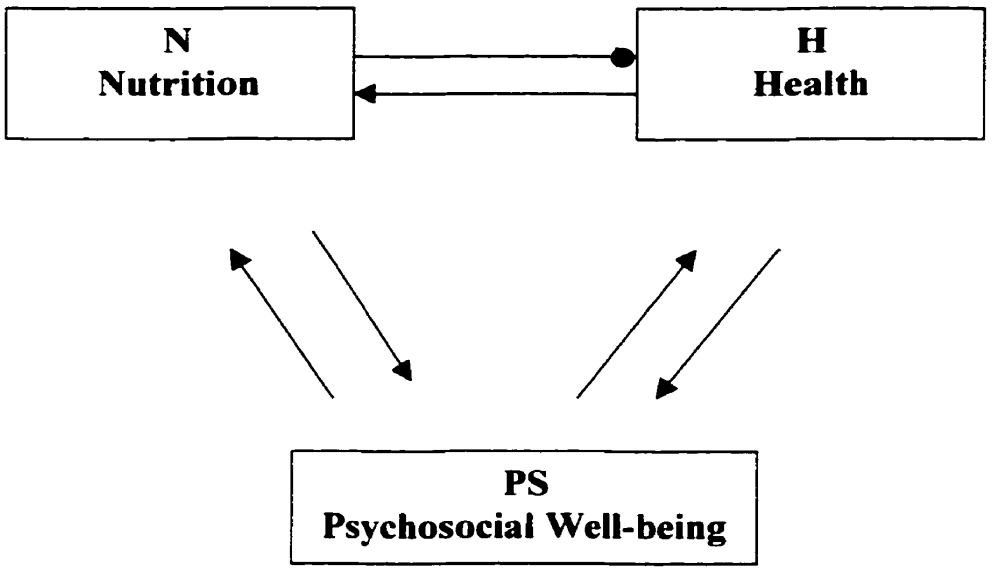
Nutritional needs	Psychosocial needs	Health needs
Food insecurity	Psychosocial needs	Healthcare needs
Safe water supply	Adult care needs	Nutritional needs
Healthcare access	Educational needs	Psychosocial needs
Material needs	Generation gap	Government support
Inheritance	Children's playground	
Government support	Government support	

All the problems listed however relate to the orphans' psychosocial needs because the psychosocial dimension of a child is associated with the health and nutritional status of the child (Myers 1992). The current perspective in human development is that there are links among the nutritional status, the psychosocial wellbeing status, and the health status of an individual. The view is that there exists a synergistic link between the psychosocial well-being and the health and nutritional status as well as between the nutritional and health status of a person (Myers 1992).

Figure 3

Synergistic links among the

Psychosocial, nutritional, and health status.



Source: Myers 1992 p.171

It follows from the synergistic links therefore that nutritional and health issues must always be included in any psychosocial intervention programme for the initiative to have

the most impact both in the short and long run. The issues of food insecurity, health care access, material need, inheritance, children play centre, and government support should all therefore be components of any psychosocial intervention aimed at the Malawi orphans.

Nutritional Needs

Food insecurity was cited by all nine villages as one of the major problems faced by orphans in Malawi. Six of the eleven mentioned problems are related in some way to nutritional issues. Food insecurity is directly related to the nutritional intake, healthcare access and safe water supply are essential in the containment of secondary malnutrition. Material needs, inheritance, and government support, in the forms of land, farm equipment, seed supply, infrastructure, and social services, can all be related to food production and hence nutrition.

Undernutrition or simply the lack of adequate food supply exacerbated by secondary malnutrition, which is a condition due to illness that prevents the proper digestion or absorption of food, is a very serious problem in Malawi. Statistics show that 48% of Malawians under-five years of age were "moderately or severely stunted", and 7% were "moderately and severely wasting" between 1990 and 1997. Only 37% of Malawians had access to safe water and only 6% of the population had access to adequate sanitation between 1990 and 1996 (UNICEF 1998). Public health measures such as providing appropriate means of human waste disposal and sanitary water supply are especially important in reducing the incidence of secondary malnutrition (Foster 1992).

Psychosocial Needs

A psychosocially well adjusted child expresses the following: (i), Age appropriate cognitive skills which are the ability to think and reason; (ii) An age appropriate emotional perspective which is the ability to feel; (iii) The social ability to relate to others. Myers (1992) and Erikson (1997) state that children with dysfunctional psychosocial status experience major disruptions in their development. Research participants from all the villages reported that the orphans need adult love and care, formal education, access to information on the illness and death of parents, spiritual guidance, and knowledgeable teachers who can provide professional guidance and counselling to grieving orphans.

Six of the problems exposed by the research participants relate directly to the psychosocial needs of the orphans. Psychosocial needs, adult guidance, school, generation gap, children's playground and government support are all related to the child's cognitive, emotional, and social skills development. Proper adult care, guidance, and affection produce children who are content, self reliant, and explorative (Berns 1993). Schools and playgrounds promote cognitive skills development through classroom learning, and emotional and social skills through play and socialisation with other children. Government support in funding education, health and social services is essential in the development of human resources.

Health Needs

The World Health Organisation (WHO) defines health as a state of complete physical, mental, and social well-being, and not merely the absence of diseases or infirmity. All the problems highlighted by the Malawi data relate to health needs. Adequate food supply, access to healthcare services, access to material needs, and safe water supply are all essentials for the physical well-being of a child. Adequate adult care that meets the psychosocial needs promote the mental well-being while school, and play are important for both the mental and social wellbeing of a child.

Orphan Age Demography

Most of the Malawi orphan population is in the childhood (3 -12 years) age group and is reflected at 69% in Table I. The concentration of orphans in this age group can be explained by the following two reasons. One, there is a very high child mortality rate in Malawi. In 1996 Malawi was number eight in the world in the "under-five mortality rate" (U5MR) ranking, with 217 deaths for every 1000 live births (UNICEF 1998). Poverty, malnutrition, plus the difficulty in accessing safe water and adequate sanitation make the survival of infant orphans very difficult. A key informant from Dzenje village confirms this position with the statement "*They [orphans in an orphan headed household] recently lost their baby sister because of malnutrition. The nurses had tried to give her Soya, but this did not help*". Two, adulthood in Malawi is attained in the early teen years. Orphanhood has a childhood (minority) connotation as it implies the lack of needed adult care and guidance. At the age of 15 years Malawi girls and boys are socially considered adults who can fend for themselves and can even get married as evidenced by the

following excerpts. "*A fifteen years old orphan (female) left school just last week to look for employment*" (FGD Namwera-Malekano). In describing the work of church counsellors a key informant states" *Youth awaiting marriage (16 – 20 years) (RC) and those recently married are (CCAP) counselled along the same lines; Women typically marry at 14-15 years*" (KI Kabudula). The Medical Post (Feb. 1999) states that in Malawi today "men are hunting girls of age[s] 12 to 14 [years] for marriage because they are less likely to be infected with HIV." Intervention programmes aimed at the childhood (3 – 12 years) age group would therefore reach the most number of orphans and have the most impact in the community.

Primary Care Provider

Table 4 shows that female relatives in the persons of the grandmothers, biological mothers, sisters and aunts, provide primary care to up to 85% of the Malawi orphan population. Thirty percent of Malawi households are headed by women and Malawi women like their counterparts elsewhere in Sub Saharan Africa are confronted by "arduous household tasks, [of] child bearing and child raising, collection of fuelwood, [and the] continuous engagement in productive activities both on and off the farm" (United Nations and Malawi Government 1993). Adult literacy rate among Malawi women is only 58% of that of Malawi men, and secondary school enrolment is at 67% of that of Malawi men (UNICEF 1998).

Intervention programmes targeted at improving the social, economic, and educational status of women can significantly impact child development. Women support groups at

the village levels and credit schemes for small business incentives based on access to capital, control of resources, entitlement to resources, decision making and informed participation (Holcombe 1995) can for example provide immediate results. Long term impact can be achieved by supporting girls to stay in school as long as possible as formal education has been demonstrated to have a positive effect on the status of childcare. Societies that invest in mothers and children tend to have healthier populations than societies that do not. (Per Pinstrup-Andersen et. al. 1995).

THE SOCIAL ECOLOGY

The Malawi Orphan Microsystem

"A microsystem is a pattern of activities, roles, and interpersonal relations experienced by the developing person in a given setting with particular physical and material characteristics" (Bronfenbrenner 1979 p.22).

The Malawi orphan's immediate relationships or rather the microsystem of the Malawi orphan is composed of the relations with the primary care giver, older siblings, the church, health centres, traditional healers, schools, peers, and the village chief.

The primary care giver can be the biological mother, the wet-nurse, the grandmother, the aunt, an adopted parent, or any other relatives. The primary care giver is the person responsible for the entire child rearing activities like providing food, care, guidance and affection. Health centres and traditional healers frequently interact with children because of the high morbidity rate in Malawi. The health centres in the form of the district hospitals, or village dispensaries are the structure where families receive healthcare services. Infants interact with the health centres regularly through the visits for

immunisation against diseases like tuberculosis, measles, and polio among others. The prevalence of diseases like whooping cough, diarrhoea, malaria, pneumonia, bilharzia and others also do force families to visit the heath centres regularly.

Older orphan siblings constantly interact with their younger siblings during play, and act as supplementary caregivers providing breaks to the primary care giver, or taking over when the primary care givers are sick. Myers (1992) contends that a child's interaction with the older siblings results into a high level of interaction with many people providing visual and auditory stimulation as well as early socialisation. Bronfenbrenner (1979) endorses this position in the following hypothesis.

> Development is enhanced as a direct function of the number of structurally different settings in which the developing person participates in a variety of joint activities and primary dyads with others, particularly when these others are more mature or experienced (page 212).

Older siblings enable primary caregivers to engage in other activities, like paid work, that are vital for family survival. In other circumstances, like in an orphan headed household, the older siblings take on the full responsibility of primary care giving as seen in this excerpt. "*The eldest [boy] has left home and is now working on Minimini Estate in Mulanje.... The other sister stays at home to cook and look after the family*" (KI Dzenje). Here, two older siblings in an orphan-headed household have dropped out of school to take on the full responsibility of providing care for the family.

The peer microsystem is a very important component of the orphan's social ecology as it provides a reliable alternative source of companionship and support when parents are sick

or when foster parents fail in their duty to provide care, guidance, and affection to the orphan as seen in the following excerpts. "*They just play with friends, games like football [and] netball during their parent(s) illness*" (key informant from Malekano village). "*To reduce grief, orphans should be encouraged to play with their friends during their free time*" (key informant from Malekano village). "*The children do not talk to anyone in particular. Most of the times they just keep their grief to themselves, or talk to their close friends*" (key informant Balakasi village). "*If s/he has a problem with the adopted family s/he tells his/her friend about the problem s/he is facing...*" (focus group discussion Kabuthu village).

Belonging to a peer group has developmental implication as peer groups satisfy certain basic human needs.

1. The need to belong to a group (Freud, 1963 and Maslow, 1970).

As children grow older, they get to spend less time with their parents and more time with other children in the neighbourhood. Concomitant to this development is the shift in the need for recognition and approval from parents to peers.

2. Independence and self-esteem (Berns, 1993).

Peer groups provide children the opportunity to experience the concepts and implications of power, compliance, conflict, and co-operation. These issues are important and contribute to the development of independence and self esteem as the children learn to be assertive and to negotiate while at play.

The church is a very influential institution in the lives of Malawi families through the counselling it provides to children and parents, the control it has over the education and health institutions, through its participation in community development projects, and through its spiritual work with the community. The interaction with the village chief is mainly around reporting problems and the search for solutions as seen in this excerpt. "*In elder children, they go to the chief, uncles or other relatives with their problems*" (FGD Kabuthu Mulanje).

The Mesosystem

> A mesosystem comprises the interrelations among two or more settings in which the developing person actively participates (such as, for a child, the relations among home, school, neighbourhood peer group; for an adult, among family, work, and social life) (Bronfenbrenner 1979 p.25).

The mesosystem of the Malawi orphan appears to be very weakly linked as evidenced by the following excerpts. "*Most of the time the teachers are not informed of the illness that a child' parents are suffering; Unfortunately the school authorities do not know the exact number of orphans they accommodate*" (KI Namwera-Malekano). Here there appears to be a very limited linkage between the orphan's family microsystem and the orphan's school microsystem. Collaboration between bio-medicine and traditional therapy also appears to be minimal as captured in these excerpts. "*Traditional healers work hand-in-hand with medical personnel from Jalasi and Namwera Health Centres*" (FGD Namwera-malekano). "*When a person is ill, parents and relatives are the most responsible people. They go to the hospital for the care of the sick, but when the hospital fails to do anything, they go to the traditional healer while at home*" (KI Dzenje).

"People usually go to the traditional healer first but when the patient gets serious, they go to the hospital" (FGD Domasi). *The collaboration between the "hospitals and traditional healers [is that they] take care of the sick in terms of medicine and advice which the people follow"* (FGD Kabuthu-Lilongwe).

Co-operation between the orphan's health centre and traditional healer microsystems is primarily non-existent except for the Village of Namwera where the two are reported to be working "hand in hand". Collaboration between or among a child's microsystem provides continuity for the developing child, and feedback and support for the people working with the child in the various microsystem settings. Bronfenbrenner (1979) encapsulates the situation in the following hypothesis.

> The developmental potential of a setting is increased as a function of the number of supportive links existing between that setting and other settings [such as family and school]. Thus the least favourable condition for development is one in which the supplementary links are either non supportive or completely absent - when the mesosystem is weakly linked (p.215).

Projects targeting orphans in Malawi therefore should strive to strengthen the mesosystems in order to create an environment conducive for child development. Some of the mesosystem that need bolstering are discussed below.

1. The relationship between the traditional healers (including traditional birth attendants) and the health centres. Traditional birth attendants are very important in the delivery of babies in most Third World settings. Delivering babies in the sterile confines of the health centres in the presence of qualified medical personnel is a dream that is not feasible given the economic constraints and lack of trained medical

personnel in Malawi. One inexpensive option would be for the health centres to provide biomedical training and support to the traditional birth attendants. The incorporation of biomedical skills into the work of traditional birth attendants would address the issue of hygiene that has been a sore point in the practice of traditional birth attending. Providing basic medical supplies like gloves and disposable razors would address infection concerns between the mother and infant, between the traditional birth attendant and the infant, between the traditional birth attendant and the mother, and between the tools used in the birthing process and all the parties involved. Keeping birth records and sharing it with the health centres can aid the process of tracking the national demographic trend toward the development of national health policy. Current HIV/AIDS intervention programs in Africa are overly burdened with religious constraints. Alternative culturally sensitive approaches that are usually not acceptable to the churches and or Western funders might hold the key to the mitigation of the HIV/AIDS carnage in Africa. The use of traditional healers in the rural areas where most of the population is illiterate should be investigated. Traditional healers constitute the core of an important healthcare network and have considerable authority in many African societies. The development and usage of cultural constructs of the HIV virus and the AIDS disease in education done in collaboration with or through traditional healers would send the HIV/AIDS intervention message to a wider audience.

2. A relationship between the older siblings and the health centres can produce a major

developmental impact on the lives of infants. The health centres can for example develop programmes to teach sibling caregivers the basics in health, nutrition, and hygiene. Such a programme would go a long way toward addressing the high prevalence of diseases discussed earlier that are mainly air and water borne. Myers (1992) concurs with this position stating that such a programme would have an immediate impact on the infants receiving care today, and a long-term impact on the raising of future infants when these siblings providing care today reach the age of reproduction.

3. Another mesosystem that should be strengthened is between the wet-nurse/primary care provider and the health centres. Regular visits to the health centre for medical check ups and infant health status reporting can promote child survival and development as the opportunity for arresting diseases at their start is increased.
4. A relationship can also be built between the older siblings and the wet-nurse. The older siblings can provide support to the wet-nurse by running errands and doing household chores to help compensate for the wet-nurse's time taken up breastfeeding and caring for the infant.
5. A relationship between the family and the school should be developed. This would provide continuity in child development and the reinforcement of the two the development settings.

Ecological Transition

"An ecological transition occurs whenever a person's position in the ecological environment is altered as a result of a change in role, setting, or both." (Bronfenbrenner 1979 p.26).

Orphans experience ecological transition when their parents fall sick, when their parents die, and when they are moved into foster care. The practice in Malawi today is that children are frequently removed from their parents and placed in with relatives without any explanation at both the points of sickness and death as evidenced by the following excerpts. "*The [orphans] do not know that their parents are dead, and they say that they [the parents] will come back. She [the foster mother] feels that way the children feel no grief*". (KI Balakasi). "*when a parent is ill, the children are taken care of by relatives. If the mother dies, the children are shared among the mother's relatives*" (KI Dzenje)

The ecological transitions that the orphans go through must be buffered to minimise the disruptions on the psychosocial development. Arrangements should be made in advance, when the HIV positive parent/s are still strong, with the prospective foster family, to introduce and explain to the children the rationale for the transition in order to permit a smoother transition and enable the children to function in the new setting. Bronfenbrenner summarises the need to create an optimal condition for the establishment and maintenance of a primary link in the following hypothesis.

> The developmental potential of a setting in a mesosystem is enhanced if the person's initial transition into that setting is not made alone, that is, if he enters the new setting in the company of one or more persons with whom he has participated in prior settings (page 211).

The Orphan Exosystem

> An exosystem refers to one or more settings that do not involve the developing person as an active participant, but in which events occur that affect, or are affected by, what happens in the setting containing the developing person. (Bronfenbrenner 1979 p.25)

There are many entities at the exosystem level in the social ecology of the Malawi orphans today. There are the NGOs, government community development personnel, the party leadership, the village bureaucracy, and the religious institutions. The proliferation of the exosystem in the patrilineal villages compared to the matrilineal villages should primarily be a function of location. All the three patrilineal villages are in the district of Lilongwe, which is the capital district with the seat of the national government. Poor infrastructure and communication difficulty in the Third World, influence the decision on the site of operation for many NGOs. Proximity to government offices is essential, as many bureaucratic procedures require personal physical presence to accomplish. The absence of community development assistants (CDA) and health surveillance assistants (H S A) in some of the villages can be a function of the difficulty in finding government employees willing to relocate to upcountry districts where social services are limited. Although some villages did not mention them, chiefs, headmen and party leaders are present in all the villages, as administrative and political structures cover all parts of the country. The village bureaucracy, relatives, and the religious institutions appear to be the most effective entry points to support orphan care since they are functional in all the villages.

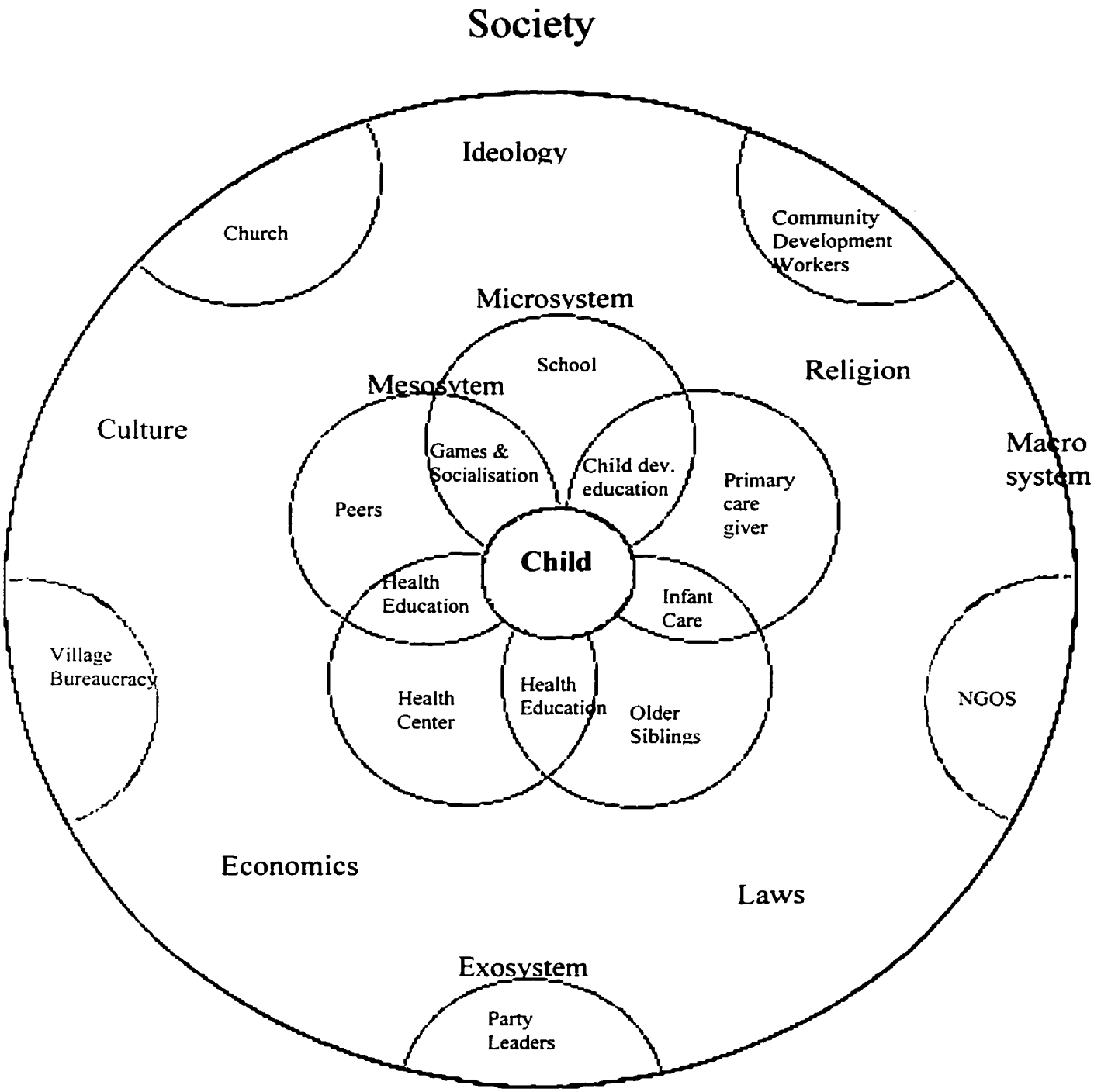
The Malawi orphan exosystem structure however, appears to be dysfunctional and not very supportive of the orphan development as evidenced by the following statements from the research participants. "*A lot of people come here, but nothing is done. All they do is register orphans. There is no explanation or feedback as to what they are going to do with the names [that] they have taken down. Because of this, the community has lost*

heart and do not want to participate in any of the orphan programmes that come in" (key informant from Djenze village). "*They ask their Member of Parliament for help, but he rarely holds meetings, and when he does, he promises support, but no support is coming*" (key informant from Balakasi). "*The DC was informed [of the work of a foster family] but she [the foster mother] does not get any help from the government*" (key informant Balakasi). "*They [the villagers] expect clothing, food, shelter from the government but none of this has come. There is no change from this government. It is just like the last government*" (key informant from Balaksi village). The "*inactivity of government extension workers*" was cited by a key informant from Namwera village as one of the main obstacles to community care mobilisation.

The ineffectiveness of the exosystem structures can be transformed through the education and empowerment of the village communities. Grassroots based advocacy can challenge and hold bureaucratic and organisational structures accountable for their actions and inactions.

Figure 4

The Proposed Ecological Model of Human Development



Source: Adopted from Berns (1993)

RESILIENCY

Resiliency is "the individual's ability to manage or cope with significant adversity or stress in ways that are not only effective, but may result in increased ability to respond to future adversity" (Louise Harvey Consulting 1996 p.13). The emphasis on resiliency is in line with the current philosophical shift, in the human services industry, away from a psychopathological approach to a strength orientation with the emphasis on the promotion of competence, coping and hence prevention. (Ferguson et. al. 1993). Certain factors have been found to enhance the development of resiliency in children. Mangham C., McGrath, P., Reid, G., and Stewart, M. (1995) contend that there are three categories of factors that contribute to the development of resiliency. The three categories are individual factors, familial factors, and support factors. Individual factors include cognitive skills, problem solving ability, optimism, and resourcefulness in seeking support. Effective parenting, affection, family support, and family cohesion are considered familial factors, while the category of support factors include the presence of a caring and supportive adult, a supportive peer group and a supportive social environment that promotes autonomy and responsibility.

Addressing the psychosocial needs of orphans and enhancing the development of their cognitive, emotional, and social skills equips orphans with resiliency's individual factors. Fortifying the orphans' microsystem, mesosystem, exosystem, and macrosystem furnishes the orphans with resiliency's familial, and support factors. Dugan and Coles (1989) endorse this position with the statement that a functional and supportive relationship with peers and the community goes a long way toward replacing the lack of

family or parental support. "Corrective emotional experiences"(p.75) found among juvenile peer relations, Dugan and Coles continue, is a major source of support for children without parents. The orphan's relationship with peers, relatives, and elders can therefore be developed to meet the familial and support factors needs, toward enhancing the development of resiliency.

MATRILINEAL Vs PATRILINEAL CULTURAL SETTING

There does not appear to be any difference in the care available to orphans or in the way it is provided between villages with NGO activity and those without NGO activity. This could be due to the ineffectiveness of the NGO operations / activities amongst other variables.

Care providers

There are differences between the matrilineal and patrilineal villages in the people who provide care to orphans during parental illness and after parental death, as illustrated in Table 7 in chapter III. In the matrilineal setting, the mother's relatives are primarily the people who orphans talk to and who provide primary care both during parental illness and after parental death. Mother's relatives include maternal grandparents, uncles, and aunts. In the patrilineal setting, relatives, village elders, and church elders are the people orphans talk to in times of distress. Grandparents, however, are the primary care providers both during parental illness and after parental death.

The differences in the care providers in the two cultural settings can be explained through

the differences in the blood relationships. Logan (1996) identifies "blood ties" as taking precedence over all types of relationship in African family patterns. Blood ties however must be understood in the context of the Malawi culture where children are primarily raised by women. In the matrilineal cultural setting, the man lives in the wife's village and all the women, the aunts, in the extended family structure within the village have blood ties to the children. In the patrilineal cultural setting the wife lives in the husband's village. The orphans in this cultural structure have no blood ties to their aunts, their uncles' wives, and are therefore usually taken care of by their paternal grandmothers with whom they have blood ties. It is important to note here that there are usually several aunts in the matrilineal setting while there can only be one paternal grandmother.

Quality of care

In the matrilineal setting, orphans who have lost both parents can still get quality care from their mother's sisters, their aunts, with whom they have blood ties and who are still young and in the prime of their productive lives. In the patrilineal setting on the other hand, as seen in Table 7, orphans who have lost both parents can only get care from their grandmother. Access to quality adult-care and guidance therefore is very limited as the grandparents are usually very old, illiterate, and with old age related health complications. Orphans who reside with the wives of their uncles, with whom they have no blood ties, are many times subjected to very mean situations as noted in this excerpt. "*Usually it is the women of the house that are most cruel to the orphan. The men stay very well with the children, and sometimes they may even rebuke the women for behaving badly towards the orphans(s).*" (FGD Women Domasi). This cultural reality explains

Table 3 and shows why the problem of the generation gap between the care providers and the orphans was only mentioned in the patrilineal villages.

The quality of women's work at raising children is a function of amongst others, the amount of power and the level of security enjoyed by the women. A gender analysis shows that under both lineage settings the control over family resources is in the hands of male family members. Under the patrilineal setting the husband and his male relatives make most of the family decisions. In the matrilineal setting the grandfather and the maternal uncles have authority over the family resources. "From the woman's point of view [however] the matrilineal system offers more security [and latitude] because she is on her own land, in her own village and amongst her own people" (United Nations and Malawi Government 1993. p.35).

Inheritance

One of the main problems faced by orphans in Malawi is the non-access to parental property as discussed earlier in chapter III. Under both the matrilineal and patrilineal settings the relatives of the husband "grab" the family property upon his death, and the wife has no say on the issue. Under the matrilineal setting children inherit from their maternal grandparents. The orphans in this cultural setting therefore have the guarantee of some inheritance property to jumpstart their adult lives even if all their immediate family property is taken over by their paternal relatives. Land, the most important property in the Malawi subsistence economy is passed through the grandparents-grandchildren line here. In the patrilineal structure inheritance is through the father-son

line. If a man dies when his children are still young, his property and his wife are usually inherited by one of his brothers. The large number of children, dwindling resource base, and the influence from the wife, who has no blood ties with the orphans, usually make portioning inheritance to nephews impossible. The orphans under the patrilineal cultural setting are therefore left without any inheritance prospect from the older generation. It must be pointed out here that the patrilineal cultural wisdom of taking over the deceased's property is for safe custody and the property is to be passed to the orphan children when they come of age.

Polygamy

Polygamy is a more common practice in patrilineal Malawi than in the matrilineal setting. *"Men in Lilongwe [a culturally patrilineal district] are prone to polygamy"* (KI Kabudula). Under the matrilineal setting the man lives in the wife's village where he has very limited authority. The comparative amount of power availed women under this cultural structure makes the getting of a second wife impossible. In the patrilineal structure however, a woman lives in the village of her husband who is the centre of the family and is responsible for making most family decisions. A second wife or even a third is a frequent occurrence in this cultural setting. More than one wife generally means more children and a larger number of orphans to take care of if the parents die. A large number of children in one household puts excessive stress on the limited family resources and exposes all to vulnerability. Polygamy also increases the possibility of family feud between or among the wives and the children over family property. A focus group

discussion from Kabuthu village captured this situation with the statement that *"In [the] event of polygamy, the first wife may claim the property from the second wife"*

In conclusion therefore it is safe to say that orphans in the patrilineal cultural setting are more at risk than their counterpart in the matrilineal setting because of the number and ages of care providers, the quality of care provided, the access to inheritance available to orphans in the matrilineal setting and the practice of polygamy in patrilineal Malawi.

CHAPTER V

ADVOCACY

Advocacy is

> ...the act of speaking in support of human concerns or needs. Where people have their own voice, advocacy means making sure they are heard; where they have difficulty speaking, it means providing help; where they have no voice, it means speaking for them (Chauncey, Parfitt, Preston, George, Eso, Cunningham and Cowel, 1992, p.49).

Children need advocates because they require special policies and programmes to protect them from the many risks that surround their formative years. Given Africa's desperate economic status and the constant political upheaval, the African child needs advocacy more than ever. In many African countries the political climate is autocratic with one leader and one party in control of the executive, the legislative, the judiciary, and the army. The brutality with which oppositions to the government are repressed and the blatant disregard for human rights have left many citizens unaware of their civil rights.

For thirty years, from independence in 1964 to 1994, Malawi was ruled by "President – for – Life" Hastings Kamuzu Banda with his Malawi Congress Party (MCP). Under Banda the Malawi Youth Pioneer (MYP), the ruling party's secret police in the guise of a youth wing, muted all oppositions and terrified the entire population. Mr. Vera Chirwa a human rights activist, who presently heads the Law Society of Malawi (LSM), was detained by the Banda regime for many years. Professor David Rubadiri, Malawi's current Permanent Representative to the United Nations was forced into exile for most of the 30 years Banda was in power.

THE UNITED NATIONS CONVENTION ON THE RIGHTS OF THE CHILD

The United Nations Convention on the Rights of the Child (UNCRC) was adopted by the General Assembly of the United Nations on the 20th of November 1989. Malawi acceded to the UNCRC on January 2nd 1991. While the Convention can generally be applied to the plight of children in Malawi, several specific articles in the Convention particularly apply to the situation of the orphans.

Article 6 of the Convention states that every child has the inherent right to life and that the State has an obligation to ensure the child's survival and development. Malawi was number eight in the world "under five mortality" rankings with 217 deaths per 1,000 live births in 1996 (UNICEF 1998).

Article 18 states that parents have joint primary responsibility for raising the child, and the State shall support them in this. The State shall provide appropriate assistance to parents in child raising. Article 20 specifies that the state is obliged to provide special protection for a child deprived of the family environment and to ensure that appropriate alternative family care or institutional placement is available in such cases. Efforts to meet this obligation shall pay due regard to the child's cultural background. The Malawi data, however, indicate that foster families are not receiving any support from elected officials or the governments.

Article 24 asserts that the child has a right to the highest standard of health and medical care attainable. States shall place special emphasis on the provision of primary and

preventive health care, public health education and the reduction of infant mortality. They shall encourage international co-operation in this regard and strive to see that no child is deprived of the access to effective health services. Article 27 states that every child has a right to a standard of living adequate for his or her physical, mental, spiritual, moral and social development. Parents have the primary responsibility to ensure that the child has an adequate standard of living. The State's duty is to ensure that this responsibility can be fulfilled, and is. State responsibility can include material assistance to parents and their children. The current health status of Malawi children is very poor. There is widespread food insecurity and a high rate of children with arrested development. The Malawi health service is poor with very limited pharmaceuticals making many treatments beyond the reach of most families. The high rate of unemployment and the lack of arable land make the attainment of a decent standard of living for most families impossible. Malawians living below the absolute poverty level ranges from 10% in urban areas to 85% in rural areas (World Bank, 1996). Single parent families and families with orphans constitute the bulk of the poor population.

Article 28 states that the child has a right to education, and the State's duty is to ensure that primary education is free and compulsory, to encourage different forms of secondary education accessible to every child and to make higher education available to all on the basis of capacity. School discipline shall be consistent with the child's rights and dignity. The State shall engage in international co-operation to implement this right. In 1995 only 56% of Malawi adults were literate (UNICEF 1998). The Malawi data illustrate that truancy and school dropout is very high among orphans. Statistics of orphan school

enrolment in Namwera region, Table 5 in chapter III, show that more than one half of the orphan population was not enrolled in school. Article 4 of the Convention states that

> State Parties shall undertake all appropriate legislative, administrative, and other measures for the implementation of the rights recognised in the present Convention. With regards to economic, social, and cultural rights, State Parties shall undertake such measures to the maximum extent of their available resources and where needed, within the framework of international co-operation.

The Malawi government can support orphan care through the following: the enactment of children centred legislation, training psychosocial counsellors, the development of effective and accessible health service, and through developing an equitable agrarian infrastructure.

ADVOCACY STRATEGIES

The UNCRC is potentially a powerful advocacy tool that can be useful in the defence and the protection of the rights of the child. UNAIDS (1998) notes that

> Despite the almost universal ratification of the United Nations Convention on the Rights of the Child, many children lack access to such basics as food, shelter and medical care. In addition, children infected with HIV, those affected by the epidemic, and those living in the shadow of HIV infection continue to suffer serious discrimination, exploitation and abuse in most countries. These violations of the rights of children can be a result of their real or perceived HIV status or that of members of their families. The violations can also make those children not already infected become more vulnerable to infection. In line with ... the Convention all children, regardless of their health status (including whether or not they are HIV positive), must have access to treatment, counselling, education, recreation and social support, and be protected against any form of discrimination. (page 5).

Earlier in chapter I it was stated that this study is a critical social science based research aimed at uncovering hidden forces that shape social relations, and at the empowerment of the disenfranchised. Many of the orphans in Malawi are either from women-headed, or orphan-headed, or grandparents-headed households, and constitute a weak constituency at the bottom of the economic strata. Empowering this constituency would therefore produce a dramatic impact on the lives of many orphans, as the constituency would be able to hold the entities at the exosystem level accountable for their actions and inactions and take them to task accordingly. One way of achieving this would be through the creation of a village based child advocacy organisation. Such an organisation would have to be financed, manned and controlled by the villagers themselves to avoid the risk of getting hijacked by other interest groups. The advocacy organisation would have to include an equal representation of women and children to that of men so that the voices of women and children are not lost.

The voice of women is essential for any intervention to succeed in Malawi because most of the people providing care for orphans are women. The presence of children on the advocacy committee would lend the advocacy organisation the child's voice. Children's participation would also be in accordance with article 12 of the UNCRC which says that a child has the right to express his or her opinion freely and to have that opinion taken into account in any matter or procedure affecting the child.

The advocacy organisation would have to be educated on the structure and function of the governments, the Convention on the Rights of the Child (CRC), and on techniques in

advocacy. With such a knowledge base the committee would have the ability to effectively carry out the following among others:

- Work with the churches and schools to raise the awareness of children, families, health centres and governments on the Convention on the Rights of the Child.
- Educate families and the villages about the importance and relevance of a will. This would address the problems around inheritance faced by orphans today.
- Put a stop to the activities of research, studies, and programmes that do not provide feedback to the villages, a complaint raised by one of the research participants.
- Advance the need for an urgent change in the current sex culture and allay the trepidation, rumours, and the blemishes associated with the HIV/AIDS disease.

A powerful orphan advocacy organisation would make the various levels of governments to pay attention to the orphan issue and to address the electorates' concerns to avoid political repercussions. The potential of the active participation of the village based orphan advocacy organisation in the political arena is captured by Bronfenbrenner (1979) in the following hypothesis.

> The developmental potential of a setting is enhanced to the extent that there exist direct and indirect links to power settings through which participants in the original setting can influence allocation of resources and the making of decisions that are responsive to the needs of the developing person and the efforts of those who act in his behalf (page 256).

The advocacy work for the Malawi orphan should be focussed at the following three directions:

1. Awareness: Many people in positions of power are not aware of the UNCRC let alone their responsibility as a government (State Party) under the Convention. Partnership with experts in the field of child's rights to raise the awareness of the children, the communities, and the local and national governments would be one appropriate strategy. A public that is aware of its rights and the responsibility of the government can be very successful in the process of political manoeuvring.
2. Legal Advocacy: The Malawi data speak of boys involved in stealing, smoking "chamba", and drinking alcohol. This kind of behaviour pushes the youth into conflict with the law. Orphans who do not have parents to speak for their interests can get abused or neglected in the court system. Legal representation is one effective way of advocating for the legal rights of the child.
3. Legislation: The village bureaucracy, the chief and the headman, the district administration, the national government, and the party leadership should be lobbied to develop legislation that support orphan-care, and to fund programmes that support the communities in containing orphans' issues. Legislation addressing the disparity on land title among the two genders, and on the issue of inheritance would demonstrate the seriousness of the government in tackling the orphan issue.

CONCLUSION

This is a critical social science based research and the pages of this study is therefore not the right forum for arriving at definitive intervention strategies, for this would require the participation of the affected population, the citizens of Malawi.

Children raised with adequate adult care generally grow up into productive well-adjusted adults. During strenuous socio-economic times, however, families with many young children bear the largest scars of the times. Keating and Mustard (1993) state that there is a strong relationship between the development of psychosocial skills and health, nutritional, and socio-economic status. Psychosocial interventions aimed at making the social ecology conducive for child development is therefore one important place to start as improving the social environment enhances a child's competence and coping skills.

This research study achieved the following: it ascertained that the Malawi orphan population is concentrated between the ages of 3 and 12 years (Table 3): two, the study determined that orphans in Malawi are generally cared for by female relatives (85% in Table 4): three, the study explicated the main problems faced by orphans in Malawi today: four, the study established a profile of the most vulnerable orphan: five, the study developed a comprehensive understanding of the microsystem, mesosystem, and exosystem of the Malawi orphan.

This study analysed the Malawi orphan's social ecology using frameworks, concepts, and terminology of the human and social development academic field. This was an important stage because the various forces in the orphans' social environment need to be properly understood for any effective intervention to be planned and implemented. This study's findings however should be translated into a lexicon accessible to Malawi villagers and shared with them in order to ascertain the external validity of the findings. The research findings can only be generalised to the whole Malawi population, and used as the

foundation for intervention if confirmed by research participants. The findings of this study can help the village communities in critically assessing the relevance of traditional cultural practices to contemporary social needs. The issues of inheritance, and land title need to be subjected to the children and gender analysis lenses.

This study provides the leadership in the process of social engineering that is missing but yearned for by Malawian families as seen in the following excerpts. "*For people to do any work here [on orphan care] there is need to encourage the community, even if it is just feedback [of studies] or directions*" (KI Dzenje). Another key informant from Dzenje talking on what can be done with available resources in the villages stated that "*there are many needs of orphans, and we would like to help them, but we need someone to guide us*".

The use of Bronfenbrenner's socio-ecological framework in understanding the Malawi orphan is of great significance. For community development planners, or "child and youth care workers to respond effectively to the needs of children, parents, and families, they must be able to understand and be comfortable in assessing and intervening within all four of these ecological levels" (Ferguson et al 1993 p.257). The health centres, the church, the school, the community development workers, the NGOs, and the various government levels can also use this study for initiating new intervention programmes and fine tuning existing ones.

This study primarily focussed on the structure of the family and the village. The understanding of the exosystem structures without the village like the working condition of parents working in the cities, and the comprehension of the macrosystem features like the legal infrastructure, the political ideologies, and the national economic status were therefore limited. Further studies focussing on the exosystem and the macrosystem would help the comprehension of the Malawi orphans' social ecology in totality.

REFERENCE

All Africa News Agency (AANA) (1998). http://www.africanews.org/south/malawi/stories/19980626_feat1.html

Bamford, M., Gailey, R. and Miller, R. (1988) *HIV_AIDS: Social Work Perspective.*

Bernardi, B. (1985). *Age Class system.* New York NY: Cambridge University Press

Berns, R. M. (1993). *Child, Family, Community.* San Diego California: Harcourt Brace Jovanovich College Publishers

Black, D. (1978). The Bereaved Child. *Journal of Child Psychology and Psychiatry* 19, 287-292.

Bowlby, J. (1979). *The Making and Breaking of Affectional Bonds.* London: Tavistock

Brofenbrenner, U. (1979). *The Ecology of Human Development.* Cambridge Mass: Harvard University Press

Chauncey, P., Parfitt, B., Preston, J., George, P., Eso, M., Cunningham, I., and Cowel, J., (1992). *Making Changes*: A place to Start – Report of the Community Panel on family and children's services legislation review in British Columbia, Victoria, BC: Queen's Printer.

Chirwa, W. C. (1998). Aliens and AIDS in South Africa: The Malawi -South Africa Debate. *African Affairs* Vol.97 no.386 Jan. 1998

CIA Report on Malawi (1997) http://www.odci.gov/cia/publications/factbook/mi.html

Colletta, N. J., Balachander, J., and Liang, X. (1995*). The Condition of Young Children in Sub Saharan Africa.* The World Bank Technical Papers No.326. Washington DC: The World Bank

Crain, W. (1992). *Theories of Development: Concepts and Applications.* New Jersy: Prentice-Hall Inc.

Cruikshank, D. (1998) *The UN Convention on the Rights of the Child: Dose Domestic Legislation measure up?* Vancouver BC: The Society for Children and Youth of BC

Dugan, T. F. and Coles R. (1989). *The Child in Our Times*. New York NY: Brunner / Mazel Publishers.

Erikson, E. H. (1997) *The Life Cycle Completed.* New York NY: W. W. Norton & Company Inc..

Europa World Year Book, The (1997). London England: Europa Publication Limited

Ferguson, R., Pence, A., Denholm, C. (1993*). Professional Child and Youth Care.* Vancouver BC: UBC Press.

Foster, P. (1992). *The World Food Problem; Tackling the causes of undernutrition in the third world.* Boulder Colorado: Lynne Rienner Publishers Inc..

Freud, A. (1963). "The Concept of development lines" *The Psychoanalytic Study of the Child.* New York NY: International Universities Press.

Holocome, S. (1995). *Managing to Empower* New Jersey NY: Zed Books Ltd.

Keating, D. and Mustard, J.F. "Social Economic Factors and Huamn Development" in *Family Security in Insecure Times*, 1993 p.94.

Lawrence Neuman, W. (1994). *Social Research Methods: qualitative a*+-8nd quantitative approaches*. Boston: Allyn and Bacon.

Livuza, A. (1997). Malawi's AIDS orphans turn to begging or drugs. *Electronic Mail & Guardian July 17, 1997.* Http://www.mg.co.za/mg/news/97jul1/17Jul-Malawi_aids.html.

Logan, S. L. (1996). *The Black Family*. Boulder Colorado: Westview Press.

Luoise Harvey Consulting (1996). *Risk Vulnerability, Resiliency – Health System Implications:* Ottawa Ontario. (Prepared for Health Canada).

Mangham, C., McGrath, P., Reid, G., and Stewart, M. (1995). *Resiliency: Relevance to Health Promotion*: Discussion Paper. Ottawa: (Alcohol and other Drug Unit, Health Canada).

Maslow A. H. (1970). *Motivation and Personality*. New York NY: Harper & Row.

Medical Post (February 23, 1999). Toronto Ontario: MaClean Hunter Publishing Ltd.

Minister's Advisory Committee on Ethical Issues in Health Care, British Columbia (1996). *HIV Testing for Pregnant Women.* Victoria BC.

Monette, D. R., Sullivan, T. J., & DeJong C. R. (1994*). Applied Social Research.* Forth Worth TX: Harcourt Brace College Publishers.

Myers, R. G. (1992). *The Twelve Who Survive.* New York: Routledge in co-operation with UNESCO.

Myers, R. G. (1988*). Programming for early childhood development and growth.* Paris: UNESCO-UNICEF Co-operative Program.

Peace Corps (1998). *Malawi* http://www.peacecorps.gov/www/io/malawi/malawi.html .

Pennells, M., and Smith, S. C. (1995). *The Forgotten Mourners.* London England: Jessica Kingsley Publishers Ltd.

Per Pinstrup-Andersen, Pelletier, D., Alderman, H. (Eds.) (1995*). Child Growth and Nutrition in Developing Countries.* Ithaca USA: Cornell University Press.

Politt, E. (1990). *Malnutrition and Infection in the Classroom.* Paris; UNESCO.

Price Waterhouse (1990). *Canada Qualitative Research on School Leavers.* Ottawa Hull. (Prepared for Employment and Immigration Canada).

Raising, T. (1995). *Passing on the Rites of Passage.* Amsterdam: African Studies Centre.

Theory & Practice of the UN Convention on the Rights of the Child (1996). (Course material CYC 365) The School of Child and Youth Care, University of Victoria.

UNAIDS (1998). The Vienna Declaration and Programme of Action. http://www.unaids.org/highband/document/humright/ecosoc2.html

UNAIDS and WHO (1996). *The Global Epidemic* http://kali.ucsf.edu/topics/international/2098.2b89.html

UNICEF (1998). *The State of the World's Children.* Oxfordshire UK: Oxford University Press.

United Nations Convention on the Rights of the Child, The (1989). New York: The UN General Assembly.

United Nations & the Government of Malawi, (1993) *Situational Analysis of Poverty in Malawi.* Lilongwe Malawi.

Vansina, J. (1980). *The Dangerous Journey*. The Hague: Mouton Publishers.

Weber, R. P. (1990). *Basic Content Analysis*. Newbury Park California: Sage Publications.

Williamson, J. (1995). *Children and Families Affected by HIV/AIDS* (draft) Prepared for the Health Promotion Unit of UNICEF.

World Bank, *The Technical paper no. 328* (1996). page 37.

World Bank (1996). *Poverty in Sub-Saharan Africa*: Washington D.C.: Africa Technical Department.

APPENDIX I

Starting from Strengths: Working with Communities to Care for AIDS Orphans.

A Malawi/Canada National Capacity Building Program

A Draft Research Proposal

Submitted to

The International Development Research Center (IDRC)

by

School of Child and Youth Care, University of Victoria; Department of Psychology, Chancellor College, Malawi; Center for Social Research, Malawi; UNICEF Malawi; World Vision Malawi; World Vision Canada.

1) Background

The number of orphaned children in sub-Saharan Africa is increasing as the incidence of HIV/AIDS climbs. In Malawi, government and community resources are already strained in supporting these children in especially difficult circumstances. The following project proposal suggests a research strategy to identify local strengths in order to build community capacity to support these children. The project uses a participatory research approach and is built on a unique partnership involving universities, nongovernmental organizations (NGO's), and international agencies supporting children in Malawi and Canada. Results of the research will be used to train local and government human service professionals working with children and families.

The World Health Organization (1993) estimates that HIV has infected 13 million people to date of whom I million are children. Furthermore, 70 percent of these infected adults and 90 percent of the children live in sub-Saharan Africa. The 1993 WHO report listed Uganda and Malawi as the two countries with the highest per capita rate of AIDS in the world.

The picture does not improve as one looks to the immediate future as the number of AIDS cases that emerge during the 1990s is likely to be 10 times greater than those diagnosed during the 1980s (Mann, J., Tarantola, D., & Netter, T., 1992; United Nations International Children's Fund, 1993a). The World Development Report (WDR) of 1993 entitled Investing in Health similarly identifies sub-Saharan Africa as a global priority for health research and development, with HIV/AIDS program development being of special

importance.

As the number of people dying of AIDS increases the number of orphaned children also rises. It is estimated that there will be 10 million unaccompanied (orphaned, abandoned, runaway) children in sub-Saharan Africa due to HIV by the end of the century - 3 times the current estimate from other causes (Mann et al., 1992). Particularly in rural areas, orphans have usually been adopted by members of their immediate family or extended family, but as the number of orphans increases, this tradition is coming under increasing strain. HIV tends to cluster in families and to target the relatively young adults who might otherwise take responsibility for orphans. Grandparents, who once thought their children would care for them in old age, are finding themselves raising a second generation of children that they may be ill equipped, both physically and financially, to handle.

In Africa HIV/AIDS is fundamentally a developmental challenge, intermingling issues of poverty, inequality, culture, and sexuality in complex ways. Containing the spread of the disease and caring for those already suffering from the results of AIDS often entails tackling deeply imbedded traditions that encourage discrimination against young people, especially girls, allow harmful cultural practices, and preclude discussions of sexuality. The U.N. Convention on the Rights of the Child (UNCRC) provides the foundation for altering these harmful traditions and building on traditions nurturing children and youth within a family and community context (UNICEF, 1993a).

One of the great challenges facing the majority of sub-Saharan African countries is the

lack of indigenous human resources, or national capacity, to address a multitude of health and social dilemmas, including the AIDS pandemic (UNICEF, 1989, 1993b). While many NGO's and international donor agencies have made significant progress in implementing basic child survival measures in developing countries there has, unfortunately, been a corresponding lack of provision for human resource development targeting children's basic developmental and psychosocial needs (Myers, 1992, UNICEF, 1994). This is particularly so in countries severely affected by the spread of HIV/AIDS. In these countries, gains in child survival and development made during the last twenty years are being eroded by the impact of AIDS on children and communities' ability to care for children orphaned by AIDS (UNICEF, 1994). In nations where NGO's and International donors are struggling to meet such basic childhood survival needs as food, shelter, and inoculation, partnerships between NGO's and university departments specializing in research and training for child and family care offer a unique opportunity to fill this gap. Specifically, these partnerships could assist to develop sustainable local capacity to meet the more general developmental needs of children within a family/ community context.

This proposal seeks to develop such a partnership between International, National and local Malawi NGO's, and Malawi and Canadian university departments with research and training expertise in child, youth, and family care. The focus of the partnership will be the development of a national research-training program targeting the psychosocial needs of children. The entry point for this program will be a project focusing on community based care for children orphaned by AIDS. The first phase of the project will focus on four research sites in Malawi and a small scale childcare training module. The results of the

project could be implemented on a larger scale in Malawi and other sub-Saharan African countries.

Malawi is currently ranked as one of the poorest sub-Saharan states (Kalipeni, 1993). While the country has seen significant macro economic growth during the 1987 – 1991 period, there has not been a similar alleviation of poverty, and the economic disparity between the various population groups has widened (Government of Malawi 1993). Women in Malawi remain the most vulnerable to poverty with debilitating consequences for themselves, their families, and their children in particular. The dramatic increase in HIV/AIDS infection in Malawi will only worsen this situation. The Malawi National AIDS Control Programme estimates that between 600,000 and 800,000 Malawians are now infected with HIV (UNICEF Malawi, 1994a). Much of the AIDS burden in Malawi will fall on children and it is expected that by the year 2000 there may be more than 870,000 orphaned children due to AIDS, more than 63,000 HIV infected newborns, more than 52,000 new cases of paediatric AIDS, and a cumulative number of more than 323,000 deaths due to AIDS (UNICEF Malawi, 1994b). In a recent analytical survey of orphans' needs and problems, UNICEF Malawi reports that, while orphanhood is not a recent phenomena in Malawi, the impact of AIDS has considerably worsened that situation. There are few, if any, formal foster care or government services for these children and most orphans are still cared for by an increasingly overburdened extended family. Human resource development specializing in childcare is identified as a need particularly at the family and community level. In addition, the report emphasizes the need for increased coordination between government ministries, NGOs working with AIDS orphans, and

communities

The present program aims to build on these recommendations by creating greater community capacity to care for AIDS orphans, first by strengthening the ability of families to care for orphans, and second by improving the links between the various governmental and non-governmental sectors working to support these children. The research employed in this project uses existing household and community level orphan support capacity. The training program envisioned, termed the Generative Curriculum Model (Pence, Kuehne, Greenwood- Church, Opekokew, 1993), is based on an interactive model of community-based values, beliefs, and understanding, and literature-based understanding of child care development. The research findings will be used to develop, implement, and evaluate generative, community-based orphan care training programs in the form of workshops for youth, families, community development personnel, social welfare officers, and home care workers. In addition, the program will offer research opportunities for a small number of Malawi graduate students.

The project is unique in that the research and development partnership model will be child-focused and community based, actively involving families and communities as local resources and active participants in AIDS research and program and training development. The project will draw on the UNCRC as a framework for encouraging community support for AIDS orphans. The Convention promotes a first call for children in difficult circumstances and specifically addresses a number of issues relating to AIDS orphans. For example, the Convention targets a child's basic right to survival, and healthy development

including access to services such as health care and education. Similarly, the Convention suggests that children's participation in community matters affecting their well being be encouraged wherever culturally appropriate.

AIDS orphans are currently denied many of these basic rights, and the UNCRC is a useful tool for mobilizing government agencies, NGO's, universities, communities and families to address this need. Strategies for applying the Convention across these sectors still need to be developed. From the macropolicy level (social policies for children, parents, and families) to the grassroots levels of everyday life, the gaps between research policy and practice need to be bridged. This project will attempt to apply the Convention by devising, implementing, and evaluating strategies that enable communities to better care for AIDS orphans. The research will promote a first call for children and will attempt to involve youth in both the research and program implementation.

The program will be tested in four Malawi communities selected to represent variation in culture, and economic and social support. A research development model will be established linking a diverse group of partners including: Malawi youth, families, and communities; government social welfare officers; national and international NGO's (UNICEF, World Vision) working with children and youth; and universities and social research agencies. University departments and social science research institutes (School of Child and Youth Care, University of Victoria; Department of Psychology, Chancellor College, Malawi; and the Center for Social Research, Malawi) will specifically examine the capacity of four Malawi communities to establish AIDS orphan support programs, and

will evaluate the development and implementation of a training program. Government social welfare officers, Ministry of Women and Children's Affairs, and Regional NGO offices for World Vision and UNICEF will incorporate the training of community support workers into existing training programs. Finally, World Vision Canada and UNICEF Eastern and Southern Area Regional office have agreed to examine the potential application of this program in other Eastern and Southern African countries.

The program draws on existing social science research capacity within Malawi and partners these strengths with Canadian expertise in Child and Youth Care, specifically in child and family support in community based care. Though this program targets AIDS orphan support, the model resulting from this research partnership could be applied to a variety of community-level issues affecting children, youth, and their families in sub-Saharan Africa and other global developing regions.

2) Program Purpose and Objectives

Goals. This program has two goals:

The first is to devise, implement, and evaluate a research/ training program addressing the issue of community based support for AIDS orphans in four Malawi communities. Specifically, the program will build community based, child care capacity targeting the psychosocial needs of AIDS orphans, first by researching the local need and capacity for this support, and then using this information to develop and evaluate community based orphan support training programs in the four communities.

The second purpose is to apply the knowledge from community based AIDS orphan support research to the development of a blueprint for a Malawi national child care research/training program targeting the psychosocial needs of children. This unique partnership approach aims to move beyond children's survival needs by supplementing government and NGO child survival programs that are currently not able to address children's broader developmental needs within a community perspective.

Objectives.

1) to carry out action-oriented, participatory research involving youth, families, communities, NGO personnel, social welfare officers, and educational institutions to investigate the local need and capacity for AIDS orphan support in four Malawi communities.

The research on needs and capacity will include collaborative research activities to:

2) identify four communities: two patrilinear and two matrilineal in which one community from each set has government and NGO provision for children's basic survival needs and the other does not;

3) carry out a needs assessment and situational analysis of AIDS orphans in these four communities;

4) identify Malawi cultural traditions, beliefs, and institutions that nurture children and youth, and allow families and communities to care for AIDS orphans;

5) identify "local community capacity" (e.g. persons and community institutions able to support AIDS orphans) based on information collected in stages 3) and 4);

6) based on the Generative Curriculum Model, devise, implement and evaluate AIDS

orphan support workshop training programs involving youth, their families, communities, social welfare officers, and NGO personnel. These workshops will be grounded on the information collected in objectives 3) though 5), and will be used to produce a Cadre, or core group of personnel, skilled in community based orphan care;

7) evaluate all project stages and develop a blueprint for applying the knowledge from community based AIDS orphan support research to the development of a Malawi national child care research/training program targeting the psychosocial needs of children.

3) Research/Training/Evaluation Process.

The program will consist of seven stages, one planning (P) stage, three research (R) stages, two training (T) stages, and an ongoing evaluation (E) process. As the project seeks to be a community based, "bottom up" approach to research and training development, each stage will involve a program team composed of representatives from each of the project partners and community representatives.

Research process.

The Center for Social Research will coordinate the research stages of the project and will provide expertise in carrying out community based child-focused research in Malawi. UNICEF Malawi and World Vision Malawi will support this process by providing sites for the research and lending any technical support that may be required for the entry to the communities and collection of data. The Department of Psychology, Chancellor College will select four Masters level students to act as research assistants and will provide faculty expertise in health and community psychology. The School of Child and Youth Care

(SCYC), University of Victoria, will provide specific research expertise in implementing the UN Convention on the Rights of the Child, in modifying the Generative Curriculum Model for use in the Malawi project, and in participatory, ecocultural research.

Methodology. The research method employed in this program seeks to meet the program partner needs in a manner that is neither culture "bound" nor "blind". One tested strategy which has been used to develop culturally sensitive community based childcare programs is the Ecocultural Framework (Cook, 1995).

This research paradigm is context based, and examines the role of individual and cultural level variables influencing community care of AIDS orphans. This approach is, therefore, ecological in its focus on context, and culturally sensitive in addressing both individual and cultural level variables. The Ecocultural Framework has been used to devise, implement, and evaluate culturally sensitive community based children's health projects in India, Indonesia, and Canada. Research using this framework has examined such issues as assessing the relationship between individual, community, and cultural level variables in establishing child care programs for special needs children, and identifying the local capacity at these three levels as criteria for establishing training programs.

A participatory, action oriented research method will be used throughout all stages of the data collection, interpretation, and application. That is, it values the perspectives and interests of the participants involved in the project as the basis of designing, implementing, and evaluating all aspects of the research (Ellis, Reid, & Barnsley, 1990).

Thus, wherever possible community members will be involved in setting research objectives, outlining hypotheses, collecting data, interpreting results, applying the research results to the design of training modules, and evaluating all stages of the project.

Research design. Due to the lack of information on the situation of orphans in Malawi an exploratory design will be used to gather information for this project. Information for objectives 3, 4, and 5 will be collected through a variety of sources in order to "triangulate", or validate, the data. Triangulation measurement tries to pinpoint the values of a phenomena more accurately by sighting in on it from different methodological viewpoints. By obtaining multiple instances of the data from different sources, the study finding are more trustworthy (Webb, Campbell, Schwartz, & Sechrest, 1965). Thus, key witness interviews, participant observation, interviews employing open and closed ended questions, and focus group discussions will all be used to examine Malawi community responses to AIDS orphans. Key witnesses will be selected from NGO program officers working in the target sites. Community research participants will include: community leaders, other community members, and where possible children and youth.

Ethical considerations.

The involvement of participants in the research will be entirely voluntary. No coercion will be used in interviewing respondents, and participants will be free to break off their involvement with the research at any time (full ethics approval will be obtained before the research proceeds). All research instruments will first be approved by an ethical committee at the University of Malawi and University of Victoria.

Training process.

The training approach taken in this program will be based in part on SCYC experiences in developing and using the Generative Curriculum Model (GCM). The Model was designed as a culturally sensitive, community based approach to child, family and community development. The Model is inclusionary, embracing the expertise and knowledge of community members as well as the knowledge contained in the established literature. The training process will draw on the experience of each project participant in developing the training workshops. Specifically, UNICEF Malawi and World Vision Malawi will lend local technical support to developing culturally appropriate AIDS - orphan support workshop training materials based on the research collected in stages 2-4. SCYC will provide expertise in developing, implementing, and evaluating community based, child care and family empowerment curricula for the workshops. The Department of Psychology and the Center for Social Research will work with SCYC to modify the GCM approach to the Malawi context. World Vision Canada will provide support through World Vision Malawi for the implementation of the training programs.

Evaluation process.

Program evaluation will be conducted on an ongoing basis. Evaluation will be both goal and process oriented and will involve all partners and community members in order to better represent the various project "systems". The Ecocultural Framework has been applied to the evaluation of the various systems of community based child care programs and will be applied in the present program.

Process stages.

Stage 1 (P): Program planning meeting. A meeting will be held to clarify the research and training agenda and produce a final proposal for IDRC, World Vision, and UNICEF

Outcome: IDRC, SCYC, World Vision, and UNICEF provided support for representatives from the various partner groups to meet in Victoria, Canada July 6-10, 1994. At these meetings a blueprint of the program goals, objectives, timeline, evaluation, and budget was drafted.

Stage 2 (R): Community selection. Four Malawi communities will be selected by the project partners. The communities will be sites in which UNICEF Malawi and World Vision Malawi already have projects underway or are planning to establish projects. Two of these communities will be patrilinear and two matrilineal. In addition, one each of the patrilinear and matrilineal communities will have basic children's survival needs provided by either NGO's or the Malawi Government, and two will be without these services. By comparing these communities it is anticipated that the research will identify the capacity of each community to care for AIDS orphans under various conditions of culture, and economic and social support.

Outcome: Four communities will be selected for the research and training on community care of AIDS orphans.

Stage 3 (R): AIDS orphans needs assessment and site visits. A planning meeting will be held in Malawi in February 1995 to visit the four communities, train the research

assistants in participatory research methods, conduct a GCM orientation and training session, and prepare the research instruments. A needs assessment and situational analysis of AIDS orphans will then be carried out in the four communities. The research at this stage will include an assessment of the various physical and psychosocial needs of orphans as well as an assessment of the broader community's perception of the need for AIDS orphan support (in comparison to other community needs)

Outcome: A preliminary needs assessment and situational analysis of AIDS orphans will be carried out in four Malawi communities.

Stage 4 (R): Research examining the context of AIDS orphan support. Research will be carried out in the four communities to investigate the individual, community, and cultural level factors influencing the care of AIDS orphans.

Specifically, the research will examine Malawi cultural traditions, beliefs, and institutions that nurture children and youth, and allow families and communities to care for AIDS orphans, and identify local community "capacity" (e.g. persons and community organizations) able to support AIDS orphans.

Outcomes: 1) Research providing psychological, community, and cultural level information on why communities may or may not be able to care for AIDS orphans. 2) Research identifying community strengths or local capacity for AIDS orphan care.

Stage 5 (T): Cadre training materials. Two series of Cadre workshops will be

developed from the research results. The first series will target social welfare officers, home craft workers, NGO community development workers, and community leaders. The other workshops will target youth and families in the four research communities. At this stage a Tier 2 educational linkage proposal strengthening the partnership orphan care training capacity will be prepared and submitted to CIDA.

Outcome: Two Cadre training draft manuals will be produced. An AIDS orphan community care curriculum package will be drafted and reviewed by all project partners and members of the program advisory committee (See Appendix 1). A Tier 2 proposal will be prepared and submitted to CIDA.

Stage 6 (T): Cadre training workshops. One series to be held for social welfare officers, home craft workers, NGO Community Development Workers and community leaders, and one series delivered to youth, families, and community members.

Outcome: A Cadre of youth, families, community leaders, social welfare officers, home craft workers, and community development workers will be mobilized to train youth, families to care for AIDS orphans. Two AIDS orphan child care manuals will be produced, one for community members and one for NGO and government personnel.

Stage 7 (E): Final evaluation. A summative evaluation will be carried out to assess the degree to which the initial program objectives and goals have been met. Based on this evaluation a blueprint for a Malawi national child care research training program targeting the psychosocial needs of children will be developed.

Outcome: A final project evaluation and Malawi child care proposal.

4) Benefit to Malawi and Project Outcomes

The government of Malawi has identified the situation of orphans as deserving immediate attention and has begun discussions with UNICEF Malawi and other NGO's on addressing this issue (UNICEF Malawi, 1994). The ministry of Women and Children's Affairs supports the present project and has expressed an interest in integrating the training materials into their staff training program (See Attached Letter).

The project will directly benefit Malawi AIDS orphans by improving community services for these children. The project will also benefit the communities participating in the program by feeding the research results back to each community through the research involvement and training of youth, parents, community members. In addition, the project will develop the capacity of Malawi social welfare officers, Chancellor College graduate students, and World Vision and UNICEF Malawi personnel involved in training workshops to meet the challenge of caring for AIDS orphans. Finally, the project will strengthen networks which support AIDS orphans, thus possibly relieving the overburdened health services by encouraging a community care approach to AIDS orphans. Specific project outcomes will include:

4.1) An AIDS orphan research network linking universities, NGO's, communities and families.

4.2) A research report describing the needs of AIDS orphans and local capacity to support these children in four Malawi communities.

4.3) An AIDS orphan community care workshop curricula; one version for social welfare officers and one for families and community members.

4.4) A blueprint for a Malawi national child care research/training program targeting the psychosocial needs of children.

5) Research site description

The selection of the four research sites will be finalized at the December 1995 project meeting. The framework for choosing these sites is described in Stage 2.

6) Project Promotion and Dissemination and Utilization of Results

The Starting from Strengths program will be promoted and results disseminated and utilized in a number of ways including:

1) the production of a detailed report on the design, implementation, and evaluation of the AIDS community care partnership model using the UN Convention on the Rights of the Child;

2) the production of an AIDS orphan care training of trainer's manual for social welfare officers, NGO community development personnel. and graduate students;

3) the production of a simplified manual on AIDS orphan care for youth, families, and community members;

4) published reports in newspapers and professional journals;

5) presentation of the program at national, and international conferences.

The research results will be utilized to develop training materials for community development workers and staff within the Ministry of Women and Children's Affairs. The blueprint resulting from the final summative evaluation will be considered as a framework for a Malawi national child care program targeting the psychosocial needs of children will be developed. This framework will be shared with other World Vision and UNICEF

country offices supporting orphans.

7) **Administration**

At the July 1994 planning meeting the program partners decided to centralize the project coordination at the School of Child and Youth Care, University of Victoria. This decision was made based on SCYC's capacity to manage communications and keep participants and committee members updated. SCYC will also take the lead in submitting a CIDA Tier 2 institutional linkage proposal in the Spring of 1995. That proposal will further strengthen the program partnership through the development of a university linkage focusing on community based child care. The Center for Social Research will take the lead in organizing research activities, with specific support being supplied by the Department of Psychology, Chancellor College, and the School of Child and Youth Care, University of Victoria. The Department of Psychology will select and supervise the four graduate students involved in data collection, and will partner with SCYC in preparing the CIDA proposal.

UNICEF Malawi and World Vision Malawi will facilitate the selection and entry points for the four communities, and will organize and deliver the training workshops. In addition, UNICEF Malawi and World Vision Malawi will lend technical support to the research, training, and evaluation, and will help facilitate Malawi program meetings. World Vision Canada will support World Vision Malawi in integrating the AIDS orphan training program into existing community training programs, and will evaluate the feasibility of integrating this partnership model in other child care programs in developing countries.

8) Project Time Frame

Stage 1:Program planning meeting (July, 1994)

Stage 2:Community selection (October - December, 1995)

Stage 3:AIDS orphan needs assessment planning meeting (December, 1995) AIDS orphan needs assessment (March - June, 1996)

Stage 4:Research examining the context of AIDS orphan support (March - June, 1996)

Stage 5:Curriculum development workshop (July, 1996) Community and Social Welfare/ NGO personnel training materials development (June, 1996 - August, 1996)

Stage 6:Community and Social Welfare/NGO personnel training workshops, each workshop approx. I week (October, 1996 November, 1996)

Stage 7: Final program evaluation (November - December, 1996)

Preparation of Child Care blueprint and final report (December, 1996 - January, 1997)

8) Proposed Program Budget (Canadian Dollars)

See attached budget

References

Cook, P. (1995). The application of an Ecocultural model to children's Community Based Rehabilitation programs in India. In J. Georgas (Ed.), The Application of Cross-Cultural Psychology. Amsterdam: Swets & Zeitlinger Press.

Ellis, D., Reid, G., & Barnsley, J., (1990). Keeping on track: An evaluation guide for community groups. Vancouver: Women's Research Center.

Kalipeni, E. (1993). Determinants of infant mortality in Malawi. Social Science and Medicine,31, 183-198.

Mann, J., Tarantola, D., & Netter, T. (1992). AIDS in the world. Cambridge, MA: Harvard University Press.

Myers, R. (1992). The twelve who survive* Strengthening programmes of early childhood --development in the Third World. London: Routledge.

Pence, A., Kuehne, V., Greenwood-Church, M., & Opekokew, M.R. (1993). Generative curriculum: A model of university and First Nations cooperative, post-secondary education. International Journal o Educational Development,11, 339-349.

United Nations International Children's Fund (1989). Towards national capacity building in Africa. Florence, Italy: UNICEF International Child Development Center.

UNICEF (1993a) . AIDS: The second decade. New York: UNICEF.

UNICEF (1993b). Capacity building: A prospectus. Nairobi, Kenya: UNICEF Eastern and Southern Africa Region. Unpublished Manuscript.

UNICEF (1994). The progress of nations. New York: UNICEF.

UNICEF Malawi (1994a). HIV/AIDS situation and impact in Malawi. Lilongwe, Malawi: UNICEF.

UNICEF Malawi (1994b). Orphan needs and problems: An issues summary from the analytical surveys report. Lilongwe, Malawi: UNICEF.

Webb, E.J., Capbell, D.T., Schwartz, R.D., & Sechrest, L. (1965). Unobtrusive measures Chicago: Rand McNally.

World Bank (1993). World development re2ort 1993: Investing in- health. Oxford: Oxford University Press.

World Health Organization (1993). AI12S in the 1990's. WHO Reports, 52, pp. 5493.

APPENDIX II

GUIDELINES FOR FOCUS GROUP DISCUSSIONS

INTRODUCTION:

Care and support structures

1) Presence and activities of medical structures, NGO's, social services administration, institutions, etc.

Presence and activities of traditional medicine

If possible, do not mention the structures, but prod the interviewee, particularly when AIDS-specific (vulnerable support systems) structures or activities are brought up.
Bear in mind non-implicit structures

Perception of these structures in the community (acceptance, appreciation)
Collaboration between these structures and the community, if any
Interviewee's opinion of their action, their efficiency and their beliefs for the community.

2) The Community and Illness and Death

The most common illness
Who takes care of those and how are they treated
The care of chronically ill people
Isolation, shame
Home care, care takers (Knowledge of any who live at home)
Treatments, consultation for care (whom and where)
Visitors (frequency, relationships or kinship with the sick)
Help and from whom

Is there a change in the care for the chronically ill people
(now and say ... years ago?)
How does the community respond to these problems

Care of children when those who look after then are sick
Main problems confronting chronically ill people and their families

If there is death
Organisation of the funeral
Care of the children
Inheritance

Opinion about the existing structures
Opinion on the way to improve community capacity
Traditional belief about HIV/AIDS i.e. perception of community

3) Psychosocial Needs

What do children need (general)
Support while parents are ill (standby guardian)
Who do children talk to when:
Their parents are ill
After the death of the parent(s)
Stigma of orphaned children if parents die of LONG illness (Discrimination?)
How is children's grief perceived

What is being done to address the needs (psychosocial /other) of children (If yes - why / if no-why not?)

How are children accepted by fostered children
How are fostered children brought up in relation to the guardians own children?
Psychosocial impact of increased poverty in relation to the increasing number of orphaned children

Level of acceptance of children whose parents have died and possible obstacles

What do children feel when their mother or father dies

Who are the vulnerable children and what problems do they face

What do the community feel when parent(s) die leaving children behind

Is any behaviour change noticed (of those whose parents have died)

What are the noticeable change in the caring of orphaned children during the past ...years.

GUIDELINES FOR INTERVIEWING KEY INFORMANTS

INTRODUCTION:

1) Composition, organisation of the community

Lifestyles of the population, family organisation, the place and activities of children, inheritance, patrilineal or matrilineal societies, etc

Activities and occupation of the population Religion(s) of the population

Existence of prayer groups, solidarity groups organised around religious practice. (their roles and action)

Existence of other types of groups (nature, role, action)

Existence of mutual help and assistance networks, of what kind.

Existence of other community initiatives, individual or collective

The problems addressed by these other initiatives

Has the community changed in the past five years (poorer, richer)

As soon as the interviewee mentions support activities, particularly those aimed at sick people in general and/or their families have him/her go into more detail.

2) Care and Support Structures

Presence and activities of medical structures, NGO's, social services, administration, institutions, etc.

Presence and activities of traditional medicine

If possible, do not mention the structures, but prod the interviewee, particularly when AIDS specific (vulnerable support systems) structures or activities are brought up.

Bear in mind non-implicit structures

Perception of these structures in the community (acceptance, appreciation Collaboration between these structures and the community, if any

Interviewee opinion of their action, their efficiency and the beliefs for the community.

3) The Community and Illness and Death

The most common illness

Who takes care of those and how are they treated

The care of chronically ill people

Isolation, shame

Home care, caretakers (Knowledge of any who live at home)

Treatments, consultations for care (whom and where)

Visitors (frequency, relationship or kinship with the sick)

Help from who

Is there a change in the care for the chronically ill people (now and say ...years ago?)

How does the community respond to these problems

Care of children when those who look after them are sick

Main problems confronting chronically ill people and their families

If there is death

Organisation of the funeral

Care of the children

Inheritance

Opinions about the existing structures

Opinions on the way to improve community capacity

Traditional belief about HIV /AIDS i.e. perception of community

4) Psychosocial Needs

What do children need (general)

Support while parents are ill (standby guardians)

Who do children talk to when:

Their parents are ill

After the death of parents

Stigma of orphaned children if parents die of a LONG illness (Discrimination?)

How is children's grief perceived

What is being done to address the needs (psychosocial / other) of children (If yes-why, If no -why not?)

How are children accepted by fostered children

How are fostered children brought up in relation to the guardians own children

Psychosocial impact of increased poverty in relation to the increasing number of orphaned children

Level of acceptance of children whose parents have died and possible obstacles

What do children feel when their mother or father dies

What are the most vulnerable children and what problems do they face

Resilient children?

What do the community feel when a parent(s) dies leaving children behind

Is any behaviour change noticed (of those whose parents have died)

What are the noticeable change in the caring of orphaned children during the past ...years