

Care & Protection for Orphaned Children in Sub-Saharan Africa:
A Case Study of The Kingdom of Swaziland

By

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Abstract

Care & Protection for Orphaned Children in Sub-Saharan Africa: A Case Study of The Kingdom of Swaziland

Allyson M. Chisholm

At the end of 2003, it was estimated that there were 143 million orphans in 93 countries around the world (UNICEF, 2004c), with the percentage of orphaned children significantly higher in Sub-Saharan Africa (UNICEF, 2003). Countries with high orphan rates are facing a critical challenge in finding sustainable solutions for the care and protection of the thousands of children left orphaned and vulnerable within their borders. If orphaned children are not cared for and protected adequately, the long-term consequences on a country's political, economic and social structures and overall stability will be devastating (UNAIDS, 2006).

This report analyzes the main approaches used in Sub-Saharan Africa for the protection and care of orphaned children, while presenting some of the key challenges confronted by these different approaches. A policy discussion on the two dominant approaches, these being community-based and residential care, used today by policy makers at the national and international level seeking sustainable solutions for the care and protection of orphaned children is presented. Through an eleven-month work placement with an NGO based in Manzini, Swaziland that utilized both residential and community based strategies, I was able to analyze both systems of care and determine to what extent they were meeting the needs of orphaned children.

A case study on Swaziland is presented, with an analysis of Swaziland's National Plan of Action for Orphaned and Vulnerable Children, which reveals the many existing obstacles and challenges that may prevent or impede the realization of the goals outlined in the plan.

The importance that community-based care has in responding to the orphan crisis is acknowledged, while emphasizing that residential care may be needed in some cases where other care arrangements are not available. Therefore, this report argues that both residential and community-based care strategies must be incorporated into national and international plans for the care and protection of orphans in order to ensure that all children are adequately provided for in Sub-Saharan Africa in the future.

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Chapter 1

Introduction

At the end of 2003, it was estimated that there were 143 million orphans in 93 countries around the world (UNICEF, 2004c), with the percentage of orphaned children significantly higher in sub-Saharan Africa (UNICEF, 2003). Countries with high rates of orphans are facing a critical challenge in finding sustainable solutions for the care and protection of the thousands of children left orphaned and vulnerable within their borders. If orphaned children are not cared for and protected adequately, the long-term consequences on a country's political, economic and social structures and overall stability will be devastating (UNAIDS, 2006).

The objective of this report is to analyze the current policies and strategies put forward for the care and protection of orphans in Swaziland, and to make recommendations for the best policy options for the care of orphaned children in this region. The underlying assumption of this report is that orphaned children are better cared for and protected in community-based settings, where family and community members have assumed the primary care-giving roles.

Methodology

This report presents a policy analysis of the common strategies used today for the protection and care of orphaned children in Sub-Saharan Africa, these being residential and community-based approaches. The policy analysis was conducted through a case study on Swaziland, that analyzed the country's National Plan of Action for orphaned and vulnerable children. A case study was chosen to analyze the policy because it allowed for

greater insight into how the different strategies for the protection and care of orphaned children play-out in practical real-life settings. The information gathered from the case study was gained from using qualitative methods of research. The qualitative methods used included participation, direct observations and experiences gained while working over an eleven month period with an NGO based in Manzini, Swaziland, that cared for orphaned and vulnerable children. The organization I worked with in Swaziland was chosen because it used both residential and community-based care strategies, both of which were evaluated while on placement.

While working in Swaziland I had the opportunity to visit many different organizations' programs and projects, some focused on community-based care and others focused on residential care for orphaned children. The information I collected from these visits, and throughout my work-term included children's daily routines, how children and staff interact and the nature of these relationships, data on the ratio of staff to children, the availability of resources, the problems encountered and the conditions in which children live within different care arrangements in Swaziland. Qualitative research was conducted for this report because it was important to gain a holistic understanding of the natural setting in which different policies for the care and protect orphans were being implemented. In order to fully analyze these issues, I had to have direct contact with the beneficiaries and policy implementers, which allowed for close observation of people's behaviour, daily routines, moments of conflict, as well as cultural norms, practices and beliefs.

Swaziland was chosen for this case study for three main reasons. First, Swaziland is experiencing an increasing orphan crisis that is quickly leaving thousands of children

throughout the country without proper care and protection. Secondly, Swaziland has many different actors, including government and UN agencies, NGO's, and community based organizations, working within the country that utilize residential and/or community-based approaches for the care of orphans, which could be examined. Finally, the government of Swaziland has recently adopted a national plan of action to address the orphan crisis within the country, which could be analyzed to highlight some of the practical problems that may be faced with the policies and strategies adopted for the care and protection of orphaned children.

The organization I worked with in Swaziland assists over 3,000 young people each day through its many different social, educational and entrepreneurial projects. With six residential care facilities located within the Manzini region of the country, the organization provides full-time residential care for over 160 orphaned and vulnerable children. The organization runs two neighborhood care points (NCP's), that provide daily food to 500 children living in the peri-urban areas of Manzini, and provides yearly school bursary funds to approximately 1,000 children who would otherwise never be able to attend school. The organization has built a primary school, which allows over 300 children from impoverished backgrounds to attend formal education for free. Among many other program and projects, the organization continues to run three different skill centers that provide one and two-year skills-based courses reaching over 1,000 out-of-school youth every year.

More specifically, my role during the first three months of my NGO placement in Swaziland was to design and conduct an evaluation of the organization's social programs. The purpose of the evaluation was to outline the organization's strengths and weaknesses,

as well as address needed changes and different opportunities that could be capitalized upon in the future. The evaluation focused mainly on analyzing the quality of care, protection and opportunities that are provided to the children who live on a full-time basis within the organization's six residential homes. The outcome of the evaluation was a report presented to the organization outlining the main problems within the social programs department of the NGO, with possible solutions to these problems included.

Following my presentation of the evaluation report to the director and staff of the organization, I fulfilled the role of youth worker within the social programs department for the next seven months. My responsibilities under the title of youth worker included: supervising 160 children living within the organization's six residential homes, conducting home visits and in-take interviews with children newly arriving to our centre, conducting night visits checking up on children who still live on the streets, and providing assistance to these children (options for health care, education, shelter and food), representing the organization in a variety of meetings involving government ministries, other NGO's and the private sector throughout the country, dealing with the day-to-day social issues as they arose both within our children's residential homes and the main office, assisting with the organization's school fee bursary program and monitoring and assisting with the daily activities at the two NCPs and the primary school run by the organization.

Chapter Outline

Chapter Two outlines the struggles that orphaned children, in particular, face, and how these struggles impact different aspects of their lives. The main objective of this

chapter is to show that orphaned children fare worse in terms of economic, social, material, educational, health and overall care, than non-orphaned children.

Chapter Three highlights the orphan crisis in Sub-Saharan Africa, demonstrating that orphaning is a long-term chronic problem (Smart, 2003), requiring the development of international and national strategies to adequately respond to the emerging crisis. The second part of this chapter carries out a policy debate which focuses on the two dominant strategies upon which policy for care of orphaned children in Sub-Saharan Africa is designed, at the international and national level; these being residential and community-based care. An analysis of both systems of care based on observations and experience gained from my work placement in Swaziland is presented in this chapter.

Chapter Four analyzes Swaziland's National Plan of Action for Orphaned and Vulnerable Children 2006-2010 and reveals many obstacles and challenges that may prevent or impede the realization of the goals outlined in the plan. The analysis and challenges presented in this chapter are based on observations and experience gathered from my work in Swaziland that entailed weekly visits to Neighborhood Care Points (NCPs), Rural Health Motivators (RHMs) and *Lihlombe Lekhukalela* (Child Protectors) (explained in the second section of this chapter), rural health clinics, community chiefs, police stations and homes and schools, as well as my work reintegrating residential children back into their home communities.

The report concludes with a summary of the main challenges that Swaziland must address before the goals listed within the country's National Plan of Action for orphaned and vulnerable children can be realized.

The overall conclusion this report makes is that international and national plans for the protection and care of orphaned children that do not incorporate residential care strategies, leave these facilities un-regulated and un-monitored, leaving the children within these facilities at risk to abuse, exploitation and neglect, ultimately hampering the development of nations for future generations.

Chapter 2

Introduction to Strategies for

Care & Protection of Orphaned Children in Sub-Saharan Africa

This chapter outlines the struggles that orphaned children, in particular, face and how these struggles impact different aspects of their lives. The main objective of this chapter is to show that orphaned children fare worse in terms of economic, social, material, educational, health and overall care, than non-orphaned children.

Children & Development

Children, identified as people aged 0 to 18 years, who are properly cared for and educated are the basis of prosperous economies and stable states, and are key to sustainable development for future generations (Smart, 2003). The 2001 UN report, *We The Children*, says that the disparities in wealth and pervasive poverty evident around the world today are directly related to under-investment in young people, especially relating to their health, education and protection. The UN reports that many countries around the world have fallen short of achieving their national development goals, largely because investments for children were not made (UNICEF, 2001). In order to realize national and human development in the future, government leaders must ensure that national priorities make the investment in the well-being of children a top priority (UNICEF, 2001). Children should be the focus of all national and international poverty-reduction and development agendas if a reduction in poverty and an overall growth in national development is to be realized in the future (Dale, 2007).

The first five years of a child's life are the most important, as this is the period when children experience the greatest physical, emotional, social and cognitive growth. In order to develop in a healthy manner children require a consistent and loving caregiver, proper nutrition, health care, social and emotional security and education on various life skills. Research has shown that if children do not receive these necessities in their first five years of life, they are more vulnerable to health risks, abuse, exploitation, discrimination and death as compared to children whose needs are satisfied (UNICEF, 2004c).

Factors Affecting Child Vulnerability

Each day, thousands of children around the world are exposed to dangers that affect their growth and development. Children suffer as casualties of war and violence, victims of racial discrimination and crime, refugees and internally displaced people, and as victims of neglect, abuse and exploitation. In some of the worst cases, children are forced to be soldiers, prostitutes, laborers and servants (UNICEF, 2005). Each day, millions of children suffer from the effects of poverty, disease, economic collapse, social and political unrest and from the lack of sustainable growth in their regions. Many serious child protection issues can develop out of emergencies (famines, floods and war), resulting in large numbers of children becoming orphaned or separated from their families and communities (UNICEF, 2005). UNICEF reports that the majority of vulnerable children throughout the world can be found in developing countries, in particular many of them are found in Sub-Saharan Africa (UNICEF, 2005).

Orphaned Children

For the purpose of this paper orphans are defined as children who have effectively lost both of their parents, that is, both parents may not be deceased, but neither parent is present in the child's life providing any type of care for them. By the end of 2003, it was estimated that there were 143 million orphans in 93 countries around the world (UNICEF, 2004c). The percentage of orphaned children is significantly higher in Sub-Saharan Africa than in other regions of the world. In 2003, in Sub-Saharan Africa, 12 percent of all children were orphaned, compared with 6.5 percent in Asia and 5 percent in Latin America and the Caribbean (UNICEF, 2003).

Orphan-hood can be caused by a number of factors including conflict, war, natural disasters, emergencies and widespread epidemic diseases (such as HIV/AIDS). Historically, large-scale orphaning was sporadic, and more of a short-term problem that was usually associated with different emergencies such as war, famine and natural disasters. But today orphaning is on the rise, and is now being viewed as more of a long-term, chronic problem due to HIV/AIDS (Smart, 2003). In countries where HIV/AIDS has hit hardest, the percentage of children who have been orphaned has risen dramatically (UNICEF, 2004c).

Orphaned children are among the most vulnerable children in the world; they have lost their first line of protection, their parents. Orphaned siblings are often placed in different homes to help distribute the burden of care (Nampanya-Serpell, 2001), but the separation of a child from both their parents and siblings can be detrimental to the child's overall well-being and development. Studies from eastern and southern Africa show that orphaned children are more likely to be abused, sexually exploited, in conflict with the

law, malnourished and married at a younger age than others (UNICEF, 2001) & (Levine, 2001). Many orphans have been forced into child-headed households, assuming adult roles and responsibilities at an early age (Ainsworth et al., 2006), and losing their inheritance and other legal entitlements after the death of their parents (Kahan, 1979). In some of the worst-case scenarios, orphaned children may be enrolled as child soldiers or driven to hard labour, sex work or life on the streets (UNAIDS, 2004).

Studies from around Africa show that there is a significantly higher proportion of orphans involved in the work force than non-orphans. Studies from Ethiopia show that more than three quarters of the child domestic labourers in Addis Ababa are orphans (UNICEF, 2003). Research from Zambia has found that the majority (approximately 70%) of children involved in prostitution throughout the country are orphans, as are the majority of street children (UNICEF, 2003).

Several studies have shown that the loss of a child's parents has a detrimental impact on the child's school enrollment and educational attainment (Bicego et al., 2003) & (Hyde et al., 2002). A study in Uganda found that while 14 percent of primary-school children had at some point missed a term of school, the proportion of orphans missing a term was significantly higher at 27 percent (Hyde et al., 2002). The difference was even greater in secondary school, with 16 per cent of non-orphans and 43 percent of orphaned children missing a term (Hyde et al., 2002). Looking at school attendance and achievement in a neighborhood in Dar es Salaam, Tanzania, orphans were found to be significantly less likely to be enrolled in school than non-orphans of the same age. The same study found that orphans were less likely than non-orphans to be at their proper educational level (Makame et al., 2002) & (Case et al., 2004). Overall, the percentage of

orphans enrolled in educational facilities is much lower in all Sub-Saharan African countries compared to the enrollment of non-orphans in those same countries (UNICEF, 2003).

Psychological problems, including anxiety, depression, guilt, lack of trust, insecurity and fear are prevalent among orphaned children (UNICEF, 2006c). The lack of a parental bond, especially for infants and very young children, can severely affect a child's physical, emotional and psychological development. A study in Brazzaville, Congo, of 354 orphaned children, found that 71 were suffering from some kind of psychological problem (Makaya et al., 2002). Of these, 39 percent were affected by 'posttraumatic stress', 27 percent were suffering from problems of 'adaptation', and the final 34 percent had problems with depression, anxiety, irritability, or feelings of rivalry (Makaya et al., 2002). A study in the suburbs of Dar es Salaam, Tanzania, reported similar findings when comparing psychological problems among orphaned and non-orphaned children between the ages of 10 and 14 years. The results showed that orphaned children experience significantly higher levels of anxiety, pessimistic views on life, and higher feelings of failure than non-orphans in the same community (Makame et al., 2002). The findings from a study that was conducted in the Rakai District of Uganda, indicated that orphaned children were less optimistic about their future; they not only expected to have shorter lives but were less likely to want to be married or to have children than non-orphans (UNICEF, 2003) & (Sengendo & Nambi, 1997). A study conducted in 2005 on the symptoms of depression among orphaned children in the Bushenyi District of Uganda, found that orphans experience significantly higher levels of depression than non-orphans (Atwine et al., 2005).

National studies examining the impact that the death of a parent has on a child's health and well-being, revealed that orphaned children face a higher risk of malnutrition, stunting, illness and death than non-orphans. Surveys conducted in Zimbabwe and Uganda show that orphans are less likely to receive medical care when ill, they have higher mortality rates and are more likely to be malnourished than non-orphans (Nakiyingi et al., 2003) & (UNICEF, 2006c). Research from Tanzania and Kenya found that orphaned children measure significantly lower in height and weight compared to non-orphans of the same age (Ainsworth, 2000) & (Lindblade et al., 2003).

When comparing children who live within the same household, studies have shown that orphaned children who have been taken in by relatives tend to be discriminated against, in terms of receiving lower levels of health care, food and education more often than other children in the same household (Bledsoe et al., 1988) & (UNICEF, 2006c) & (Case et al., 2003).

Orphaned children are more likely than other children to be found living in poor rural households, headed by female relatives who have no formal education, and are not actively involved in the work force (Birdthistle, 2004, p27-28) & (Bicego et al., 2003), (Case et al., 2003) & (Nyamukapa et al., 2003). A large proportion of homes caring for orphans have not been able to meet their household's educational, health care, food and clothing needs (Whitehouse, 2002) & (Axios International, 2001). Although children are better off in most cases when living under the care of their parents, orphans that end up living with extended family members tend to fare better than children who end up living in households that are headed by non-relatives (Case et al., 2004) & (UNICEF, 2003). In addition, it has been found that orphans who are taken in by their grandparents tend to

fare even better than those living with their other extended family members (Nyambedha et al., 2003).

While children can lose their parents at any age, the proportion of children who are orphaned usually increases with age (UNICEF, 2004c). On average about 12 percent of orphans are 0-5 years old, 33 percent are 6-11 years old, and 55 percent are aged 12-17 years (UNICEF, 2004c). It is important to understand the age patterns of orphaned children, as responses to the crisis must be tailored differently in order to adequately meet the needs of children within each age group (UNICEF, 2004c).

Chapter 3

Strategies for the Protection & Care of Orphans

in Sub-Saharan Africa

The objective of this chapter is to highlight the orphan crisis in Sub-Saharan Africa and to carry out a policy debate on the common strategies for care of orphaned children used throughout the continent today. The policy debate focuses on the two dominant strategies around which policy for care of orphaned children in Africa is designed; these being residential and community-based care. Personal observations and experience working in Swaziland are drawn upon to provide insight into some of the practical problems experienced within each of these strategies for orphan care. From the policy debate, an international framework for the protection and care of orphans and vulnerable children was developed with the aim of guiding governments in Sub-Saharan Africa in the design of their national policies, strategies and action plans targeting the orphan crisis within their borders (UNICEF & UNAIDS, 2004). The final section of this chapter presents this framework and addresses some of the main criticisms surrounding its design.

Africa's Orphan Crisis

At the end of 2005 the total number of children orphaned in Sub-Saharan Africa was 48.5 million (UNICEF, 2006, p3). Africa is home to 24 of the 25 countries with the world's highest levels of HIV prevalence, which has contributed to the rapid rise in the number of orphaned children (UNICEF, 2004c). The majority of orphaned children in

Africa are located in the central and southern regions of the continent, where HIV prevalence is the highest (UNICEF, 2004c, p8). In just two years, from 2001-2003, the number of orphans due to AIDS increased from 11.5 million to over 15 million globally, with 90 percent of these located in Sub-Saharan Africa (UNICEF, 2004c). The orphan projections for the year 2010, show that orphans will account for between 15 to 25 percent of all children in 12 different countries in Sub-Saharan African (UNICEF, 2004c).

Common Strategies of Orphan Care in Africa

The majority of orphaned children are still cared for by relatives in most African countries, as tradition dictates (UNICEF, 2005a). A recent study conducted by UNICEF on caring practices in 40 countries in Sub-Saharan Africa shows that extended families have assumed responsibility for more than 90 percent of the orphaned children in the region (UNICEF, 2004c, p10). Today, 20 percent of households in Southern Africa are caring for one or more orphaned children (UNICEF, 2004c). In many of these households, children's grandparents have assumed responsibility for providing care and protection for the children (UNICEF, 2003).

African children are increasingly being required to take on the responsibility as head of their households, and providing care for their siblings after parents pass on (Inter-Agency, 2004). These homes are usually referred to as 'child-headed households,' and children as young as eight years old have been known to act as heads of such homes. Child-headed households face many difficulties, but the most pressing relate to poverty and the child's and other dependents' survival needs (Inter-Agency, 2004). Child-headed households have been established in many regions of Africa which have been heavily

affected by HIV/AIDS. In Rwanda, the number of child-headed households has been estimated to be as high as 227,500 throughout the country (ACORD, 2001, p3). The existence of child-headed households provides evidence that the extended family systems are collapsing and failing to cope with the increasing numbers of orphans (Subbarao & Coury, 2003) & (Bequele, 2007, p4).

Orphan adoption and formal foster care are not practiced widely in Africa (Phiri & Webb, 2007). One reason for this is the high value attached to blood ties in many countries throughout the continent, which has resulted in a general lack or under-development of adoption and formal fostering services. The reality is that adoption and formal foster care have been and are presently taking place on such a small scale that they are not a viable solution at the moment to the emerging orphan crisis in Africa.

Although community-based care is the more dominant approach used in caring and protecting orphaned children in Africa, in recent years there has been a significant rise in the number of residential facilities being implemented. In 2004, a UNICEF study across six countries found that 35 percent of the residential care facilities it identified had been established since 1999 (UNICEF, 2004b, p12). There are two main approaches around which policy for care of orphans in Africa is being designed. Residential based and community-based care are being pursued by different organizations and actors to try to care for the increasing needs of orphaned children. The policy debate that follows focuses on these two strategies of care for orphaned children. Through my eleven month work placement with an NGO based in Manzini, Swaziland that utilized both residential and community based strategies for the care of orphaned children, an analysis of both systems of care was conducted. In particular some of the negative consequences observed

and experienced while working within six residential care facilities, as well as my experience and observations from working within two slum communities will be drawn on in the following section.

Residential/Institutional Care for Orphans

Residential, or institutional care (interchangeable term) for children varies widely in terms of the level of resources and services provided, in the way the facilities are organized internally and in the extent to which they facilitate or impede social integration within the wider community. Some of the more common institutional facilities for children include: orphanages, group homes and transit centers (Inter-Agency, 2004).

Residential facilities are generally set up to house abandoned, orphaned and/or street children. Many institutions consist of some form of counseling, rehabilitation and self-development programs for the children within their care (Inter-Agency, 2004).

Residential care may be run directly by the state, but in most African nations these facilities are managed and run by non-governmental (NGOs) and faith based organizations (FBOs) (UNICEF, 2006d). Residential facilities are usually located in urban areas, and include both temporary and long-term care for groups of children. Residential care is meant to provide 24-hour care for children, where their basic needs of food, shelter, clothing and education are met on a regular basis (UNICEF, 2006d).

Orphanages and other residential facilities may seem like a logical response to the growing orphan population. Institutions can be appealing because they usually provide for children's basic needs including: food, shelter, clothing and education, but they generally fall short in meeting the psychosocial, emotional, developmental and long-term

needs of children (Tolfree, 2003, p9) & (UNICEF, 2004c, p37) Children need more than good physical care, they need the affection, attention, security and social connections that most families and communities provide.

In many cases, impoverished families use residential care facilities as a survival strategy; families often anticipate that their children will receive the greater levels of material support that most institutions promise, including better healthcare, food, educational services and housing conditions, and hence leave their children to be cared for within institutions (Phiri & Webb, 2007). In countries with high levels of poverty, an increase in the numbers of residential facilities can actually promote an increase in child abandonment (Levine, 2001), as caregivers may encourage their children to stay in residential facilities in order to ensure the child is materially provided for. My research in Swaziland showed similar findings. I spent many days conducting home visits with children who lived in one of our NGO's six residential care facilities. The home visit involved visiting children's home community and family members, assessing the resources available to the community, the overall living conditions, and the main reasons that the child had left the care of their family. Family and community poverty, followed by abuse were the most commonly cited reasons that children left the care of their families. Many families complained that they were too poor to provide the basic necessities of food, water, clothing, education and health care for their children, hence they felt they were forced to send their children away to work in the cities, where the children ended up living on the streets, and eventually into residential care facilities. Some families said they sent their children directly to one of the residential facilities to live, because they heard the children in these facilities receive daily food, and have their

school fee's paid for by the organization running the facility. When poverty is the main driving force pushing children away from the care of their families, increasing the number of residential facilities in a country may actually increase the rates of orphaned children, ultimately impeding the development of local and national solutions to the orphan crisis (UNICEF, 2004c).

Many children living in residential care facilities have relatives who, with minimal support, would be able to provide sufficient care and protection for them in their home communities. From my experience working in Swaziland, the majority of children living within our six residential facilities had traceable relatives. Research from Zimbabwe and Uganda has found similar findings with 75 percent of the children living in residential facilities in Zimbabwe (Phiri & Webb, 2007) & (UNICEF, 2004c), and 85 percent of residential children in Uganda having contactable relatives (Powell, 1999). In such cases, children should be actively reunited with their family (UNICEF, 2006c). There are many different strategies being used to reunite residential children with their relatives and communities, one such example comes from Ethiopia. In Ethiopia, the SKIP project worked to de-institutionalize children (reintegrating residential children back into their communities) by first enabling them to travel to their birthplaces during school holidays to make connections with their family and community members. Following the initial connections, children were encouraged to visit their communities and relatives more regularly (Gebru & Atnafou, 2000). As well as promoting reunions between institutionalized children and their relatives, the SKIP project also changed the structure of their facilities to family-type units where children lived in the same style of housing as other community children, had the same standards of clothing and nutrition, went to the

same schools and worshipped in the same centers as their peers in the community. As a result, after eight years, SKIP had reintegrated 98 percent of the children in their care back into their home communities (Phiri & Webb, 2007).

In Ethiopia, Rwanda and Uganda, findings on the negative effects that long-term stays in orphanages had on the children led these governments to adopt policies of de-institutionalization (re-integrating residential children back into communities) and support for community-based care (UNICEF, 2004).

Research shows that children fare better socially and developmentally when they live in small family-style units that are integrated within their home communities (Inter-Agency, 2004). Therefore, instead of removing children who require temporary placement in residential facilities from their communities, these facilities should be located within the children's home communities and should strive to replicate the local family structures and levels of physical support available to other children in that same community (Phiri & Webb, 2007). Studies have shown higher levels of psychological disturbances among children who live in institutions with dormitory accommodation, leading to the conclusion that these types of care arrangements should be decentralized or completely phased out (UNICEF, 2006d) & (Powell, 2002, p3).

Residential facilities often have a very small number of staff who usually lack the knowledge, training and skills needed to properly protect and respond to the needs of the children within their care. Therefore, the capacity of residential staff to provide children with the affection, attention, personal identity and social connections that they need in order to develop properly, is greatly limited (Williamson, 2004) & (Berry, 1975, p153). My experience in Swaziland supports this point. Each of the six residential facilities,

some with up to 36 children, had one housefather, an assistant housefather and one housemother supervising the children in each facility. None of the staff working directly with the children had any form of training on the appropriate ways to care, protect and discipline children. On many occasions, I arrived at one of the residential facilities to find 30 children in the home alone, with no adult caregiver present. Without adult supervision, it was easy for the children to turn to doing drugs, alcohol and committing crime, activities in which many of the children were actively involved. With up to 36 children living in one facility and with a very limited number of staff available, the personal attention and care that an adult could give to one child was extremely minimal. Some weeks, days would go by before anyone noticed that one of the children was missing.

Children who grow up in residential facilities experience widespread psychosocial wounds, including incidences of personal isolation, tension, distress and a general lack of self-confidence (Berry, 1975, p156). Children who are brought up in institutional care facilities generally fare worse physically, mentally and emotionally than children who remain living within their home communities and families (Frank et al., 1996). The main problem with the Swaziland residential facilities that I worked in was that caregivers were not trained, not monitored, and viewed their responsibilities with the children as a paid job. The staff were paid by the organization to provide love, protection and care for the children within their walls. True love and care for a child cannot be created by paying a person to fulfill the role of parent in a child's life. Children need more than an employed person to care for them; they need people who will commit the rest of their lives to them, while showing them honest love, care and affection. Because the staff were not properly monitored, widespread abuse against children occurred on a weekly basis in most of the

facilities I worked in. The overall protection of the children within the residences was not adequate. Outsiders were allowed to enter the facilities at any time of the day, and were able to interact with the children as they pleased.

Institutionalized children express feelings of stigmatization from their home communities, and feelings of being left behind when other children and staff move out of the facility. Most children find it difficult to maintain close and lasting relationships, as they lack the basic interpersonal and communication skills, as well as traditionally accepted social and cultural norms needed to function in their societies (Berry, 1975, p16–17).

Close ties to family and community are especially important in Africa, and help to provide a sense of connectedness and belonging, as well as a child's personal, cultural, spiritual, community and family identity (Tobis, D., 2000, p36) & (Kahan, 1979, p99). Residential facilities usually do not encourage children to maintain close relationships with their relatives or communities (UNICEF, 2006d). Once children have lost connections with their community and relatives, it becomes almost impossible to reintegrate these children into their societies after they leave residential facilities (Tolfree, 2005, p4) & (Williamson, 2004, p21). Young people leaving institutions are usually unprepared for the challenges of adult life; they generally have little knowledge of the risks they face or what they can do to protect themselves (McCreery, 2003). Research from several countries in Eastern Europe show that children who have grown up in residential facilities are over-represented among young people in conflict with the law, and in cases of sexual exploitation, drug abuse and suicide (McCreery, 2003) & (Tobis, 2000).

Typically, institutions do not provide the holistic care that children need for their healthy development. Residential facilities usually segregate children by age and sex, and instead of encouraging independence and creative thinking, they tend to promote dependency and conformity. There has been widespread criticism that the developmental needs of children living in residential facilities are not being addressed, especially when children with various problems and needs are placed together in one home (UNICEF, 2006d).

Residential facilities tend to have a high visibility with donors, who usually view institutions as a small central place where they can provide resources and social services to some of the most vulnerable children in the country (Levine, 2001). The problem is that residential centers tend to attract resources, services and funding away from other forms of care that may be more sustainable and may provide better short or long term care for orphans (Tolfree, 2003). Institutional care is often driven by external donors, and in many cases the type of care provided reflects the morals, values, beliefs and ways of life of the donors, rather than the children and society in which they live. Few outsiders are concerned with what happens inside institutions, and most facilities lack guidance, monitoring, coordination and regulation from communities, governments or other agencies (UNICEF & International Social Services, 2004) & (Dunn et al., 2003).

One of the largely debated issues with institutional care for orphans is the high associated costs. It has been estimated that the cost of institutional care for orphans can be up to 14 times more than other forms of care (Powell, 1999) & (Phiri & Webb, 2007). The World Bank reported the annual cost for one child in residential care in the Kagera region of Tanzania was more than US \$1,000, almost six times the cost of supporting a

child in a family setting (World Bank, 1997, p221). Surveys from Zimbabwe and South Africa show similar results, concluding that institutional care is an expensive way to cope with poverty and a growing orphan population; hence the more cost-effective forms of care for orphans are those that are based in communities (Desmond & Gow, 2001, p42) & (Powell, 1999) & (Phiri & Webb, 2007).

Although residential care facilities for children have been widely criticized over the years, they do fulfill a significant need in most countries. Children that have been demobilized from armed forces, such as in Liberia and Sierra Leone, need a period of adjustment from harsh military life before integrating back into their family and communities. Residential group care that provides programs of education, psychological adjustment and personal support is believed to be the most appropriate way of rehabilitating children in these circumstances (Tolfree, 2003). In other situations, residential living may be considered an appropriate approach, for example, in assisting children who have been disowned by their families or communities (an HIV positive child or a child with a mental illness may be abandoned by their family and community) (Guest, 2001). In situations of conflict and displacement (as in Rwanda following the genocide), the numbers of unaccompanied and orphaned children were so high that residential care centers had to be built to house children who would have otherwise ended up on the streets (Tolfree, 2003). Residential facilities provide another social safety net for children who are temporarily or permanently without family or community care.

Community-Based Care for Orphans

Community-based care is an approach that seeks to keep orphans within their home communities, while strengthening the capacity of their family, caregivers and community members to provide care and protection for them (Tolfree, 2003). Some of the more common strategies used in Africa to support this form of care include: the drilling of community boreholes, community income generation projects, skills training for orphans and caregivers, workshops on HIV/AIDS awareness and prevention, providing access to basic medical and educational services for rural communities, opening child care services for at risk children and families and the implementation of school feeding programs and soup kitchens in areas experiencing food insecurity. Community-based care can be supported by all actors in the field including governments, NGOs, church based groups, local community volunteers and families.

In most developing countries, extended families and communities are still the most important social safety nets for orphans, and disconnecting children from these support systems will greatly increase their long-term vulnerability. In order for children to have a sense of safety and belonging, they need to feel valued and have a distinct role to play within their families and their larger communities. In order to have a valued role in their home environments, children must be taught the acceptable cultural norms, social skills, values, beliefs and behavior practiced in the wider society (Williamson, 2004, p4). Community and family members are in the best possible position to ensure that children are taught these important norms and skills, and are better able to determine which children are at greatest risk and what priorities should be set for local action (Levine, 2001). By remaining within their communities orphans both retain a sense of belonging

and identity and benefit from the continued support of networks from that particular community (Tolfree, 2003, p14). In turn, children grow up and become adults who try to provide the same sense of safety and belonging for their own children (Williamson, 2004, p4). Adolescents making the transition to adulthood rely heavily on their families and communities to equip them with the knowledge and skills required for independent adult life. Families and communities are able to offer orphans a lifelong connection to people who care the most about them.

Community-based care builds on existing local structures and systems using local resources where appropriate, while leaving the overall ownership of the solution in the community's hands. This form of care allows people in hard to reach rural areas to have access to essential services that may otherwise not be available to them (Levine, 2001), and it aims to assist the entire community holistically, rather than just one child. With adequate support community-based care for orphans can be a sustainable solution to Africa's orphan crisis (Inter-Agency, 2004). A number of studies have concluded that countries, communities, families and children are better served by programs that keep children within their community, surrounded by leaders and peers that they know and love (Phiri & Webb, 2007) & (UNICEF, 2004c).

There are a number of problems associated with community-based care that can have negative repercussions for the children concerned. Many rural communities do not have adequate resource bases or supporting structures to properly care for all of the orphans within their boundaries. Most families in rural settings are struggling to meet their own family member's needs, and the addition of an orphan will only increase this burden. In some cases, extended family and community members have taken in an

orphaned child, with the expectation that they will receive some type of financial, material or service benefit for their own family members. When this is the motive for taking in an orphan, cases of abuse, neglect, malnutrition and child labour tend to be higher for these children.

Most of the community-based systems providing care for orphans are unregulated and not properly monitored. There is a general lack of research that exposes the weaknesses of community-based care in different situations and cultures, as well as studies that outline criteria for assessing when it is not in the best interest of the child to keep them within their communities.

Community-Based & Residential Based Care for Orphans Discussed

In the past, the number of orphaned children in Sub-Saharan Africa was very small and local responses were therefore sufficient to adequately address the problem. The situation is much different today in Sub-Saharan Africa where the percentage of orphaned children has risen dramatically (UNICEF, 2004c); orphaning is now considered a long-term, chronic problem (Smart, 2003). With the large numbers of children orphaned in Sub-Saharan Africa today, combined with the many criticisms against residential facilities in the past, the need to adopt approaches to adequately respond the emerging orphan crisis is pressing. Community-based care was the approach promoted, among international and national policy makers, and seemed to solve the many problems that had been associated with residential care in the past.

Today, community-based care is the favoured approach, among UN agencies and governments, used to respond to the orphan crisis in Sub-Saharan Africa, and has been

used as the basis for the design of many new policies and strategies aiming to address the orphan crisis in countries with high rates of orphans. There are some non-governmental organizations (NGOs) working within African countries today that promote the development of residential facilities for orphan care. Most of these NGOs are small in nature, and are only able to provide care for a small number of children within a country. Today, the majority of policy makers (including government, UN agencies, NGOs and communities) argue that placing orphans in residential facilities should be reserved as a last resort where better care options have not yet been developed or as a temporary measure pending placement in a family (UNICEF, 2004c). Although efforts are being made to keep children out of institutions, the reality is that thousands of them currently have nowhere else to go. Children who have been abused, abandoned, are living on the streets or have been involved in conflicts, may be in need of temporary residential care before integrating back into their home communities and families (Guest, 2001, p163) & (Wright, 1999) & (Subbarao et al., 2001) & (Grainger et al., 2001). Although community-based care is the more dominant approach used in responding to the orphan crisis today, residential facilities are needed in cases where other care options are not available for orphaned children. National policies, strategies and plans for the protection and care of orphaned children, that leave out residential care facilities in their design, leave children within these care facilities vulnerable to exploitation, abuse and neglect, hampering the development of their country as a whole.

To be effective, residential facilities must have a clear set of standards that are enforced and monitored to ensure that the best possible care and protection is provided to the children within their centres. Steps need to be taken to ensure that all staff are

properly trained and fully committed to the center's philosophy and objectives, and that each possesses the skills necessary to carry them out (Tolfree, 2003). Residential care should be strongly supported by the government, and must be regularly monitored by government agencies to ensure that national standards, policies and action plans for the care and protection of children are being respected (Save the Children, 2005) & (Levine, 2001). The main aim of residential care in the future should be to re-establish and strengthen family bonding, with the objective of reintegrating children back into their families and communities permanently (UNICEF, 2006d).

Although community-based care is the dominant approach to orphan care in Sub-Saharan Africa today, communities require significant capacity building, including monitoring and evaluation systems and procedures, an increase in the quality and availability of resources and services provided at the community level, and mechanisms to ensure that the services and resources provided within every community throughout the country are standardized, in order to properly support families and communities in caring for orphaned children within their borders. This will require large amounts of support from governments, families, communities, NGOs, FBOs, UN and government agencies and donors, who are all ultimately responsible for the care and protection of children.

International Framework for the Care and Protection of Orphaned and Vulnerable Children

The policy debate between community-based and residential based care arrangements, discussed above, led to the creation of an international document that

combined a variety of best practices and lessons learned on how to appropriately respond to the growing number of orphaned and vulnerable children in African countries (UNICEF & UNAIDS, 2004). In March 2004, The UNAIDS Committee of Co-sponsoring Organizations (made up of more than 70 practitioners and policymakers from bilateral and multilateral donors, UN agencies, foundations and NGOs), adopted the international document entitled: *'A Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS.'* The framework is structured around a community-based approach, as it emphasized child-centered, family and community based forms of protection and care for orphaned children (UNICEF & UNAIDS, 2004).

This framework is directed particularly to senior government officials, leaders and decision-makers, and reflects a broad international consensus regarding goals, principles, strategies and programming that governments can use to help design, guide and implement their national response to the orphan crisis (UNICEF & UNAIDS, 2004). The five key strategies outlined in the framework are: to strengthen the capacity of families to protect and care for orphans and other children made vulnerable by HIV/AIDS, to mobilize and strengthen community-based responses, to ensure that all orphaned and vulnerable children have access to essential services, to ensure that government's have a central role to play in all aspects of the orphan response within their borders, and to raise awareness in order to create a supportive environment for children affected by HIV/AIDS.

Although the international framework consists of broad recommendations for the care and protection of children, the framework does not include residential care in its

strategies and recommendations for future action. The failure to include residential care facilities in international and national policies, strategies and plans of action for the care and protection of orphaned and vulnerable children, leave children within these care facilities vulnerable to exploitation, abuse and neglect, which may hamper the overall development of the country for future generations.

Governments in Africa have been slow to respond to the orphan crisis for many reasons, including: the lack of public funds and resources available; the lack of openness among governments and the general public to discuss issues surrounding HIV/AIDS, and the fact that families and communities have shouldered most of the strain of the crisis, which has relieved pressure on governments and other organizations from having to actively respond (UNICEF, 2003, p35). At the end of 2003, of the 40 African countries facing the most acute orphan crisis, only six had national policies on the protection and care of orphans and other vulnerable children (UNICEF, 2003).

In 2006, Swaziland, with a quickly growing crisis, was faced with the challenge of finding sustainable solutions for the care and protection of the thousands of children left orphaned and vulnerable throughout the country. The government of Swaziland adopted a national plan of action to help address the orphan crisis, as well as to curb the long-term consequences that this crisis would have on the country's political, economic, social and overall stability (UNAIDS, 2006). Swaziland's national plan of action for orphaned children was based on the International Framework for the protection and care of orphans in countries with high rates of HIV/AIDS, discussed above. Swaziland's national plan will be discussed in more detail in the next chapter.

Chapter 4

Care & Protection for Orphans in The Kingdom of Swaziland

The objective of this chapter is to present a case study on Swaziland and to analyze Swaziland's National Plan of Action for Orphaned and Vulnerable Children 2006-2010, addressing some of the main challenges that may be faced in the near future before the national plan can be realized. The analysis and challenges presented in this chapter have been acquired through observations and experiences gained during my eleven month work placement with an NGO based in Manzini, Swaziland. The observations described in this chapter largely relate to my work with community-based strategies for protection and care for orphans, that included weekly visits to Neighborhood Care Points (NCPs), Rural Health Motivators (RHMs) and *Lihlombe Lekhukalela* (Child Protectors) (explained in the second section of the chapter), rural health clinics, police stations and homes and schools, as well as my work reintegrating residential children back with their home communities.

This chapter will begin with an overview of The Kingdom of Swaziland in order to contextualize the case study and to give background on how the orphan crisis evolved in the country.

General Overview of Swaziland

Swaziland, with a population of 1,175,000, is a landlocked country surrounded by South Africa and Mozambique (Government of Swaziland, 2007). Swaziland is ruled by a monarchy, with the head of government, King Mswati III (crowned King of Swaziland

in 1986), having an absolute authority in all aspects of Swazi life (CIA, 2006). The Kingship is hereditary in the Dlamini clan, and the King, as well as the Queen mother are viewed as the heads of the country-wide family (Kuper, 1963). Today, King Mswati III retains power over the government, parliament, the High Courts and judges, and can use his power to change or ignore any constitutional right as he sees fit (Economist, 2006).

The country is divided into four districts (Hhohho, Lubombo, Manzini and Shiselweni), each of which is organized on principles similar to those underlying the central government. Within each district, communities are divided into separate chiefdoms. A chief, who has been appointed by the king, is responsible to centralize law, economics and rituals within his area of jurisdiction (Kuper, 1963). In Swaziland, a community is referred to as an area consisting of a number of households under the auspices of a Chief (CIA, 2006).

Patriarchal authority is very strong throughout the country, with male children given more preference in inheriting land and accessing education at higher levels (UNICEF, 2004, p13). Through every stage of a Swazi's life, there are customs that preserve the traditional rules and prescribe codes of social behavior (Government of Swaziland, 2007).

Problems associated with widespread poverty have left many families throughout the country unable to meet their basic needs. Over 67 percent of people in the country live below the poverty line (live on less than a dollar a day), and income distribution is heavily skewed, leaving much of the population living in absolute poverty (UNICEF, 2004. p14). Most Swazis are struggling to survive; food is often scarce and more than one-fourth of the population is in need of emergency food aid each year (CIA, 2006).

Only 51 percent of the population has access to safe drinking water, which has been further compounded by several years of drought affecting nearly one-third of the country (UNICEF, 2004). The country's unemployment rate in 2004 was at 40 percent (CIA, 2006). The growing poor-rich divide in access to information, technology, higher education, and specialized health care services threatens to leave the poor even further behind (Government of Swaziland, 2007).

Most of the international aid that flows into Swaziland is bilateral, and comes in the form of grants, humanitarian service, development aid and emergency assistance. Some of the major donors to Swaziland are the Republic of China, the EU, Japan, UK, Italy, Germany, Denmark and various agencies of the United Nations (Government of Swaziland, 2007). The majority of international aid targets the health, social welfare, economic and agricultural sectors of the county.

The economy of Swaziland is largely dependent on agriculture, although only 11 percent of Swaziland land is arable (Government of Swaziland, 2007). The heavy reliance on agriculture leaves the country's economic growth vulnerable to climatic shocks, as overgrazing, soil depletion, drought, and sometimes floods persist throughout the nation (CIA, 2006).

Swaziland has the world's highest HIV rate; the UN estimates that nearly 40 percent of the adult population in the country is HIV positive (Government of Swaziland, 2007). AIDS deaths have been detrimental to the orphan crisis, as well as to the agricultural, health and education workforces, contributing to a food crisis brought on by crop failures in recent years (Government of Swaziland, 2007). Following years of silence from the government and media on issues surrounding HIV/AIDS, the Swazi government and communities throughout the nation have begun talking about such

issues. Discrimination against those with HIV/AIDS has declined, but there still exists a level of stigma that makes people reluctant to get tested or to live openly with HIV (UNICEF, 2004).

The country's health care system consists of a formal and an informal sector. The informal sector consists of traditional health practitioners and other unregulated service providers. Traditional healers are part of the Swazi heritage; they are herbalists, using natural materials to heal the sick. Approximately 80 percent of Swazi's consult traditional healers for personal and health issues, as they are believed to provide a genuine form of medical assistance. Traditional healers are respected members of the community and enjoy a high social position in cultural life. The health service that is based on western medicine is considered to be formal and consists of public and private health facilities (Government of Swaziland, 2007).

Funding of the health sector has not kept pace with the needs of the people, as the impact of HIV/AIDS has overwhelmed the service capacities. The facilities themselves have not been able to maintain high quality of services due to shortages of staff, equipment, supplies and medication. A combination of social isolation, distance from the services and lack of finances to pay fees has prevented many people from accessing health services throughout the country (UNICEF, 2004, p23). In 2005, life expectancy at birth for males was 32.5 years, and for females was 34 years (Government of Swaziland, 2007).

Although Swaziland is a signatory of the UN's Education For All Declaration, high rates of HIV, disease, poverty and orphaned children throughout the country has threatened this attainment. There are serious concerns with respect to overcrowding in

schools, accessibility, relevance, understaffing, under-trained teachers, as well as the affordability of learning materials, school uniforms and fees, and the overall quality of educational facilities throughout the country (Government of Swaziland, 2007).

Swaziland, with the highest rate of HIV in the world, and with a rapidly expanding orphan population, faces its two largest challenges; reversing the spread of the HIV/AIDS epidemic, and finding sustainable solutions for the care and protection of the thousands of children left orphaned and vulnerable throughout the country.

The Orphan Situation in Swaziland

In 2005, the total number of orphans in Swaziland was estimated to be 95,000 (17 percent of the entire population of children within the country) (UNICEF, 2006, p36). The projections show that by 2010 Swaziland will have an orphan population of over 120,000 (22 percent of the entire population of children in the country) (UNICEF, 2006, p36). One of the major contributing factors to the high numbers of orphans in the country has been HIV related deaths among children's family and community members (UNICEF, 2006b).

Increasingly, extended family members (especially grandmothers) are taking on the responsibility of caring for orphaned children (UNICEF, 2004). Child-headed households appeared in Swaziland in 2001, when widespread drought and increases in food prices left many extended families unable to take in additional children. At the end of 2002, a UNICEF survey conducted in 49 communities in Swaziland identified over

10,000 children living in 2,600 child-headed households, many of them unable to meet their daily basic needs, and not attending school (UNICEF, 2004, p21).

A very small proportion of orphaned children in Swaziland are cared for in residential facilities, which are usually run by non-governmental and faith-based organizations. Formal adoption and foster care are not culturally practiced in the country, and a very small proportion of orphaned children are living on the streets. The majority of orphans throughout the country are living with their extended family or community members. In Swaziland, children without parents are not labeled as “orphans” but as “*bantfwana bendlunkhulu*” (children of the community) (UNICEF, 2006e). Community-based care is therefore regarded as the more acceptable approach in caring and protecting orphaned children in the country, as Swazi tradition holds that every child who has lost their parents can find a place as a child of the nation-wide extended family of Swaziland.

Swaziland’s National Plan of Action for Orphaned and Vulnerable Children 2006-2010

On April 12th, 2006, the government of Swaziland adopted a National Plan of Action for Orphaned and Vulnerable Children 2006–2010, which was based on the International Framework for orphaned children, mentioned in the previous chapter. Based on Swaziland’s tradition that every child who has lost their parents can find a place as a child of the nation-wide extended family, the design, policies and strategies outlined in the national plan focused entirely on community based approaches to care and protection for orphans (UNICEF, 2006a). The National Plan outlines actions to be taken, in order to promote the survival, growth, well-being, development and protection of the 132,000

OVCs within the country. The National Plan calls for a collaborative effort among communities, non-governmental organizations (NGOs), faith-based organizations (FBOs), UN and government agencies and the international community that builds and strengthens existing community structures and safety nets, to promote long-term, sustainable responses that will reach all orphaned and vulnerable children throughout the country (Connolly, 2003). The budget for the entire National Plan is US\$ 228 million, which is expected to be spent over a five-year period (from 2006 – 2010).

The main goals set out in Swaziland's National Plan of Action for the Care & Protection of Orphaned and Vulnerable Children (OVCs) are to ensure that: all vulnerable individuals and households are able to produce or acquire sufficient amounts of food to meet their short and long term nutritional needs, all children will have access to shelter and protection from abuse, violence, exploitation, discrimination, trafficking and loss of inheritance, the national goal of attaining universal primary education will be achieved, all orphaned and vulnerable children will have access to basic health care services and all children in Swaziland will be able to participate in decisions that affect their livelihoods.

Each of the National Plan of Action goals is highlighted below with an analysis of some of the main strategies put forward, as well as a discussion on some of the challenges that may effect the attainment of the goals in the future. The analysis and challenges presented in the next section are based on observations and information gathered during my eleven month work placement with an NGO based in Manzini, Swaziland. The information and analysis of the Swazi orphan care system I provide in the next section is largely based on observations made during my work with community

based strategies for protection and care for orphans, which entailed: weekly visits to Neighborhood Care Points (NCPs), Rural Health Motivators (RHMs) and *Lihlombe Lekhukalela* (Child Protectors) (explained in the second section of the chapter), rural health clinics, police stations and homes and schools, as well as work reintegrating residential children back with their home communities.

Goal #1: Ensuring that all vulnerable individuals and households are able to produce or acquire sufficient amounts of food to adequately meet their short-term and long-term nutritional needs:

In 2001, the government of Swaziland, through recommendations and guidance from UNICEF, adopted a nation-wide, community-based strategy to assist families and communities in caring for the orphaned and vulnerable children within their communities (UNICEF, 2006b). The initiative was to build Neighborhood Care Points (NCPs) in every community throughout the country where orphaned and vulnerable children could have some of their basic needs met, including access to nutritious food, informal education and basic health care services on a daily basis (Government of Swaziland, 2007). UNICEF has described what the ideal NCP should look like; this includes: nutritious food served twice daily, day-time shelter and protection, developmental activities for young children, basic health care, activities such as sports, recreation and life skills training, HIV/AIDS awareness, non-formal and after-school educational activities and psychosocial support and counseling for all orphaned and vulnerable children (OVCs) (UNICEF, 2006b, p8).

Many hours were spent over my eleven-month placement in Swaziland, working at two different NCPs located in the slum areas of Manzini. The daily tasks included delivering food and cleaning supplies to the NCPs, as well as cooking and distributing

food to the children within these communities. On occasion, these two NCPs would coordinate the distribution of clothes, home and medical supplies to community members. Both of the NCPs that I worked at had seven volunteer women from the communities in which these facilities were located, who were responsible for the daily tasks. I visited many different NCPs throughout Swaziland over my eleven month placement, and observed many challenges faced by these facilities. I find UNICEF's 'wish list', mentioned above, extremely idealistic, and in reality none of the NCPs that I worked with or visited in Swaziland were functioning at this level. I found that the functionality of NCPs throughout the country varied widely from one NCP to the next. Some NCPs that I visited were providing regular protection, support and care to the orphaned and vulnerable children in their jurisdiction; such NCPs had daily early education for children who were too young to attend formal education, informal education and skills training for out of school children, weekly courses on HIV/AIDS awareness for all communities members and daily distribution of food. Other NCPs that I visited were barely functioning; some of these NCPs were set up under a tree, without a concrete building to house the cooking pots, food or supplies. In these NCPs the distribution of food was erratic, with only a small portion of the children in the community benefiting. NCPs are supposed to provide protection and care for OVCs through diverse programs, but many of the NCPs I visited provided daily food, with very little emphasis on other activities or programs. UNICEF's assessment of OVCs in 2004, found that the majority of NCPs in Swaziland, including the ones that are functioning well, generally lack emotional, spiritual and psychological support services for the children (UNICEF, 2006b, p22). The day-to-day running of the NCPs that I visited were

solely dependent on community volunteers who had little to no training on how to deal with the many problems that OVCs face. In some of the communities I visited, NCP volunteers were blamed for stealing food and supplies from the NCPs, but in a country with high levels of poverty, and wide food shortages, it is hard to blame people for taking something that they need to sustain their lives. From my observations as well as from discussions with beneficiaries and community leaders, I found that the food delivery at many NCPs was irregular and many days would go by without food being served (UNAIDS, 2006). The sanitary situation in the NCPs that I visited was poor, and many did not have access to safe drinking water. In 2004, UNICEF reported that only 19 percent of the NCPs in Swaziland had proper toilets built (UNICEF, 2006b).

On average, each NCP provides daily assistance to 58 OVCs, but again this number varies largely from one community to the next. In some communities there are as few as 30 children receiving daily assistance, while in others over 300 children attend NCPs on a daily basis (UNICEF, 2006b, p10). One of the NCPs that I worked in had 300 children receiving daily assistance, while the other NCP I helped out at had 200 children receiving daily assistance.

Between 2001 and 2005, UNICEF spent over US\$ 8 million on Swaziland's NCP initiative (UNICEF, 2006b), with the expectation that together NGOs, FBOs, community groups and UN and government agencies would collaborate as project implementers. By 2006, there were over 625 Neighbourhood Care Points working in communities throughout the country (UNICEF, 2006a).

UNICEF conducted assessments of NCPs in Swaziland in 2004 and found that children who lived in communities with NCPs had better access to health services,

informal schooling and nutritious food (UNICEF, 2006d). Based on this assessment, UNICEF recommended that NCPs should be established in all communities throughout the country, and that the capacity of NCPs should be strengthened to ensure that all NCPs not only meet the physical and social needs, but also meet the psychological, emotional, spiritual and development needs of OVCs. UNICEF also recommended that community-based monitoring of NCPs should be strengthened. In addition, efforts must be made to ensure NCP access to improved water sources (for safe drinking water, better sanitation and hygiene), and gardens should be established in all NCPs to supplement the feeding program (UNICEF, 2006b, p25).

The government of Swaziland has incorporated the NCP initiative in the 2006-2010 National Plan of Action for Orphans and Vulnerable Children. The National Plan emphasizes the importance and need to increase the capacity, as well as the number of NCPs, to ensure that every community throughout the country has a properly functioning NCP by 2010 (UNICEF, 2006b).

NCPs give Swazi communities a sense of empowerment and hope for the future. They provide a cost-effective, stable structure for children who would otherwise have nothing, while at the same time supporting the government's and society's opinion that orphans should be kept and cared for within their home communities (UNAIDS, 2006).

Although a multi-sectoral response to the OVC crisis is called for within the National Plan of Action to ensure that all children throughout the country receive support, the coordination, guidance, monitoring and evaluation of the community and other organization's responses will be a challenge. It will be difficult for the government to properly monitor and evaluate all of the NCPs throughout the country, especially when a

large portion of NCPs are funded and run by many different NGOs, each with its own mandate, expertise and program priority. There are many different NGOs working on behalf of children in Swaziland, and to date most NGOs working in the country have been largely un-monitored. A large portion of NGOs funding comes from abroad, meaning donor interests, rather than the beneficiaries interests themselves are usually reflected in the program design. As well, the sustainability of NGO's resources, programs and services greatly depend on ad hoc donor funds.

Goal #2: All children will have access to shelter and protection from abuse, violence, exploitation, discrimination, trafficking and loss of inheritance

The National Plan seeks to strengthen the capacity of communities to provide all children with protection from abuse, violence, exploitation, discrimination, trafficking and a loss of inheritance. The National Plan focuses mainly on expanding resources, services, training, funding and support to rural communities, by focusing on strengthening the traditional community mechanisms already providing psychosocial support. Some of the more successful traditional mechanisms and structures already in place in communities throughout Swaziland include: community chiefs, NCP caregivers, Rural Health Motivators (which will be discussed in more detail in the next section), as well as *Lihlombe Lekhukalela* and *Lutsango IwakaNgwane* initiatives (both explained below).

Lutsango IwakaNgwane is a siSwati word meaning an enclosure, where all married women automatically become members. The main role of this group is to mobilize women for ceremonial functions and to train them in traditional roles, ensuring

that good cultural practices and behaviour are transferred from one generation to the next. Through assistance from the Swazi government, *Lutsango IwakaNgwane* care mothers have been trained in basic life skills, in HIV education and prevention strategies, and in how to care for OVCs and HIV positive children. Local *Lutsango IwakaNgwane* members are assigned to orphaned households to ensure that these children are protected from abuse and exploitation, have access to essential services and are being properly cared for.

In 2002, UNICEF introduced the *Lihlombe Lekhukalela* (A Shoulder To Cry On) initiative which trained “Child Protectors” in communities throughout the country to protect children from sexual abuse, to provide psychological and social support to traumatized children, and to link children to vital services for their protection (UNAIDS, 2006). At the end of 2005, UNICEF, in collaboration with government and other agencies, had set up “Child Protector” committees in 188 communities, with a total of 5690 child protectors trained on issues involving the protection of children (UNICEF, 2005).

Reinforcing these traditional structures gives government and UN agencies, as well as NGOs, FBOs and donors a better structure with which to work, as well as access to those who need assistance the most. Engaging traditional chiefs will be central to the success of community initiatives to protect and care for OVCs, as chiefs are the head of the community and are ultimately responsible for ensuring that assistance is provided effectively and efficiently to the most needy within their jurisdiction (UNAIDS, 2006). The people of Swaziland understand and accept these traditional systems and norms. As

well, encouraging local participation in all areas of the OVC response will ensure the sustainability of the national OVC response.

Both the *Lihlombe Lekhukalela* Program and the *Lutsango IwakaNgwane* Initiative have come across similar challenges in recent years. Women are doing much of the psychosocial work as well as the home-based care. The cultural constraints of working with men and older boys mean that the women can only do so much; therefore, getting men more involved is essential and has so far proven to be a difficult task in many rural communities. Lastly, there is a general lack of monitoring and evaluation mechanisms set up within communities to ensure that these structures are successfully meeting the needs of OVCs.

Defining exactly what constitutes abuse versus discipline for children in Swazi tradition will be difficult. Corporal punishment is used in schools throughout the country and family problems are viewed as more of a private matter to the law enforcers, meaning abuse cases between married couples, parents and children are rarely addressed legally. On many occasions, during my placement in Swaziland, I was challenged by the local people on the issue of child-abuse. Children who misbehaved within the residential care facilities were beaten, usually with a stick, by one of the elders hired to care for them. In some cases children were held on the ground by two or three adults, while one punched the child repeatedly. In other cases children were whipped multiple times with TV cords. In other cases children were hit twice on their hand with a small stick. The degree to which the child was beaten depended on how angry the elder was towards the child when the discipline was to be administered. I held meetings with the staff of the NGO to discuss standards for discipline procedures within the residential facilities, but was faced

with lots of opposition from the local staff. The staff argued that beating children was the Swazi form of discipline, and the severity of the beatings were at the discretion of the adult administering the punishment.

Educating the general public on standards and laws related to child protection, as well as enhancing the reporting systems and responses to abuse cases throughout the country will be beneficial. However, expecting people to change their way of life, traditions and beliefs, on issues surrounding abuse and the protection of children, may be a difficult task in the years to come. Swaziland Action Group Against Abuse (SWAGAA) is an organization located in Manzini that works to educate the population on issues of abuse and to give support to victims of abuse throughout the country. The NGO I worked with in Swaziland asked SWAGAA to hold an education awareness seminar on abuse for the staff and children within our organization. Many of the staff said that they were not going to attend the seminar, as they argued that SWAGAA was trying to change the traditional ways of life in Swaziland. Two of our staff members explained to me that educating children on issues of abuse will discredit the elders authority over children throughout the country. SWAGAA did hold an awareness seminar on abuse for the staff and children within our organization, but from my observations nothing changed as a result of this seminar.

A lesson learned while working in Swaziland about caring for orphaned children is that organizations, such as NGOs and foreign based programs, should leave the primary day-to-day care of children in the hands of locals. People who are outsiders usually do not fully understand the traditions, customs, culture, or way of daily life, which are all very important aspects of child-care and must be taken into consideration.

These aspects of child-care can make or break the overall development of children. I made quite a few observations on this issue while working in Swaziland with an NGO that had many different people from abroad volunteering in its programs. All of the volunteers and visitors that came from abroad to help out had regular contact with the children being cared for under this NGO. Some volunteers would stay for months or years, while others would stay for weeks or only days. The longer-term volunteers had close relationships with many of the children under the care of the NGO, which were broken when the volunteers eventually left the country. In the time frame of eleven months I witnessed 30 different volunteers who came to the NGO to work with the children for different periods of time and then left. Each time a volunteer would leave the children would express their anger and sadness that another person that they thought cared for them was leaving. Children who are orphaned and/or vulnerable, and living in residential facilities usually have a history of broken relationships and problems with trusting people. Allowing different people to come in and out of the children's lives on a regular basis can be detrimental to the children's well-being and overall development.

Another problem observed with the volunteers who came to assist in the NGO that I worked with in Swaziland, was that they did not fully understand the Swazi culture, traditions or way of life. On many occasions volunteers would get into arguments with the organization staff on what the proper child rearing practices were in the country. This created many problems within the organization as some volunteers would ignore the rules set up by the local staff, and do as they please with the children. From my experience, I have learned that outsiders should not be placed in situations where they are providing direct day-to-day care for children. Outsiders can assist with the protection and care for

children in ways such as the following: delivering food and supplies to communities, the building of schools, neighborhood care points, or water wells, encouraging governments to adopt child-friendly policies and to listen to the concerns and interests of the people within the country. However, ultimately, the day-to-day care for children must be locally owned and managed. Locally determined solutions are better able to outline needs and problems and are better equipped to find sustainable solutions that address local challenges within a local context.

Goal #3: The national goal of attaining universal primary education will be achieved, along with support provided to OVCs in secondary schools

The Ministry of Education has implemented an Education Bursary Awards initiative over the past few years that covers yearly school fees for a portion of the orphaned children in the country who would otherwise not be able to attend formal education. In 2006, through an allocation of \$6.7 million US, 60,000 OVCs throughout the country were provided with free access to formal education; as well, free textbooks and stationery were provided to primary grades in all schools throughout the country (UNICEF, 2006a, p4).

To meet the goal of attaining universal primary education, the National Plan of Action seeks to increase the number of OVCs receiving government grants, covering the costs of education and stationery supplies, so that by 2010, 80 percent of OVCs aged 6-14 years will have free access to formal and non-formal education. The National Plan says that all teachers and NCP caregivers will receive training in psychosocial care for OVCs, as well as training in early childhood education, non-formal education, life skills

and gender sensitivity. Gender sensitive learning materials and life skill courses will be implemented in all school curriculums throughout the country, and the number of technical skills centers will be increased from 13 to 55 by the year 2010, targeting 11,000 out of school youth.

Although the Education Bursary Awards initiative has made some positive steps over the past year or so, my experience in Swaziland has shown me there continues to be widespread criticisms of the initiative from the general public. Many argue that the initiative lacks transparency and accountability, as the number of orphans who have received the bursary each year, and the criteria on which orphans are chosen is vague. The distinctions between who is classified as an orphan or a vulnerable child are not fully understood among people throughout the country. School headmasters have been criticized for claiming to have many more orphans in attendance at their schools than they in fact do; some of the children who are listed as orphans actually have parents who may be able to pay for their school fees. As much as the Education Bursary Awards initiative has proven to be a positive response to the orphan crisis in some situations, the entire program has not been properly implemented and/or monitored, and to date many orphans throughout the country still do not have access to formal education.

With a number of resources, structures and standards needing to be developed and implemented in order to enhance the Education Bursary Awards initiative so it can appropriately meet the educational needs of all OVCs, my experience leads me to believe that it would be less complicated, and more beneficial to all Swazis, if the government simply provided free primary education for all children throughout the country.

Goal #4: Ensure that all OVCs have access to basic health care services

The Rural Health Motivators (RHM) initiative was launched by the government in 2000, and focused on home based-care, HIV/AIDS risk reduction and providing better access for rural communities to essential basic health care services (Government of Swaziland, 2007). In 2000, each community in Swaziland nominated one representative to be trained as the community's Rural Health Motivator (RHM). The training was provided by the Ministry of Health and Social Welfare, and consisted of basic education on HIV/AIDS, techniques on how to properly care for the sick at home, and information on how to educate the community on basic health issues. At the launch of the initiative in 2000, 4,500 RHMs were trained over a 10 week period, which was funded by both the government of Swaziland and the Global Fund at a cost of US \$ 110,933 (UNAIDS, 2006, p33). Refresher courses have been given on a continual basis throughout the country, as many RHMs have become ill themselves (UNAIDS, 2006). RHMs receive a monthly allowance from the Ministry of Health and Social Welfare office of approximately US \$15 for their work (UNAIDS, 2006, p32).

RHMs are equipped with basic equipment such as first aid kits, gloves, disinfectant, soap and adult-sized diapers (UNAIDS, 2006). They are expected to make home visits and care for the sick within their communities, take people to the hospital when necessary and to make sure people are taking their medications properly (UNAIDS, 2006). As part of their work Rural Health Motivators encourage people to go for voluntary HIV counseling and testing, and put together awareness campaigns to educate their community members on HIV/AIDS, sexually transmitted infections, and other health related issues (UNAIDS, 2006, p32).

RHMs responsibilities have grown since the initial implementation of the initiative in 2000, and today they have a more central role in their communities. They work closely with community chiefs and other community members assisting in the distribution of food and supplies to OVCs, helping coordinate the daily activities at the NCPs, helping to select orphans who are in the greatest need of the Education Bursary Awards, and addressing protection issues for the children within their jurisdiction (UNAIDS, 2006).

In 2006, Rural Health Motivators were believed to be the most accessible source of health care support, with over 90 percent of rural households reporting to have received medical care, supplies and advice from a RHM (UNICEF, 2006b).

Rural Health Motivators, as central figures in their communities, are in a perfect position to help care for and protect the OVCs within their jurisdiction. Providing free antiretroviral drugs to HIV positive children throughout the country is a positive step forward. The cost of transport or entrance fees to distant hospitals or health clinics may be too expensive for many rural people to access; therefore, equipping Rural Health Motivators with the skills and resources to provide basic health needs to people in hard to reach communities will greatly help in ensuring that all people, especially OVCs, have regular access to basic health care services.

Goal #5: Ensuring that all children in Swaziland will be able to participate in all decisions that affect their livelihoods

To meet the goal of increasing children's participation in decisions that affect their livelihoods, the National Plan of Action states that life-skills programs will be

implemented in schools and NCPs throughout the country that will teach both in and out of school children about their rights, how to find legal and community assistance, and how to voice their opinions in all levels of society. Training and workshops will be held in each community countrywide to educate community and government personnel on their obligations to engage in productive dialogue with children, and to allow the children to have a say in decisions that affect their livelihoods. By 2010, children's assemblies (forums) will be established at the community, regional and national levels allowing children to have input in all levels of governance structures and national policies.

Ensuring that children have access to essential services and are able to participate fully in all decisions that affect their lives will be a large challenge in the coming years. Tradition dictates that children are to be 'seen and not heard;' girls are traditionally kept home from school to help out with the domestic work while boys may be taken out of school for years at a time to take care of the family's cattle. Ensuring that all children, girls in particular, have equal participation and equal access to essential services will be a huge challenge for the Swazi society, and the transition may not be welcomed by some of the country's elders and leaders.

Overall Coordination of The National Plan of Action

One of the larger international development lessons learned while working in Swaziland is that governments must take a central role in setting and enforcing policies and standards, as well as coordinating, monitoring and evaluating the overall response to different development problems within their borders. Other actors, including UN agencies, NGOs, FBOs and community-based groups, can assist in the national response,

but the overall responsibility must remain in the government's hands. From my experience working on issues of child protection and care in Swaziland, I was able to visit many different organizations that worked on these issues throughout the country. Each organization had its own program priorities that fit the interests of that particular organization and its donors. In some communities there were up to twenty different organizations working on children protection and care issues, while in other communities there were no organizations active. NGO's and other organizations are spread unevenly throughout Swaziland, leaving the responses to child protection and care issues within the country erratic. Therefore, the government must take a central role in coordinating, monitoring and evaluating, as well as setting and enforcing policies and standards in response to the problems within its borders to ensure that all people in the country benefit equally from the support and services being provided. It is just as important for governments to set policies and standards on care and protection for citizens within their borders as it is for them to ensure the implementation and enforcement of these standards and policies. The continued monitoring and evaluation of programs and responses to development problems is critical in order to properly assess if goals and targets for particular responses are being reached.

The government of Swaziland recently established The Children's Coordination Unit, under the Ministry of Health and Social Welfare, which is responsible for overseeing and coordinating the entire OVC national response. This unit is responsible for developing, reviewing and implementing legislation and policies pertaining to children, as well as coordinating the activities of different organizations and agencies to ensure that all children are properly protected and cared for based on the national

governments standards. The government established an OVC task force under the Prime Minister's Office that is responsible for developing and implementing systems for collecting, recording, managing and analyzing data on OVCs, as well as creating systems for the dissemination of relevant data to all partners working on children's issues. This task force will help to ensure a consistent flow of data regarding key indicators of the national plan for OVCs. The National Plan concludes by addressing the importance of developing and implementing systems to monitor and evaluate the implementation, and examine the effect that programs, strategies and activities responding to the OVC crisis have on attaining the goals outlined above.

In the past, many government agencies have been widely criticized for corruption, poor management, unaccountability, unresponsiveness and inefficiency in service delivery to the most needy in the country. Although the government has made formal commitments to assist OVCs throughout the country, gaining assistance and trust from the wider society in the government's ability and commitment to reach the goals set out in the National Plan of Action for OVCs will be a challenge.

Another challenge in meeting the goals outlined in Swaziland's National Plan will be ensuring widespread commitment and coordination between all government and UN agencies, NGOs, FBOs and communities to the strategies outlined in the plan, and ensuring that sufficient resources and support are provided and are channeled properly to communities and their intended beneficiaries (Levine, 2001). On many occasions while working in Swaziland I attended different NGO, UN and government meetings on issues involving the protection and care for children. In many cases only a small fraction of the organizations working on child care and protection issues attended the meeting's,

meaning the sharing of lessons learned and the overall coordination of organizations working on child related issues throughout the country was minimal.

Communication and the collection of reliable data to monitor and evaluate program responses in a country such as Swaziland, where the majority of people live in hard to reach rural areas without access to electricity, will also prove to be a challenge in the future.

Summary of the Overall Assessment of Swaziland's National Plan of Action for the Care and Protection of Orphans.

The overall objective of Swaziland's National Plan of Action for Orphaned and Vulnerable Children is to enable all communities throughout the country to provide care, protection and support for the children within their jurisdiction. Communities, NGOs and FBOs generally have few resources with which to work; most of the existing structures in communities are extremely limited, and poverty is widespread throughout the country (Guest, 2001, p64). These realities coupled with the HIV/AIDS crisis crippling the economic, educational, social and health sectors of the country will prove to be huge challenges for the government in attaining the goals outlined in the National Plan. In addition to these challenges, Swaziland's national plan of action has not incorporated residential care into it's policies and strategies for future action. Because residential care facilities for orphaned children are not included in Swaziland's national plan for the care and protection of orphans, these facilities remain un-regulated, un-monitored, and leave many orphans exposed to abuse, exploitation and neglect throughout he country.

I have outlined above many different challenges that may be faced in the near future concerning each of the Swaziland's National Plan's main goals, which may effect the attainment of these goals. It is important that policy makers and people working to find solutions to the orphan crisis take note of the challenges mentioned in this report, as the attainment of the goals listed under Swaziland's National Plan of Action for orphaned and vulnerable children depends on addressing these challenges. If the goals outlined within Swaziland's National Plan are not attained, the long-term consequences for the country's political, economic and social structures and overall stability will be devastating (UNAIDS, 2006).

Chapter 5

Conclusion

This report identified the importance of community-based care in responding to the orphan crisis, while emphasizing that residential care may be needed in some cases where other care arrangements are not available. An analysis of both systems of care was presented, drawing upon my observations and experience gained through an eleven month placement with an NGO based in Manzini, Swaziland that utilized both residential and community-based strategies for the protection and care of orphaned children.

This report presented a case study on Swaziland and analyzed Swaziland's National Plan of Action for Orphaned and Vulnerable Children, which based its policies, strategies and recommendations exclusively on community-based care approaches. An analysis of the National Plan revealed that many obstacles and challenges exist that may prevent or impede the realization of the goals outlined in the plan. The analysis and challenges presented in this case study were based on information and observations obtained from my work within six residential facilities, housing a total of 160 children, and through working in community-based settings that included weekly visits to Neighborhood Care Points (NCPs), Rural Health Motivators (RHMs) and *Lihlombe Lekhukalela* (Child Protectors), rural health clinics, police stations and homes and schools, as well as from my work reintegrating residential children back with their home communities.

One of the initial challenges outlined in the case study was the fact that there are many different organizations working on behalf of children in Swaziland, each with its

own mandate, expertise and program priority. The overall coordination, monitoring and evaluation of the many partners responding to the orphan crisis, as well as ensuring that sufficient resources and services are provided and are channeled properly to communities and their intended beneficiaries (Levine, 2001) throughout the country was presented as a large challenge the government may face in the near future. Communication and the collection of reliable data to monitor and evaluate program responses in a country such as Swaziland, where the majority of people live in hard to reach rural areas without access to electricity, was another challenge presented in this report. In Swaziland, tradition dictates that children are to be 'seen and not heard.' This may cause many challenges when organizations begin implementing strategies to ensure that all children throughout the country have full participation in all decisions that affect their lives. One of the final challenges that the report highlighted is that the people of Swaziland may have trouble trusting in their government's commitment and ability to reach the goals set out in the National Plan of Action, as many government agencies have been widely criticized in the past for corruption, poor management, unaccountability, unresponsiveness and inefficiency in service delivery to the most needy in the country.

Other challenges presented in this report included the fact that communities, NGOs and FBOs generally have few resources with which to work, most of the existing structures in communities are extremely limited, and poverty is widespread throughout the country (Guest, 2001, p64). These realities coupled with the HIV/AIDS crisis crippling the economic, educational, social and health sectors of the country will prove to be huge challenges for the government in attaining the goals outlined in Swaziland's National Plan of Action for Orphaned and Vulnerable Children. The final challenge

brought out in this report is that Swaziland's national plan of action has not incorporated residential care into its national plan, leaving children within these facilities at risk of maltreatment.

The report concludes that national and international policies, strategies and plans for the protection and care of orphaned children that do not include residential care facilities in their design, leave these facilities un-regulated, un-monitored, and leave many orphans exposed to abuse, exploitation and neglect, ultimately hampering the overall development of future generations.

It is my hope that practitioners, researchers and policy makers will use the knowledge gained from my report as they work to find more appropriate and sustainable strategies to promote the well-being of orphaned children in both Swaziland, and throughout the continent of Africa.

Children who are properly cared for and educated are the basis of prosperous economies and stable states, and are the key to sustainable development for future generations (Smart, 2003). Therefore, the responsibility for ensuring that all children are properly cared for and are protected from exploitation and abuse, lies with all governments, NGOs, UN agencies, civil society groups, FBOs, communities and families worldwide.

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