

Information seeking behaviour of orphans and vulnerable children, caregivers, and the role of service providers in Ohangwena and Khomas regions in Namibia. A preliminary report¹.

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Abstract

One of the main problems in Namibia is how to deal with orphans and vulnerable children (OVC), many of whom are left destitute as their parents succumb to HIV/AIDS. This study addresses this issue by examining the information needs of OVC and caregivers and the information seeking strategies of key stakeholders in managing the OVC situation in Namibia. Both qualitative and quantitative- survey research methods were employed in this study. Questionnaires were posted to various service providers who responded to the questions in their own time, while the interview schedule was used for OVC and caregivers and was adjusted to meet their diverse situations. Focus group discussions were also used for caregivers and informants in order to explore and capture data on the respondents' general attitudes, feelings, beliefs, experiences and reactions, which would not be possible using individual interviews. A total sample of 566 OVC, 70 caregivers, and 19 service providers from both regions took part. Preliminary findings identify largely information access, poverty and resource related problems. The study provides concrete recommendations on how to improve information access and use by the stakeholders that includes, among others, include networking and coordination of activities among the stakeholders involved, provision of information in local languages, registration of organization dealing with OVC, enabling capacity building forums, providing leadership, creating awareness forums and enabling resource support from both government and philanthropists.

Keywords: Information needs, information seeking behavior, vulnerable children, caregivers, service providers, Ohangwena, Khomas, Namibia.

¹ This paper was presented at the 6th biennial ProLISSA Conference, 9- 11th March 2011, Pretoria, South Africa. The proceedings are in a CD form.

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3 1 U.S Dollars equals to 7 Namibia Dollars (N\$) rate as January 2011

1. Introduction and background

The impact of HIV/AIDS is devastating worldwide, particularly in developing countries. It is estimated by UNAIDS 2009 on the Global Aids Epidemic that almost 60 million people have been infected with HIV and 25 million have died of HIV-related causes. This survey also reveals that approximately 33.4 million people are living with HIV, with 2.7 million new infections annually. Further reports by UNAIDS reveal that sub-Saharan Africa accounts for two-thirds (67 %) of people living with HIV. The epidemic in sub-Saharan Africa has orphaned more than 14 million children (UNAIDS, 2009 online).

The Namibia 2010 Sentinel Survey showed a slight increase in the HIV prevalence rate compared to 2008 from 17.8 to 18.8 percent (Ministry of Health and Social Services, 2010:12). The 2010 survey shows HIV prevalence peaks in the age group of 30-39 years with 29.6 percent although the prevalence has showed a decline among the youth (15-24) since 2004 from 15.2% to 14.2 in 2006, 10.6% in 2008 and 10.3% in 2010, more programs on prevention are still needed targeting the risk population especially the youth.

One of the major problems facing Namibia is the issue of orphans and vulnerable children, most of whom are left destitute as a result of HIV/AIDS. It is expected that if the present trend continues, Namibia will have at least 250,000 (10 % of the Namibian population) orphans in the next 20 years, of which over three quarters (3/4) will be children (UNICEF, 2006:5).

Orphans and vulnerable children (OVC) are defined as children between 0 and 18 years who have lost one or both parents and/or whose primary caregiver has died, or who are in need of care and protection (Ministry of Women Affairs and Child Welfare, 2004:1).

In most traditional African social environments, children belong to the extended family. This means that the extended family members are responsible for children when their parents are sick or deceased. However, the extended families can no longer cope with the burden of the pandemic, thus the government, with the help of other social agencies, has to carry the burden. The OVC face a number of problems. Notably, most of the orphans are forced to head households, which means that they take care of their sick parent(s) and siblings. In most cases they don't know where to get help when the need arises. Poverty prevents them from paying tuition fees and school supplies, and in some cases they are exploited and ill treated by their caregivers. Some caregivers misuse the social grants provided by the government for orphans for their own use (e.g. alcohol).

Girls are at a much higher risk of abuse, particularly sexual, at the hands of adult males in society because of their vulnerability. Other children are left in the hands of greedy family members who grab the properties/items left behind by their deceased parents instead of offering support. Many children are taken care of by grandparents who are often left with this enormous responsibility with a meagre pension. (According to National Pension Act 10 of 1992, all Namibian citizens and permanent residents who attained 60 years are entitled to apply for Old Age Grant which is N\$ 500.00 equivalent to U\$ 71.00 per month). In most cases, they lack information on how to access government services that aim to assist OVC and their caregivers. A number of agencies provide different services to support OVC, but it seems the information does not reach them - there is a gap or communication breakdown between the information provider and information consumer. Factual information is very important because it equips a person with power, the power to choose

and to make informed decisions. A study in Botswana on caregivers found that caregivers who were not aware of the different service providers were denied their right to make choices and use services that would help them (Kange'the, 2010:197).

Several models have been identified on information needs and information seeking behaviour in the last three decades some of which informed this study. Among them are Dervin (1986), Ellis (1989), Wilson (1981, 1997), Krikelas (1983 and 1999) and Kulthau (1991) which provide a strong foundation for studying and understanding information needs and seeking behaviour and have relevance in the information seeking behaviour of OVC, caregivers and service providers. As Jarvelin and Wilson (2003:3) point out, models help researchers formulate hypotheses and theories by identifying the research problems at hand. We use Wilson's model of information seeking behaviour that we found suitable for this study.

Briefly, Wilson model of information seeking behaviour was developed over a considerable period of time, with the first version published in 1981. This model describes the need for information and the limitations that may prevent the person from taking action to seek information, with an emphasis on the results of searching, i.e. success or failure and the level to which the need is satisfied (Case, 2002:128). According to Wilson (2005:31), the model consists of the information seeker, the system employed or intermediary which the person uses to search for information, and the information resources that might or could be used by the seeker to get the information. The model underscores the importance of the personal, social and environmental roles that stimulate the need for information. Because of environment and social factors such as poverty, long distance from one service provider to the next, it is difficult for OVC and caregivers to access information.

1.2. Origins of orphan hood

The phenomenon of orphaned children in Africa and their multiple and complex needs is complex and disturbing.

UNICEF (2005:67) observes that children do not need to have HIV/AIDS to be devastated by it. When HIV/AIDS enters a household by infecting one or both parents, the very fabric of the child's life falls apart. Around 15 million children under the age of 18 had been orphaned by the pandemic by the end of 2007. In sub-Saharan Africa, the epidemic has orphaned more than 14 million children (UNAIDS, 2009 Online).

The 2001 Census indicated that Namibia has more than 97,000 orphans up to the age of 15 (the next census will take place in 2011). However as already mentioned elsewhere, it is estimated that if present rate of infections continue, by 2021 the country will have over 250,000 orphans. It was estimated in 2004 that about two-thirds of all orphans were orphaned by AIDS. The projected figures for the year 2010 showed that Namibia would have 156,000 orphans, 118, 000 having been orphaned by AIDS (Foster, 2004:24). With the number of orphans rising, the number of child-headed households has also increased (UNICEF, 2005:4; Ruiz-Casares, 2007:154).

Elderly women are the primary caregivers of orphans in Namibia (Edwards-Jauch, 2010:43; Mnubi-Mchombu, Ocholla, Mostert 2009). This means that they are responsible for all the needs of OVC, in most cases with meagre resources. If the caregivers are sick, stressed or

poor, the wellbeing of the OVC as the dependants is directly affected. Rose and Clark-Alexander have suggested that more studies are required to identify the information needs of caregivers, particularly their coping strategies and methods to provide care and support. They noted that eighty percent of their population used prayer as a coping mechanism (Rose and Clark-Alexander, 1998:62)

In Namibia, the geographic distribution of orphans reflects the pattern of HIV/AIDS prevalence in the country. As Watson quoted in the Edwards-Jauch (2010) report, the regions with the highest orphan populations are Ohangwena, Oshikoto, Oshana, Omusati, Caprivi and Kavango. These regions account for 50 % of the Namibian population and also generate more than 50 % of the country's orphans (Edwards-Jauch, 2010:37). These places provide temporary stopping places for mobile population along the highways to neighbouring countries.

Several writers have observed that most OVC live with their extended families. However there is an increase of orphans in households headed by grandparents and older siblings, and increases in street children, households with orphans from two or more families, working children and school drop-outs. Food insecurity and reduced access to health services are further clear indications that the extended family system is under strain (Foster and Williamson, 2000; Ntosi, 1997; Masabane, 2002:6).

The physical and mental wellbeing of OVC depends on their caregivers. Kang'ethe (2010:194) defined two types of caregivers, the primary caregivers who include immediate family members, and community caregivers or volunteers who move from house to house.

It is very important for the primary caregivers to know where to access different services in order to assist OVC. A number of researchers (Foster, 2004:64; Barnett and Whiteside, 2006:227), for example, have suggested that the first line of support for vulnerable children is their family, including the extended family and distant relatives, while households that struggle to meet the needs of vulnerable children may be assisted by members of their community.

These informal safety nets are responsible for the care and support of the majority of vulnerable children in Southern Africa. Formal mechanisms, such as those provided by government and civil society, also provide services, especially for children living in situations of extreme vulnerability (Foster, 2004:64; Barnett and Whiteside, 2006:227)

1.2.1 Service providers in Namibia

Through the work of service providers who come into regular contact with OVC, such as social workers, community workers and health workers, these children manage to get some form of assistance.

Service providers play a very crucial role in linking children and caregivers to the relevant authorities, providing assistance on various aspects, and providing them with useful information. A study done in South Africa identified a number of methods showing how teachers can detect vulnerable learners in their schools and connect them to service providers for assistance. These include using essays to ask children to write about their personal experiences; introducing 'post-boxes' at school where children can anonymously post letters

to teachers about anything they want the school to know; introducing 'communication books' for children to take home so that caregivers can communicate concerns about the child; using drawings and other forms of expression to find out more about the children's experiences and how they cope; and holding regular meetings to provide information and support to children's caregivers. During the latter sessions, the study notes, different service providers come to school to talk to caregivers on how to get help (University of Cape Town and Children's Institute, 2006:4)

The same study by the University of Cape Town and Children's Institute (2006:6) found that many families in South Africa struggle to access government grants that aim to help poor families care for their children because they don't know about them, lack the necessary documents, or can't get to the welfare offices (University of Cape Town and Children's Institute, 2006:8).

Barnett and Whiteside (2006:225) also noted that grandparents are often ignorant of how, or lack the energy to go to school and defend their wards, or at least enable them to get a fair hearing and treatment in cases involving insubordination to school authorities (Barnett and Whiteside, 2006:235).

Lack of information among old caregivers also prevents them from accessing fully the services tailored to help them and the children.

2. Research problem

The literature reviewed above reveal the seriousness of HIV/AIDS pandemic in Namibia and one of its main outcomes namely the large number of orphans and vulnerable children who need care and proper upbringing. It is also clear that the traditional way of taking care of orphans, namely the extended family system can no longer cope given the huge number of children in need of care. The country faces a major challenge in managing orphans and vulnerable children (OVC) to ensure that the children are taken care of. Attempts have been made to meet the basic needs of the OVC by various stakeholders in the provision of shelter, food, school uniforms and grants. As Father Bauer of Catholic Aids Action (2010:18) commented, children affected by the HIV pandemic in Namibia have different needs for positive development and health. However, a gap that still exists is the provision of adequate information to both the OVC and their caregivers in Namibian society to empower and enable them to better their lives, given that access to information not only a human right but plays a critical role in decision making. Although there have been several studies done on several aspects of the OVC situation, no study has been done on the information needs and seeking behaviour of the OVC and their caregivers and how OVC satisfy their information needs at present in Namibia.

This study therefore seeks to address this gap by examining the information needs of OVC and their caregivers and the information seeking strategies of key stakeholders in managing the OVC situation in Namibia. The aim of the study is to determine how OVC and caregivers seek and use information that empowers them in different aspects of their lives. The research objectives of the study were: i) To determine the information needed by OVC to help them cope with their situation;

ii) To establish the information needs of caregivers (institutional and non institutional) dealing with the OVC in Namibia; iii) To identify sources of information used by OVC and caregivers to address their needs; iv) To determine the channels used to obtain and transfer information by both the OVC and the caregivers; v) To identify information gaps and suggest ways of addressing these information gaps; vi) To determine the impact and usefulness of information sources and services; vii) To establish the problems that caregiver service providers experience when accessing, disseminating and sharing information; and viii) To provide recommendations and develop a model of what information systems need to be in place to address the OVC situation in Namibia.

3. Methodology

In this study, both qualitative and quantitative research methods were used. A survey method was applied through questionnaires posted to various service providers who filled in the questions at their own time, while the interview schedule was used for OVC and caregivers and was adjusted to meet their diverse situations. The target population in this research was orphans and vulnerable children, caregivers and service providers. OVC and caregivers living in Windhoek and Ohangwena were selected because Windhoek represents an urban setting while Ohangwena represents a rural setting. Ohangwena is the third poorest region in Namibia, with a human poverty Index (HPI) of 31 percent after the regions of Caprivi and Omaheke, which have HPI ratings of 36 and 32 percent respectively (New Era, 2009). This is in contrast to the Khomas region where the majority of the population lives in urban areas and depends on wages and salaries as their source of income. Khomas has 93 % of its people living in urban areas while 7 % live in rural areas. It has a total population of 250, 262, of which 123, 613 are female and 126, 648 are male. The main languages spoken are Oshiwambo, Afrikaans and Nama/ Damara (National Planning Commission, Republic of Namibia, 2007:5). The target research population for the study was OVC between the ages of 8 - 18 years, their caretakers, and service providers in Namibia. Caregivers in this survey included individuals who were providing direct care to the OVC. These include grandparents, counselors, traditional leaders, relatives, friends, neighbors, teachers and parents (single parents). Service providers included organizations, agencies, non-governmental organizations (NGOs), community based organizations (CBOs), faith based organizations (FBO), government departments, international organizations, and institutions.

According to Struwig and Stead (2001:109), obtaining information from a sample is often more practical and accurate than obtaining the same information from the entire universe or population. This study was carried out in Namibia, which has a population of 1.8 million people. A purposive sample was used to select OVC who were 8 -18 years, single and double orphans, girls and boys, and caregivers who were taking care of one or more OVC (grandparents, child-headed households, counsellors, traditional leaders, teachers). It was impossible to list all the OVC and caregivers and sample randomly from a list. Instead, social workers, traditional leaders, teachers and church leaders were used to identify a sample of respondents in Ohangwena and Windhoek for inclusion in the study. The aim was to include a representative sample from the OVC and caregivers in both urban and rural settings. The snowball sampling technique was used to locate informants by asking respondents to identify individuals or groups with a special understanding of the topic being researched. We asked respondents to recommend any other persons who met the criteria of the research and who might be willing to participate in the project. The snowball technique was chosen because there was no master list from which to draw a sample, thus it was difficult to achieve probability sampling. Furthermore, some families that were taking care of AIDS orphans

did not want to be exposed because of the stigma associated with the disease. As there was no authoritative list of service providers, the snowball technique was also used to choose the organizations/ departments (government departments, NGOs, community based organizations, faith based organizations, and traditional leaders). This means that major organizations/ departments that dealt with OVC in Khomas and Ohangwena were contacted and asked to nominate other contacts who were appropriate to include in this study. The organizations/ departments that were nominated were contacted telephonically and via email to find out whether they qualified for inclusion in the study and if they would be willing to participate. The criteria for participation for organizations/ departments included those that provided services like healthcare and nutrition (food provision/ school feeding programs; ARV therapy; referral services); educational support (providing school uniforms, school funds, fees exemptions, training skills); psychosocial and counselling support (after school programs, kids clubs, counselling); financial support (bursaries, social assistance grant, supplies); legal protection (litigation/ legal services); life skills (HIV/AIDS awareness) accommodation (places of safety/homes); spiritual support; material support (clothes/ blankets) and other support like home-based care, income generating activities, or condom distribution. For the sampling size, this study used a sampling ratio of 2.8 percent (368 OVC) for Ohangwena and around 3 % (198) for Khomas. The 2.16 percent was thought to be adequate because of the difficulties in accessing OVC and caregivers due to the lack of an authoritative list of names which would have served as a sampling frame. It was believed that the number would provide reliable information that would represent OVC in the rural areas and urban areas. The study included 655 respondents (368 OVC from Ohangwena and 198 Khomas), 70 caregivers (51 Ohangwena and 19 Khomas) and 19 service providers (9 from Ohangwena and 10 from Khomas). The figure for caregivers and service providers was determined through discussion with experts in the Ministry of Gender and Child Welfare. As there was no authoritative service provider's directory or a caregivers list that could be used to select them for the study, the snowball technique was used to select the caregivers and service providers. A large number of the service providers were concentrated or based in Khomas, and a few of them had branches in Ohangwena. This was also observed in a research study by Badcock-Walters and others (2008), who found that service providers are few and far between in rural areas (Badcock-Walters et al., 2008:5). Thus all service providers were included in the sample by sending the questionnaires to all those dealing with OVC and caregivers. The total sample is presented in Table 1.

We combined interviews, questionnaires and focus group discussion in order to get a broader picture of the behaviour of the OVC and caregivers in searching for and using information. Structured interviews were used for OVC and caregivers to determine their information needs and information-seeking behaviour; focus group discussions (FGD) were used for caregivers and informants to determine their views, attitudes and thoughts; and mailed questionnaires were used to gather data from service providers. The reason for using interviews and FGD was because the OVC and caregivers were assumed to be semi-literate. The mailed self-administered questionnaire was cost effective in collecting information from service providers who were geographically scattered and literate to the extent that they were able to complete the questionnaire unaided. The quantitative technique was used in order to produce more valid and reliable results by establishing cause-and-effect relationships. It was also used to measure variables, test hypotheses and produce information.

4. Preliminary findings

The findings are covered under items 4.1 to 4.7

4.1. Information needs

Most of the OVC intimated that they sometimes needed more information to cope with the challenges in their daily lives in both Ohangwena (90 %) and Khomas (84 %).

It was observed in the study that the older the children, the more information they needed in both rural and urban areas. This may imply that service providers need to work hand in hand with children to address their information needs. According to Usdin (2003:131), effective measures to protect children include access to information and programs at the right time to help them make the right decisions. Such information includes information about contraceptives, gender, HIV/AIDS and sex, which is very crucial in encouraging life-saving habits. One of the daily newspapers had a story of a seventeen year old boy from Ohangwena who thought that people get HIV from dogs. He decided to join a youth club (organized by Development Aid from People to People in Ohangwena) to get the truth on the causes of HIV and how to protect himself (The Namibian, 2010:6) This is a good example of how NGOs can work with the youth to provide information and eliminate ignorance.

OVC in the rural areas needed information on financial assistance or grants followed by tuition/school fees exemptions, child care support and feeding schemes. In urban areas, school fees exemptions were very important, followed by financial assistance or grants, child care, and feeding schemes. Data shows that both rural and urban children are faced with the same problems, with slight differences in their first choice. The same trend emerged in Okahandja where financial assistance, information on school development fund exemptions and child care support was considered important (Mnubi-Mchombu, Mostert and Ocholla 2009:42). Studies by Sasman in Namibia (2008:6) and De Witt (2007:77) point to how OVC go to school without stationery and toiletries, and how teachers have to assist them. They can't afford to pay N\$100 (around U\$14) in school development fund . As a result of poverty, most OVC in urban and rural communities need more information on economic survival related issues such as financial support and school development fund exemptions. Data from the caregivers in Ohangwena, showed that feeding schemes topped the list, followed by information on transport to collect medication, information on how to register their grandchildren to get grants, and the availability of training opportunities. Respondents from Khomas also had similar suggestions, citing information on feeding schemes as important.

Findings from the caregiver focus group discussions in both Ohangwena and Khomas identified educational support as one of their main priority areas. Caregivers in Namibia face a lot of economic hardship. Bronson et al. (2006:2) found that caregivers in Namibia were not able to pay for school fees and uniforms or to purchase food, and could not access health services due to high costs and other related problems. They also observed that 89 % of their population of caregivers were relying on regular hand outs of cash and material goods.

According to the National Planning Commission (2003), the poverty level in the Ohangwena region was very high compared to the rest of the country. Edwards-Jauch (2010:31) also confirms that Caprivi and Ohangwena are the poorest regions in Namibia, with the highest level of AIDS-related deaths and a high orphan population.

Another issue raised in the focus group discussions by caregivers was psychosocial or counselling support and discipline. Some caregivers don't know how to take care of OVC, especially with respect to psychosocial support and counselling skills. The emotional trauma that these children face has also been raised by some writers.

Lack of adequate social workers makes it difficult for the caregivers to get assistance. According to Ikela (2010:4), Namibia is faced with an inadequate number of social workers to cater for the psychosocial needs of orphans and vulnerable children. A study done in Botswana (Kang'ethe, 2010:197) and South Africa (Moses and Meintje 2010:111) on caregivers suggests that many caregivers are poorly informed about the availability of service providers. Such information is crucial for them to seek assistance and make decisions.

The Namibian government policy on OVC recognises the need to protect and care for the children by providing them with health care, economic opportunities, basic needs and psychosocial support (Ministry of Women and Child Welfare: 2004:4). Training caregivers can help improve the quality of life of OVC. This is even more important when caregivers are too young or too old to properly care for the orphaned children. Kumar, Aarti and Arabinda (2001:20) identified the following needs: basic knowledge of HIV; children's emotional needs and how to address them; health problems like symptoms and signs of medical problems; nutritional requirements; methods to combat stigma and discrimination directed at the child or family; how to access different services like grants, identification documents; and counselling (Aarti and Arabinda, 2001:20). The last point raised by the focus group in Ohangwena was job opportunities. Caregivers felt that their children, especially those who finished or failed grade 10 and 12, needed to pursue job opportunities. It was mentioned in the FGD that some job announcements did not give sufficient time for the candidates to gather all the relevant documents.

In Khomas, caregivers in the focus group also identified educational support as a priority area, followed by information on how to establish small businesses. Most of the caregivers (56 %) in Khomas were young women between the ages of 33 to 40. They were active and eager to establish small businesses in order to alleviate their poverty. As the National Planning Commission (2007:5) reveals, Khomas is a fast growing region to which a number of people migrate in search of greener pastures. The government alone cannot assist the caregivers. This calls for a combined effort from both government and civil society. A study by Rosenberg et al. (2008:51) on government-NGO collaboration and the sustainability of OVC in Southern Africa found that NGOs can assist by helping governments realize their missions of providing social grants to the targeted groups. In their study, one academic institution was funded to improve caregivers' ability to access grants and healthcare information.

Service providers in this study also suggested that the type of information that is useful in rural areas for OVC and caregivers includes information on where they could get additional food, how to apply for grants, and how to get birth certificates. A few service providers suggested that caregivers needed to know the procedures of how to get exempted from paying school development funds. In Khomas, service providers pointed out that information on how to apply for grants and birth certificates and how to get additional food was important. According to the service providers in the study, topics which are useful for OVC and caregivers include psychosocial support and the need to revise the policy regarding

school development fund so that procedures should exempt caregivers. This partly illustrates the service providers' lack of information because the policy exempts OVC from paying school development fund. And lastly, it was suggested that information on how to acquire identity documents and how to take care of OVC is important. In Khomas, service providers felt that the policy regarding school development fund exemptions procedures should be clarified for caregivers to understand.

The responses received by caregivers and service provider's show some level of consistence. Information on feeding schemes, school development fund exemptions and grants all emerged, with food being higher in the rural research site of Ohangwena.

4.2. Sources of information

The information sources mostly used by OVC in Ohangwena were the radio, followed by friends, relatives and teachers. A few respondents cited newspapers as their source. In the Khomas region, the study found that radio was also a popular source, followed by television and friends or relatives. We note that radio continues to be a reliable source of information in rural and in urban areas. Television became the second source of information in urban areas. Julien (1999:38), Branch (2003:50) and Valenza (2006:21) all suggest that young people lack information seeking strategies because of lack of awareness of different sources of information. These researchers found that too many sources confuse young information seekers. Data from this study showed that most of the OVC (57 % Ohangwena) and (54 % Khomas) were 13 - 17 years of age. They were therefore still young and inexperienced, and perhaps didn't know how to access different sources of information, apart from using the radio. Data from various focus groups indicated that traditional leaders, friends and councillors were mostly consulted. A few groups mentioned that they sometimes consulted teachers. However, there were also many respondents that had no one to consult, and thus seemed to be isolated when battling with the numerous challenges and problems of helping the OVC.

A study by Wilson (2006:661) concluded that an information user can use various sources of information to satisfy his/her needs. The pattern in this study is, to some extent, in accordance with Wilson's findings. The data from the respondents suggests that in Ohangwena and Khomas, traditional or community leaders, friends or family members and councillors are among the most consulted people by caregivers.

4.2.1. Knowledge about organizations

Data on knowledge about organizations indicates that other sources were used to access information for identifying who are the service providers in Ohangwena. The identified service providers include Red Cross volunteers, TCE Volunteers, newspapers, regional councillors, church leaders and Child Line officials. In Khomas, friends/ relatives/ neighbours were the first source of information, second choice was the category of others (church leaders, volunteers, newspapers and Hon Minister Mugunda), and radio was third. In urban and rural areas, the use of oral communication by OVC was very popular. This (means) implies that the use of volunteers by service providers might help to create awareness about service providers. Findings from the study show that the radio featured prominently as one reliable source used by caregivers to receive their information about

organisations, followed by friends and relatives, and a few social workers. In the Khomas region, friends and relatives were the first priority (7; 37 %), followed by the radio (4; 21 %) and social workers, with a few opting for the community library. Caregivers in the urban area seemed to have more sources of information compared to the rural areas, which is not surprising given the richer urban information environment.

In the focus group discussions, most participants revealed that friends/ relatives/ social workers/ church leaders/ teachers were their main sources of information, followed by radio/ newspaper/ television and regional councillors. In some cases, respondents could not link the assistance they got to a specific organization. The study found that for most respondents, it was important to get the services, no matter who provides the service. This highlights the respondents' desperation in the face of poverty.

4.3. Channels of information

The findings on OVC respondents show that the radio was the most favoured channel of information in Ohangwena, followed by newspapers, church leaders, regional councillors, and traditional leaders by a few. In Khomas, television was the most popular channel of information, followed by radio, newspapers and books. Libraries were among the least favoured channels. The trend again shows predominance of both personal and mass media sources, but it also suggests that the number of channels mentioned is much wider and varied, perhaps showing the richer information environment found in urban areas. A study by Badcock-Walters et al. (2008: 28) supports these results, stating that learners were using both personal and media sources while schools had very little information about services.

In Ohangwena, the findings indicate that community radio was a powerful channel of information among caregivers, followed by regional councillors and traditional leaders. Social workers and traditional leaders were only mentioned by a few respondents. In Khomas, for most respondents, radio was the first choice, followed by TV and newspapers. Church leaders and regional councillors were the third and fourth choices. The caregivers' responses reveal that the radio was the most used channel of information in rural and urban areas to get information. This is in contrast to a study by Momodou (2002:409) which took place in Nigeria, where most people preferred informal channels (such as word of mouth), especially the illiterate. A study by Kaye (1995:422) observed that even managers who sought information preferred oral sources from a colleague or friend. A study in Uganda noted that the availability of appropriate materials was a problem and not the illiteracy level. The author argued that the level of literacy is not a barrier to access to information, the problem being the unavailability of simplified materials with less technical terms that could be understood by school going children and women (Musoke, 2007:306)

43 % of the service providers were using open forums, traditional leaders, regional councillors, and meetings to communicate their services. Kaye (1995) "Sources of Information, Formal and Informal 29 % were using volunteers to make house to house calls and communicate with the community members. Only a few were using radio and television. In Khomas, most (33 %) of the service providers were using volunteers who moved from house to house, followed by 27 % who used newspapers, brochures or printed media, while only 20

% were using radio and television. Again, there is a mismatch of the channels used by service providers and the preference of target groups, as findings have already indicated that the radio and TV were popular channels used by OVC and caregivers to get information in rural and urban areas.

4.3.1. Effectiveness of the channels

A few service providers in the survey indicated that the channels were not effective because not many OVC were coming forward to receive the services. They also pointed out that the community was scattered and they did not have the transport to reach everyone. The material/ information also need to be translated into local languages (like Oshiwambo). One organization commented that the radio was the most effective channel because a lot of people listen to the radio. In Khomas, respondents also recommended the use of volunteers (44 %), as in Ohangwena. While the remaining 44% admitted that the channels were not effective, again only one organization suggested that the radio and television were very effective channels because the majority of people listen to the radio. Most service providers used volunteers who move from house to house; radio and TV were not used often due to the cost element. As a report from UNAIDS (2004:6) notes, service providers face challenges like inadequate funds and lack of technical skills and human resources. This may imply that even if radio and television are effective channels, most service providers simply cannot afford to use them to market their services.

4.4. Information dissemination by service providers

The majority (70 %) of the service providers in Ohangwena said that they used meetings or forums to create awareness about their services. This includes community meetings, traditional authorities, churches, school meetings, workshops and home visits by their volunteers. 10 % of the respondents were each using printed materials; TV and radio; and posters and adverts. In Ohangwena, service providers used community forums to create awareness about their organisations, but most OVC and caregivers used the radio to get information. This might be because it is cheaper to use community forums than radios. Most organisations operating in Ohangwena are NGOs and FBOs with tight budgets that limit their publicity services. The service providers need to learn skills on how to create awareness about their activities and services. In Khomas, the majority of the service providers stated that they used meetings and forums, similar to Ohangwena (40 %), while 20 % use printed materials, TV and radio. A few respondents (13 %) said that they used posters, adverts, drama, songs and OVC camps to create awareness about services. The service providers in urban areas are more skilled in using multimedia to create awareness of their services. In contrast, OVC and caregivers in the study were using friends and relatives to get information. This suggests a mismatch between the service providers and the targeted groups.

4.5. Information services that was useful

Data indicated that the most important information required by OVC in both urban and rural areas was similar. School/tuition fees exemption was the first priority and financial assistance and grants came second. The third choice was a bit different across the two regions; in Ohangwena, health services were third on the list, while in Khomas child care or support came third. The fourth most important information required by Ohangwena's respondents

was child support, while in Khomas it was health services. The fifth choice for Ohangwena was training opportunities while in Khomas it was counselling. Most OVC in rural and urban areas are faced with poverty and can't afford to pay school development fund. Unfortunately, they are not aware that they can apply for an exemption. A few who know the procedures for applying for exemptions are refused permission by the head teachers or principals. The study found that some principals demand that caregivers pay for school development fund if they receive grants from the Ministry of Gender Equality and Child Welfare. School development fund can therefore prevent a child from a poor household from accessing education even while maintaining the facilities offered at the school (Hancox, 2010:7).

4.5.1. Why information was useful

Data from the caregivers interviewed at Ohangwena indicated that information they received was useful because it enabled them to register their children to get grants, food, blankets and clothes. A few respondents were able to get financial assistance, register with Red Cross, obtain birth certificates, and obtain information on how to handle their children, send their children to school, and get medical attention for their children. In Khomas, respondents provided similar responses, citing information on how to handle their children, how to get birth certificates, and how to use the grants effectively. Some respondents managed to register their children with the Ministry of Gender Equality and Child Welfare to get grants, while a few obtained financial assistance. This shows the importance of the resources and services in terms of the assistance they provide to caregivers.

4.6. Problems faced by OVC and caregivers in accessing information

The study findings show that OVC from urban areas were facing more problems when accessing information than the OVC in rural areas. This might be because of the many service providers available, which causes the children confusion. The focus group discussion in Ohangwena indicated a number of problems, such as: radio announcements on job opportunities do not provide enough time for job seekers to obtain all the relevant documents in time; distance was also mentioned - it was difficult to get information from various service providers because of the distance between one agency and the next; and lack of relevant documents such as birth and death certificates, which prevents them from accessing important information on grants from the Ministry of Gender Equality and Child Welfare.

It was reported in a local daily newspaper that only 26 % of births are registered in northern Namibia. Thus a number of OVC do not have birth certificates that would help them benefit from the services targeting them. According to the 2006 statistics, there were 250,000 OVC, with only 95,000 accessing child welfare grants (New Era, 2010:3). A study by Cluver and Orkin (2009:1190) in South Africa also found that programmes aiming to reduce child hunger are not reaching all the targeted members due to a lack of birth and death certificates. The key informants in Ohangwena pointed out that the caregivers cannot access information because they are illiterate. However in this study, data shows that 44 % of respondents had achieved grades 8-12, although there were 21 % with no formal education. In the focus group discussion, 14 % of the respondents said that they'd never gone to school. This would partly explain why they could not access printed information and the high preference for oral sources of information.

The informants in Ohangwena also pointed out that the lack of representation of children in OVC forums denies them access to information. Most OVC in Ohangwena are taken care of by grandparents. Grandparents are often too old to attend meetings, and in most cases depend on information given by their grandchildren. In the Khomas region, participants indicated various reasons that prevented them from accessing information including alleged corruption and tribalism; language barriers; and hunger – “if you have empty stomach it is not easy to move around” as was said by one respondent.

In the rural areas, distance was the main stumbling block. The introduction of mobile services like the one introduced by the Ministry of Home Affairs to register and distribute identity documents is very important. It might be a good idea for the government to build related offices nearby in order to reduce the movement of people seeking services. The informant in Khomas revealed quite plainly that some organisations are located too far from the community to access them or their information.

There is also the stigma attached to people who try to access services from NGOs dealing with OVC, particularly those who are HIV positive or associated with HIV positive family members. A study in Botswana found that because of stigma and discrimination directed at HIV/AIDs caregivers, some of them were hiding their clients by taking them to service providers that were far away from their village (Kang’ethe, 2010:198). Some caregivers are illiterate and have no access to radios or TVs, and depend on friends and family members. Although in this study only 5 % of the respondents had no formal schooling, the majority (79 %) had achieved grades 8 - 12. It can therefore be assumed that most of them can read and write. Lack of skilled social workers and limited resources by many NGOs prevents them from providing information to the intended audience. As Ikela (2010:4) noted, there was a dire need for social workers to attend to the psychosocial needs of OVC in Namibia.

4.6.1 Problems faced by service providers when disseminating information

More than half of the respondents in Ohangwena indicated that distance and too much flood water during the rainy season prohibited them from disseminating information properly. The main problems were lack of transport and long distances from one area to the next, and the need to translate information into local languages. In the Khomas region, local languages and transport were also cited. Two further problems were when the wrong information is passed on to the beneficiaries, and poor coordination among service providers. Almost all NGOs depend on financial assistance from donors. If they don’t have support, they can’t work effectively, for example by using radios to announce their programs or translating material into different languages.

Shaanika (2010) notes that a community-based organization, the Tutekula Children’s Organisation, is currently operating from an informal corrugated iron sheet structure which was handed to the children by one of the donors. At the time of this study, the project was on the look out for additional funding to build a centre which will take care of 720 children in Omafufu, Ohangwena. This is a typical example of how NGOs are struggling to get funds to assist the OVC.

4.7. Suggestions on how to improve information flow

The respondents offered several suggestions on how to improve the flow of information. In Oshanaana, it was suggested that there should be improved networking between service providers for OVC and caregivers with the MGECW. This includes the establishment of a database of OVC that can be accessed by all service providers. Respondents also emphasised the issue of coordination, i.e. knowing who provides which service and working together as a team at community and regional levels. This includes planning activities together in order to avoid duplication of efforts. For example, organizations that provide the same services should meet on a regular basis to share their achievements and problems or challenges and find solutions. Another suggestion was to provide traditional authorities and teachers with information on the availability of services because they deal with OVC on a daily basis.

In Kunene, respondents suggested that information should be distributed in local languages. This means that all printed material targeting OVC and/or caregivers needs to be translated. The issue of coordination was also raised in Kunene. All organizations working with OVC have to be registered with the MGECW so that they know each other. These caregivers need to receive training on how to work with OVC because some of them take care of OVC in order to get money (as a business) and not out of love for the children. Some caregivers were said to take the children even if they didn't know how to care for them, as long as they pocketed some money. Respondents from Kunene also suggested that OVC forums must be active but under the leadership of people other than social workers who are overloaded with responsibilities and at times not available in some places. Awareness forums should also be used to allow community members to seek clarity and organizations to understand the dynamics within the various communities. One respondent also suggested the need to register all OVC with disabilities in each constituency so that they can get services. The National Federation of People with Disabilities in Namibia should also disseminate information concerning the special needs of OVC with disabilities.

The respondents also gave an example of some organisations like the Aids Care Trust which introduced its program to the children during their school holidays in order to empower them with information. Lastly, the respondents suggested that more donors should be involved to support the capacity building of people who are working with OVC. They cited the need to sponsor social workers because Namibia lacks skilled workers to assist with psychosocial support.

5. Conclusion

We note that information access and provision is a crucial resource for OVC and their caregivers for informed decision making and service delivery. Although there was significant duplication of information received from source, channel, dissemination and services related questions, it was possible to identify crosscutting challenges. The main challenges facing information access and use are: illiteracy, capacity building to enable information access to the stakeholders, proper records management, timing of information services, language, and increased resource support to reduce poverty and dependence. Also enabling access to services closer to the community is

crucial. We find it useful to give attention to recommendations made on how to improve the flow of information to the target population. Among the recommendations were: networking and coordination of activities among the stakeholders involved largely in order to avoid duplication, provision of information in local languages to increase access, registration of organisation dealing with OVC, enabling capacity building forums, providing leadership, creating awareness forums and enabling resource support by both government and philanthropists. We note that more work is required to establish the role of mobile phones in information access and use by this community and the technology is increasingly popular in Namibia.

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