



**What role can public libraries play in providing information to women caregivers of orphans and vulnerable children (OVC) in Namibia?**

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**Abstract:**

*The paper is based on the findings of a study carried out in northern Namibia and Khomas Region in 2009. The study had a sample of 70 caregivers, who were interviewed and involved in focus group discussions. The key findings indicate that caregivers include OVC in Namibia have a range of information needs which include - educational support, feeding schemes, financial assistance/grants, counselling and income generating activities. The information seeking behaviour of caregivers is mainly based on an oral information system making use of both interpersonal channels and the mass media. The identified information needs and seeking behaviours of caregivers which are influenced by the poverty environment in which they live provide the base from which the paper proposes how Namibian public libraries can be redesigned to respond effectively to this disadvantaged group of users.*

**Keywords**

Caregivers; Women; Public Libraries; Namibia; and Information Needs

## **Introduction and Background**

### **The Impact of HIV/AIDS**

Namibia is one of the countries in sub-Saharan Africa which has been severely affected by the HIV/AIDS pandemic. The Ministry of Women Affairs and Child Welfare (MWACW) (2010) estimated that on average, 18.8% of Namibians are HIV positive, and an average of 5,000 deaths occur each year due to HIV/AIDS related complications. HIV/AIDS affects all aspects of the socio-economic system of a country. Not surprisingly, the most affected is the health care system, which means more doctors, nurses, beds, medicine and equipment are needed, meaning that more money is needed for health-care. The consequences for the citizens has also been serious as life expectancy has declined by 60 – 43 years, human resources/experts and breadwinners are lost, more money is needed by families to pay medical costs. In the context of this paper, many young mothers and fathers have perished leaving behind a big population of orphans and vulnerable children.

The growing population of OVC requires upbringing and care which stretched to breaking point informal networks and formal safety nets (El Obeid et al., 2001:4 1; Kauffman and Lindauer, 2004:97). This social reality has brought to the fore the role of caregivers of OVC in society and the need for strong support structures including provision of relevant appropriate information and usable information.

A study by UNICEF (2003: 5) confirmed that the spread of HIV/AIDS affects families through the loss of breadwinners, which means reduced income and savings, and less food production which may result in food insecurity. The children may be taken out of school to save resources and to care for the sick parent(s).

The emergence of child-headed households has become a new trend as a result of HIV/AIDS. Children's are left to take care of themselves under the guidance of the oldest sibling among them. Kelly (2005:9) refer to this as a new structure of child-headed or sibling households, while Uys and Cameroon (2003: 177) term it child "parentification" when a child take care of a sick parent(s) or siblings.

People who are affected and infected often suffer from stigma and discrimination in their community which is fuelled by fear and ignorance about how HIV/AIDS spreads and how it can be controlled. Children and women who experience the illness or death of their loved ones are often subjected to abuse, exploitation, abandonment and resulting in social trauma and various forms of social exclusion.

Due to the unavailability of a cure, prevention through behavioural change is the only prevention strategy which can play a vital role to reduce the spread of HIV/AIDS in the country. HIV/AIDS decimates the most productive members of society - those in the age group from 15-49 years with women and girls particularly vulnerable because of biological and cultural reasons. This result is an increase of poverty in families, and reduced production in all sectors of economy, and has reduced the considerable development gains achieved since Namibia's independence in 1990. The impact of HIV and AIDS on organizations performance includes: increased absenteeism, increased staff turnover, loss of skills, loss of institutional memory and a decline in morale (MoHSS, 2007:5, Directorate of Special Programs, 2007:2) Based on these impacts, it is almost certain that the government will fail to meet its National Development Planning (NDP) objectives and may fail to achieve the Millennium Development Goals.

## **HIV/AIDS and Orphan hood**

As already pointed out, there is an increase in the number of OVC resulting from the escalating HIV pandemic in sub-Saharan Africa. Van Beelen (2007:1) has estimated that the number of orphans from all causes will approximately be 50 million within the next few years. The most affected area is currently southern Africa, where one third of the children living in this area have already lost one or both parents. This is corroborated by UNICEF reports (2006:2a; 2006:3b) on sub-Saharan Africa, which indicates that AIDS is the major cause of death among the age groups 15-59 years resulting in the high orphan rates. Sub-Saharan Africa is currently the home of over 48 million orphans, 12 million of them orphaned as a result of the AIDS pandemic (UNICEF 2006 a 2006 b).

Although the figures of the number of orphans differ from one source to another, the important point is the big number of orphans in sub-Saharan Africa which is a great concern.

## **OVC Situation in Namibia**

The increasing number of OVC in Namibia is aggravated by the deaths of young adults due to HIV/AIDS. Namibia is one of the countries which has been seriously affected by HIV/AIDS. The Ministry of Women Affairs and Child Welfare (MWACW) (2003:1) noted on average, 23% of Namibians aged 15 to 49 are HIV positive. The life expectancy has decreased from 60 years in 1990 to 43 years in 2001 (Ministry of Women Affairs and Child Welfare, 2003:1).

In 2001 there were 156,000 orphans between the ages of 0 to 18 in Namibia. By 2004 about two-thirds of the orphans had become orphaned because of AIDS. It was estimated that the number of OVC in 2007 was 117,000 and an additional 11,000 was projected each year (Ministry of Gender Equality and Child Welfare, 2008; Bause, 2009:5. Given current trends, it is projected that by 2021 there will be 250,000 orphans under the age of 15 which will be approximately 10% of the total population or a third of the population under the age of 18, with the number of child-headed households also increasing (UNICEF 2005 a:1, UNICEF, 2005 b: 4; UNICEF, 2006a:5 , UNICEF, 2006b: 16; MWACW, 2003:1)

OVC in Namibia face a number of problems. Very often parents do not write wills specifying who will inherit their property and take care of the children. Several researchers (Van Dyk 2005; UNICEF 2006 Kapenda 2007) found that after the death of the parent(s), children often lose their family property, including their identity documents, birth certificates and the death certificates of the parents. In some cases, unscrupulous relatives move in and grab everything and leave children destitute. As a result, children can no longer have access to education and may end up in street (Van Dyk 2005:269; UNICEF 2006 b:11; Kapenda 2007:5). To be noted is that loss of the identity documents / birth certificates mean children cannot register for government benefits and social grants.

In addition, orphaned children may face different types of abuse including physical and emotional abuse such as sexual abuse, chronic malnourishment, mistreatment by the extended family members, separation from other siblings, forced into prostitution, premature death, receiving inadequate clothing, beaten, overburdened by domestic chores, no access to health care and rejection by other family members (Van Dyk, 2005; MWACW, 2003:2 UNICEF, 2006 b: 4)

## Caregivers

There are various definitions of caregivers. Van Dyk (2005:323) defined caregivers in the context of HIV/AIDS, as anyone involved in taking care of the physical, psychological, emotional and or spiritual needs of a person infected or affected by HIV/AIDS. The providers of care giver services at family level are mostly women and girls, although men are also increasingly willing to take care for sick partners. A study by Global Coalition on Women and AIDs in 2004 found that 90% of care for the ill is provided by women and girls (Steinitz and Ashton, 2007:223)

Children are also carrying the burden of care for their sick parents or siblings. Goodman, Potts and Pasztor (2007:428) described caregivers as uncles, siblings and grandparents, who take care of their younger family members. This was termed kinship care. In some cases, one finds volunteers in the community who are recruited and trained to provide care. Examples of informal volunteers are friends, neighbours and church members. There are also health care professionals such as nurses and social welfare workers who work with Aids patients in hospitals and clinics and on home-based care basis. An important group, which is not often acknowledged, are the traditional healers who are widely consulted throughout Africa.

In most cases their importance role of caregivers within communities is often not recognized, they care for people with HIV/AIDS and OVC often without training or support from the formal health services (Van Dyk, 2005: 324).

However, children are often cared for by the extended families and community members whose financial resources are already overstretched beyond capacity. As pointed out, there is a need to assist poor families caring for OVC to improve access to services (MGECW, 2008:31) Skinner and Davids; (2006:62) and Kameeta et al (2007:11) also noted that most of OVC appear to stay with grandparents and aunts as caregivers. Most families are too poor to take care of OVC, resulting in cases where potential caregivers are not willing to adopt or foster anymore OVC. The OVC are thus left to fend for themselves and become either child-headed households or street children (Skinner and Davids, 2006:62; Kameeta et. al 2007:11).

In Namibia, the number of grandparents who are taking care of OVC has increased from 44 per cent in 1992 to 61 per cent in 2000 (Tjaronda,2007:3). Grandparents are forced to care for their grandchildren with their meagre pension as the only source of income paying for uniforms, food, health care and school fees. (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). Some works claim that Grandparents can't provide them with all their basic need, and in some cases they can't provide psychosocial support. As De Witt (2007:77), Booysen & Arntz (2002: 181) point out, caregivers lack information on orphan hood and can't support socio-emotional and educational needs of the children

Most works on care givers put emphasis on material needs rather than their information needs. Phiri and Tolfree (2005) recommend that caregivers need support by providing community-managed child centers, income generating activities, spiritual and emotional support, material support, community vegetable or nutrition gardens and referral services (Phiri and Tolfree,2005:19). Significantly, the authors do not recognise information support for caregivers as equally important.

In most cases, caregivers lack information on how to access government services and donor funding aimed at assisting OVC and caregivers. A number of agencies provide different services to support OVC, but it seems the information about the services provided does not reach the target group - there is a gap or communication breakdown between the service providers and information consumers. 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 utilize services that would have helped them (Kange'the, 2010:197).

A study by Bray (2002:13) on child wellbeing in neighbouring South Africa, found that there was a significant number of caregivers who were not receiving the social grants aimed at them, especially these from the poorer rural areas. In most cases, the different categories of caregivers, lack information about services provided, and the nature of orphan hood. Thus they often support the orphaned children without sufficient information on how to deal with their material and emotional needs.

### **Research problem statement**

The literature reviewed indicates that Namibia has a high number of orphaned children due to HIV/AIDS. The orphans are cared for by caregivers ranging from grandparents, volunteers, the extended family system and in some cases, older siblings (child-headed households). Although the material and financial needs of caregivers have been identified in many reports, information needs have not been singled out as an important and vital need (MWACW 2003: 1: UNAIDS, 2004 b: 10; Van Dyk, 2005:269; UNICEF, 2005b: 10; UNICEF, 2007:5; Khin-Sandi, 2005:7). This study therefore set out to address this knowledge gap, and establish the information needs of caregivers, the majority of who are women ( ). From the findings of the study, the role public libraries can play to provide information to women caregivers of OVC and thus filling the information gap will be extrapolated.

### **Research design and methodology**

The research was conducted through interviews and focus group discussions in two locations in Namibia, Ohangwena region (rural) and Khomas region (urban). In Ohangwena, respondents were interviewed in the four constituencies of Eenhana, Ondobe, and Engela, while in Khomas region respondents were interviewed in the following constituencies Okahandja Park, Moses Goroeb, Greenwell Matongo and Khomasdal. In both cases, the constituencies were selected because they have a high number of orphans. As already noted before, Ohangwena is a rural constituency while Khomas is an urban constituency. The research population of caregivers in this study include: Family members, traditional leaders, teachers, community members, foster parents, and child headed household heads.

### **Preliminary findings**

#### **Demographic Data**

The demographic data of caregivers from Ohangwena and Khomas Region indicates that the biggest group of caregivers who responded were in the age range of 33-40 years 18 (26%) followed closely by respondents of 57 years and above at 17(24%). Interestingly, in Ohangwena, the biggest group was that of respondents of 57 years and above 17(33%). This could be confirmation that grandparents are taking care of their grandchildren. The second

highest 10(20%) were caregivers who are 33-40 years of age. The lowest group 1(2%) were caregivers who are 9-16 years old. A comparison of the two sites reveal that while in Khomas region the majority of caregivers were in the range of 33-40 years 8(42%), followed by 25-32 years 5(26%). There were no caregivers in the 9-16 age categories. The combined demographic data of caregivers from Ohangwena and Khomas regions reveal that the biggest group of caregivers who responded were in the age range of 33-40 years 18(26%) followed closely by respondents of 57 years and above at 17(24%).

## **Gender**

In both regions, female respondent caregivers (84%) were more than male caregivers. In Ohangwena the response rate of female caregivers was 42(82%) and 17 (90%) in Khomas. This indicates male caregivers were a minority of 9(18%) and 2(11%) of respondents in Ohangwena and Khomas region respectively.

## **Education level**

Data on the educational level of respondents reveal that, the highest education reached by respondents was grades 8-12 (44%) of respondents, followed by no formal education at (21%) among respondents. Other respondents fall in between the two extremes. In Ohangwena, respondents highest educational level was grades 8-12 at 16(31%), followed by no formal schooling at 14(28%). In Khomas region, respondents who had reached grades 8-12 were 15 (79%), followed by respondents with college/vocational training at 2(11%). The data would seem to indicate there is a major difference in educational levels between rural and urban caregivers. For example, as already stated, there was a big number 21(41%) of caregivers from Ohangwena who had no formal education or whose highest education was grade 3 level. A few respondents 4 (8%) had college and University education. In Khomas region, only a few respondents 1(5%) had no formal education, and some respondents had had reached college level 2(11%).

## **Employment**

Overall, the majority of the respondents did not have formal employment 46(66%), while only a few were employed 24(34%). The majority 40(78%) of caregivers in Ohangwena, were not employed as compared to Khomas respondents where 13 (68%) had some form of formal employment. Thus in total, more than half 49(70%) of the caregivers had no formal employment and had incomes of less than N\$499 per month. This was followed by 10(14%) who earned less than N\$1499.00 per month. There were only 3(4%) who were better paid, earning N\$2500 and above per month.

In Ohangwena, most respondents earned less than N\$499.00 per month 40(79%), and only a few respondents 3(6%) earned N\$2500 and above. Whereas in Khomas region, 9(47%) respondents earn less than N\$499.00 per month and only 1(5%) earn between N\$ 2000-2499.

The main sources of income in Ohangwena and Khomas were from selling food products (fish, fat cake and “*kapana*”- (roast meat cut into small pieces, popular with low income workers). Other products were traditional baskets, traditional beer and *Mahangu* i.e. millet, a staple food in the northern part of Namibia), domestic work, pension fund, and grants from the Ministry of Gender and Child welfare. As stated, there were only a few respondents

employed in different sectors of the economy.

### **Most useful information**

In an open-ended question, respondents were asked to state the type of information which they perceive as most useful. There were 9 respondents from Ohangwena and only 1 response from Khomas indicated information on the feeding schemes. In Ohangwena, feeding scheme was considered the most important by 3(34%) frequency, followed by information on transport to collect medication by 2(22%) of respondents, and information on how to register children to get grants, and availability of training opportunities received 1(11%) mention.

The focus group discussions with participants however yielded deeper insights into the information regarded as most useful by respondents. The following was a typical response from Ohangwena:

**Education Support:** caregivers felt that, they need information on various issues concerning education of the orphaned children under their care.

*“I need to know on how to get exemption from paying school development fund. “I once tried to apply for exemption at Eenhana Ministry of Gender, but the school Principal told me to pay because I receive a grant for the child from the Ministry of Gender. If the child fails to pay hostel fees, he/she will not get a mattress (hostel fees is N\$83 per term and school fund is N\$150 per term)”*

Another participant in the focus group discussion complained about the low level of resources available to care givers:

*“How can my child be supported to get books and stationeries....If the child fails to pay full school fees, she will not receive books.....the child is in grade 10 preparing for the final exams. I don’t want my grandchild to be uneducated.”*

To be noted is that there are several national and continental policy documents which recommend that every child deserves free and good quality education at least up to primary school level. The Dakar Framework for Action, for example, recommended “Free and Compulsory Education of Good Quality for all”. This goal is also affirmed in the Millennium Development Goal no 2, to which member states of United Nations committed themselves, by year 2015, to ensure they achieve Universal Primary Education.” (Otaala, 2007:5) The Namibian Constitution Article 20 (1) and (2) also states that, all persons shall have the right to education, and the State shall provide reasonable facilities for compulsory, free primary education. However, having a good policy in place does not lead to good implementation if information is lacking at the grassroots level.

As already indicated from data presented above, most caregivers interviewed were poor and faced challenges on how to pay hostel fees, buy stationeries and often didn’t know the procedures (ie. lacked information) on how to apply for exemption on these payments:

- **Financial Support :** Most groups participating in the discussions indicated that, they needed information on where to get financial support/grants

Sentiments of the desperate need for information on where to get additional support were voiced frequently during discussions, such as by this Khomas respondent:

- *“Information is needed to know where to get money to pay school development funds. It is very expensive and the money is not enough. I have to pay for three children, N\$ 600 per child... where is all this money going to come from?”*
- **Discipline:** caregivers often experience discipline and emotional problems from the children they look after, and they needed help. The following were some of the comments which came out from the caregivers during the discussions:

*“My grandchildren need discipline – they think every coin in the house is theirs. They think they are masters of the house because their money is being used to buy kilos of maize meal”*

The interpretation of these clashes could also be explained by the fact that the orphaned children are suspicious that the funds they are given are being misused, which was sometimes indeed the case. They however don't have accurate information showing that the money coming in for their support is actually quite small so they develop an attitude that they have more than they actually have.

Given the big number of OVC the capacity of the extended family to care for OVC can't cope any more. Abebe & Aase (2007) pointed out that the capacity of families to cope with orphans depends on social and economic factors and geographical conditions. Freeman & Nkoma also mentioned, many caregivers are financially too poor to provide adequate care to additional children. Not surprisingly, during the discussions information on economic opportunities was a topic on top of the agenda and was frequently raised by the different focus groups.

**Job Opportunities:** caregivers need information on job opportunities so that their children who complete grade 10 and 12 can get some income.

*“When your child fails and stays at home, one need information on the job opportunities so that he can apply and get a job”*

There was however a complaint by the rural respondents that by the time they get the information on job opportunities it is often too late for the children to apply for the advertised jobs as the closing date for applications has already passed.

Poverty affects the household especially for the grandparents who are taking care of their grandchildren particularly in rural areas. Caregivers are faced by the daunting task of providing care to older children who have failed grade 10 or 12.

Badcock-Walters et al (2008) noted that, poverty affects the families and limits access to education; limits the availability of nutritional food per family and other opportunities.

The data presented above is a snapshot of the wide range of needs caregivers have for information and services to enable them to take action and provide better care for the OVC.

### **Caregivers' information seeking and use patterns**

The main information seeking behaviours of the caregivers was towards a preference for access information through the oral information system – where friends, family members and formalised “expert sources” such as political councillors, social workers and teachers all featured prominently. An additional avenue for accessing oral information was public

meetings at community public meetings and church services. Radio was also prominent among the channels cited as one way of accessing information. Print information sources were low in the rating of caregivers and public libraries did not feature among the various methods utilized to access information.

The findings also indicate the rate of semi-literacy was low (28%) among rural caregivers and even lower among urban caregivers (5%) thus indicating they have the capacity to use printed information if made available in the local language. However accessing printed information received a low rating indicating that caregivers might not have a well-developed reading culture or print-based information use culture.

However language was a major barrier to accessing information as caregivers reported sometimes they would go to an office only to be told that the person who can communicate in their local language was not available and that they should return at a later date when the official was available. Often they were kept waiting without being informed when the official became available again.

To sum up the findings, the existing information system serving caregivers was characterised by multiple bottlenecks, its rudimentary nature and frequent breakdowns leading to caregivers missing opportunities to obtain much needed assistance for the OVC. Some examples narrated include – cases where information providers such as magistrates, police and government officials lacked interest to provide the required information concerning documentation for grants, death certificates, and other requirements. Caregivers complained often that they had to visit an office many times before they received assistance because of lack of staff to assist them, or low morale among public service staff, which was a major problem for those who had to travel long distances. It was also said that it took a long time to get a response to questions and often a response was ever received. Given the problems of distance, bureaucracy and physical distances, caregivers said they sometimes felt too tired and hungry to go out and look for information, even when they knew where to eventually get the required information.

### **The role of public libraries in providing information to caregivers in Namibia.**

The data collected through this study has indicated the information requirements of caregivers, their information seeking and use patterns and the characteristics of the existing information system from which they information trickles down to caregivers. For the public library to be relevant to this group, it would have to redesign its services and come up with an innovative information provision strategy in the community. Both research locations had a public library of some kind, in place which would have to be adapted to serve the new role. There are several areas where this adaptation could occur – based on the information needs and information seeking behaviour patterns of caregivers and the imperfections of the existing information system serving caregivers.

Each public library should consider the creation of a Unit dealing with the information needs of caregivers possibly as part of a broad strategy to provide development information to the community, with the following main functions:

#### **1) Information content creation**

This aspect would consist of an information repository of materials containing hard practical information required by caregivers and OVC relevant to their information needs. The first

step would be to identify what information actually exists - a lot of the information will be unrecorded and in the grey literature from government ministries, parastatals, NGOs, civil society organisations and donor agencies. A second dimension of the information repository would be recording oral accounts of caregivers (anecdotal evidence) who have succeeded to solve the problems that other caregivers find difficult to deal with. Such information could be recorded in such a way that it can be shared and listened to by other caregivers so as to learn from the experience of their own peers. Another primary resource would be government information on the various policies, laws, reports, manuals and handbooks, which deal with problems of OVC and the procedures of accessing assistance and grants and getting exemptions from schools and related agencies. Examples include - Namibia National Policy for OVC; Education Sector Policy for Orphans & Vulnerable Children; Namibia Constitution, procedures for applying for grants from different agencies etc. Newspaper cuttings on orphans and vulnerable children could also be an important part of the information repository. The Unit could also collect different application forms such as application for birth and death certificates, forms for applying for identity documents and make them accessible to the caregivers. Yet other resources could be examples of letters to donors requesting for grants and funding assistance.

## **2) Information and knowledge transfer and sharing platform**

Formal information however should be only one part of the functions of the Unit, another important part would be to create an information transfer and sharing platform based on the information seeking behaviours and use patterns of caregivers. Using the oral information seeking behaviour as a cue, the Unit could create space for groups of caregivers to come and share ideas and network with each other, and also organise public talks by social workers and other extension workers on the issues which are of concern to them. Such sharing of information would allow caregivers to learn from the experiences of others and share their own experiences and thus draw strength from learning that they are not alone. The Unit could also develop a local and national directory of important organisations and individuals who can be of assistance to caregivers. Such information should be updated regularly to ensure it is current and relevant. An additional strategy could include the provision of facilities for viewing video materials and listening to audio cassettes on relevant topics to caregivers. The Unit could also provide photocopy and fax services for caregivers to be able to contact the various service providers.

## **3) Advocacy and empowerment programme for caregivers**

This function could play an important role as well where an advocacy programme is conducted through volunteers to help those who are intimidated by officials which restrict their willingness or ability to seek for information and assistance for OVC. Such a programme would incorporate the use of volunteer's in the community e.g. church leaders/religious leaders, political leaders, community leaders, to take the caregivers who are afraid by the hand and lead them through the corridors of offices where they can seek help from bureaucrats. The aim of this aspect is to build self-confidence of claimants to cope with the intimidation of officials and bureaucrats. The strategy could include formation of caregivers clubs/grassroots groups so that they learn to help each other and become self-reliant. The Units advocacy can also be used to sensitize the community on the issues of HIV/AIDS in order to promote a culture of tolerance and compassion in the community so that, no child or caregivers suffer from stigmatization.

#### **4) Training programme**

In order to introduce and consolidate such organisational changes in the public library, it would require training of library staff and volunteers to gain new skills required by the new roles they are expected to play in helping caregivers obtain the information they require to assist OVC. The short course for library staff should orient them to all aspects of creating and running the Unit for caregivers envisaged in this paper i.e. *information content creation, information sharing and transfer facilitation, and advocacy and empowerment of caregivers and OVC in the community*. Other areas of importance are to understand how caregivers *apply for assistance and grants, the various forms they have to fill, and letters they are required to write (develop a template for such letters)*. Equally important is how to *mediate between the caregivers and OVC and extension services* particularly with regard to start-up of small scale projects in the community for income generation. The *methods of running an advocacy programme in the community*, on behalf of OVC and caregivers would also form a vital part of the training programme.

#### **Conclusion**

This paper falls into four main parts – background, preliminary findings, and the role of the public library in providing information to caregivers. The background consists of a literature review which reveals starkly that the HIV/AIDS pandemic onslaught has led to many deaths of young mothers and fathers resulting in a big number of orphans and vulnerable children in the country. The preliminary findings sheds light on the information needs and information seeking behaviour of the caregivers, and reveals that most caregivers, mostly women, work under conditions of extreme poverty and depend on government and donors for assistance to provide for the OVC. One of the factors which enable them to access available assistance is appropriate information on the various forms of assistance from government ministries and donor agencies, and how to access the grants and various forms of help which are on offer. The existing information system for caregivers is however fragmented, and has many communication break downs which results in only a low percentage of caregivers being able to make use of available assistance on a continuous basis. In the final part of the paper attempts to answer the question - how can public libraries breach the information gap for caretakers to access the information they require to help OVC? The proposal is for public libraries to create a Unit which specialises in serving caregivers and OVC which will perform four key functions, namely information content creation; create an information and knowledge transfer and sharing platform; initiate an advocacy and empowerment programme for caregivers and OVC and lastly train library staff and volunteers to be able to manage the new roles required by this new approach.

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