Beyond the Gender Differential: Very Young Children Coping with HIV/AIDS

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This article reports on a recent study of HIV/AIDS which investigated the role of gender in the experiences of young children in one region of Namibia. The findings reveal that while gender is reported to shape school-age girls' and boys' experiences of being infected or affected by HIV/AIDS in many African nations, gender was not an influential variable in the experiences of very young children coping with HIV/AIDS. Conditions of poor health, deprivation and stigma were equally distributed amongst young girl and boy participants. Connectivity with families and communities was shown to be influenced by living conditions but not differentiated by gender. No gender differences were identified regarding young children's sense of hope and vision for the future. The article implies that there may be a particular juncture when gender begins to make a difference in the life of girls and boys—and that this could be an important focus for research. Copyright © 2006 The Author(s).

Introduction

This article is derived from a recent study which investigated situations for very young children infected and affected by HIV/AIDS. Using open-ended questions to facilitate the articulation of narratives from children and their carers, the study sought to provide an insight into what it is like to be a young girl or boy, orphaned and infected or affected in other ways by HIV/AIDS. Participants included children aged 3–9 years in three types of care situations in one urban region of Namibia.

Analyses of the data, based on the hierarchy of human rights and needs (Haihambo and others, 2004), produced four significant categories for assessing experiences of the children. These were threats to their survival, their access to services and to supportive environments including caretakers, the child’s sense of connectedness (with family and community) and the child’s sense of hope/vision for the future. Each category was tested for gender differentials. Before examining
the findings in relation to these four categories, the study begins by providing a brief overview of what is known about the influence of gender on the impact of HIV/AIDS and also the experiences of children either infected or affected by it.

Is HIV/AIDS a gender-based disease?

Female poverty, their lack of employment opportunities, their lower levels of education and their inability to insist on preventative measures are features of most regions with a high HIV prevalence. Globally 55 per cent of new HIV infections are now deemed to be amongst women.

Women are physiologically, socially and economically more vulnerable to the impacts of HIV/AIDS than men (Association of Commonwealth Universities, 2001). Women with HIV/AIDS and those who are associated with them suffer from additional forms of discrimination and stigma. Female relatives who have an association with HIV/AIDS victims (including their sisters and other female relatives) are considered to be taboo as marriage partners—and may be shunned by their community.

Another gender issue is related to the caregiving role for HIV patients. The burden of care for people living with HIV/AIDS and for children orphaned by HIV/AIDS falls on females in nearly all situations. Young girls and grandmothers are increasingly responsible for caregiving. This population is likely to suffer concomitant economic vulnerability, poor health and exclusion from services because of their immobility and psychosocial trauma (HelpAge International, 2003).

HIV/AIDS and girls

The effects of AIDS-related poverty and other stressors are exacerbated by the low status of females in many nations. AIDS-affected girls are subject to sexual abuse and, in many cases, denied available treatments. Poverty and/or the lack of adult support have resulted in increased numbers of girls living on the streets. This situation exacerbates their vulnerability to violence, coercion and (HIV) infection (UNICEF, 1994; World Bank, 2004).

Studies have reported that HIV-positive females are less likely than males to receive family support and resources, that the burden of care often falls on females and that orphaned girls are more likely to be withdrawn from school than their brothers (Kelly, 2000). Young girls are often called upon to forgo childhood pursuits and/or schooling and can become restricted all of their lives within a caregiving role, sometimes moving from one stricken relative to another (Kelly, 2005).

Girls’ primary school enrolments are also affected. Girls’ participation in formal schooling is decreasing in those countries with the highest prevalence of HIV (Kiragu, 2001). Amongst other deprivations, girls who leave school early do not have access to AIDS education programmes. Meanwhile cultural beliefs may prevent girls and young women from engaging in discussions and sharing information on sex and sexuality. For these reasons, and others, teenage girls are less likely than boys to have a
basic knowledge about how to protect themselves from HIV/AIDS (WHO/UNESCO, 1994).

The situation of female prevalence, along with the increasing incidence of the disease, their experience of discrimination, abuse, stigma and lack of awareness of issues by girls and the burdens of female caregiving, has resulted in the labelling of HIV/AIDS as a gender-based disease (Iipinge and others, 2004).

What is known about young children and HIV/AIDS?

The plight of children infected with and affected by HIV/AIDS has been named by the United Nations as the most critical issue regarding the human rights of children in this decade. Four million children have died of the disease. Thirteen million children are orphaned. Huge numbers are affected in myriad ways that are not recorded (such as by stigma, abandonment and discrimination). The figures of affected and infected children continue to rise. By 2010, it is estimated that more than 25 million children will be affected as a result of the pandemic (UNICEF, 2005).

Some studies have shown a co-relationships between infection or association with HIV/AIDS and morbidity, stunting, nutritional wasting and failure to thrive (see Lusk and O’Gara, 2002).

Infected and affected children suffer psychosocial distress and are at risk of exclusion, abuse, discrimination and stigma. Children aged 5–14 years who have lost one or both parents are less likely to be in school and more likely to be working 40 hours or more per week. A survey of 646 orphaned and 1239 non-orphaned children in Kenya found that 52 per cent of orphaned children were not in school, while only 2 per cent of non-orphaned children were not enrolled (Lusk and O’Gara, 2002).

Affected children who do attend school have high rates of absenteeism because of sickness at home or because they are sick themselves. When they do attend classes they may have trouble concentrating because of distress and worries or because of alienation from their peers. Teachers who are uninformed of their home circumstances are likely to punish children for their lack of attention, falling asleep in class or not completing homework (The Children’s Institute, 2001).

As parents and other family members become ill, children take on greater responsibility for income generation, food production and the care of family members. Loss of adequate nutrition, basic healthcare, housing and clothing, the risk of being denied an education, a loss of inheritance, abuse and/or the effects of running a child-headed household are some of the impacts of the pandemic on young children (USAID, UNAIDS and UNICEF, 2002). Ironically, some services which target these children have exacerbated their exposure to abuse, neglect and exploitation. Studies have shown that affected children who disclose their situation in order to seek support (such as help with school fees) become subject to social isolation and psychological abuse (The Children’s Institute, 2001). In one study children who disclosed were shown to be discriminated against at home and in schools, shops, taxis and other settings. Further, there is ample evidence that children affected and infected by
HIV/AIDS are frequently denied basic rights. Some carers report that in situations of food and other scarcities, it is healthy children, not sick ones, who receive primary access (The Children’s Institute, 2001). Similarly, children who move into situations with relative or other ‘foster care’ can suffer from discrimination in food allocation, education and workloads in comparison with the foster parents’ own children (Subbaro and others, 2001).

Misconceptions about the spread of HIV/AIDS add to discrimination against children who are often shunned by other children or refused entry to schools and kindergartens. Infection or association with HIV can be viewed as a punishment ‘from God’ or a result of being bewitched.

None of the studies cited above differentiated between boys and girls in their reporting of conditions for very young children (below school age).

What is not known

Most of the HIV/AIDS programmes tend to focus on adults and youth while the needs of children are often overlooked. Even where concern is expressed and action taken to address the needs of orphans, the tendency is to focus on orphans who have arrived at school-going age. (Kelly, 2005, p. 1)

Multitudinous research projects have been directed at the epidemiology and/or the sociocultural aspects of HIV/AIDS. At the University of Namibia, for example, research themes include women’s power in sexual and domestic situations; problems of women, breast feeding and the vertical transmission of HIV; problems of youth, values, sexuality, condom use; overcoming stigma and positive living (Gabriel, 2004).

In Namibia and beyond, research regarding HIV/AIDS and issues for very young children is rare. No studies could be found which include the voices of children, which examine gender differential for children or which investigate the experiences of caregiving for children below school age. The study reported herein (sponsored by the University of Namibia) was designed to address this gap.

The Namibian study

Methodology

The urban area of Khomas region, Namibia (a designated high prevalence area for HIV/AIDS) was targeted for the study. Participants included male and female orphans aged 0–8 years. Most of the children had a mother who had died from AIDS and were themselves HIV-positive. Children in the study were living in one of two settings:

- Safe houses. These are ‘orphanages’ or compounds which are situated behind gates outside of neighbourhoods. Alternatively, ‘safe houses’ could be community-based ‘homes’ for up to 25 children. Safe houses are generally highly secured and easily identifiable (often labelled the ‘AIDS House’). Carers are employees or volunteers (of
government or non-governmental organisations). They receive payment or in-kind remuneration for this role.

- Residential houses. These are indistinguishable from other houses in the community. Residential carers tend to have a connection with the child (through blood or friendship with their relatives). No formal sources of payment, support or assistance are available to residential carers.

**Participants and interview procedures**

Children participants were nominated by workers in the care settings or by a charitable organisation that provided support to residential carers. Sixteen children took part in the study: six girls and 10 boys, aged 3–8 years.

A schedule of open-ended questions was used to solicit information based on the hierarchy of human rights and needs. The hierarchy was developed by Haihambo and others (2004) from three sources: Maslow’s (1970) *Hierarchy of Human Needs*, the UN *Declaration of Human Rights* and the UN *Convention on the Rights of the Child* (United Nations General Assembly, 1948, 1989). The hierarchy addresses the notion that human beings need, and have a right to, conditions that progress from ‘survival’ through to ‘freedom and hope’. Firstly by humans have the right to nourishment, shelter and protection from violence and harm. The next level includes conditions that allow for their growth and development—disease-free environments and access to health services. At the third level, human beings need, and have a right to, positive, reciprocal affiliation with others. Membership within a family and community grouping are basic needs at this level. Next, human beings have the right to formal education and to seek conditions that allow them to fulfil their potential and follow their own interests. At the top of the hierarchy, human beings have rights and needs which allow for self-actualisation. These include freedoms of expression, choice and movement (Haihambo and others, 2004).

Research assistants (RAs) spent many hours at settings prior to engaging the children and carers in formal discussion(s). Interviews were conducted in the language of the child/carer and subsequently translated into English by RAs. Audio recorders were used during interviews where appropriate. All transcripts were analysed through the Nvivo computer program to reveal data themes and patterns.

The interview questions served as a guide for discussions with the children, and were as follows:

- How did you come here? (Who brought you here? How did they know about it?) Do you have brothers, sisters or any other relatives here with you? Do you have friends here now?
- Who takes care of you (gives you food, clothes, helps you) when you feel sick or tired?
- Who is your best friend—or person you like the most in the world? Are they here with you? Do you ever see them?
- What is good about being here (what do you like the best)?
- What would you like to change about being here?
- What do you want to become when you grow up?
- Is there anything you would like to tell me about living (coming) here?
Observations were also included in analyses of the experiences of children, based on the following:

- The child’s level of communication skills (ability to respond, initiates communication, seems able to express feelings).
- The child’s general demeanour (eye contact, smiles, talkative, friendly, withdrawn, tearful).
- The child’s perceived level of health and wellness (including cleanliness, nutrition, etc.).
- Other comments.

The data from the children were categorised according to the hierarchy as follows:

- Threats to survival.
- Access to services and environments and which support psychosocial health and well-being (including the health and well being of carer).
- Children’s connectedness (sense of belonging to family and community).
- Carers vision for the children and children’s own sense of hope/vision for the future.

Data from girls and boys were categorised separately in an attempt to identify differences in experiences or opportunities.

**Threats to survival**

Some children were identified as at risk for basic health needs. In one safe house and in several residential houses living conditions were observed, or reported, to be below community standards; including inadequate space, bedding and inconsistent supplies of food. Some children did not meet community standards of cleanliness. Some unhygienic practices (such as sharing eating utensils amongst sick children) were observed.

The place is not hygienically clean. The children are sometimes fed with one spoon, even though some of them are obviously ill and could be infectious. The toddlers’ nappies are not changed regularly, because there is not enough manpower. The toddlers can also not nap, especially after school, because the children are too many for three rooms. (RA observation of safe house)

Children in residential settings were more likely to be lacking in health-related basics.

Their clothes are torn and they are getting cold during winter and they are also barefoot. (Residential carer)

Most of the time they don’t eat breakfast, lunch and most meals during the weekends. (Residential carer)

At this level there were no discernable differences between the experiences of young girls and boys.
Access to services and environments which support psychosocial health and well being, including carer health and well-being

The participants in the study were ‘registered’ and had access to the (health-related) supports of the referring organisation. Some participants in the study exhibited symptoms of earlier health problems but appeared to be receiving improved care.

S has skin rashes all over her body. Her eyes are reddish and she is quite thin for her age… She was well-dressed and looked clean. (RA observation of girl, age seven years)

J appears too small for six years, but clean. (RA observation of girl, age six years)

In one residential house the children appeared stunted and malnourished. They had recently been registered at a charitable organisation and were just beginning to receive food and other goods on a regular basis.

D was not able to respond well to the interview. She’s very withdrawn and shy. One can really see that she is living in a poverty-stricken house. Her clothing was not well, especially regarding the weather conditions on this day. She was too underdressed. She also looked underfed. For a child of seven years, she was very small. She looks more like a 4-year-old. (RA observation of girl, age seven years)

Opportunities for cognitive and psychosocial development

Children’s daily routine in safe houses included eating, bathing, taking medicines and playing outside (or watching TV in some cases). A number of children reported that they had ‘friends’ in their safe houses. Age-appropriate toys and play materials were not observed in safe houses or residential houses. (Some children aged 3–5 years from residential homes were enrolled in a community day-care programme. These children were receiving age-appropriate, cognitive, social and nutritional experiences through the programme.) Consistent individual attention for babies, two-way interactions between children and adults, co-operative group play, exposure to stimulating and challenging experiences through a variety of materials and activities, opportunities for large muscle development and opportunities for quiet and reflective experiences were not observed during visits to the houses. Experiences associated with school readiness such as talking, looking at written symbols, singing, counting and similar activities were not witnessed during the study period. No child had been psychologically assessed nor were they given formal counselling of any sort.

In response to questions about providing developmental experiences for children, carers in safe houses gave answers such as:

We would like to take them to the park but we have no transport.
We rarely have time to read [play with] them.
[All I can do is] walk around the block with the child … when they are upset. We definitely need a psychiatrist.
Despite these concerns, many observations by RAs revealed positive attributes of the situation:

The children were clean and appropriately fed. The older children coming from school seemed happy.

Residential carers in this study were sending children to a day-care centre where the children received nourishment, visits by health personnel and some goods such as clothing when needed. The day-care centre provided stimulating group experiences appropriate to the age of the children.

Despite material deprivations, observations by RAs indicated psychosocial well-being in many residential children.

J [girl, age 4 years] is a very friendly little girl. She is not shy at all. Her level of communication is good and she was able to respond well. She looked healthy and clean. She smiles a lot and could express herself well. (RA observation of girl in residential house)

W (boy, age 5 years) can express himself well and he is very talkative. He is friendly and smiles a lot. He has a high level of communication and he seems very healthy although he looks very small for his age, and he did not look too clean. (RA observation of boy in residential house)

The children themselves reported on ‘good things’.

I like it here. I get macaroni. (Boy age 3 years in safe house)

I like playing with the children. I like cleaning our rooms. (Girl age 6 years in safe house)

(I like) playing … when [grandma] tells me stories … watching TV at neighbours. We eat nice food. [Boy, age 6 years in residential house]

My mom [sic] takes care of me. She loosens my hair and washes the clothes. She cleans the home. She gives me food. We eat bread. [There are] birthdays and Christmas. We watch TV and video. We have porridge and chocolates. (Girl age 7 years in residential house)

Health and well-being of carers

Carers in safe houses were employees or volunteers. They received food and shelter and, in some cases, a salary. While some reported being overworked, many safe-house carers had chosen, and were satisfied with, their role. Some of the safe-house carers were HIV-positive themselves. Safe-house carers were accessing health services. There appeared to be backup carers when they were ill or hospitalised.

[The best thing is that] some of these children had no hope. Many of them, when they came here, you don’t believe they will wake up the next day. But now, most of them are well. They are fine. They put a smile on my face … Now I think I’ve got what it takes to live to old age. I want to live my life to the fullest. I am out there doing public speeches, I went public (about my HIV-positive status) and I am determined to motivate others. (Carer in safe house)
Residential carers were elderly and impoverished but as this state was not distinctly different from that of neighbours, the children were not necessarily stigmatised by the poverty. The physical environment of some residential houses was deemed to be deficient:

B is a very old lady ... The house is really not in good condition. It is empty. There is nothing in her house. The house is very old and the paint is also falling off.

J is really very poor, there is not even a single chair, and we were sitting on stones outside.

The health status of many residential carers was observed by RAs to be poor.

She is very sick, she is coughing. Her feet are swollen and she is having wounds on the parts of the body which are exposed ... The environment is not conducive for children. It is dirty. The pots are lying around and they are dirty.

Many residential carers themselves reported illness and exhaustion which may have been associated with their own limited access to nutritional requirements.

Most of the time (we) don’t eat breakfast, lunch and most meals during the weekends.

Carers mentioned the need for rest and respite. They felt that they were working hard to meet the needs of the children and others in their care.

I do all the cooking and cleaning in the house and during weekends my daughter will help me. My only free time is when [child] is at [day-care programme]. I do not receive any kind of payment to take care of him. I only depend on my pension and help from my daughter.

Some residential carers reported that they could not access adequate health services or did not know where to seek assistance for the children in their care (despite the fact that they were registered with an agency which provided this kind of referral):

She is not well informed ... She does not know where to seek help, who to talk to and how to find solutions to her problems. (RA observation of residential carer)

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

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

Many residential carers reported being unable to find a way to increase their income—despite a willingness to do so.

(The hardest part is) ... the fact that I cannot provide for the children and the fact that I am unemployed ... only employment. [is what I would want]
If I can get a sponsor for a project so that I can bake bread and sell or even for ovens and a building … or even a machine so that I can sew aprons and dresses and sell, then at least my children’s food will be covered every day.

If I had employment, everything would be better.

Some residential placements were better resourced:

O is the mother of one baby and two older children. She tested HIV-positive two years ago and she is not healthy. She looked a bit sick but told me that she is now much better. The house was well furnished. She was the only one at home during the interview and it was really comfortable and private. (RA observation)

Very few safe-house carers and none of the residential carers reported an awareness of support or training programmes which addressed caregiving issues. A few carers knew about these programmes but had been unable to access them.

No gender differentials were noted at this level. RAs did not note any distinctions and carers could not answer questions about differences in the experiences, opportunities, or support for girls or boys.

Children’s sense of connectedness (with families and communities)

Children in residential houses were much more likely than their peers in safe houses to have a sense of their own history and to be integrated within their communities (see Hayden and Otaala, 2005).

Carers or children in residential homes knew where they came from, who their relatives were and other aspects of their stories:

I brought up J’s mother. When she passed away because of HIV/AIDS, I brought up J and her brother. They have both been with me since birth. They are like my own children and even if I passed away, J will stay with my cousin who is also part of the family. (Residential carer reporting on history of girl orphan)

It was when I received the letter that his mother died that I asked my brother to take me to the north to get the boy. After a family gathering it was decided that it is best for me to take the boy. By then the boy was very sick and nobody want to take care of him. He was only one year old then. Now he is four years old. (Residential carer reporting on history of boy orphan)

B seems to have accepted his situation quite well. He also seemed to understand that his parents died and this home was the only other place he could go. (RA observation of boy in residential house)

Conversely, the majority of carers in the safe houses did not know about the history of the children and would be unable to pass on stories to them.

W came when he was only one year old. He lost his mom during childbirth. He was brought by the social workers and we’ve heard nothing about his relatives since.
F came from hospital. He was five months. His mother was positive. He came as Baby F; no mother’s name, nothing. No details of family. Only this year did we find out his surname.

K was brought by the police. His parents are in prison. The police never came back to inform him about anything concerning his family.

I believe he is not well-informed about himself. He does not know his own age. (RA observation of child in safe house, age five years)

Narratives by children in the safe houses often revealed a sense of confusion or rejection. Some children obviously believed that something wrong with them had resulted in their current predicament and/or they held other simplistic views about their situation: in answer to the question ‘Why are you here?’ children in safe houses responded:

My mother does not want me anymore.

My mother is in Ovamaboland. She doesn’t want me to live there. [Why not?] I don’t know.

Aunty brought me with my mother and my sister. [Where are they now?] They are in [a different city].

[Why are you here?] I am sick.

Children’s future

The future needs of children was a major concern for residential carers. Nearly all mentioned increased needs as children get older, and their potential inability to meet these needs. Some comments included:

[I worry about] … funds for paying the school fees, food, clothes, hospital.

The pension fund money is not enough … I do not know what the future will bring … One day the children will go to a secondary school and life is very expensive out there.

Carers in safe houses did not articulate a concern about the future. This could be because safe-house carers believed that the children would be adopted or find relative care, or that they might not live into adulthood.

Carers generally were positive about the current situation for children. Despite the deprivations noted for many of the children, nearly all carers (residential and in safe houses) reported their belief that this was the best situation possible under the circumstances.

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

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

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

The children have a place to sleep and eat, they have a home.
Some of these children have nothing, nobody ... they are better off here.

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

Most residential carers, despite their own health worries and concerns about being able to provide for the children, were positive about the current situation.

Yes, I must say it’s stable; the only problem is to pay for water and electricity. Without my daughter’s help I won’t be able to maintain our house.

What can I say?—If you really love children, there is nothing difficult about taking care of them.

I love children; I could not leave that little boy with strangers that do not love him. He will be with me forever.

**Children’s own sense of hope/vision for the future**

During the interview I witnessed the respondent telling the boy to stop playing in the street. He told her that one day when he grows up he is going to play in the national team. He will also go abroad and play soccer there and get a lot of money. His grandmother will see him on television and he will be well-known. He will also buy his grandmother a big house ... and a television. You can see how much [the carer] enjoys it when he is telling her his dreams and promises. (RA observation of boy in residential house)

Both girls and boys in this study readily answered the question, ‘What do you want to be when you grow up’? Responses were related to life experiences, which included trips to hospitals, interactions with police and funeral attendance. The notion that the future held more abundance in terms of material goods was prevalent. Gender-based responses were typical of children in this age range except that some girls’ visions transcended the gender biases of the occupations in Namibia at this time—envisioning a highly educated or professional role for themselves.

The children’s visions included being a doctor who would cure people (girl), a police worker who would ‘kill’ or arrest ‘bad’ people (boy), a ‘shoveller’ who put people in the ground (boy), a house cleaner (girl). Several children reported that they would be providers for their families and that they would stay with them (boys and girls). In all cases, the responses did not reflect despair or a sense of impending death:

- I want to work and earn a lot of money to be rich and buy a lot of things and many things to eat. Buy a lot of furniture and a big house. (Girl, age six years)
- I want to buy clothes. (Girl, age eight years)
- I want to work for a company and buy myself a big house and a lot of FOOD. (Girl, age seven years)
- I will have a house and stay with my children. (Girl, age six years)
I want to become a doctor so that I can heal sick people so they won’t die and they can return home to their families. (Girl, age six years)

Conclusion: gender differentials

This article shows that the situation for both very young girl and boy children infected and affected by HIV/AIDS is in need of urgent attention. Some basic rights and needs are not being addressed. The study recommends action at several levels, including programmes for children to meet health and development needs and which incorporate psychological assessment, counselling and money-making. Directing resources and support to carers in the form of networking, training, income-generation projects, respite care and referral services is crucial to alleviate deprivation and stress for both the child and carer cohorts.

The Namibian study produced findings dissimilar to those reported in the research about gender differences in how older children and young people cope up with HIV/AIDS in African and other nations. While it is well documented that girl children who are infected or affected by HIV/AIDS are less likely to stay in school, less likely to know about protection issues and more likely to be subject to discrimination, violence and abuse than AIDS-affected boy children, this study showed that for the youngest, and perhaps most vulnerable citizens of Namibia, these gender differentials have not yet ‘kicked in’. The experiences of young children, aged up to eight years, did not appear to be influenced by gender. It is much more likely that their living situations (safe houses versus residential houses) and that carer health and well-being influence their experiences in the early years of life.

The findings from this study suggest that there could be a particular juncture when gender does and does not make a difference in the lives of young children. This would seem to be a critical focus for further research.

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References


**Contributor’s detail**

Jacqueline Hayden has researched issues related to human rights and social justice for children and caregivers in both minority and majority world situations. A major focus of her work is identifying and analysing programmes and support related to the social determinants of health and well-being for children and families during the critical early years of life (see www.healthychildhood.org). Jacqueline is currently situated at the Research Centre for social Justice and Social Change, University of Western Sydney, Australia. She was visiting Professor at the University of Namibia in 2004.