A Rapid Appraisal of the Orphan Situation in Malawi: Issues, Challenges and Prospects

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Abstract

The HIV/AIDS epidemic poses a very serious social, health, and economic problem around the world, and is especially serious in Sub-Saharan Africa. Almost all families in Malawi have lost a loved one to AIDS. The productive age group of 15-49 years is the most affected. Of the many vulnerable members of the Malawian society, young people who have lost one or both parents are among the most helpless. This is particularly true where few social support systems exist and where basic social services are largely inadequate. The main purpose of this paper is to give an appraisal of the orphan situation in Malawi as a result of the HIV/AIDS epidemic. In a more specific way, the paper focuses on five major areas: (a) the magnitude and impact of HIV/AIDS in Malawi, (b) the care and support of orphans in Malawi, (c) the national orphan policy and programmes in Malawi, (d) the challenge of increasing number of orphans in Malawi and (e) what should be done. The impact of HIV/AIDS on orphans is multifaceted and very complex. Given time and other resource constraints, this paper simply provides an initial analysis of the current situation and likely future impacts of the epidemic on the orphans, and on the bases of this analysis, presents a series of recommendations about what should be done in the short-medium term. This paper also provides pointers for research that may lead to developing a well-conceived, relevant and detailed strategic response to the crisis. Such recommendations would inform the Malawi National HIV/AIDS Strategic Framework 2000-2004 with regard to an agenda for action concerning orphans.
Introduction

Responding to the rapid spread and consequences of Human Immuno-deficiency Virus (HIV) and Acquired Immune-Deficiency Syndrome (AIDS) presents one of the critical challenges to human development in Sub-Saharan Africa. Although only 10 per cent of the world’s population is in this region, more than 70 per cent of the estimated 34.3 million people living with HIV and AIDS are in the region (UNAIDS, 2000). Of the estimated 13.2 million AIDS orphans, more than 90 per cent are in Sub-Saharan Africa with the Southern African region bearing the brunt of this figure (SAPES-UNDP-SADC, 2000).

According to the Malawi Government, an orphan is defined as a child who is under 18 and has lost one or both parents. Of the many vulnerable members of the Malawian society, these young people who have lost one or both parents are among the most helpless. This is particularly true where few social support systems exist and where basic social services are largely inadequate. The main purpose of this paper is to give an appraisal of the orphan situation in Malawi as a result of the HIV/AIDS epidemic. In a more specific way, the paper focuses on five major areas: (a) the magnitude and impact of HIV/AIDS in Malawi, (b) the care and support of orphans in Malawi, (c) the national orphan policy and programmes in Malawi, (d) the challenge of increasing number of orphans in Malawi and (e) what should be done. To set the context of this paper a brief background of Malawi is presented.

Malawi

Malawi is a small African country occupying the southern part of the East African Rift Valley. It lies between 9 and 17 degrees south of the equator. It has an area of 119,140 square kilometres of which 20 percent is water (Republic of Malawi, 1986). It is landlocked and borders Mozambique, Tanzania and Zambia. Its topography is varied, ranging from the Rift Valley floor at sea level to the majestic Mulanje Mountain at 3000 metres.

Malawi attained its independence from Britain in 1964 and was ruled by a one party dictatorship until 1993 when internal and external pressure ushered in a multiparty system of government. Elections were held in 1994 and a new democratically elected government came into power.

Malawi has a national population of 9.7 million people (Malawi National Statistical Office, 1998). It has been described as one of the poorest countries in the world with a macro economy of US$ 70 with 60% of the population living below the absolute poverty line (Ministry of Health & Population, 1999). The country is predominantly agricultural based with 85% of the population living in rural areas. Agriculture accounts for 40% of gross domestic product and is responsible for 93% of the country’s export earnings and 80% of employment. Manufacturing industry accounts for only 13-14% of gross domestic product. The Malawi economy depends on economic assistance from the
international monetary fund (IMF), the World Bank and individual donor nations such as
Japan and Denmark. The gross national product per capita income is US$ 600. In 1998
GDP grew by 3.1%, which was smaller than the previous estimation of 4.1% (Reserve
Bank of Malawi, 1998). The main agricultural export has been tobacco, but this has in
more recent years been adversely affected by the growth of the anti smoking lobby in its
traditional markets. Malawi has one of the lowest rates of literacy in the world. 80% of
rural women can neither read nor write. Only 4% of the country’s overall population have
had access to secondary school education. In 1994 the teacher/pupil ratio was 1:70
(Ministry of Health & population, 1999). Malawi’s health indicators are dire. They are
among the poorest in the world. Malawi has a live birth infant mortality rate of 134/1000.
50% of the children under the age of five are chronically malnourished. The reasons
given for this are household food insufficiency due to poverty, poor weaning and feeding
practices and frequent infections. 56% of the women attending antenatal clinics are
anaemic (Ministry of Health & Population, 1999).

A 1995 survey indicated that only 36.8% of Malawians had access to safe drinking water
within a distance of 1 Km. 72% had access to sanitation with a pit latrine. HIV/AIDS was
the leading cause of death among the productive 20-48 year age group (Ministry of

A. The Magnitude and Impact of HIV/AIDS in Malawi

Since the first cases of AIDS were diagnosed and reported in Malawi in 1985, HIV-
related diseases have precipitated an epidemic of unprecedented proportions
(MacLachlan et al., 1997). A senior National AIDS Control Programme (NACP) official
estimated that 70-80% of adult in-patients were suffering from AIDS-related illnesses in
2000.

Between 1985 and June 1999, a cumulative total of over 53,000 AIDS cases were
officially reported to the NACP. However, since most cases are not reported, the NACP
estimates that the actual figure for this period was over 265,000. The incidence of HIV as
recorded through Sentinel Surveillance sites has risen rapidly in the 1990s. Prevalence
rates among pregnant women attending clinics in Blantyre rose from 3% in 1986 to 35%
in 1996 (Malawi Government and World Bank, 1998a). Nationally, 16.4% of the
population between the ages of 15 and 49 are infected with HIV (Malawi Government
and World Bank, 1998b).

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Population Size</th>
<th>HIV Rate</th>
<th>No. HIV Positive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 15 years</td>
<td>4,038,484</td>
<td>2.2%</td>
<td>88,847</td>
</tr>
<tr>
<td>15-49 Years</td>
<td>4,683,910</td>
<td>16.4%</td>
<td>768,161</td>
</tr>
<tr>
<td>50 or more years</td>
<td>846,112</td>
<td>1.1%</td>
<td>9,138</td>
</tr>
<tr>
<td>National Total</td>
<td>9,838,486</td>
<td>8.8%</td>
<td>865,786</td>
</tr>
</tbody>
</table>

It should be noted that the prevalence rates in Malawi are much higher in urban areas and also in the Southern region (see Table 2).

Table 2

HIV prevalence by location, 1999

<table>
<thead>
<tr>
<th>Location</th>
<th>Total Population</th>
<th>Adults 15-49</th>
<th>HIV+</th>
<th>% Prevalence (15-49)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>1,065,264</td>
<td>507,066</td>
<td>133,963</td>
<td>26.4</td>
</tr>
<tr>
<td>Semi-Urban</td>
<td>2,442,011</td>
<td>1,162,397</td>
<td>295,197</td>
<td>25.4</td>
</tr>
<tr>
<td>Rural</td>
<td>6,331,211</td>
<td>3,013,657</td>
<td>337,666</td>
<td>11.2</td>
</tr>
<tr>
<td>Northern region</td>
<td>1,229,360</td>
<td>585,175</td>
<td>78,980</td>
<td>13.5</td>
</tr>
<tr>
<td>Central region</td>
<td>4,041,636</td>
<td>1,923,819</td>
<td>236,333</td>
<td>12.3</td>
</tr>
<tr>
<td>Southern region</td>
<td>4,567,490</td>
<td>2,174,125</td>
<td>451,513</td>
<td>20.8</td>
</tr>
<tr>
<td>Total</td>
<td>9,838,486</td>
<td>4,683,119</td>
<td>766,826</td>
<td>16.4</td>
</tr>
</tbody>
</table>


The NACP estimates that 46% of all new infections in 1998 were among young people aged 15-24 and, of these, 60% were female. For the 15-19 age group, HIV infection rates are five times higher among female than males. Cumulative AIDS cases between 1995 and 1998 show that more females are infected in the 15-29 age group whereas more males are infected in the 30 and above age group. NACP projections of HIV indicate that the number of Malawians living with HIV is likely to increase to more than a million over the next ten years.

In 1992 there were 22,000 children under the age of 15 who had lost their mothers to AIDS. By the end of 1998 it was estimated that this number had increased to 124,000 and by the end of 2000 the number was at 300,000 (UNAIDS, 2001). This number is expected to triple in the next ten years. According to NACP (2000), about one in three infants born to mothers with HIV infection become infected with the virus due to transmission of the virus from mother to child.

B. The Care and Support of Orphans in Malawi

In the past, the extended family system in Malawi provided an effective safety net for the small number of orphans in society, especially in rural areas. Children did not only belong to the nuclear family into which they had been born but also to the whole clan through the extended family, which had the responsibility of ensuring that they were well brought up and cared for. After the death of the second parent, orphaned children would
either be shared among members of the extended family or kept together under the
guardianship of grandparents, aunts or uncles.

With the advent of AIDS, some strands in the extended family have become increasingly
frayed. AIDS deaths are highest among the productive age group who in the past would
have been most likely to accept their orphaned nieces or nephews into their homes.
Today, many of these uncles or aunts have already died of AIDS, or are chronically ill
and close to destitution. Others have already accepted the orphans of other deceased
relatives into their homes and simply cannot afford to take any more.

It is still rare in rural communities for orphaned children to be fostered or adopted by
non-relatives. Elderly grandparents, however, are increasingly having to bear the burden
caring for large numbers of orphaned grandchildren, with little or no support from the
surviving members of the extended family or other sections of the community. There are
also growing numbers of households headed by children in their teens in the urban areas
because relatives are either unwilling or unable to accept them into their homes. A small
number of orphans are admitted to orphanages. The government runs a foster care
scheme for childless couples who wish to foster orphans (Bandawe & Louw, 1997).

Malawi’s Official Support System

According to The National Task Force on Orphans in Malawi (1996), within Malawi
there are several levels of care that exist to ensure that the well being of vulnerable
children, especially those orphaned by the HIV/AIDS pandemic. They also strive to
strengthen families and communities to better meet the needs of vulnerable children.

At the national level there is the Ministry of Gender, Youth and Community Services and
within this body there is a multi-sectorial National Task Force on Orphans that is
specifically responsible for the well being of orphaned children.

Following the signing of the UN Convention of the Rights of the Child in 1990, Malawi
made a National Programme of Action to address the situation of orphans. Then in 1991,
following a National Consultation, policy guidelines were established and the National
Task Force for Orphans was created. This multi-sectorial task force then elaborated on
the National Programme of Action, creating a National Orphan Care Programme
(NOCP).

To assist in the implementation of government policies a complete hierarchical structure
has been developed (See Figure 1). Within the NOCP, there are three Regional Social
Welfare Offices (RSWO’s) that operate within the three regions of Malawi, i.e. North,
Centre and South. The RSWOs are operated by Social Welfare Officers.

The regions are divided into twelve districts in South, nine district in the Centre and six
districts in the North. Accordingly, there are 27 District Social Welfare Officers
(DSWOs) who employ District Social Welfare Assistants (DSWAs). These DSWOs and
DSWAs are usually part of a multi-disciplinary team called the District AIDS Coordinating Committee (DACC), that work together on orphan care issues. Within the DACCs/DSWOs there are four subcommittees, the Orphan Care Technical Subcommittee, the Youth Care Technical Subcommittee, Home-Based Care Technical Subcommittee and High-Risk Care Technical Subcommittee.

At the community level, there is the Community AIDS Coordinating Committee/Community Technical Subcommittee which operates under the District Orphan Care Technical Subcommittee.

Each village has the Village AIDS Coordinating Committee which in turn has four subcommittees.
Figure 1: Malawi’s Official Support System for Orphans

**National Level**
- Ministry of Gender, Youth and Community Services – National Task Force for Orphans
- National Orphan Care Programme (NOCP)

**Regional Level**
- Regional Social Welfare Offices operated by Social Welfare Officers

**District Level**
- District AIDS Coordinating Committee (DACC) District Social Welfare Officers
- Community AIDS Coordinating Committee (CACC)/ Community Technical Subcommittee (CTSC)
- Village AIDS Coordinating Committee (VACC)

**Community Level**
- Orphan Care Technical Subcommittee (OTSC)
- Youth Care Technical Subcommittee (YCTC)
- Home-Based Care Technical Subcommittee (HBCTSC)
- High Risk Care Technical Subcommittee (HRCTSC)

**Village Level**
- Orphan Care Technical Subcommittee
- Youth Care Technical Subcommittee
- Home-Based Care Technical Subcommittee
- High Risk Care Technical Subcommittee
C. The National Orphan Policy and Programmes in Malawi

The Government of Malawi with assistance of UNICEF organised a National Consultation on children orphaned by AIDS in 1991. The outcome was a twelve point “Policy guidelines for the Care of Orphans in Malawi and the Coordination of Assistance”.

Key Elements of Malawi’s National Orphan Policy

1. **Community based approaches** to orphan care are primary. The government will coordinate service providers to support and enable communities.
2. **Formal foster care** will be expanded as the second source of care.
3. **Institutional care** is the last resort, although temporary care may be needed for children awaiting placement.
4. Hospitals should record next of kin so that relatives can be traced if children are abandoned.
5. Birth and death registration should be revitalised to monitor orphans.
6. Government will protect the property rights of orphans and these should be widely publicised.
7. Self-help groups should be developed to assist families with counselling and other needs.
8. NGOs are encouraged to set up a system of community based care in consultation with the government.
9. The needs of orphans should be included regardless of cause of death, religion or gender.
10. The National Task Force will continuously plan, monitor and revise programmes and policies.
11. Government will solicit donor support for resources of capacity building.
12. The Ministry of Gender, Youth and Community Services is the lead government body on these issues.

Government Strategies and Policy Guidelines for the Care of Orphans in Malawi

The following government strategies are mainly from the National Plan of Action and Orphan Care Programme (1996):

1. Committee infrastructure coordinated by the Ministry of Gender, Youth and Community Services
2. Support training of governmental and non-governmental workers in counselling to help families cope with the burden of orphans.
Empowering and supporting extended family and communities in caring for their orphans. Foster care and assistance from social workers if orphans are unable to be cared for by extended family. Adoption. Public assistance programme and government donor solicitation – donations to orphans to address physical needs. Institutional care if no other support is available – to be temporary with a focus on tracing relatives. Registration of orphans through CACC and the identification of vulnerable children. Individual Home Needs Assessment to plan interventions. Establishment of a data base. Encouragement of Birth and Death registration. Hospitals to record names of the next of kin. Acknowledgement of decreased psychosocial capacity, especially dealing with grief. Advocating for Children’s Rights Ensuring that orphans benefit from their deceased parents’ estates. All interventions to include all orphans regardless of parental death or the gender or religion of the child. To continue to research, monitor and evaluate the situation and the interventions. Creation of key principles to identify a vulnerable child.
The plight of the orphan has also been embraced in the National AIDS Control Programme Strategic Plan for the fight against HIV/AIDS from 2000-2004 (Strategic Planning Unit, National AIDS Control Programme, 2000).

**Malawi National Strategic Framework 2000-2004**

This framework was developed through a participatory and consultative process with communities, individuals and institutions. The Strategic Framework directs the national HIV/AIDS response in the period 2000-2004 (Strategic Planning Unit, National AIDS Control Programme, 2000). Hence all programmes that are HIV/AIDS related should operate within the broad objectives of the response. The Agenda for action of this response comprises nine priority components, each with its own goal and strategic actions. Briefly these areas are,

1. Culture and HIV/AIDS
2. Youth, social change and HIV/AIDS
3. Socio-economic status and HIV/AIDS
4. Despair and Hopelessness
5. HIV/AIDS care and support
6. **HIV/AIDS and orphans, widows and widowers**
7. HIV prevention
8. HIV/AIDS information, education and communication
9. Voluntary counselling and testing.

The **HIV/AIDS and orphans, widows and widowers** component arose because of the challenge of inadequate and ineffective strategies and mechanisms for the care, support and integration of orphans in families and communities. The goal is to strengthen and support these capacities. (Strategic Planning Unit, National AIDS Control Programme, 2000).
The Challenge of Increasing Number of Orphans in Malawi

With the rapid spread of HIV/AIDS, the number of children affected by the illness and the loss of loved ones continues to increase. Problems children face as a result of HIV/AIDS begin long before the death of a parent or guardian. Children have to live with a sick parent and watch the parent deteriorate and eventually die. This drastically heightens children’s vulnerability as one loss inevitably leads to another loss.

What makes orphans vulnerability?

- No parents
- No family
- No home
- No voice
- No education
- No money/poverty
- Exploitation
- Abuse
- Humiliation
- Discrimination
- Isolation
- Age
- Sex
Provision of psychosocial care is very important. If their psychosocial needs have not been addressed, orphaned children experience feelings of grief, abandonment, loneliness, depression, anxiety, trauma, stigma, confusion. Guilt, discrimination and stigma. It is sad that many cultures discourage the open display of grief especially among male children. As such psychological problems persist into adulthood to the detrimental of the orphaned child.

Kadzamira, Maluwa-Banda, Kamlongera and Swainson, (2001) conducted a study on “The Impact of HIV/AIDS on Primary and Secondary Schooling in Malawi”. One of the components of the study focussed on orphans and other children affected by AIDS. The results clearly revealed the following:

2 There were large numbers of orphans at primary and secondary schools. From the sample of students in the survey, 41% of primary and 36% of secondary students had already lost one or both parents.

2 Most orphans were being looked after by grandparents who were often poor and vulnerable.

2 However, it should be noted that those who stayed in school were survivors. They had somehow learnt coping mechanism. Those who could not cope dropped out of school. The most common reason orphans dropped out of school was financial constraints. Although primary schooling is officially free, orphans and their guardians were often asked to pay the extra charges common levied at primary schools. The access of orphans and poor students to secondary school was even more restricted because they cannot afford the school fees.

2 Lack of support and guidance was the key reason why dropout rates tend to be higher among orphans than non-orphans. Once students had dropped out they almost never return to school.

2 There was very little overt discrimination in schools against orphans or other children affected by AIDS. However, school policies were insensitive to the plight of such children, who were frequently sent home from school because of lack of uniforms or the poor condition of their clothes.

2 Many children with sick family members were often anxious and depressed and lack care and support.

2 The majority of teacher and student respondents (both primary and secondary) recognise that orphans did not receive adequate support from the school.
Problems and needs of AIDS orphans

- Physical needs
- Education and vocational skills
- Loss of income
- Health care
- Stigmatisation
- Socialisation
- Exploitation
- Emotional and psychological support

To compensate for the loss of income, children often stop going to school in order to work, thus decreasing their long-term prospects of overcoming the burden of poverty (Cook, Ali and Munthali, 1998). Young girls and boys may even be drawn into dangerous lifestyles in order to provide for themselves and their siblings, especially if they have been unable to find psychosocial support.

Such children are prone to a wide range of child abuse such as sexual abuse, emotional abuse, physical abuse and institutional abuse and neglect. They are prone to labour exploitation and child prostitution (Malawi National Task Force on Children & Violence, 2000). The worst cases can lead to homelessness, delinquency, street life and prostitution among other problems unless specific measures are taken to prevent these (Kalemba, 2000).

In situations of extreme poverty, much attention is unintentionally focussed only on the material and physical needs of the orphans. Programmes are relief in nature and provide assistance that addresses only the immediate or survival needs of individual orphans such as shelter, food, and clothing. Unfortunately other needs of orphans for psychosocial, legal, spiritual and other support are neglected.

A Child’s story

My name is Mphatso and I am 11 years old. I am in standard four. I have three sisters and two brothers. After the death of both my mother and father, we joined our grandmother who is old and is looking after other seven orphans. Now, there are thirteen children under one roof. Our grandmother’s house has two bedrooms. Some of us sleep on the living room. Food is not adequate. We all dropped out of school because the grandmother could not afford to pay extra fees that the school was demanding. One thing that worries me is that the grandmother is very old and if she dies what would happen to us.
E. The Way Forward

There is need for a practical and culturally relevant approach to combating the growing problem of AIDS orphans. The approach needs to be multi approached since there are so many direct and indirect factors that determine the problem. Multiple actors will be required and they will need to establish ways of working together.

There is need to co-ordinate the Malawi National Orphan Policy and ensure its implementation at various levels. Government should seek to work very closely with local and international NGOs, faith community, youth organisations, schools and educators, donor community, grass roots organisations and local leadership in responding the orphan situation. According to Williamson (1995), these groups would need regular opportunities to come together to share information, build consensus and partnerships, clarify their respective roles and mobilise resources. As such, there is need for collaboration and networking. The government should develop systems of monitoring programmes and the quality of coordination among programmes providing similar services for increased impact.

The extended family support systems should be encouraged to continue their traditional obligation to absorb, care for and protect orphaned children, and any relief aid and assistance should be directed to assisting extended family members sustain and improve their coping mechanisms.

The provision of guidance and counselling services to both orphans and their guardians would be beneficial, especially on psycho-social issues, care and support.

Effective impact mitigation will depend on the quality of care and support provided to orphans. Communities are willing to absorb the orphans but there are problems with registration and assessment of their needs. Furthermore, there are inadequate mechanisms for building capacity for effective resource mobilisation and utilisation of resources.

Life skills training is a key to addressing some of the major problems encountered by orphans. Most of the orphans do not always have the necessary skills to enable them survive socially and economically. This situation requires particular skills, knowledge and attitudes that empower them to cope with the pressures and stresses of orphanhood. Accordingly, there is need to build the capacity of orphans to engage in income generating activities for self-reliance and support.
Comprehensive operational research needs to be carried out in partnership with the local communities and key stakeholders in order to:

- Examine the emerging needs and problems of orphans in different rural and urban settings.
- Identify the ways that orphans, families and communities are being affected by HIV/AIDS epidemic including problems they are experiencing, ways they are coping with these and factors influencing problems on coping, positively or negatively.
- Determine the capacity of the communities to offer care and support to orphans and vulnerable children, including availability of resources, childcare practices, and socio-cultural factors.
- Describe the current programmes and existing services for orphans including the involvement of grassroots groups in responding to problems among orphans and families affected by HIV/AIDS.
- Find out aspects of the local contexts that are most significant when designing a programme intended to benefit orphans.

Programme evaluation is needed to provide a clear picture, in a particular context, of the kinds of activities that are the most effective – (what works and what does not).

Conclusion

The care for orphans in Malawi remains a major challenge for decades to come. The number of orphans is increasing each day. However, it is important that it be addressed urgently. Besides its large size, the orphan problem is very dynamic and is still growing. This means that whatever measures and strategies are planned should keep pace with this dynamism and be flexible enough to accommodate any changes in community that may arise. It is therefore necessary to determine the specific impacts of this problem on the children themselves, their families and community at large through comprehensive research activities.

It is evident that the impact of HIV/AIDS will not go away easily. Kalemba (2000) has observed “quick fix solutions, such as establishing orphanages, providing handouts direct to orphaned children have no lasting effect and are themselves overwhelmed in due course and may cost a lot in opportunity costs” (pp. 17-18). Given the long-term nature of the HIV/AIDS problem, it would be best to examine the present efforts towards orphans and seek to develop long-term perspectives and strategies that promote economic empowerment, health and education, protection and psychosocial support. Furthermore, gender dimensions of HIV/AIDS must be integrated in the planning of interventions in orphan care.

It should be highlighted that community willingness to absorb and care for orphans appears to be high and sustainable through carefully planned and selective interventions.
Research findings have shown that communities prefer community based solutions to institutional care for orphans. According to Kalemba (undated), communities indicate that placing children in institutions is unacceptable because it removes them from their traditions, their property and their relatives. In addition, reintegration of children who have been raised in an institutional setting is psychologically difficult. It is important that efforts should be made to strengthen community based orphan care programmes. By supporting families, extended family and communities that donor agencies, non-governmental organisations and government agencies can strengthen the possibility of children being well-cared for as a child’s needs are ideally met within this context. Traditionally, family, extended family, community and culture keep children safe and provide children with the support and guidance they need to develop physically, emotionally, spiritually, and socially.

References


