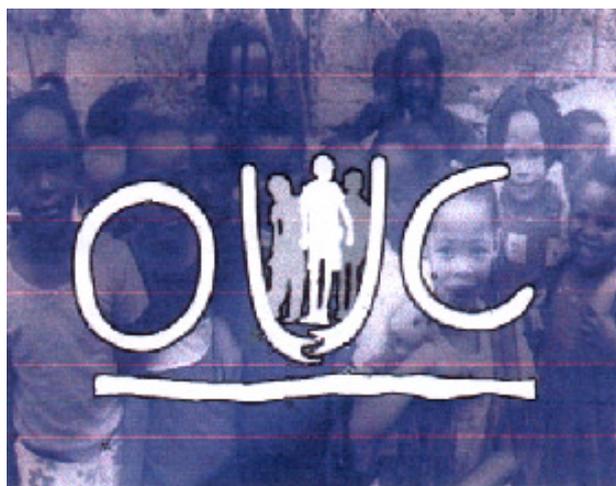


First National Conference on Orphans and Other Vulnerable Children

Windhoek, Namibia
8-10 May 2001

Summary Report



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Directorate of Developmental Social Welfare Services
Ministry of Health and Social Services

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- ▶ Votes of thanks.
- ▶ Information on video screened during the proceedings, titled *Save Our Children, Save Our Future*.
- ▶ Questions and comments from the floor and speakers’ responses after each presentation.

Acronyms and abbreviations used in this report

AIDS	Acquired Immune Deficiency Syndrome
CAA	Catholic AIDS Action
CBO	community-based organisation
CCN	Council of Churches in Namibia
DDSW	Directorate of Developmental Social Welfare Services
DRC	Democratic Republic of Congo
ECD	Early Childhood Development (Programme)
FHI	Family Health International
HIV	Human Immunodeficiency Virus
MBESC	Ministry of Basic Education, Sport and Culture
MOHSS	Ministry of Health and Social Services
MRLGH	Ministry of Regional and Local Government and Housing
MWACW	Ministry of Women Affairs and Child Welfare
NANASO	Namibian National AIDS Service Organisation
NEPRU	Namibian Economic Policy Research Unit
NGO	non-governmental organisation
OVC	orphans and other vulnerable children
PRA	poor resource area
SADC	Southern Africa Development Community
SIAPAC	Social Impact Assessment and Policy Analysis Corporation
SMEs	small and medium enterprises
UNAIDS	United Nations AIDS Programme
UNAM	University of Namibia
UNICEF	United Nations Children's Fund
WHO	World Health Organization

OPENING ADDRESSES

Statement by **Ms Khin-Sandi Lwin**, UNICEF Representative and Chairperson of the UN Theme Group on HIV/AIDS

The efforts and foresight of the Minister of Health and Social Services and her ministry to address the problem of a rapidly growing OVC population are commendable. They are congratulated for organising this conference to bring together all the experts and people working with or having the potential to work with OVC, to help Namibia define what actions are needed to care for them. The future of each of these children is in the hands of the participants. This conference clearly falls into the category of 'more important' national conferences.

Namibia is classified as one of the countries in the world most affected by AIDS, and more and more Namibian children are becoming orphans. This conference is linked to the concurrent National Youth Conference in that more and more adolescents will become primary caregivers for their young siblings, so they have to learn parenting and household management skills.

At this stage the exact numbers of OVC in Namibia are unknown. Estimates for orphans range from 21 000 to 67 000. There are no estimates for other vulnerable children. There is agreement, however, that the numbers of OVC will increase dramatically in the next 5-10 years, hence some critical measures must be put in place quickly. Three critical action areas are: *policy on OVC*; *support systems for families and communities*; and *ensuring access to basic services for OVC*.

The first step is to formulate a *clear and holistic national policy on OVC care* – a specific policy to address OVC needs and rights. A 'holistic' policy addresses not just material/physical needs and rights, but also the need for building knowledge and skills and providing psychosocial care, and issues like eligibility criteria for state assistance, implementation procedures and accountability measures. A holistic policy will underpin efforts to care for people living with HIV/AIDS. This conference should identify very specific action points for drafting this policy.

Regarding *support systems to help families and communities cope* in caring for their orphans, the current approaches will not suffice: assistance of the 'welfare' or 'charity' type is inadequate in terms of resources and sustainable human development; there is not enough money to hand out, and handouts make people dependent. People need help to help themselves.

The capacity of the *traditional extended family structure* is already straining under the growing burdens of caring for more and more orphans. If this 'frontline' of care or primary social safety net collapses, the problems will worsen, and problems such as street children, exploitative child labour and school dropout will become very serious and threaten not only the relevant children but also Namibia's well-ordered society and national development. People living with HIV/AIDS need help to prepare for death and their children's future – emotionally, spiritually, psychologically and materially. Such preparation entails, among other things, agreeing on guardianship and inheritance rights, preparing wills, reducing effects of social stigma, and providing psychosocial support. Community structures (e.g. CBOs, churches, local leaders and authorities) must support these preparatory steps. Communities are the second line of support for the children and the first line of support for the families affected. They in turn need help to develop the necessary support structures. Those closest to affected families are in the best position to determine who is most vulnerable or at risk. Local self-help efforts (e.g. micro-credit and savings schemes, education bursaries, home-based care and counselling) must be encouraged and supported so as to avoid creating dependency. Government extension workers, local authorities and NGOs need mechanisms to build their own capacity to support communities.

Regarding *access to basic services for OVC*, three kinds are critical: access to *education*; access to *preventive and curative health services*; and access to *psychosocial support*. Means must be sought to increase awareness of the *school fund exemption policy* for those who cannot afford to pay funds, and to simplify the exemption application procedures which are difficult especially for caregivers who are illiterate or too old or too poor to deal with the bureaucracy. There must be greater outreach to increase and sustain *immunisation and Vitamin A coverage* and other preventive measures. With the stigma attached to HIV/AIDS, many will not come forward for treatment. At least one third of children born to HIV-infected women will also be infected. Until there are policies and mechanisms in place to prevent *mother-to-child transmission*, health services must be geared up to attend to the children infected. *Psychosocial support* for OVC is presently unavailable from government services. Churches and CBOs can play a critical role in this regard, and they should be linked to the home-based approaches being introduced.

Ultimately a *holistic continuum of care* is needed. The family circle – supported by the community and governmental and non-governmental services – is the best and most suitable caregiver, but backup systems must be in place in the event that a family no longer exists or cannot or doesn't want to provide the necessary care. Institutional care should be the last resort, but where it is unavoidable, institutions must be adequately staffed and qualified to care for OVC. These are monumental challenges. UNICEF and the UN Theme Group on HIV/AIDS stand ready to support Namibia in tackling them.

Statement by **Dr Lucy Steinitz**,
National Coordinator of Catholic AIDS Action (CAA)

It is difficult to exaggerate the dimensions of trauma that our country will inevitably face in the next 5-10 years in terms of the rising numbers of OVC. HIV/AIDS is a plague of epic proportions that could destroy the fabric of our society. Every other problem we face, e.g. crime, unemployment and the abuse of women, is dwarfed by comparison, partly because the rising numbers and overwhelming needs of OVC will almost inevitably add to these ills – “almost” because we still have a chance to turn this nightmare into a nation-building opportunity – this conference being a crucial first step in that process.

A study jointly commissioned by UNICEF and the MOHSS in 1997 resulted in a report titled *More than the Loss of a Parent: Namibia's First Study of Orphans*. (The findings are included in the conference handout titled “For the Love of Children”.) Dr Steinitz led the research and produced the report. She recalled the caregivers' exhaustion, sense of hopelessness for the future and despair at not being able to afford school funds. She gave specific examples of the desperate situations that children and families found themselves in, and “each story makes you cry.”

CAA has almost 600 trained volunteers now caring for orphans as a direct outgrowth of its Home Based Family Care Programme. At first CAA thought that an orphan-support programme would emerge as a separate unit or specialty within CAA, but the volunteers asked to continue visiting the children whom they got to know while caring for their parents, and the bonds and continuity established with these children is an important foundation for future efforts. The volunteers are already known and trusted, thus the children and their caregivers are likely to turn to them for advice, support and referral. In quite a few cases the volunteers have taken orphans into their own homes, at least temporarily. The volunteers began registering needy orphans in 1999, and over 4 000 have been registered in the localities in which CAA works. To set a framework and guidelines, CAA developed an Orphan Care Policy in 1999 (one of the conference handouts).

CAA offers holiday packages twice a year to as many needy orphans as possible, and provides gifts to them at Christmas and Easter time, thus far mainly in the form of school supplies, jerseys

and blankets. In 1998 CAA established a small emergency fund from which it distributes the equivalent of a one-month foster-care grant. CAA workers or MOHSS social workers doing the screening. To date the fund has helped 565 orphans, but the demand could soon outstrip the resources, which are largely drawn from private donors overseas. CAA's Bernhard Nordkamp Centre in Katutura has a soup kitchen and an orphan tutoring and support programme with about 200 children receiving help on a regular basis. In 2000, with assistance from Family Health International (FHI), 99 of these children were considered to be at risk of not attending school and so were helped with school funds and uniforms. CAA hopes to expand this programme to the 4 'O' Regions in 2002, and then to the Erongo Region (primarily to Karibib and Usakos).

CAA is presently working on a training curriculum covering psychosocial issues affecting OVC, e.g. normal childhood development, loss and bereavement, children's rights and meeting the emotional and spiritual needs of OVC, who are often neglected. Training should begin in 2002. This child-focused psychosocial curriculum will be made available – along with a Training of Training Programme curriculum – to other interested parties.

CAA believes that the conference participants all have a role to play in meeting the challenges posed by OVC, and that their efforts should start at the community level. It is known that poverty is almost always a barrier to solutions. The participants must work together to empower people. The involvement of religious organisations is key, since churches are ubiquitous in Namibia; they are found in every village and neighbourhood. Apart from being motivated by compassion and visions of hope, they have the organisational infrastructure and the leadership necessary to fight this "war". CAA is honoured to be a partner in the bid to engender enthusiasm for the highest of all human callings: the valuing and care of our orphans and other vulnerable children.

Statement by Ms Batseba Katjuongua,
Director of Developmental Social Welfare Services, MOHSS

Ms Katjuongua provided background information and the reasons for holding this conference.

The Directorate of Developmental Social Welfare Services is charged to ensure the legal care and protection of children. Each social work office has social workers who provide statutory services to children and their families. These include: foster care; adoption; places of safety; institutional care; and diversion programmes. To complement these services – and leading from the World Summit Plan of Action for Children in 1990 – the directorate embarked on a plan of action with its partners, which developed into the Mobilisation for Children's and Women's Rights Programme in 1991. This programme contributes to the realisation of the rights expressed in the UN Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination Against Women for growing numbers of children and women in Namibia. Within the broad framework of the two conventions, the Mobilisation for Children's and Women's Rights Programme directs support for the priority issues established in Namibia's First National Development Plan and highlighted in the National Programme of Action for Children. It is also in line with other programmes developed since the world environment, social development and population summits, and the global conferences on nutrition and women. The main focus of this programme is to continue developing capacity in government and partner civil organisations to: (i) advocate for increased attention to all the rights expressed in the two conventions; (ii) to plan and implement effective protection and prevention services, and empower men, women and children to practise positive behaviours and make full use of the available protection and care services.

The programme has had a major impact on the daily lives of women, children and families in Namibia. Programme achievements to date include the following:

- ▶ Commitment of the government, private sector and other social sector partners to provide resources for the Women and Child Protection Programme (WCPP).
- ▶ A continual increase in the number of Woman and Child Protection Units in the country, of which there are now nine covering most of the 13 regions.
- ▶ A resource book on services available for children in need has been compiled.
- ▶ Data on the extent of child labour in the country has been collected.
- ▶ A number of training courses in the early detection of disabilities have been provided.
- ▶ A drop-in centre for street children has been established in Rundu.
- ▶ Reintegration of street children into families and mainstream society has increased.
- ▶ Better partnerships are in place for the identification and placement of children orphaned by HIV/AIDS and other factors.
- ▶ Estate allowances are more accessible due to good partnerships with the law courts.
- ▶ There is a night shelter for children in Windhoek.
- ▶ There is an after-school centre in Windhoek serving children from disadvantaged families.

This conference has been called because even with all our joint programmes, Namibia faces a crisis in respect of OVC, mainly due to the impact of HIV/AIDS. Failure to address the significant social, economic, demographic and other impacts of AIDS will undermine development and social stability, and the numbers of disaffected, undereducated, inadequately nurtured, undernourished and under-socialised young people will grow. The scale of the problem is so large and the challenges so diverse and widespread that no single body has the resources to support an effective unilateral response. Broad collaboration among a wide range of governmental and non-governmental role players is essential.

We hope that this conference will yield strategies and recommendations that will enable us to reach hard-to-reach rural communities and marginalised communities, and to build stronger community ties, making better use of extension workers and ensuring a more equitable utilisation of resources. We hope for the establishment of a multi-sector forum that will coordinate and monitor the provision of services to OVC along with the development and implementation of life skills and income-generating programmes for OVC and their caregivers.

Opening Address by **Hon. Dr Libertine Amathila**, Minister of Health and Social Services

Like every other country, Namibia has its share of orphans and vulnerable children, and like other African countries, Namibia in the past was able to support them through extended family networks, social safety nets and programmes designed to support them, but what we have in place no longer suffices in the face of the AIDS pandemic. As the presentations on current and projected estimates on OVC numbers will reveal, we are in a crisis situation.

AIDS is generating unprecedented threats to the well-being and safety of children, whose vulnerability begins to increase long before a parent dies. The common impacts of a parent's death include deepening poverty, pressure to drop out of school, food insecurity, reduced access to health services, deteriorating material conditions, and a host of added problems such as funeral costs, destitution when the family of a deceased man claims his property and leaves nothing for his widow and children, and siblings being divided among households of the extended family, which compounds their grief and leaves them in emotional distress for a long time. The stigma attached to AIDS, school dropout and orphans working on the streets all serve to reduce social support and intensify psychosocial distress.

The identification and support of OVC is paramount, and our main aim is to ensure that children remain in a family setting. The MOHSS does not want to create more institutional care facilities.

Namibia is a land of families and we want to build on this reality, not destroy it. We aim to empower communities to support and care for their own. We want to build on our successes in home-based care and support, and learn from our neighbours how OVC may be cared for and supported by their communities, and by social and medical services.

The Director of Developmental Social Welfare Services gave an overview of the directorate's work and achievements to date. The Family Life Empowerment Programme (FLEP), a Government of Namibia/UNICEF programme of cooperation which this directorate facilitated and coordinated, would not have been so successful in the absence of the partnering ministries, NGOs and donor agencies. The Government and UNICEF recently agreed on a new programme of cooperation for 2002-2005, with projects to focus on, for example:

- ▶ *decreasing exclusion*, whereby 60% of OVC will have access to basic education, medical care, counselling and protection from loss of property, and at least 80% of OVC and their caregivers will have increased knowledge of their rights and the services available to them;
- ▶ *communication on improved child and maternal care*, the objective being to reach at least 50% of all parents and guardians of children under 5 years of age, and parents expecting children, to inform them on best childcare and maternal care practices in terms of health, nutrition and psychosocial development;
- ▶ *health system support*, whereby the planning, coordination and management skills of health programme managers will be developed to ensure better access and coverage, and the efficiency and quality of services; and
- ▶ *promoting collective childcare*, whereby at least 50% of all children will have access to quality day care, and at least 80% of the day-care facilities will provide free day care for OVC, and childcare workers will mobilise parents and communities to adopt better childcare practices.

These kinds of projects will:

- ▶ increase the capacity of families to care for young children, adolescents and OVC;
- ▶ increase the capacity of communities to support young children, adolescents and OVC by way of collective problem-solving, and construct new social relationships and dependencies;
- ▶ build an enabling environment in which it is easier for children and families to cope;
- ▶ strengthen the capacity of essential services; and
- ▶ build on the coordination of a multi-sectoral response.

But even with projects like these, the directorate and its partners may not be able to handle the crisis, thus we are holding this conference. As in the case of the Second National Strategic Plan on HIV/AIDS launched by President Sam Nujoma in 1999, we are placing this challenge before you in the belief that we all have a responsibility to care for and protect our OVC. We have set very clear objectives for your discussions:

- ▶ To prioritise issues of concern for OVC.
- ▶ To develop specific strategies for protecting the rights of OVC.
- ▶ To develop terms of reference for all stakeholders.
- ▶ To mobilise all sectors of the community.

No single intervention will make a substantial impact on the full range of problems facing OVC. The problems are too many and too varied. A planned and coordinated set of policy, social mobilisation and programmatic interventions by the public sector and civil society is the way forward. This is a conference of great importance and the future of our OVC depends on us.

EXPERT PRESENTATIONS

Projections of OVC in Namibia – Dr Fred van der Veen, Technical Advisor for the National AIDS Coordination Programme, MOHSS

Dr Van der Veen gave a slide presentation on the modelling of the HIV/AIDS epidemic in Namibia, prepared in a consensus-building workshop organised by the MOHSS with technical staff involved in modelling in many sectors and agencies: the Central Bureau of Statistics, the National Planning Commission Secretariat, UNAM, NEPRU, UNAIDS, WHO the World Bank and the insurance sector. (Only the content of the slides is recorded in this summary, not the commentary.)

The purpose of modelling:

- ▶ To understand the dynamics of the epidemic.
- ▶ To predict the future impact on demographic indicators.
- ▶ To use this information for planning.
- ▶ To update the model according to new findings.

How can the epidemic be modelled?

- ▶ By understanding the natural course of the HIV disease (see Graph 1).
- ▶ By understanding basic epidemiological principles.
- ▶ By understanding the effect of the epidemic.
- ▶ By agreeing on data sources and assumptions.
- ▶ By using a comprehensive computer programme.
- ▶ By verifying, disseminating and discussing the outcome.

Some characteristics of the epidemic – an S-shaped curve:

- ▶ Initial phase with slow increase in prevalence.
- ▶ Phase of exponential growth – doubling every 2 years.
- ▶ Levelling off to the plateau phase.

A graph titled *The Natural Course of HIV Disease* shows the average course of infection in all individuals. There is a lot of variation in the way HIV affects individuals, so it is difficult to predict the course of infection in any individual, but on a large scale the average course of infection and disease is well understood: A short acute phase starts immediately after infection and lasts about 3 months. A long phase lasting 8-10 years on average follows, during which people are healthy and usually unaware of their infection. In the third phase infection symptoms related to the weakness of the immune system begin.

The effect of HIV and AIDS on demographic indicators:

- ▶ Increased mortality of adults aged 15-49 years.
- ▶ Increased mortality of children under 5 years.
- ▶ Reduced fertility of HIV-infected women.

HIV Sentinel Sero Surveys:

- ▶ Pregnant women during first visit.
- ▶ Anonymous and unlinked.
- ▶ Representative.
- ▶ Accessible.
- ▶ Constant over time.
- ▶ Affordable and sustainable.

Validity of HIV Sentinel Sero Survey data:

- ▶ HIV prevalence in pregnant women.
- ▶ Population-based surveys (3 maps showing regional Sentinel sites and rate of infection):

1992 – the first survey in sites in all regions: 10-14% in Caprivi; 1-4% everywhere else.

1998 – nowhere in the country is HIV prevalence less than in 1992: 5-9% in Omaheke, Kunene and Karas; 10-14% in Kavango; 15-19% in Ohangwena, Erongo and Otjozondjupa; 20-24% in Oshikoto and Khomas; 25-29% in Caprivi and Erongo; 30-34% in Oshana.

The data from the sentinel sites was extrapolated to give the following distribution per region. The most populated regions are also the most infected.

1998: 5-9% in Kunene, Omaheke, Hardap and Karas; 10-14% in Kavango; 15-19% in Otjozondjupa, Omusati and Ohangwena; 20-24% in Oshikoto, Erongo and Khomas; 25-29% in Caprivi; 30-34 in Oshana.

Other graphs presented:

- ▶ *Trend in HIV Prevalence in Pregnant Women in Namibia, 1985-2005* shows a rise (an S-shaped curve) from 0 in 1989 to nearly 25% in 2005;
- ▶ *Estimated Number of Persons Living with HIV/AIDS, Namibia, 1991-2006* shows a rise from about 15 000 in 1991 to 100 000 in 1995/96, 200 000 in 2000/01, to over 260 000 in 2006.
- ▶ *Projected Deaths from AIDS (for adult males, adult females and children), 1995-2006* shows a rise in the number of deaths in all cases from 2 000 or less in 1995 to nearly 25 000 for adult males, nearly 15 000 for adult females and \pm 2 500 for children in 2006.
- ▶ *Projected Orphans from AIDS, Namibia, 1995-2010* shows a rise from 1 630 in 1995 to 31 000 in 2000/01, 118 000 in 2006, to nearly 155 540 in 2010.
- ▶ *Trend in HIV Prevalence in Pregnant Women, Windhoek, 1985-2010* shows a rise from 0-1% in 1990 to nearly 40% in 2010, and *Trend in HIV Prevalence in Pregnant Women, Kavango, 1985-2010* shows a rise from less than 1% to 18% in 2015.
- ▶ *Rates of new HIV Infections, Hospitalisations and Deaths per 1 000 Population per Region, Namibia, 1999* shows the rises and reductions in each case for each region. Khomas had the highest new infection rate (18 per 1 000) and Kunene the lowest (3); Oshana had the highest hospitalisation rate (\pm 7) and Kunene the lowest (less than 1); Oshana had the highest number of deaths from AIDS (close to 4) and Kunene the lowest (almost none).
- ▶ *Modelled Age Group Distribution of the Namibian Population, 1991-2010* shows an average distribution of 3-5% aged 65+, 42-46% aged 0-14 and 55% aged 15-64.

Limitations of the current model:

- ▶ The international definition of orphans – 15 yrs and under rather than Namibia's 18 years.
- ▶ The model only calculates HIV-related orphans.
- ▶ Only national estimates are available.
- ▶ There is no data available on migration of orphans.

Conclusions:

- ▶ There is national consensus about the impact of HIV/AIDS on demographic indicators.
- ▶ The available data are a sound basis for planning.
- ▶ Capacities exist to update and refine the model (working group: contact Dr Forster).
- ▶ Programme and data are available for free (download from MOHSS website).
- ▶ The number of orphans will increase by a factor of 5 over the coming 10 years.
- ▶ There will be only minimal changes in the overall dependency ratio.
- ▶ This does not exclude major impact within households and families.
- ▶ Some regions are more affected by the epidemic than others.
- ▶ Some sectors are more vulnerable to the impact of the epidemic (subsistence farming).

Response:

- ▶ Maintain a sound macroeconomic environment.
- ▶ Social cohesion is a major factor determining the course and impact of the epidemic.
- ▶ The HIV/AIDS epidemic itself may affect social cohesion.
- ▶ Existing solidarity mechanisms should be strengthened to maintain "family life".
- ▶ We have to remain decision-focused on these long-term priorities.

Findings of OVC Study – Dr David Cownie, Managing Director of the Social Impact Assessment and Policy Analysis Corporation (SIAPAC)

Dr Cownie gave a slide presentation on the findings of a study conducted by SIAPAC, commissioned by the MOHSS and financed by UNICEF Namibia.

A SITUATION ANALYSIS OF ORPHAN CHILDREN IN NAMIBIA

APPROACH

- ▶ National Key Informant Interviews.
- ▶ Local Level Key Informant Interviews.
- ▶ Focus Group Discussions with Caregivers.
- ▶ Focus Group Discussions with Orphans.
- ▶ Group Discussions with Regional AIDS Committees.
- ▶ Case Studies.

FINDINGS

Who is looking after orphan children?

- ▶ *Most common:* extended family members on both the mother's and father's side – usually aunts and grandmothers.
- ▶ *Next most common:* adult brothers and sisters.
- ▶ *Uncommon:* child-headed households.
- ▶ *Uncommon:* non-relatives.

Are orphan siblings kept together?

- ▶ Caregivers noted the importance of keeping the children together.
- ▶ The children themselves noted that they were friends with the other children in the household, including their own brothers and sisters.
- ▶ Most orphan siblings appear to be taken in by a single caregiving family, and there is no variation across poor and non-poor households.

Do the children adjust to their new circumstances?

- ▶ Because the children are usually taken into a familiar situation, adjustment is less problematic than would otherwise be the case. Adjustment problems were reportedly most severe in cases where children were moved from an urban to a rural environment.
- ▶ Around one-third of the orphans were already living in the household before their parent/s died.
- ▶ The trauma of losing a parent or both parents did create emotional adjustment problems, but most were reportedly not severe. Caregivers recommended “transitional” counselling.
- ▶ Orphan children tended to feel that they were well accepted in the new household, and were not teased by other children for being orphans, either at home or at school.

Do orphan children attend school?

- ▶ It is commonly assumed that orphan children are losing access to education. However, this was not found to be the case in Namibia at this time.
- ▶ Households are going to great lengths to keep their own and the orphan child/ren in school.
- ▶ Still, many poorer households reported having problems raising funds for schooling and drawing extensively on extended family networks for support. Some also had to request assistance from school authorities in terms of school uniforms and exemption from paying school funds.
- ▶ After a period of adjustment orphan children were reportedly doing well in school and were not performing substantially differently to how they otherwise would.

The extended family clearly plays an important role in caring for orphans. What about neighbours and the community more generally, as well as NGOs and government?

The international literature on orphans highlights the key role played by the wider community in helping to meet the needs of orphans and caregiving households. But in Namibia, asked about the importance of neighbours, community organisations, and community leaders assisting in this regard, virtually all respondents said that presently they do not play much of a role. Support from NGOs and government was felt to be more important or potentially important.

- ▶ *Support required:* valued at N\$250+ per orphan.
- ▶ *Type of support desired:* cash contributions; payment of school costs; food; clothes; blankets.
- ▶ *'Most needy' households:* those without a wage earner; those without livestock; those looking after many children.

ISSUES ARISING

- ▶ *Emotional needs:* 'adjustment' counselling.
- ▶ *Education:* keeping children in school.
- ▶ *What to do:* when extended family structures are not enough.
- ▶ *What to do:* child-headed households.
- ▶ *What to do:* community-based interventions.
- ▶ Monitoring.
- ▶ Child-minding.
- ▶ Facilitating adoption.

Psychosocial Issues Facing OVC – Ms Khin-Sandi Lwin, UNICEF Representative and Chairperson of the UN Theme Group on HIV/AIDS

Ms Lwin gave a slide presentation on the psychosocial issues facing OVC, based on global and sub-Saharan African research or experience.

Holistic approach to OVC care (all 3 are essential):

- ▶ Physical care: addressing adequacy regarding material needs (shelter, food, clothing).
- ▶ Transfer of knowledge and skills for sustainable self-help and development (education, vocational training, life skills).
- ▶ Psychosocial care and support.

What are some psychosocial issues facing OVC?

- ▶ Coping with grief and bereavement.
- ▶ Greater social isolation, stigma and discrimination due to HIV/AIDS infection.
- ▶ Need for social protection given the greater risk of lack of care and of exploitation.
- ▶ For some, greater risks of longer-term anti-social behaviours and aggressiveness if special care is not available.

Why do we need to provide psychosocial support?

- ▶ "To protect the capital of social energy, motivation and self-confidence of the children for their own and society's benefit." In other words ...
- ▶ Children need that extra helping hand to regain their 'balance' in life when one or both nurturing/ supporting 'crutches' disappear. Without this help society may end up with more unproductive and anti-social adults in the long run.

Four areas of possible reaction to loss of a parent:

- ▶ *Emotional life:* sadness, loneliness, guilt, anxiety, anger (the latter possibly leading to over-active, aggressive, fearful behaviour).
- ▶ *Self-perception/image:* loss of self-efficacy (influence/control) and self-esteem (worth), leading to withdrawal, allowing others to exploit – exacerbated by the discrimination/stigma of HIV/AIDS -- or greater sense of maturity in the long run.

- ▶ *Health*: with greater and acute stress and internal turmoil, greater chances of psychosomatic symptoms (headaches, stomach problems), real illnesses or becoming accident prone.
- ▶ *School performance*: greater difficulties with learning and concentration.

Different levels of reaction:

- ▶ Depending on age and sex (of both parent and child), preparation, level of independence, vulnerability, innate resilience, availability of close alternate source of emotional care.
- ▶ Effects may not surface until years later for some children.
- ▶ Depending on risk factors.

If these 4 risk factors coincide, some form of disorder in development or behaviour will almost inevitably result:

- ▶ Terminal illness of a parent (i.e. not sudden death).
- ▶ Separation from siblings.
- ▶ Exclusion from or discontinuation of school.
- ▶ Poverty/deprivation.

Levels of vulnerability:

- ▶ Past experience of repeated loss or whether a strong and nurturing family environment existed.
- ▶ All ages are affected (even infants), but for emotional stress, children aged 5-7 appear to be more vulnerable – old enough to understand permanent loss but lack the social skills to deal with it (to express or externalise feelings).
- ▶ Girls are more vulnerable to social risks given their social status and economic dependence. They are at greater risk of sexual exploitation and abuse.

What can/should be done?:

- ▶ Help child recover from shock of loss.
- ▶ Make child aware of her/his own resources and strengths.
- ▶ Help child overcome feeling of helplessness and that there is no future.
- ▶ Help child maintain/develop self-esteem and self-confidence.
- ▶ Make child aware that society/community hasn't abandoned her/him.

How can these things be done (within the family circle)?:

- ▶ Preparation for death: helping the dying parent to cope and to prepare the child emotionally.
- ▶ Give clear and understandable information (lack of which creates greater anxiety and a feeling of being less important or even responsible for the death).
- ▶ Ensure involvement/inclusion – in both preparation for death and death rituals.

External support by communities or services:

- ▶ As part of home-based care for people living with HIV/AIDS.
- ▶ Through specific group or individual psychosocial support activities.
- ▶ Ensuring continuation of routines (schooling) for stability and extra support in school by teachers.
- ▶ Ensuring safe structures/environment (keep siblings together).

Who can provide this care?

- ▶ The first circle of care must be the family (nuclear or extended), but caregivers need support in learning to cope with their own stress and with the children.
- ▶ Church structures and local/community-based groups are most capable of providing this support, but their capacity needs to be strengthened.
- ▶ Schools can provide emotional support and outlet (teachers, friends, extra-curricular activities). Play and art (drawing) for younger children are strong tools to help recover from trauma.
- ▶ Ultimately NGOs and government outreach services have to help build the capacity of communities and schools to provide support.

“Other” vulnerable children:

In situations of child abuse (physical, sexual) and gross neglect for various reasons, the psychosocial effects are of a slightly different nature: in cases of abuse the effects are very serious, however the caregiving elements are similar and the same community and services should respond with professional psychological care where available.

The OVC Situation in Zambia – Ms Mulenga Kapwepwe, OVC Consultant

Ms Kapwepwe presented an overview of the OVC situation in Zambia, focusing on the development of the country’s response to it over the past decade.

BACKGROUND INFORMATION

In the mid to late 1980s Zambia recognised HIV/AIDS as an epidemic. At this early stage interventions like safe blood supply, STD programmes, behavioural change communication, condom promotion, voluntary testing and counselling became the backbone of the Zambian response. Sentinel surveys and studies in critical areas were commissioned to track the impact and cost of AIDS. Its impact on children was becoming visible as many lost one or both parents. Increasingly they were not going to school, not being fed properly and not accessing health care. By 1996 the situation was critical. Zambia then had 4.1 million children (aged 0-18). The 1996 Living Conditions and Monitoring Survey found 13% (\pm 550 000) of all Zambian children to be orphans. Single orphans (one parent; 86%) outnumbered double orphans (no parents); 64% of orphans had lost their father, 22% their mother and 14% both parents. The proportion of orphans was found to increase with age – from \pm 4% aged 0-4, to 19% aged 10-14 and 23% aged 15-18. In the mid '90s the dynamics of poverty in relation to HIV/AIDS were discernible. In 1997 nearly 70% of Zambians lived below the poverty line; by 1999, 80% lived in poverty. Today nearly three-quarters of Zambian children live in poverty, with little notable quantitative or qualitative difference between OVC and others. In the mid '90s child malnutrition cases and mortality rates were increasing; 56% of orphans and 49% of non-orphans are stunted. Nearly 50% of Zambian children are not enrolled in primary school today, regardless of orphan status; countrywide there is little difference in primary school attendance rates of orphans and non-orphans. Homeless children have been appearing on the streets since the early '90s, begging or working for food/money for themselves or their families. The 1998 Zambia Human Development Report estimated that there were 75 000 street children (mainly boys), over two-thirds of whom were aged 6-14, 40% of whom had lost both parents and 7% of whom had no home to return to. Children’s rights have been eroded in Zambia since the '90s. The strain on the family, particularly the extended family, began to show in the mid '90s. Cultural inheritance practices protecting widows and children were disappearing: children were being disinherited; property-grabbing was increasing. Family composition and form began to change: child-headed, single female-headed and grandparent-headed households were emerging; adult siblings were taking over the parenting of younger siblings in their own households; relocation and displacement of children from home to home were increasing. Today nearly 50% of all orphans reside in a household headed by a surviving parent. Grandparents and aunts/uncles care for a large percentage of double orphans – grandparents 38%, aunts/uncles 29% – so the extended family does still share the burden of orphan care. In rural areas double orphans are more likely to live with a grandmother; in urban areas more often with aunts/uncles than other relatives.

THE ZAMBIAN RESPONSE

A conference on the crisis facing OVC was held in 1994. It focused on shelter issues, financial and material support for communities and families, home-based care, orphan access to education and vocational training, income-generating activities, legal support and legal reform on behalf of orphans and widows. Families and communities responded first to the call to assist: they took in orphans; supported relatives and neighbours materially and psychologically; initiated income-generating and other activities to address the problems and devised means to sustain these activities. CBOs were the

next to respond, particularly churches, e.g. the Catholic Church developed coordinated family-care programmes and others encouraged orphan care. The churches' attempts were commendable, but their large-scale programmes lacked funding and a focused effort. Government was slow to react due to budgetary constraints. NGOs and CBOs stepped in by implementing extensive donor-funded activities, but their respective efforts did not lend themselves to producing a coherent, collaborative, coordinated and well-documented response to the crisis.

The 'first-generation' responses were directed at meeting orphans' physical needs; these were very localised and immediate responses. NGO/CBO programmes focused on direct financial and material relief (providing food and clothing, establishing drop-in centres, etc.), and on organising communities to provide such assistance. NGOs and CBOs realised that direct financial and material support was creating dependency, and that communities had to mobilise their own resources, so building their capacity to be financially autonomous was the most desirable course of action. At this stage too, the problem of defining 'orphan' was still raging. In 1997 NGOs and CBOs realised that all definitions applied to date carried significant risks: they led agencies to focus exclusively on orphans rather than on *all* children in need. Most communities *didn't* distinguish orphans from other vulnerable children, and a great lesson was learnt at this stage, which shifted the whole focus and scope of interventions for OVC: *it is best left to communities to define and identify who is an orphan, who is vulnerable and who requires what assistance*. Statistics have confirmed the accuracy of community perceptions and the inaccuracy of template definitions. This lesson has enabled agencies to provide more focused and effective direct assistance.

In the second response phase, having noted that most income-generating activities aimed at helping OVC were unsuccessful and that money given as grants was not being invested/reinvested but rather used to buy food or pay medical expenses, NGOs began mobilising entire communities to action through new programmes focusing on: building the capacity of families to care for OVC; enhancing community mechanisms to support OVC and households; assisting children affected by HIV/AIDS to support themselves and younger siblings; lobbying and advocacy for government to protect OVC and provide leadership, policy and essential services; and creating public awareness of the needs and problems of OVC. The cornerstones of NGO programmes for OVC are community mobilisation and capacity-building, education (mainly through community schools) and income generation. Communities receive training in areas like leadership, business skills, monitoring and evaluation, nutrition and health care, HIV/AIDS and gender. NGOs have been building their own capacity in participatory methodologies, resource mobilisation, advocacy and lobbying, project planning and management, community approaches and social work.

Government was seriously alerted to the OVC problem by studies like the 1999 UNICEF study, many findings of which were incorporated into the operations of the Zambia Social Investment Fund. A government task force on OVC was set up in 1999, composed of the Ministries of Youth, Sport and Child Development; Community Development and Social Services; Education; Health; and Legal Affairs, as well as umbrella NGOs and religious and civic organisations. The Disaster Management and Mitigation Unit in the Office of the Vice-President also began critically examining its role in the care of OVC. At this stage it was realised that interventions paying greater attention to the psychosocial needs of OVC were needed, but the response to initiate these was slow. The first responses focused on home-based care, but these required specialised skills in counselling and psychosocial support mechanisms, and these were lacking in Zambia.

Over the years numerous organisations have responded to the OVC crisis and there have been many developments. Zambia is now in the phase of redefining and aligning strategies – focusing on standardising programming and care practices, identifying who is doing what, advocating for regional councils and coordinating and monitoring bodies – to bring coherence, coordination, collaboration and quality to its response. This phase of Zambia's response to OVC is based on these realisations: The OVC crisis requires a multi-sectoral response; OVC poverty is a primary problem; OVC have special psychosocial needs; the OVC issue is a family and community one; efforts to stem the spread of HIV/AIDS and assist parents/guardians living with HIV/AIDS must be incorporated into OVC programming; and a protective, responsive and supportive environment must be created by legislation.

In each case much is being done: multi-sectoral district committees are being formed, and private sector initiatives are emerging; government and NGOs are establishing systems to provide material support to needy families/individuals, and the Public Welfare Assistance Scheme has been revamped to assist needy children; the College of Health Sciences is developing culturally relevant counselling techniques and training councillors, a national counselling body has been established, community members are being trained to counsel OVC, and international organisations like AIDS Alliance as well as national umbrella organisations like Children in Need are complementing all these efforts; the Zambia Social Investment Fund is disbursing funds to communities and NGOs to support efforts for OVC; HIV/AIDS prevention and care interventions and projects like the Anglican Street Children's Project are being incorporated into OVC programming; concerted law reform efforts are underway to bring legislation in line with the Convention on the Rights of the Child, key legislation protecting children's rights is being popularised, and a National OVC Steering Committee is in place to facilitate the formulation of a national policy. Developing an effective national response entails a long process of learning, assessment and revisiting strategies and options.

PANEL DISCUSSION: Setting the Stage

Mr Abner Xoagub,

Manager of the National AIDS Coordination Programme, MOHSS

Mr Xoagub gave a slide presentation titled "Children Living in a World with HIV/AIDS" in which he addressed numerous issues pertaining to OVC in Namibia. (The slide content is summarised here.)

Legal and policy framework: Non-compliance with legal and policy mechanisms is a major barrier to effective, coordinated action. The National Strategic Plan on HIV/AIDS (MTP II) should be implemented by all sectors as a matter of urgency.

Database of organisations/institutions working with and for children: A comprehensive database would greatly facilitate and improve communication and co-operation among the partners.

Networks and co-ordination mechanisms: The advantages of a network of organisations working with and for OVC are obvious. A generic model of how a network can operate should be developed and training provided for potential partners throughout Namibia on initiating, constructing, managing and sustaining a network.

Poverty: HIV/AIDS precipitates family poverty. An appreciation of this is fundamental to developing appropriate responses. Wherever possible poverty alleviation programmes should work hand in hand with OVC programmes, and all should aim to provide basic necessities like food and clothing.

Identification of OVC: This should be mandatory. A standardised form for registering OVC should be developed, which could in turn feed into the process of allocating grants and provide invaluable data with which to plan for the impact of increasing numbers of AIDS orphans.

Home-based care as the access point: The care of children affected/orphaned by AIDS is a natural extension of any home-based care programme for people with HIV/AIDS. Every home-based care programme should cater for affected/orphaned children as an integral programme component.

Holistic care and support within a comprehensive continuum: 'Care' and 'support' are the terms most frequently used in the MTP II in considering children affected by HIV/AIDS. 'Holistic care' and 'holistic' support entails addressing the full range of human individual, family and community needs: physical, emotional, spiritual and social. In practice this would require health- and welfare- focused initiatives to consider expanding their respective models.

Planning for the future of children who will be orphaned: The stigma associated with a positive HIV status often results in silence about a parent's impending death, this being a barrier to planning

for a child's future. Bereavement and family counselling should include discussion on a child's future. Whether by means of a 'Memory Book' or in a family conference setting, creating an appropriate time to talk about the future is of great benefit to both parents and children. Fostering within the extended family should be considered, through a multi-sectoral approach.

Supporting child caregivers: Little has been done to prepare and support children who are caring for dying parents. Where there is no viable alternative caregiver, these children must be prepared for and supported in playing this role.

Promoting a rights-based approach: Educating caregivers and children on children's rights gives children alternatives based on these rights. The best interests of the child must be a guiding principle in all projects, and all training programmes should include modules on children's rights. Strategies to ensure effective participation by children and youth in all programmes should be implemented.

Support for affected children:

There is growing consensus that drop-in centres catering for support groups, counselling, homework supervision, meals, etc. for affected children would play a valuable role. CBOs should identify the specific needs of affected children in their programmes and consider establishing such centres.

Community mobilisation: There is global consensus that effective responses to HIV/AIDS must be situated in and owned by communities, but in reality AIDS is impoverishing communities and unravelling families. The starting point for mobilising communities is to let the community identify its own concerns and what responses are possible with existing internal resources. Then there must be a process to decide on priority needs. Only at this point should any outside capacity or resources be added to enable a community to undertake its chosen activities.

Discrimination and stigma associated with HIV/AIDS: These still constitute significant barriers to effective service delivery. Projects have found that not being AIDS-specific, i.e. providing home-based care to people having *any* fatal disease and supporting *all* orphans, minimises this barrier.

Capacity-building: Projects whose primary aim was service delivery are being drawn into providing training, many to the extent that their focus is changing. It is necessary to identify who requires training at national, regional and local/community level, and to share training resources.

Grants: Nationwide awareness-raising programmes are needed to educate the general public on available grants and benefits for OVC. The grant application process must be simplified as presently it is long and complicated, especially where birth certificates and other IDs are needed.

Research: It is necessary to generate a research agenda since there are multiple areas in which research is required to provide data to guide the implementation of a national strategy for OVC.

Ms Petronella Coetzee-Masabane, Deputy Director of Developmental Social Welfare Services, MOHSS

Ms Coetzee-Masabane gave a presentation on some critical challenges regarding OVC and critical actions to be taken to meet each one. By no means are these prescriptive, but as a government body responsible for social welfare, the MOHSS believes these should be placed on the national agenda.

CRITICAL CHALLENGES	CRITICAL ACTIONS
1. Leadership agenda on OVC	1. Reach consensus on policy framework. 2. Resources in accordance with needs and extent. 3. Strengthen partnership. 4. Advocacy for integrated inclusive approach to planning and service delivery. 5. Review legislation.

2. Better care and support to parent/family caregivers	<ol style="list-style-type: none"> 1. Access to Early Childhood Development (ECD) Programme. 2. Access available material/resources information, identify gaps and establish an information dissemination mechanism. 3. Set up a database of service providers and distribute. 4. Expand teams of community mobilisers. 5. Avail home-based care kits to caregivers for their protection.
3. Expanding the number and quality of organisations	<ol style="list-style-type: none"> 1. Strengthen coordinating structures at all levels. 2. Expand emerging support groups to under-served areas. 3. Advocate for organisations to expand activities to OVC. 4. Develop best practices, document them and disseminate.
4. Resources to base (welfare and economic/productive strengthening)	<ol style="list-style-type: none"> 1. Expand income base, e.g. SMEs and micro-finance schemes. 2. Overhaul social assistance system to focus on childcare group. 3. Continue and expand PRAs. 4. Provide material assistance to service providers, e.g. the ECD Programme, to encourage orphan care.
5. Expanding the role of schools and education systems	<ol style="list-style-type: none"> 1. Widely distribute Learner/Parent/Caregiver Charter on Rights, e.g. waiving of school funds and boarding fees. 2. Implement policy on educationally marginalised children. 3. Establish extent and causes of dropout at primary schools. 4. Basic (vital) life skills.
6. Strengthening participation of children, families and communities	<ol style="list-style-type: none"> 1. Simplify laws and policies and produce user-friendly booklets to inform on rights. 2. Establish integrated community service centres (one-stop) in under-served areas. 3. Participatory drafting of orphan-care strategy.

Ms Selma Shejavali, Programme Officer for HIV/AIDS and Violence Against Women and Children, Council of Churches in Namibia (CCN)

Ms Shejavali was requested just a few minutes before the panel discussion to replace CCN General Secretary Rev. Kathindi, who was unable to be present at the time. Being unprepared, she spoke very briefly about the current activities of the CCN in relation to HIV/AIDS and OVC.

The CCN affiliates are churches with full membership, associated membership or observer status. As “the voice of the voiceless” in the liberation struggle, the CCN took on the role normally played by government in educating and implementing programmes. The CCN is no longer an implementing body; it now facilitates the involvement of its members in programmes implemented by others, and works in partnership with several ministries and organisations. HIV/AIDS is one of the CCN’s major concerns. Though its members have been slow to react to calls to initiate programmes on HIV/AIDS for their congregations, some have started programmes and it is hoped that others will follow suit. As a Lutheran Church congregant, Ms Shejavali shares the concern that fellow congregant Hon. Dr Amathila expressed in her speech regarding the slow response of this church, but all three Lutheran churches are now responding positively and quickly, and all have appointed pastors as programme coordinators – Pastor Diergaardt (a conference participant) being one of them. The three pastors are working very hard and the CCN is trying hard to encourage their work. The United Reformed Church of Rev. Platt (also a participant) intends starting a programme for orphans. The CCN is facilitating the involvement of churches in educating people, and a duty of any church is to provide Christian and social counselling, so counselling will be emphasised in future plans. The CCN also wants to focus on cultural values, as Namibian cultures have very good values to be built on to help people. Community unity is one cultural value to pick up on in relation to OVC: Namibians are the children of their parents *and* of their communities. The CCN wants to see all its members becoming just as involved as the Catholic Church in combating HIV/AIDS and caring for those affected. The CCN stands ready to help implement the recommendations of this conference and all previous forums on HIV/AIDS.

Ms Emma Tuahepa-Kamapoha, Coordinator of the Namibian National AIDS Service Organisation (NANASO)

Ms Tuahepa-Kamapoa gave a very brief overview of NANASO's work. NANASO is an umbrella and networking organisation for 38 NGOs working on HIV/AIDS. It is not an implementing body, so it does not have its own OVC programme, but will do everything possible to support its affiliates in their work for OVC. Very few NANASO affiliates deal with OVC at present. The Catholic affiliates are heavily involved in work for OVC, but they cannot deal effectively with OVC alone, thus NANASO will request all its affiliates to incorporate OVC-related initiatives into their HIV/AIDS programmes. NANASO is also looking at launching a responsive programme, as an umbrella NGO, for all vulnerable children, based on proper research to be undertaken by the relevant partners. NANASO particularly wants to see affiliated rural CBOs dealing with the OVC problem in their own communities, and will encourage well-established affiliates to complement the rural CBO efforts. A big problem for NANASO has been that well-established NGOs/CBOs start competing with newly established ones. NANASO agrees with the MOHSS that institutional care for OVC should be a last resort, and will encourage its affiliates to see to it that OVC are taken in by families in their communities, and that fostering families receive support from affiliates' donor funds. NANASO will also start advocating for OVC and disseminating information to its affiliates on the services available for OVC.

Ms Adelheid Butkus-Ndazapo, National Coordinator of Early Childhood Development, Ministry of Women Affairs and Child Welfare

The Division of Early Childhood Development within the Directorate of Community Development has been following the situation of orphans since the transfer of the Early Childhood Development (ECD) programme from the Ministry of Regional and Local Government and Housing (MRLGH) to the newly established Ministry of Women Affairs and Child Welfare (MWACW). With financial assistance from UNICEF, the MRLGH initiated a pilot orphan-care programme in two regions, namely Omusati and Ohangwena, to address the fact that HIV/AIDS was contributing to a dramatic rise in orphan numbers. Communities in the pilot regions were found to have different strategies to assist OVC. In many cases OVC care is transferred to the extended family, and there are fostering families and community-caring initiatives and institutions caring for the others, however all these are insufficient. From an emotional, social and moral standpoint, the most serious problem is the existence of child-headed households and so-called non-visible orphans. In Omusati 1 200 orphans have been registered so far, and 110 ECD centres are caring for them free of charge, with incentives provided through UNICEF. Children too young (i.e. 0-3) to be located at the centres are cared for by six community volunteers who visit homes to help OVC in various ways. In Ohangwena 203 orphans have been registered so far, 76 ECD centres are caring for them and the very young are in the care of extended families.

The MWACW does not aim to monitor children affected by HIV/AIDS, but rather to ascertain the total number of OVC in the country so that it can recommend ways and means to deal more efficiently with the crisis posed by their increasing numbers. Namibia is faced with potentially fatal diseases other than HIV/AIDS, e.g. malaria and tuberculosis, and coupled with social hardships like unemployment, malnutrition and inadequate health care, these will add to the number of children in difficult situations. The ECD Division has focused mostly on the 0-6 age group, and primarily on those served by ECD institutions, but MWACW programmes must target children in all age groups (i.e. 0-21). This is a new task for a new ministry, and the MWACW is still creating adequate organisational structures to fulfil it. The MOHSS caters for children of all ages, and the two ministries have to devise new ways to coordinate and cooperate on their common ground. The MWACW is aware that its indicators are still very limited, but it intends to conduct a survey to accurately assess the status of OVC. It also plans to disseminate information to potential donors and role players in the hope of bringing OVC under the care of society and making them the objects of true social solidarity and caring.

Ms Claudia Tjikuua, Chief Education Officer, Ministry of Basic Education, Sport and Culture (MBESC)

Ms Tjikuua spoke about the challenges facing the MBESC in respect of OVC and what has been done so far to meet them.

The complexity of the education arena and the challenges for those involved in education at all levels cannot be underestimated. This was the case even in the absence of HIV/AIDS, but with HIV/AIDS the challenges have become insurmountable. The four main objectives in providing "Education for All" are: access; quality; equality; and democracy. The MBESC vision has always been to increase school enrolment to 100%, and to decrease dropout rates especially at primary level. To date the following has been done to achieve these constitutional obligations: In the mid '90s, in view of the social evils and past political disparities that affect/ed so many, the MBESC set up the Intersectoral Task Force on Educationally Marginalised Children with the aim of increasing access to schooling for all children excluded. A policy on marginalized children was then developed and is now being implemented. It covers AIDS orphans too. A charter for primary and secondary education has been developed, which outlines what every child should expect from the MBESC. Guidelines and press releases have been produced to inform people of the right to exemption from school development funds and hostel fees. A school-feeding programme is being run in some schools, and school counselling support groups have been set up.

Despite all this, the MBESC is unsure if the children really in need of these services are being reached. A place in school and policies in place do not mean that a child gains the maximum benefits from schooling. Children need many forms of support, and if a child has no parent, all stakeholders are called upon to demand the services meant to assist them and to complement the efforts of schools to reach them. The MBESC is considering expanding and strengthening these programmes because, for example, teachers and education officers need specialised training to counsel children affected by HIV/AIDS, and referral units are needed in schools since counselling support groups do not suffice. Easy mechanisms for school fund exemptions are needed, and these must be impermeable to abuse so that neither OVC nor schools find themselves lacking. The curriculum must be reviewed so it addresses HIV/AIDS issues like prevention, living positively with HIV/AIDS and caring for the sick. The MBESC can achieve all this only with good mechanisms for coordinating and networking with the other stakeholders, hence the MBESC is present at this conference.

Ms Mulenga Kapwepwe, OVC Consultant, Zambia

Ms Kapwepwe gave an overview of the OVC situation throughout the SADC region, but also in other African countries.

HIV/AIDS and poverty are the major factors leading to orphanhood and vulnerability among children in the 12 SADC countries. About a third of people in SADC countries are socially deprived. Angola has the highest poverty level, Mauritius the lowest. The DRC has the biggest population at 49,1 million, Swaziland the smallest at 1 million. Angola, Zimbabwe, Malawi, Mozambique and Zambia have 10-20 million people, and Lesotho, Namibia, Botswana, Mauritius and Swaziland 1-2 million. Botswana has the highest HIV prevalence (in the world) among people aged 15-49, with 1 in 3 adults HIV-positive. Botswana, Swaziland, Lesotho and Zimbabwe are above the 20% prevalence mark; Zambia, South Africa and Namibia are hovering around the 19-20% mark; Malawi and Mozambique are at the 14-15% mark; Tanzania, the DRC, Angola, Uganda and Mauritius are below the 10% mark. Overall, life expectancy has dropped by about 6 years, in Zimbabwe by 12 years. Tanzania has the most orphans (1,1 million), followed by Zimbabwe (900 000), the DRC (680 000), Zambia (650 000), South Africa (400 000), Mozambique (310 000), Malawi (300 000), and Namibia, Botswana, Angola, Lesotho and Swaziland (all under 100 000). The region is thus in a crisis economically and due to HIV/AIDS. The following challenges for OVC were articulated at the "Eastern and Southern Africa Regional Workshop on Orphans and Other Vulnerable Children" held in Lusaka on 5-8 November 2000.

Placing OVC on the leadership agenda: Much advocacy and lobbying is needed at national level to give the issue national prominence. An OVC Desk at SADC level has been proposed. Some countries have drawn up advocacy plans, many are tackling OVC policy formulation, some have formed action forums, many have not done an in-depth OVC situation analysis or do not yet have a clear picture.

Provision of better care to families and caregivers: This delays the onset of orphanhood, but many countries still have to start inventorying what is happening on the ground in terms of care practices and programmes. Some need to develop strategies and tool kits for home-based care, others need to enhance what they have. Some are pursuing micro-finance activities to support families. Some are seeking to improve the legal environment for children and amend outdated legislation.

Expanding the number and quality of organisations: Much has been done in many countries, but many first had to do mapping and registration exercises to gauge current capacity, coverage, locality, focus, quality and quantity of organisations. Some are focusing on strengthening capacity and opportunities for networking. Many are at the stage where they need to start tackling the quality of care for OVC and of OVC programming. Some are developing care policies.

Resources to base: The problem of getting resources to base keeps resurfacing. Some countries are looking at resource distribution at community and district level and realigning district structures to filter resources to base. In countries affected by conflict, funds and social safety nets were set up focusing on child refugees or victims of conflict, and some have been restructured to cover OVC too.

Expanding the role of schools and education systems: Some countries must review their curriculums, others must restructure their entire systems. Many are disseminating OVC policy to education authorities to bridge gaps between this policy and the education system. Some are orienting teachers on the problems of OVC and giving them psychosocial counselling skills, and some are introducing life skills. Kenya wants to use schools to deliver health services too.

Strengthening child, family and community participation in OVC programme development: This is a way to bolster solutions to problem, so all countries are now raising awareness on all kinds of human rights to enable people to debate more ably in seeking solutions.

There was agreement in Lusaka that what happens in one country in the region affects what happens in others, so the region must act as a region in response to OVC. Namibia is taking a strong lead by placing the issue on the agenda of the MOHSS.

Ms Lavinia Shikongo, Information and Child Rights Officer, UNICEF

Ms Shikongo gave a slide presentation focusing on future support for OVC programmes, and chiefly on the Government/UNICEF programme of cooperation for 2002-2005.

This programme will embrace two cross-cutting issues: HIV/AIDS and disparity reduction. The OVC groups to be specifically targeted are orphans, educationally marginalised children, abused children and children in conflict with the law. The programme will also have an adolescent HIV prevention component to provide information and skills to prevent infection, and to create an enabling environment within communities for young people to access information, skills and services. Ms Shikongo emphasised the need to link youth programmes to OVC as young people are increasingly becoming responsible for the care of orphans due to the high rate of parental death from AIDS. Three specific objectives of the Government/UNICEF Special Protection and Disparity Reduction Programme are:

- ▶ to ensure that 80% of all children in conflict with the law in urban areas and at least 60% in rural areas are administered according to the Juvenile Justice Act (a bill has been produced);
- ▶ to ensure that 60% of all OVC have access to basic education, medical care, counselling and protection from loss of property; and
- ▶ to ensure that at least 50% of all children from educationally marginalised groups have completed their primary education by the end of 2005.

GROUP SESSIONS

Strategies and recommendations as adopted

The following is a verbatim reproduction of the written summarised group responses.

SESSION 1

How can the local community support OVC?

FACILITATORS

Ms Francis van Rooi and **Ms Caroline Thomas**, Special Projects Officers, Catholic AIDS Action.

KEY STRATEGY

Develop a national comprehensive home-based family and orphan support programme.

RECOMMENDATIONS

1. Programmes based on voluntarism, involving entire communities and other stakeholders.
 - ▶ Standardised and systematic training.
 - ▶ Decide who should be responsible for this.
 - ▶ Monitoring and evaluation mechanisms to be put in place.
2. Develop a national register of OVC
 - ▶ Free (really free!) education and health care to be provided.
 - ▶ OVC to be identified by volunteers and other stakeholders, e.g. teachers.
3. Develop a national register of caregivers and foster parents (to be identified from grassroots level upwards)
 - ▶ The main purpose of this is to have people available in this capacity.
 - ▶ Volunteers can identify these persons.
 - ▶ A network of faith-based organisations (being at the heart of the community) to take responsibility for overseeing, monitoring, supporting and following up on caregivers after placements.
4. Establish an OVC Fund
 - ▶ The OVC Fund should be administered by a new body.
 - ▶ Social workers and the Master of the High Court are not recommended because their existing workloads would make it impossible for them to administer a fund with the potential for a 20-fold increase.

SESSION 2

Who are the key stakeholders and what role should they play?

FACILITATORS

Ms Lavinia Shikongo, UNICEF Information and Child Rights Officer

Ms Mulenga Kapwepwe, OVC Consultant, Zambia

Ms Ngondi Ngatjeheue, NANASO Committee Member

KEY STRATEGY

Develop a plan of action to mobilise all stakeholders' input for a coordinated response to orphans and other vulnerable children.

RECOMMENDATIONS

1. Develop a policy on orphans and other vulnerable children by December 2002.
2. Simplify and reinforce the implementation of the school funds exemption policy by January 2002 and ensure access to quality education by January 2002.
3. Develop linkages where they do not exist and strengthen the existing linkages between communities (an inclusive term meaning all stakeholders) and government to ensure that orphans and other vulnerable children have access to services.
4. Ensure the active participation of the private sector in the National Steering Committee on OVC, including insurance companies.

SESSION 3

How can we ensure that the rights of OVC are protected?

FACILITATORS

Ms Oletu Nakaambo, Development Planner, MWACW

Ms Mariane Shalumbu, Chief Community Liaison Officer for Omusati Region, MWACW

Ms Michaela Figueira, Coordinator of the AIDS Law Unit of the Legal Assistance Centre

KEY STRATEGY

Develop a National Policy on Orphans and Other Vulnerable Children.

RECOMMENDATIONS

1. Identify key persons for lobbying parliament to pass all outstanding bills, e.g. the Child Care and Protection Bill, the Children's Status Bill, the Education Bill, the Maintenance Bill.
2. Government and donors to make sufficient budgetary provision for programmes serving orphans and other vulnerable children.
3. Legal action should be taken against those who engage in the economic exploitation of children.
4. Develop and implement mechanisms to facilitate easy access through community structures to services such as education, health, welfare, rights protection and information.

SESSION 4

How can we use current prevention and care activities to support and promote OVC?

FACILITATORS

Ms Sarah Bowsky, OVC Specialist, Family Health International

Mr Abner Xoagub, Manager of the National AIDS Coordination Programme, MOHSS

Mr Shamani-Jeffrey Shikwambi, Coordinator of the National ECD NGO Association

KEY STRATEGY

Strengthen existing prevention and care activities through a multi-sectoral and coordinated process whereby they become community owned and of direct benefit to orphans and other vulnerable children.

RECOMMENDATIONS

1. Develop an inventory or database of existing services, partners and resources involved in HIV/AIDS prevention and care, and care and support for orphans and other vulnerable children (including medical, social welfare, psychosocial, and human and legal rights), and an implementation plan for this inventory or database.

2. Build and utilise the capacity of:
 - ▶ services providers, who should be better able to address the needs of orphans and other vulnerable children in respect of HIV/AIDS prevention and care; and
 - ▶ communities, which should identify problems, orphans and other vulnerable children, coping mechanisms, internal and external resources, and which should have the capacity to design and implement their activities and solutions.
3. Increase awareness of and access to services relating to and organisations working with HIV/AIDS and orphans and other vulnerable children, including medical, social welfare, psychosocial, and human and legal rights services and organisations.
4. Develop standardised monitoring and evaluation mechanisms at national and community levels to ensure that orphans and other vulnerable children are benefiting from services and activities.

SESSION 5

How can we ensure long-term and effective social safety nets for our OVC?

FACILITATORS

MOHSS Directorate of Developmental Social Welfare Services:

Ms Laura Cronje, Chief Social Worker for Erongo Region

Ms Loide Nekundi, Chief Social Worker for Oshana Region

Ms Bernadette Harases, Control Social Worker, North West Health Directorate

RESOURCE PERSON

Ms N Mavulu, Control Officer for Social Assistance

KEY STRATEGY

Develop and strengthen existing networking forums for OVC at all levels including constituency and regional.

RECOMMENDATIONS

1. Legislation, policies and guidelines pertaining to OVC should be put in place and existing policies should be implemented (e.g. exemption from school funds and access to health care).
2. Information materials pertaining to OVC, such as *Resources for Vulnerable Children* (one of the conference handouts) should be updated, translated and disseminated for use at grassroots level.
3. Develop and implement an equitable, long-term and sustainable social assistance plan, including a simplified grant system for OVC and their families. (The present grant system is complicated and entails a lot of work for social workers.)
4. Develop a networking system for OVC service providers at all levels.

NATIONAL STEERING COMMITTEE ON OVC

Terms of Reference

- ▶ Prioritise conference recommendations and strategies.
- ▶ Develop a five-year plan of action with an annual review.
- ▶ Draft a national OVC policy and guidelines for implementation.
- ▶ Ensure effective transfer of information and communication to and between all stakeholders.
- ▶ Devise an effective monitoring and evaluation tool to ensure collaboration and coordination of programme implementation.

Members

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Erika van Rooi Chief Social Worker, MOHSS Hardap Regional Office	063-242803	242727	PO Box 238 Mariental

CONFERENCE HANDOUTS

'Hold-all' bag with printed conference title, containing:

- ▶ *Resources for Vulnerable Children*, a manual compiled in 1999 by Dr Steinitz of Catholic AIDS Action, reviewed and update by Vezera Kandetu in 2000.
- ▶ *First Call for Children: World Declaration and Plan of Action from the World Summit for Children*, (including the Convention on the Rights of the Child), published by UNICEF.
- ▶ "For the Love of Children: Namibia's Growing Population of Orphans and Vulnerable Children – Background Information for the First National Conference on OVC in Namibia", prepared by the Directorate of Developmental Social Welfare Services, MOHSS.
- ▶ "Policy Guidelines for Catholic AIDS Action on the Care of Needy Orphans", adopted in 1999.
- ▶ "A Situation Analysis of Orphan Children in Namibia: Overview of Findings", prepared by SIAPAC.
- ▶ "Coping with the Impact of HIV/AIDS on Children", an information pamphlet on FHI's approach.

T-shirt with printed conference title.