Analysis of USAID/Namibia’s OVC Landscape

November 2014

This publication was produced at the request of the United States Agency for International Development. It was prepared independently by DeeDee Yates, Terence Beney, Collette Peck, Amelia Peltz, Jason Wolfe, Brenda Yamba and Nangado Kauluma.
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Global Health Program Cycle Improvement Project
1299 Pennsylvania Avenue NW, Suite 1152
Washington, DC 20004
Phone: (202) 625-9444
Fax: (202) 517-9181
ANALYSIS OF USAID/NAMIBIA’S OVC LANDSCAPE

NOVEMBER 2014

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ACRONYMS

AIDS  Acquired Immune Deficiency Syndrome
ART  Antiretroviral therapy
CAA  Catholic AIDS Action
CACOC  Constituency AIDS Coordination Committee
CAFO  Christian Alliance for Orphans
DAPP  Development Aid from People to People
DHS  Demographic and Health Survey
ECD  Early childhood development
EMIS  Education management information system
eMTCT  Elimination of mother-to-child transmission
ETSIP  Education and Training Sector Improvement Programme
FANTA  Food and Nutrition Technical Assistance
GBV  Gender-based violence
GRN  Government of the Republic of Namibia
GSHS  Global School Health Survey
HEW  Health education worker
HIV  Human Immunodeficiency Virus
ICF  ICF International [originally Inner City Fund]
KAYEC  Katutura Youth Enterprise Centre
KYD  Katutura Youth Development Programme
LL/CL  Lifeline/Childline
MGECW  Ministry of Gender Equality and Child Welfare
MoE  Ministry of Education
MoHSS  Ministry of Health and Social Services
NAC  National Agenda for Children
NANASO  Namibia Network of AIDS Service Organizations
NAPPA  Namibia Planned Parenthood Association
NDP4  Fourth National Development Plan
NHIES  Namibia Household Income and Expenditure Survey
NSA  Namibia National Statistics Agency
NSF  National Strategic Framework for HIV and AIDS
OGAC  Office of the U.S. Global AIDS Coordinator
OVC  Orphans and vulnerable children
PAY  Physically Active Youth
PEPFAR  U.S. President’s Emergency Plan for AIDS Relief
PLHIV  People living with HIV and AIDS
PMTCT  Prevention of mother-to-child transmission
PTF  Permanent Task Force for Orphans and Vulnerable Children
RACOC  Regional AIDS Coordination Committee
SBCC  Social and behavior change communication
SRH  Sexual and reproductive health
UNDP  United Nations Development Programme
UNFPA  United Nations Population Fund
UNICEF  United Nations Children’s Fund
USAID  United States Agency for International Development
VSL  Voluntary savings and loan
WACPU  Woman and Child Protection Unit
WHO  World Health Organization
EXECUTIVE SUMMARY

In November 2014, USAID/Namibia appointed a technical team to conduct a situational analysis of the orphans and vulnerable children (OVC) programming landscape in the country. This report represents the substantive output of the analysis. The executive summary focuses on an overview of development challenges confronting children in Namibia, the current programming response, findings from the field visits and observations and recommendations for future programming.

OVC DEVELOPMENT ANALYSIS

Poverty and Vulnerability
Approximately 250,000 children in Namibia are considered vulnerable, while 15.7 percent of children under 18 years are orphans.

Children and women are disproportionately disadvantaged by poverty, with up to 56 percent of children either living in poverty or at risk of becoming poor.

HIV and Nutrition
HIV prevalence is highest among women between the ages of 35 and 44, while disproportionate prevalence in women 15-24 compared to their male peers indicates that adolescent girls are more vulnerable to infection than boys.

The geographic distribution of HIV prevalence aligns closely with the geographic distribution of poverty and OVC burden, suggesting clear prioritization options for USAID/Namibia programming.

Twenty-four percent of Namibian children are stunted, and comprehensive immunization coverage is only 68 percent, although at least 90 percent of children received BCG, pentavalent 1, polio 1, and the measles vaccine.

ECD, Education and Prospects
Early childhood development (ECD) interventions offer a high-leverage opportunity to comprehensively address the health, social protection and educational needs of OVC at the earliest stages of development, with the promise of significant impact. However, their reach is currently limited.

Well more than half of Namibia’s children do not complete primary school. This is true of more than 70 percent of children under 16 in seven regions. Consequently youth unemployment is estimated to be as high as 42.8 percent.

Persistent barriers to adolescent girls’ completion of school include resistance to the diligent implementation of Ministry of Education’s (MoE) Learner Pregnancy Policy, the lack of suitable sanitation and inadequate hostel facilities at boarding schools.
The 2013 Demographic and Health Survey (DHS) reports that 19 percent of young women age 15-19 have begun childbearing, an increase from 15 percent in the 2006-07 DHS. Teenage pregnancy is more than three times higher among young women in the lowest wealth quintile than among those in the highest wealth quintile.

**Gender-based Violence (GBV) and Child Protection**
The 2013 DHS found that nearly one in three (32 percent) women age 15-49 years has experienced physical violence since the age of 15 years, and 14 percent reported experiencing physical violence within the past 12 months.

A UNDP study identified the following forms of violence affecting children: sexual and domestic violence, particularly against women and girls; sexual exploitation of children; child abuse; early marriage of girls; and detention of children in conflict with the law. Other child protection concerns reported in the literature include baby dumping (infanticide), disinheritance of widows through land and property grabbing, human trafficking and a lack of birth registration.

**GOVERNMENT, DONOR AND CIVIL SOCIETY RESPONSE**

**Government of the Republic of Namibia (GRN) Response**
The GRN has responded to the HIV pandemic by instituting a comprehensive policy framework and providing health services that have resulted in more than 80 percent of eligible adults and 95 percent of eligible children receiving treatment, and mother-to-child transmission being reduced to less than 4 percent.

Support to early childhood development (ECD) facilities was expanded through the introduction of subsidies to ECD caregivers.

The MoE abolished the school development fund, making primary education more accessible to all children. The 2012 education management information system (EMIS) reported 125,250 orphans and 106,914 vulnerable children enrolled in school.

The number of OVC receiving a social welfare grants continues to expand and exceed the targets, with 151,500 children receiving a grant of N$250 per month per child in September 2014. Most children (86 percent) and young adults (91 percent) have birth certificates.

**Donors and Partners**
There are relatively few international donors and multilaterals playing a strategic role in HIV/AIDS by funding Namibian programs. The principal donors are the Global Fund for AIDS, Tuberculosis and Malaria, U.S. Government and the Republic of Germany, while UNICEF is a crucial partner with specific reference to OVC.

Annual U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) funding for Namibia dropped by 72 percent from $90 million in 2012 to $25 million in 2014. Funding from
the HKID budget code for OVC programming also declined by 64 percent from $7 million in 2012 to $2.5 million in 2014.

FINDINGS

Addressing poverty: Child grants and universal pensions are important social protection mechanisms in Namibia. Household economic strengthening activities implemented through USAID-funded partners are complementary, leveraging these government resources with support for money management, additional savings, nutritional information and food security initiatives. Voluntary Savings and Loans (VSL) programming also effectively integrates a parenting curriculum, in which parents and communities have shown significant interest.

The potential of ECD: The Ministry of Gender Equality and Child Welfare (MGECW), with previous support from USAID/PEPFAR through a cooperative agreement with Pact, made major strides in formalizing the provision of ECD and has established a mechanism for subsidizing ECD centers. Substantial efforts are underway to mobilize consensus around the importance of ECD nationally. Fieldwork observations support the impression that ECD programs offer a clear opportunity for linking children to health and social services.

Prospects for vulnerable adolescents: Pivotal interventions influencing the sexual and reproductive behavior of adolescents, as well as their future prospects, focus on keeping children in school. The approach of Katutura Youth Enterprise Centre (KAYEC) through the Katutura Youth Development Programme (KYD) has been to offer academic support programs coupled with life skills (Stepping Stones) and activities to improve self-esteem. Samples show this has had a positive effect on progression through the high school grades for participants. Other smaller programs in the country, such as Physically Active Youth (PAY), have shown similar results.

Parenting support: Throughout its fieldwork, the assessment team noted a significant interest in parenting programs, and observations suggested that such support, which includes caregivers of OVC who are not biological parents, was addressing a number of critical risk factors for child health, including violence, adolescent sexual and reproductive health and psychosocial support. Support for parenting also appeared to be readily integrated into other programs, and offers clear opportunities for linking children to health and social services.

Persistent GBV and stigma: GBV, stigma and discrimination persist as substantive issues undermining the effectiveness of the HIV response and exacerbating the vulnerability of children. Interventions that appeared to be effective in the field combined social and behavior change communication (SBCC) with a range of health and psychosocial support services, including counselling on GBV and HIV-related topics. Teen clubs like the one at Onandjokwe Hospital offered a supportive peer group
experience in addition to counselling and support for HIV disclosure, antiretroviral therapy (ART) adherence and life skills. The clubs also provide support services to parents and caregivers, which have been very popular and a welcome addition to the services provided by the hospital.

**Social service workforce capacity:** Capacity of social workers from the MGECW to provide specialized services for children was identified as a critical challenge. For example, the *Assessment of the Woman and Child Protection Services* report cites quality of counselling services for children referred from Woman and Child Protection Units (WACPU) as inadequate, and reports that it is usually only a one-off session when provided.¹ Social workers are typically overstretched with high volume caseloads. One social worker interviewed at a regional office of the MGECW estimated handling 8 to 10 new inquiries per day. This inevitably has an impact on their ability to attend to critical cases.

**Social service workforce efficacy:** Efficacy appears to be hampered by severe inefficiencies in the system. For example, Ministry of Health and Social Services (MoHSS) social workers do not have the mandate to manage child-related cases, even if they have the skill to do so. This not only presents a lost opportunity to manage a case in a timely manner, but referring the child to MGECW social worker does not always guarantee specialized service, especially when dealing with issues of pediatric HIV treatment adherence, a skill that the social workers do not have.

**KEY GAPS**

**There is insufficient focus on very young children, especially the first 1,000 days (from conception to two years).**

Although coverage of elimination of mother-to-child transmission (eMTCT) is high in Namibia and has brought down infant HIV incidence, problems persist. Early infant diagnosis is inadequately implemented, there is substantial loss to follow-up during post-natal care, and only 68 percent of children receive comprehensive immunization (DHS 2013). Stunting, at 24 percent, remains inexplicably high for a middle-income country.

A comprehensive strategy that focuses on the first 1,000 days could address these care and treatment deficits, monitor nutrition and integrate support for more skilled and responsive parenting that will address nutrition and early cognitive development.

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**Parenting programs are appreciated but limited in scope and coverage.**

Support to effective parenting offers a means to address multiple deficits in care and treatment, nutrition, early developmental milestones and access to services. Parenting support should not only focus on ECD but also adolescence, where the focus would be on equipping parents to counsel their children on sexual choices, behavior and services, and to monitor adherence in the case of HIV+ adolescents. Support to parenting also provides an opportunity to address norms and cultural practices that disadvantage children and women.

**Addressing gender inequalities and GBV is a crucial need.**

Gender inequalities fuel GBV, which is endemic in Namibia, especially intimate partner violence. Projects have an awareness of the gender dimensions of their work and some intention to address harmful gender norms and practices. Dialogue on how to combat GBV is needed at all levels, from policy makers to community members and households. This should be explicit in all USAID programs.

**Current programs for adolescent girls and boys may be efficacious, but they are insufficiently documented, targeted and institutionalized within schools and other facilities.**

The high percentage of new infections among adolescent girls and young women is a concern, and impactful, targeted and intensive interventions in high-prevalence areas are required. The high dropout and low completion rates of high school students can potentially undermine many prevention interventions. The multiple risk factors confronting vulnerable adolescent girls and boys require a sophisticated and multi-dimensional response.

**The provision of accessible, quality social services, over and above social grants, requires more collaboration among the social service workforce providers.**

Currently the social workers in the regions are overloaded. In addition, the Child Care and Protection Act requires new levels of effort from the social service workforce in terms of preventing child abuse, neglect and family dissolution, as well as facilitating access to expanded social grants.

Not only is the system overloaded, but it is also frequently inefficient. The social workers in different ministries, such as MGECW and MoHSS, have specific mandates that delineate whom they can serve, based on their employer’s jurisdiction. These arrangements at times preclude the most efficient provision of services to clients. Better synergy between government and civil society social workers, community workers and other similar cadres is needed.
RECOMMENDATIONS

Strengthen collaboration with the GRN for continued protection of HIV programming investments.

- Provide technical assistance to the MGECW and MoE in conjunction with the UNICEF support to establish a full menu of ECD programs in Namibia. These should include a pro-poor, HIV-sensitive approach with strong health linkages, including nutrition. This should be a short-term (12-18 month) intervention to finalize the transition of ECD from MGECW to MoE and to position the government to utilize funds from the national budget and from the envisioned future European Union budget support.

- Integrate the concept of the “1,000 days” into health extension worker (HEW) training in the MoHSS and into home visits by NGO partners. Support any emerging initiatives on home-visiting associated with the new ECD framework for Namibia. A home-visiting component of ECD can reach mother and infant pairs exiting from prevention of mother-to-child transmission (PMTCT) services, young children at risk, children in families with people living with HIV and AIDS (PLHIV) and under-nourished children. The recent Care for Child Development Manual by WHO/UNICEF provides an excellent resource for such an intervention.

- Provide targeted technical assistance to MGECW in preparation for the implementation of the Child Care and Protection Act, with due consideration to workforce deployment, possible task shifting, and a whole-government approach to social work mandates.

Bridge the divide between OVC services and HIV prevention, treatment and care.

- Provide strategic support for effective parenting activities under the leadership of the MoHSS Parenting Unit and the Parenting Network that target vulnerable communities and families in PEPFAR priority regions with a focus on integrating service linkages for HIV-affected children.

- Model a localized, coordinated service for young OVC that establishes integrated standard operating procedures with HEWs from MoHSS, constituency child care workers from MGECW, early childhood education workers from MGECW/MoE and community volunteers from organizations such as Catholic AIDS Action (CAA), Development Aid from People to People (DAPP) or Christian Alliance for Orphans (CAFO).

Expand HIV care and treatment uptake and linkages for vulnerable young women and adolescents.

- Build on experience of current OVC partners to develop and model a well-researched and evidence-based youth OVC program aimed at adolescent girls (but including boys). The youth program should include age-appropriate sexual
and reproductive health information and referrals, referrals for VMC and family planning, academic support to progress through secondary school, psychosocial support and GBV prevention and protection. The program would involve NGO partners but would ensure linkages to schools, hostels, after school centers, clinics and other GRN facilities for youth, especially young women, possibly through the Safe Schools initiative of the MoE.

Strengthen coordination and networking within the social service system.

- Strengthen the coordination capacity of Child Care and Protection Forums in PEPFAR priority regions to engage with other line ministries and civil society organizations, with a focus on providing easy access to HIV and protection services for OVC, over and above referrals for key services. This could include developing protocols, memoranda of understanding, data analysis, and other tools as best practice in these regions.
- Establish a regular meeting agenda with UNICEF and Global Fund (PMU) to discuss development partner coordination in the OVC sector. This could be in conjunction with Permanent Task Force for Orphans and Vulnerable Children (PTF) meetings and thus lead to improved coordination among development partners and with MGECW.

Strengthen information management and accountability mechanisms of the OVC system.

- Support the MGECW in developing procedures for monitoring National Agenda for Children (NAC) implementation at the regional and sub-regional levels and for using the available data for prioritizing resource allocations.
- The System for Programme Monitoring should be made functional and should integrate relevant OVC data (SPM, grant data, etc.) in a single repository.
- A common research agenda determined in consultation between development partners, the GRN and other key stakeholders should be compiled to address relevant evaluation and research questions.
I. INTRODUCTION

BACKGROUND

In November 2014, USAID/Namibia appointed a technical team to conduct a situational analysis of the programming landscape for orphans and vulnerable children (OVC) in the country. This report represents the substantive output of the analysis.

The findings and recommendations from this analysis are intended to inform current and any future USAID project design for OVC, and to ultimately contribute to improving the status of vulnerable children in Namibia.

This assessment incorporates the principles and leverages the resources of the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR), the Government of the Republic of Namibia (GRN) and other donor agencies working in OVC programming. It also demonstrates responsiveness to the Memorandum of Agreement signed between the Namibia Country Office and the Office of the U.S. Global AIDS Coordinator (OGAC), and applicable as of July 24, 2014.

The primary audience for this assessment is USAID/Namibia. A secondary audience is the Ministry of Gender Equality and Child Welfare (MGECW) and other stakeholders in Namibia, including U.S. Government agencies, bilateral and multilateral donors, and civil society stakeholders.

OBJECTIVES OF THE SITUATIONAL ANALYSIS

The objectives of the situational analysis are to:

1. Identify the most important challenges to the well-being of children in Namibia.
2. Offer a comprehensive overview of policy and programming responses to the challenges identified, including:
   a. A brief review of USAID programming;
   b. The involvement of country-level stakeholders, other donors and the private sector where relevant.
3. Identify the gaps in policy and programming responses, with an emphasis on:
   a. Linking OVC social services to HIV-related health services;
   b. The U.S. Government’s comparative advantage in implementing OVC programming.
4. Offer recommendations that constitute a clear roadmap for short- and long-term investments (including potential new procurement needs) for strengthening the PEPFAR OVC portfolio in Namibia. The recommendations should:
   a. Demonstrate a commitment to a Namibia-led process and plan;
b. Allow for working collaboratively with other partners and stakeholders in OVC programming;
c. Explain how proposed investments will increase gender equity and sustain OVC programming.

STRATEGIC CONSIDERATIONS

In the preparation of findings and recommendations, this assessment takes care to respond to the critical strategic considerations articulated in the July 2014 Memorandum of Agreement. The core agreement relevant to OVC programming is to “bridge the divide between OVC social protective services, and HIV prevention, treatment & care.” OVC programming will meet this imperative by integrating activities that deliberately address linkages and by structuring programs to support other core agreements including:

- Prioritizing and realigning high-yield prevention activities at high-yield sites;
- Strengthening the continuum of response, especially early detection, retention and adherence;
- Linking of target populations to HIV services, especially vulnerable young women and adolescents;
- Integrating quality assurance and quality improvement to protect investments.

In addition, the assessment adhered to the strategic imperative of prioritizing programming by geographic analysis of needs. Recommendations proposed in this assessment are explicit about priority geographic regions and how OVC programs can be structured to include activities that respond to core agreements.

METHODS AND LIMITATIONS

In conducting the assessment, the technical team adopted a four-step methodology to ensure findings would be as robust and evidence-based as possible within the parameters of a rapid assessment. The steps are described in Table 1. The technical team consulted closely with the leaders and relevant staff of the USAID/Namibia Health Team.
Table 1: Overview of Assessment Methodology

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Desk Review</td>
<td>The team reviewed a large volume of existing data and evidence-based reports on OVC-related issues and development challenges (see list of references).</td>
<td>A comprehensive review of existing data provides the scientifically robust foundation for meeting the key objectives of this assessment.</td>
</tr>
<tr>
<td>Stakeholder Meetings</td>
<td>Meetings were arranged with key stakeholders involved in OVC policy and programming activities, including the GRN, country-based partners and donors.</td>
<td>Stakeholder meetings afforded the technical team the opportunity to identify and collect secondary data not identified in the initial scoping of the desk review, obtain clarification on and insight into the information gleaned from secondary data and collect additional information on policy developments and programs being implemented.</td>
</tr>
<tr>
<td>Site Visits</td>
<td>The technical team visited a sample of service delivery sites (see Appendix D) targeting children, and USAID implementing partner sites.</td>
<td>Site visits offer the technical team the opportunity to ground the interpretation of data in a crucial first-hand experience of the implementing context.</td>
</tr>
<tr>
<td>Stakeholder Validation Meeting</td>
<td>Initial and emerging findings being formulated by the technical team were tested with an audience of USAID implementing partners, GRN staff and other donors.</td>
<td>Validating emerging findings is a critical step in a rapid assessment process, allowing for appropriate adjustments to emerging findings based on the experienced and informed expertise of country-based technical personnel, as well as accommodating broad-based buy-in of USAID efforts.</td>
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This rapid assessment was primarily limited to available data and documentation related to the OVC landscape in Namibia. The technical assessment team found these data and documents to vary from reasonable to high quality. Stakeholder meetings and site visits were used to supplement existing data and information. Given the limited time and resource constraints, the findings presented in this report may not give a full picture of the OVC situation in Namibia. Furthermore, the assessment cannot be considered a basis for pronouncements on the efficacy of existing programs, including the programs of USAID/Namibia implementing partners.

**REPORT STRUCTURE AND CONTENT**

The report leads with a presentation of the key development challenges undermining the well-being of children in Namibia. This is followed by an overview of the policy and programming response by the GRN, and the broader donor community. These sections set a context for the subsequent discussion of assessment findings, integrating all
sources of evidence (secondary data, stakeholder inputs and team observations). Priority gaps and opportunities are summarized, followed by recommendations derived from the preceding analysis.
II. OVC DEVELOPMENT ANALYSIS

Approximately 250,000 children in Namibia are considered vulnerable, and 15.7 percent of the total population under 18 years is orphaned. While Namibia’s classification as an upper-middle-income country is a positive endorsement of national economic performance, it obscures the reality of high inequality and systemic poverty. Human development indicators in Namibia have shown disappointing improvement, and the achievement of the 2015 Millennium Development Goal targets are likely to fall short across various indicators, particularly in areas linked to maternal health, nutrition and access to proper sanitation. The sharp reduction in development assistance as a result of Namibia’s global economic status adversely impacts children, “effectively meaning that the primary victims of systemic economic inequality in Namibia are at risk of suffering an additional penalty” (UNICEF, 2013).

Throughout this assessment, development challenges are understood as a constellation of factors, such as poverty and access to services, that undermine children’s future prospects and increase the likelihood of their exposure to HIV infection and related sexual and reproductive health risks. The extent to which the policy and programmatic responses implemented by the GRN, the donor community, civil society and the private sector are equal to the challenges confronting children is the primary consideration for identifying appropriate supplementary or future investments in OVC programming.

KEY DEVELOPMENT CHALLENGES AFFECTING CHILDREN

Economic Inequality and Child Poverty
Although Namibia’s per capita income of $5,840 (World Bank, 2013) qualifies it as an upper-middle income country, average income paints a misleading picture. Income distribution is among the most unequal in the world, with a Gini coefficient2 estimated at 0.5971 by the latest (2009/10) household survey and almost one-third of the population living under the upper poverty line.

Children are disproportionately disadvantaged by poverty (NSA, 2012). While 15.3 percent of the population is in severe poverty (less than N$3,330.48 annual income per adult), 18.3 percent of children are in severe poverty. Furthermore, while 28.7 percent of the entire population finds itself below the upper poverty line (less than N$4,535.52 annual income per adult); this is true for 34 percent of children. In its child-centered analysis of the Namibia Household Income and Expenditure Survey (NHIES) 2009/2010 data (2012), the National Statistics Agency (NSA) introduced a third, higher poverty line (less than N$6,803.28 annual income per adult equivalent) to identify those at risk of

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2 The Gini coefficient is a statistical measure of income distribution. A Gini coefficient of 0 is a measure of perfect equality, while a measure of 1 is maximum inequality.
falling into poverty. According to this measure, 48.4 percent of the population is vulnerable, while the proportion increases to 55.7 percent for children.

The relative extent of poverty in the Namibia’s general population and among children is reflected in Figure 1.

**Figure 1: Proportion of Populations Living in Poverty**

![Proportion of Populations Living in Poverty](image_url)

Adapted from *A Namibia Fit for Children*, UNICEF, 2013.

The heightened vulnerability of children to being poor or falling into poverty is clarified when considering the factors correlating with child poverty, as demonstrated in the NSA analysis of NHEIS data and presented in Table 2. As the table shows, the actual living circumstances of impoverished children do not necessarily align with the extreme factors identified in the analysis.
Table 2: Household Factors Correlating with Child Poverty

<table>
<thead>
<tr>
<th>Factors Correlating with Child Poverty</th>
<th>Typical Conditions of Impoverished Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living in a household with young children</td>
<td>Live in a household with young children</td>
</tr>
<tr>
<td>Living in a household with four or more children</td>
<td>Live in a household with four or more children</td>
</tr>
<tr>
<td>Living with orphans in the household</td>
<td>Live in a household without orphans</td>
</tr>
<tr>
<td>Living in a female headed household, and/or where caregiver is divorced or separated</td>
<td>Caregivers are married or in a consensual union</td>
</tr>
<tr>
<td>There is no working adult in the household</td>
<td>There are one or more working adults in the household</td>
</tr>
<tr>
<td>Female caregiver has no education or only primary education</td>
<td>The female caregiver has at least secondary education</td>
</tr>
<tr>
<td>Household is Khoisan, Caprivi Languages, Rukavango or Nama/Damara speaking</td>
<td>The household speaks Oshivambo or Rukavango, and/or is located in Kavango, Caprivi or Oshikoto</td>
</tr>
</tbody>
</table>

The geographic distributions of poverty and OVC are of particular interest for programming purposes. The USAID/Namibia OVC portfolio has historically operated in every region of Namibia. Efforts are spread thin, which may reduce impacts and increase costs. This is disconcerting in an environment of diminishing resources. Strategically refocussing programs using available evidence, taking advantage of potential cross-program (clinical/community) synergies, and without doing irreparable harm to current beneficiaries, would substantially enhance impacts.

Figures 2 and 3 compare geographical distribution of OVC, poverty and HIV. To get the most complete picture of geographic priorities, prevalence data alone are insufficient; the actual numbers of people living in poverty and OVC are also critical to the analysis. Figure 2 compares estimates of OVC and poverty burden. Mapping this data shows a clear overlap in the geographic distribution of both indicators. This distribution aligns closely with the geographic distribution of HIV prevalence (Figure 3), suggesting clear prioritization options for USAID/Namibia programming. Priority regions would include Ohangwena, Omusati, Kavango (East and West), Oshikoto, Zambezi, Khomas and Oshana.
Figure 2: Comparison of Geographic Distribution of Poverty and OVC Burden
**HIV and Nutrition**

Namibia has a generalized HIV epidemic with a prevalence of 14 percent for ages 15-44. The 2014 MOHSS National HIV Sentinel Survey and the 2013 DHS report of the following results that are especially pertinent for OVC programming:

- HIV prevalence among pregnant women dropped from 18.2 percent in 2012 to 16.9 percent in the 2014 sentinel survey, and it is approximately the same in this population in rural and urban areas.
- HIV prevalence is highest among women aged 35-39 years (30.3 percent) and 40-44 years (30.6 percent). While prevalence has decreased in the former age group from 33.9 percent in 2012, it has increased in the latter age group by 9.9 percent since 2012 (sentinel survey).
• Prevalence increased among 15-19 year-olds from 5.4 percent (MOHSS 2012) to 5.8 percent.
• Prevalence has decreased from 10.9 percent in 2012 to 9.8 percent among 20-24 year-old women.
• HIV prevalence in 15-24 year-olds is 3.6 percent (4.4 percent among young women and 2.7 percent among young men). As HIV prevalence in this age group can be used as a proxy for incidence, it appears that adolescent girls are still more vulnerable to HIV infection than young males are.

The percentage of stunted children has declined from 29 percent in 2006/07 to 24 percent in 2013 (DHS). Similarly, the percent of children who were underweight and wasted declined from 8 percent and 17 percent, respectively, to 6 percent and 13 percent in 2013. However, these proportions remain high for an upper-middle-income country. Factors correlating with malnutrition are pertinent to future programming:

• Nutritional status among children deteriorates after age 9-11 months, when breastfeeding declines sharply.
• Male children are much more likely to be nutritionally disadvantaged than female children.
• Rural children are much more likely to be nutritionally disadvantaged than urban children.
• Children in Oshikoto are more than twice as likely to be underweight than children in Otjozondjupa, Oshana, Khomas and Erongo.
• Children of mothers with no education (23 percent) are about four times as likely as children of mothers with more than secondary education (6 percent) to be underweight.

Early Childhood Development and Educational Programs

It is becoming increasingly apparent that successful OVC programs are dependent on early interventions. While ECD has benefited substantially from biomedical interventions with mothers and infants, especially PMTCT, these gains are undermined by child poverty, nutrition deficits, and lack of early cognitive stimulation. When reviewing all dimensions of effective ECD intervention, it is apparent that there are significant gaps that OVC programming should take into account. The state of ECD from this multi-dimensional perspective is summarized in Table 3.

ECD interventions offer a high-leverage opportunity to address the needs of orphans and extremely vulnerable children at the earliest stages of development, with the promise of significant impact. However, their reach needs to be extended. In a study commissioned through USAID funding entitled Early Childhood Development and Education in Namibia (RAISON, 2014) a total of 42,916 children younger than 10 were recorded as orphans in the 2011 population census, while 2,670 orphans were reported
at ECD centers in 2012. These 2,670 children comprise 6.2 percent of all orphans, which is about half the enrolment ratio (12.1 percent) of all non-orphans.

Table 3: State of ECD in Namibia

<table>
<thead>
<tr>
<th>ECD Component</th>
<th>Key Indicators</th>
<th>National(^3)</th>
<th>Key Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Maternal and child health services (DHS)</td>
<td>Immunization</td>
<td>68%</td>
<td>Incorporate ECD messages and care into health extension workers’ duties and clinics and health messages into ECD facilities</td>
</tr>
<tr>
<td></td>
<td>PMTCT coverage</td>
<td>84%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Early childhood mortality</td>
<td>54/1000</td>
<td></td>
</tr>
<tr>
<td>2. Social services (DHS)</td>
<td>Child grants (MGECW )</td>
<td>152,992</td>
<td>Continue the expansion and streamlining of civil registration and social grants according to the Child Care and Protection Act</td>
</tr>
<tr>
<td></td>
<td>Birth certificates among children &lt;1 year</td>
<td>59%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Child poverty -NHIES</td>
<td>34%</td>
<td></td>
</tr>
<tr>
<td>3. Nutrition (DHS)</td>
<td>Stunting</td>
<td>24%</td>
<td>Improved water, sanitation and hygiene in homes and facilities</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Feeding at ECD centers</td>
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<td></td>
<td></td>
<td></td>
<td>Improved nutrition information</td>
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<tr>
<td>4. Nurturing family environment and parenting support (DHS)</td>
<td>Children&lt; 18 years who are orphaned</td>
<td>15.7%</td>
<td>Support parenting programs through a variety of delivery options (home-visits; community centers; media campaigns)</td>
</tr>
<tr>
<td></td>
<td>Domestic violence in the past 12 months</td>
<td>13%</td>
<td>Subsidize quality day care for vulnerable families</td>
</tr>
<tr>
<td>5. Stimulation for early learning (EMIS)</td>
<td>% of children attending ECD program</td>
<td>13% of 0-4 year-olds (Census)</td>
<td>Establish high-profile institutional home for ECD in government</td>
</tr>
<tr>
<td></td>
<td>Grade 1 repeats</td>
<td>20%</td>
<td>Invest government funds for quality comprehensive ECD programs in poor communities</td>
</tr>
<tr>
<td>6. Governance and Financing</td>
<td>Fragmented system: 5-8 year-olds with MoE 0-4 year-olds with MGECW, nutrition and parenting with MoHSS</td>
<td>Limited budget for ECD within MGECW and MoHSS</td>
<td>Improve understanding among decision makers of the importance and role of ECD in nation building</td>
</tr>
</tbody>
</table>

\(^3\) DHS 2013; Census 2011; NHIES 2009; EMIS 2012.
The proportion of orphans at ECD centers was similar in all regions (ranging from 4.4 percent to 7.5 percent), except Kavango where enrolment rates were about double those elsewhere (12 percent of girls and 11 percent of boys) (Figure 4). A total of 2,124 children at ECD centers were recorded as having a disability in 2012. That number is 16.9 percent of all children under 10 who were recorded as having a disability during the 2011 census. The percentage is much higher than the 11.5 percent enrolment ratio for children who were not regarded as disabled.

This difference suggests that either higher proportions of children with disabilities compared to those without a disability attend ECD centers, or the criteria for recording disabilities differed between the ECD survey and population census. For example, learning disabilities were probably reported more frequently by caregivers in ECDs than by parents or guardians at home.

More than half (1,368 or 64 percent) of children with a disability at ECD centers suffered from learning difficulties. This was followed by hearing impairments (324 or 15.3 percent), physical impairments (271 or 12.8 percent) and visual problems (161 children or 7.6 percent). There were many more children with disabilities in ECD centers in Omusati and Kavango than the other regions (RAISON, 2014).

**Figure 4: Percentages of Orphans under 10 Attending ECD Centers**

Adapted from *Early Childhood Development and Education in Namibia*. RAISON, 2014.
**Education and Children’s Prospects**

Two salient features of the Namibian education system are the high enrolment rate and the poor completion rate as can be seen in Figure 5. In Namibia, the primary net enrolment rate is 88 percent, and the primary completion rate is 85 percent. Both of these indicators provide a sense of the progress a country is making towards universal primary education—a key UN Millennium Development Goal—and, for Namibia, suggest that the country has yet to achieve universal primary education (Education Policy Data Center, 2014).

The student transition rate to secondary school is only 82 percent (Education Policy Data Center, 2014), after which time completion rates fall substantially. This has resulted in the larger proportion of young people having at best completed only a few years of primary education (see Figure 6). High dropout rates, which escalate through the grades and peak in grade 10, are assumed to contribute to risky survival strategies among youth, especially girls. Incomplete education is also anecdotally associated with alcohol abuse by children and young people country-wide.

Low educational attainment is typically correlated with high rates of unemployment. National Labour Force Survey results from 1997, 2000, 2004 and 2008 confirm the validity of this observation for Namibia, where lack of complete schooling correlates with unemployment rates of between 41 percent and 59.9 percent. Namibia has been subject to high unemployment for decades; the rate is currently estimated at 29.3 percent. Unemployment among youth aged 15-29, however, is estimated to be as high as 42.8 percent (UNICEF, 2014).

Despite a progressive policy that provides for attendance and completion of school by pregnant girls (the Learner Pregnancy Policy), various barriers to girls completing education still exist. A primary weakness in the MoE policy seems to be institutional resistance to its diligent implementation, which reflects the influence of traditional values and cultural norms held by parents and educators. Other major barriers to girls’ continuous education access are the troubling lack of suitable sanitation services in many Namibian schools and the poor quality of many boarding schools and hostels for students. For such a diverse and sparse population across so many regions of Namibia, safe and suitably maintained boarding schools and hostels have demonstrated their value in improving both school access and performance, but often fall well short of adequate standards (UNICEF, *Situational Analysis*, 2011).

The following three graphs developed from the 2011 Census data and EMIS by the University of Stellenbosch provide a stark picture of the educational landscape.
Figure 5: School Enrolment by Age

Note Census under-count (or EMIS over-count)

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Figure 6: Percentage of 16-Year-Olds Who Have Not Completed Primary School by Region

Figure 7: Dropout Rate by Grade
Gender-based Violence and Child Protection

The 2013 DHS found that nearly one in three women (32 percent) aged 15-49 years has ever experienced physical violence since age 15, and 14 percent reported experiencing physical violence within the past 12 months. Among women who experienced physical violence in the past 12 months, three percent reported that the physical violence occurred often, while 11 percent experienced physical violence sometimes5. The DHS noted that violence is highest in Kavango, where one in three women reported recent physical violence.

The 2005 WHO Multi-Country Study on Women’s Health and Domestic Violence Against Women noted that when interviewed face-to-face, five percent of respondents reported sexual abuse before age 15 years. In anonymous reporting, however, using cards the women marked and put into envelopes themselves, 21 percent reported sexual abuse before age 156. Furthermore, the WHO study reported that approximately six percent of women reported that their first sexual experience was physically forced. Of those who reported having their first sexual experience before the age of 15, 33 percent were physically forced7.

A UNDP assessment of the Woman and Child Protection Services8 identified numerous forms of violence affecting children, which include (but are not limited to) sexual and domestic violence, particularly against women and girls; sexual exploitation of children; child abuse; early marriage of girls; and detention of children in conflict with the law. Other protection concerns reported in the literature include baby dumping (infanticide), disinheritance of widows through land and property grabbing, human trafficking and a lack of birth registration.

The statistics on GBV incidence is supplemented by a USAID/Namibia gender assessment completed in 2012, which examined how gender inequalities and GBV affected the lives of Namibian men, women, boys and girls. It is apparent from the findings that adolescent boys and girls in Namibia face tremendous challenges, and they often have little control over the decisions that shape their lives. With profound social changes, including disrupted family structures and the death of adults due to

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5 Ministry of Health and Social Services, National Statistics Agency, the National Institute of Pathology, and ICF International. Namibia Demographic and Health Survey 2013 Main Findings. 2014.


AIDS-related complications, many young people find themselves without traditional family support structures and positive role models.

Adolescent pregnancy is a significant problem for many girls, particularly in rural northern communities. The 2013 DHS reports that 19 percent of young women age 15-19 have begun childbearing, an increase from 15 percent in the 2006-07 NDHS survey, while a study conducted in 2011\(^9\) demonstrated that teenage pregnancy in the Kavango region is very high (approximately 34 percent among 15-19 year-olds). When considered in light of high school dropout rates and the social and cultural norms constraining parents when discussing sexual behavior with their children, these figures suggest substantial socioeconomic and health risks for adolescent girls.

Compounding these matters are gender-specific challenges. For adolescent boys, the culture of gangs prescribes risk-taking behaviors, including excessive alcohol and drug use, having multiple sexual partners and acting in a domineering, if not violent manner. Another risk factor is peer pressure for early onset of first sex. Moreover, the lack of good role models, positive social networks, education and economic opportunities leaves boys vulnerable to violence and exploitation. Adolescent girls confront different challenges, many rooted in a patriarchal culture that, despite laws to the contrary, does not recognize the rights of females. Transactional sex between adolescent girls and older men (sometimes only a few years older) is becoming more common, for multiple reasons. With limited economic opportunities in rural communities, some girls travel to cities or peri-urban areas in search of better opportunities where, in some cases, transactional sex is a means of acquiring basic needs (such as food and cash for themselves or their families). For other girls, a mix of peer pressure and a desire for material goods (such as mobile phones) is the impetus for such relationships. In this case, transactional sex is not motivated by the “glamor” of being with older men. Given that these relationships often begin in the shebeen, alcohol consumption often plays a significant role in reducing perceptions of risk, leading to more unprotected sex (USAID, 

*Namibia Gender Study*. Amelia Peltz).

**GOVERNMENT OF NAMIBIA RESPONSE: POLICY AND PROGRAMS**

**The Policy Framework for Addressing OVC Challenges**

The fourth iteration of National Development Plan (NDP4) is instrumental in achieving the priorities of tackling poverty and inequality. Many of the key challenges acknowledged in it relate directly to supporting OVC, including those associated with administration, citing the backlog in civil registration, statutory requirements and the shortage of social workers who are better assigned to child protection issues than to

document-processing for grant eligibility. It recognizes that the proposed introduction of a kinship grant will be of assistance and that a more universal grant for children may better address poverty.

It is important to note that the NDP4 acknowledges that cash transfers are not a means for tackling the causes of poverty. This is implicit within its discussion of social grants and improved food security, which also calls for increased ‘research into the causes of extreme poverty in order to address the causes rather than the symptoms’ (National Planning Commission, 2012, p. 67). A clearer understanding of measures for achieving sustainable poverty reduction will presumably feature in subsequent iterations of the NDP.

Namibia has a reputation for progressive policies with regard to HIV, gender and children. The National HIV Policy (2007) is currently under review and will be updated to better address the pandemic in Namibia’s evolving context. The current version has been implemented through consecutive Medium Term Plans, or more recently through the National Strategic Framework (NSF) for HIV/AIDS. The NSF, which governs the national response to HIV and AIDS, included a substantive component on impact mitigation, which aims to reduce household poverty and increase household income, enabling vulnerable households to cope with the socioeconomic impacts of the epidemic and better provide for the OVC in their care. This is also the core objective of NDP4, which outlines strategies to reduce poverty and income inequality and to promote growth areas and efficiencies.

The care and support sub-component of the NSF promotes comprehensive and quality care and support for OVC, including equitable access to emotional, social, material and school-related support. The new Combination Prevention Strategy integrates biomedical, behavioral and social/structural approaches in a comprehensive approach to reduce new infections. The prevention component of the strategy emphasizes the need to strengthen social support and community mobilization to maximize prevention impacts, and includes support to OVC as an important mechanism for prevention efforts.

The National OVC Policy has been in place since 2004 and will be reviewed and revised in the coming year. The National Agenda for Children (2012–2015) has been recognized as a comprehensive framework for addressing the needs of children, outlining five priority areas: health and nutrition; education; HIV prevention, treatment and care; legal rights and standard of living; and protection from abuse. The National Agenda is monitored through the national PTF under the chair of the MGEWC. Annual reports are submitted to the Cabinet. In addition, the MoE recently launched the Inclusive Education Policy and the Learner Pregnancy Policy. This policy cluster will soon be supplemented by the Child Care and Protection Bill, recently referred to the National Assembly and National Council.
The National Gender Policy 2010-2020 outlines gender issues and strategies in twelve programmatic areas. There is also a National Plan of Action on Gender-Based Violence 2012-2016 with the two goals of reducing incidence of GBV and improving responses to GBV. This plan is to be coordinated by a multi-sectoral task force, which is currently being reinvigorated by the MGECW.

**The Institutional Framework for Addressing OVC Challenges**

The MGECW is responsible through its Directorate of Child Welfare for OVC. The PTF is the coordinating body for this work, with representatives from the donor community, civil society and the relevant line ministries. It meets quarterly and includes regional representation through the regional social workers of MGECW. The PTF is included in the National Coordination Framework for the NSF as a sector specific steering committee inclusive of impact mitigation activities. At the regional and constituency levels, the PTF operates as Child Care and Protection Forums.

The MGECW with its civil society partners published a National Protection Referral Network and flow chart to explain the avenues for reporting and dealing with child abuse. The system, however, remains fragmented. A Child Rights Network has been established among civil society organizations. Data on GBV and child abuse are not standardized or centralized across service providers and are often not disaggregated by gender or age.

The Child Care and Protection Bill will have significant impact on the social service workforce, with a greater emphasis on preventing family breakdown and child abuse, and a change in the criteria for grants to allow for a kinship care grant that does not require a court order, as does the foster grant. Discussions with the Ministry of Finance are also underway to consider opening up the child grants still further, to include more poor children, rather than only orphans. As a result, some administrative burden on social workers will be relieved, but the absolute numbers of those qualifying will very likely rise substantially.

**Programs: HIV Treatment**

Namibia has made significant strides in providing care and treatment to people living with or affected by HIV. The government’s program is articulated in the National Strategic Framework (NSF) for HIV and AIDS 2010/11 -2015/16. The framework provides strategic policy, planning and implementation guidance and leadership for the national HIV/AIDS multi-sectoral response. The NSF has mainstreamed gender and human rights in all aspects of planning and service delivery. Significant progress has been made in improving availability, access and use of treatment, care and support. Treatment guidelines were revised in 2012 and Namibia has adopted the new 2013 WHO treatment guidelines. Access to treatment, care and support services has increased through the opening of new full ART, integrated management of adolescent and adult illness, nurse-
initiated and managed antiretroviral treatment, and outreach sites. To make ART more widely accessible, nurses are permitted to initiate ART treatment at decentralized health facilities. The adoption, application and wider use of new technologies such rapid tests, point-of-care CD4 cell count, viral load and early infant diagnosis continue to make services more convenient for people (Mid-Term Review, October 2013).

According to the 2014 Sentinel Survey, almost half (49.1 percent) of all women who tested HIV-positive were already on ART. The percentage of HIV-positive women already on ART is lowest in the youngest age group (16.7 percent among 15-19 year-olds) and highest in the older age groups (66.7 percent among women ages 35-39 and 73.3 percent among HIV positive women ages 40-49). This is likely due to the older age groups having longer-standing infections (and associated treatment responses) in comparison to the relatively new infections displayed in the younger age groups.

HMIS shows that between 2008 and 2012, HIV/AIDS caused up to three percent of under-5 mortality and was the 10th cause of under-5 mortality. According to the 2013 UNAIDS Progress Report on the Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive, Namibia has achieved universal treatment access and over 88 percent of the children who are eligible to receive HIV treatment are doing so successfully.

Birth Registration
The Ministry of Home Affairs and Immigration has made progress in making national documents more accessible through mobile services and hospital-based registration points. Most children (86 percent) and young adults (91 percent) have birth certificates. Proportions of young people with birth certificates were higher in urban than rural areas, and in most regions more than 80 percent of children and 90 percent of young adults had birth certificates. An exception was in East and West Kavango, where only 69 percent of children had birth certificates. This may be due in part to the high proportion of Angolan immigrants in Kavango. (Census 2011)

ECD
Support to ECD facilities expanded through the introduction of subsidies to ECD caregivers following a Cabinet directive (4th/27.03.12/006) to MGECW. Currently more than 800 ECD caregivers, the vast majority of which are female and located in poor communities, receive an allowance through the regional councils. The budget for ECD programming in MGECW rose from N$5 million in 2011/12 to N$15 million in 2013/14 to N$ 24 million in 2014/15 (Medium Term Expenditure Framework).

Educational Access
The MoE abolished the school development fund, making primary education more accessible to all children. The 2012 EMIS reported 125,250 orphans and 106,914
vulnerable children enrolled in school. The numbers of orphans attending school by region can be seen in the table below. The EMIS defines vulnerability in socio-economic terms. The percentage of OVC attending school is not available from the annual data provided by the MoE.

**Figure 8: Number of Orphans Enrolled in School by Region**

![Bar chart showing the number of orphans enrolled in school by region.](chart)

**Social Protection**

The number of OVC receiving a social welfare grants continues to expand and exceed the targets, with 151,500 children receiving a grant of N$250 per month per child in September 2014. Grants are provided for foster care, maintenance (for poor, single parents) and special maintenance (for children with disabilities). There are also universal pensions for people over the age of 60, which now stand at N$500 per month. The 2011 Census shows that in rural areas 29.6 percent of households with children rely on social grants as a primary source of income, while in urban areas the figure is 7.6 percent.

To reduce the burden on social workers, the MGECW created a constituency-level cadre of community child care workers (administrative officers) to help deal with the accumulation of paperwork needed to process child allowances (maintenance and foster grants). So far a total of 102 of these positions have been filled. This task-shifting enabled more highly trained staff to perform duties more appropriate to their skills. Currently MGECW has 72 percent of its 104 social work positions filled.
DONOR, CIVIL SOCIETY AND PRIVATE SECTOR INVOLVEMENT

The Wider Donor Community

USAID’s main development partner for work with children is UNICEF, which works closely with MGECW, MoHSS and MoE in addressing the challenges spelled out in the latest *Towards a Namibia Fit for Children: Situational Analysis on the Status of Children’s and Adolescents’ Rights 2010-2013*.

Some of UNICEF’s key current program interventions as reported to the landscape assessment team are:

1. Costing of the Child Care and Protection Act
2. A functional review of the work of social workers in relation to the Child Care and Protection Act, given changes in the grants from foster and maintenance to include kinship care, and changed criteria focusing on poverty versus orphanhood alone
3. Operationalizing of the act by providing technical assistance for human resource planning, considering monitoring requirements and the development of a more effective referral system providing for the changes to child protection implied by the act.

Under its education program, UNICEF is also supporting the transition of ECD from MGECW to MoE with a small team of local and regional consultants working with a high-level technical team appointed by the two permanent secretaries. UNICEF is also
sourcing additional funds for support to the expansion of ECD in Namibia, including operational interventions to provide proof of concept. Elma Foundation is interested in supporting the development of an ECD framework in Namibia.

The European Union is developing its next Development Fund package for education, which will focus on ECD and vocational training. It has also helped establish the Civil Society Support Foundation, located within the Namibian Non-Governmental Organizations Forum but legally a separate entity, which has made mid-size grants to USAID implementing partners such as CAFO and KAYEC.

The Global Fund, Phase 2 has two prime recipients: Namibian Network of AIDS Service Organizations (NANASO) for civil society responses, and the MoHSS for government responses. NANASO is implementing Phase 2 of a $28 million grant from June 2013-June 2016. Most of the local non-governmental organization sub-recipients are focusing on social and behavior change messages to youth under 24. Others provide care and support to 14,500 OVC. Philippi Trust, for example, is providing training to the MoE teacher counsellors on psycho-social support for children. Many smaller OVC activities that were funded through the NANASO grant are being consolidated under Catholic AIDS Action.

There is scope for improved collaboration with these partners, especially UNICEF. Some sharing of information happens at the PTF for OVC, but a more in-depth discussion between managers may reveal areas of mutual interest and help avoid potential duplication of effort.

Civil Society

HIV awareness and prevention programming for youth in Namibia is currently being conducted through a variety of entities, formats and media.

The Namibia Planned Parenthood Association (NAPPA) focuses on sexual and reproductive health (SRH) care and support for youth through peer education projects. NAPPA’s mandate is to manage youth-friendly clinics where individuals can access SRH information and materials and contraception. There continue to be challenges in coordinating the various activities within the portfolio, as well as ensuring the youth-friendly services are in fact youth-friendly; however the organization continues to offer these essential services to youth in numerous marginalized communities.

NAPPA recently launched a new project: a SRH youth camp in partnership with UNFPA and PAY. This UNFPA-supported combines communication and education on SRH and gender with other fun programming, such as sports (cycling, volleyball and soccer), arts and culture (dance and spoken word) and social media training. The social media component is considered an important way to ensure continuation of the dialogue started among the camp’s 170 participants from four regions. UNFPA considers social media to be an essential platform for SRH discussions for youth in Namibia.
Assessments of the camp (pre- and post- questionnaires and focus group discussions) revealed that the week-long intervention had considerable impact on shifting knowledge relating to post-exposure prophylaxis and PMTCT. It found that youth experience many challenges related to disclosure, sexual rights and gender; however, considerable improvements were observed as a result of the multi-faceted programming.

Catholic AIDS Action offers training programs for youth: Adventure Unlimited for younger children and Stepping Stones for older youth and adults. These programs use a participatory approach to empower youth with the necessary life skills to prevent HIV infection or onward transmission. With a well-established curriculum and over 450 trained volunteers, this programming reaches more than 10,000 youth annually.

The USAID Portfolio and Performance
USAID OVC programming is guided by the legislation (Lantos-Hyde) and the PEPFAR OVC Guidance 2012. The definition of OVC according to the legislation is:

“Children who have lost a parent to HIV/AIDS, who are otherwise directly affected by the disease, or who live in areas of high HIV prevalence and may be vulnerable to the disease or its socioeconomic effects.” (Lantos-Hyde Reauthorization Act 2008)

“PEPFAR is mandated to care for children orphaned or made vulnerable by HIV/AIDS. Mitigating the impact that HIV is having on children and the families that support them is integral to a comprehensive HIV response. It is important to note that the definition of "affected" children includes, but is not limited to, children infected with HIV/AIDS. PEPFAR recognizes that individuals, families, and communities are affected by HIV in ways that may hinder the medical outcomes of HIV-positive persons as well as the emotional and physical development of children orphaned or made vulnerable by HIV/AIDS. A variety of services are supported through PEPFAR to mitigate these effects in order to improve health and well-being outcomes of adults and children. These services include programs that support the developmental growth of children and the quality of life of adults and children living with and affected by HIV/AIDS.” (PEPFAR Monitoring, Evaluation and Reporting, November 2014)

These considerations help align the PEPFAR definition with the National Agenda for Children, moving away from targeting orphans, who in many cases were not the most vulnerable, to reaching a broader group of vulnerable and marginalized children.

The definition purposely mentions socio-economic effects to ensure that the money set aside is not used for straight clinical interventions, as those are the focus of other parts of the budget. The legislation further states that PEPFAR strategies should be guided by
an analysis of “factors contributing to children’s vulnerability to HIV/AIDS vulnerabilities caused by the impact of HIV/AIDS on children and their families.”

As per OGAC guidance and the standard interpretation of the law by congressional liaisons within PEPFAR leadership, money cannot be spent on pediatric care, but integration of pediatric care, OVC programming and all HIV services should be more intentional in PEPFAR programs.

Annual PEPFAR funding for Namibia dropped by 72 percent from $90 million in 2012 to $25 million in 2014. Funding from the HKID budget code for OVC programming also declined over the same period. However, this reduction was less steep, representing a 64 percent cut from $7 million in 2012 to $2.5 million in 2014. The net result is that funds for OVC programming now represent a larger share of total PEPFAR funds: up from 7.9 percent in 2012 to 10.3 percent in 2014.

As with all PEPFAR activities, these budgetary cuts require the OVC portfolio to be more focused, strategic and cost-effective than ever before. The increasing share of HKID funds also puts pressure on the OVC portfolio to go beyond its core impact mitigation mandate to contribute to other PEPFAR program areas and outcomes. Unsurprisingly, the results of the OVC portfolio fell over the same period as the budget cuts: from a steady annual level of 75,000 beneficiaries served in 2012 to 18,000 in 2014. However, the decline in results was not commensurate with the decline in funds: results fell by 76 percent while program funding fell by 64 percent. While interpreting the trend in results is complicated by a change in OVC indicators between 2013 and 2014, the decline may indicate the need to strengthen the strategic focus, quality or efficiency of the OVC portfolio to optimize results in the currently constrained funding environment.

The introduction of new OVC indicators, with highly detailed age disaggregation, facilitates a more nuanced analysis of the OVC portfolio’s performance than was previously possible. Namibia reported on two new indicators in 2014: (1) OVC_SERV for active beneficiaries served by supported programs, and (2) OVC_ACC for active beneficiaries supported to access HIV services. Both indicators require age disaggregation for five age ranges of children (pre-natal to 3 years; preschool; middle years; early adolescents; late adolescents to adulthood) and a sixth age range for all adults over the age of 18. OVC_SERV is very similar to the previous C1.1.D outreach indicator, but OVC_ACC is completely new. For this reason, many partners struggled to report on OVC_ACC in 2014, and data are incomplete.

Examining the OVC_SERV age disaggregation is likely more reliable. Consistent with the traditional strengths of funding for OVC programs, a significant share of the children served were of primary school age (5-9 years), and very few were infants (<1 year). But the Namibia’s OVC portfolio also reaches large numbers pre-primary children (1-4 years) and adolescents (15-17 years), with adolescents representing the largest group (37
percent) of children served. This may be a potential strength of the portfolio to build on, especially for contributing to HIV prevention and pediatric HIV outcomes.

Figure 10: Summary of USAID Portfolio Trends
III. FINDINGS

POVERTY AND ECONOMIC STABILITY

In Namibia, as in other parts of the world, poverty is the most significant constraint compromising the ability of caregivers to protect children from the effects of HIV/AIDS and facilitate core services for children, including adequate material and psychosocial support. HIV/AIDS has further exacerbated pre-existing economic vulnerability by interrupting income streams, depleting assets, introducing labor constraints and increasing dependency ratios. In addition, poverty limits the uptake and impact of HIV/AIDS prevention and treatment. Reducing socioeconomic vulnerability among caregivers through a range of economic strengthening activities frequently contributes to greater investment of caregivers’ resources towards meeting the essential needs of the children in their care. Complementing these economic strengthening activities with education and support activities for caregivers enables better access to core services across the continuum for care, improved health, nutrition, education and psychosocial well-being, as well as a reduction in abuse, exploitation and neglect among OVC and youth.

Providing direct support to children rather than empowering families to provide for children’s needs can undermine family relationships and capacity to care for children in the long term. Project interventions designed to strengthen the capacity of families to achieve child well-being outcomes through lowering their socioeconomic vulnerability and other education and support initiatives should ensure that families and caregivers have access to basic support and are able to access resources to meet important family needs (e.g., school fees, health costs, food, etc.). They should also enable families and caregivers to provide children with regular, nutritious meals, address health concerns among children in a timely and appropriate manner and ensure that children are fully immunized.

The efficacy of economic strengthening for the health and well-being of adolescent girls in particular has been documented in a number of studies. Young women and adolescent girls have a higher HIV prevalence than their male counterparts due to engendered practices of early marriage, pressure to have sex in return for money or material goods, early sexual debut and forced sexual encounters. Empowering adolescent girls and young women both economically and socially is an important impact mitigation approach.

Project HOPE’s VSL groups targeted caregivers of OVC. The groups (Oshipumbu and Oiwilili) that the landscape analysis team visited in Omusati Region appeared well established, and indeed had continued for 2 years and 5 months since the close of any actual support from Project HOPE. Between the 21 members that the group met, there
were 89 OVC being cared for. Participants indicated that the VSL group affords them a much-needed basic level of financial security. They observed that the model supported many of their personal or group business initiatives and thus led to increased financial security.

The VSL model was enhanced by a parenting curriculum that was delivered alongside the savings training sessions. The participants expressed satisfaction with the parenting curriculum and cited outcomes as less harsh punishment, less discrimination towards OVC within the home environment and improved nutrition knowledge and skills. They indicated that there was a great interest from other community members to start more VSL groups and obtain the associated parenting training, but that the rate at which training was being provided did not keep up with demand, resulting in a waiting list of interested participants. Nevertheless, the team considered this to be a highly relevant, cost-effective and easily replicable model to address concerns of poverty in isolated communities such as these.

**Linkages:**
In Namibia, the availability of child grants and universal pensions provides a crucial social protection mechanism. The grants criteria are currently under review as part of the Child Care and Protection Act, and expansion is likely with a refocus on addressing child poverty. Household economic strengthening activities can leverage these government resources with support for money management, additional savings, nutritional information and food security initiatives, for example.

The Directorate of Women’s Empowerment with MGECW is responsible for programming government funds through small grants. There is potential again to leverage these funds as well and supplement them with critical household and child support such as sensitive parenting, referrals to SRH services, nutrition education and other community services.

**EARLY CHILDHOOD DEVELOPMENT**
A strong and vocal consensus is growing internationally, regionally and nationally concerning the critical importance of the early years of a child on subsequent health economic and social outcomes. ECD programs should be considered a high priority in all areas where OVC programming is taking place, especially those with high HIV prevalence (PEPFAR OVC Guidance, 2012).

According to recent modelling done by PEPFAR (Consequences of Adult HIV for Affected Children: Modelling the Impact, September 2014), risks associated with maternal HIV-related poor mental and physical health are concentrated in the early years of a child’s life, with possible long-term implications. This resilience study indicates that supportive interventions should be targeted to affected families with young
children. The PEPFAR OVC Guidance recommends that ECD programs should be considered a high priority in all areas where OVC programming is taking place, especially those with high HIV prevalence. These programs should be linked to related programs, such as child survival and eMTCT.

An essential ECD package is illustrated in Figure 11. Such a package provides multiple opportunities to reach children affected and infected with HIV and AIDS as well as their parents.

**Figure 11: Essential ECD Package**

ECD is a multi-sectoral program that is currently not implemented in a manner that integrates services among responsible line ministries and between the public sector and civil society. ECD initiatives for newborns to 4-year-olds are led by the MGECW, while initiatives for 5-8 year-olds are the responsibility of the MoE. The Ministry of Health has divisions for family health under Primary Health Care and for parenting support under Social Services. The Ministry of Home Affairs is responsible for birth certificates and national documents. ECD facilities are run by private individuals, community structures, non-governmental and faith-based organizations, and in the case of Windhoek, the Municipality. This approach does not maximize the possible linkages with HIV services for parents, young children and older siblings. However, the MGECW is now starting on a process to build a national consensus around ECD in the country and to transfer some of the mandates to MoE.

The MGECW, with previous support from USAID/PEPFAR implemented by Pact, made major strides in formalizing the provision of ECD. This included:

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**Analysis of USAID/Namibia’s OVC Landscape**

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• The inclusion of ECD and nutrition into the NAC with aligned indicators
• The development of Namibian Standards for ECD Facilities, which include parent committees, nutrition and health issues [with support of Education and Training Sector Improvement Programme (ETSIP)]
• A baseline survey of all ECD facilities in 2012 and the creation of a database that looks at coverage for orphans and children with disabilities (with ETSIP)
• The development of unit standards for ECD caregiver training submitted to the National Qualifications Authority, with two national ECD qualifications (direct USAID technical assistance)
• The design of a curriculum for 3-4 year-olds to articulate with the MoE pre-primary class (direct USAID technical assistance)
• The initiation of allowances to ECD caregivers (currently 804)
• The increase in government ECD program funds to NS$24 million
• Facilitation of UNICEF support for a consultancy to help position ECD in the country and to transition ECD from MGECW to MoE, as called for in the NDP4.
• An analysis of the ECD database information from 2012 and comparison with data from the 2011 Census.10

The anecdotal evidence heard during the landscape review, which needs to be confirmed by a proper assessment, suggests that subsidies for ECD caregivers have helped improve the quality of ECD services. Parents and communities seem to be taking a greater interest in these facilities and contributing funds for improvements. At the same time, a number of centers have decreased their fees and are admitting more vulnerable children.

The ECD system can serve as a platform for referrals and follow–up, especially for HIV-positive mothers and their children.

With previous support from USAID, under the New Partners Initiative, the Church Alliance for Orphans (CAFO) assisted community groups to provide OVC with services. This approach continued under a direct agreement with USAID. Major activities included Kids Clubs and soup kitchens for primary school children, with some support for church- and community-based ECD centers as well. An evaluation of the activity was done in 2010.11 In consultation with USAID, CAFO increasingly focused on the ECD centers, helping them align with the MGECW standards and providing some material support.

10 Data on ECD facilities is collected by MGECW staff in the regions on an annual basis and put into the database. The staff member responsible for the database resigned, and her replacement has not yet been recruited. Without her expertise, the database is underutilized.

CAFO’s engagement with these centers helped identify children without birth certificates or social grants, and the relevant referrals were made.

In addition, CAFO volunteers and staff received training from the Food and Nutrition Technical Assistance (FANTA) team on issues pertaining to food and nutrition. The training included the use of the Measuring Mid-Upper Arm Circumference method which was then rolled out to ECD centers, resulting in more than 1,000 children being referred to health centers (CAFO Annual Report 2013).

The assessment team visited one of the centers in an informal settlement, Okahandja Park, in Katutura. The center caregiver was receiving an allowance through the MGECW subsidy system and some material support from CAFO. The quality of the program in terms of the five components of ECD seemed moderate. The owner runs another ECD center in a more prosperous part of Katutura that seems to subsidize this one. She does not charge fees at the Okahandja Park facility. She provides a meal for the children and a reasonably safe interior space for them during the morning. There is no outside play area, and the fence and glass windowpanes had been stolen.

The owner tries to link children of pre-primary and primary school age to the local schools, but often these schools are full. The parents in this community struggle to send children to other schools due to transport cost. A few children nearby were not attending.

Except for the absence of fees, this ECD center was similar to many others: well-intentioned and caring providers with few resources responding to a need in their community. With a more integrated and resourced program, such centers can become beacons in their neighborhoods, reaching parents, caregivers and children with appropriate health information and linkages to services, such as growth monitoring and nutrition education, responsive parenting, child protection, and access to grants.

CAFO and Lifeline/Childline have recently received a joint grant from the Roger Federer Foundation for ECD with a focus on parenting. This is another opportunity for incorporating and institutionalizing HIV linkages into ECD programs.

**Linkages**

There is a great deal more to be done to ensure that HIV-affected and infected children are accommodated in an ECD program and that such programs link children to a range of services. These include immunization, growth monitoring, HIV testing and support for cognitive delays. ECD programs can also link parents to HIV services through parenting support.

A comprehensive ECD program addresses the pyramid of needs (Figure 12), with the most resources directed at the bottom of the triangle, to reach the vulnerable children in highly affected regions. More expensive and targeted services may be required and
should be made available for young children with particular needs, such as disabilities, developmental delays and HIV infection. Finally, ECD services should be able to facilitate referrals and services for children with particular needs, for example birth certificates, enrolment in early learning programs, growth monitoring and referrals to clinics, HIV testing and child protection.

**Figure 12: Pyramid of Response**

**OPTIONS FOR ADOLESCENTS**

Despite high levels of knowledge about HIV/AIDS among Namibian adolescents, risky sexual behavior is high, with little reported condom use, low levels of HIV counselling and testing and forced sexual encounters. Forty percent of new HIV infections were among young women 15-19 (UNICEF) and according to the 2011 study on teenage pregnancy in Kavango, pregnancy rates are approximately 34 percent among 15-19 year-olds. According to the 2010 PEPFAR OVC Portfolio Review, keeping vulnerable children in school is a reliable strategy for many positive health outcomes, including lower HIV infection rates. The PEPFAR OVC Guidance of 2012 refers to studies in many countries that have linked higher education levels with increased AIDS awareness and knowledge, higher rates of contraceptive use and greater communication about HIV prevention among partners. Evidence also demonstrates that education can affect infection rates, as more highly educated girls and young women are more likely to be able to negotiate safer sex and reduce HIV rates.

A number of USAID and Global Fund partners and other entities employ interventions to help vulnerable adolescents attend and progress through secondary school. The reasons for the high dropout rate from Namibian schools are complex, including poor infrastructure, poor quality of teaching and learning, academic failure, pregnancy and
possibly stigma (General Reader, National Education Conference 2011, Ministry of Education, Namibia).

KAYEC’s approach through the KYD program has been to offer academic support programs coupled with life skills (Stepping Stones) and activities to boost self-esteem. Samples show this has a positive effect on progression through the high school grades for participants. Other smaller programs in the country, for example PAY, have shown similar results. The implementation of the original MoE program for in- and out-of-school adolescents (My Future, My Choice) appears stymied. An evaluation of the MoE HIV program is currently being finalized. It should provide rich information for future interventions around prevention for adolescents.

The MoHSS has a School Health Policy that covers health services, health education, school community relations, nutrition and food, physical education and a supportive environment. In 2013 the MoHSS and the U.S. Centers for Disease Control and Prevention conducted the Global School Health Survey (GSHS). The GSHS reported that 45.8 percent of learners experienced bullying in 2013. School violence undermines young people’s rights to quality education and health services. The MoE has a school health portfolio with a particular focus on addressing violence and bullying in schools and communities, which is being supported by UNICEF in a one-year action plan (2015-2016). School violence, coupled with high teenage pregnancy rates, makes it crucial to target adolescent girls with SRH services and HIV prevention activities.

During the recent PTF meeting, the MoE reported plans to work with different stakeholders, including civil society organizations such as Lifeline/Childline and Philippi Trust, to distribute responsibilities for creating Safe Schools according to the plan. This initiative has potential to establish a vehicle for linkages from schools to civil society partners and MoE and MoHSS for the continuum of care for OVC. This could create opportunities to increase HIV testing in schools, address harmful gender norms and build a referral system for SRH including family planning and gender-based violence.

Like child protection and early childhood development, school health is by definition a multi-sectoral program requiring multiple stakeholders to work in collaboration to reach and serve children. Individual projects need to be consolidated or coordinated into a national framework based on evidence.

**Linkages:**

KAYEC and Lifeline/Childline work in and with schools. The recent Safe Schools initiative under MoE is an opportunity to integrate the KYD and similar work with vulnerable adolescents more closely into school hostels and into additional schools in PEPFAR focus regions. Consultations are expected to occur at the Permanent Secretary level, as there was guidance last year that organizations intending to work in schools should
apply to the Permanent Secretary due to the perceived high number of organizations
operating in schools.

Although UNICEF leads in much of the work on HIV prevention and SRH with the MoE,
there is scope for USAID to encourage and facilitate coordination between its partners
and the MoE, especially at the regional level. This could include convening of regional
meetings of partners engaged in similar youth work to standardize basic approaches
and messages, possibly through Regional AIDS Coordination Committees (RACOCs). A
particular emphasis should be engaging adolescents and youth in such meetings to gain
their insights, experiences, and recommendations.

**SUPPORT FOR PARENTING**

There is growing evidence suggesting that that support for parenting, which includes
caregivers of OVC who are not biological parents, addresses a number of critical risk
factors for child health, including violence, adolescent SRH and psychosocial support.
The PEPFAR OVC Guidance recommends that a much greater priority should be placed
on reaching parents and primary caregivers.

An estimated 200 million children under 5 in developing countries are not meeting their
developmental potential due to exposure to multiple risks, including poverty, lack of
nurturing and responsive care and poor health and nutrition\(^\text{12}\). Among these risk factors,
harsh punishment and severe discipline has been consistently associated with poor
cognitive, social and health outcomes during childhood and across the entire life course.
Research shows that positive parenting practices and a nurturing relationship between
caregiver and child can buffer the adverse effects of poverty and violence, and
contribute to positive developmental outcomes\(^\text{13}\). There is a strong evidence base on
the effectiveness of parenting interventions in high-income countries, and an emerging
body of research from low- and middle-income countries, suggesting that such
interventions may be effective at improving parenting practices in low-resource
settings\(^\text{14}\). In addition, parenting interventions that situate positive parenting within a
wider ecological framework by improving child behavior problems and caregiver
depression may buffer against risks for poor child mental and physical health outcomes
in families affected by HIV/AIDS and poverty\(^\text{15}\).

\(^{12}\) UNICEF. *Hidden in Plain Sight*. September 2014.
The latest research coming from the field of epigenetics is elucidating how toxic stress effects brain development, resulting in weaker higher-level executive functions and poor impulse control. Parental practices and nutrition are fundamental in determining this in infants, and many psychopathological behaviors such as substance abuse, violence, risky behavior and early sexual debut may have their origins in infant brain development. (presentation by Dr. Barack Morgan, UNICEF/DSD Conference on ECD, Pretoria, South Africa, December 2014).

Parenting support interventions offer a platform for multiple linkages to health and HIV services and educational support, among other services. Parenting support is also consistent with the family-centered approach outlined in the PEPFAR OVC Programming Guidance and is a recommended priority intervention.

National parenting programming in Namibia is led by the sub-division of Family Welfare, in the division for Professional Social Work under the directorate of Developmental Social Welfare within MoHSS. This office has plans to expand parenting programming and has connected with regional technical resources such as the Parenting in Africa Network; however, its current reach and quality—not to mention overlap with PEPFAR OVC target populations—is a bit unclear. With the technical help of Lifeline/Childline, they are now spearheading a Parenting Network with MGECW, MoHSS and MoE along with various civil society organizations, many of whom are USAID/PEPFAR partners.

During the rapid assessment conducted by the OVC landscape analysis team, parenting arose as a central issue, and some current interventions were observed during site visits and discussed during key informant interviews. Feedback from numerous partners during the team’s review cited a high level of interest in parenting support activities (one cited an “insatiable appetite for parenting support”), with some indicating a demand beyond the ability of their current program to meet. Social workers and HEWs with whom the team met indicated that one of the most prevalent issues in their client base was parents grappling with children’s behavioral problems, sometimes leading to children being expelled from the home or referred to the social worker to find alternate care.

Direct parenting support activities within the current PEPFAR Namibia OVC portfolio include activities such as Project HOPE’s savings groups incorporating parenting education and Lifeline/Childline parenting groups. Participants in Project HOPE’s savings groups–each of whom was caring for at least two vulnerable children–reported that the parenting support had greatly improved their ability to communicate with their children, and in some cases reduced the level of physical punishment. Participants also seemed better equipped to address children’s basic needs such as health and hygiene, and all the members knew their own and their children’s HIV status and reported accessing treatment when necessary. Lifeline/Childline reported the considerable success of its
parenting training program, based on an adapted Positive Parenting Program (Triple P), and an increasing demand for this type of support. Lifeline/Childline also noted that its parenting groups were more successful and sustainable when they allowed members to self-select into groups. In addition to these interventions, CAFO, which currently provides support to a number of ECD centers, noted lack of parental engagement as a critical challenge in addressing the needs of children in their centers. The organization is therefore planning (in conjunction with Childline and funded by the Roger Federer Foundation) to introduce a parenting element as part of its ECD support.

Parenting interventions should be evidence-based and reflect best practices in the Namibian context. Program planning for this intervention should also keep in mind issues around targeting. While self-selection could be a best practice for intervention effectiveness, it may result in the intervention not reaching the most vulnerable, i.e., those which may not self-select into the activity. This is especially true as isolation and stigma are associated with poor parenting.

**Linkages:**
Continued strategic support for effective parenting activities can target vulnerable communities and families in PEPFAR priority (HIV-affected) regions. Activities might include economic strengthening combined with parenting support (through savings groups), using ECD centers as a platform for parental engagement and support, or stand-alone parenting support groups. This would incorporate deliberate interventions to support parents with disclosure for children and adolescents living with HIV. These activities should include linkages to health and HIV services.

Support for the development and roll-out of MoHSS’ parenting program is feasible, particularly in PEPFAR priority regions, with special focus on integrating service linkages for HIV-affected children.

**GENDER INEQUALITY, STIGMA AND DISCRIMINATION**
Stigma and discrimination of disabled people, sex workers and HIV-positive people are significant structural drivers of the HIV epidemic in Namibia and are closely interwoven with gender inequality and gender-based violence. As such, there is a strong link between gender inequality, gender-based violence and issues such as a lack of disclosure, shame, poor adherence to ART and barriers to accessing services. Stigma is a harmful social process that devalues people or groups of people based upon a real or perceived difference (such as age, gender or ethnicity). Discrimination follows stigmatizing attitudes and beliefs, and can result in biased, harmful, or unjust attitudes, behaviors, laws and policies.

Key informants who were interviewed for the landscape analysis described the types of complex and interrelated issues facing children and youth, many of which are based on
factors such as stigma, discrimination, and gender inequality and violence. Many children face bullying and other forms of violence at schools. Such bullying is done in person and through mobile phone text messaging and other forms of social media. Several social workers that spoke with the assessment team related the problems faced by single-parent homes, as well as high levels of family breakdown and violence and the effect those have had on children’s physical and psychosocial well-being and performance at school. In addition, many young children who are HIV-positive and on ART do not know the reason they are taking medication every day, because their families or caregivers have not disclosed their status to them.

Adolescents face similar issues as those faced by children. As one key informant said, “every problem facing children and youth can be a risk factor for HIV.” HIV-positive youth can face challenges in adhering to ART due to a sense of shame or stigmatizing attitudes from friends and family members. However, it was noted that some adolescents are better at adhering to ART than adults if they start out with good adherence behaviors. There are stark gender differences between boys and girls when it comes to accessing services such as counselling and adherence support. Lifeline/Childline noted that most of their adolescent clients are female, and the male clients attending counselling are those that have been referred from schools for behavioral problems. Very few boys come on their own, which is consistent with gender differences in accessing services across sub-Saharan Africa. As was noted with children, stigma from family members and bullying by peers at school and within the community are unfortunately a common reality for many HIV-positive adolescents. The lack of a stable home environment, coupled with an increased risk of depression and suicide, are significant risk factors. Adolescent girls face particular risks and challenges associated with high rates of pregnancy and transactional sex. It was frequently noted that the adolescent girls’ motivation to engage in transactional sexual relationships is not solely for economic gain but also driven by the need for emotional connections and love, as well as to fulfil sexual desire. Despite the fact that there is a strong national policy on keeping pregnant learners in schools, there are many other socio-cultural and structural barriers that inhibit pregnant adolescent girls from completing their education. Teachers, school administrators and family and community members frequently discourage girls from continuing their education once they become pregnant, preferring that they stay home.

During the landscape analysis, the assessment team heard stories from several key informants about the types of stigma and discrimination faced by children and adolescents. For example, in one household an HIV-positive child was given a separate cup and utensils for eating and was stigmatized by other family members in the home. In another case, HIV-positive children have reported that their peers are bullying them at school because of their HIV status. Harmful gender norms perpetuate inequality,
violence and a culture accepting discriminatory attitudes. The assessment team was told the story of an adolescent girl who was raped, consequently infected with HIV and also impregnated. Her community shamed her, blaming her for the sexual assault, and stigmatizing her due to her HIV status.

An assessment of the Woman and Child Protection services conducted by the UNDP noted that Namibia has a strong legal and policy framework for addressing protection and gender-based violence. According to the assessment\textsuperscript{16}, seven government ministries are engaged in the delivery of the government’s protection mandate: MGECW; Ministry of Safety and Security; Ministry of Justice; MoHSS; Ministry of Home Affairs and Immigration; MoE; and Ministry of Labour and Social Welfare. However, many key informants interviewed for this landscape analysis noted that the implementation of these laws and policies is weak, which affects the quality, timeliness and comprehensiveness of service delivery. Several stated that many victims of violence are afraid to go to a clinic to access services, such as post-exposure prophylaxis, for fear they will be required to make a police report and open a case against the person (or persons) who committed the violence. Many women and girls do not want to pursue a legal case, and for those that do there are many obstacles to justice. The assessment of the Woman and Child Protection services, cited above, provides a very comprehensive analysis, including specific recommendations for strengthening services and coordination.

The assessment team was able to see some good programs that are addressing many of the issues related to gender inequality, GBV, stigma and discrimination. Lifeline/Childline is implementing a social and behavior change communication program to transform harmful gender norms that undermine adolescent girls’ and boys’ well-being, as well as a Safe Schools program using the USAID-funded Doorways curriculum. In addition, Lifeline/Childline is providing a range of health and psychosocial support services, including counselling on GBV and HIV-related topics. The teen clubs at Onandjokwe Hospital were another good example of services for children and youth. In addition to providing counselling and support for HIV disclosure, ART adherence and life skills, the clubs also provide support services to parents and caregivers, which have been very popular and a welcome addition to the services provided by the hospital. As noted in its 2013 Annual Report\textsuperscript{17}, UNICEF supported the Office of the First Lady in efforts to increase male involvement in PMTCT through a series of media messages, including public service radio announcements in local languages.

Linkages:
Throughout the assessment it became clear that stigma and associated discrimination—whether based upon HIV status, gender inequality or another socio-cultural determinant—is prevalent in Namibia and is both a source of psychosocial distress and a barrier to accessing services. Efforts to address stigma and discrimination throughout the program portfolio are needed so they are not a stand-alone intervention but an integrated component of all program activities.

Based upon the rapid assessment and conversations with a range of partners and stakeholders, several priorities emerged for future programming:

- **Support partners to continue and expand GBV prevention activities and response mobilization at the community level.** When discussing how best to allocate limited U.S. Government funds, this recommendation came through quite clearly from several stakeholders. Given the strong policy framework and existing infrastructure of the WACPUs, and the UNDP assessment discussed above, this recommendation aims to fill a gap in existing services and support, and is based upon the premise that the GRN will continue to be a strong partner with the resources to provide services through the WACPUs. The focus of GBV prevention and response programs should be through community-based support for victims, including safe spaces, counselling and addressing issues around stigma, discrimination and safety within the home and community. Stakeholders emphasized that having a strong community response to GBV is very important, because strengthening the immediate environment where people live into a supportive and safe space is essential. Such prevention and response programming should include working with traditional leaders, health extension workers, counsellors in the community and family members. In addition, it should support community-based organizations providing legal aid and support to survivors of domestic violence and should challenge harmful gender roles, norms and behaviors that condone violence through community sensitization and mobilization. While some of this work should be funded through the OVC budget code, USAID/Namibia should also look for opportunities to fund GBV prevention and response programming with additional budget codes. For example, support for post-exposure prophylaxis can be funded through the treatment budget codes.

- **Integrate strategies to address harmful gender norms and stigma reduction throughout program portfolio.** The SBCC program that Lifeline/Childline implements is a good approach to addressing harmful gender norms that inhibit health-seeking behaviors, undermine caregiver-child relationships and fuel GBV. This type of approach should be integrated into other programs such as Positive Parenting, community-based prevention and response to GBV and campaigns to...
address stigma, discrimination, and bullying. It should also be incorporated within HIV-related services, such as testing and counselling, HIV disclosure and ART adherence and retention support, as well as KYD and other youth groups. Interventions to address harmful gender norms should be linked to a specific outcome—such as uptake of HIV-related services, personal risk assessments, measures of improved child well-being or parental engagement—in order to have a measurable goal upon which to evaluate program outcomes.

**SOCIAL SERVICE WORKFORCE AND SYSTEMS**

The National Agenda for Children emphasizes building systems and strengthening national and local capacities and partnerships. The social service workforce in Namibia is dispersed among a number of ministries; the two primary ones are the MGECW and the MoHSS. These ministries have clear mandates with regard to delivery of social services. While MGECW is the government agency responsible for coordinating service delivery for children, MoHSS focuses only on persons over the age of 18.

The MGECW comprises the following three program directorates:

- The Child Welfare Directorate implements child support interventions including the child welfare grant program.
- The Gender Equality and Women’s Empowerment Program addresses issues of women’s rights, including SRH rights, and GBV.
- Women’s Empowerment Directorate (previously Community Mobilization and Early Childhood Development) leads the national response to advance community and ECD services. The early childhood component is being transitioned to the MoE. 18

Social workers on the MGECW staff are based at national and regional levels. Social workers at the regional level administer child welfare grants, make foster care placements and counsel and represent children who are in conflict with the law or who are abused or neglected. Also under the MGECW, the community child care workers operate at the constituency level, registering children for the maintenance grant.

The ministry has at times outsourced services to civil society organizations such as the Regional Psychosocial Support Initiative, Lifeline/Childline and DAPP as a strategy to address human resource shortages and specialized skills insufficiencies, for example in the area of disclosing HIV status to children.

The MoHSS’s Directorate of Social Welfare Services through its Division of Developmental Social Welfare Services is responsible for providing social services for persons older than 18. The focus of the family welfare sub-division is to provide

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sustainable services to persons older than 60, promote strengthening of family values and morals and reduce social problems within the family.\textsuperscript{19} There is also a parenting sub-division.

The district social workers in the MoHSS are only mandated to provide counselling to persons above the age of 18 on social matters such as domestic violence, parenting, drug and alcohol abuse, neglect of older persons or property grabbing. All child-related cases identified through the MoHSS are referred to the MGECW.

A relatively new cadre within the MoHSS is the health extension worker (HEW). These workers have been trained to provide basic primary health care services at the village level. There are currently 562 workers, and an additional 1,000 are currently receiving six months of training and are expected to graduate in May 2015 for deployment to communities across currently covered and new regions. A total of 4,100 HEWs are planned for the rest of the country, and 2,615 are expected to be recruited in the seven priority regions. The roles of the HEW are to mobilize communities for good health practices and assess the health and social well-being of children and their families. This assessment includes checking children’s health passports for immunization status and HIV treatment adherence, as well as nutrition and birth certificates. Children who do not possess birth certificates are referred to the local headman for further referral to the MGECW social worker or to Ministry of Home Affairs and Immigration.

Insufficient capacity of MGECW social workers to provide specialized services for children was identified as a critical challenge. For example, the \textit{Assessment of the Woman and Child Protection Services} report cites inadequate quality of counselling services for children referred from WACPs, and reports that such counselling, when provided, is usually only a one-off session.\textsuperscript{20} Respondents also mentioned dealing with suicide, HIV counselling for treatment adherence, counselling for HIV-positive children with behavioral problems and working with children with disabilities as areas in which social workers did not have the necessary expertise. This is coupled with high-volume caseloads that overstretch capacity. One social worker interviewed gave an estimate of handling at least 10 new clients per day.

Both MGECW and MOHSS highlighted strategic information and monitoring and evaluation as areas that still needed to be strengthened, especially for monitoring the National Agenda for Children. The issues of data quality and use were raised.

MOHSS social workers do not have the mandate to manage child-related cases even if they have the skill to do so. This not only presents a lost opportunity to manage a case

\textsuperscript{19} Ministry of Health and Social Services, \url{http://www.mhss.gov.na/} Namibia, 2014.

\textsuperscript{20} Government Republic of Namibia. \textit{Assessment of the Woman and Child Protection Services in Kavango, Karas, Khomas, Omusati & Omaheke regions in Namibia}. 2012.
in a timely manner, but referring a child to the MGECW social worker does not always guarantee specialized service, especially when dealing with issues of HIV treatment adherence for pediatric cases, a skill that the social workers do not have. Stakeholders from the MGECW reported that not all social workers have skills in addiction counselling, HIV counselling or HIV disclosure with children.

**Linkages:**
System strengthening is a vital area of focus to ensure quality service delivery. Although findings reveal gaps at the different levels of the national response, there seems to be a greater need at the community level. The USAID response should therefore focus on strengthening regional and community systems for a quality and comprehensive service delivery package. This should include ways to link HEW to OVC community structures.

Support to strengthen national-level systems should occur through targeted technical assistance for specific elements that have a direct bearing on service delivery. For example, support the MGECW in monitoring NAC implementation; provide technical support to MoHSS to develop a package for responsive parenting; provide support for the expansion and coordination of ECD services.

**COORDINATION AND REFERRALS**
The National Coordination Framework for the HIV Response and the National Strategic Framework for HIV, as well as the National Policy for HIV have been recently revised or are under review. The latest version of the Coordination Framework maintains the national technical working groups, the RACOCs and the Constituency AIDS Coordination Committees (CACOCs). Line ministries and civil society organizations are represented at all of these levels. The relevant personnel, a community liaison officer and a regional monitoring and evaluation officer, as well as a CACOC coordinator in some of the constituencies, are based out of the Regional Council, funded through the Ministry of Regional and Local Government, Housing and Rural Development. These bodies at sub-national level have potential to address some of the needs for better coordination and linkages with regard to services for children. They could be a platform for:

- generating regional solutions to the social workers’ mandate
- identifying the most well-placed civil society organization to provide GBV, adherence and disclosure counselling
- supporting groups of PLHIV and their families as well as OVC caregivers with economic strengthening activities and other similar functions
- aligning the work of the HEWs to the needs of the most vulnerable
- targeting cases most at risk

The National Agenda for Children 2012-2016 provides a comprehensive multi-sectoral framework for an integrated service delivery for children and their families. Cabinet
established the PTF for OVC as the national coordinating body responsible for monitoring and reporting on the implementation of the NAC. This body may be replaced by a National Children’s Council that comes into effect with the enactment of the Child Care and Protection Bill. The PTF, comprising government, civil society and development partners, meets quarterly to review progress on the NAC, share information and discuss other policy implementation issues.

At regional and constituency levels, the Child Care and Protection Forum is the multi-sectoral body to coordinate child-related service delivery. The forum is yet to be established in all the constituencies. Where it does exist, the Regional Council chairs quarterly meetings, the main purpose of which is to share information and identify children needing referrals. The HEW will play a key role at the community level in facilitating referrals from village to government service providers.

The National Protection Referral Network was an attempt by government and stakeholders to further provide guidance on the flow of services for abused children. Although most respondents participated in its development, usability of the tool was questioned. Stakeholders seemed to value the informal networks established during the process of developing the flow chart. These relationships foster multidimensional linkages among civil society organizations and public services.

**Figure 13: National Protection Referral Network (from MGECW)**
The challenge of effective referrals was a constant theme during the landscape review. There seems to be stronger referral linkages from community to health facilities than from health facilities to community services. The quality of the service provided, the time and transport costs associated with multiple referrals, and the limited use of non-governmental partner services were cited as challenges to effective referrals.

Although there is relative success with referrals, this relies on a process that is not client-centered but paper-centered. The focus is more on reporting on the number of referrals conducted than ensuring the completion of the referral. Not all partners track outcomes of the referrals.

Social workers may not be skilled to provide specialized services. This, compounded with huge caseloads, affects the quality of services offered, thus becoming a barrier to referrals. The enactment of the Child Care and Protection Bill will entail greater emphasis on early identification and prevention issues, with a subsequent increase in the duties and possibly case load of social workers.

Lack of clarity on what cases need to be referred and to whom creates a barrier to linkages and also increases the social workers’ case load. Ideally, only children in need of specialized services should be referred, but without clear guidelines, this is not happening. There are opportunities for task-shifting and for more community-located services that would serve children better.

**Linkages:**
Within the social service workforce and coordination structures, there is a need to identify dedicated personnel to formalize linkages and bi-directional referrals and to provide services directly as required.

The coordination capacity of the Child Care and Protection Forum in PEPFAR priority regions could be augmented and mobilized to engage line ministries and civil society organizations on providing easy access, as well as referrals, to key services. This could include developing protocols, memoranda of understanding and other tools as best practice in these regions.

At the national level, technical support to the newly established Parenting Networking Forum could eventually strengthen regional and community linkages.
IV. SUMMARY OF PRIORITY GAPS AND OPPORTUNITIES

INDIVIDUAL PARTNER ANALYSIS

The following table provides a partner analysis based on what core and near-core activities current partners and mechanisms are covering to obtain a clear idea of gaps and how to structure next mechanism, with an eye on the four global OVC outcomes.

Table 4: Summary of Current OVC Program Portfolio

<table>
<thead>
<tr>
<th>Outcomes suggested by the OVC Technical Working Group</th>
<th>Activities that bridge the divide between OVC social protective services and prevention, treatment and care and Activities that expand uptake of and linkages to HIV care and treatment for key populations and vulnerable young women and adolescents</th>
<th>Collaboration with GRN for continued protection of HIV investments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy</td>
<td>HIV and life skills provided for all vocational and KYD participants (Stepping Stones) 33% of vocational trainees were tested for HIV Referrals for VMCC</td>
<td></td>
</tr>
<tr>
<td>Safe</td>
<td>KYD refers youth for testing and protection services The KYD reaches approximately 1,500 adolescents a year with self-esteem, PSS, resilience building and gender norms</td>
<td></td>
</tr>
<tr>
<td>Stable</td>
<td>Lifeline/Childline provides some parenting support to parents of KYD participants</td>
<td>Vocational training and skills provided in Khomas region and Oshana Region (funded in part by Namibia Training Authority)</td>
</tr>
<tr>
<td>Schooled</td>
<td>Schools refer vulnerable children to KAYEC’s KYD who then provides academic support once per week. No dropouts among participants and pass rate of participants above national and school averages</td>
<td></td>
</tr>
</tbody>
</table>

KAYEC: Service Delivery
<table>
<thead>
<tr>
<th>Outcomes suggested by the OVC Technical Working Group</th>
<th>Activities that bridge the divide between OVC social protective services and prevention, treatment and care and Activities that expand uptake of and linkages to HIV care and treatment for key populations and vulnerable young women and adolescents</th>
<th>Collaboration with GRN for continued protection of HIV investments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lifeline/Childline – Service Delivery and National Support</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Healthy</strong></td>
<td>Social and behavior change activities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Referrals to HIV counselling and testing for in- and out-of-school youth</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Internal referrals between parenting-SBCC-HTC</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Referrals made to SBCC and parent participants for nutritional support locally</td>
<td></td>
</tr>
<tr>
<td><strong>Safe</strong></td>
<td>Free counselling telephone service with referrals with a special dedicated line for children</td>
<td>Support to Gender Directorate in MGECW</td>
</tr>
<tr>
<td></td>
<td>Face to face counselling given</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Safe schools program</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Addressing gender norms integrated in all services</td>
<td></td>
</tr>
<tr>
<td><strong>Stable</strong></td>
<td>Parenting classes</td>
<td>Leading on Parenting Network with MoHSS</td>
</tr>
<tr>
<td><strong>Schooled</strong></td>
<td>Self-esteem for young girls</td>
<td>Safe Schools program with MoE</td>
</tr>
</tbody>
</table>

**Project HOPE: Service Delivery and Regional Support**

| **Healthy** | Bi-directional referral system; | |
| **Safe** | Training CBHW in gender norms and child protection | |
| **Stable** | Household economic strengthening, currently not focused on caregivers of OVC, but instead on PLHIV. | |
| **Schooled** | Some support through sub-recipient CAA on getting children enrolled | |

**CAFO: Service Delivery**

<p>| <strong>Healthy</strong> | Assistance with sourcing food for some ECD centers | |
| <strong>Safe</strong> | Hygiene training and provision of handwashing materials | |
| <strong>Safe</strong> | It is unclear if the ECD caregivers are able at this stage to identify signs of abuse and refer appropriately. | |</p>
<table>
<thead>
<tr>
<th>Outcomes suggested by the OVC Technical Working Group</th>
<th>Activities that bridge the divide between OVC social protective services and prevention, treatment and care and Activities that expand uptake of and linkages to HIV care and treatment for key populations and vulnerable young women and adolescents</th>
<th>Collaboration with GRN for continued protection of HIV investments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stable</td>
<td>CAFO-supported centers help with referrals for birth certificates and social grants.</td>
<td>Parenting support training in conjunction with Lifeline/Childline</td>
</tr>
<tr>
<td>Schooled</td>
<td>Providing materials to ECD centers; children assisted to enter pre-primary</td>
<td>Assessing centers using MGECW tools</td>
</tr>
</tbody>
</table>

| Pact: National and Regional Capacity Development |
|---|---|
| Healthy | Work with Regional AIDS Coordination bodies to strengthen coordination of services and efficacious referrals for OVC  
Assist RACOCs to use HIV-related data for resource allocation and decision-making | |
| Safe | Work with Regional AIDS Coordination bodies to strengthen coordination of services and efficacious referrals for OVC | |
| Stable | | Identifying possible government resources in support of HIV responses at national and community level |
| Schooled | | Technical assistance to MGECW to finalize transfer and development of ECD  
Works with the PTF and MGECW on request |

Considering the above matrix, the USAID OVC portfolio is quite balanced, with partners reaching OVC of different ages through both government and non-governmental pathways, and addressing all the outcomes. Not all activities of every partner are implemented in all seven PEPFAR priority Regions.

**ANALYSIS ACCORDING TO PEPFAR AGENDA AND USAID SYSTEMS FRAMEWORK**

The USAID systems framework corresponds well to the five key PEPFAR agenda points, as can be seen in the graphic below.
There are many opportunities for the USAID partners to work collaboratively and build on each other’s strengths. There are some good examples of KAYEC and Lifeline, and Lifeline and CAFO doing this, and of good teamwork among sub-recipients in the NARP. Lifeline is often called upon to act as a technical provider or advisor for gender and for child counselling for many PEPFAR partners.

There can be no efficiency without quality, since interventions with insufficient duration, frequency, dose and relevance may have little results and thus be a poor investment. The many small projects throughout Namibia may mean duplication of efforts and limited quality assurance. The MoE has recognized the need for greater coordination of efforts with regard to interventions at the school level, including social and behavior change, HIV prevention and life skills. This is a positive development. The essential role of government and communities in supporting OVC and their families through institutionalized and funded responses needs to be recognized and promoted.

**Relationships and Partnerships**
Throughout the landscape analysis, the critical importance of family and community interventions was emphasized, as this is where norms are formed, prevention and early detection take place and first-line protection is sought. Partnerships with the community are thus critical.
Project HOPE and Lifeline/Childline have multi-dimensional programs with different PEPFAR funding streams (prevention, treatment, OVC) so there are opportunities for in-house referrals, for example from a parenting courses to SBCC to HIV counselling and testing. These seem better articulated by Lifeline/Childline than by Project HOPE, where there are no clear linkages between groups of PLHIV and parenting, for example.

Other partners have been successful in making referrals and linking beneficiaries to services. Referrals remain an important yet problematic activity. Bi-directional referrals from community to facility and from facility to community remain elusive, with few referrals from clinics to community programs. There was evidence of schools referring learners to KAYEC and to Lifeline/Childline.

There are networks such as the PTF, Child Care and Protection Forum, RACOCs and CACOCs at national and local levels that formalize relationships and provide opportunities for enhanced relationships. These are helpful when functional, and there are opportunities for USAID to support these pre-existing forums so they become more able to identify families, children or communities at risk of not accessing services such as birth registration, social grants, health services, etc. The forums may need skills and information on how best to assist people to access services.

**Rules, Human Rights and Gender**

Government has excellent policies and guidelines addressing human rights, GBV and stigma and discrimination. Despite these, barriers remain especially for adolescents in accessing HIV services and ongoing participation in the continuum of care. Isolated or stigmatized mothers will also be less likely to approach service providers for the necessary treatment advice and care.

All partners include some training or mainstreaming on gender norms and GBV. USAID may want to consider a more detailed review of the materials and approaches used and identify any best practice that could then be integrated into all the current and new programs.

There is no biomedical model to address GBV, and key informants stressed the importance of addressing these issues within families and communities.

**Resources and Sustainability**

All of the USAID/PEPFAR OVC partners are well respected and established non-governmental organizations that have experience partnering with government. In addition, they have managed to diversify their funding base to a greater or lesser extent, including through some government service-level contracts, public fundraising and attracting philanthropic and cooperate funding. CAFO, Lifeline/Childline, KAYEC, and Project HOPE are all national organizations. Pact Namibia is an international organization.
Partners identified three enabling factors strengths which support sustainability of the response:

1. Addressing a need
2. Community ownership
3. Alignment to GRN policies

All the partners align their work with government policies and guidelines, such as the National Agenda for Children, the NSF for HIV, Adolescent Adherence, and Inclusive Education Policy.

The partners are having some success with attracting other funders, governmental and non-governmental, national and international. Much more could be done with philanthropies and private sector corporate social investment funds. USAID may want to consider its convening role in facilitating such discussions.

There are bottlenecks in the channeling of government funds to non-governmental organizations for development work. Although outsourcing is part of GRN procurement policy, it is not widely used. The public tender process gives an opportunity to civil society organizations to apply for different assignments, including service delivery, but none of the USAID/PEPFAR OVC partners have followed that route. There are service-level agreements between various line ministries and OVC partners, for example between MGECW and Lifeline/Childline. In addition KAYEC has benefitted from the new training levy that goes through Namibia Training Authority.

Household-level economic strengthening remains a relevant and sustainable family intervention.

The portfolio is balanced between systems strengthening and direct service delivery. Since Namibia is facing declining resources, it makes sense to maintain and even bolster the GRN systems, especially the social service workforce, regional coordination, resource allocation and strategic information, in order to activate or channel such resources for the HIV response.

The USAID OVC portfolio can best maintain its substantial investment in the sector by

- providing technical assistance and advocacy to help unlock GRN funds to support the continuum of care;
- identifying those critical areas in which to continue GRN institutional support, e.g., ECD, workforce, coordination and strategic information;
- continue to support its OVC partners’ work in the PEPFAR focus regions, using their core competencies and strengths to reach the identified populations of young OVC and adolescent girl OVC through community interventions;
• convening around mobilizing the private sector corporate social investment and philanthropies to support the continuum of care provided by local non-governmental organizations.

Results and Outcomes
The PEPFAR indicator of “OVC referred to an HIV service” may not be capturing the actual outcomes desired for children, especially in Namibia where the service may be sub-standard. Even with assisted referrals, desired child outcome may not be achieved. Within their sphere of influence, however, USAID/PEPFAR OVC partners are efficacious and are changing lives of children and adolescents and helping them on the road to adulthood.

As stated in the PEPFAR OVC Guidance, strengthening families through holistic services is central to OVC programming and has the greatest likelihood of sustainable impact. Working alongside and in collaboration with government, the partners need to find mechanisms to document the work they are doing in this regard and to evaluate for impact.

System strengthening is crucial for impact and sustainability, but it is not well articulated as an OVC indicator and thus difficult to report on and justify.

Key Gaps

There is insufficient focus on very young children, especially the first 1,000 days from conception to 2 years.

Although eMTCT coverage is high in Namibia and has brought down infant HIV incidence, certain problems persist. Early infant diagnosis is inadequately implemented, and there is substantial loss to follow-up during post-natal care. While over 90 percent of children have received BCG, pentavalent 1, polio 1, and the measles vaccine, only 68 percent of children receive comprehensive immunization (2013 DHS+). Stunting, at 24 percent, remains inexplicably high for a middle-income country.

A comprehensive strategy that focuses on the first 1,000 days could address these care and treatment deficits, monitor nutrition and integrate support for more skilled and responsive parenting that will address nutrition and early cognitive development. In addition, a 1,000 days program would emphasize linkages of children to all services for which they are eligible, including grants.

There are numerous entry point options for a 1,000 days intervention, including antenatal and immunization services. However, locating an ECD-specific program at facilities may be ineffective, considering the already overwhelming workload of clinic staff. An alternative to consider would be the staffing of an ECD program with auxiliary workers in a manner that mirrors the use of expert patients.
Home visiting is another delivery mechanism to be explored as part of early ECD services—especially for vulnerable at-risk mothers who may be isolated, depressed, marginalized, stigmatized or otherwise at risk along with their babies.

**Parenting programs are appreciated, but are limited in scope and coverage.**

Support to effective parenting offers a means to address multiple deficits in care and treatment, nutrition, early developmental milestones and access to services. Support to parenting should not only focus on ECD but also adolescence, where the focus would be equipping parents to offer their children counsel on sexual choices and behavior and access to services, and to monitor adherence in HIV+ adolescents. Support to parenting also provides an opportunity to address norms and cultural practices that disadvantage children and women.

A significant advantage offered by support to parenting is that it is easily integrated into existing program activities.

**Gender**

Gender inequalities fuel GBV, and the latter is endemic in Namibia, especially intimate partner violence. Projects have an awareness of the gender dimensions of their work and some intention to address harmful gender norms and practices. Dialogue on how to combat GBV is needed at all levels, from policy makers to community members and households. This should be explicit in all USAID programs.

**Current programs for adolescent girls and boys may be efficacious, but they are insufficiently documented, targeted and institutionalized within schools and other facilities.**

The multiple risk factors confronting vulnerable adolescent girls and boys require a sophisticated and multi-dimensional response. In addition, programs should be established within government plans, institutions and budgets, to the extent possible. The high percentage of new infections among adolescent girls and young women is a concern. Impactful, targeted and intensive interventions in high-prevalence areas are required.

The high dropout rates in school and the low high school completion rate among boys and girls can potentially undermine many prevention interventions. Helping adolescents progress through school, including secondary school, remains a tested effective intervention. The many positive, supportive civil society approaches to this need to be encouraged.
The provision of accessible, quality social services, over and above social grants, requires more collaboration among the social service workforce providers.

Currently the social workers in the regions are overloaded and unable to provide the necessary follow-up for vulnerable children and households. In addition, the Child Care and Protection Act, recently enacted, requires new levels of effort from the social service workforce in terms of prevention of child abuse, neglect and family dissolution. The potential expansion of social grants to poor children, regardless of orphan status, will also entail some increased workload for certain cadres.

Not only is the system overloaded, it is also frequently inefficient. The social workers in different ministries, such as MGECW and MoHSS, have specific mandates that delineate who they can serve, based on who their employer’s jurisdiction. These arrangements at times preclude the most efficient provision of services to clients.

Better synergy between government and civil society social workers, community workers and other similar cadres is needed. To achieve efficiencies and ensure quality and access for very vulnerable and isolated households, memoranda of agreement, service-level agreements and other mechanisms for outsourcing services from government to non-governmental organizations can be used. Within government, some task-shifting from social workers to others cadres is needed, as is better coordination and communication with community workers across government, and finally rationalization of social worker mandates across line ministries.
V. RECOMMENDATIONS

PROGRAM AREA RECOMMENDATIONS

The following recommendations are proposed in order to:

- Strengthen collaboration with GRN for continued protection of HIV investments;
- Expand uptake of and linkages to HIV care and treatment for vulnerable young women and adolescents;
- Bridge the divide between OVC services and HIV prevention, treatment and care.

The categories used below further reflect the priority systems-strengthening interventions proposed in the PEPFAR OVC Guidance of 2012.

- Improving financing for social service systems
- Strengthening social service workforce
- Strengthening coordination and networking within the social service system
- Strengthening information management and accountability mechanisms of the OVC system
<table>
<thead>
<tr>
<th>Lifespan Focus</th>
<th>Recommendations and Programmatic Considerations</th>
<th>Mechanism</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>0-6 years</strong></td>
<td>Continue to provide technical assistance to the MGECW and MoE in conjunction with the UNICEF support to establish a full menu of ECD programs in Namibia, that include a pro-poor and an HIV-sensitive approach, with strong health linkages, including nutrition. This should be a short-term (12-18 month) intervention in order to finalize the transition of ECD from MGECW to MoE and to position the government to use funds from the national budget and from the envisioned future European Union budget support for ECD. Integrate the concept of the “1,000 days” into HEW training in MoHSS and into home-visits by NGOs partners. Support any emerging initiatives on home-visiting associated with the new ECD framework for Namibia. A home-visiting component of ECD can reach mother-infant pairs exiting from PMTCT services, young children at risk, children in families with PLHIV, and under-nourished children. The WHO/UNICEF recent Care for Child Development Manual provides an excellent resource for such an intervention.</td>
<td>Technical assistance to GRN</td>
</tr>
<tr>
<td><strong>Organizational</strong></td>
<td>Provide technical assistance to the Social Services directorate of MoHSS to streamline the current system of welfare grants to registered organizations.</td>
<td>Technical assistance to GRN</td>
</tr>
<tr>
<td><strong>0-18 years</strong></td>
<td>Provide targeted technical assistance to MGECW in preparations for the implementation of the Child Care and Protection Act, with due consideration to workforce deployment, possible task shifting, and a whole-government approach to social work mandates.</td>
<td>Technical assistance to GRN</td>
</tr>
<tr>
<td><strong>Family (HES)</strong></td>
<td>Build on previous technical assistance to the Directorate of Community Development (now known as Women’s Empowerment) to improve and focus the economic activities undertaken with the current government grants to Regional Council. This may include the introduction of VSL.</td>
<td>Technical assistance to GRN</td>
</tr>
</tbody>
</table>
Table 6: Summary of Recommendations: Expand uptake of and linkages to HIV care and treatment for vulnerable young women and adolescents

<table>
<thead>
<tr>
<th>Lifespan Focus</th>
<th>Recommendations and Programmatic Considerations</th>
<th>Mechanism</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescents</td>
<td>Build on experience of current OVC partners, to develop and model a well-researched and evidence-based youth OVC program aimed at adolescent girls (but including boys). The youth program should include age-appropriate SRH, referrals for VMC and family planning, academic support to progress through secondary school, psycho-social support and prevention and protection from GBV. The program would involve NGO partners but would ensure linkages to schools, hostels, after school centers, clinics and other GRN facilities for youth, especially young women, possibly through the Safe Schools initiative of MoE. There should be a focus on school retention for in-school youth and transition into adulthood, decision-making and money management interventions for older adolescents. Ensure an innovative program concept that is evidence-based, applies best practices and has a strong quality assurance component. As much as possible services would be co-located near clinics where NAPPA is operating and where PEPFAR is supporting adolescent HIV treatment.</td>
<td>New Procurement</td>
</tr>
<tr>
<td>0-18 with focus on adolescent girls</td>
<td>Support partners to continue and expand gender-based violence prevention and response mobilization and activities at the community level including safe spaces, counselling, and addressing issues around stigma, discrimination, harmful gender norms and safety within the home and community.</td>
<td>All</td>
</tr>
</tbody>
</table>
### Table 7: Summary of Recommendations: Bridge the divide between OVC services and HIV prevention, treatment and care

<table>
<thead>
<tr>
<th>Lifespan Focus</th>
<th>Recommendations and Programmatic Considerations</th>
<th>Mechanism</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>Provide strategic support for effective parenting activities under the leadership of MoHSS Parenting Unit and the Parenting Network that target vulnerable communities and families in PEPFAR priority (HIV-affected) regions with a focus on integrating service linkages for HIV-affected children. Activities might include economic strengthening plus parenting (through savings groups), using ECD centers as a platform for parental engagement and support, communication skills for disclosure and for communicating with adolescents, strategies to address harmful gender norms.</td>
<td>Technical assistance to GRN &amp; local partner</td>
</tr>
<tr>
<td>0-6 years old</td>
<td>Model a localized, coordinated service for young OVC that establishes integrated/interlinked standard operating procedures with HEWs from MoHSS, constituency child care workers from MGECW, Early childhood education workers from MGECW/MoE and community volunteers from organizations such as CAA or DAPP, or CAFO. The children in the families would receive nutritional assessment and support, HIV testing, early stimulation, referrals for adolescent sexual and reproductive health and access to social protection mechanisms such as social grants where applicable. Child protection services and prevention of GBV would be included as needed.</td>
<td>New procurement</td>
</tr>
</tbody>
</table>
Table 8: Summary of Recommendations: Strengthening coordination and networking within the social service system

<table>
<thead>
<tr>
<th>Lifespan Focus</th>
<th>Recommendations and Programmatic Considerations</th>
<th>Mechanism</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organizational</td>
<td>Strengthen the coordination capacity of Child Care and Protection Forums in PEPFAR priority regions to engage with other line ministries and civil society organizations with a focus on providing easy access to HIV and protection services for OVC, over and above referrals for key services. This could include developing protocols, MoUs, data analysis, and other tools as best practice in these regions.</td>
<td>Technical assistance</td>
</tr>
<tr>
<td>Adolescents</td>
<td>Establish a regular meeting agenda with UNICEF and Global Fund (PMU) to discuss development partner coordination in the OVC sector. This could be in conjunction with PTF meetings and thus lead to improved coordination among development partners and with MGECW.</td>
<td>USAID</td>
</tr>
<tr>
<td></td>
<td>Facilitate the convening of regional meetings of partners engaged in similar youth work to standardize basic approaches and messages, possibly through RACOCs or Child Care and Protection Forum.</td>
<td>Technical assistance to RACOCs</td>
</tr>
</tbody>
</table>

Table 9: Summary of Recommendations: Strengthening information management and accountability mechanisms of the OVC system

<table>
<thead>
<tr>
<th>Lifespan Focus</th>
<th>Recommendations and Programmatic Considerations</th>
<th>Mechanism</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Support the MGECW in developing procedures and processes for monitoring NAC implementation at regional and sub-regional levels and for using the available data for prioritizing resource allocations.</td>
<td>Technical assistance to GRN</td>
</tr>
<tr>
<td></td>
<td>The System for Programme Monitoring should be made functional. An additional level of functionality should be added that would focus on integrating OVC-relevant data (SPM, grants data etc.) in a single repository.</td>
<td>Technical assistance to GRN</td>
</tr>
<tr>
<td></td>
<td>A common research agenda determined in consultation between development partner, GRN and other key stakeholders should be compiled to address key evaluation and research questions.</td>
<td>Convening</td>
</tr>
</tbody>
</table>

OVC PROGRAMMING GOING FORWARD: OPTIONS FOR CURRENT AND FUTURE MECHANISMS

The following implementation mechanisms and approaches are suggested to operationalize the recommendations listed above.
Current Mechanisms

Current mechanisms continuing through at least the next year should seek to incorporate or focus on the recommended activities identified in this report, summarized below, to the extent that they are consistent with existing agreement scopes and overall PEPFAR programming guidance from USAID/Namibia.

NARP - Project HOPE (end date: Sept 2016):

- Continue savings groups for household economic strengthening for caregivers (Technical Working Group Core)
- Consider how CAA’s working within NARP can be modelled around best-practice home-visiting approaches for a family focus that includes young children and links to HIV services. (Core)
- Ensure the parenting component (OVC Curriculum) is included whenever possible with both PLHIV and caregiver groups. (Core)
- Assess where community-level processes and workforce can be improved to link health, HIV and social services for OVC and their families, including GBV prevention and response. (Core)
- Develop simple operating tools or procedures to assist the Child Care and Protection Forums at regional and constituency levels.
- Hold discussions with the Women’s Empowerment Directorate of MGECW to assess their interest in and capacity for implementing particular HES strategies such as VSL.

Namibia Institutional Strengthening – Pact (end date: Sept 2016):

- Finalize ECD policy and any implementation support in the PEPFAR priority regions.
- Provide technical assistance to the MoHSS and the Parenting Network on developing their national program materials and plans, and consider ways to roll out in priority regions/constituencies.
- Provide short-term technical assistance so that the social welfare workforce development forum (which meets quarterly) focuses on improved access to and quality of services, rather than only on rigid definition of mandates. As noted earlier, MoHSS is responsible for care for the elderly, addressing alcoholism and addiction and parenting, while MGECW has a mandate for child welfare.
- Provide technical assistance for the social service directorate to make grants to registered welfare organizations.
- Provide technical assistance around monitoring and reporting on the National Agenda for Children, particularly at the regional level.
- Assist RACOCs and Child Care and Protection Forums at the regional and constituency levels to model new localized service delivery and referral
approaches that improve uptake of health and HIV services through better linkages between community and health facilities.

**New Mechanisms**

**Regional and Community Levels**

Given that the other OVC mechanisms will be ending within the next 6-9 months (LL/CL, KAYEC, BLC/CAFO), USAID/Namibia may want to consider planning either a new procurement or extensions (with or without cost) to existing partners that would focus on strategic interventions to support OVC, especially adolescents and young women, at the regional, community and household levels in the seven priority regions. Such procurement could focus on saturation of best-practice youth development programs in the most vulnerable constituencies and with specific target groups (e.g., girls in hostels). The procurement may consider how to expand and institutionalize parenting and caregiver support, which can have multiple positive results, such as addressing gender norms, family communication about sexuality, disclosure of HIV status between adults and with children, reducing harsh discipline and improving economic distribution in the home.

**National Level**

For limited and targeted national-level support after Pact’s current program ends, USAID/Namibia might consider either a new procurement or buying into the central Comprehensive Care for Children agreement for this scope of work.

This could cover support for the development and roll-out of the MoHSS parenting program, particularly in PEPFAR priority (high HIV prevalence) regions, with special focus on integrating service linkages for HIV-affected children.

Address any outstanding issues in formalizing and institutionalizing the envisioned focus on the first 1,000 days as outlined in a draft ECD framework.

**MONITORING, EVALUATION AND RESEARCH**

The development of OVC programs relies substantially on the incorporation of evidence on what works from experience outside of Namibia. There is limited robust evidence on the effectiveness of OVC support implemented by the GRN and partners to date. As consensus and resources are mobilized for significant interventions, such as extending ECD, the implementation of the NAC and the rollout of kinship care grants, evidence to justify expenditures and to optimize programs becomes increasingly important.

A country learning agenda based on three substantive initiatives is called for:
1. The MGECW should be supported in developing procedures and processes for monitoring NAC implementation at regional and sub-regional levels and for using the available data for prioritizing resource allocations.

2. Routine data on multi-sector programs remains elusive. The System for Programme Monitoring remains dysfunctional, and this needs to be addressed, either by investing in its improvement or by replacing it. The system needs an additional level of functionality that integrates relevant OVC data (System for Programme Monitoring, grants data, etc.) into a single repository.

3. A common research agenda determined in consultation between development partners, the GRN and other key stakeholders should be compiled in a mirroring of the HIV/AIDS Country Research Agenda established as a component of the National Strategic Framework process.
APPENDIX A. SCOPE OF WORK

Global Health Program Cycle Improvement Project
Contract No. AID-OAA-C-14-00067
SCOPE OF WORK
Activity No. 020
(Revised October 30, 2014)

I. TITLE: Namibia: Landscape Analysis of the Orphans and Vulnerable Children Program
   Contract: Global Health Program Cycle Improvement Project (GH Pro)


III. FUNDING SOURCE: USAID/Namibia (HIV/AIDS)

IV. OVERVIEW AND PURPOSE OF THE ASSIGNMENT

This scope of work calls to conduct a landscape analysis of the status of orphans and vulnerable children programming in Namibia. The findings and recommendations from this analysis may inform current and any future USAID project design in the area of Orphans and Vulnerable Children (OVC). The primary audience for this assessment is USAID/Namibia. A secondary audience of the analysis is the Ministry of Gender Equality and Child Welfare (MGECW) and other stakeholders in Namibia, including U. S. Government agencies, bilateral and multilateral donors, and civil society stakeholders.

The analysis will provide a clear roadmap for short- and long-term investments (including potential new procurement needs), demonstrates a commitment to a Namibia-led process and plan, and works collaboratively with other partners/stakeholders in OVC programming. Based on a comprehensive and integrated strategic approach that addresses the multiple dimensions needs of OVC, this analysis must aim to improve the status of OVC of Namibians. Additionally, this assessment must incorporate the principles and leverage the resources of the President’s Emergency Plan for AIDS Relief (PEPFAR), Government of Republic of Namibia (GRN) and other donor agencies working in OVC programming.

To conduct this analysis, USAID/Namibia will hire a team of local/regional consultants to assess the following issues in addressing the needs of OVC:

- Comprehensive OVC programming in the country in Namibia;
- Linkage between OVC programming and HIV/AIDS interventions;
● Current policy environment related to OVC;
● Current programs and resources;
● U.S. government/USAID comparative advantage in implementing OVC programming; and
● Involvement of country-level stakeholders, including other donors and the private sector in OVC interventions.

This consultant team will be joined by USAID RHAP and GH/OHA staff.

The fieldwork for this assignment is anticipated to begin on or about November 10, 2014 and will include meetings with the mission, stakeholder interviews, as well as visits to two regions/sites. The team must submit a draft of an assessment report before their departure from Namibia.

V. BACKGROUND

The HIV/AIDS epidemic in Namibia is mature, generalized and driven by heterosexual and mother-to-child transmission. In 2012/13, HIV prevalence among adults aged 15-49 years was estimated at 13.3 percent, with approximately 195,000 people living with HIV. New infections among young people aged 15-24 are high, with estimates that by 2015, 49 percent of new infections will occur among this group. The 2012 Antenatal Clinic (ANC) Survey reported HIV prevalence among pregnant women attending ANC at 18.2 percent, a decline from the peak ANC prevalence estimate of 22 percent reported in 2002. ART coverage in Namibia is estimated at 88 percent (CD4 <350), but will decline as the country adopts new WHO guidelines. PMTCT coverage is estimated at 83 percent. The Demographic Health Survey (DHS 2006/7) estimates that 155,000 children in Namibia have lost one or both parents and 95,000 are vulnerable. Although HIV infection has generally been declining over the years, age disaggregated prevalence rates show a disproportionate burden of new infections among young people, especially women and girls, aged 15-24.

The GRN is making headway in addressing issues affecting OVC in the country. For example, the National Agenda for Children latest report indicates that 75 percent of eligible children received child welfare grants by 2011, although these grants are yet to show impact in reducing poverty and vulnerability. Despite the achievements being made, the situation of OVC remains a challenge. For example new HIV infections among adolescents constitute 31 percent of new infections, 24,005 children had acute to moderate malnutrition and 29 percent of children under 5 had an indication of chronic malnutrition. According to the National AIDS Council report issues of child poverty, violence and abuse against children and teenage pregnancy continue to be an area of concern.
VI. SCOPE OF WORK

As its primary objective, the team must conduct a situation analysis of the orphans and vulnerable children programming landscape in the country to identify implementation gaps, review current USAID/PEPFAR OVC portfolio against country context and priorities (‘The Five Knows’) as well as new PEPFAR guidance and monitoring requirements, and make recommendations for priority areas for strengthening the PEPFAR OVC portfolio in Namibia. In response to the PEPFAR OVC guidance (July 2012), this landscape analysis must provide a clear roadmap for short- and long-term investments (including potential new procurement needs), demonstrate a commitment to a Namibia-led process and plan, and map collaborative relationships with other partners/stakeholders. Based on a comprehensive and integrated strategic approach that addresses the multiple dimensions needs of OVC, this analysis must aim to improve the quality of OVC services in Namibia and linkage of OVC programming with HIV/AIDS interventions. Additionally, this assessment must explain how proposed investments will increase gender equity and sustain OVC programming.

The team must seek guidance from the leaders and relevant staff of the USAID/Namibia health team members, who will provide information and technical advice, and the Health Office Director. Tara O’Day will provide overall direction for the team.

VII. METHODOLOGY

This landscape analysis will follow a non-quantitative methodology, which will include the following activities:

- Desk review of relevant data sources and documents,
- Team planning meeting,
- Stakeholder meetings, including interviews with key stakeholders, and OVC and caregivers, and
- Two field site visits.

Prior to conducting site visits, the team will review various documents including (but not limited to) projects and reports, PEPFAR OVC guidance, the USG Children in Adversity action plan, Namibian strategic plans on children and other relevant documents.

**Desk review:** The USAID/Namibia team will provide the relevant documents via a shared Google drive for review as soon as possible.

**Team planning meeting (TPM):** The purpose of the TPM is to provide consulting teams with an opportunity to carefully define and plan their work and develop any tools that would be necessary to achieve the goals of the assignment. A two-day TPM will be required at the start of this activity to define team member roles and responsibilities, establish a communication plan, formalize the methodology and in-brief with
USAID/Namibia and other stakeholders and resource partners to receive any relevant background information necessary for the assignment. All information required for the desk review (above), including surveys, evaluations, background reading, etc., will be sent to the team by USAID prior to the start of the TPM. GH Pro will assist the team by providing a toolkit to drive the TPM and ensure that the necessary deliverables come out of the TPM process.

**Stakeholder meetings:** USAID/Namibia will prepare the stakeholder meetings in advance of the assignment. This includes preparing and following up on participant invitations, and securing adequate space for the meetings to take place at the mission.

**Site visits:** USAID/Namibia will choose the site visit locations in advance of the start of the activity.

**VIII. TEAM COMPOSITION, SKILLS AND LEVEL OF EFFORT**

The contractor team will be comprised of team leader, one regional expert and a logistics/administrative consultant. The team leader will be responsible for team coordination and performance and for ensuring the timeliness and quality of deliverables. USAID may also propose representatives from USAID or other U.S. Government agencies to participate in parts of the assessment and/or travel with the consultant team to site visits. At least one of the team members will be a local technical consultant knowledgeable of the Namibia context.

Core team members should include:

**a) Team leader** should have a post graduate degree in public health or social sciences. S/he should have extensive experience in conducting evaluations in sub-Saharan Africa and familiarity with the Namibia context. The team leader must have extensive experience providing strategic leadership to USAID programs and writing strategy documents, as well as expertise in child protection and OVC programing. S/he will provide leadership for the team, finalize the evaluation design, coordinate activities, arrange periodic meetings, consolidate individual input from team members and coordinate the process of assembling the final findings and recommendations into a high quality document and a presentation to USAID and other major partners.

**b) Regional consultant** should have a degree in public health or social sciences. S/he should have several years’ experience working with child protection or OVC projects in sub-Saharan Africa. S/he should be knowledgeable in program assessment and evaluation methodologies. S/he should have experience and demonstrate state-of-the-art knowledge in conducting evaluations/assessments of OVC projects.
c) **Logistics/Administrative specialist** should have several years’ experience coordinating events and/or field work in Namibia. S/he will manage all in-country travel, logistics and other duties as assigned by the team leader.

d) **U.S. Government participants** will engage with implementing partners and stakeholders, bringing regional and USAID/Washington perspectives and guidance on this activity during their TDY.

- OVC Technical Advisor, USAID OHA Washington Colette Peck
- Representative from OGAC Gender Technical Working Group or Pediatric/PMTCT Technical Working Group
- OVC Advisor RHAP, Brenda Yamba
- OVC Advisor Malawi or Botswana

IX. **LOGISTICS**

USAID/Namibia will coordinate with other U.S. Government agencies, implementing partners and other country-level stakeholders to arrange courtesy calls, substantive meetings, field site visits and in-country travel for U.S. Government TDY staff from Washington, RHAP and other missions, including transportation and accommodation. U.S. Government personnel are responsible for securing their own travel arrangements.

X. **DELIVERABLES AND PRODUCTS**

a) **Document review:** Prior to field work, USAID/Namibia will provide the team with an electronic package of briefing materials related to OVC in Namibia.

b) **Team planning meeting:** A team planning meeting will be conducted in advance of commencement of the review. This meeting will allow for team members to review and clarify objectives, review team members roles and responsibilities, review list of key informants and site visits. The team leader will prepare and present interview guide for stakeholder interviews and also present draft outline for the report for discussion and agree on report writing assignments.

c) **Meeting with relevant interagency (U.S. Government) technical teams** for input and participation.

d) **Ministry of Gender Equality and Child Welfare (MGECW) meeting:** A consultative meeting will be held with the MGECW staff to solicit their views on the OVC landscape in the country, to include information on current stakeholders and programmatic and funding gaps. USAID/Namibia is responsible for setting up and coordinating this meeting for the consultant team.

e) **Stakeholder meeting in Namibia:** A one-day meeting will be held with OVC stakeholders including government (MGECW, MOHSS, and others), UN agencies (UNICEF), Global Fund (GF), University of Namibia (UNAM) social work section,
civil society organizations, and implementing partners (Project HOPE, Lifeline/Childline, Kayec Trust) to solicit information on the OVC landscape in Namibia. USAID/Namibia is responsible for setting up and coordinating this meeting for the consultant team.

f) Stakeholder interviews: The team leader will propose list of key informants who are best suited to provide input for high level strategic direction. Stakeholders will include national and regional government officials (MGECW, MOHSS), UNAM, UN agencies (UNICEF), development partners funding OVC programs (GF), current implementing partners and other NGOs. Interviews will be conducted in Windhoek and in two of the PEPFAR/USAID Namibia priority regions.

g) Debriefing with USAID: The team will present the major findings of the evaluations to USAID upon completion of field work. The debriefing will include a discussion of strategic direction recommendations. The team will consider USAID comments to revise parts of the draft report accordingly, as appropriate. This will be done prior to any other debriefings.

h) Debriefing with MGECW: The team will present the major findings of the evaluations to MGECW upon completion of field work. The debriefing will include a discussion of strategic direction recommendations and will solicit input on the recommendations. USAID/Namibia is responsible for setting up and coordinating this meeting for the consultant team.

i) Draft report: After debriefing, the team leader will submit an electronic draft report on the findings and recommendations to USAID/Namibia within five working days. The written report should clearly describe key consensus points, findings, conclusions, and recommendations for future strategic direction of the OVC portfolio. USAID will provide comment on the draft report within five days of submission.

j) Final report: USAID has 14 working days to review the draft report and provide written comments to the contractor on the draft report. The contractor will have five working days to incorporate these comments into a final report. The contractor must provide both an electronic version and one hard copies of the final report to USAID Namibia.
### Illustrative Level of Effort (LOE)*:

<table>
<thead>
<tr>
<th>Task/Deliverable</th>
<th>Team Leader</th>
<th>Regional Consultant</th>
<th>Local Logistics Coordinator</th>
<th>USAID team members LOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Read background documents</td>
<td>2 days</td>
<td>2 days</td>
<td>0 days</td>
<td>1 day</td>
</tr>
<tr>
<td>Travel to Namibia</td>
<td>0 days</td>
<td>1 day</td>
<td>0 days</td>
<td>2 days</td>
</tr>
<tr>
<td>In-briefing with USAID HIV/AIDS team (and partner(s) as needed)</td>
<td>1 day</td>
<td>1 day</td>
<td>1 day</td>
<td>1 day</td>
</tr>
<tr>
<td>Team planning meeting (including development of survey instruments, report outline, writing assignments)</td>
<td>2 days</td>
<td>2 days</td>
<td>2 days</td>
<td>2 days</td>
</tr>
<tr>
<td><strong>Assessment work</strong></td>
<td>19 days</td>
<td>11 days</td>
<td>7 days</td>
<td>2 days</td>
</tr>
<tr>
<td>• Site visits and key informant interviews (includes in-country travel days)</td>
<td>(12 days)</td>
<td>(6 days)</td>
<td>(3 days)</td>
<td>(2 days)</td>
</tr>
<tr>
<td>• Discussion, analysis and draft report and debriefing preparation</td>
<td>(4 days)</td>
<td>(2 days)</td>
<td>(2 days)</td>
<td></td>
</tr>
<tr>
<td>• Mission and partner debriefing</td>
<td>(1 day)</td>
<td>(1 day)</td>
<td>(1 day)</td>
<td></td>
</tr>
<tr>
<td>• Ministry debriefing</td>
<td>(1 day)</td>
<td>(1 day)</td>
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</tr>
<tr>
<td>• Complete report draft: revise report &amp; incorporate debriefing comments</td>
<td>(1 day)</td>
<td>(1 day)</td>
<td>0</td>
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</tr>
<tr>
<td>Return Travel</td>
<td>0 days</td>
<td>1 day</td>
<td>0 days</td>
<td>2 days</td>
</tr>
<tr>
<td>Mission sends technical feedback/comments on draft report to GH Pro (within 10 days of submission)</td>
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</tr>
<tr>
<td>Consultants revise/finalize report</td>
<td>5 days</td>
<td>3 days</td>
<td>0 days</td>
<td>0</td>
</tr>
<tr>
<td>Mission reviews/signs off on final report (within 5 days of receipt)</td>
<td>0</td>
<td>0</td>
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</tr>
<tr>
<td>GH Pro edits and finalizes report – approx. 30 days after mission approval</td>
<td>0</td>
<td>0</td>
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</tr>
<tr>
<td><strong>Total LOE</strong></td>
<td>29 days</td>
<td>21 days</td>
<td>10 Days</td>
<td>10 Days</td>
</tr>
</tbody>
</table>

*A six-day workweek is approved.*
XII. RELATIONSHIPS AND RESPONSIBILITIES

GH Pro will coordinate and manage the evaluation team and will undertake the following specific responsibilities throughout the assignment:

- Recruit and hire the team.
- Make logistical arrangements for the consultants, including travel and transportation, country travel clearance, lodging and communications.

USAID TDY staff (section VIII above) will assist or observe the landscape analysis due to the limited availability of their time in country. They will not be responsible for deliverables of the assignment. Activities may include:

- Preparation of interview questions and facilitator guides
- Assisting with in-country logistical arrangements for the assessment team
- Typing interview notes
- Other general assistance as needed by request of the team leader

USAID will provide overall technical leadership and direction for the evaluation team throughout the assignment and will provide assistance with the following tasks:

Before Field Work

- **SOW:** Respond to queries about the SOW or the assignment at large.
- **Consultant conflict of interest (COI):** To avoid conflicts of interest or the appearance of a COI, review previous employers listed on the CVs for proposed consultants and provide additional information regarding potential COI with the activity contractors evaluated/assessed and information regarding their affiliates.
- **Documents:** Identify and prioritize background materials for the consultants and provide them to the contractor, preferably in electronic form, at least one week prior to the inception of the assignment.
- **Site visit preparations:** Provide a list of site visit locations, key contacts and suggested length of visit for use in planning in-country travel and accurate estimation of country travel line-item costs.
- **Lodging and travel:** Provide guidance on recommended secure hotels and methods of in-country travel (i.e., car rental companies and other means of transportation). Driver from the Namibia mission will assist the consultant team with transportation to some locations.

During Field Work

- **Mission point of contact:** Throughout the in-country work, ensure constant availability of the point of contact and provide technical leadership and direction for the team’s work.
• **Meeting space**: Provide guidance on the team’s selection of a meeting space for interviews and/or focus group discussions (i.e., USAID space if available, or other known office/hotel meeting space).

• **Meeting arrangements**: Assist the team in arranging and coordinating meetings with stakeholders.

• **Facilitate contact with implementing partners**: Introduce the evaluation team to implementing partners and other stakeholders, and where applicable and appropriate prepare and send out an introduction letter for team’s arrival and anticipated meetings.

**After Field Work**

• **Timely reviews**: Provide timely review of draft/final reports and approval of deliverables.

**XIII. USAID NAMIBIA CONTACTS**

**Tara O’Day**
Title: Health Office Director  
Email: today@usaid.gov  
Tel: +264 61 273 712

**Abeje Zegeye**
HIV/AIDS Treatment Advisor & Manager of Clinical Services  
Email: azegeye@usaid.gov  
Tel: +264 61 273 710

**Molisa Manyando**
Care and Nutrition Senior Specialist  
Email: mmanyando@usaid.gov  
Tel: +264 61 273 765

**XIV. COST ESTIMATE**

The contractor will provide a cost estimate for this activity.

**XV. REFERENCE DOCUMENTS**

• PEPFAR OVC and COP Guidance  
• PEPFAR Blue Print  
• Namibia Demographic and Health Surveys  
• Namibia National Agenda for Children (2012-2016)  
• UNICEF Multiple Indicator Cluster Surveys  
• GRN National Strategic Framework  
• GRN National Health Strategic Plan
- Namibia Draft Combination Prevention Strategy
- Relevant national policies and guidelines
- Relevant program documents from current projects/activities
- Relevant published and grey literature for Namibia.
## APPENDIX B. REFERENCES

<table>
<thead>
<tr>
<th>Source Document:</th>
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<tbody>
<tr>
<td>1 Health and Social Services Sector Skills Plan</td>
</tr>
<tr>
<td>2 Final Report OVC Review</td>
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<tr>
<td>3 PEPFAR OVC and COP Guidance</td>
</tr>
<tr>
<td>4 PEPFAR Blueprint</td>
</tr>
<tr>
<td>5 Namibia Demographic and Health Surveys</td>
</tr>
<tr>
<td>6 Namibia National Agenda for Children (2012-2016)</td>
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<tr>
<td>7 UNICEF Multiple Indicator Cluster Surveys</td>
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<tr>
<td>8 GRN National Strategic Framework</td>
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<td>9 GRN National Health Strategic Plan</td>
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<tr>
<td>11 Namibia Draft Combination Prevention Strategy</td>
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<td>18 National Agenda for Children</td>
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<td>19 Annual report on the National Agenda for Children, 2012-2013</td>
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<tr>
<td>20 UNICEF Situational Analysis</td>
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<td>21 Sero-sentinel Survey 2012</td>
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<tr>
<td>22 MoHSS. Mid-term Review of the National Strategic Framework for HIV/AIDS.</td>
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<td>24 Project HOPE Annual Progress Report FY 14 (Oct. 1, 2013-Sept. 30, 2014) to USAID</td>
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### APPENDIX C: PERSONS CONTACTED

<table>
<thead>
<tr>
<th>Name</th>
<th>Role and Organization</th>
<th>Name</th>
<th>Role and Organization</th>
</tr>
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<tbody>
<tr>
<td>Helena Andjamba</td>
<td>Director of Child Welfare MGECW</td>
<td>Sandi Tjaronda</td>
<td>Executive Director NANASO</td>
</tr>
<tr>
<td>Lydia Shikongo</td>
<td>Deputy Director of Grants MGECW</td>
<td>Peter Katjavivi</td>
<td>Chairperson of the Red Cross</td>
</tr>
<tr>
<td>Brigitte Nshimyimana</td>
<td>M&amp;E Officer MGECW</td>
<td>Ayesha Wentworth</td>
<td>School Health Coordinator MoE</td>
</tr>
<tr>
<td>Amelia Senda Musukubili</td>
<td>MGECW</td>
<td>Felicity Haingura</td>
<td>HIV/AIDS Management Unit, MoE</td>
</tr>
<tr>
<td>Samuel Kamati</td>
<td>Senior Social Worker MGECW Outapi</td>
<td>Jane Shityuwete</td>
<td>LLCL</td>
</tr>
<tr>
<td>Taimi Amukwaya</td>
<td>North Central Regional Manager Project HOPE Namibia</td>
<td>Efrain Ipinge</td>
<td>CAA</td>
</tr>
<tr>
<td>Dr. Islam</td>
<td>Country Representative World Health Organisation (WHO)</td>
<td>Stephanie Posner</td>
<td>PACT</td>
</tr>
<tr>
<td>Dr. Mukondomi</td>
<td>Senior Medical Officer, Onandjokwe hospital</td>
<td>Steven Neri</td>
<td>Project HOPE</td>
</tr>
<tr>
<td>Petrina Shiimi</td>
<td>Head Oonte OVC Centre LLCL</td>
<td>Rachel Basirika</td>
<td>MSH/BHC</td>
</tr>
<tr>
<td>Bernadette de Wet</td>
<td>Regional Manager LLCL</td>
<td>Laura Cronje</td>
<td>CAFO</td>
</tr>
<tr>
<td>Delila Lenga</td>
<td>SBCC Coordinator LLCL</td>
<td>Denise Moongo</td>
<td>Project HOPE</td>
</tr>
<tr>
<td>Fillipina Lukas</td>
<td>Counsellor and Coordinator LLCL</td>
<td>Fred Alumasa</td>
<td>FANTA</td>
</tr>
<tr>
<td>Millinda Coffee</td>
<td>Counselling Center Manager LLCL</td>
<td>Florence Soroses</td>
<td>Project HOPE</td>
</tr>
<tr>
<td></td>
<td>Counsellor</td>
<td>Helena Andjamba</td>
<td>MGECW</td>
</tr>
<tr>
<td>Simone Halbich</td>
<td>Counselling and Protection Manager LLCL</td>
<td>Liza Van Rhyn</td>
<td>MoHSS</td>
</tr>
<tr>
<td>Bernadette Harases</td>
<td>Programmes Manager LLCL</td>
<td>Naomi Jacobs</td>
<td>MoHSS</td>
</tr>
<tr>
<td>Nelson Prada</td>
<td>KAYEC Trust Director</td>
<td>Lydia Shikongo</td>
<td>MGECW</td>
</tr>
<tr>
<td></td>
<td>KAYEC (Oshana)</td>
<td>Roswitha Mahalie</td>
<td>PACT</td>
</tr>
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</tr>
<tr>
<td>Nortin Brendell</td>
<td>HEW Programme Director</td>
<td>Brigitte Nshimiyimana</td>
<td>MGECW</td>
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<td>MCHIP</td>
<td></td>
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<tr>
<td>Mrs. Kapuka</td>
<td>Regional manager</td>
<td>Joyce Nakuta</td>
<td>MGECW</td>
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<tr>
<td>Gerrit Maritz</td>
<td>Chief of Education</td>
<td>Angela Noabes</td>
<td>MoHSS</td>
</tr>
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<tr>
<td>Aune Victor-</td>
<td>Education Specialist</td>
<td>Rose-Marie de Walt</td>
<td>MoHSS</td>
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<tr>
<td>Jolanda van der Westerling</td>
<td>Chief of Child and Social Protection</td>
<td>Heather Smith</td>
<td>State Department</td>
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<td>Marie-Lisa</td>
<td>UNICEF</td>
<td>Lenne Deck</td>
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<tr>
<td>Myo-Zin Nyunt</td>
<td>Chief of Health</td>
<td>Christa Fischer-Walker</td>
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<tr>
<td>Jacqueline Kabambe –</td>
<td>Adolescent and HIV/AIDS Specialist</td>
<td>Tanja Englberger</td>
<td>PEPFAR</td>
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<tr>
<td>Marcus Betts</td>
<td>Deputy Representative</td>
<td>Josephine</td>
<td>Regional Support Officer</td>
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<tr>
<td></td>
<td>UNICEF</td>
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<td>CAFO</td>
</tr>
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</table>
# APPENDIX D. FIELD SCHEDULE

## Monday 10 November 2014

<table>
<thead>
<tr>
<th>Activity</th>
<th>Time</th>
<th>Where</th>
<th>Contact</th>
<th>Notes</th>
<th>Confirmation status</th>
</tr>
</thead>
<tbody>
<tr>
<td>USAID in-brief with team members</td>
<td>08:00-09:00</td>
<td>USAID Offices Channel Life Tower 39 Post street mall</td>
<td>Tara O’Day USAID tel: (061) 273700</td>
<td>USAID in walking distance of Kalahari Sands Hotel and Hilton Hotel</td>
<td>Confirmed</td>
</tr>
<tr>
<td>In-brief with Barry</td>
<td>09:30-10:00</td>
<td>USAID Offices Channel Life Tower 39 Post street mall</td>
<td>Tara O’Day USAID tel: (061) 273700</td>
<td>USAID in walking distance of Kalahari Sands Hotel and Hilton Hotel</td>
<td>Confirmed</td>
</tr>
<tr>
<td>In-brief with U.S. Government</td>
<td>10:15-11:15</td>
<td>POA auditorium American Cultural Centre Sanlam Centre Independence Avenue</td>
<td>Geniene Veii (061) 229801 ext. 221</td>
<td>American Cultural Centre in walking distance of Kalahari Sands Hotel and Hilton Hotel</td>
<td>Confirmed</td>
</tr>
<tr>
<td>Internal team meeting</td>
<td>12:00 – 13:00</td>
<td>Hilton hotel lobby seating area</td>
<td>Nangado - 0812922188 DeeDee - 0811281223</td>
<td></td>
<td>Tentative</td>
</tr>
<tr>
<td><strong>TEAM 1:</strong> Collection at hotels – to MGECW</td>
<td>14:00</td>
<td>Hilton and Kalahari Sands</td>
<td>Dial-a-cab (061) 223531</td>
<td></td>
<td>Confirmed</td>
</tr>
<tr>
<td><strong>TEAM 1:</strong> Meeting with Ministry of Gender Equality and Child Welfare (MGECW)</td>
<td>14:30-17:00</td>
<td>MGECW Juvenis building Independence Avenue 1st floor boardroom</td>
<td>Lydia Shikongo (061) 2833111</td>
<td>Collection at hotels at 14:00 by Dial-a-cab</td>
<td>Confirmed</td>
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<tr>
<td><strong>TEAM 1:</strong> Collection at MGECW – to Hilton Hotel</td>
<td>17:00</td>
<td>MGECW</td>
<td>Dial-a-cab (061) 223531</td>
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<tr>
<td><strong>TEAM 2:</strong> Collection at hotels – to UN House</td>
<td>14:30</td>
<td>Hilton and Kalahari Sands</td>
<td>Dial-a-cab (061) 223531</td>
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<td>Confirmed</td>
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<tr>
<td><strong>TEAM 2:</strong> Meeting with Dr. Islam – World Health Organisation (WHO)</td>
<td>15:00-17:00</td>
<td>UN House Klein Windhoek 36 Stein St. Klein Windhoek</td>
<td></td>
<td>Collection at hotels at 14:00 by Dial-a-cab</td>
<td>Confirmed</td>
</tr>
<tr>
<td><strong>TEAM 2:</strong> Collection at UN House – to Hilton Hotel</td>
<td>17:00</td>
<td>MGECW</td>
<td>Dial-a-cab (061) 223531</td>
<td></td>
<td>Confirmed</td>
</tr>
<tr>
<td>Informal meeting with team to reflect</td>
<td>17:30-18:30</td>
<td>Hilton hotel lobby seating area</td>
<td>Nangado - 0812922188 DeeDee - 0811281223</td>
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**Tuesday 11 November 2014 – Team 1:**

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<th>Activity</th>
<th>Time</th>
<th>Where</th>
<th>Contact</th>
<th>Confirmation status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collection at hotels – to airport</td>
<td>05:30</td>
<td>Hilton and Kalahari Sands</td>
<td>Dial-a-cab (061) 223531</td>
<td>Confirmed</td>
</tr>
<tr>
<td>Flight to Ondangwa</td>
<td>07:00-08:05</td>
<td>Eros airport</td>
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<td>Confirmed</td>
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<tr>
<td>Collect cars</td>
<td>08:30-09:00</td>
<td>ZEBRA Car Hire Ondangwa airport</td>
<td>Zebra Car Hire - Martha: (065) 240070 Ludwig - 0812139405</td>
<td>Confirmed</td>
</tr>
<tr>
<td>Visit to Ms. Lydia Iipinge – Senior Social Worker from MGECW Oshana</td>
<td>09:30 -11:00</td>
<td>Ministry of Gender Equality and Child Welfare Ongwediva Oshana</td>
<td>Ms. Lydia Iipinge (Senior Social Worker Oshana Region) 065- 231316 0813078001</td>
<td>Confirmed</td>
</tr>
<tr>
<td>Onandjokwe Hospital</td>
<td>11:00 -13:00</td>
<td>Onandjokwe Hospital</td>
<td>Dr. Mukondomi – Senior Medical Officer</td>
<td>Confirmed</td>
</tr>
<tr>
<td>LL/CL Oonte OVC Centre</td>
<td>13:30 - 14:45</td>
<td>Oonte OVC Centre Outskirts of Ondangwa</td>
<td>Bernadette de Wet - Regional Manager LL/CL 081 244 0369</td>
<td>Confirmed</td>
</tr>
<tr>
<td>KAYEC</td>
<td>15:00-16:30</td>
<td>Ondangwa Centre Rossing Foundation Main road between Ondangwa and Ongwediva</td>
<td>Joe Mundukuta - Deputy Director KAYEC 081 240 7533</td>
<td>Confirmed</td>
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<tr>
<td>Return cars</td>
<td>17:00</td>
<td>ZEBRA Car Hire Ondangwa airport</td>
<td>Zebra Car Hire - Martha: (065) 240070 Ludwig - 0812139405</td>
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<tr>
<td>Return flight to Windhoek</td>
<td>18:35</td>
<td>Ondangwa airport</td>
<td>Dial-a-cab (061) 223531</td>
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<tr>
<td>Collection from Eros airport – to hotels</td>
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<td>Eros airport</td>
<td>Dial-a-cab (061) 223531</td>
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**Tuesday 11 November 2014 – Team 2:**

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<th>Time</th>
<th>Where</th>
<th>Contact</th>
<th>Confirmation status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collection at hotels – to airport</td>
<td>05:30</td>
<td>Hilton and Kalahari Sands</td>
<td>Dial-a-cab (061) 223531</td>
<td>Confirmed</td>
</tr>
<tr>
<td>Flight to Ondangwa</td>
<td>07:00-08:05</td>
<td>Eros airport</td>
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<td></td>
</tr>
<tr>
<td>Meet with Taimi Amukwaya - Project HOPE to join group Team 2</td>
<td>08:05</td>
<td>Ondangwa airport</td>
<td>Project HOPE - Taimi Amukwaya North Central Regional Manager</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>0811411240 0812601553</td>
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<tr>
<td>Collect cars</td>
<td>08:30-09:00</td>
<td>ZEBRA Car Hire Ondangwa airport</td>
<td>Zebra Car Hire - Martha: (065) 240070 Ludwig - 0812139405</td>
<td>Confirmed</td>
</tr>
<tr>
<td>Drive to Outapi</td>
<td>09:00-10:30</td>
<td>Ondangwa to Outapi</td>
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<tr>
<td>Visit to Mr. Samuel Kamati – Social Worker from MGECW Omusati Region</td>
<td>10:30-11:30</td>
<td>Ministry of Gender Equality and Child Welfare Outapi Omusati Region</td>
<td>Dr. Mukondomi – Senior Medical Officer</td>
<td>Confirmed</td>
</tr>
<tr>
<td>To Project HOPE Oshipumbu &amp; Oiwilili</td>
<td>12:00-13:30</td>
<td>Project HOPE Oshipumbu (20km from Outapi towards Ruacana)</td>
<td>Project HOPE - Taimi Amukwaya North Central Regional Manager 0811411240 0812601553</td>
<td>Confirmed</td>
</tr>
<tr>
<td>HEW programme</td>
<td>14:00-15:30</td>
<td>To contact Johanna Haimene for directions</td>
<td>Johanna Haimene – Senior Regional Advisor HEW Programme</td>
<td>Confirmed</td>
</tr>
<tr>
<td>Drive to Ondangwa</td>
<td>15:30-17:00</td>
<td>Oupati to Ondangwa</td>
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<tr>
<td>Return cars</td>
<td>17:00</td>
<td>ZEBRA Car Hire Ondangwa airport</td>
<td>Zebra Car Hire - Martha: (065) 240070 Ludwig - 0812139405</td>
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<tr>
<td>Return flight to Windhoek</td>
<td>18:35</td>
<td>Ondangwa airport</td>
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<tr>
<td>Collection from Eros airport – to hotels</td>
<td>20:00</td>
<td>Eros airport</td>
<td>Dial-a-cab (061) 223531</td>
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**Wednesday 12 November 2014:**

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<th>Where</th>
<th>Contact</th>
<th>Confirmation status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TEAM 1:</strong> Collection at hotels – to LL/CL Counselling Centre</td>
<td>08:30</td>
<td>Hilton and Kalahari Sands</td>
<td>Dial-a-cab (061) 223531</td>
<td>Confirmed</td>
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<tr>
<td><strong>TEAM 1:</strong> Visit to LL/CL Counselling Centre</td>
<td>09:00 – 10:30</td>
<td>LL/CL Counselling Centre 8 Storch St, Windhoek</td>
<td>Millinda Coffee – Counselling Centre Manager 0813382480</td>
<td>Confirmed</td>
</tr>
<tr>
<td><strong>TEAM 1:</strong> Meeting with UNICEF</td>
<td>11:00 – 13:00</td>
<td>UN House Klein Windhoek 36 Stein St, Klein Windhoek</td>
<td>Irma Naanda</td>
<td>Confirmed</td>
</tr>
<tr>
<td><strong>TEAM 2:</strong> Collection at hotels – to CAFO Kindergarten</td>
<td>08:30</td>
<td>Hilton and Kalahari Sands</td>
<td>Dial-a-cab (061) 223531</td>
<td>Confirmed</td>
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<tr>
<td><strong>TEAM 2:</strong> Visit to CAFO Kindergarten</td>
<td>09:00 – 10:00</td>
<td>CAFO Kindergarten Windhoek (address to be determined)</td>
<td>Macci Boois and Caroline Kaluvi – to join with Josephine Kaluvi (RSO)</td>
<td>Tentative</td>
</tr>
<tr>
<td><strong>TEAM 2:</strong> Visit to KAYEC Forklift</td>
<td>10:30 – 11:30</td>
<td>Prosperita, Adolf Naruseb, Western Warehouse #6</td>
<td>Melanie Gaoes – Forklift Programme Manager 0813511461</td>
<td>Tentative</td>
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<tr>
<td><strong>TEAM 2:</strong> Meeting with NANASO and PMU</td>
<td>12:00 – 13:00</td>
<td>NANASO 30 Lister St.</td>
<td>Sandi Tjaronda (061) 261122</td>
<td>Tentative</td>
</tr>
<tr>
<td>Internal preparation for stakeholder consultation</td>
<td>14:00 - 17:00</td>
<td>Venue to be determined</td>
<td>Nangado - 0812922188 DeeDee - 0811281223</td>
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**Thursday 13 November 2014:**

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<th>Confirmation status</th>
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<tr>
<td>FGD with U.S. Government OVC implementing partners</td>
<td>08:30 - 12:00</td>
<td>POA auditorium American Cultural Centre Sanlam Centre Independence Avenue</td>
<td>Nangado - 0812922188 Deedee – 0811281223 Geniene Veii (061) 229801 ext. 221</td>
<td>Confirmed</td>
</tr>
<tr>
<td>Stakeholder Consultation in Windhoek</td>
<td>14:00 - 17:00</td>
<td>POA auditorium American Cultural Centre Sanlam Centre Independence Avenue</td>
<td>Nangado - 0812922188 Deedee – 0811281223 Geniene Veii (061) 229801 ext. 221</td>
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**Friday 14 November 2014:**

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<th>Contact</th>
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</thead>
<tbody>
<tr>
<td>Team meeting - writing up report</td>
<td>08:00 - 12:00</td>
<td>Venue to be determined</td>
<td>Nangado - 0812922188 Deedee – 0811281223</td>
<td>Tentative</td>
</tr>
<tr>
<td>Outbrief with USAID/Windhoek Health Office</td>
<td>13:00</td>
<td>USAID Offices Channel Life Tower 39 Post street mall</td>
<td>Tara O'Day USAID tel: (061) 273700</td>
<td>Confirmed</td>
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<tr>
<td>Team meeting - writing up report</td>
<td>TBD</td>
<td>Depending on end of Outbriefing meeting</td>
<td>Venue to be determined</td>
<td>Tentative</td>
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## APPENDIX E: FIELD NOTES

<table>
<thead>
<tr>
<th>Organization/Ministry/Person</th>
<th>Time</th>
<th>Where</th>
<th>Observations/potential for linkages</th>
</tr>
</thead>
</table>
| **Ministry of Gender Equality and Child Welfare (MGECW)** | 14:30-16:00 | MGECW Juvenis building Independence Ave. 1st floor boardroom | • Awaiting passage of the new child protection bill  
• Moving towards a broader definition of vulnerability to focus on all children who need care and protection; kinship grants  
• No national guidelines on how to care for child victims of violence  
• Very positive about the technical capacity support received under the Pact program  
• National Agenda for Children 2012 – 2016 provides the national framework for a comprehensive rights-based approach to addressing issues affecting children, including orphans.  
• Cabinet established the Permanent Task Force (PTF) for children as the national multi-sectoral coordinating forum for policy direction on matters affecting children. PTF meets quarterly and reports to cabinet.  
• At constituency level, coordination of children’s matters is through Child Care and Protection Forums.  
• Child Care and Protection Bill, once enacted, will provide for formalization of kinship care. Government will introduce kinship grants under the social protection program. This will help address barriers to accessing grants that are currently based on complicated foster care requirements.  
• Early Childhood Development: moving to MOE  
• Staff establishment: 406 social workers in the country; community child care workers based at constituency level.  
• Technical assistance partners: UNICEF, Global Fund, Regional Psychosocial Support Initiative and previously Pact.  
• Capacity needs:  
  - Social workers not equipped to counsel children on adherence.  
  - Monitoring and evaluation support to help monitor implementation of the National Agenda for Children. |
| **Dr. Islam – World Health Organisation (WHO)** | 15:00-16:00 | UN House Klein Windhoek 36 Stein St. Klein Windhoek | • Common issues observed: cross-border variances in service provision and associated loss to follow-up: children and adolescents extremely vulnerable in rural areas; stunting and wasting, child-dumping, quality of health-care service continue to be challenges; teenage pregnancy, adolescent friendly-services present challenges in management and effectiveness of attracting youth; centralised management and associated capacity for MoHSS; new ART guidelines and associated treatment and adherence challenges  
• Require decentralisation of decision-making and capacity to speed up activities  
• Supervision of facilities and service-providers across entire country required  
• One-stop-shop services approach  
• HEW’s have good capacity and are making in-roads into some isolated communities. |
| **Ms. Lydia Iipinge – Senior Social Worker from MGECW Oshana** | 09:30 - 11:00 | Ministry of Gender Equality and Child Welfare Ongwediva | • Child care workers work closely with social workers who provide psychosocial support; also work with school counsellors and do some awareness-raising campaigns on certain issues (SRH, teen pregnancy, trafficking)  
• Common issues: child neglect, single-parent homes, no birth certificates  
• Cases are referred from NGOs and CBOs, and there are good child protection forums.  
• Need for more places of safety, especially in cases of ongoing investigations |
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<th>Organization/Ministry/Person</th>
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<th>Observations/potential for linkages</th>
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</table>
|                             | Oshana     |                      | - Need for family tracing services and support, reintegration into family care  
- Many new cases every day – up to 10 a day  
- No specialization between the seven social workers in the region |
| Dr. Mukondomi – Senior Medical Officer | 11:00 - 13:00 | Onandjokwe Hospital | - Approx. 17,000 patients on ART, including about 800 adolescents  
- Hospital has a teen club, youth center, and a caregiver program; teen club meets twice per month, and caregivers meet at the same time as teens.  
- Teen club divided by age cohorts and cover age-appropriate material; older teens (19+) given a role as peer educators, with a focus on health, social issues and life skills  
- Issues youth face: some challenges adhering to ART (questions from others, shame); stigma from family members, school (a lot of bullying), and community; depression/risk of suicide; lack of a stable home. However, adolescents who start on ART are often better at adhering than adults who start later.  
- Of approximately 800 adolescents on ART about 80-100 come to monthly teen club meetings (approximately 60% female and 40% male)  
- Caregivers program is very important to adolescent adherence and retention on ART; focus issues are adherence and staying healthy; began a garden to help improve nutrition, as well as IGAs (bead-making); many grandmothers caring for children  
- A lot of problems with disclosure for children, i.e. need to have parent/caregiver involved; lack of transportation is a problem for many  
- Any children/youth under 19 must be referred to the MGECW social workers, which can lead to a gap in service provision; MoH SS social workers at hospitals do not have legal mandate to help this age cohort. |
| LL/CL Monte OVC Centre      | 13:30 - 14:45 | Monte OVC Centre  
Outskirts of Ondangwa | - LL/CL provides parenting support and SBCC here and in the local schools for 15-18 year olds. This addresses gender norms, teenage pregnancy, personal risk assessment, MCC and self-esteem building.  
- Oonte (started in 2004) offers ECD since 2012 and after school services to OVC free of charge. The ECD includes nutrition support.  
- They link children to clinics and to social workers at MGECW. The Safe Schools program aims to strengthen families and provide child protection and prevention services.  
- The Positive Parenting course also addresses disclosure of HIV status for adolescents in the home and encourages HIV testing. The counsellors talked about the generation gap which seems to result in little talk about sexuality in the home. |
| KAYEC                      | 15:00-16:30 | Ondangwa Centre  
Rossing Foundation  
Main road between Ondangwa and Ongwediva | - Using the Stepping Stones curriculum in their HIV awareness work  
- Also working with LL/CL to do sessions on health, HIV and alcohol use/abuse  
- Issues facing children/youth: abuse, violence (home, community) HIV  
- Schools identify the at risk young people to send to the KAYEC KYD  
- Those learners show progress in school (evidence) and in improved behavior (reportedly) |
<table>
<thead>
<tr>
<th>Organization/Ministry/Person</th>
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<th>Observations/potential for linkages</th>
</tr>
</thead>
</table>
| Mr. Samuel Kamati – Social Worker from MGECW Omusati Region | 10:30 - 11:30 | Ministry of Gender Equality and Child Welfare Outapi Omusati Region | • MGECD Programs for children at regional level:  
  - Tentative Care (foster care or residential care) – for abused or children in conflict with the law.  
  - Child Justice – for children in conflict with the law.  
  - Vulnerable Witness – pre-court counselling  
  - Child labor  
• MGECW community child care worker based at constituency level is mainly responsible for managing cash grants.  
• Child Care and Protection Forum meets quarterly mainly for the purpose of sharing information and identifying children needing referral. The forum is chaired by the Regional Council with MGECW as secretary.  
• Difference in roles between MGECW social workers and MOHSS social workers. The former is mainly responsible for addressing children’s issues while the other deals with adult cases. Any child cases identified at health facilities are referred to the MGECW social worker. HIV-related cases are mainly concerning HIV-positive children with behavioral problems.  
• School access is not a problem due to the universal primary education policy. Social worker provides exemption certificates for vulnerable children to present to the schools.  
• Adolescent girls: Teenage pregnancies are a big problem mainly attributed to lack of recreation activities, alcohol abuse and peer pressure. Social workers try to mitigate this by conducting in-school talks on sexual and reproductive health. Government policy on teenage pregnancy helps the girls stay in school during pregnancy and after delivery.  
• MGECW recognized the role played by USAID-funded Pact project in capacity-building interventions and paying community volunteers.  
• Gaps:  
  - Elderly caregivers need help to take care of children, especially around discipline.  
  - Specialized training to work with children who have behavior problems  
  - Emergency response support when the region experiences drought. Regional Council has an account to provide food to households.  
  - Recreation activities and libraries to keep children busy when they are not in school.  
  - ECD training. |
<table>
<thead>
<tr>
<th>Organization/Ministry/Person</th>
<th>Time</th>
<th>Where</th>
<th>Observations/potential for linkages</th>
</tr>
</thead>
</table>
| Project HOPE Oshipumbu & Oiwili | 12:00 – 13:30 | Project HOPE Oshipumbu (20km from Outapi towards Ruacana) | • Oshipumbu and Oiwili Savings Groups in Uutapi Constituency (20 km between Outapi and Ruacana)  
• Both groups formed in October 2012  
• Meet weekly at Oshipumbu  
• Oshipumbu has 10 active members who are taking care of 54 OVC  
• Oiwili has 11 members who are taking care of 35 OVC  
• Both groups both have chicken projects since 2013  
• Both groups are actively saving  
• After receiving certificates for initial parenting and savings training, both groups lost members (approximately 50%) to other work and business opportunities  
• Parenting training is highly valued in the group. They report having learned about caring for OVC and meeting their needs, nutrition, providing psychosocial support to OVC who have lost loved ones, banking and savings  
• They consider the savings groups to be very important in terms of providing security for themselves and their families  
• Money from savings helps to support their entrepreneurial pursuits (personal and group-level)  
• The group reported having gained important skills in how to handle “bad behavior” of youth and indicate a positive shift in their view of the needs of OVC and youth at large  
• Group reported having personally addressed their stigma/discrimination towards OVC due to the parenting curriculum  
• Large numbers of community members are on a waiting list to go through the parenting curriculum and saving training  
• Easily replicable and cost-effective model |
| HEW Programme | 14:00 – 15:30 | Outapi Hospital | • Broad health screening and information dissemination conducted at the family-level  
• Access to very isolated communities  
• HEWs hail from the community they are attached to thus reducing language and cultural barriers  
• Identify OVC in need of health and MGECW services and refer accordingly  
• Challenges: observe that registration for grants is still a major challenge/bottleneck |
| LL/CL Counselling Centre | 09:00 – 10:30 | LL/CL Counselling Centre  
8 Storch St, Windhoek | • Implementing a Safe Schools program using the “Doorways” curriculum; particular focus on caregivers and parents taking care of vulnerable children; using schools as a platform to make communities safer  
• Children facing bullying and other forms of violence at schools; problems at home also have an impact on student performance; adolescent girls face problems with transactional sex (not just about $ but also emotional connections and need for love/acceptance), and teen pregnancy  
• There is a good national policy on keeping pregnant learners in schools; however, there are many other barriers the girls face from teachers, school administrators and other family/community members who discourage them from continuing their education once they become pregnant  
• Quote: “Every problem facing children and youth can be a risk factor for HIV.”  
• Counselling program also focuses on adherence and HTC; most of the adolescent male clients (approximately 80%) are those that have been referred from schools for behavioral problems; few come on their own  
• Focus of GBV prevention and response programs should be through community-based support for victims, including safe spaces, counselling and addressing issues around stigma and safety; having a strong community response is critical  
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<th>Organization/Ministry/Person</th>
<th>Time</th>
<th>Where</th>
<th>Observations/potential for linkages</th>
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<tr>
<td>UNICEF</td>
<td>11:00 – 13:00</td>
<td>UN House Klein Windhoek, 36 Stein St, Klein Windhoek</td>
<td>• Victims of violence afraid to go to clinic for PEP as they will be required to make a police report and open a case, and many do not want to do this for a variety of reasons.</td>
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<td>• Three main priorities: upstream policy work, knowledge management/building evidence/research, and operations (proof of concept ideas)</td>
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<td>• Focus on HIV-sensitive programs and vulnerability across the board</td>
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<td>• Issues of violence widespread and socially acceptable</td>
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<td>• Main bottleneck in GRN is the overall HR capacity (skills and number of qualified staff); more site supervision is needed.</td>
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<td>• 26% of children under 5 are stunted</td>
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<td>• Very poor sanitation and associated issues</td>
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<td>• Recommend a focus on systems strengthening</td>
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<td>• On GBV: prevention at community level very important; work with traditional leaders, health extension workers, and counsellors at community level as they are well known and respected</td>
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<td>• Need to work on harmful gender norms and how they are perpetuated/reinforced at school/community level</td>
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<td>(Please see additional attached notes)</td>
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<td>CAFO Kindergarten</td>
<td>09:00 – 10:00</td>
<td>CAFO Kindergarten, Windhoek, Okahandja Park, Katutura</td>
<td>• CAFO provides support to kindergartens (ECD centres) throughout 11 regions (not Kunene and not Kavango west)</td>
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<td>• The support is mainly play and learning materials and food when it is sponsored.</td>
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<td>• The ECD center in Katutura charges no fees; one caregiver is on the GRN subsidy, and they do provide one meal a day.</td>
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<td>• The owner seems to subsidize this center through another one in a more affluent area of Katutura.</td>
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<td>• The two rooms appeared clean and reasonably spacious. There was no outside area – fence and windows had been stolen.</td>
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<td>• Little parent/community engagement apparently</td>
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<td>NANASO</td>
<td>12:00 – 13:00</td>
<td>NANASO, 30 Lister St.</td>
<td>• NANASO is a network-based organization with 200 members.</td>
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<td>• Global Fund grant - $17M in Phase 1 and $28M now in Phase 2 ($45M total)</td>
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<td>• 10 sub-recipients, including a huge grant for civil society</td>
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<td>• The $45M must be absorbed over 6 years, which is challenging.</td>
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<td>• Conditionality on SBCC activities</td>
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<td>• Lots of OVC work in Phase 1, largely material support such as school fees, documentation, food</td>
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<td>• Phase 2 is shifting OVC back to the MGECW</td>
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<td>• Under OVC, needs include psychosocial support, counselling, access to social grants, preparing and equipping foster parents and coping skills in schools.</td>
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<td>• Through Philippi Trust (Phase 2), conducting a teacher counselling program</td>
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<td>• Child protection issues – most rapes are perpetrated by someone close to the family (or within the family)</td>
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<td>• There is a need to strengthen the institutions around OVC.</td>
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<td>• Doing lots of work around SBCC – both in school and out of school adolescents – through activities like drama, theatre, dance</td>
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<td>• Working on access to services for adolescents</td>
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| FGD with U.S. Government OVC implementing partners | 08:30 - 12:00 | POA auditorium American Cultural Centre Sanlam Centre Independence Avenue | - NAPA is working on youth-friendly services, including SRH and child rights.  
- They are transitioning some OVC services from current grantee (AIDS Care Trust) to Catholic AIDS Action.  
- OVC work has been more at the service delivery level and less on policy/advocacy level.  
- There is no legislative framework around NGO partnership with government, thus limited or no mechanisms for government to get funding to NGOs.  
- NANASO does not have the expertise to deal with the volunteers directly – need training in this area. |
| Stakeholder Consultation in Windhoek | 14:00 - 17:00 | POA auditorium American Cultural Centre Sanlam Centre Independence Avenue | Priorities and themes from discussions:  
- Parenting courses/support: USAID can help with identifying ideal package of support, including fatherhood; support for management of new kinship grants to help families help children  
- ECD: need for resources; focus on most vulnerable children and other modes of delivering ECD (i.e. homes)  
- Ensuring and measuring quality services  
- Support for the social welfare side of MOHSS (indicators, staffing plans)  
- Quality of data and data management systems  
- Violence: gaps with WACP services (see assessment report); need for more focus on child justice and children in the legal system  
- Malnutrition and food security; nutrition a key area of care for children |
Present from UNICEF:

Gerrit Maritz - Chief of Education
Aune Victor - Education Specialist
Jolanda van der Westerling - Chief of Child and Social Protection
Marie-Lisa
Myo-Zin Nyunt – Chief of Health
Jacqueline Kabambe – Adolescent and HIV/AIDS Specialist
Marcus Betts – Deputy Representative

The meeting was chaired by the Deputy Representative of UNICEF. He outlined the new UNICEF program which broadly entails:

- Upstream policy work for an enabling environment
- Knowledge management (including data quality and use)
- Operational interventions either at a systems level or to provide proof of concept.

These themes fit in with the new reality of Namibia as an upper middle income country with a “manageable” HIV epidemic. Their programs are thus HIV-sensitive and focus on vulnerability and broader social protection issues.

Child Protection

From the Census we know that of all children:

- 22 percent live in a household that is surviving on a grant
- 3.2 percent are disabled
- 15 percent are orphaned

Some planned activities are:

- Costing of the Child Care and Protection Act implementation
- A functional review of the work of social workers in relation to the Act
- Changes in the grants from foster and maintenance to include kinship care and changed criteria focusing on poverty versus orphanhood alone
- Greater emphasis on prevention activities to maintain families
- Operationalizing of the Bill: looking at data needed and referral system

Gender-Based Violence

- Violence is widespread and socially acceptable
- Violence prevention at community level very important
• Prevention work needs to engage with traditional leaders, health extension workers, and counsellors as they are well known and respected and can be an important source of support and leaders for social change
• It is also crucial to work on changing the harmful gender norms that help to perpetuate violence; it is also essential to understand how they are reproduced and reinforced at school, community, and home and work to change these harmful norms.

Health

From the recent DHS we know:
• 6.85% maternal mortality
• 54/1000 child mortality
• 26 percent stunting
• 52 percent still practice open defecation – third highest on the continent.

These figures are slightly less than the previous DHS, but are not sufficiently improved to meet the Millennium Development Goals despite 12-14 percent of GRN expenditure going to health.

Why?
• HR capacity – both in terms of quantity and quality. Quality supervision is particularly lacking.
• UNAM nursing training is theoretical but lacks strong enough practical component

ART and PMTCT coverage is high but will have to be maintained. UNICEF will support some operational and some program development.

• Healthy Behaviours in the Family as an approach.
• Referrals and links between clinic and community – working with Red Cross on this and links through the 565 HEWs now working – but supervision may be a problem
• Positive Vibes is (or was) working with teen clubs through UNICEF
• Have a consultant to look at National Guidelines for Adolescents on ART
• Did some school based VCT in 14 schools in Omusati and Oshana. Lifeline did it in Ohangwena. Apparently more orphans were positive than non-orphans and of 16-17 year olds 25 percent are orphaned. But the final results need further analysis – ready in a month or so.
• Need for more PSS and appropriate referrals

Education

In the fifth lowest quintile of schools (rural and marginal) of the 1,200 who enter only 84 pass Grade 12.
Requires a systems strengthening approach. UNICEF is assisting with the HRDP for Education and with the transition of ECD from MGECW to MoE. Looking for ways to open up GRN resources. Planning to look at what models work.

Recommendations

- Need to focus on community systems strengthening, with a strong family and parenting component.
- This can help bridge the community-health facility gap
- Prevention of HIV and prevention of GBV need to happen at the family and community level through SBCC and addressing norms
- Need for better donor coordination
NOTES FROM STAKEHOLDER WORKSHOP, THURSDAY 13 NOVEMBER

Summary of Discussion on Observations from the Field

Persistent Challenges

- Spiking HIV incidence, teen pregnancy, violence effecting adolescence
- Nutrition
- Access to comprehensive and quality services for poorest, and a standard profile of bottlenecks to access – national documents, burden of facilitating access
- Time and effort devoted to getting documents and accessing grants

Systems Capacity and Functioning

- MOH does not have the mandate to manage child cases
- Case management capacity of MGECW social workers is under severe pressure
- Community systems of support outside of services, e.g. survivors of GBV, PLHIV, exist but efficacy is unclear
- Safe Schools is an example of an intervention that reaches beyond the institution into the community
- Government ECD subsidies allowing more children to attend and stimulating improvement of facilities
- Quality of ECD programming is insufficient to realize outcomes
- Quality (lack thereof) is a persistent theme across services – health, ECD, WACPU
- Level of trust with service providers is an important enabling factor at community level
- HEWs as an entry point for services beyond health – already sensitized and equipped, but there is a downside: overburdening the cadre
- The case management burden on social workers is immense - how do we prioritize and assign to ensure we resolve it?
- Understanding OVC interventions in terms of the accumulation of risk factors; and the enhancement of resilience factors makes HIV linkages clear

Linkages, coordination and integration of services

- There is evidence of linkages
- Child protection forums at constituency level have an important role
- Reported instances of working together, so seems that it may function to some extent where it happens
- It does not happen everywhere, and we are not sure what the norm is
- HEW engaged with have already established linkages
- Partners respond with three key observations on referrals:
  - The bottleneck profile related to national documentation
- The importance of assisted referral versus the ineffectiveness of the usual types of referral
- The quality of services being referred to is frequently questionable

**Stigma and Discrimination**
- Stigma and discrimination persists and effects disclosure, accessing services, and outcomes
- The above effects groups differently and it may be important to explore these differences to target interventions appropriately
- Interventions should not perpetuate discrimination
- Integrating gender norms programming linked to specific outcomes, e.g. adherence

**Parenting interventions**
- An example of community systems strengthening that extends the effect of a service based intervention into the challenging context
- Parenting is getting more attention and is a real need people are responding to positively
- The home environment and parental interaction are the context that dominates children’s lives
- Parents reported concern is how to relate to their children
- Combination of SLA and parenting appears to be an effective example of integration

**Options for Adolescents**
- Adolescent friendly health services – cost versus payoff; the deficiencies in quality of care implied by DHS makes the setting up of a parallel system to mainstream care a questionable option
- The value of the supporting or accessory interventions – mitigating stigma, supporting adherence, reaching out to caregivers, psychosocial support – is evidence in favor of setting up adolescent friendly services
- The role of youth social, recreational, educational and extra-curricular activities in mitigating health risk factors and improving health outcomes
- Lack of recreational activities for adolescents, lack of community facilities such as libraries are frequently raised concerns from community informants and partners
- Well-designed interventions for adolescents facilitate constructive interaction in age cohorts if programming is for both males and females

**Opportunities**
- Parenting network
• Gender norms interventions better integrated with other interventions e.g. parenting, testing and disclosure, adherence and retention, GBV
• Extending the social welfare net, what is the role for Savings Groups?
• Urgency to better tailor interventions for younger children, adolescents and the very poorest

**Partners Responses to Workshop Questions**

**Question 1**
Community ownership is key for Project HOPE
Skills development in Project HOPE?
Community ownership of ECD is also positive
Regional support is important for CAFO
Aligning with government policy is positive?
High need for vocational training
High attendance of KYD program
FANTA in MOH and government alignment
There is a need for FANTA services

People, process and structures in generating community ownership

Parenting map that Project HOPE uses
How are we measuring child well-being over time?
Demonstrating effect

Community leaders mobilized
Community leaders disclosing
Rushing after targets may undermine the efficacy of mobilizing community
Mobilizing local volunteers

Communities’ ability to contribute resources is limited and top-up is needed, e.g. ECD
Communities taking the lead is a result

Good relationships with ministries and government

Landscape has changed dramatically with relative success of social grants
Having that in the landscape is meaningful
Universal pensions
Programs we are implementing are augmenting that, e.g. care-givers are given parenting programs so that pension is used properly

Assessment of needs and linking children to services

Case management
Community involvement in SBCC
The success story was about monitoring
Case management shifted to families
But we do not want to manage cases because it is a huge burden
Bringing in service providers to support that particular case – but it is very difficult
Exceptional case management maybe? Where there is no resolution alternate. Child care and protection forum as an example. It is based on a risk assessment model/pyramid. The right people are not necessarily sitting on the forum.

Soup kitchens for children improve nutritional status and relieve a parenting burden.

Psycho-social support and building resilience

**Question 2**
Children and young people with disabilities – what are the services available?
Reaching the rural poor and the geographically distant
30 percent not living with their parents
Boys and men, are we programming to reach them?
ALHIV – our programs are so focused on sexual debut when that is just one of their concerns.
Caregivers are critical entry group, and parenting is a crucial intervention.

We can link these groups to government priorities, actual needs, and community mobilization.

No single organization can deliver all the services.
Taking a holistic approach across all needs

Recruitment is not hard; you just have to be deliberate.
You may be concerned that you are not getting the most vulnerable; you can get community help to do it.

The quality of services you may want to link them to is poor.
We need to think that through.
We are not always good enough at identifying the most vulnerable and those that are accumulating risk.

We are under-reporting neglect, and maybe insufficiently concerned, and it is extremely pervasive and insidious.
I don’t beat my child anymore for crying because I realize that she was crying because she lost her mother. Now we talk. This change is hard to capture.

Psycho-social issues are leading indicators for disaster in the future. Direct intervention – counseling – is not always the best response. Something like parenting interventions alleviates the distress.

There are good tools for monitoring emotional health, we should be using those.

And the correlation between parental and child mental health

PPP research: promoting quality time has many outcomes, e.g. reduced violence, better nutrition. If you do not tell people they are bad parents, just give them tools, then you are supportive and enabling and the outcomes are substantial.

Insatiable appetite for parenting interventions.

A more involved father does not just make children better, but fathers better. People self-identify and self-invite and then they complete.

It is important to have clear causal links; just because savings group works so much, does not mean there is much change in child outcomes. We need to track at aggregate level to see change.

Education – good policies, implementation challenges

- There are school counselors and life skills teachers.
- Service providers have moved out of school because MOE wants it in-house, but there is now a capacity issue.
- Activities are not really taking place in school.
- Schools still turn to partners to intervene.
- Work with not in schools
- Lots of KAYEC successes with kids and collaboration with schools
Link between community ownership and self-selecting

- We need to ask who are the people that choose not to participate and why.
- The key extra step is that self-selectors become persuaders and the advocacy is devolved to the community.
- “Why do you value this?” is a good question to ask the self-selectors and we can learn from them.
- Insisting on moving to scale is maybe neglecting how change happens. You want to take advantage of social movements. But how do we make sure that happens?
- Recruitment – programs need to understand who we have, who we are missing and is that ok?

Question 3

Institutional relationships

Linkages between sectors – civil society and government – has been improving over time.

Within civil society there is still a lot more to be done. There are networks and examples of joint programs, but there is more to be done on coordination.

Reliance and assumptions on bodies is high, but bodies are not always functional.

Relative success: we know how to refer but it is flawed. The process isn’t client-centered; it is pieces-of-paper-centered.

Referral completion is key; how do we get there?

The assisted referral depending on need

Bi-directional referral – little from government to civil society

Barriers:

- disclosure, especially when it comes to children tested, and especially within the family and community
- HIV infection is often not the presenting problem, so are HIV services required, so it is often in the background
- Coordination forums and bodies are not working well all the time; there is scope and need for those bodies to prioritize this
- Opportunity is the child care and protection bill that will require everyone to do a lot more in terms of coordination
- Quality is maybe the criteria to decide on what referrals to prioritize

Success story: referrals to preventative TB therapy for children are quite effective.
How can we automate as much of this, so that it shifts from intensive case management to something that’s just embedded, and escalated based on priority?

What about a referral resource at local level that can help, especially smaller organizations, like an ECD center or a soup kitchen?

LIFT has developed such a directory as an example, but the project has ended and has been handed over to RACOC.

Not sure how well the national flowchart is being used

The associated initiatives such as standard operating procedures not done

The process brought government and civil society together and there is potential.

The essential referral skill is the ability to identify a need early; this is absolutely crucial.

How can we support the implementation of childcare protection bill?

This is an important moment and opportunity

Supporting kinship care rollout

Parenting interventions

Support community care workers who can fulfill statutory obligations.

HEWs are a big opportunity – an area for support because these are going to be burdened.

Health sector recognizes the need for outreach but may not to recognize the value of civil society to support this role; HEWs may be regarded as the fulfiller of this role and that is not necessarily a good thing.

Ethiopian experience: the model evolved over time to meet needs.

In-service training should include the civil society landscape relevant to their work.

**Discussions Including GRN and Others**

**Poverty and Economic Stability**

Child grants extension and are we ready?

Savings groups and integration of positive parenting

**ECD**

500 subsidies for centers

Fees lowered or not charged

Parents contribute more to improve facilities
Unlocking government resources in meaningful ways
Quality remains an issue

**Parenting**
Not material support but emotional engagement was emphasized – this is important if we consider risk factors (Cluver)
ECD centers integrating parenting
High demand for parenting interventions

**Stigma and Discrimination**
Stigma related to low disclosure and poor adherence, and barrier to access
Harmful norms leading to acceptance of violence
Treated differently in the home
Bullying of HIV+ youth

**Systems, linkages and HR**
Coordination going on
Task force and child care protection forums
CCPS referral forums – case management?
Not working everywhere, and not everywhere
HEWs 3 workers on the job for only 7 months – there’s a lot of screening and referral

**Systems**
WACPU
Profile of bottlenecks accessing formal services
Case burden, reaching resolution and how to get more efficiency in the system

**Yolanda**
The services are in place
Quality and the need for specialized skills
Referral system – overcoming geographical barriers, expertise to make right referrals

Birth certificates are a huge problem
Parents don’t have papers, so child can’t get them
Referrals is an issue
Clarifying what we mean when we say refer
Is it a call, is it a letter
Communication, follow-up

Overlapping of services is a problem that manifests in the social worker mandate issue we found at Onandjokwe
What is who responsible for?
So there is the question of who is responsible for the urgent and basic need
No-one is clear on who to refer to
MOH has a guideline for referrals
National referral flowchart to refer correctly

Efficient referrals – there is the need to filter for acute cases
Then bi-directional referral
The right skills are also a consideration

Recommendations
Ministry is looking at case management, needs to be better
Need for specialization but we don’t have the numbers
Dealing with the human resource issue is where we need assistance
[It’s about efficient case management]

Social workers also need a skill reset, from development to counselling
Early detection and referral capacity at community level
Distracted by grant administration

Social should map locally and get a local flowchart
Use other resources – other welfare organizations (is this option provided for in the act?)

Karas 4
Hardap 3
Outsourcing – using civil society
Referral skills
Referring efficiently should influence referring correctly. It is not just about official mandates.
Extend the mandate across ministries; a social worker is a social worker with same statutory mandates after all.

**Concluding Discussion on Priority Needs and Issues for OVC**

**Parenting skills**

From MOH

- Definitely a priority
- It is a critical psycho-social theme.
- Relevant in terms of GBV
- They have begun to implement parenting programs; there is a forum on which some implementing partners sit (still in its infancy).
- They are producing terms of reference and a 5-year work plan.
- Improve capacity of related professionals to intervene with those skills
- They like the Lifeline/Childline curriculum and have already entered training of trainers.
- Ministry is doing awareness campaigns.
- USAID may be able to help with looking at ideal parenting intervention package.
- Notice who doesn’t self-select and how to address that?
- The other need in this regard is the kinship grant, i.e. intervening with the caregivers receiving that grant.

**ECD**

- The quality of services is very low.
- To address that you need resources.
- Many children miss out on the service.
- The fact that this is not a free service is a problem.
- Different modes of delivery – like parenting
• NDP4 prioritizes ECD, but there is no policy to enforce it.
• Integrate this into accessing services, especially (but not exclusively) HIV services.
• Early detection for social work driven interventions
• Do community liaison officers have the requisite tools and skills to deliver?

Technical Assistance
• SI Support: measureable indicators, systems and interoperability, data quality, analysis and use
• Staffing norms for social work
• HRH planning
• Workflow planning of social work services and the varying mandates and tasks across the workforce and ministries
• Training in specialized areas

GBV and WAPU
• There is a study/review of WAPU with extensive and detailed recommendations.
• Forensic examinations are undermined by numerous problems.
• Medical examinations and task-shifting to nurses needs to be considered.
• Issues of child justice and children in conflict with the law are not adequately addressed.
• There are community structures to address all these challenges, but prevention of GBV is not adequately addressed and remains very important.

Nutrition
• Where do we address this and how?
• Is there a 1000-day program?

Adolescent Options?
• Adolescent-friendly services
APPENDIX F. CONSULTANT NON-DISCLOSURE AND CONFLICTS AGREEMENTS

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

USAID NON-DISCLOSURE AND CONFLICTS AGREEMENT

As used in this Agreement, “Sensitive Data” means any information that is marked or unmarked, oral, written, or in any other form, “sensitive but unclassified information,” procurement sensitive and source selection information, and information such as medical, personnel, financial, investigatory, visa, law enforcement, or other information which, if released, could result in harm or unfair treatment to an individual or group, or could have a negative impact upon foreign policy or relations, or USAID’s mission.

Intending to be legally bound, I hereby accept the obligations contained in this Agreement in consideration of my being granted access to Sensitive Data, and specifically I understand and acknowledge that:

1. I have been given access to USAID Sensitive Data to facilitate the performance of duties assigned to me for compensation, monetary or otherwise. By being granted access to such Sensitive Data, special confidence and trust has been placed in me by the United States Government, and as such it is my responsibility to safeguard Sensitive Data disclosed to me, and to refrain from disclosing Sensitive Data to persons not requiring access for performance of official USAID duties.

2. Before disclosing Sensitive Data, I must determine the recipient’s “need to know” or “need to access” Sensitive Data for USAID purposes.

3. I agree to abide in all respects by 41 U.S.C. 2101 – 2107, The Procurement Integrity Act, and specifically agree not to disclose source selection information or contractor bid proposal information to any person or entity not authorized by agency regulations to receive such information.

4. I have reviewed my employment (past, present and under consideration) and financial interests, as well as those of my household family members, and certify that, to the best of my knowledge and belief, I have no actual or potential conflict of interest that could diminish my capacity to perform my assigned duties in an impartial and objective manner.

5. Any breach of this Agreement may result in the termination of my access to Sensitive Data, which, if such termination effectively negates my ability to perform my assigned duties, may lead to the termination of my employment or other relationships with the Departments or Agencies that granted me access.

6. I will not use Sensitive Data, while working at USAID or thereafter, for personal gain or detrimentally to USAID, or disclose or make available all or any part of the Sensitive Data to any person, firm, corporation, association, or any other entity for any reason or purpose whatsoever, directly or indirectly, except as may be required for the benefit USAID.

7. Misuse of government Sensitive Data could constitute a violation, or violations, of United States criminal law, and Federally-affiliated workers (including some contract employees) who violate privacy safeguards may be subject to disciplinary actions, a fine of up to $5,000, or both. In particular, U.S. criminal law (18 U.S.C. § 1905) protects confidential information from unauthorized disclosure by government employees. There is also an exemption from the Freedom of Information Act (FOIA) protecting such information from disclosure to the public. Finally, the ethical standards that bind each government employee also prohibit unauthorized disclosure (5 CFR 2635.703).

8. All Sensitive Data to which I have access or may obtain access by signing this Agreement is now and will remain the property of, and under the control of, the United States Government. I agree that I must return all Sensitive Data which has or may come into my possession (a) upon demand by an authorized representative of the United States Government; (b) upon the conclusion of my employment or other relationship with the Department or Agency that last granted me access to...
### GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

<table>
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<tr>
<th>Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.</th>
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<tr>
<td>9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.</td>
</tr>
</tbody>
</table>

---

### ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

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**Signature**

**Date** 31 Oct 2014

---

**Name**  
**Title**
GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
PROJECT

USAID NON-DISCLOSURE AND CONFLICTS AGREEMENT

As used in this Agreement, “Sensitive Data” means any information provided to USAID by the United States Government, and specifically includes all data which is
sensitive but unclassified information, procurement sensitive and source selection information, and information such as medical, personnel, financial, investigatory, visa, law enforcement, or other information which, if released, could result in harm or unfair treatment to an individual or group, or could have a
negative impact upon foreign policy or relations, or USAID’s mission.

Intending to be legally bound, I hereby accept the obligations contained in this Agreement in consideration of
my being granted access to Sensitive Data, and specifically I understand and acknowledge:

1. I have been given access to USAID Sensitive Data to facilitate the performance of duties assigned to
me to safeguard Sensitive Data disclosed to me, and to refrain from disclosing
Sensitive Data to persons not requiring access for performance of official USAID duties.

2. Before disclosing Sensitive Data, I must determine the recipient’s “need to know” or “need to access”
Sensitive Data for USAID purposes.

3. I agree to abide in all respects by 41, U.S.C. 2101 - 2107. The Procurement Integrity Act, and
specifically agree not to disclose source selection information or contractor bid proposal information
to any person or entity not authorized by agency regulations to receive such information.

4. I have reviewed my employment (past, present and under consideration) and financial interests, as
well as those of my household family members, and certify that, to the best of my knowledge and
belief, I have no actual or potential conflict of interest that could diminish my capacity to perform my
assigned duties in an impartial and objective manner.

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person, firm, corporation, association, or any other entity for any reason or purpose whatsoever,
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criminal law, and Federally-affiliated workers (including some contract employees) who violate
privacy safeguards may be subject to disciplinary actions, a fine of up to $5,000, or both. In
particular, U.S. criminal law (18 USC § 1963) protects confidential information from unauthorized
disclosure by government employees. There is also an exemption from the Freedom of Information
Act (FOIA) protecting such information from disclosure to the public. Finally, the ethical standards
that bind each government employee also prohibit unauthorized disclosure (5 CFR 2653.703).

8. All Sensitive Data to which I have access or may obtain access by signing this Agreement is now and
will remain the property of, or under the control of, the United States Government. I agree that I must
return all Sensitive Data which has or may come into my possession (a) upon demand by an
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employment or other relationship with the Department or Agency that last granted me access to
GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
PROJECT

Sensitive Data, or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE
The undersigned accepts the terms and conditions of this Agreement.

Signature

Date 31/10/2014

Name Terence Edmond Beney
Title Partner
GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

Sensitive Data; or (e) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

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ACCEPTANCE
The undersigned accepts the terms and conditions of this Agreement.

[Signature] [Name] [Date]

[Signature] [Name] [Date]