GOVERNMENT OF THE REPUBLIC OF NAMIBIA

Namibia's National Agenda for Children 2012-2016

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Acronyms and Abbreviations

AEC	Annual Education Census
AIDS	Acquired Immunodeficiency Syndrome
ANC	antenatal care
ARV/ART	anti-retroviral / anti-retroviral therapy
CDC	Constituency Development Committee
CRC	Convention on the Rights of the Child (United Nations)
CSO	civil society organisation
DNEA	Directorate of National Examinations and Assessment
DWSSC	Directorate of Water Supply and Sanitation Coordination
ECD	Early Childhood Development
EDF	Education Development Fund
EMIS	Education Management Information System (of the MoE)
ETSIP	Education and Training Sector Improvement Programme (of the MoE)
HIS	Health Information System (of the MoHSS)
HIV	Human Immunodeficiency Virus
IECD	Integrated Early Childhood Development
IMAM	Integrated Management of Acute Malnutrition
IMCI	Integrated Management of Childhood Illnesses
IYCF	Infant and Young Child Feeding
LBW	low birth weight
MAWF	Ministry of Agriculture, Water and Forestry
MDGs	Millennium Development Goals
M&E	monitoring and evaluation
MGECW	Ministry of Gender Equality and Child Welfare
MHAI	Ministry of Home Affairs and Immigration
MICT	Ministry of Information and Communication Technology
MLSC	Ministry of Labour and Social Welfare
MoE	Ministry of Education
MoHSS	Ministry of Health and Social Services
MoJ	Ministry of Justice
MoU	Memorandum of Understanding
MRLGHRD	Ministry of Regional and Local Government, Housing and Rural Development
MSS	Ministry of Safety and Security
MYNSSC	Ministry of Youth, National Service, Sport and Culture
NACS	Nutrition Assessment Counselling and Support Programme
NAMCOL	Namibian College of Open Learning
NDHS	National Demographic Health Survey
NDP	National Development Plan
NHIES	National Household Income and Expenditure Survey
NIED	National Institute for Educational Development
NGO	non-governmental organisation
NPA	National Plan of Action for Orphans and Vulnerable Children 2006-2010
NPC	National Planning Commission
NSF	National Strategic Framework for HIV and AIDS Response in Namibia 2010/11-2015/16
NSFP	National School Feeding Programme
NTA	National Training Authority
OPM	Office of the Prime Minister
OVC	orphans and vulnerable children
PMTCT	prevention of mother-to-child transmission (of HIV)
PTF	Permanent Task Force for Orphans and Vulnerable Children
RDCC	Regional Development Coordinating Committee
SACMEQ	Southern Africa Consortium for Monitoring Educational Quality
SDF	School Development Fund
SS	Sentinel Surveillance
TBD	to be determined
UNAM	University of Namibia
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WACPU	Woman and Child Protection Unit
WASH	Water and Sanitation and Hygiene
WATSAN	Water and Sanitation Programme (of UN-HABITAT)
WHO	World Health Organisation

Contents

Foreword

Article 15 of the Constitution of the Republic of Namibia provides for children's rights. These rights include the right from birth to a name and nationality; the right to be protected from economic exploitation; and the right to be protected against forced labour and preventive detention. In addition, Article 20 of the Constitution guarantees that "all persons shall have the right to education" and that "children shall not be allowed to leave school until they have completed their primary education or have attained the age of sixteen".

The National Agenda for Children 2012-2016 is a call to action to put the constitutional mandate on the rights of children into implementable strategies. The Agenda is anchored on five pillars: health and nourishment; early childhood development and schooling; HIV prevention, treatment, care and support; adequate standard of living and legal identity; and protection against neglect and abuse.

These pillars of children's rights are cross-cutting to many sectors. This means that the responsibility of the Ministry of Gender Equality and Child Welfare is to serve as the coordinating agent for the implementation of the National Agenda for Children. The Office of the Prime Minister commends and supports the Ministry's efforts.

Currently, the Office of the Prime Minister is the convenor of the National Association for the Improvement of Nutrition (NAFIN). NAFIN is a member of the global movement for scaling up nutrition, and aims at scaling up child nutrition in Namibia. Therefore, in implementing the National Agenda for Children, NAFIN shall contribute to the pillar of nourishment.

I am encouraging the Ministry of Gender Equality and Child Welfare to ensure that the proposed High-Level Technical Committee is led by a committed and competent officer in order to put the National Agenda for Children into action. Our children are our future. Ensuring that their rights are realised through the National Agenda for Children will be a major investment in the next generation of citizens and leaders and a secure, stable and prosperous country.

Rt Hon. Nahas Angula, MP
Prime Minister

Preface

The importance of Namibia developing its first-ever National Agenda for Children was highlighted through the publication of *Children and Adolescents in Namibia 2010: A Situation Analysis*, and through a review of the National Plan of Action for Orphans and Vulnerable Children (2006-2010). Two critical issues were identified through these processes: that Namibia needed to adopt a multi-sectoral approach to planning and implementation towards child-centred development, and that we needed to look more broadly at the concepts of vulnerability and inequity through the lens of a child's life cycle.

Through a broad-based consultative process which involved government, NGOs, civil society organisations, children and development partners, the national commitments for children were identified, discussed and prioritised. While these five-year commitments have been integrated into current sector policies and plans to a large extent, the National Agenda for Children brings them together concisely, which will enable all stakeholders to plan, implement and monitor their actions for children in a coordinated manner. The Agenda also serves as a major contribution to overall national development planning processes.

While the Ministry of Gender Equality and Child Welfare has been assigned the task of facilitating the development of the National Agenda for Children, the primary responsibility for ensuring that is is implemented lies with the line ministries and their partners.

We express our appreciation to all those in government and civil society who contributed to the development of the National Agenda for Children, and to UNICEF for its technical and financial support for its development.

The Government of Namibia and its partners are committed to the country's future – our children. The realisation of the rights of our children to survival, development and protection through the National Agenda for Children will be a significant contribution to our achievement of Vision 2030 and an equitable society in which children are free from poverty and discrimination, and are able to fully contribute to the continued development of a prosperous Namibia.

Hon. Doreen Sioka, MP
Minister of Gender Equality and Child Welfare

Summary of the Agenda

The National Agenda for Children is organised around five *priority commitments* and fifteen *key results*.

COMMITMENTS	RESULTS
1. **All children are healthy and well nourished**	1.1 All children under 5 years of age have access to adequate nutrition, growth monitoring and health services. 1.2 Neonatal mortality is decreased and child survival is improved. 1.3 All children in schools and childcare facilities have access to clean water and adequate sanitation.
2. **All children have equitable access to quality integrated ECD services, and pre-primary, primary, secondary and vocational education**	2.1 All children access quality integrated early childhood development (ECD) services and pre-primary education. 2.2 All children access quality primary education. 2.3 All children access quality secondary education and vocational education.
3. **All children have access to age-appropriate quality HIV prevention, treatment, care and support**	3.1 Fewer young people are HIV positive. 3.2 Fewer infants are infected with HIV as the rate of mother-to-child transmission is reduced. 3.3 Children with HIV receive comprehensive treatment, care and support.
4. **All children have an adequate standard of living and a legal identity**	4.1 Child vulnerability is addressed through a comprehensive national social protection system. 4.2 Vulnerable children have improved access to social grants. 4.3 All children are registered at birth, and have access to deceased parents' death certificates if required.
5. **All children are safe from neglect, violence, abuse and exploitation**	5.1 Children benefit from an enabling legislative and policy environment. 5.2 Children benefit from integrated protection services. 5.3 Teenage pregnancies are reduced and support services are in place.

Introduction

The National Agenda for Children is a five-year framework (2012-2016) devised to guide all sectors in Namibia towards fulfilling their obligation to ensure that all the rights of children are met. Five priority commitments form the basis of the Agenda. These commitments build on the achievements and progress made under the National Plan of Action for Orphans and Vulnerable Children (2006-2010) (NPA), as well as sectoral commitments made by government ministries tasked to fulfil children's rights. These commitments also address the gaps highlighted in the NPA progress monitoring reports, and the critical issues identified in *Children and Adolescents in Namibia 2010: A Situation Analysis*, a publication launched by the National Planning Commission (NPA) and the Ministry of Gender Equality and Child Welfare (MGECW) in 2010.

Purpose

The National Agenda for Children (2012-2016) aims to achieve the key child development outcomes defined in the Millennium Development Goals (MDGs) and Vision 2030, and to strengthen multi-sectoral collaboration to that end. The Agenda recognises the need for government and partners to collaborate and collectively coordinate their endeavours to achieve the desired outcomes, which cannot be achieved solely through a vertical response. The results and strategies outlined in the Agenda derive from government and partner sector plans, and consultative discussions in which key gaps were identified. The Agenda will better position national planning tools such as National Development Plans 3 and 4 to mobilise national commitment towards child development outcomes.

Process

A participatory approach was adopted for government and partners to identify and agree on priority areas, i.e. areas which need addressing over the next five years. The MGECW facilitated an initial consultation in the OVC Permanent Task Force (PTF), and followed this up with sectoral consultations, presentations and desk reviews.

A wide range of stakeholders were consulted, including government ministries, civil society organisations, the Children's Parliament, United Nations agencies and other development partners. Their discussions focused also on the priorities identified by children in the extensive consultations held with children in 2009 as part of the public participation for the revision of the Child Care and Protection Bill (CCPB). Additional input from children was made available by a survey of children's opinions conducted by the National Institute of Democracy with UNICEF support prior to the National Education Conference in June 2011.

A team of local consultants, working under the MGECW Child Welfare Directorate and supported by UNICEF, facilitated the consultation process and finalised the National Agenda for Children.
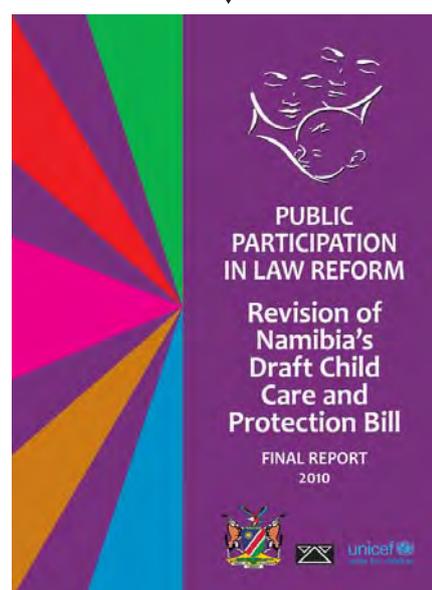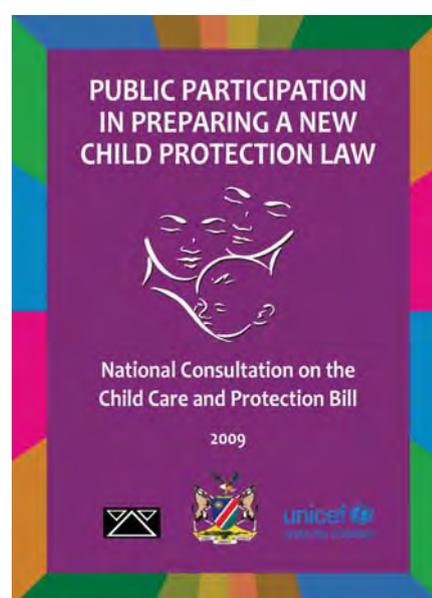
Strategic Focus

As in many southern African countries, the initial response to the situation affecting vulnerable children focused predominantly on direct service delivery. In the National Agenda for Children, the focus has shifted towards a more comprehensive national response with an emphasis on building systems and strengthening national and local capacities and partnerships. This shift aims to ensure an HIV-sensitive response that is integrated and sustained, and which fulfils children's rights.

This Agenda builds on past achievements, progress and lessons learnt, while focusing on the critical gaps impeding Namibia's achievement of the MDG Targets and Vision 2030 Goals.

Ensuring the wellbeing of all children and the fulfilment of all their rights is the core of national development. Children are citizens with specific rights which have to be fulfilled with the assistance of key duty-bearers including parents, caregivers, decision-makers and service providers. However, the fulfilment of children's rights and the achievement of their wellbeing are undermined by socio-economic risks and vulnerabilities.

One key driver of children's vulnerability is poverty: according to a recent assessment of 2003/04 National Household Income and Expenditure Survey, 43.3% of Namibia's children and 37.8% of the general population live below the poverty line. Poverty has extremely detrimental impacts on a child's survival, health, education and wellbeing. Poor families and children face barriers in seeking to access quality services, due to distance, cost, lack of information and/or gaps in service provision. Child poverty and vulnerability are multi-dimensional, impacting on wellbeing and development in all areas of a child's life.

To reduce child poverty, the National Agenda for Children moves away from targeting orphans, who in many cases were not the most vulnerable, to reaching a broader group of vulnerable and marginalised children. The Agenda embraces an 'equity approach', i.e. that of strengthening the social protection and service delivery system to create a balance between reaching out to the broader group of vulnerable children and ensuring that the most marginalised are accessing quality services. This approach has already begun to galvanise and obligate government and partner duty-bearers to expand their focus to reach a broader set of poor and marginalised children in families and households. The Agenda lays the foundation for more integrated service delivery which sustains delivery between multiple sectors and concurrently reduces child poverty through the lens of a child-sensitive social protection framework.

Children can also become vulnerable through separation from their main caregiver, and through experiences of neglect, violence and sexual abuse within their family or community. Over a third of Namibia's children do not live with either their father or their mother, therefore strong and robust systems of child protection are necessary. The need for protection from neglect, abuse and violence is a primary concern of many children consulted.

The Agenda considers integrated prevention and protection services as a way to address root causes of problems before more costly and complex interventions become necessary. This is in line with the CCPB which provides for a range of prevention and protection services for families and children.

HIV and AIDS continue to impact on children's health and wellbeing. While substantial progress has been made in treatment and prevention, the National Agenda for Children seeks to ensure that every baby born in Namibia is free of HIV, and that every young person has the skills to avoid HIV infection, and that all children and adolescents infected with HIV receive respectful and quality care, support and treatment.

Against this background, the Agenda focuses on priority areas in which action is most needed over the next five years. It prioritises key evidence-led interventions which can make the most difference for the most children, while protecting the rights of those who need the interventions most. Different sectors have to work together to ensure that the rights of all children are fulfilled holistically, and that no child misses out on any critical service.

The National Agenda for Children –

▶ provides an accountability framework which will enable equitable resource allocation for children as per their rights;
▶ ensures integrated programming by different sectors in the best interests of children;
▶ supports the building of national systems and innovative programming; and
▶ allows for the clear articulation of progress on each result through strengthened monitoring and coordination mechanisms.

Guiding Principles

The commitments, results and strategies outlined in the National Agenda for Children are guided by certain underlying key principles, as follows.

1. The National Agenda for Children is in line with the guiding principles of the United Nations Convention on the Rights of the Child (CRC) and the African Charter on the Rights and Welfare of the Child:
    -   The best interests of the child as primary consideration in all actions concerning children.
    -   Non-discrimination regardless of any child's background or status.
    -   The right of every child to survival and development, which includes adequate food, clean water, shelter, education, skills and health care.
    -   The right of the child to be treated with dignity and not to be exploited, abused, neglected or treated with cruelty.
    -   The right of children to express their views and actively participate in decisions affecting them.
    -   The African Charter strengthens the fulfillment of children's rights guaranteed by the CRC by taking into account social and economic conditions specific to the African continent.

2. The National Agenda for Children precludes unintended negative consequences such as further stigmatisation of individuals or families. The Agenda is inclusive of children with special needs such as children with disabilities, those affected by HIV, those caught up in child labour or trafficking, those on the street and those without family care.

3. Different stages in children's development require different sets of interrelated services. The National Agenda for Children adopts a lifecycle approach to be responsive to the changing needs of children as they grow up, from infancy through childhood to adolescence.

4. Wide disparities persist between poor and well-off families, between rural and urban areas, and between boys and girls. The National Agenda for Children strives for greater equity, informed by disaggregated data on child outcomes as well as evidence on what works in reducing disparities. The different experiences and vulnerabilities of boys and girls are considered and incorporated into the operational strategies and anticipated results.

5. The realisation of children's rights requires duty-bearers including families, communities, government and civil society organisations to work together to fulfil these rights. The National Agenda for Children recognises the importance of family and parental responsibility for a child's upbringing, and the community's role in supporting its families with government providing appropriate assistance.

6. The strategies adopted in this framework form part of existing or developing sectoral implementation plans. This helps to ensure the realisation of the key results within the five-year time frame of this plan. Some strategies cut across the different commitments and have multiple benefits, but they will only be mentioned once to avoid duplication.

7. Monitoring of the National Agenda for Children is aligned with existing indicators and national data-collection mechanisms, aiming at better use and integration of the available data-collection mechanisms.

Alignment with National Policies and Planning Tools

The National Agenda for Children is aligned with national policies and planning tools, and is designed to be integrated into these for the purpose of strengthening the applicable national systems and processes.

The framework of commitments in National Agenda for Children (2012-2016) is aligned with national as well as international commitments, in particular the Millennium Development Goal Declarations, Vision 2030, Namibia's National Development Plan and the National Strategic Framework for HIV and AIDS Response (2010/11-2015/16). The following table cross-references these national and international commitments to the commitments in the National Agenda for Children.

Commitment	MDGs	Vision 2030	NDP 3	NDP 4 Strategic Areas
1. All children are healthy and well nourished.	▸ Reduce Child Mortality. ▸ Improve maternal health.	Namibia is a healthy, food-secured nation.	Quality of Life	Extreme poverty and social fabric
2. All children have equitable access to quality integrated early childhood development services and to pre-primary, primary, secondary and vocational education.	▸ Achieve Universal Primary Education. ▸ Promote Gender Equality and Empower Women.	▸ Early childhood education and development provided. ▸ Education system is unified and adequate education infrastructure is provided in all regions. ▸ Access to senior secondary education exists for at least 80% of learners. ▸ Well-qualified teaching staff are available for all levels. ▸ Vocational training centres are established in all regions.	Productive and competitive human resources and institutions	Education and skills
3. All children have access to quality and age-appropriate HIV prevention, treatment, care and support.	▸ Reduce Child Mortality. ▸ Combat HIV and AIDS, malaria, and other diseases.	▸ All communicable diseases are under control, including HIV.	Quality of Life	Extreme poverty and social fabric
4. All children have an adequate standard of living and a legal identity.	Eradicate extreme poverty and hunger.	▸ Minimum standards ensure equitable access to services. ▸ Registration of vital events (births, deaths, marriages) is universal, complete and reliable.	▸ Equality and social welfare ▸ Peace, security and political stability	Extreme poverty and social fabric
5. All children are safe from neglect, violence, abuse and exploitation	Promote Gender Equality and Empower Women.	▸ Citizens trust in the ability of the uniformed services to provide protection. ▸ There are high levels of vigilance in the community and cooperation with law-enforcement agencies.	Equality and social welfare	Equality and social welfare

The National Agenda for Children is also aligned with other international, regional and national treaties and commitments, including the United Nations Convention on the Rights of the Child, the African Charter on the Rights and Welfare of the Child, and the Namibian Constitution. The principles and objectives of these instruments informed the development of the commitments in the National Agenda for Children, therefore these commitments support these principles and objectives, and will contribute to their domestication.

Anchoring the National Agenda for Children in this broader development framework has several advantages:

▶ Children's priorities are integrated into primary national planning frameworks and sectoral strategic plans, thereby ensuring greater national ownership, accountability and commitment to child-sensitive social development on the part of all ministries and partners.
▶ It raises the profile of children at national level, which results in improved national and regional prioritisation, appropriate resource allocation and regular monitoring of progress made towards the achievement of key national priorities.
▶ It facilitates improved equity-based analysis and planning for the purpose of effectively reaching a broader group of vulnerable children while continuing to reach the most marginalised.

Over the next five years, the National Agenda for Children has the potential to achieve significant improvements to realise all of the rights of children.

II Commitments

Ensuring Equitable Results for All Namibian Children

Health and Nutrition

Education

HIV and AIDS

Protection

Living Standards
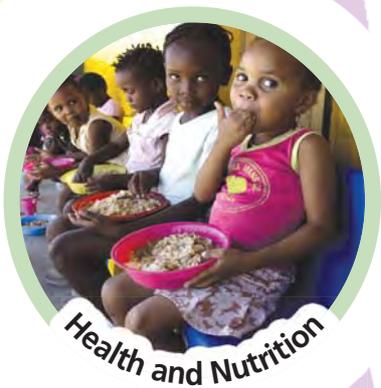
All Children are healthy and well nourished

National Commitment

A child has the right to life, survival, health and development. Namibian infants and young children are likely to find these rights fulfilled, but society fails to ensure the basic services required to fulfil each of these rights for every child in all areas of the country. Successes include the high numbers of mothers who receive antenatal care, give birth in health facilities and receive PMTCT if needed. The concerns are the rising rates of maternal mortality, little or no improvement in infant mortality, high rates of wasting, low levels of immunisation, and a lack of water and sanitation which increases the risk of children becoming malnourished and ill.

Result 1.1	**All children under 5 years of age have access to adequate nutrition, growth monitoring and health services.**

Indicators

- ▶ Number of children diagnosed with moderate or severe malnutrition
- ▶ % of children under 5 with stunting reduced
- ▶ % of children under 5 underweight reduced
- ▶ % of children who are exclusively breastfed for up to 6 months
- ▶ % of health facilities with trained staff, tools/equipment (MUAC* tapes, weighing scales, height board and food scales) and supplies (vitamin A, zinc, iron, RUTF*, CMV* and fortified blended food)

    * MUAC – mid-upper arm circumference; RUTF – ready-to-use therapeutic food; CMV – Cytomegalovirus

Situation

Adequate nutrition is critical to child development – for optimal growth and brain development, for learning abilities, and in the long term for work capacities and economic productivity. Malnutrition increases the risk of diseases such as measles, malaria and pneumonia, and increases the incidence of disability and death.

Under-nutrition is the most pressing nutritional issue facing Namibia, with critical action required at pre-natal, infant and young child stages. The NDHS 2006/07 concludes that the nutritional condition of children in Namibia is poor:

▸ 24 005 children had acute and moderate malnutrition, with 6 081 being in a severe state of acute malnutrition requiring medical and nutritional care.[1]

▸ 29% of Namibian children are stunted (short for their age). Stunting affects 38% of children aged 18-23 months. Stunting indicates chronic malnutrition and implies permanent damages to the child's development.[2]

▸ 17% of children under 5 years are underweight (thin for their age), and 7.5% of children under 5 are wasted (thin for their height), implying acute malnourishment.

▸ 14% of children had a low birth weight. The main causes of low birth weight among newborns are poverty, poor nutrition and infections such as malaria, the mother's age and the interval between births.[3]

▸ Children living in households affected by floods were more malnourished than those living in non-affected households.[4]

As nutrition is not only a health issue, solutions require multi-sectoral collaboration. Food shortages at household level, unhygienic household environments, inadequate care and a lack of health services are the underlying causes of malnutrition, and all are due to low income or no income at all.

Lead Agency

MoHSS

Partners

OPM & NPC, MAWF, MRLGHRD, MoE, MICT, MGECW, CSO

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[1]   MoHSS, *Guidelines for Integrated Management of Acute Malnutrition in Namibian Children aged 0-59 months, and pregnant and lactating women*, 2009, based on findings of the NDHS 2006/07.

[2]   WHO, *Maternal and Child Health in Namibia*, 2009.

[3]   Ibid.

[4]   MoHSS, "Nutrition Survey in the Northern Regions in Namibia", July 2009.

Priority Strategies

1.1.1   Improve infant and child health including ARV prophylaxis for infants of HIV-positive mothers, immunisation and micronutrient supplementation.

1.1.2   Promote optimal infant and young child feeding practices: early initiation of breastfeeding, exclusive breastfeeding for the first 6 months of life, and timely introduction of complementary feeding.

1.1.3   Promote caring practices especially in health and nutrition, through effective communication for behaviour change using ANC and immunisation as opportunities.

1.1.4   Establish and improve community-based nutrition surveillance and growth monitoring.

1.1.5   Roll out community-based integrated management of acute malnutrition.

1.1.6   Facilitate universal salt iodisation.

1.1.7   Provide food supplements at ECD centres, e.g. a glass of milk each day, fortified with iron, zinc and vitamin A.

Implementation and Monitoring

These strategies form part of the Strategic Plan for Nutrition 2011-2015 housed in the Family Health Division of the Directorate of Primary Health Care Services. The outcome indicators will be monitored every five years through the NDHS, and the output indicators will be monitored annually through the Health Information System.

Result 1.2	Neonatal mortality is decreased and child survival is improved.

Indicators

▶   Neonatal mortality is reduced

▶   Infant mortality is reduced

▶   Under-5 mortality is reduced

▶   % of children aged 12-23 months who received all of their immunisations[5]

▶   Number of district hospitals equipped with emergency obstetric care and newborn resuscitation equipment, and staff who have skills to provide newborn care services

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[5]   BCG (Bacillus Calmette-Guérin – vaccine to prevent tuberculosis), three doses of DPT (combination vaccine to prevent diphtheria, pertussis (whooping cough) and tetanus), three doses of polio vaccine (excluding polio vaccine given at birth) and measles.

Situation

The numbers of children and mothers dying at childbirth or in the first year is rising. Efforts to reduce the risk of a mother dying during birth have included increasing the number of births with a trained birth attendant available. The top three reasons for neonatal deaths are pre-term births, birth asphyxia, severe infections and congenital abnormalities. After the first four weeks of life, the reasons for death are AIDS, diarrhoea and related diseases, acute respiratory infection and injuries (WHO, 2009). The 2006/07 NDHS found that 12% of children under 5 had had diarrhoea in the two weeks prior to the survey. The highest rate was in Kavango with 20%. Coverage for the full course of vaccinations still remains below the target of 90% set by the MoHSS. Coverage in Namibia ranges from 35% in Kunene to 81% in Omusati. Violence and alcohol abuse are further challenges to maternal and child health.[6]

Lead Agency

MoHSS

Partners

Civil society

Priority Strategies

1.2.1 Roll out and support the "Reach Every District" approach, and strengthen routine immunisation coverage.
1.2.2 Extend health services into communities by recruiting paid community healthcare workers.
1.2.3 Develop and implement strategies to reduce maternal mortality.
1.2.4 Equip all district hospitals with emergency obstetric care and newborn resuscitation equipment.
1.2.5 Build healthcare workers' capacity to perform optimal newborn care practices: newborn resuscitation, early and exclusive breastfeeding, warmth, hygienic cord and skin care, timely and appropriate care-seeking for infections, and care of those whose birth weight is low.

Implementation and Monitoring

These strategies form part of the Roadmap for Accelerating the Reduction of Maternal and Newborn Morbidity and Mortality (2007) housed in the Family Health Division of the Directorate of Primary Health Care Services. The outcome indicators will be monitored every five years through the NDHS, and the output indicators will be monitored annually through the Health Information System.

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[6] WHO, *Maternal and Child Health in Namibia*, 2009.

Result 1.3

All children in schools and childcare facilities have access to clean drinking water and adequate sanitation.

Indicators

▸ % of schools and childcare facilities with adequate toilets
▸ % of schools and childcare facilities with clean drinking water on site

Situation

Water and sanitation are basic services. In 2008, 97% of urban households had access to safe drinking water, as did 80% of rural households (NPC 2008). Progress towards access to sanitation is less satisfactory, with only 58% of urban and 14% of rural households having access to acceptable levels of sanitation, and some households living in poverty being 50% less likely to have access to clean water or adequate sanitation. Access to safe drinking water and sanitation facilities at schools has increased considerably. Nevertheless, there are quite a number of schools with no access to safe water and sanitation systems. In 2010, 77.5% of schools had a water supply, 78.4% had toilets for learners, and 76.2% had toilets for teachers. In recent years there has been very little progress in reducing these deficits (EMIS 2010). Absence of these facilities contributes significantly to a wide range of diarrhoeal diseases. Water/sanitation-related diseases affecting children include diarrhoea, schistomiasis and scabies. The presence of animal waste and garbage dumps in the school environment also poses dangers, health risks and hygiene problems for learners.

Lead Agency

MAWF

Partners

MoE, MoHSS, MGECW, civil society

Priority Strategies

1.3.1   Develop and implement standards for sanitation at all childcare facilities and schools.
1.3.2   Increase national planning for and investment in Water and Sanitation and Hygiene (WASH) in schools through advocacy, partnerships and regular monitoring.

Implementation and Monitoring

Water supply and sanitation is the responsibility of the Directorate of Water Supply and Sanitation Coordination (DWSSC) of the Ministry of Agriculture, Water and Forestry. The DWSSC coordinates inputs from all relevant stakeholders through the WATSAN Forum which works at national, regional and local level. These strategies also form part of the ETSIP housed in the MoE and the MoHSS National Policy for School Health. The MoHSS will conduct health inspections at school and hostel premises, and provide health education on personal and oral hygiene and nutrition. Health education will be conducted on health risk factors and other health-related topics identified according to the needs of the specific school. The WATSAN Programme will advise on the proper construction of sanitation facilities. The indicators will be monitored as part of EMIS and as part of the MGECW registration process for ECD and residential childcare facilities.

All children are healthy and well nourished

All children have equitable access to quality integrated ECD services, and pre-primary, primary, secondary and vocational education

National Commitment

The government recognises that education should be grounded in a people/learner-centred pedagogy which values and celebrates learners and students. Education should be valued as a key social investment and a means to reduce inequality. Alliances are required with other social sectors such as health and agriculture, and with the private sector. Inclusive strategies are needed to respond to marginal communities and students with special needs. Education legislation is committed to making education a right and making explicit the link between education and improving human capital and economic development. The government is committed to decentralising primary, secondary and special needs education to all regions, and to popularising education policies throughout all communities.

Result 2.1

All children access quality integrated early childhood development (ECD) services and pre-primary education.

Indicators

▸ Number of registered and subsidised ECD centres
▸ Number of children enrolled in registered ECD centres
▸ Number of educarers trained in a course accredited by the Namibia Qualifications Authority
▸ Number of children in government pre-primary classes
▸ Repetition rate in Grade 1

Situation

Early childhood is a time of unparalleled growth and development. It is during a child's first few years that the neural connections which shape physical, social, cognitive and emotional competence develop most rapidly. Connections and abilities developed in early childhood form the foundation of subsequent development. So, providing the right conditions for healthy early development is likely to be much more effective than treating problems later in life. ECD interventions are among the most cost-effective approaches to improving outcomes for vulnerable and at-risk children (Cunha and Heckman 2007; Engle et al 2007).

Early learning opportunities for young children in Namibia are extremely limited, especially in rural areas. Nationwide, out of 200 000 children in the 3-6 age range, only 50 000 are estimated to be attending facility-based ECD programmes (MGECW 2007). ECD programmes for children aged 2-5 are primarily community or privately run with little or no government funding and little coordination with health and nutrition programmes or services. Currently there are no laws regulating the provision of ECD services. The NPA Progress Report for 2008-2009 shows that no progress has been made in getting feeding programmes to ECD facilities and in scaling up the services to reach more children.

The government has recognised the importance of integrated ECD. An objective of Vision 2030 is "to promote and support quality, sustainable holistic, Integrated Early Childhood Development for children aged 0-6 years and to develop capacity of care-givers (educarers) to increase quality". The MGECW developed an integrated ECD Policy in 2009 "to make provision for family and community-based sustainable and integrated ECD programmes that are accessible to all young children and their families, with a special focus on the development of IECD programmes for young children living in difficult circumstances". An implementation plan for this policy was developed in 2010. The current draft Child Care and Protection Bill (CCPB) (2009) makes provision for the regulation of ECD facilities, and a Technical Committee has been established to recommend a broad framework for formalising and transforming ECD.

In Namibia, poor Grade 1 performance may be linked to the lack of ECD and pre-primary opportunities. Grade 1 repetition rates increased from 18.8% in 2003 to 20.2% in 2009 (EMIS 2010). The Education and Training Sector Improvement Programme (ETSIP) of the MoE provides for more and improved ECD and pre-primary classes and pre-primary education, and by 2010 the MoE had enrolled 8 475 children (4 320 girls) in 272 pre-primary classes (EMIS 2010).

Lead Agencies

MoE, MGECW

Partners

NAMCOL, civil society, private sector

Priority Strategies

2.1.1   Promote and expand integrated ECD services at community and national level.

2.1.2   Implement the integrated ECD Policy according to the existing plan, including training ECD workers, building facilities in targeted regions, setting standards for registration and registration facilities, subsidising facilities and monitoring ECD provision on a pro-poor basis.

2.1.3   Establish and capitalise an ECD fund.

2.1.4   Expand the provision of pre-primary classes at the rate of *at least* 100 per year.

2.1.5   Articulate and certify all training of ECD and pre-primary teachers.

2.1.6   Develop ECD curricula (for ages 3 and 4) which are articulated with the curricula for the 5-year-olds in pre-primary classes.

Implementation and Monitoring

The MGECW Directorate responsible for ECD will spearhead the strategies for the under-5 age group in conjunction with the MoE to ensure careful articulation of ECD with pre-primary classes. The work of the ECD Technical Committee established by the MoE and the MGECW will continue to look at, inter alia, a career path for ECD workers, standards and norms for ECD facilities and programmes, and scaling up of resources for ECD. The Directorate responsible for ECD will develop a registration process which will feed into an electronic database for monitoring purposes.

The MoE, in terms of the ETSIP ECD sub-programme, together with the National Institute for Educational Development (NIED) and Regional Education Offices, will implement strategies for pre-primary education. The data on classes will be available from the EMIS. Training in ECD is currently provided by the Namibian College of Open Learning (NAMCOL), the University of Namibia (UNAM), private institutions, NGOs and the MGECW.

NIED is responsible for curriculum development and development of training materials. The National Qualifications Authority is responsible for accrediting training.

Result 2.2

All children access quality primary education.

Indicators

▸ Scores in SACMEQ IV by gender, socio-economic status and region
▸ % of learners graded at the "basic achievement" and "higher" levels in Standardised Achievement Tests in Grades 5 and 7, by gender and region
▸ Net and gross enrolment ratios for primary-age learners, by gender and region
▸ Survival rates to Grade 8, by gender and region
▸ OVC aged 10-14 years attending school

Situation

For children in poor households, access to primary education is declining. In the poorest 10% of households, some 20% of primary-age children are not attending school, according to National Household Income and Expenditure Survey (NHIES) 2003/04 data. There was a decline in the number of Grade 1 entrants from 57 957 in 2003 to 51 407 in 2009 – a fall of 11%. In 2010, Grade 1 enrolments increased to 52 186. Children with special learning needs and disabilities are also not being adequately served.

SACMEQ data for the period 1995-2007 show a persisting and wide gap in performance between rural and urban learners at Grade 6 level. In Ohangwena Region, 70% of Grade 5 learners received the "below basic achievement" grading for English in Standardised Achievement Tests in 2009, compared to 21% in Khomas Region.

This state of affairs is partly due to the diverse private costs of primary education. Neither schools nor parents can afford to buy stationery and books which are essential for learning to read and write. The State does not provide enough of these essentials because it assumes that parents are purchasing them, which is not the case in poor and rural communities. The Education Act provides that, *"All tuition provided for primary and special education in state schools, including all school books, educational materials and other related requisites, must be provided free of charge to learners until the seventh grade, or until the age of 16 years, whichever occurs first."* Therefore, the School Development Fund (SDF) system which has been in force since 2001 appears to be in contravention of the constitutional right to free primary education at state schools.

Reduced private costs of education will mean that more poor and vulnerable children will attend school, and do so more regularly. Increased support is needed for schools in poor and rural neighbourhoods to achieve a quality of education comparable to that in most urban areas.

Lead Agency

MoE

Partners

MoHSS, civil society
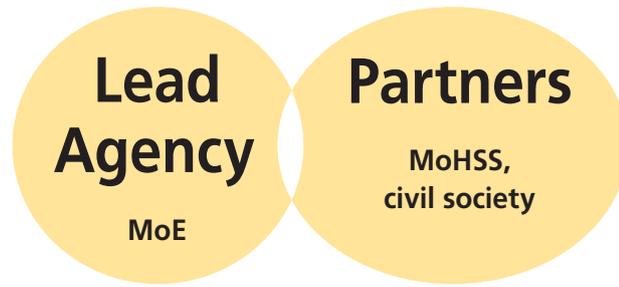
Priority Strategies

2.2.1   Address the private costs of education by investigating its affordability in view of the constitutional provision for free and compulsory primary education and making recommendations to Cabinet as to how government can adhere to this provision.

2.2.2   Implement a per capita funding formula for equitable resource allocation to schools.

2.2.3   Implement all aspects of the ETSIP and the (forthcoming) Roadmap for Education that concern quality of primary education and retention of learners.

2.2.4   Ensure adequate and equitable provision of school books, stationery and other essential inputs.

2.2.5   Expand access to and provision of education for educationally marginalised learners.

2.2.6   Establish units for special educational needs at selected primary schools in all regions, giving priority to regions which currently have none.

2.2.7   Expand and improve the quality of school feeding programmes.

2.2.8   Strengthen school health programmes and increase the number of toilets at schools.

Implementation and Monitoring

The MoE is responsible for investigating the affordability of education in relation to the constitutional provision for free and compulsory primary education and making recommendations to Cabinet. The per capita funding formula, expansion of school feeding and quality enhancement measures in general education are components of the ETSIP. The provision of improved access to school for learners with disabilities and special needs through inclusive education will soon be elaborated in the new Sector Policy on Inclusive Education. Increasing the provision of school toilets will require an increase in funding for or an amendment of the MoE programme for capital works. Health visits to schools are a responsibility of the MoHSS. The outcome indicators will be monitored every five years through the NDHS, and the output indicators will be monitored annually through the EMIS.

Result 2.3

All children access quality secondary education and vocational education.

Indicators

▸ Net enrolment and gross enrolment ratios for junior secondary and senior secondary education

▸ Proportion of candidates who achieve at least a Grade D in English and Science in Grade 10 and Grade 12 national examinations for full-time and part-time candidates, by gender and region

▸ Survival rates to Grade 11

▸ Number of dropouts disaggregated by grade, gender and reason

▸ Unit standards successfully completed by occupation, region and gender

Situation

Secondary school enrolment and retention remain low. The survival rate of learners to Grade 8 (beginning of secondary education) was 79% in 2009 (80% for girls). However, the survival rate to Grade 11 (beginning of senior secondary education) was only 40% (42% for girls) in 2009. In 2010, 90.8% of 16-year-olds (92.9% girls) and 64.7% of 18-year-olds were attending school. However, 63.4% of 18-year-old girls were at school compared to 66% of boys.

Secondary and further education build social capital. Children whose mothers have more than secondary education have much lower mortality than children whose mothers have less education. School attendance also delays the onset of childbearing and exposure to HIV risks. The longer learners stay in secondary education, the higher their future earnings. A strategy to provide secondary education more equitably will help to break the cycle of poverty and vulnerability. Industries in Namibia constantly cite high skills shortages as a constraint to growth, while youth unemployment is at a record high. Not all children require a purely academic secondary education.

Lead Agency

MoE

Partners

NTA, MoHSS, MGECW, private education institutions

Priority Strategies

2.3.1   Collect more accurate data on school leaving, and identify and adopt strategies to minimise dropout of girls and boys in all grades, especially at the stages of transition from primary to secondary and junior secondary to senior secondary.

2.3.2   Improve equitable access to vocational training.

2.3.3   Establish gender-responsive guidelines and mechanisms for attaining a protective and safe learning environment.

2.3.4   Expand access to senior secondary education by building and staffing more secondary schools.

Implementation and Monitoring

The expansion of secondary education and vocational education and training is a component of the ETSIP. Vocational training is now the responsibility of the National Training Authority (NTA). Gender-responsive guidelines and mechanisms for attaining a protective and safe learning environment will be established as part of the implementation of the National Standards for Schools (Key Area 4 – the School as a Social Unit; and Key Area 5 – Management and Leadership of School and Hostel), and is therefore the responsibility of the MoE Directorate for Programme Quality Assurance. The EMIS collects data annually through the Annual School Census. The NTA will provide data on the successful completion of unit standards.

Commitment 3

All children have access to age-appropriate quality HIV and AIDS prevention, treatment, care and support

National Commitment

Vision 2030 calls for an aggressive implementation of a national HIV reduction plan. NDP 3 and the National Policy on HIV and AIDS have further articulated strategies and policy guidelines to inform and guide HIV prevention interventions. These strategies are premised on the understanding that investing in HIV prevention has direct long-term benefits for treatment, care, support and impact mitigation.

Result 3.1

Fewer young people are HIV positive.

Indicators
(All disaggregated by gender and age)

▶ % of young women and men aged 15-24 who are infected with HIV
▶ % of in-school youth aged 10-14 and 15-24 reached by skills-based HIV prevention education within the regular school curriculum in the last year
▶ % of women and men aged 15-24 who had higher-risk sex during the last 12 months and who reported using a condom on the last occasion of higher-risk sexual intercourse[7]

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[7] Republic of Namibia, *National Strategic Framework for HIV and AIDS Response in Namibia (2010/11-2015/16)* (NSF) – Outcome 11 (OC 11).

Situation

Although HIV infection among young people has been declining, 31% of all newly infected people are adolescents (NPC 2010 p. 82), and the HIV prevalence rate among women aged 15-19 is 6.6% (Sentinel Survey 2010). The drivers of the epidemic include multiple and concurrent partnerships, inconsistent use of condoms, excessive consumption of alcohol, inter-generational sex, transactional sex, and mobility and migration.[8] Other drivers of the epidemic include gender inequalities, income inequalities, gender-based violence and sexual abuse. The NSF for HIV and AIDS outlines a combination prevention approach which includes addressing structural issues such as gender inequality, behaviour change issues such as transactional sex and early sexual debut, and bio-medical issues such as male circumcision and prevention of sexually transmitted diseases. Strategies in the NSF include life skills education for in-school children aged 10-14 and 15-19, and small group and individual social and behaviour change programmes for out-of-school youth in the 10-14 and 15-24 age groups.

Lead Agencies

MoHSS, MoE, MIB

Partners

MGECW, civil society
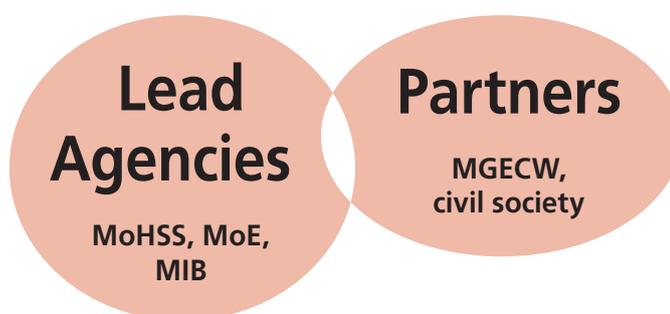
Priority Strategies

3.1.1   Teach HIV/AIDS Life Skills to Grades 1-12.

3.1.2   Strengthen HIV combination prevention (bio-medical interventions and changing sexual behaviour as well as underlying socio-economic norms), targeting children and adolescents, with a special focus on young people at high risk.

3.1.3   Implement interventions for social change relating to high-risk behaviour in adolescents, including gender norms and roles, alcohol and drug abuse, multiple and concurrent partnerships, trans-generational sex, transactional sex and sex work.

3.1.4   Improve access to quality health information and counselling and testing services for all children.

Implementation and Monitoring

These strategies form part of the National Strategic Framework for HIV and AIDS Response in Namibia (2010/11-2015/16) (NSF), and are implemented by different partners represented in the National Prevention Technical Advisory Group. The *Road Map Toward Zero New Infections in Namibia* provides concrete steps for implementing a combination of high-quality evidence-based HIV prevention interventions. The results will be monitored annually through the Joint Prevention Consultations.

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8   MoHSS, *HIV/AIDS in Namibia: Behavioural and Contextual Factors Driving the Epidemic*.

Result 3.2

Fewer infants are infected with HIV as the rate of mother-to-child transmission is reduced.

Indicators

▸ % of HIV-infected pregnant women who received ARVs to reduce the risk of mother-to-child transmission of HIV
▸ % of HIV-infected infants born to HIV-positive women

Situation

Namibia's PMTCT programme is very successful, yet the initial diagnosis of and follow-on treatment for infants is often late – at 14 weeks rather than the recommended 6 weeks. Although 93% of mothers choose to breastfeed, only 23% reported breastfeeding exclusively (with no added water or foods) for the first 6 months of their child's life. Involving male partners in PMTCT remains a challenge.

Lead Agency

MoHSS

Partners

Civil society

Priority Strategies

3.2.1 Develop a comprehensive mother-to-child transmission elimination plan.
3.2.2 Provide comprehensive counselling on Infant and Young Children Feeding to all women before and after they deliver a baby.
3.2.3 Provide efficacious ARVs to more HIV-positive pregnant women to reduce the risk of HIV transmission to their children (increased to 90% in 2014/15)
3.2.4 Improve testing for HIV at 6 weeks and 18 months using the DNA-PCR test.

Implementation and Monitoring

The PMTCT programme continues to be scaled up rapidly to provide a comprehensive package of services including HIV counselling and testing, and care, treatment and support for infected and affected persons. Although there has been a significant expansion of PMTCT beyond district hospitals into peripheral facilities, the nature of the services provided varies from one facility to another.

Result 3.3

Children with HIV receive comprehensive treatment, care and support.

Indicators

▶ % of children enrolled in HIV care and eligible for CTX prophylaxis (according to national guidelines) who are currently receiving CTX prophylaxis (NSF OP 51)

▶ % of children (0-14) with HIV still alive at 12 months after the initiation of ART (NSF OC 33)

▶ Number of eligible adults and children provided with psychological, social, or spiritual support

Situation

Thirteen thousand children under 14 years of age are HIV positive. This number is expected to peak at 20 000 and remain steady until 2015. These children may feel isolated in school.[9] There are few institutionalised support systems for them, and they may be vulnerable to stigmatisation. A study on HIV-infected learners in Namibia and Tanzania found ample evidence of pervasive fear of stigma and discrimination faced by HIV-positive children. This is aggravated by poverty and a lack of services, especially in rural areas.[10] Parents and educators are ill-equipped to discuss a child's HIV status. As these children reach adolescence, they, like other children with chronic diseases, will require support. This of course is also true for the adolescents who constitute 31% of all newly infected persons in Namibia.

Lead Agency

MoHSS

Partners

MoE, MGECW, civil society

Priority Strategies

3.3.1   Promote provider-initiated and routine testing of children to identify those infected with HIV.

3.3.2   Develop guidelines for providing child-friendly comprehensive treatment, care and support systems for HIV-positive children.

3.3.3   Provide free external support to households with orphans and vulnerable children to enable them to care for each HIV-positive child.

Implementation and Monitoring

The implementation and monitoring of these strategies are detailed in the health and education sectors' operational plans for implementing the NSF.

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[9]   MoHSS, *2008/09 Estimates and Projections of the Impact of HIV/AIDS in Namibia*, 2009.

[10]   UNESCO, *Supporting the Educational Needs of HIV Positive Learners: Lessons from Namibia and Tanzania*, 2008.

Commitment 4

All children have an adequate standard of living and a legal identity

National Commitment

Poverty reduction is a national commitment set out in Vision 2030, NDP 3 and NDP 4. By laying the foundations for human development through quality education and committing to skills development for young people, the government is aiming to improve labour force participation. By generating evidence on child poverty and deprivation, reviewing existing social welfare and protection systems, and moving towards a more comprehensive and integrated approach to social protection, the government and its partners can address the vulnerabilities that children and families face. Key elements under this commitment include access to birth registration, providing quality integrated early childhood development (IECD) services, and adopting a revised social grants system for children.

Result 4.1

Child vulnerability is addressed through a comprehensive national social protection system.

Indicators

- ▶ % of children living in poverty
- ▶ % of social service posts in Child Welfare that are filled

Situation

Despite Namibia's strong economic growth and its upper-middle income status, many Namibians are poor, and children bear the brunt of this poverty. GDP per capita has more than doubled since independence, but poverty rates have essentially remained the same, with 43% of children and 38% of adults living in poverty. Also, Namibia has the highest income disparities in the world (Gini coefficient of 0.74). Poverty rates vary from region to region in the country, with the child poverty rate highest in Kavango at 67% and Ohangwena at 58%, and lowest in Khomas at 9% (Van der Berg and da Maya 2010).

Poverty and deprivation have long-lasting impacts on children's development. Research shows direct links to infant mortality and low birth weight, and children's health, nutrition and educational attainment. Having no birth certificate is a barrier to children's access to education and other services. Children's early years are particularly decisive for their development and future chances, and the impacts of poverty are more severe the earlier it starts and the longer it lasts (Grantham-McGregor et al. 2007; Magnuson and Votruba-Dral 2009). Poor health and education outcomes in turn make it more difficult for young people to enter the labour market, which increases the risk of poverty again being passed on to the next generation. The latest labour force survey (MLSW 2010) shows that two out of three young people are unemployed. If unaddressed, child poverty poses long-term risks to economic stability and social cohesion.

Strengthening the national social protection system to provide for better integration and coordination of different provisions and a stronger focus on poverty reduction requires a better understanding of the country's poverty profile, the living conditions and wellbeing and coping strategies of poor households with children, and the effectiveness of current social protection measures in reducing poverty and inequality. The latter also includes the administration of social grants and strengthening of the social welfare workforce to ensure that vulnerable children are accessing critical services.

Lead Agency

MGECW

Partners

**NPC, MLSW, MoE, MoHSS
civil society**

Priority Strategies

4.1.1 Develop a social protection strategy that integrates and enforces different social grants, exemptions and other social protection measures to serve and reach children in poverty.

4.1.2 Strengthen national monitoring systems to include indicators on child poverty and service accessibility for vulnerable children.

4.1.3 Strengthen social welfare workforce capacity and inter-agency coordination to ensure that children access critical services.

Implementation and Monitoring

The MGECW will lead these strategies by continuing to implement the recommendations of the Human Resources and Capacity Gap Analysis and to restructure the social welfare workforce cadre as deemed appropriate. The NPC will include reports on child poverty following each National Household Income and Expenditure Survey. Periodic longitudinal surveys and short-term tracer studies to review the impact of poverty reduction and social protection interventions will be undertaken. There will be a review, with the aim of incorporating the necessary indicators into Naminfo for routine collection of information.

Result 4.2 — Vulnerable children have improved access to social grants.

Indicator

▸ Number of grants, disaggregated by type, gender and region

Situation

Namibia has a comprehensive social grant system comprising basic state grants (old-age pension and disability grants), child welfare grants and war veteran grants. Pensions and child welfare grants make an especially important contribution to the welfare of families with children. However, social grants are not yet fulfilling their potential as a mechanism for reducing the poverty and vulnerability of children and their families.

Social grants have proven effective as a means to improve children's nutrition, health outcomes and school enrolment, and as a means to support parents' economic activities. In Namibia considerable progress has been made in institutionalising social cash transfer programmes through child welfare grants. These are presently reaching over 125 000 orphans (75% of the estimated total) with maintenance, disability, foster care and place of safety grants. The number of grants increased from 18 000 at end 2004 to 125 230 in March 2011. A qualitative study, *The Effectiveness of Child Welfare Grants in Namibia,* identified key strengths and weaknesses of child welfare grants. It confirmed that grants are spent mainly on food and education, and identified barriers in accessing grants.

One key recommendation was expansion of child welfare grants to the broader group of poor and vulnerable children whose parents are alive and thus generally not eligible for child welfare grants despite poverty (MGECW 2010). The Child Care and Protection Act will strengthen kinship care and simplify the child welfare grant access process for caregivers of vulnerable children. In addition, strategies will be explored for expanding access to child welfare grants for poor children living with their parents – an important contribution to children's development.

Lead Agency

MGECW

Partners

MoF, civil society

Priority Strategies

4.2.1   Enact the Child Care and Protection Bill and the necessary regulations to ensure that grants (including kinship care grants) are implemented efficiently.

4.2.2   Investigate mechanisms (including grant criteria and grant amount) to ensure that social grants address child poverty, and advocate for their implementation.

4.2.3   Inform families about how to access services.

Implementation and Monitoring

The MGECW Child Welfare Directorate will build on the two previous studies concerning grant effectiveness, and undertake further consultations and studies. The MGECW will also develop regulations to allow for implementing the provisions of the Child Care and Protection Act. The MGECW will work collaboratively with the NPC through the Central Bureau of Statistics to utilise child poverty information to inform the process of potentially amending grant eligibility criteria to reach the broader group of poor and vulnerable children. Monitoring of the total number of grant beneficiaries is undertaken routinely as part of the MGECW programme monitoring function.

Result 4.3

All children are registered at birth, and have access to deceased parents' death certificates if required.

Indicator

▸ % of children whose births have been registered within the first year of life

Situation

In 2008, the births of 31% of all children under 1 year of age were registered. The births of the majority of children were being registered later in life. These numbers called for a new and sustained response.

With over 80% of children in Namibia born in health facilities, an innovative and logical approach to making birth registration more accessible to parents has been developed in the form of birth registration facilities in 21 high-volume hospitals. This unique approach to accelerating birth registration complements the existing registration system in stand-alone Ministry of Home Affairs and Immigration (MHAI) offices and mobile campaigns targeting hard-to-reach children and families.

This three-pronged multi-sectoral approach helped to increase birth registration levels for children under 1 year of age from 31% in 2008 to 55% in 2010. The approach will be scaled up to ensure more efficient, timely and accessible registration.

Lead Agency

MHAI

Partners

MoHSS, MGECW, MoE
OPM, CSOs

A BIRTH CERTIFICATE IS A CHILD'S RIGHT!
Register your child immediately after birth.

Birth registration is easy and free!

HOW: Fill in a BIRTH NOTIFICATION FORM.

WHERE: At the hospital where your child was born, or at the nearest office of the Ministry of Home Affairs and Immigration. Some magistrates' courts also register births.

DOCUMENTS NEEDED:
• The child's health passport (proof of birth).
• The birth certificate and ID or passport of one or both parents.
• If the parents are not married and the father's name is wanted on the birth certificate, he must be present or he must provide a sworn statement confirming that his name should be on the certificate.

unicef
unite for children

How to Register the Birth of a Child

Priority Strategies

4.3.1 Ensure access to decentralised birth and death registration systems in hospitals, regional and sub-regional offices, and through mobile campaigns in hard-to-reach areas.

4.3.2 Improve security of documents and monitoring through digitalisation of population registration.

Implementation and Monitoring

The MHAI will oversee the implementation of these strategies through its Directorate of Population Services. Inter-ministerial collaboration will be strengthened through MoUs signed with other ministries, e.g. the MGECW. The MHAI will collect the registration data at all birth registration facilities annually, collate it and compare the registration rates with the total annual birth rates to gauge the proportion of births registered.

All children have an adequate standard of living ...

All children are safe from neglect, violence, abuse and exploitation

National Commitments

The government is committed to ensuring that children in Namibia are protected from neglect, violence, abuse and exploitation. This is demonstrated by its efforts to strengthen the legislative enabling environment and improve child protection through strengthened national, sub-national and community protective systems.

The MGECW is in the process of replacing the Children's Act of 1960 with the Child Care and Protection Act (CCPA) (the Bill is in the final stage of promulgation) and integrating the Children's Status Act of 2006 into the CCPA. Efforts are also underway to revise the Child Justice Bill, which will incorporate principles contained in the UN Convention on the Rights of the Child, the Beijing Rules and the Riyadh Guidelines. These principles include enabling children in conflict with the law to access treatment that promotes their sense of dignity and worth, taking their age into account, with the aim of reintegrating them into society. The Child Justice Bill will provide protective guidelines for courts and relevant professionals dealing with cases involving children in conflict with law, children who are victims of crimes and children who are witnesses to crime so that these children are not 're-victimised' by the justice system.

The Ministry of Safety and Security (MSS) and the MGECW aim to strengthen collaborative linkages between key government ministries and civil society partners to better respond to violence against children. The current system is fragmented and uncoordinated, with various components of child protection divided between partners, with the result that collaborative opportunities are lost. This problem will be addressed through child protection mapping and assessing and redesigning integrated protection services, so as to ensure accessibility, a continuum of care, prompt responsiveness and monitoring of children's right to protection. The paucity of national child protection statistics and indicators is another problem which will be addressed with improved collaboration between partners.

<table>
<tr><td>**Result 5.1**</td><td>**Children benefit from an enabling legislative and policy environment.**</td></tr>
</table>

Indicators

▸ Child Care and Protection Bill enacted
▸ Child Justice Bill enacted
▸ Accession to the Hague Convention on the Protection of Children
▸ Number of duty-bearers trained, disaggregated by age and gender
▸ Number and percentage of child-friendly courts
▸ Number of children in conflict with the law screened and diverted

Situation

Namibia has introduced various policies aimed at addressing the rights of children to health, safety, wellbeing and development. The OVC Policy and Planning Effort Index (2007) indicated a 3-point improvement in the Legislation component from 65 to 68 (out of 100), and the aggregate score improved from 73 to 76.[11] This indicates that there has been an improvement in the national response to the situation affecting OVC. Since 2001, several relevant laws have been passed. Although there has been a shift away from OVC programming to a more HIV-sensitive approach of reaching a broader group of vulnerable children as well as the most marginalised, the OVC Policy and Planning Effort Index provides a useful proxy and baseline.

The Child Care and Protection Bill (CCPB) is in the final stage of preparation, and is expected to be passed by Parliament in 2012. This law will replace the Children's Act No. 33 of 1960. It defines a child in accordance with international practice, and also defines the roles of other significant family relationships. The CCPB was refined through an extensive consultative process, which incorporated a parallel Children's Reference Group. This group guided the consultative process jointly with the Steering Committee chaired by the MGECW. The enactment of this Bill and implementation of the provisions will allow for a wide range of initiatives in support of child protection.

The Namibian Government is a signatory to the CRC, Article 40 of which obliges State Parties to establish child-oriented justice systems. Child justice in Namibia seeks to divert children in conflict with the law from placement in a closed facility, especially with adult offenders. There has been some progress in this area with a decrease in the number of children detained.

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[11] The OVC Policy and Planning Effort Index was developed by UNICEF, USAID and the Futures Group to measure sub-Saharan African countries' responses to the crisis facing OVC as a result of the HIV and AIDS epidemic. The survey for updating the Index is conducted every four years.
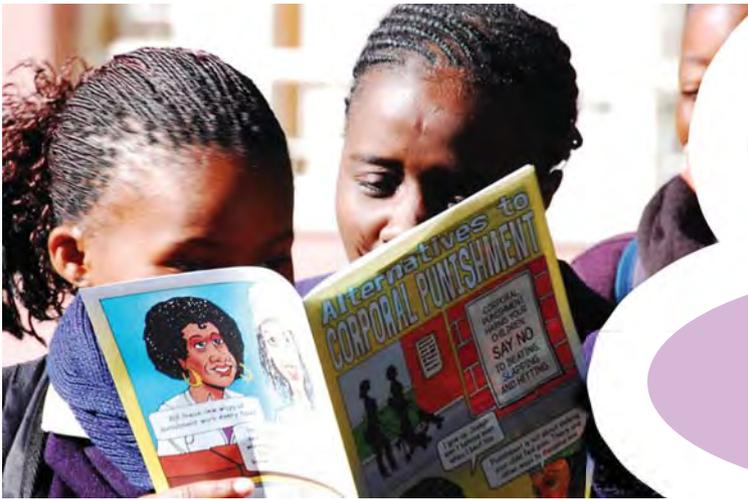
Lead Agencies

MGECW, MOJ

Partners

MSS, MoHSS, MYNSSC, NGOs, FBOs, CBOs

Priority Strategies

5.1.1   Implement the Child Care and Protection Act including through the development of supportive regulations.

5.1.2   Advocate, sensitise and train duty-bearers on the provisions and regulations of the Child Care and Protection Act and other relevant legislation.

5.1.3   Facilitate accession to the Hague Convention on the Protection of Children.

5.1.4   Finalise and enact the Child Justice Bill.

5.1.5   Promote child justice programmes and standards of care for all children in conflict with the law.

Implementation and Monitoring

The MGECW is responsible for finalising the drafting of relevant legislation and submitting the final draft Bills to Cabinet and Parliament for approval.

Consultations are required to ensure that accompanying regulations are developed, and that the necessary training to equip the relevant professionals to implement the law is provided.

The results, including the number of court cases in which the legislation is utilised, will be monitored through the justice system and through the systems established by the MGECW for accessing alternative care (foster and kinship care, adoption and residential care).

## Result 5.2 — Children benefit from integrated protection services.

Indicators

▸ Number of cases of child abuse and neglect reported at various entry points (social workers, police, Legal Assistance Centre, PEACE Centre)
▸ Standard operating procedures developed
▸ Number of operational shelters and places of safety
▸ Number of MoUs signed with partners
▸ Number of calls to the 116 crisis call line which resulted in a further service being provided

Situation

Children repeatedly list protection as a priority right. In the public participation process for revising the CCPB, children listed the following issues as "very serious" problems: family members abusing alcohol, domestic violence and physical abuse. The Children's Parliament of 2011 prioritised reducing violence against women and children for the National Agenda for Children. The Report on the Convention on the Rights of the Child states that 41% of the women who reported being raped were under 18 years of age. A study conducted by the MGECW in eight regions, i.e. *Knowledge, Attitudes and Practices Study on Factors and Traditional Practices that may Perpetuate or Protect Namibians from Gender Based Violence and Discrimination* (2009), found that 27.4% of the children under 12 had experienced forced sexual intercourse, and 44.5% of children of all ages had been subjected to one form of physical violence, of whom 36.4% had experienced physical violence serious enough to leave bruises.

The Woman and Child Protection Units (WACPUs) experience staff shortages, and presently there are only 15 WACPUs countrywide – in all 13 regions. The Namibian Police are placing specially trained detectives at station level in many of the smaller towns to deal with cases of gender-based violence and sexual assault. Given that Vision 2030 aims "to ensure that violence is completely eliminated in relationships at home as well as outside", the protection of women and children is a national priority.
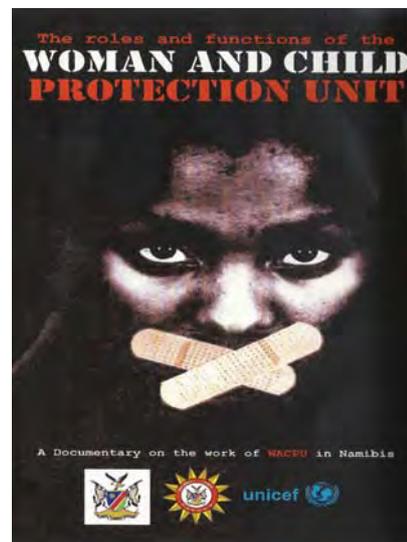
Lead Agencies

MGECW, MSS

Partners

MoJ, MoHSS, MoE, MLSW, MYS, MHAI, civil society

Priority strategies

5.2.1 Strengthen integrated child protection, prevention and response services (such as WACPUs, shelters and specialised services at police station level) through development and implementation of standard operating procedures and MoUs with partners for effective referrals.

5.2.2 Strengthen national child protection data management and information-sharing systems including "e-policing".

5.2.3 Strengthen child participation in protection including expansion of the 116 crisis call line.

5.2.4 Give families information and alternatives to address substance abuse.

5.2.5 Guide implementation of the Liquor Act and substance abuse prevention service.

5.2.6 Establish rehabilitation services for children.

5.2.7 Implement diverse and comprehensive initiatives to address specific issues affecting families in the community, such as violence against children, child labour and child trafficking.

5.2.8 Strengthen protection of children in emergencies.

5.2.9 Strengthen quality alternative care systems including adoption, foster care, kinship care and residential care.

5.2.10 Mainstream psychosocial support in training approaches and in the strategies listed above.

Implementation and Monitoring

The MGECW and MSS will jointly lead the implementation of these priority strategies, and will consult with key professionals in various ministries, including the MoHSS, MoJ, MLSW and MoE. The purpose of this consultation is to promote integrated prevention and response services based on the implementation of standard operating procedures. The MGECW will work with key CBOs and NGOs to sustain effective referral mechanisms.

Protection priorities are articulated in the Impact Mitigation component of the National Strategic Framework for HIV and AIDS Response in Namibia (NSF). The monitoring of incidences of violence, abuse, neglect and exploitation will take place through routine collation of the regional MSS data, particularly that of the WACPUs. The MSS Division of Specialised Investigation is responsible for this collation. The MGECW, through its quarterly reports from the control social workers, will collect additional data on child protection, e.g. from the civil society organisations working in collaboration with the MGECW and MSS. Efforts will be made to consolidate all this data in one monitoring system that can strengthen evidence- and results-based programming in the area of child protection.

<table>
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Result 5.3

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**Teenage pregnancies are reduced and support services are in place.**

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Indicators

▶ Number of girls of 19 years of age who attend antenatal care (ANC) classes
▶ Number of girls who drop out of school due to pregnancy

Situation

Over one-third of all reported victims of rape and attempted rape are younger than 18.[12] One survey of 265 girls aged 15-24 in Kavango, Omaheke and Ohangwena found that 19% of them had already been pregnant – with 40% of these pregnancies resulting from forced sex.[13]

A study in 2006 found that 58% of all teenage girls who had begun bearing children had no education, and 6.1% had completed their secondary schooling.[14] Teenagers in the poorest households were found to be nearly five times more likely than those in the richest households to become pregnant (22% compared to 5%), and rural teenagers were more likely than urban teenagers to have started bearing children (18% compared to 12%). The NDHS 2006/07 found that 22 500 (15.4%) of teenagers in Namibia had started bearing children. Childbearing among teenagers increases rapidly between the ages of 17 and 19 – from 14% among women aged 17 to 35% among those aged 19. In 2010, 1 493 girls were reported to have dropped out of school due to pregnancy (EMIS 2010).
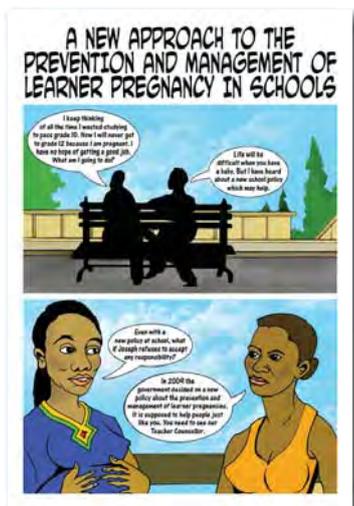
Lead Agencies

MoHSS, MoE

Partners

MGECW, MYS, civil society

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[12] Legal Assistance Centre, *Rape in Namibia: Full Report*, 2007, p. 8.
[13] UNICEF, *HIV and AIDS Knowledge, Attitudes, Practices and Behaviour – KAPB study in Namibia*, 2006.
[14] NDHS 2006/07, p. 51.

Priority strategies

5.3.1   Finalise and implement the Education Sector Policy for the Prevention and Management of Learner Pregnancy.

5.3.2   Finalise and implement the standards and guidelines for adolescent and school health.

5.3.3   Review and revise as necessary the 2001 National Policy for Reproductive Health in order to promote adolescent-friendly sexual and reproductive health services at all levels of the healthcare system, including community level.

5.3.4   Promote positive parenting to build open and positive child-parent communication and interaction.

5.3.5   Improve the regulatory framework, as the ETSIP calls for, to enhance the safety and security of learners, and to improve the conduct of learners, teachers and hostel staff.

5.3.6   Implement prevention and protection strategies to address social norms and harmful cultural practices.

Implementation and Monitoring

Implementation of these strategies is primarily the responsibility of the MoHSS Directorate of Primary Health Care Services and the MoE. Data on teenage pregnancies, services provided and information and awareness campaigns conducted will be gathered through the EMIS, the Health Information System (HIS) and tracer studies.

All children are safe from neglect, violence, abuse and exploitation.

III
Coordination, Accountability and Multi-sectoral Implementation

Coordinating Mechanisms

Background

Under the National Plan of Action for Orphans and Vulnerable Children 2006-2010 (NPA), the Permanent Task Force for OVC (PTF), chaired by the MGECW, provided the institutional framework for coordinating and monitoring the provision of services to vulnerable children. This body was composed of regional representatives of the MGECW, representatives of other line ministries, and representatives of a number of NGOs. The PTF met a few times every year. It proved to be a very valuable body for sharing information and mobilising the response for children. It was less effective as a coordination and management body, due in part to the lack of high-level (Director and Deputy Director) ministerial participation from ministries other than the MGECW. A number of government ministries and civil society stakeholders were responsible for implementing the NPA.

At regional level, OVC Forums were established and trained. Only those which were receiving specific support were tasked to prepare and implement regional work plans, but even in these instances, local resource mobilisation and implementation capacity were often inadequate.

Regional service providers and children consulted on the revision of the CCPB in 2010

The MGECW prepared two progress reports on the implementation of the NPA – one for 2007-2008 and one for 2008-2009. Data collection was a challenge as availability of data from the various stakeholders was limited. The differing reporting timelines applied by the ministries, NGOs and development partners involved in implementing the NPA caused some difficulties in the data collection and compilation processes. There were also too many indicators and data were not available on some of them.
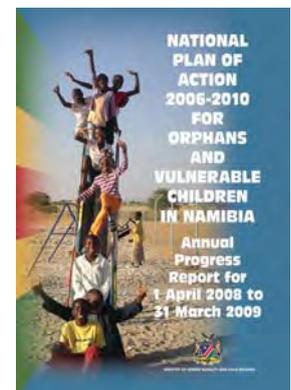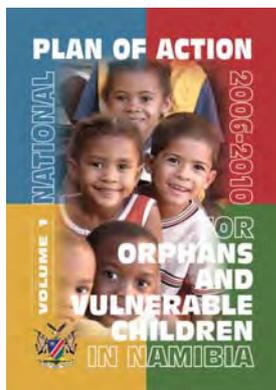
Proposed mechanisms

To address these management, implementation and monitoring concerns, the agenda outlined in the National Agenda for Children will be managed and monitored through the overarching national frameworks (NDP, NSF) and the various ministries' strategic and operational plans which are already in place.

Complete and regularly updated information and data for monitoring and reporting will be gathered through the EMIS (MoE) and the HIS (MoHSS), as well as national and regional studies and surveys such as the DHS and SACMEQ. Additionally, household-level data particularly on poverty and income profiles and the reach of critical services will be collected through the regular NHIES undertaken by the CBS housed in the NPC. Most of the indicators used in this National Agenda for Children framework are collected on an annual or semi-annual basis, and are already integrated into existing data-collection mechanisms of different ministries.

The MGECW will request this information from the designated contact points of each line ministry, collate the reports from these ministries and in turn present the overall report to the Cabinet. The MGECW will also make the data collected accessible to all of the stakeholders and the public.

Proposed management structure – multi-sectoral and multi-layered

The National Agenda for Children is a nationally generated accountability framework and guiding tool for the government, civil society and development partners to collectively ensure that a critical set of results for all Namibian children is achieved within a five-year time frame. Commissioned and adopted by the Cabinet, the National Agenda for Children requires appropriate and timely financial and technical resources, clear strategies for equitable access to a package of services, and agreed parameters for results-focused accountabilities for government, civil society and development partners.

The MGECW, as the custodian tasked to ensure results for children, will orchestrate the rolling out and management of the National Agenda for Children, and will ensure integrated and coordinated action by key ministries and civil society organisations. The general public, parents and caregivers, and especially children, will be kept aware of what is being done in their name and interests. Support from the private sector and international development partners will be maximised, coordinated and accounted for.

Since high-level engagement of government, civil society, the private sector and international development partners is a requirement for the success of this programme, it is proposed that a High-Level Technical Committee be established, composed of the Permanent Secretary of the MGECW as chairperson, the Permanent Secretaries of the MoE, the MoHSS and the NPC, and one representative each for civil society, the private sector and international development agencies. However, this will be an interim arrangement: the High-Level Technical Committee will be replaced by the Children's Council foreseen in the CCPB.

To fulfil its leadership role, the MGECW Permanent Secretary will convene an annual meeting of the High-Level Technical Committee prior to the submission of the National Agenda for Children annual progress report to the Cabinet.

Reports on the National Agenda for Children will be prepared by the management team (see details below). The High-Level Technical Committee (and later the Children's Council instead) will be responsible for approving the reports to be submitted to the Cabinet, and the MGECW will forward them to the Cabinet Office.

The High-Level Technical Committee (and later the Children's Council instead) will also approve reports to be submitted by the Minister of Gender Equality and Child Welfare to relevant parliamentary committees.

The MGECW Permanent Secretary will also constitute a management team composed of senior managers, with the following responsibilities:

1. Leadership and facilitation, including setting the strategic direction and persuasively explaining the National Agenda for Children framework to diverse audiences and agencies, so as to ensure their sustained participation and support.
2. Liaision with the various agencies – including their regional structures – responsible for implementing components of the Agenda, to ensure that all agencies are aware of the details of their responsibilities, and that any difficulties in implementation are quickly brought to light.
3. Public relations, especially with the media, Parliament, parents, other caregivers and children, to ensure widespread support for the programme.
4. Problem-solving, so as to ensure that bottlenecks and difficulties of whatever nature are quickly overcome by finding alternative solutions, resolving conflicts/disputes, and bringing positive and creative energies to bear.
5. Management of technical assistance.
6. Liaison with and coordination of international development partners and private sector supporters, ensuring that these do not unduly divert the Agenda.
7. Monitoring and analysis, and ensuring the production of regular reports, especially in relation to the stated/relevant indicators.

The management team will liaise with senior managers in the planning directorate of each ministry involved in implementing the National Agenda for Children, so as to continue influencing resource allocation, programme implementation, and the monitoring and reporting systems.

To assist the management team, each agency responsible for any part of the Agenda should nominate an official contact point for all communication concerning the Agenda. Accountability in terms of monitoring and data-collection arrangements and reporting on indicators will be discussed and followed up in individual meetings with each agency.

The PTF which served as the main management structure for implementing the NPA 2006-2010 will be retained, but its terms of reference will be reviewed so as to clarify its role in information-sharing, networking, ensuring mutual accountability, reviewing, investigating particular issues, and advising the Minister of Gender Equality and Child Welfare. In addition, one of the PTF meetings each year should be regarded as an annual review meeting in which the management team will provide an annual report on the implementation of the Agenda and the achievements in terms of the set indicators. Any major adjustments to the Agenda should be agreed on in this review meeting.

The proposed management structure can be illustrated as follows:

PARLIAMENT (including relevant committee/s))

CABINET (duly informed by the Minister of Gender Equality and Child Welfare)

HIGH-LEVEL TECHNICAL COMMITTEE (to be replaced by the Children's Council established under the CCPA)

PERMANENT TASK FORCE (including all institutional and regional stakeholders)

MANAGEMENT TEAM (established by the MGECW with defined functions)

IMPLEMENTING AGENCIES (line ministries, civil society organisations, private sector partners, international development partners, etc.)

Roles and Responsibilities

The priority commitments and results articulated in the National Agenda for Children have emerged from a rights-based and robust programming process, and are strategic in nature. This section identifies the duty-bearers responsible for taking action to improve the realisation of children's rights as identified in the Agenda, and summarises their direct sectoral roles and responsibilities under the Agenda. As an annual progress report will be prepared and submitted to the Cabinet for deliberation, the duty-bearer responsibilities include sharing with the MGECW their annual results specific to the Agenda, to enable the MGECW to compile the annual progress report on behalf of all duty-bearers.

The following summary of roles and responsibilities is arranged according to the names of the duty-bearers in alphabetical order, commencing with the government duty-bearers.

The **Ministry of Education (MoE)** is responsible for giving all Namibian residents equitable access to quality education programmes which develop the ability of individuals to acquire the knowledge, understanding, skills, values and attitudes required throughout life. The MoE has various policies which guarantee access to primary schooling for all children, including those with disabilities. Specifically, these include policies on age-appropriate life skills and counselling for all children, and on school feeding programmes reaching primary schools in targeted areas. The MoE is responsible for rolling out pre-primary education in a pro-poor sequence, and will implement the Prevention and Management of Teenage Pregnancy Policy.

The **Ministry of Finance (MoF)** is responsible for developing and managing fiscal and financial policies which ensure macro-economic stability, and sustainable and equitable socio-economic development. Together with the National Planning Commission, the MoF is responsible for finalising priorities for developmental and operational budget allocations. It is also responsible for reviewing the sectoral budget submissions, and for timely disbursement of the approved funds to the relevant sectors.

The **Ministry of Gender Equality and Child Welfare (MGECW)** is responsible for ensuring gender equality, equitable socio-economic development of women and men, and the wellbeing of children. To the latter end, the MGECW is responsible for facilitating the coordination and implementation of the National Agenda for Children. This includes consulting annually with duty-bearers to solicit their inputs against the expected results. The MGECW is to share with all duty-bearers the draft of each report on the Agenda for their final inputs before the finalised draft is submitted to the Cabinet or a parliamentary committee. The MGECW's direct implementation responsibilities include expanding child welfare grants and developing a national child protection system.

The **Ministry of Information and Communication Technology (MICT)** is responsible for producing, disseminating and facilitating the free flow of information to empower the Namibian people to participate in nation building and development. In implementing the National Agenda for Children, the MICT is responsible for supporting the dissemination of information on good childcare practices and protecting children from violence, as well as messages on HIV prevention, care and treatment, through the mass media, printed materials and various campaigns.

The **Ministry of Health and Social Services (MoHSS)** is responsible for providing quality integrated, affordable and accessible health and social welfare services which respond to the needs of the Namibian population. In implementing the National Agenda for Children, the MoHSS is responsible for coordinating the implementation of the National Strategic Framework for HIV and AIDS Response through the Directorate of Special Programmes. It is also responsible for implementing the Strategic Plan for Nutrition (2011-2015), and for achieving national priorities under the Integrated Management of Childhood Illnesses (IMCI) programme. The Division of Family Health coordinates efforts to deliver adolescent-friendly health services and to reduce teenage pregnancies.

The **Ministry of Home Affairs and Immigration (MHAI)** is responsible for ensuring the expansion of universal civil registration, which includes the strengthening of birth and death registration facilities, and the integration of MHAI services with the services of the MoHSS, the MGECW and other relevant duty-bearers implementing the National Agenda for Children.

The **Ministry of Justice (MoJ)** is responsible for delivering an effective, affordable, simple, efficient and fair legal service to all Namibians, and for ensuring that all Namibians are aware of their human rights. Relevant to the National Agenda for Children, the MoJ operates the court system and appoints magistrates as Commissioners of Child Welfare. Court proceedings involving a child are closed to protect the child's identity. The MoJ plays a key role in the finalisation of new or amended legislation affecting families and children.

The **Ministry of Labour and Social Welfare (MLSW)** is responsible for ensuring social justice, equity and fair labour practices in accordance with international labour standards, and for providing appropriate labour market information to facilitate employment creation and eradicate poverty. The MLSW provides social welfare grants to the elderly, which assist children in many households. The MLSW provides data on child-related work/labour issues. It also provides information on child-related and general work/labour issues to schools. In implementing the National Agenda for Children, the MLSW is responsible for ensuring that labour-related strategies supporting children continue to be supported.

The **Ministry of Regional and Local Government, Housing and Rural Development (MRLGHRD) and the Regional Councils** are responsible for promoting participatory democracy at sub-national government level through decentralisation. This includes promoting the effectiveness of the Regional Development Coordinating Committees, Constituency Development Committees, Local Authorities, Village/Community Development Committees and Traditional Authorities. These bodies, in conjunction with civil society organisations, coordinate community-based nutrition and income-generation activities, food distribution to vulnerable groups and those facing emergencies, and access to critical services at community level, especially for children. In implementing the National Agenda for Children, the MLGHRD is responsible for supporting the process of decentralising inter-sectoral services through the relevant ministries and their partners in constituencies and communities.

The **Ministry of Safety and Security (MSS)** plays an important role in protecting women and children from violence and abuse through the 15 Woman and Child Protection Units (WACPUs) operating countrywide under the jurisdiction of the Namibian Police (Nampol). The WACPUs are at the forefront in bringing together the MGECW, the MoJ and the MoHSS to collaboratively ensure that children are protected, and that there is prompt follow-up on incidences of violence and abuse.

The **Ministry of Youth, National Service, Sport and Culture (MYNSSC)** is responsible for developing and empowering young people, and promoting sport, culture and the arts to this end. Actively engaging children and adolescents in sport especially presents a unique opportunity to reach them with essential life skills.

The **National Planning Commission (NPC)** is responsible for planning to address national priorities, and for directing the course of national development, including through coordinating the implementation of the National Development Plan (NDP). The NDP is instrumental in guiding ministries and their partners towards realising certain priorities. The NPC will be instrumental in ensuring that the priorities of the National Agenda for Children are achieved through the implementation of NDP 3, and through the formulation and implementation of NDP 4. The NPC's Central Bureau of Statistics, responsible for compiling Namibia's official statistics, will contribute to the evidence-based achievement of results through the compilation of objective, relevant, comparable, reliable, timely and publically available child-related statistics of national interest and relevance.

The **Office of the Prime Minister (OPM)** is responsible for leading and supporting government institutions in their efforts to deliver outstanding public services and goods. In this capacity, the OPM supports the MGECW in its facilitation role, and all of the line ministries and their partners in carrying out their direct responsibilities to achieve the expected results of the National Agenda for Children. As the government

'spokesperson', the OPM is also responsible for assisting in sensitising ministries and their partners on the significance of the Agenda and the importance of their contributory roles.

Civil Society Organisations (CSOs) include non-governmental organisations (NGOs), faith-based organisations (FBOs) including churches, community-based organisations (CBOs) and the private sector. In the context of achieving the objectives of the National Agenda for Children, CSOs are responsible for supporting the government and its partners in their efforts to achieve national development priorities for children. This can take place through direct service delivery, advocacy, analysis of policy and practice, and the development of specialist strategies for reaching hard-to-reach groups. CSOs identify children and households in need, and facilitate community support for them. CSOs are effective in advocating for policy changes and in holding service providers accountable for the implementation of their programmes. The private sector, through corporate social responsibility programmes, supports many community-based initiatives and contributes to government policy development.

International Development Partners contribute technically and financially to policy development, programming and implementation of strategies aimed at ensuring children their rights. They are responsible for assisting the government to raise its global profile, and for supporting national priorities that address key development outcomes as outlined in the Millennium Development Goals and Vision 2030. As these partners often work across sectors, they have the potential to strengthen multi-sectoral collaboration.

Monitoring and Evaluation

It is the responsibility of the management team within the MGECW to request the result indicator data from the relevant duty-bearers and collate it. Most of the indicators selected for the National Agenda for Children are drawn from the strategic plans of the key ministries, thus the annual collection of this data is scheduled. The collated data will be compiled in a single annual progress report which the PTF, the High-Level Technical Committee (in future the Children's Council instead) and the Cabinet will review.

After two years of implementation of the National Agenda for Children, a team consisting of independent consultants and staff members drawn from the participating agencies should be appointed to conduct a mid-term evaluation of the progress and achievements of the Agenda.

The Monitoring and Evaluation Plan applying to the National Agenda for Children is annexed to this document.

Monitoring and Evaluation Plan

Commitment 1: ALL CHILDREN ARE HEALTHY AND WELL NOURISHED

Results	Indicators	Baselines	Targets	Sources	Frequency
1.1 All children under 5 years of age have access to adequate nutrition, growth monitoring and health services.	Number of children diagnosed with moderate or severe malnutrition	TBD	TBD	HIS	Annually
	% of children under 5 with stunting reduced	29% in 2006/07	15% in 2015	NDHS	2012 + 2016
	% of children under 5 underweight reduced	17%	15%	NDHS	2012 + 2016
	% of children who are exclusively breastfed for up to 6 months	5.7% in 2006/07	60%	NDHS	2012 + 2016
	% of health facilities with trained staff, tools/equipment (MUAC tapes, weighing scales, height board and food scales) and supplies (vitamin A, zinc, iron, RUTF, CMV and fortified blended food)	9 districts	34 districts in 2015	NACS	Training – annually Supplies – monthly
1.2 Neonatal mortality is decreased and child survival is improved.	Neonatal mortality is reduced	24 per 1 000 live births	15 per 1 000 live births	HIS	Annually
	Infant mortality is reduced	46 per 1 000 live births in 2006/07		HIS NDHS	Annually 2012 + 2016
	Under-5 mortality is reduced	69 per 1 000 live births in 2006/07	21 per 1 000 live births	HIS NDHS	Annually
	% of children aged 12-23 months who received all of their immunisations[1]	68.7% in 2006/07			
	Number of district hospitals equipped with emergency obstetric care and newborn resuscitation equipment, and staff who have skills to provide newborn care services	TBD		Health Facility Census	2-3 years
1.3 All children in schools and childcare facilities have access to clean drinking water and adequate sanitation.	% of schools and childcare facilities with adequate toilets	78.4% in 2010	TBD	EMIS	Annually
	% of schools and childcare facilities with clean drinking water on site	77.5% in 2010	TBD	EMIS	Annually

[1] BCG (preventing tuberculosis), three doses of DPT (preventing diphtheria, pertussis (whooping cough) and tetanus), three doses of polio vaccine (excluding polio vaccine given at birth) and measles.

Commitment 2: ALL CHILDREN HAVE EQUITABLE ACCESS TO QUALITY INTEGRATED ECD SERVICES, AND PRE-PRIMARY, PRIMARY, SECONDARY AND VOCATIONAL EDUCATION

Results	Indicatorss	Baselines	Targets	Sources	Frequency
2.1 All children access quality integrated ECD services and pre-primary education.	Number of registered and subsidised ECD centres	Unknown	TBD	Registration forms and report	Annually
	Number of children enrolled in registered ECD centres	Unknown	TBD	Registration forms	Annually
	Number of educarers trained in a course accredited by the Namibia Qualifications Authority	Unknown	TBD	NAMCOL Registration	Annually
	Number of children in government pre-primary classes	2010: 8 475	TBD	EMIS	Annually
	Repetition rate in Grade 1	2009: 20.2%	TBD	EMIS	Annually
2.2 All children access quality primary education.	Scores in SACMEQ IV by gender, socio-economic status and region	SACMEQ III 2007: Reading 496.9; Maths 471.0	TBD	SACMEQ	Every 5 years – 2012 next
	% of learners graded at the "basic achievement" and "higher" levels in Standardised Achievement Tests in Grades 5 and 7, by gender and region	Grade 5 2009: English 45%; Maths 54%	TBD	DNEA	Alternate years for Grades 5 and 7
	Net and gross enrolment ratios for primary-age learners, by gender and region	2010: 98.5%[1]	TBD	EMIS	Annually
	Survival rates to Grade 8, by gender and region	2009: 79% (80% female)	TBD	EMIS	Annually
	OVC aged 10-14 years attending school	2007: 94.6%	100%	DHS	2012 + 2016
2.3 All children access quality secondary education and vocational education.	Net enrolment and gross enrolment ratios for junior secondary and senior secondary education	2010: 55.7%[2]	TBD	EMIS	Annually
	Proportion of candidates who achieve at least a Grade D in English and Science in Grade 10 and Grade 12 national examinations for full-time and part-time candidates, by gender and region	JSC full time 2010: Eng SL 46.3%; Phys Sc 48.6% NSSC O level full time 2010: Eng SL 32.44%; Phys Sc 44.97%	TBD	DNEA	Annually
		VET unit standards completed March-July 2011: Level 1 – 209; Level 2 – 221	TBD	NTA	Annually
	Survival rates to Grade 11	2009: 40% (42% female)	TBD	EMIS	Annually
	Number of dropouts disaggregated by grade, gender and reason	2010: 12 968 (6 479 female)	TBD	EMIS	Annually
	Unit standards successfully completed by occupation, region and gender	TBD	TBD	NTA	Annually

1 + 2 This figure should be regarded as provisional. It is based on a projection of the 2001 Census which probably underestimated the number of children of primary school age.

Commitment 3: ALL CHILDREN HAVE ACCESS TO AGE-APPROPRIATE QUALITY HIV AND AIDS PREVENTION, TREATMENT, CARE AND SUPPORT

Results	Indicators	Baselines	Targets	Sources	Frequency
3.1 Fewer young people are HIV positive. (IR-2)*	% of young women and men aged 15-24 who are infected with HIV	11% in 2008	7% in 2012/13 5% by 2015/16	ANC SS	Annually Biannually
	% of in-school youth aged 10-14 and 15-24 reached by skills-based HIV prevention education within the regular school curriculum in the last year	45% in 2009	60% in 2012/13 85% by 2015/16	EMIS	Annually
	% of women and men aged 15-24 who had higher-risk sex during the last 12 months and who reported using a condom on the last occasion of higher-risk sexual intercourse	64%/81% (f/m) in 2006/07	77%/86 (f/m) in 2012/13 80%/90% (f/m) in 2015/16	NDHS	2012 + 2016
3.2 Fewer infants are infected with HIV as the rate of mother-to-child transmission is reduced.	% of HIV-infected pregnant women who received ARVs to reduce the risk of mother-to-child transmission of HIV (NSF OC 24)*	70% in 2007	80% in 2012/13 95% in 2015/16	Routine data for numerator; surveillance and modelling for denominator	Annually
	% of HIV-infected infants born to HIV-positive women (IR-4)	12% in 2007	8% in 2012/13 4% in 2015/16	Routine programme data; PMTCT/HIS	Annually
3.3 Children with HIV receive comprehensive treatment, care and support.	% of children enrolled in HIV care and eligible for CTX prophylaxis (according to national guidelines) who are currently receiving CTX prophylaxis (NSF OP 51)*	100%	100%	Routine programme data	Annually
	% of children (0-14) with HIV still alive at 12 months after the initiation of ART (NSF OC 33)	82% in 2007	95% by 2015/16	Routine programme data	Annually
	Number of eligible adults and children provided with psychological, social, or spiritual support	TBD	TBD	Community-based care programme records	Annually

* IR = Intermediate Result; OC = Outcome Result (in the NSF); OP = Output REsult (in the NSF)

Commitment 4: ALL CHILDREN HAVE AN ADEQUATE STANDARD OF LIVING AND A LEGAL IDENTITY

Results	Indicators	Baselines	Targets	Sources	Frequency
4.1 Child vulnerability is addressed through a comprehensive national social protection system.	% of children living in poverty	43%		NHIES	3-5 years
	% of social service posts in Child Welfare that are filled	TBD	Pending approval of new structure	MGECW HR report	Annually
4.2 Vulnerable children have improved access to social grants.	Number of grants, disaggregated by type, gender and region	Maintenance: 113 787 Foster: 17 166 (September 2011)	TBD	MGECW Database	Annually
4.3 All children are registered at birth, and have access to deceased parents' death certificates if required.	% of children whose births have been registered within the first year of life	54,7 % in 2010	90% in 2016	MHAI birth registration central database	Annually

Key result	Indicator	Baseline	Target	Source	Frequency
5.1 Children benefit from an enabling legislative and policy environment.	Child Care and Protection Bill enacted	Revised Bill	CCP Act	Government Gazette	Annually
	Child Justice Bill enacted	Bill	CJ Act	Government Gazette	Annually
	Accession to the Hague Convention on the Protection of Children	Unsigned	Signed		
	Number of duty-bearers trained, disaggregated by age and gender	Not available	100	Reports	Quarterly/Annually
	Number and percentage of child-friendly courts	4	13	Reports	Annually
	Number of children in conflict with the law screened and diverted				
5.2 Children benefit from integrated protection services.	Number of cases of child abuse and neglect reported at various entry points (social workers, police, Legal Assistance Centre, PEACE Centre)	Not available	TBD	Docket Inspection Reports; Social worker + WACPU reports	Quarterly/Annually
	Standard operating procedures developed	None	SOPs in every shelter and WACPU	Social worker and WACPU reports	Annually
	Number of operational shelters and places of safety	5	13	MGECW Social Worker reports	Quarterly/Annually
	Number of MoUs signed with partners	None	10	MGECW Social Worker reports	Quarterly/Annually
	Number of calls to the 116 crisis call line which resulted in a further service being provided	815 cases June 2010 to May 2011	TBD	LifeLine Report	Annually
5.3 Teenage pregnancies are reduced and support services are in place.	Number of girls of 19 years of age who attend antenatal care (ANC) classes	18 per 1 000 in 2009	TBD	HIS	Annually
	Number of girls who drop out of school due to pregnancy	1493 in 2010	TBD	EMIS	Annually

Summary Framework

Commitment 1: ALL CHILDREN ARE HEALTHY AND WELL NOURISHED

Results	Indicators	Priority Strategies
1.1 All children under 5 years of age have access to adequate nutrition, growth monitoring and health services.	▸ Number of children diagnosed with moderate or severe malnutrition ▸ % of children under 5 with stunting reduced ▸ % of children under 5 underweight reduced ▸ % of children who are exclusively breastfed for up to 6 months ▸ % of health facilities with trained staff, tools/equipment (MUAC tapes, weighing scales, height board and food scales) and supplies (vitamin A, zinc, iron, RUTF, CMV and fortified blended food)	1.1.1 Improve infant and child health including ARV prophylaxis for infants of HIV-positive mothers, immunisation and micronutrient supplementation. 1.1.2 Promote optimal infant and young child feeding practices: early initiation of breastfeeding, exclusive breastfeeding for the first 6 months of life, and timely introduction of complementary feeding. 1.1.3 Promote caring practices especially in health and nutrition, through effective communication for behaviour change using ANC and immunisation as opportunities. 1.1.4 Establish and improve community-based nutrition surveillance and growth monitoring. 1.1.5 Roll out community-based integrated management of acute malnutrition. 1.1.6 Facilitate universal salt iodisation. 1.1.7 Provide food supplements at ECD centres, e.g. a glass of milk each day, fortified with iron, zinc and vitamin A.
1.2 Neonatal mortality is decreased and child survival is improved.	▸ Neonatal mortality is reduced ▸ Infant mortality is reduced ▸ Under-5 mortality is reduced ▸ % of children aged 12-23 months who received all of their immunisations[1] ▸ Number of district hospitals equipped with emergency obstetric care and newborn resuscitation equipment, and staff who have skills to provide newborn care services	1.2.1 Roll out and support the "Reach Every District" approach, and strengthen routine immunisation coverage. 1.2.2 Extend health services into communities by recruiting paid community healthcare workers. 1.2.3 Develop and implement strategies to reduce maternal mortality. 1.2.4 Equip all district hospitals with emergency obstetric care and newborn resuscitation equipment. 1.2.5 Build healthcare workers' capacity to perform optimal newborn care practices: newborn resuscitation, early and exclusive breastfeeding, warmth, hygienic cord and skin care, timely and appropriate care-seeking for infections, and care of those whose birth weight is low.
1.3 All children in schools and childcare facilities have access to clean drinking water and adequate sanitation.	▸ % of schools and childcare facilities with adequate toilets ▸ % of schools and childcare facilities with clean drinking water on site	1.3.1 Develop and implement standards for sanitation at all childcare facilities and schools. 1.3.2 Increase national planning for and investment in Water and Sanitation and Hygiene (WASH) in schools through advocacy, partnerships and regular monitoring.

1 BCG (preventing tuberculosis), three doses of DPT (preventing diphtheria, pertussis (whooping cough) and tetanus), three doses of polio vaccine (excluding polio vaccine given at birth) and measles.

Commitment 2: ALL CHILDREN HAVE EQUITABLE ACCESS TO QUALITY INTEGRATED ECD SERVICES, AND PRE-PRIMARY, PRIMARY, SECONDARY AND VOCATIONAL EDUCATION

Results	Indicatorss	Priority Strategies
2.1 All children access quality integrated ECD services and pre-primary education.	▶ Number of registered and subsidised ECD centres ▶ Number of children enrolled in registered ECD centres ▶ Number of educarers trained in a course accredited by the Namibia Qualifications Authority ▶ Number of children in government pre-primary classes ▶ Repetition rate in Grade 1	2.1.1 Promote and expand integrated ECD services at community and national level. 2.1.2 Implement the integrated ECD Policy according to the existing plan, including training ECD workers, building facilities in targeted regions, setting standards for registration and registration facilities, subsidising facilities and monitoring ECD provision on a pro-poor basis. 2.1.3 Establish and capitalise an ECD fund. 2.1.4 Expand the provision of pre-primary classes at the rate of *at least* 100 per year. 2.1.5 Articulate and certify all training of ECD and pre-primary teachers. 2.1.6 Develop ECD curricula (for ages 3 and 4) which are articulated with the curricula for the 5-year-olds in pre-primary classes.
2.2 All children access quality primary education.	▶ Scores in SACMEQ IV by gender, socio-economic status and region ▶ % of learners graded at the "basic achievement" and "higher" levels in Standardised Achievement Tests in Grades 5 and 7, by gender and region ▶ Net and gross enrolment ratios for primary-age learners, by gender and region ▶ Survival rates to Grade 8, by gender and region ▶ OVC aged 10-14 years attending school	2.2.1 Address the private costs of education by investigating its affordability in view of the constitutional provision for free and compulsory primary education and making recommendations to Cabinet as to how government can adhere to this provision. 2.2.2 Implement a per capita funding formula for equitable resource allocation to schools. 2.2.3 Implement all aspects of the ETSIP and the (forthcoming) Roadmap for Education that concern quality of primary education and retention of learners. 2.2.4 Ensure adequate and equitable provision of school books, stationery and other essential inputs. 2.2.5 Expand access to and provision of education for educationally marginalised learners. 2.2.6 Establish units for special educational needs at selected primary schools in all regions, giving priority to regions which currently have none. 2.2.7 Expand and improve the quality of school feeding programmes. 2.2.8 Strengthen school health programmes and increase the number of toilets at schools.
2.3 All children access quality secondary education and vocational education.	▶ Net enrolment and gross enrolment ratios for junior secondary and senior secondary education ▶ Proportion of candidates who achieve at least a Grade D in English and Science in Grade 10 and Grade 12 national examinations for full-time and part-time candidates, by gender and region ▶ Survival rates to Grade 11 ▶ Number of dropouts disaggregated by grade, gender and reason ▶ Unit standards successfully completed by occupation, region and gender	2.3.1 Collect more accurate data on school leaving, and identify and adopt strategies to minimise dropout of girls and boys in all grades, especially at the stages of transition from primary to secondary and junior secondary to senior secondary. 2.3.2 Improve equitable access to vocational training. 2.3.3 Establish gender-responsive guidelines and mechanisms for attaining a protective and safe learning environment. 2.3.4 Expand access to senior secondary education by building and staffing more secondary schools.

1+2 This figure should be regarded as provisional. It is based on a projection of the 2001 Census which probably underestimated the number of children of primary school age.

Commitment 3: ALL CHILDREN HAVE ACCESS TO AGE-APPROPRIATE QUALITY HIV AND AIDS PREVENTION, TREATMENT, CARE AND SUPPORT

Results	Indicators	Priority Strategies
3.1 Fewer young people are HIV positive. (IR-2)*	▸ % of young women and men aged 15-24 who are infected with HIV ▸ % of in-school youth aged 10-14 and 15-24 reached by skills-based HIV prevention education within the regular school curriculum in the last year ▸ % of women and men aged 15-24 who had higher-risk sex during the last 12 months and who reported using a condom on the last occasion of higher-risk sexual intercourse	3.1.1 Teach HIV/AIDS Life Skills to Grades 1-12. 3.1.2 Strengthen HIV combination prevention (bio-medical interventions and changing sexual behaviour as well as underlying socio-economic norms), targeting children and adolescents, with a special focus on young people at high risk. 3.1.3 Implement interventions for social change relating to high-risk behaviour in adolescents, including gender norms and roles, alcohol and drug abuse, multiple and concurrent partnerships, trans-generational sex, transactional sex and sex work. 3.1.4 Improve access to quality health information and counselling and testing services for all children.
3.2 Fewer infants are infected with HIV as the rate of mother-to-child transmission is reduced.	▸ % of HIV-infected pregnant women who received ARVs to reduce the risk of mother-to-child transmission of HIV (NSF OC 24)* ▸ % of HIV-infected infants born to HIV-positive women (IR-4)	3.2.1 Develop a comprehensive mother-to-child transmission elimination plan. 3.2.2 Provide comprehensive counselling on Infant and Young Children Feeding to all women before and after they deliver a baby. 3.2.3 Provide efficacious ARVs to more HIV-positive pregnant women to reduce the risk of HIV transmission to their children (increased to 90% in 2014/15) 3.2.4 Improve testing for HIV at 6 weeks and 18 months using the DNA-PCR test.
3.3 Children with HIV receive comprehensive treatment, care and support.	▸ % of children enrolled in HIV care and eligible for CTX prophylaxis (according to national guidelines) who are currently receiving CTX prophylaxis (NSF OP 51)* ▸ % of children (0-14) with HIV still alive at 12 months after the initiation of ART (NSF OC 33) ▸ Number of eligible adults and children provided with psychological, social, or spiritual support	3.3.1 Promote provider-initiated and routine testing of children to identify those infected with HIV. 3.3.2 Develop guidelines for providing child-friendly comprehensive treatment, care and support systems for HIV-positive children. 3.3.3 Provide free external support to households with orphans and vulnerable children to enable them to care for each HIV-positive child.

* IR = Intermediate Result; OC = Outcome Result (in the NSF); OP = Output REsult (in the NSF)

Commitment 4: ALL CHILDREN HAVE AN ADEQUATE STANDARD OF LIVING AND A LEGAL IDENTITY

Results	Indicators	Priority Strategies
4.1 Child vulnerability is addressed through a comprehensive national social protection system.	▶ % of children living in poverty ▶ % of social service posts in Child Welfare that are filled	4.1.1 Develop a social protection strategy that integrates and enforces different social grants, exemptions and other social protection measures to serve and reach children in poverty. 4.1.2 Strengthen national monitoring systems to include indicators on child poverty and service accessibility for vulnerable children. 4.1.3 Strengthen social welfare workforce capacity and inter-agency coordination to ensure that children access critical services.
4.2 Vulnerable children have improved access to social grants.	▶ Number of grants, disaggregated by type, gender and region	4.2.1 Enact the Child Care and Protection Bill and the necessary regulations to ensure that grants (including kinship care grants) are implemented efficiently. 4.2.2 Investigate mechanisms (including grant criteria and grant amount) to ensure that social grants address child poverty, and advocate for their implementation. 4.2.3 Inform families about how to access services.
4.3 All children are registered at birth, and have access to deceased parents' death certificates if required.	▶ % of children whose births have been registered within the first year of life	4.3.1 Ensure access to decentralised birth and death registration systems in hospitals, regional and sub-regional offices, and through mobile campaigns in hard-to-reach areas. 4.3.2 Improve security of documents and monitoring through digitalisation of population registration.

Commitment 5: ALL CHILDREN ARE SAFE FROM NEGLECT, VIOLENCE, ABUSE AND EXPLOITATION

Key result	Indicator	Priority Strategies
5.1 Children benefit from an enabling legislative and policy environment.	▶ Child Care and Protection Bill enacted ▶ Child Justice Bill enacted ▶ Accession to the Hague Convention on the Protection of Children ▶ Number of duty-bearers trained, disaggregated by age and gender ▶ Number and percentage of child-friendly courts ▶ Number of children in conflict with the law screened and diverted	5.1.1 Implement the Child Care and Protection Act including through the development of supportive regulations. 5.1.2 Advocate, sensitise and train duty-bearers on the provisions and regulations of the Child Care and Protection Act and other relevant legislation. 5.1.3 Facilitate accession to the Hague Convention on the Protection of Children. 5.1.4 Finalise and enact the Child Justice Bill. 5.1.5 Promote child justice programmes and standards of care for all children in conflict with the law.
5.2 Children benefit from integrated protection services.	▶ Number of cases of child abuse and neglect reported at various entry points (social workers, police, Legal Assistance Centre, PEACE Centre) ▶ Standard operating procedures developed ▶ Number of operational shelters and places of safety ▶ Number of MoUs signed with partners ▶ Number of calls to the 116 crisis call line which resulted in a further service being provided	5.2.1 Strengthen integrated child protection, prevention and response services (such as WACPUs, shelters and specialised services at police station level) through development and implementation of standard operating procedures and MoUs with partners for effective referrals. 5.2.2 Strengthen national child protection data management and information-sharing systems including "e-policing". 5.2.3 Strengthen child participation in protection including expansion of the 116 crisis call line. 5.2.4 Give families information and alternatives to address substance abuse. 5.2.5 Guide implementation of the Liquor Act and substance abuse prevention service. 5.2.6 Establish rehabilitation services for children. 5.2.7 Implement diverse and comprehensive initiatives to address specific issues affecting families in the community, such as violence against children, child labour and child trafficking. 5.2.8 Strengthen protection of children in emergencies. 5.2.9 Strengthen quality alternative care systems including adoption, foster care, kinship care and residential care. 5.2.10 Mainstream psychosocial support in training approaches and in the strategies listed above.
5.3 Teenage pregnancies are reduced and support services are in place.	▶ Number of girls of 19 years of age who attend antenatal care (ANC) classes ▶ Number of girls who drop out of school due to pregnancy	5.3.1 Finalise and implement the Education Sector Policy for the Prevention and Management of Learner Pregnancy. 5.3.2 Finalise and implement the standards and guidelines for adolescent and school health. 5.3.3 Review and revise as necessary the 2001 National Policy for Reproductive Health in order to promote adolescent-friendly sexual and reproductive health services at all levels of the healthcare system, including community level. 5.3.4 Promote positive parenting to build open and positive child-parent communication and interaction. 5.3.5 Improve the regulatory framework, as the ETSIP calls for, to enhance the safety and security of learners, and to improve the conduct of learners, teachers and hostel staff. 5.3.6 Implement prevention and protection strategies to address social norms and harmful cultural practices.

Notes

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