Vision 2030 is the defining plan for a more prosperous Namibia. By 2030, today’s children under five should be in the prime of life – parents, educators, politicians, artists, business leaders. Yet many of them are so physically, educationally and emotionally deprived that their future prospects – if they survive to adulthood – are bleak. Too many do not have the nurturing environment essential for human development, and since most of them do not have access to existing social support structures, they are ‘excluded and invisible’.

The 2006 State of the World’s Children Report highlights the plight of millions of children around the globe who have not benefited from the gains made. They are the ‘invisible’ ones, excluded from the progress made towards the Millennium Development Goals (MDGs), which are connected to the well-being of children.

This supplement looks at Namibia’s progress in reaching the MDGs in relation to children, and focuses on the most pressing issues around orphans and vulnerable children (OVC). It also makes a call to action to legislators, government and community leaders, faith-based organisations and development partners, to help Namibia’s children to actualise their human rights, develop their talents and guarantee their survival.

In Namibia, the many threats these most vulnerable children face are focused in three areas, known as the ‘Triple Threat’ – the HIV/AIDS pandemic, with all its devastating impacts on society; food insecurity, which could increase dramatically with the weakening productive capacity of families and communities and chronic environmental problems; and the weakening capacity of social and economic services. The elements of the Triple Threat, together with other cross-cutting issues, interact to rob Namibian children of their well-being and security, and ultimately of their lives.
The eight MDGs flow out of universal human rights. They reflect the Global Resolve to change the most critical issues affecting human development and define what must be done and by when. Namibia has made good progress towards several of these goals, but some require urgent attention.

1. Eradicate extreme poverty and hunger

Namibia is classified as a ‘lower middle-income country’. This reduces the amount of aid, or ‘official development assistance’ (ODA) the country receives. But Namibia is one of the world’s most unequal countries: the richest 7,000 Namibians spend as much as the 800,000 poorest. Child malnutrition is a serious problem, especially among historically disadvantaged groups like the San. The per capita income in female-headed households (over a third of all households in Namibia) is on average half of that in male-headed ones. Extreme poverty in Namibia will worsen with the AIDS pandemic, as sick people become unable to work. When drought, food insecurity and AIDS tip the scale from malnutrition to severe deprivation, it is children who will suffer most.

2. Achieve universal primary education

Since Independence, more children have enrolled in primary school and fewer have dropped out. Yet the quality of education and the growing number of orphans are causes for concern. The problems of poverty, teenage pregnancy and HIV/AIDS must be overcome. Young girls often have to leave school to care for the sick and support the family. Children from educationally marginalised groups like the San, the Ovahimba and farm workers require special attention. It is ever more critical that existing policies are translated into action on the ground to help keep children in primary school so they can successfully complete 12 years of basic education.

3. Promote gender equality and empower women

While there is gender equality in primary education, the low status of women remains a critical gap in Namibia. Gender-based violence suffered by women and girls, and degrading attitudes such as those which regard them as property, are widespread in society. Only one-third of top legislative, government and private sector positions, and about one-fifth of seats in the National Assembly, are held by women. The target set by the SADC Declaration on Gender and Development is that by 2005, at least 30% of politicians and decision-makers should be women. However, despite legislation promoting gender equality, Namibia has attained less than 20%.
4. Reduce child mortality

The main causes of death for children under five are AIDS, diarrhoea, malaria, pneumonia and malnutrition. Although progress towards reducing child mortality has been slow, and the incidence of pneumonia has increased dramatically, nationwide measles immunisation has improved, with the 2006 target of 80% coverage likely to be met. Child mortality rates are decreasing, but by 2021 infant mortality is expected to be 60% higher than it would have been without AIDS.

<table>
<thead>
<tr>
<th>Status at a glance</th>
<th>1992</th>
<th>2000</th>
<th>2006 target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant mortality</td>
<td>67</td>
<td>52</td>
<td>36</td>
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<tr>
<td>(birth to one year; deaths per 1,000 live births)</td>
<td></td>
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<tr>
<td>U5 mortality</td>
<td>87</td>
<td>71</td>
<td>54</td>
</tr>
<tr>
<td>(deaths per 1,000 live births)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Underweight among children U5</td>
<td>26%</td>
<td>24%</td>
<td>17%</td>
</tr>
<tr>
<td>Stunting among children U5</td>
<td>28%</td>
<td>24%</td>
<td>19%</td>
</tr>
<tr>
<td>Wasting among children U5</td>
<td>9%</td>
<td>9%</td>
<td>6%</td>
</tr>
<tr>
<td>Proportion of U5 children immunised against measles</td>
<td>63%</td>
<td>72%</td>
<td>80%</td>
</tr>
</tbody>
</table>

5. Improve maternal health

The Safe Motherhood initiative provides family planning, antenatal care, safe delivery and postnatal care services to all Namibians. Currently, more than one in five pregnant women are HIV-positive. This is a major factor in maternal morbidity, along with malnutrition and complications around pregnancy and childbirth. Nevertheless, there have been some improvements since Independence, and antiretroviral (ARV) drugs, the prevention of mother-to-child transmission (PMTCT) of HIV, and other programmes targeting malaria and tuberculosis should help to reduce maternal and early child deaths. While good progress is noted, it has to be closely watched.

6. Combat HIV/AIDS, malaria and other diseases

AIDS has been the leading cause of death in Namibia since 1996. About 24,000 Namibians will die from AIDS-related illnesses in 2005 (one every 20 minutes). Between 1991 and 2001, AIDS reduced the predicted lifespan of Namibians by more than a decade.

HIV/AIDS affects children both directly, by transmission during pregnancy, birth or breastfeeding or through sexual transmission as adolescents, and indirectly, when their parents become ill and die. Though HIV prevalence is levelling off, the growing number of orphans will be a major challenge for the country. Tuberculosis (TB), the most common HIV-related illness, causes one tenth of all deaths in Namibia, the third worst TB-affected country in the world. Malaria is the leading cause of death for children under five, and the third leading cause for adults.

7. Ensure environmental sustainability

As a developing country in an arid region with periodic droughts, Namibia is particularly vulnerable to the effects of climate change and desertification. The poorest Namibians are predominantly subsistence farmers; sustainable development and natural resource management are therefore crucial. While large-scale commercial crop projects are underway to improve food self-sufficiency and security, these initiatives must avoid environmental degradation, which would directly impact on the most vulnerable households. Access to safe drinking water and sanitation remains low in rural areas, adversely affecting children’s health.

8. Develop a global partnership for development

Namibia has an open and investor-friendly economy and a well-developed infrastructure. The country is committed to various international treaties and conventions, as well as regional initiatives and institutions to promote peace and prosperity. International support is essential if Namibia is to overcome the Triple Threat. Yet ODA has dropped, mainly due to Namibia’s classification as a lower middle-income country. While development assistance for HIV/AIDS has increased, that for essential maternal and child health, education, special protection and poverty reduction should be more dynamically addressed.
The most vulnerable children in Namibia are those in poor households who lack access to sufficient food, proper care and education. They are more at risk of being exposed to violence and abuse, both inside and outside the home. If they are to be given support, however, their vulnerability must first be recognised. For a third of Namibian children, ‘invisibility’ begins with their births not even being registered. Without a birth certificate, these children experience difficulties getting into school and accessing other support services and government grants.

**What is vulnerability?**

Being ‘vulnerable’ means being in danger of threats like physical, sexual and emotional abuse, malnutrition, no access to education, preventive health or medical care, and premature death. In Namibia, vulnerable children are defined as: “children under the age of 18 whose mother, father or both parents or primary caregiver has died, and/or is in need of care and protection”. According to the 2001 census, there were about 97,000 children under 15 who had lost one or both parents. Already, vulnerability is so pervasive in Namibia that only 26% of children under 15 are living with both their parents.

**Who are they?**

There are orphans and vulnerable children (OVC) in most communities – coming from a well-off background does not guarantee that a child will not be sexually abused, for example, or denied love and emotional support. Nevertheless, poverty is the main root cause of vulnerability, and poverty in Namibia is worsening due to the combination of AIDS, insufficient outreach service provision, and other factors like alcohol abuse.

Children whose parents have died are being ‘looked after’ by grandparents or other family members who already have many demands on their scarce resources and time. Worse still, they may have to fend for themselves before they are ready to do so, and often become responsible for looking after their brothers and sisters. Even if children live with one or both of their parents, they may still be vulnerable. Many of these parents are extremely poor, and are not able to provide food, protection and support.

**What threats do they face?**

In the absence of physical, emotional and spiritual support, OVC face a barrage of threats, including:

- lack of protection
- physical and emotional abuse
- extreme or relative poverty
- malnutrition/chronic starvation
- lack of early childhood development
- lack of access to school
- HIV/AIDS
- prostitution and crime
- premature death

These children have ‘fallen through the cracks’, and it is both a moral imperative and a critical national development goal that they be identified and helped back into the light of a caring, supportive society.

**EXTREME VULNERABILITY**

Vulnerability goes hand in hand with marginalisation – being ‘on the edge of society’, with no support, and easily ignored or forgotten. Though marginalisation cuts across ethnic and regional divisions, some Namibian communities have historical levels of marginalisation that set them apart. The San, in particular, require targeted interventions that focus on children.

Strengthening institutional capacity and raising community awareness regarding access to education are critical. At about 18%, literacy rates among the San are way below the average of 80% and higher for all other language groups. Few San children, especially girls, go on to secondary school. Low literacy levels, poverty and disempowerment make the San community the most ‘excluded and invisible’ group in the country.
The challenges are therefore to:

- **make PMTCT, VCT, anti-retroviral therapy (ART) and reproductive health services available to all Namibians**
- take actions to counter stigma, discrimination, fear, alcohol abuse, and violations of the human rights of women and children
- change the culture of non-testing and non-reporting to one of openness and proactive intervention

The immediate causes of Namibian children’s increasing vulnerability are parental mortality, parents leaving their children in the care of others, poor childcare practices, and the inability of caregivers and communities to take care of children.

Although Namibia has a good OVC policy environment, legislative framework and programme of action, various economic and social factors limit their effectiveness. An OVC census is set to commence in May 2006 to help establish a reliable database for the management of all issues relating to OVC.

### HIV in Children

#### Prevention of Mother-to-Child Transmission of HIV (PMTCT)

The leading mode of HIV infection in children under five is via the mother during pregnancy, childbirth or breastfeeding. The main reasons for this are:

- mothers not knowing their HIV status during pregnancy
- stigma and discrimination associated with an HIV-positive status
- the high cost of breast-milk substitutes
- inadequate PMTCT outreach capacity and uptake

Although the HIV prevalence rate in mothers has dropped slightly, almost one in five is HIV-positive, and they infect about a third of their children. At present in Namibia, nearly all the hospitals and health centres (77 in total) provide PMTCT services, and around 50% of pregnant women have access to this service. However, for women in rural areas, distances to these urban-based facilities is usually too great. The stigma attached to HIV and the unwillingness of mothers to establish their HIV status are stumbling blocks for PMTCT uptake.

#### Voluntary Counselling and Testing (VCT)

VCT services in Namibia are still in their infancy, with hospitals having limited capacity for counselling and support. At present, there are 14 New Start VCT centres in high HIV-prevalence areas, their monthly number of clients having climbed from 1,000 in 2004 to 3,500 today. Where mothers are registered as HIV-positive, Nevirapine (the drug used in Namibia for PMTCT) is administered free of charge to mother and child, greatly reducing transmission rates. However, the majority of women either do not have access to VCT, or choose not to make use of it.

### Orphans at a glance

- In 2001, there were 97,000 orphans in Namibia.
- By 2004, about two-thirds of all orphans had been orphaned by AIDS.
- By 2021, there will be about 250,000 orphans under the age of 15 (about 10% of the total population, or a third of the population under the age of 18).

### An Orphan Fund

- Initial funding of N$10 million, with no further allocations.
- N$34 million needed annually for the 14,150 registered orphans.
- Registered orphans estimated to account for 10% of all orphans.
- Hence, N$340 million required annually for all orphans.

‘We need to see at least 90% of HIV-positive pregnant women utilising this service in order to really make an impact.’

Health Minister Dr Richard Kamwi, speaking at the national launch of the Global Campaign on Children and AIDS, 25 October 2005

The challenges are therefore to:

- make PMTCT, VCT, anti-retroviral therapy (ART) and reproductive health services available to all Namibians
- take actions to counter stigma, discrimination, fear, alcohol abuse, and violations of the human rights of women and children
- change the culture of non-testing and non-reporting to one of openness and proactive intervention
Early Death of Children

Children are most at risk of dying in the first month of life. Neonatal mortality is highest in rural areas where access to health services is difficult. The under-five mortality rate in Namibia, which stood at 84 per 1,000 live births in 1990, fell to 62 in 2000, but rose to 78 in the period 2002–2005. According to the UN Population Division, 45% of these deaths were directly attributable to HIV/AIDS. This is the third highest proportion for the sub-Saharan countries assessed. Malaria is another leading cause of death among children under five. Clearly, the MDG 2015 goal of 28 per 1,000 live births is unlikely to be met unless there is a major turnaround in service provision capacity and funding, and priority is given to primary health care and paediatric AIDS treatment.

Psychosocial Development

A 1997 study showed that caregivers from disparate communities agree that education is the key to their children’s future. They also hoped that their children would possess a set of values which reflect the social fabric of their communities: respect for elders, willingness to work hard, obedience, self-discipline, responsibility, self-sufficiency and cleanliness. It is this fabric of society that is being frayed and torn by the Triple Threat, and while it is the OVC who suffer today, in the long run the entire nation will pay the price.

These values can only be engendered in an enabling environment, but this is often denied children by AIDS, poverty and other factors. Many mothers are too busy with work and domestic tasks to meaningfully interact with their children. Worse still, they die, and their children are left in the often precarious care of siblings or grandmothers, who are themselves in need of care and support. Across all communities, fathers continue to play the passive role of ‘provider’ rather than ‘nurturer’, or in many cases are absent.

Another disturbing dimension is the growing violence against women and children. More and more young children are victims of rape, abuse and sexual violence within the family circle itself. Though related to the widespread problem of alcohol abuse, this alarming increase needs urgent attention in terms of prevention, care and support, and tougher treatment of perpetrators.

Early Childhood Development

A 2003 study of four predominately rural regions found that many caregivers:

- misuse medicines
- misunderstand vaccination and treatment procedures
- rely on traditional healers
- keep children out of school
- cannot feed children during lean times
- discriminate against ‘AIDS babies’
- leave young children in the care of older ones
- give alcohol to children in place of food
- do not encourage cleanliness and hygiene
- do not register their children at birth
- do not stimulate their children through talk and play

Provision for Integrated Early Childhood Development (IECD) in Namibia is currently inadequate, mainly because it is not given priority within a framework that caters for pre-primary school children. In response to this, a family visitors programme is sending outreach volunteers into communities to inform people about care practices for children aged three and under – the most vulnerable age group. ECD services for OVC and training for ECD caregivers on the special needs of these children have been extended in four regions of the country.

Social welfare grants are another critical service for OVC. By October 2005 there were 37,717 children countrywide receiving maintenance and foster care grants. Extension of these services to the most vulnerable age group among OVC requires urgent attention.
Primary Education

Net primary school enrolment has grown steadily from about 89% in 2001 to just under 94% in 2002. Good progress has therefore been made in achieving MDG 2. However, the Grade 10 results indicate that almost half of all learners do not acquire an adequate primary foundation to complete their basic education.

In addition to low quality, the growing number of OVC and other impacts of HIV/AIDS on the education system may reverse the positive trends made in basic education. Exemption from paying School Development Fund fees will need to be systematically ensured for those children who cannot afford to pay, and mechanisms will need to be put in place to ensure that schools with many OVC are reimbursed through the National Education Development Fund.

Health

Even though many Namibians still lack proper health-care and rely on mobile outreach services, there has been substantial improvement in some areas of public health services.

Sanitation and water quality have improved since Independence, and by 2001, 87% of households had access to safe water, and 44% to safe sanitation. This has reduced the incidence of diarrhoea, a significant factor in the U5MR, but treatment is not sought for almost half of all children suffering from this illness. In addition, almost half of all children showing symptoms of acute respiratory infections, and two-thirds of those with a fever, are not treated. And while iodine deficiency can harm the cognitive ability of a child, with lifelong consequences, almost half of Namibia’s children live in households that do not use adequately iodised salt. Public education should therefore be seen as a priority.

Maternal health, HIV/AIDS, malaria and TB are characterised by stagnation or deterioration. Emergency obstetric care, the most important service to reduce maternal mortality, is not universally available; in some regions the home delivery rate is as high as 40%.

Integrated Management of Childhood Illnesses (IMCI), a strategy that increases the cost-efficiency of health services, was launched in 1990, but is currently operational in only 12 of the 34 health districts. IMCI provides a complementary operational framework, focusing on household and community care, basic services and local planning to maximise resources within a supportive policy environment. Given the limited and potentially weakening staff capacity of the health system, the IMCI needs to be taken to full national coverage to get the most benefit.

Funding for health services is inadequate in light of the growing challenges. The total budget share for health stood at 9.2% in 2004/05, substantially less than the 15% pledge made at the OAU’s 2000 Abuja Summit. Furthermore, payments to personnel account for 75% of total expenditure, leaving little for programme interventions.
A CALL TO ACTION

With a projected 250,000 orphans under the age of 15 by 2021, and many thousands more vulnerable children facing the Triple Threat, the time for action is now.

**International support** is essential if Namibia is to improve the lives of OVC. Although the Global Fund and new US funding mechanisms are welcome initiatives for HIV/AIDS interventions, ODA has dropped to US$60 per capita, from a high of US$130 shortly after Independence. The drop in ODA is mainly due to Namibia’s classification as a lower middle-income country – a poor measure for development anywhere, and in Namibia’s case, one that fails to take country-specific realities into account.

- International development partners are therefore urged not to link the level of assistance to the classification of Namibia as a lower middle-income country, and to address broader health, education and protection issues for the most vulnerable children.

The **Namibian Government** has provided strong leadership in the context of HIV/AIDS prevention and care and support of people living with HIV/AIDS. It has also adopted policies and passed legislation aimed at supporting OVC. The message has been heard that HIV/AIDS is a cross-cutting development issue, and HIV prevention and treatment, and care of and support for people living with HIV/AIDS are increasingly being integrated into programmes across the board. Greater efforts are needed, however, in light of the growing impact of HIV/AIDS throughout society.

- Strong top-level leadership will need to continue and be strengthened.
- Services which most immediately impact on the lives of OVC should be prioritised, notably health and education, including early childhood care and development.
- Additional funding needs to be allocated to the Ministries of Health and Social Services, Education and Gender Equality and Child Welfare for OVC services.
- Co-ordination among ministries should be strengthened, structurally and through networks.
- Interventions for OVC need to be seen in the context of rural and economic development for reducing the impact of HIV/AIDS on families and communities, and not just as social welfare support.
- In order to ensure the visibility of all Namibia’s children, the Ministry of Home Affairs should investigate ways of improving birth registration coverage.

**Community- and faith-based organisations** (CBOs and FBOs) are ideally placed to identify children at risk, and to complement existing services provided for OVC.

- CBOs and FBOs are urged to place OVC at the centre of all their social outreach programmes.
- Capacity of FBOs and churches needs to be strengthened to plan and implement effective and sustainable interventions which move away from purely altruistic welfare approaches to more developmental ones.

The **electronic and printed media** have a social responsibility to disseminate information relevant to OVC. This responsibility should be shared by private and government media channels.

- The media are urged to continue with and intensify their focus on OVC-related issues.
- Responsive reporting to highlight both positive and negative stories is essential as part of responsible media efforts.
- Free airtime and space for public service messages are critical in both government and private media.

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