

**DEVELOPMENT OF A SADC MINIMUM PACKAGE OF
SERVICES FOR ORPHANS AND VULNERABLE CHILDREN
AND YOUTH**

**The Situation of Orphans and Other Vulnerable
Children and Youth in the SADC Region**

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ABBREVIATIONS AND ACRONYMS

ACRWC	African Charter for the Rights and Welfare of the Child
AIDS	Acquired Immuno-Deficiency Syndrome
ARV	Anti-retroviral
AU	African Union
CRC	Convention on the Rights of the Child
CRBA	Child Rights Based Approach
DFID	Department for International Development
DHS	Demographic Health Survey
FAO	Food and Agricultural Organisation
HIV	Human Immuno-deficiency Virus
ILO	International Labour Organization
IYCF	Infant and Young Child Feeding
M&E	Monitoring and evaluation
NGO	Non-Governmental Organization
NPA	National Plan of Action for OVC
OVC	Orphans and Vulnerable Children
OVC & Y	Orphans, Vulnerable Children and Youth
PMTCT	Prevention of Mother to Child Transmission
PSS	Psychosocial Support
REPSSI	Regional Psychosocial Support Initiative
RISDP	Regional Indicative Strategic Development Plan
RIATT	Regional Inter-agency Task Team (on children and AIDS)
SADC	Southern Development Community
STI	Sexually Transmitted Infection
TVET	Technical and Vocational Education and Training
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organisation

DEFINITION OF KEY TERMS

Key Term	Definition
Abuse	An act of ill treatment that can harm or is likely to cause harm to one's safety, well-being, dignity and development
Caregiver	A caregiver is any person giving care to the child in the home environment. Primary caregivers are family members, including parents, foster parents, legal guardians, siblings, uncles, aunts and grandparents, or another close friend who provides regular care to the child in the home. Secondary caregivers include community members and professionals such as nurses, teachers, play centre minders who interact with the child in the community or visit the child at home, but do not live with the child. Child and Youth Caregivers include children and youth who are caring for other children, and / or heading households.
Child	Any person below the age of 18 years ¹
Comprehensive Response	An intervention or effort that meets the complete needs or defined minimum standards across multiple services. A comprehensive response addresses survival, development, protection and participation rights.
Counselling	"Counselling is talking to a counsellor about your situation and your problems and worries. The counsellor will help you make plans and decisions, give you information and help you find answers to your questions. Counselling is not about telling you what to do; it is about helping you decide what you think is best to do and giving you support for following your decisions through." ² Counselling may take place in a one-to-one situation or in groups, and may be facilitated by a professional or lay-counsellor.
Deprived	A situation in which the basic survival and developmental needs and rights have not been met. ³
Developmental needs	Physical, biological, emotional, social, psychological, intellectual, spiritual and creative necessities to survive and grow enough to sustain normal productive lives. ⁴
Disability	An umbrella term, covering social, mental and physical impairments which may lead to limitations in activity and restrictions in participation. An impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experienced by an individual in involvement in life situations. Thus disability is a complex phenomenon, reflecting an interaction between features of a person's body and features of the society in which he or she lives
Family	A social unit created by blood, marriage, adoption, or defined by common line of kinship or relationship of a paternal or maternal nature. This can be biological or adoptive. It can be described as nuclear (parents and children) or extended (the conjugal family as well as other relatives or ascendants of the husband and/or wife encompassing). ⁵
Holistic	A comprehensive approach to addressing well being and development.

¹ UN CRC, 1989; ACRWC, 1999

² Care for children infected and those affected by HIV/AIDS: A Handbook for Community Health Workers. Save the Children UK, Kampala, Uganda, 2003. P.19

³ Comprehensive Care and Support for OVC & Y in the SADC: Strategic Framework and Programme of Action 2008-2015. SADC Secretariat, November 2008. P.4

⁴ Ibid

⁵ Ibid

Household	A social unit of people (not necessarily related) living together in the same house or compound, sharing the same food or cooking facilities. ⁶
Integration	Incorporating additional approaches, interventions or services into existing programmes or services to ensure improved and comprehensive developmental outcomes. It often requires developing partnerships with other organizations or programmes or service providers to enhance capacity. ⁷
Lifeskills	Psycho-social, interpersonal and self-management skills which help people make informed decisions, communicate effectively, and cope with adversity.
Mental Health	<p>“Mental health is a set of positive attributes in a person or in a community. It is a state of wellbeing in which an individual realizes his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community”.⁸ Mental Health is a conscious, dynamic, evolving capacity, and not a pre-determined, unchangeable, all-or-nothing state.⁹</p> <p>“Child and Adolescent Mental Health is defined as the capacity to achieve and maintain optimal psychological functioning and wellbeing; it is directly related to the degree of age-appropriate physical, psychological and social development achieved using available resources¹⁰</p>
Orphan	A child age 0-17 years whose mother (maternal orphans) or father (paternal orphans) or both (double orphans) are dead. The term ‘social orphan’ may be used to describe children whose parents may be alive but who are neglected or abandoned by their parents or whose parents are no longer fulfilling any of their parental duties. ¹¹
Psychosocial Support	<p>A continuum of care and support which influences both the individual and the social environment in which people live and addresses the social, emotional and psychological well being of a person¹²</p> <p>Attempts have been made to distinguish between “psychosocial care” versus “psychosocial support.” In different countries, the terms “care” and “support”, but especially the term “care” has different meanings. For the purposes of this document, PSS is shorthand for “PS Care and Support.”¹³</p>

⁶ Ibid

⁷ Ibid

⁸ Hermann, H, Saxena, S, Moddie, R, eds, Promoting mental health, concepts, emerging evidence and practice, 2005, http://www.who.int/mental_health/evidence/promoting_mhh.pdf Source: REPSSI, February 2010. *Glossary of Key and Related Psychosocial Terms*. P.11

⁹ Alma Ata Declaration: Wikipedia. Alma Ata Declaration. http://en.wikipedia.org/wiki/Alma_Atta_Declaration Source: REPSSI, February 2010. *Glossary of Key and Related Psychosocial Terms*. P.11

¹⁰ Dawes, A. (2003) Report on the child and adolescent mental health policy guidelines workshop. (Commissioned by the National Department of Health, South Africa). HSRC Library. Source: REPSSI, February 2010. *Glossary of Key and Related Psychosocial Terms*. P.11

¹¹ Comprehensive Care and Support for OVC & Y in the SADC: Strategic Framework and Programme of Action 2008-2015. SADC Secretariat, November 2008. P.5

¹² Definition used by SADC Secretariat in OVCY Framework 2010-2015

¹³ REPSSI, February 2010. *Glossary of Key and Related Psychosocial Terms*. P.8

Psychosocial Wellbeing	Refers to the state of being in which an individual has the ability to make sense of, and have a degree of control over their world with hope for the future. ¹⁴ It includes material, cognitive, emotional, spiritual and cultural aspects of a child's/youth's life and their interpersonal relationships. With regard to children, the Psychosocial Working Group, define psychosocial wellbeing as the positive age- and stage-appropriate outcome of children's development. ¹⁵ It is characterized by the individual's ability to: (a) make appropriate decisions that have short and long term benefits to the individual and to society, (b) assume and maintain social responsibility and healthy social relationships and behaviours, and (c) maintain a condition of mental astuteness and absence of temporary or long term mental retardation and impairment.
Rights Based Approach	Programming 'where the aim of all activities is to contribute directly to the realization of one or several human rights as laid down in the Universal Declaration of Human Rights and other international human rights instruments'. ¹⁶ In relation to OVC & Y, a rights-based approach means integrating human and child rights norms and principles in the design, implementation, monitoring, and evaluation of child and youth-related policies and programmes. These include human dignity, attention to the needs and rights of vulnerable groups, and an emphasis on ensuring that essential services are made accessible to all. The principle of equality and freedom from discrimination is central, including discrimination on the basis of sex and gender roles. A rights based approach also means empowering OVC & Y and caregivers, ensuring their participation in decision-making processes which concern them and incorporating accountability mechanisms which they can access. ¹⁷
Risk	The threat that one will be deprived in the immediate or long term.
Social Protection	All public and private initiatives that provide income or consumption transfers to the poor, protect the vulnerable against livelihood risks, and/or enhance the social status and rights of the marginalised, with the objective of reducing the economic and social vulnerability of poor, vulnerable and marginalised groups ¹⁸
Sustainability	Ensuring that human development efforts achieve lasting improvement on the lives of children, youth and their families/carers and communities without bringing about any harm or compromising their well being and that of others in the present or the future. ¹⁹
Vulnerability	A state of high risk of deprivation, or "an expected welfare loss above a socially accepted norm, which results from risky or uncertain events, and the lack of appropriate risk management instruments" (World Bank). ²⁰
Vulnerable Children	Children who are unable or who have diminished capacity to access their rights to survival, development, protection and participation. Children who are deprived or likely to be deprived or harmed as a result of their physical condition or social, cultural, economic, political circumstances and environment, and require external support because their immediate care and support system can no longer cope. ²¹ Vulnerability can be defined in terms of (a) the child's individual condition; (b) the condition or situation of the child's family /household; (c) the condition of the environment /community in which the child lives
Vulnerable households	Households which are unable to meet their needs or access their rights.

¹⁴ Antonovsky, (1979) A, Health, Stress and Coping, San Francisco: Jossey- Bass. Source: REPSSI, February 2010. *Glossary of Key and Related Psychosocial Terms*. P.10

¹⁵ Psychosocial Group Working paper, Psychosocial Intervention in Complex Emergencies, The Psychosocial Working Group, Edinburgh, October 2003.

¹⁶ The Human Rights Based Approach: UN Statement of Common Understanding. Developed at the Inter-Agency Workshop on a human rights-based approach in the context of UN reform, 3 to 5 May 2003.

<http://www.unicef.org/sowc04/files/AnnexB.pdf>

¹⁷ Adapted from World Health Organisation <http://www.who.int/trade/glossary/story054/en/index.html>

¹⁸ Comprehensive Care and Support for OVC & Y in the SADC: Strategic Framework and Programme of Action 2008-2015. SADC Secretariat, November 2008. P.5

¹⁹ Ibid

²⁰ Ibid

²¹ Children on the Brink, UNICEF 2004

Vulnerable Youth	Persons aged between 18 and 24 years who are unable or who have diminished capacity to access their rights to survival, development, protection and participation, and may be at risk of being harmed, exploited and/or denied necessary age specific developmental needs as a result of their physical condition such as disability, unemployment, HIV and AIDS, conflict and war, living on the street, neglected by her/his parents, illegal migration, substance abuse, among others.
Youth	For the purposes of this framework youth are persons aged 18 to 24 years. This definition recognises that the period of transition from childhood to adulthood places young people at greatest risk of deprivation of basic needs and rights. However, the UNICEF /WHO defines youth as every person between the ages of 15 and 24 years and young person as aged between 10 and 24 years; and the African Youth Charter defines youth or young person as aged between 15 and 35 years. ²²

²² Comprehensive Care and Support for OVC & Y in the SADC: Strategic Framework and Programme of Action 2008-2015. SADC Secretariat, November 2008. P.5

1. EXECUTIVE SUMMARY

The SADC region has an estimated 250 million people among the Member States. In each Member State more than 50% of the population is under the age of 18. These children need care, protection and support. Unfortunately for many, vulnerability does not end when they leave childhood. Many youth²³ continue to be at risk. Poverty is endemic and employment scant. Many youth have limited training, are unable to find work, and potentially engage in risky coping strategies to survive. Certain groups are even more vulnerable. Young women aged 15-24 are three to four times more likely to be infected by HIV. Children and youth with disabilities are often on the margins of society. For these reasons, SADC has determined that it is more meaningful to attempt to address the needs of orphans and vulnerable children and youth (OVC & Y) collectively.

This review found that there is lot of good practice within the region, and significant progress has been made in the realm of policy improvements for orphans and vulnerable children. However there are still some significant gaps and there remains a substantial disconnect between policy into practice. Critically, younger children, and children and youth with disabilities are largely overlooked in many programmes, and there is no continuation of service provision for vulnerable youth once they reach the age of 18 years. Too many youth are not realising their rights. Certain groups of vulnerable children remain on the margins, for example services for children living on the streets and in institutions are largely absent within most National Plans of Action for OVC. Dual legal systems and resultant conflicts between statute and traditional law in 14 out of 15 SADC Member States make upholding of children's and young women's rights almost impossible. Protection of married girls, pregnant girls and unmarried mothers is another area not addressed adequately.

To this end, SADC is developing a Minimum Package of Services for Orphans and Vulnerable Children and Youth which will draw on existing experience and lessons learned from the region and documented in this situational analysis. The situation analysis is drawn from a comprehensive desk review and fieldwork in 13 of the 15 SADC Member States. The Minimum Package will make locally relevant, age and gender specific recommendations for needs-based service delivery for OVC & Y that includes a continuum of services from pre-birth to twenty-four years and that responds to the specific needs of most at-risk boys and girls. The Minimum Package will also identify gaps in current service delivery and areas for further study.

Six key core service areas emerged during the situation analysis that will serve as the framework for the Minimum Package. These are education, food security and nutrition, health, protection, social protection, and psychosocial support. In addition a number of cross cutting themes emerged and will need to be accounted for in each of the key areas of intervention. The cross cutting themes represent specific areas of consideration that are common across all of the sectors. The cross cutting themes are: HIV and AIDS, gender, children with disabilities, child and youth participation, adolescents and youth and emergencies.

This situation analysis also contextualises the current response for OVC & Y within the existing international, regional and national policy environments. The policy environment across the region is very robust and generally supportive of vulnerable children and youth, however some international and regional agreements remain unsigned by Member States. Ratification or adoption of child and youth related protocols, such as the African Youth Charter and the ACRWC is a helpful first step in increasing the focus on children and youth within national governments, however this does not necessarily translate to improved conditions for children on the ground. The Minimum Package will help to assist national governments to ensure that such agreements can result in tangible change for orphans and vulnerable children and youth.

This Situation Analysis Report is one of a series of three documents: (1) Report on the Situation of Orphans and Vulnerable and Children and Youth in the SADC Region; (2) Conceptual Framework for Psychosocial Support for Orphans and Vulnerable Children and Youth in the SADC Region; and (3) Minimum Package of

²³ In the SADC Framework on Comprehensive Care and Support for Orphans and Vulnerable Children and Youth, 'children' refers to everyone from 0 to 17 years. Youth refer to those age 18 to 24 years.

Services for Orphans and Vulnerable Children and Youth in the SADC Region. The Situation Analysis Report has informed the development of the PSS Framework and the Minimum Package of Services.

2. INTRODUCTION

In 2008, SADC developed the *SADC Framework & Plan of Action for Comprehensive Care & Support for Orphans, Vulnerable Children & Youth (2008-2012)* (Framework) and an accompanying business plan. This Framework provides a common holistic developmental philosophy and approach to addressing challenges faced by orphans, vulnerable children and youth (OVC & Y), their families and care givers, within the socio-cultural, economic and political realities of the SADC region. SADC is developing concrete policy and programmatic guidance for Member States and other partners to provide comprehensive care and support services for OVC & Y. SADC is also developing a minimum package of services to guide regional harmonisation of approaches and define quality standards for care and support for orphans, vulnerable children and youth across the Member States. This situation analysis report informs the development of the minimum package of services. The minimum package will guide approaches to the scale up of service provision, as well as addressing risk mitigation amongst vulnerable groups.

Children and youth

SADC took the decision to address the needs not only of children under the age of 18 years but that of youth (18-24) as well. While 'OVC programming' generally stops when children turn eighteen, vulnerabilities still exist. Despite being adult in the eyes of the law, youth still have a range of care and support needs as they transition from childhood. New adult expectations can pose stress for vulnerable youth who do not have appropriate education or skills and cannot secure decent employment. They may be caring for ailing parents or siblings. Even where services exist, there is a lack of continuity of services from children to youth. For these reasons, SADC supports a longer view that looks at offsetting the developing vulnerability over the life cycle.

There are a number of factors contributing to children and youth's vulnerability. Southern Africa is the epicentre of the HIV pandemic with HIV prevalence as high as 26%²⁴ in hyper-endemic countries. Whilst gains in treatment access have kept hundreds of thousands of people alive and well, new infections remain extremely high and despite some positive indications especially for younger women in Botswana, Zambia and Tanzania, overall there is limited evidence of prevalence dropping. In 2008, an estimated 390 000 children under 15 years became infected with HIV in sub-Saharan Africa.²⁵ Youth are at particular risk as well, and 5.4 million young people are currently living with the virus. Two thirds of infected youth (61%) live in sub-Saharan Africa and three quarters of these are young women.²⁶ Children still struggle to access appropriate treatment. Although substantial gains have been made, currently just under a third (30%) of children who require treatment are receiving it.²⁷ Many children in the region have been orphaned as a result of disease and other factors. SADC is home to approximately 126 million children aged 0-17 years²⁸, of which over 17 million are orphans;²⁹ that is approximately 17% of children, and 7% of the entire population. Other data indicates that East and Southern Africa (which excludes RDC) has almost 28 million children lacking one or both parents.³⁰ These figures do not provide a true picture of vulnerability in the region as they do not include children and youth vulnerable because of poverty, conflict or other economic, social and political challenges.

²⁴ Estimated adult HIV prevalence rate (Percentage of adults aged 15–49 living with HIV). Data from 'State of the World's Children', UNICEF, 2009

²⁵ UNAIDS/ WHO, 2009, 2009 AIDS epidemic update

²⁶ InterAgency Task Team on HIV & Young People, 2008, *Overview of HIV interventions for young people guidance brief*

²⁷ UNICEF, 2009, *Children and AIDS: Fourth Stocktaking Report*

²⁸ Data for 2007, UNICEF, 2009, *State of the World's Children Report 2009*

²⁹ Africa's Orphaned and Vulnerable Generations: Children Affected by AIDS, UNAIDS & UNICEF, 2006

³⁰ UNICEF, 2009, *Children and AIDS: Fourth Stocktaking Report*

An estimated two thirds of the population in the SADC region live below the international poverty line of US\$1.25 per day³¹ and the region has some of the highest levels of inequity between rich and poor in the world. Inequity has been linked to increased levels of violence against children.³² Countries such as the République Démocratique du Congo (RDC) and Angola are in or emerging from recent conflict and the region is prone to devastating natural disasters such as flood and drought, exacerbated by climate change. The combined effects of poverty, high levels of disease, high morbidity and mortality rates, social conflict, natural disasters, high unemployment and low industrial growth and productivity are all having a devastating impact on children and youth in the region.

Key informants in the field assessment identified the following as being most vulnerable in their country: children who have lost one or both parents, children living in child headed households, children living in very poor households and/or households where no adults are working, children living on the streets, girl children, children living in rural areas, children under the age of five years, children infected and affected by HIV and AIDS, youth, and children with disabilities. Additionally, in three Member States the following specific groups were mentioned: children affected by war, children living in institutions, children affected by natural disasters, children living in urban informal settlements, child victims of violence and other types of abuse, abandoned babies, children living on farms, working children, displaced and migrant children and children of migrant families, children from broken/dysfunctional families, and children with parents in prison.

Findings from the field assessment show that there is greater awareness amongst the majority of respondents of the specific risks and vulnerabilities experienced by children as compared to the lack of understanding of risks for youth. While the majority of key informants named 'youth' amongst the most vulnerable categories of youth, they could not give in-depth information on vulnerabilities facing youth nor identify related policies, strategies and programmes targeting youth specifically. The literature review also found that data on youth was very limited.

Key informants reported on a range of government and non-government programmes and activities that focus on meeting the needs of vulnerable youth, including vocational skills training, business skills development, information dissemination on youth issues (including STIs, HIV and AIDS, the law and finance), peer education, access to micro-finance, rehabilitation and reintegration of youth living and working on the streets, community services, youth centres, youth clubs, guidance and counselling, sport and recreation, and behaviour change communication.

The definition of the age of youth varies across the region, ranging from as early as 10 years to as old as 35 years. The SADC Secretariat's focus for the regional minimum package of services is orphans and other vulnerable children and youth, from birth to 24 years of age. There has been a tendency to blame disaffected youth for many of society's problems, including drug and alcohol abuse, crime, commercial sex work, unwanted pregnancies, the spread of STIs and HIV and AIDS, and 'moral decay'. Out of school and unemployed youth have been mobilised for political means, recruited into gangs, and recruited into armed groups. However there is growing recognition of the importance of youth issues globally and regionally, and of the distinct vulnerability of certain groups of youth.

Youth experience particular vulnerabilities that characterise the transitional period from childhood to adulthood. Six Ministries of Youth were interviewed during the field assessment. These respondents recognise that out-of-school and unemployed youth are particularly vulnerable to exploitation and unfair labour practices, and are at greater risk of becoming trapped in exploitative work.³³ Girls and boys experience different challenges and risks. Girls and young women are reported to be at risk of exploitative and abusive relationships, early marriage and early pregnancy. Married girls are vulnerable to abuse and exploitation, and experience significant health risks related to early pregnancy and childbirth. A lack of work opportunities restricts the development of young people from childhood to adulthood. Youth are

³¹ International poverty line as defined by the World Bank, 2010

³² Pinheiro, P.S, (2006) Independent Expert for the UN Secretary-General's Study on Violence against Children *World Report on Violence Against Children* 2006. New York: United Nations

³³ Social Protection in Eastern and Southern Africa: A Framework and Strategy for UNICEF, 2008. P.17

highly mobile, and may migrate to urban areas and across borders in search of work. The most commonly identified needs of vulnerable youth were the need to be recognised and listed to, guidance and psychosocial support, access to information (on health issues, education opportunities, protection services, the law, etc.), education, training and opportunities that will lead to improved livelihoods (access to higher education, vocational training, internships, apprenticeships, business skills training, entrepreneurship, access to micro-finance and loans, equal employment opportunities), and access to sport and recreation activities.

Even in states where services are free, (Mauritius and, to a certain extent, South Africa), vulnerable youth are difficult to reach. They may be migrants, living on the streets, heading households and caring for or supporting family members, be married and dominated by a spouse, engaged in exploitative labour, engaged in substance abuse, have physical or mental disabilities, be living in locations with no family support or simply disaffected and disenfranchised. Whereas children can more often be reached through schools, clinics, etc, vulnerable youth do not usually frequent these institutions.

One of the main issues preventing national governments and other service providers from effectively addressing youth issues is the splitting of children's issues and youth issues between different government ministries. A lack of close collaboration between the relevant ministries concerned with adolescent and youth issues prevents the provision of a continuum of services for OVC & Y. Most National OVC Policies and NPAs for OVC are based in the Social Welfare Ministries, which only cater for children up to the age of eighteen, shifting the emphasis towards children rather than children and youth. Moreover, Social Welfare ministries have tended to attract more donor funding than youth ministries in the past, although there is some evidence this may be changing as youth issues gain a higher global profile.

The field assessment revealed that the situation for OVC & Y is perceived to have improved in six countries, not to have improved or to have declined in five countries, and to have improved in some areas and declined in others in the remaining four. However, few key informants were able to give statistical evidence to back-up their views on trends. Six out of twelve groups of Community Based Organisations (CBOs) interviewed reported a worsening situation for OVC & Y in their communities, mainly due to increasing numbers, increasing poverty levels, children not being able to access education and health services, children being looked after by older carers, family dysfunction and increased 'social ills' (mainly drug and alcohol abuse) resulting in anti social behaviour. Government key informants gave a varied picture. Numbers of OVC & Y are felt to be increasing in most countries, due to the combined impact of HIV and AIDS, poverty and food insecurity. Whilst most countries do have national OVC identification and registration processes, the majority do not yet have full national coverage, and in many countries it was reported that the most vulnerable children are unable to access basic services due to lack of birth registration or other documentation. No country reported having a system for identification and registration of vulnerable youth, therefore the scale of the problem amongst young people age 18-24 is not known.

The overall legislative and policy context within SADC for OVC & Y is largely supportive. All SADC member states have signed the key international and regional conventions that recognise the rights of all children.³⁴ These include the UN Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child. All countries have signed the declaration of the UN General Assembly Special Session on HIV and AIDS. Most countries have developed or are developing costed national plans of action for orphans/most vulnerable children. Across the region there is significant action in creating or amending policy and legislative frameworks that protect children and support their development. The policy environment for vulnerable youth is also progressing. To date, 6 Member States have ratified the African Youth Charter, and national policy and legislative frameworks and strategies for youth are developing, albeit, less well resourced than those for OVC. Significantly, responses for OVC & Y remain fragmented and despite the overall commitments by Member States, translating policy into evidence-based action remains a challenge.

³⁴ Swaziland has signed the ACRWC but not yet ratified it, the other Member States have signed and ratified the ACRWC

It is expected that the 'SADC Minimum Package of Services for OVC & Y' framework and guiding principles, when applied within each national context, will help to facilitate the coordination and harmonisation of responses. By doing so, it is hoped that the already great efforts by families, communities, service providers and Member States and, not least, by children and youth themselves, will reach a greater number of children and youth and achieve greater impact.

This report provides a summary of both a literature review (from the region and globally), and field assessments in 13 SADC Member States.³⁵ Section 3: 'Methodology' briefly describes the methodology of the work, as well as the limitations of the research. Section 4: 'Situation for OVC & Y: Sectoral Reviews' brings together the research from the field assessments and literature review into individual sectors. Section 5: 'Cross cutting themes' identifies crosscutting issues that will be addressed within each sector in the Minimum Package. Section 6 provides an overview of the policy and legislative situation and identifies some of the key priorities and challenges that need to be addressed to respond to children's needs. Section 7 summarises the current OVC & Y response in the region, and identifies items for inclusion in the Minimum Package. Section 8: 'Linking Minimum Package to other Standards and Guidelines' defines the Minimum Package alongside other emerging documents.

3. METHODOLOGY

Two research methods were applied through the course of this project.

- Comprehensive literature and desk review. The review identified: international, regional and national conventions, policies, instruments and guidelines related to OVC & Y; reports addressing the situation of OVC & Y in the SADC region; and reports (published and unpublished) assessing OVC & Y service delivery, in particular psychosocial support. The focus was on the SADC region, but key materials from outside the region were utilised. Internet search was undertaken using the following: Better Care Network, Child Rights Information Network (CRIN), IRIN and general searches using key words such as social protection, child protection, child welfare, alternative care for children, paediatric HIV, youth, Orphans and Vulnerable Children, child labour, early marriage, national plan of action for OVC, inclusive education, food and nutrition, psychosocial support, child participation, and youth participation.³⁶
- Field assessments of OVC & Y service delivery, including PSS, were conducted in 13 Member States.³⁷ Fieldwork methodology included focus group discussions (FGDs), key informant interviews, and information gathering. These were conducted using common questionnaires and focus group discussion guidelines. A total of 177 key informants were interviewed representing regional organisations (INGOs, donors and the SADC Secretariat), UN agencies, National AIDS Councils and Commissions, NPA coordinating bodies, government ministries responsible for Health, Social Welfare, Education and Vocational Training, Community Services, Children's Affairs, Youth Affairs, Gender, Justice and Home Affairs, Civil Society Organisations involved in local, national and regional service provision for OVC & Y, representatives of networks of people living with HIV and AIDS, representatives of organisations for persons living with disabilities and youth organisations. Three focus groups were held in each of the 13 countries. These represented vulnerable children and youth (including unmarried mothers, children and youth living on the streets, unaccompanied migrant children, and HIV positive children and youth), caregivers and community-based organisations and took place in both rural and urban settings in each country. A full list of informants is available as Annex 2. The assessments were conducted between December 2009 and March 2010.

³⁵ The full reports plus annexes are available from the SADC Secretariat.

³⁶ A comprehensive reference bibliography is available from the SADC Secretariat

³⁷ Botswana, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Democratic Republic of the Congo, Seychelles, South Africa, Kingdom of Swaziland, United Republic of Tanzania, Zambia and Zimbabwe. Field work was not carried out in Angola or Madagascar.

The consultants created a platform for ethical and meaningful child and community participation in order to ensure that the views of children and community members influence and are incorporated into the minimum package of services for OVC & Y. All fieldwork, including meetings with children, was carried out in accordance with Save the Children's 'Child Safeguarding Policy'. In addition, face-to-face meetings with children were carried out in accordance with Save the Children's 'Safe Child Participation Policy'.

Key stakeholders were appraised of the exercise before and after field work. The SADC Secretariat identified individual focal persons from the national government of each Member State. The consultants attempted to meet with the focal person in each country before commencing to brief him or her on the planned fieldwork. The consultants requested the country focal person organise a debriefing meeting for relevant stakeholders on the last day of the fieldwork, at which the consultants shared initial findings.

Limitations of the Research:

The field assessment was carried out as a rapid assessment to support and verify the literature and desk review, and attempted to map a large sample in a short time. It was not possible to meet with all the identified Key Informants in each country. There were two main reasons for this. Firstly, the timeframe and budget for the fieldwork were both very tight, and limited the number of interviews that could take place. Secondly, the consultants had difficulty in getting appointments with some key informants. However, follow up phone calls and email contacts were made with Key Ministries that had been missed during the fieldwork, wherever possible.

In spite of the constraints, a considerable amount of data was collected and collated from the field assessment. This allowed the consultants to verify and enrich the findings of the literature and desk review with qualitative data from vulnerable children and youth, caregivers, service providers and national coordinating bodies.

4. SITUATION FOR OVC & Y: SECTORAL REVIEWS³⁸

The research indicated that the increasing focus on children in the region is leading to increased access. Overall, respondents perceive that access to basic services (education, healthcare, shelter and food) has improved, especially for children under-eighteen years in all except one Member State. CBOs that reported some improvements in the situation of OVC & Y in their communities said this is due mainly to social grants, increased confidence of children and youth to report cases of abuse and increased school attendance. However, not all children and youth are benefitting. Children and youth living in rural areas, in child and youth headed households, or on the streets, those living with disabilities, unemployed out-of-school youth, and some vulnerable groups of girls still experience considerable challenges in accessing basic services.

When respondents were asked about the essential needs of OVC & Y and their caregivers, there was general agreement across all member states. However, respondents from countries with more comprehensive national OVC care and support programmes were more aware of the psychosocial needs of OVC & Y compared to those from countries where the national response is less comprehensive and/or less well coordinated. There is a clear need to elevate psychosocial support as a core element of any essential needs package for children. To date, there is greater emphasis on the need for protection of children under eighteen years, and greater emphasis on economic strengthening and livelihoods/vocational skills, resources and opportunities for youth and caregivers. HIV prevention, treatment and care programmes were mentioned in all Member States.

Key informants highlighted the weak communication and coordination between the various organisations providing services for OVC & Y, resulting in disjointed service provision, overlapping services, gaps, and inadequate coverage.

³⁸ The categories used in this section have been identified by the Regional Technical Working Group for the development of the SADC Minimum Package of Services for OVC & Y, and are the categories for the proposed Minimum Package of Services.

4.1. EDUCATION AND TRAINING

Getting an education is an important prerequisite for OVCY to leverage improvement in their lives. Not only does academic learning increase job opportunities and earning potential; education can also reduce children's risk of HIV infection by increasing knowledge, awareness, skills and opportunities, enabling them to care for themselves better. Having an education reduces the risks of engaging in risky or exploitative work. For girls, it lessens the chances of premature marriage or pregnancy. Schools can also provide a supportive environment for orphans and vulnerable children and youth, helping them to learn social skills and providing peer and psychosocial support.

Overall there has been progress across the region in recent years towards improving access to education, with current youth literacy rates higher than adult literacy rates (average 81% compared to 77%³⁹). Within the focus group discussions, education was consistently identified by children and youth as key to their psychosocial health and long-term success in life. They reported being 'happy' when they are at school, and 'worried' when they cannot go to school. Children, as well as respondents from CBOs, NGOs and government, report that communities and caregivers do not prioritise the educational needs of OVC & Y as highly as children themselves.

All who were surveyed identified education assistance as the most common type of assistance being provided through OVC programmes. Most of these target primary education, some facilitate access to secondary education, and very few facilitate access to vocational training and tertiary education. Some government and NGO-supported programmes provide block grants to schools to enable them to waive fees for OVC. However, whilst most service providers interviewed consider education interventions to be effective, the field assessment and literature indicate that provision of school fees alone is not sufficient support to enable many vulnerable children and youth to attend school. Provision or elimination of school fees leaves the students and families to cover the costs of uniforms, scholastic materials, transport, and boarding. This is evidenced by the finding that even in countries where education is free, poorer children are less likely to achieve a proficient educational standard. Currently, the Constitutions of seven member states⁴⁰ include the right of children to education, although not always confirming that it should be both free and compulsory. Botswana, Zambia and Zimbabwe, have national policies providing for children's rights to education which make primary education compulsory or free. Angola's Education Reform Act (2001) aims to achieve universal primary education by 2015 and accords priority to the most vulnerable groups. Education is currently free and compulsory for children age 6-11 years.

The field assessment revealed that OVC & Y who are in school face other challenges. While the majority of the children who participated in the focus groups are currently attending school, all of the young mothers who participated in the field assessment had dropped out. Children who were from very poor households, caring for siblings or working were also not in school. Other reasons cited for non-attendance included the inability to pay fees and other education-related costs, distances to travel, family circumstances and behavioural problems. It was also reported that children and youth in food-insecure households perform poorly at school due to hunger. Some drop out of school to seek paid work in order to obtain food for themselves and their families. Some children are sent out to work to help make ends meet or are required to undertake arduous household work such as fetching water, digging pits and chopping firewood. Schoolgirls face violence and sexual abuse in their classroom and on their way to school.⁴¹ Male peers and teachers are responsible for most of the sexual abuse that takes place in schools. Corporal punishment is still allowed in schools in 6 SADC Member States, but children reported that it takes place in all countries. Physical and humiliating forms of punishment against children are contributing factors to poor school attendance.

³⁹ State of the World's Children, UNICEF 2009

⁴⁰ Angola, Lesotho, Malawi, Moambique, Namibia, South Africa and Swaziland

⁴¹ Evidence from 'Are Schools Safe Havens for Children? Examining School-related Gender-Based Violence', USAID's Office of Women in Development, September 2009 and the 'UN Study on Violence Against Children', Paulo S Pinheiro, 2006

4.1.1. PRIORITIES BY AGE GROUP

In spite of the importance of **early childhood education and development** (ECD) interventions during the pre-school years for effective cognitive, psychological and social development, few children have access to early childhood interventions. Available data suggests that access is linked to income. Few respondents in the field assessment mentioned ECD as an important service for children, and many of those who did saw it merely as a child-care service, '*helpful for elderly carers who have young children to look after and entertain*', or to enable young mothers to go back to school whilst their children were taken care of. The intrinsic value of early childhood education is generally overlooked. With so many children vulnerable from such young ages, quality ECD can offer the support they need to begin primary school, emotionally healthy, socially engaged and ready to learn. At least three SADC Member States have established ECD strategies, but all are facing multiple challenges in implementation, including lack of resources in terms of structures, materials, skilled and qualified professionals, and assistance for children to attend.

Across the region, **primary school** enrolment rates have improved significantly (current average is 88%), but attendance and completion rates are much lower. Although increasing numbers of children are getting the opportunity to obtain a basic education, a significant proportion enter late, repeat grades, and leave without completing the five years of primary education widely agreed to be the minimum for sustained literacy and other competencies.

Transition from primary to **secondary schools** remains low. The average net secondary school attendance ratio is only 25% for boys and 31% for girls, with no country achieving 50%.⁴² Whilst secondary school enrolment ratios are higher for girls, fewer girls than boys complete secondary education or enrol in tertiary education. Drop-out rates for girls at secondary education are higher than those of boys and occur at a younger age. Many field assessment respondents across the region reported that pregnant girls and girl mothers are expelled and prohibited from returning to school; girls are dropping out to get married before the age of eighteen; and boys and girls who are acting as caregivers to siblings or sick relatives drop out of school to provide care and to seek paid work in order to support the family. Across the region, opportunities are few and support is not prioritised for vulnerable youth over the age of eighteen to continue with their education and enrol in higher education or vocational training.

Education in the context of care and support for OVC & Y refers to access to learning opportunities in a broad sense, from formal education to learning in non-formal, informal and emergency settings. For those who have enrolled late or have dropped out of school it can be difficult to enter the formal education system. There are some good examples of **alternative education** initiatives of out-of-school children and youth in SADC Member States. However these are generally small-scale initiatives, and only operate in larger urban centres. There is a need to develop alternative approaches to basic education that target hard to reach children (e.g. domestic workers, street children, children of migrants or nomadic populations). Such interventions require specific curricula and training of facilitators to provide alternative and non-formal education.

Several Member States have policies that promote **HIV and AIDS awareness and prevention and lifeskills education in schools**. However in-spite of some progressive legislation, HIV and AIDS awareness, prevention and impact mitigation is not always prioritised and taught because either, it is not an examined subject, or teachers are not informed and not confident to teach it, or opposition from parents and community leaders (and even teachers) to discussing issues related to sex with children. Field assessment respondents in countries where lifeskills is included on the national curriculum reported that it is still a 'weak area' in terms of comprehensive coverage, lesson content and appropriately trained teachers. HIV and AIDS education should be compulsory at all levels of education, including training for staff on HIV and AIDS awareness and counselling for HIV prevention and HIV-related social problems, and promotion of non-discrimination of all teachers and students affected or infected by HIV.

⁴² Data from State of the World's Children Report, (UNICEF 2009) shows an average secondary school net attendance ratio for the SADC Region (i.e. number of children attending secondary school who are of official secondary school age, expressed as a percentage of the total number of children of official secondary school age) of only 28%

The Government of Angola has made the fight against HIV and AIDS a national priority, setting up agencies to provide counselling and testing and to teach prevention techniques. The nationwide 'Defend Life, Learn About AIDS' campaign has trained thousands of teachers and distributed educational manuals to students, informing them about the risks of AIDS and other sexually transmitted infections.

Technical Vocational Education and Training has been much neglected in the region in recent years due to concerns over cost and rates of return. This neglect particularly affects youth and adolescents who do not aspire to, or do not have the means to complete secondary and higher education. Training programmes are rare and/or of poor quality and are not always suited to finding employment upon completion. Yet such services are crucial for vulnerable children and youth. Acquiring the necessary skills to find employment or be self-employed is a key route out of the cycle of deprivation and dependency facing many OVC and youth.

4.1.2. THOSE WHO REMAIN EXCLUDED

SADC Member States have implemented various policies and programmes that facilitate *access to education for girls*. However, in a progress report on the implementation of the SADC Protocol on Gender and Development, only South Africa and Swaziland have achieved gender parity in access to education for boys and girls at primary school level, and most countries highlighted the gender insensitivity in their national education policies.⁴³ SADC Member States face high school drop-out rates when female students fall pregnant. In many countries in the region, adolescent pregnancy is grounds for the girl's dismissal from school. In an effort to address this, some Member States have introduced re-admission policies for girls who fall pregnant while in school. However negative attitudes towards teenage mothers and culturally-defined gender roles mean that in spite of some progressive legislation, girl mothers often do not return to school. More needs to be done to ensure that girls finish primary and secondary education, reduce stigma toward returning students, eliminate gender violence in schools, and eliminate stereotypes in school curricula.

Schools, colleges and universities, as is the case with the broader society, still grant access to able-bodied children more easily than they do to *children with disabilities* of various kinds. A South African report found that schools target "the normal child" and, while there are some "special schools" for children with severe disabilities, there is very little to show in practice for integrating children with special needs into mainstream public schools.⁴⁴ The field assessment revealed that the problem is made worse by parents of children with disabilities who keep their children hidden and do not enrol them in school.

The need to support HIV positive learners at school is gaining in urgency and scale. Barriers facing HIV-positive learners include lack of support from parents/guardians; stigma and discrimination and intolerant attitudes at school and at home; absence of support from school staff and the education sector as a whole; poverty – linked to school drop-out and hunger – most problematic for children on ART; lack of government and NGO services in rural areas; and lack of access to primary health care, ART and nutritional

The Second Chance Programme in Mauritius is a literacy and numeracy programme for young people between the age of 16 and 21 who have dropped out of school. There is a vocational programme component after the completion of the Literacy and Numeracy programme. The Ministry of Education operates a mobile training unit for vulnerable groups of OVC & Y, offering training in various trades

supplementation in rural areas.⁴⁵ Any HIV and AIDS training for educators must acknowledge the unique needs of HIV positive learners.

⁴³ SADC Gender Monitor 2009: Tracking Implementation of the SADC Protocol on Gender and Development. SADC Gender Unit, Gaborone, Botswana, 2009, P.31

⁴⁴ South African Child Gauge 2008/09. Children's Institute, University of Cape Town.

⁴⁵ UNESCO, 2008, *Supporting the educational needs of HIV-positive learners: lessons from Namibia and Tanzania*

It is the responsibility of both States and Civil Society to work together to ensure schools are child friendly, safe places for all learners regardless of HIV status, economic strata or disability. They need work together to ensure the girls are not put at risk through attending school. Lastly, they must abolish corporal and other humiliating and degrading forms of punishment.

There are many examples from across the region of attempts to provide comprehensive care and support for OVCY through the education system. School-based interventions include health promotion, HIV and AIDS awareness and prevention, waiver of school-fees for OVCY, counselling and support, including peer education and peer support, child-friendly school initiatives, school feeding schemes and food gardens, and extra-curricular activities (sports and clubs) to promote a healthy lifestyle. While there is evidence that the school-based approach is effective, these programmes tend to be small-scale and fragmented, and their success and sustainability is often dependent on the personal commitment of a head teacher.

4.2. HEALTH

Limited access to health care, clean water and adequate sanitation are major challenges to vulnerable children's wellbeing, development and survival. According to the Implementation Plan for the SADC Protocol on Health 2007-2015, 'the general health status in the region is unsatisfactory.' Life expectancy has been significantly reduced by the combined effect of HIV and AIDS, TB and malaria. About 50% of the population in the region lack regular access to essential medicines.⁴⁶ Malaria is one of the biggest killers of children under 5 in Southern Africa, and is endemic in most of the SADC region. Despite big increases in the supply of mosquito nets, especially of long-lasting insecticidal nets, the number available is still far below need in almost all countries. The procurement of antimalarial medicines through public health services has also increased sharply, but access to treatment, especially of artemisinin-based combination therapy is inadequate.

Southern Africa has the highest under-5 mortality rate in the world. 9.7% of children in SADC Member States die before their 5th birthday and 3.4% of children die within a month of birth.⁴⁷ Infant and child mortality rates, regardless of a child's HIV status, have been increasing since the HIV epidemic began.⁴⁸ Untreated, most children born with HIV will die before their fourth birthday, most likely in the first two years of life.⁴⁹ With the exception of Mauritius, maternal mortality in SADC countries is a great concern, ranging from 124 in South Africa to 1,400 per 100,000 live births⁵⁰. The maternal mortality rate will need to drop below an average of 228 per 100 000 to reach the MDG target. However national efforts of some Member States to promote health care for pregnant women and children through routine pre- and post-natal care and national vaccination campaigns have resulted in increased numbers of pregnant women delivering at health centres attended by qualified health practitioners and a reduction in child mortality. Coverage of prevention of mother to child transmission (PMTCT) in SADC Member States varies across the region. Several countries with high HIV prevalence have expanded PMTCT coverage to most pregnant women needing treatment: 73 percent in South Africa, 91 percent in Namibia and 95 percent in Botswana. The countries most successful at scaling up PMTCT incorporated their programmes into existing maternal and child health services.⁵¹ Most countries are making good progress on preventable childhood illness (measles, polio, etc.), thanks to national Expanded Programme for Immunisation (EPI) programmes.

Children suffer emotionally as well. Many children worry about their health and that of their caregivers. This is especially acute for children who have already lost one or more parent and are relying on a surviving parent or relative. Children also require psychosocial support as they manage their illness. HIV-positive

⁴⁶ Implementation Plan for SADC Health Protocol, 2007-2013. P. 4

⁴⁷ Based on 2007 population and under 5 mortality data for 'State of the World's Children' Report, UNICEF, 2009

⁴⁸ Miller CM, Gruskin S, Subramanian SV, Heymann J. Emerging health disparities in Botswana: Examining the situation of orphans during the AIDS epidemic. *Social Science & Medicine*. 2007 Jun, 64(12):2476-86.

⁴⁹ Engle, P., *National Plans of Action for Orphans and Vulnerable Children in Sub-Saharan Africa: Where are the Youngest Children?* Bernard Van Leer Foundation, The Netherlands, 2008.

⁵⁰ Data from State of the World's Children, UNICEF, 2009

⁵¹ UNICEF/UNAIDS/WHO/UNFPA Children and AIDS: 4 Stocktaking Report. Geneva, November 2009

children and youth have particular concerns such as adhering to their antiretroviral therapy (ART) regimes and worrying about their CD4 count. Two HIV-positive child informants reported that while ART is free, medication for related conditions is not and they could not afford to buy medication for skin rashes that were of great discomfort and concern to them as they potentially identified these children as being HIV positive.

The 2007 SADC Audit Report on mortality and morbidity indicates that the sexual and reproductive health status of people in the SADC region is relatively low. STI rates are high in countries where there is high mobility and migration, and are also linked to the rapid spread of HIV. Only one SADC Member State has legalised termination of pregnancy, and incidence of unsafe illegal abortion is high, especially amongst unmarried girls and young women.⁵² Indicators on adolescent health in general and reproductive health specifically, identify significant risks associated with this age. Risk of maternal mortality is higher for girls during adolescence; abortion rates are higher (both safe abortions and backstreet abortions); sexually active youth are likely to be exposed to multiple sex partners; girls are likely to be involved in relationships with older men and experience power imbalances and increased risk of domestic violence and rape; many girls report being forced or coerced into having sex against their will. More than 50% of all new HIV infections occur among children and youth aged 15 to 24 years. These are just some of the issues fuelling the need for comprehensive sexual and reproductive health services for adolescents and youth.

Children cited health services as the second most common component of assistance provided for OVC. Government and civil society service providers, children, youth and caregivers who were interviewed during the field assessment all reported that many OVC & Y are failing to access their basic right to health. One issue is cost. Whilst some have access to free health care (including ART), comprehensive and free access is not widespread across the region, to date only three Member States offer universal free access to comprehensive healthcare services. Other Member States provide free access for specific groups, including under-fives, pregnant women, senior citizens, and OVC. And some Member States have incorporated health care as a component of their NPA. However, even with specific mention of free services many OVC & Y lack the basic documentation, birth certificate or OVC registration, to allow such access.

Adolescents and youth face added challenges in accessing health services. When adolescents were asked if and where they had received sexual and reproductive health education, the results were rather disparate. Some information is available, from schools, parents, other relatives and caregivers, but there is no comprehensive cover. There are also legal barriers preventing children and youth from accessing services. In Zimbabwe, young people under the age of 16 are not legally entitled to seek medical treatment without being accompanied by an adult. In the Republic of Seychelles it is illegal for girls under the age of 18 to access contraceptives without parental consent, even though the age of sexual consent for girls is 15 years.

There are also some examples of outstanding initiatives that have scaled up the provision of health services to adolescents, including South Africa's National Adolescent Friendly Clinic Initiative⁵³ and Mozambique's multisectoral Geração Biz programme. The key message from both is that the scaling up of the provision of health services to adolescents in a sustainable way is clearly doable, but it requires deliberate and concerted effort.

WHO's Child and Adolescent Health Unit (CAH) is currently working with governments and national ministries of health in Malawi, the République Democratique du Congo and Tanzania to strengthen the way in which the way in which the ministry of health - and specifically the national HIV and AIDS and/or the national reproductive health programmes - address adolescents and young people. The Tanzania programme is the furthest ahead: approved quality standards have been integrated into existing workplans and budgets; activities to achieve the quality standards and expand coverage through actions at national, district and health facility level are being implemented; and monitoring of the implementation of activities at national and district levels, and quality and coverage at local levels is taking place.⁵⁴

⁵² Data from the SADC SRH Strategy (2008)

⁵³ Evolution of the National Adolescent Friendly Clinic Initiative. Case Study documented by WHO (CAH), 2008

⁵⁴ Child and Adolescent Health Progress Report 2008, Child and Adolescent Health Unit, WHO, 2008

Health care worker shortages continue to be a problem. Government key informants from some Member States reported that their governments have responded to the problem of health worker shortages by establishing community based service providers who receive basic training in nursing/first aid skills and are able to monitor child growth, do immunisation and support ART adherence. Such initiatives have been successful in increasing service delivery in more remote areas and in increasing health awareness and uptake of health services.

The field assessment revealed that many non-government service providers are assisting in the provision of health care services or facilitating access to healthcare services in SADC Member States. Interventions include home based care, contributions to or exemptions from health service user fees, collection of ART and adherence monitoring, home-based HIV counselling and testing, hygiene education, first aid and referrals.

4.3. FOOD SECURITY AND NUTRITION

Child under-nutrition remains stubbornly high in many Member States. Inadequate nutrition and overall food security was a significant concern emerging from the fieldwork. The majority of the children who participated in the focus groups mentioned hunger, being denied food and not getting enough food to eat as a regular part of their lives. The exceptions were children living in residential care or sheltered accommodation. Additionally, those receiving food assistance said it helped them stay healthy.

Many children across the region face immense challenges of food insecurity and poor nutrition. According to the World Nutrition Situation Report published in March 2004 Africa was the only continent unlikely to reach the MDG of halving its current level of under-nutrition of children under 5 years of age by 2015.⁵⁵ The prevalence of low birth weight in SADC Member States ranges from 9-17%; an average of 33% of all children under 5 years are stunted, 6.5% are wasted and 16.4% are underweight.⁵⁶ Micronutrient deficiencies of particular concern in the region are iodine deficiency disorders, vitamin A deficiency, and iron deficiency anaemia.⁵⁷ Early childhood malnutrition is irreversible and inter-generational, with consequences for adult health including impaired intellectual capacity, increased risk of diet-related chronic diseases, and reduced resilience to shocks. It affects school enrolment, educational attainment, and productivity, thus contributing to the cycle of poverty.

The combination of climate change and the global economic downturn have exacerbated the already tenuous livelihoods faced by the majority of both urban and rural households. Food insecurity and poor nutrition is intertwined with gender inequality, in that women usually bear the brunt of food insecurity at household level. In particular in the SADC region, there is a critical relationship between HIV and AIDS, food insecurity, malnutrition and protection: hunger increases the likelihood of HIV infection, as people are driven to adopt risky coping strategies in order to survive. Findings from a study in Botswana and Swaziland⁵⁸ showed that food insufficiency is an important risk factor for increased sexual risk-taking among women and the authors concluded that targeted food assistance and income generation programs in conjunction with efforts to enhance women's legal and social rights may play an important role in decreasing HIV transmission risk for women. Therefore for nutrition interventions to be successful they must tackle **gender inequality** at all stages of the life cycle to prepare women for a healthy and safe reproductive life. It is particularly important to protect the health and nutrition of girls and young women before pregnancy, and this can be done by improving their access to health, nutrition, education, and social protection programs during adolescence and early adult life.

⁵⁵ Africa Regional Nutrition Strategy 2005-2015, African Union 2005. P. 6-7

⁵⁶ State of the World's Children 2010, UNICEF. Table 2: Nutrition

⁵⁷ Food Security Assessment Research, USDA 2002, quoted in 'Africa Regional Nutrition Strategy 2005-2015', African Union 2005. P.9.

⁵⁸ Weiser et al, 2007. Food insufficiency is associated with high risk sexual behaviour among women in Botswana and Swaziland.

Southern Africa has the highest under-five mortality rate in the world. Over one third (an estimated 35%) of under-five mortality in the SADC Region is directly attributed to under-nutrition.⁵⁹ Certain groups of children are particularly vulnerable to nutrition problems. Infants (birth to 6 months) are extremely vulnerable if breast-feeding mothers are unable to provide sufficient milk or mix breast milk with often unsafe substitutes. The weaning phase, especially when women rapidly wean at six months because of HIV fears, is extremely risky. Older children receive fewer meals per day and consume food of poor nutritional value. According to the 2010 global Hunger Index, universal coverage of a package of preventive nutrition interventions for children under age two could reduce the global burden of childhood undernutrition by 25–36 percent.⁶⁰

Nutritional education is often talked about but there are few examples of programmes to address it. Food gardens were a popular intervention at one time, but there was little nutritional education attached to the programmes. Nutrition guidelines and interventions should respond to the different nutritional needs of children of different ages, and should acknowledge that good nutrition starts before birth. These guidelines should be coupled with training for caregivers on age appropriate food preparation and feeding practices to ensure that where possible children get the nutrition they require to grow and develop. Nutritional education in isolation will do little; alongside these interventions meaningful actions to increase household food security, through household and community level livelihoods support, is needed. It is essential to develop an integrated referral system to identify children suffering from extreme under-nutrition, to be referred to therapeutic feeding programmes and supported by trained health care providers.

Although food security is of major concern across the SADC region, and was noted as such by the majority of field assessment respondents from the government and non-government sectors, the Ministries interviewed did not report any significant food interventions. Some mentioned food handouts, but large-scale food distribution is usually only done during an emergency humanitarian response. Although one of the most common interventions reported by service providers, food is also described as one of the most difficult to provide, mainly in relation to the high cost and the extent of need. Whilst food assistance is well received by families and helps them meet their basic needs, caregivers and community level service providers reported food assistance is irregular, and in some instances food parcels are sold by the recipients.

School feeding schemes attempt to reach large numbers of vulnerable children and provide at least one nutritious meal a day. However, key informants reported that funding for school feeding has not been consistent and has led to schemes being cut back or stopped in some countries. Although school feeding schemes have encountered some problems, they are well received by children and parents. Teachers noted improved school attendance, better concentration and participation of children in class when the feeding schemes were operating.

The key informant interviews revealed a shift in thinking away from food handouts to longer term more sustainable livelihoods and economic strengthening interventions. In Zimbabwe DfID is funding a 5-year Protracted Relief Programme in the livelihoods sector that includes conservation farming methods and low input gardens. In Lesotho, there is a comprehensive food security programme in all the villages in the Tajane area supported by the FAO. Community level service providers in the Tajane area said they preferred this approach to food handouts, which had caused problems in the communities in the past, mainly because of unclear criteria for selection of beneficiaries.

4.4. PROTECTION

Save the Children defines child protection as measures and structures to prevent and respond to abuse, neglect, exploitation and violence affecting children. To date, interventions have focused on single issues in isolation; while this impacted the target group, the single-issue approach can fragment the child protection

⁵⁹ UNICEF 2008

⁶⁰ 2010 Global Hunger Index: The Challenge of Hunger – focus on the challenge of child under-nutrition. International Food Policy Research Institute, Concern Worldwide and Welthungerhilfe. IFPRI Brief Issue 65, October 2010. P.6

response, resulting in potential inefficiencies and pockets of unmet need. Increasingly, a more systems oriented approach is being advocated for.

The field assessment revealed several examples of national and community-level child protection mechanisms, including national, provincial and some district level coordination mechanisms in Mozambique, Child Protection Committees in Zimbabwe, Village Support Groups in Lesotho, Most Vulnerable Children Committees in Tanzania, and Community Structures in Zambia. However, in other countries child protection mechanisms are weak or non-existent, with children's issues falling between different ministries, a lack of coordination and insufficient human and financial resources.

4.4.1. VIOLENCE AGAINST CHILDREN

The majority of SADC Member States have provisions within the Constitution or other legal instruments that offer children protection from abuse. Usually, it is part of the penal code, creating an offence that is punishable by law if a child is sexually or physically abused.

Corporal punishment is widely used in Southern Africa as a method of disciplining children in school, at home and in care institutions. Evidence shows that individuals who experienced corporal punishment as children are more likely to demonstrate violent behaviour in later years, and are more accepting of violence against others. There is also evidence that youth who are corporally punished at school are at greater risk of becoming victims of other forms of violence, most concerning of which may be violence of a sexual nature.⁶¹

Corporal punishment by parents is not currently outlawed in any countries in Southern Africa. Humiliating and degrading treatment is also often used for disciplinary purposes. Parents and caregivers have traditionally regarded it as their 'right' to discipline children, even if this involves physical violence. In some countries in the region, the use of corporal punishment is authorised in schools, with regulations setting out how it is to be administered and by whom, a situation that is in contravention to the ARWRC. Six SADC Member States prohibit use of corporal punishment in schools, and a further two have draft legislation under development. Only four SADC Member States prohibit corporal punishment in the legal system (Malawi, Mozambique, Namibia and Seychelles).

Violence was a recurring theme in focus groups with children, with many reports of children being beaten by family members or at school. Sometimes this made children frightened and sometimes it made them angry. *"My mother beats me with a waist-belt"; "I am afraid to see violence like people stabbing each other"; "Some children are tortured by other children"; "I am afraid when I have done wrong and about to be given 3 strokes of the cane"; "I am feeling afraid when my father promises to beat me. This happens when I refuse to do some activities he asks me to do"; "I come home late, because my parents will beat me".*

Another form of violence that is experienced by girls in at least 2 SADC Member States⁶² is female genital mutilation/cutting (FGM). FGM is a deeply engrained tradition that affects millions of girls across the continent. However information is scarce and the practice is cloaked in secrecy. FGM is not only cruel, but has deleterious effects on the health of women and their infants. Women who have been subjected to FGM are significantly more likely to have complications during childbirth, and are at higher risk of experiencing obstetric fistula. Women affected by fistula are often rejected by their husband or partner, shunned by the community, and blamed for their condition.⁶³

Communities can play an essential role in addressing the problem of gender based violence. This has been demonstrated by Womenkind Worldwide, an NGO working in South Africa and Zimbabwe. The organisation supports men and women in providing physical and emotional support to women and girls who have experienced violence, particularly in the home. The programme also draws on the central role that culture and religion have in many African communities, providing training for traditional and religious leaders. By providing a forum for communities to discuss violence against women and girls, the project provides an opportunity for people to acknowledge that it is not acceptable. In doing so, it may help to address the

⁶¹ The 2003 South African Social Attitude Survey and the 2006 National Youth Victimization Study

⁶² *'Report on the International Girl Child Conference, 9-10 March, The Netherlands'*. Joint Publication of the UNICEF Innocenti Research Centre and the Government of the Netherlands, June 2009

⁶³ African Child Policy Foru, 2008, *The African Report on Child Wellbeing 2008*.

cycle in which violence is perpetuated by both men and women because they have come to regard it as normal. Women have seen marked improvements in attitudes towards protecting women and girls from violence.⁶⁴

4.4.2. SEXUAL ABUSE AND EXPLOITATION

Sexual violence in the region is widespread and it poses serious concerns to countries already grappling with the HIV and AIDS pandemic, yet there is no tracking system for tracking or measuring rates of violence against girls. In one SADC Member State, 40% of the 55,000 reported rapes in 2004/05 were against children – this equates to more than 60 children raped every day,⁶⁵ and in another country 59% of rapes of females in 2006 were on children. This is likely to be a fraction of the actual number of rapes, since it is estimated that only one in ten rape incidents is reported. Studies confirm that children who experience sexual abuse and sexual coercion suffer psychological effects that persist into adulthood and also endure long-term damage to their self-esteem and their sense of autonomy and, in some cases, serious depression.⁶⁶

Violence against women and girls is a serious and widespread problem. A 2006 report from the African Child Policy Forum on violence against girls demonstrates how girls' experiences of violence are accompanied by a lack of support from their families and communities. *'The harm that is inflicted by the violent act is compounded by the lack of a forum for women and girls to share experiences and views – with each other, and with men and boys'*.⁶⁷

Although it did not emerge in the course of this study, it should be acknowledged that boys may also be sexually abuse. Due to social and cultural taboos around men who have sex with men, as well as child sexual abuse in general, there is little information or data available in the region on sexual abuse of boys. However definitions, laws and policies should take both boys and girls into account.

Although all SADC Member States have legislation on sexual offences that outlaw rape and sexual abuse of children, these are difficult to enforce, due to weaknesses in the wording of the law, ambiguities over the age of sexual consent and a reluctance to intervene in the family environment. There are also problems with definition – for example, in many countries rape of boys is not recognised. Sexual abuse and exploitation of children is also difficult to address due to its “invisible” nature as it often occurs at home and is frequently unreported. Age of sexual consent and certain sexual practices fall within the realm of traditional practice and customary law. There are multiple inconsistencies between customary law and formal law, making it difficult to uphold formal laws over traditional practice. Women and girls who experience violence often face huge obstacles in trying to bring the perpetrators to justice. Many women are too intimidated by cultural attitudes and government inaction to seek redress for rape or other forms of abuse. Those who do often are confronted by a system that ignores, denies and even condones violence against women, and protects the perpetrators, whether they are state officials or private individuals. In several SADC Member States, there are reports of rape cases being settled out of court, when the perpetrator either pays compensation to the girl's father or pays a bride price and marries the girl to avoid bringing public attention and shame to the girl and her family. In other countries, women and girls who have been raped find that they are punished rather than receiving the support they need.⁶⁸

For children who are already living in precarious situations, abuse further exacerbates their vulnerability. Children who are abused at home may run away to live on the streets where they are prey to violence and

⁶⁴ Case Study: “Working with Communities to Challenge Violence Against girls”. Born to High Risk, African Child Policy Forum, 2006. P.43

⁶⁵ South African Police Services statistics taken from ISS website: http://www.issafrica.org/cjm/stats0906/_pdf/category/rape.pdf Quoted in ‘Social Protection in Eastern and Southern Africa: A Framework and Strategy for UNICEF, 2008. P.48

⁶⁶ African Child Policy Forum, 2006, *op cit*

⁶⁷ African Child Policy Forum, 2006, *Born to High Risk*

⁶⁸ African Child Policy Forum, 2006, *op cit*.

exploitation - girls may be forced to engage in commercial sex work in order to survive.⁶⁹ During the field assessment, children made direct references to child abuse, emotional, physical and sexual.⁷⁰

Evidence shows that the SADC region is also a source for trafficked persons. Poverty, war and political instability combine to increase the vulnerability of women and children making them especially vulnerable to trafficking. Women and girls are generally trafficked for sexual exploitation where boys and men are generally trafficked for forced labour. There is evidence of increased trafficking in the region in the build up to the 2010 Soccer World Cup.

4.4.3. CHILDREN WITHOUT PARENTAL CARE

Children without parental care are defined as all children not in the overnight care of at least one of their parents. They include children living in a wide variety of settings, including: residential care, with extended or foster families, in child-only households, in juvenile detention, on the streets or with employers and orphans. This is a broad definition which comprises both children at extreme risk and those who might be living with extended families as a result of traditional practice or community tradition. Significantly, there is not a clear picture of the number of children not living with parents, however figures that do exist suggest between 12% and 24% of children in SADC Region live with neither parent. These children are potentially vulnerable and any child protection strategy should carefully consider their needs.

4.4.3.1. CHILDREN LIVING AND WORKING ON THE STREET

A 2004 study carried out in Zimbabwe reported the reasons children left home to include: to earn and income or because of poverty at home, sexual and physical abuse, death or abandonment by a guardian or parent, and family breakdown. 39% of children in the study were orphaned; over 25% had never been to school, and 55% had no birth certificates; Child abuse is a major issue concerning street children - many had been sexually or physically abused at home and on the streets.⁷¹

There is little data available from Member States on children and youth living and working on the streets. National responses for OVC and NPAs themselves pay little attention to children and youth living on the streets. It is therefore important for the regional minimum package of services for OVC & Y not to overlook this extremely vulnerable group, and to make sure that services are extended to those children and youth, including assistance with registration and access to basic services (health, education, PSS) and protection.

4.4.3.2. CHILD HEADED HOUSEHOLDS

Accurate data is still not available for numbers of child headed households (CHH) in the region, but it is widely acknowledged that the numbers are growing because of HIV, armed conflict and extreme poverty. In several Southern African countries there are many de facto child headed households where the adult member(s) of the households do not live in the household for much of the time as they are away working – in another country, province, town, on the farms, etc. Children are increasingly taking on roles as caregivers and heads of households when their parents/carers die, and grow up with no adults to provide mentorship in knowledge and skills (e.g. vocational, health care, etc), counselling and emotional support.⁷² Increased economic and emotional strain, common amongst the orphaned and vulnerable, may increase the likelihood of these children engaging in risky behaviour, including exchanging sex for food or shelter and using drugs or alcohol.⁷³

⁶⁹ Save the Children UK, 2006, *op cit*.

⁷⁰ All researchers were guided by Save the Children's 'Child Safeguarding Policy' on how to respond to disclosures of abuse during FGDs with children.

⁷¹ Harare Task force on Children Living and/or Working on the Streets, Situation Assessment of Children Living and/or Working on the Streets in Harare and Chitungwiza, UNICEF, Harare, 2004. Quoted in 'Social Protection in Eastern and Southern Africa: A Framework and Strategy for UNICEF', UNICEF 2008. P.20

⁷² The Emerging Challenge of Children Heading Households: Some Reflections'. Speech delivered by Assefa Bequele, Executive Director, The African Child Policy Forum at the Opening Session of the 5th African Conference on Child Abuse and Neglect on HIV AND AIDS and Children: The Challenges of care for and protection of children in Africa organized by the ANPPCAN Uganda Chapter, Kampala, Uganda (27-29 March 2007).

⁷³ UNICEF, 2008, *Social Protection in Eastern and Southern Africa: A Framework and Strategy for UNICEF*

Children living in CHH grow up in permanent risk of neglect, violence, sexual assault and other abuses. Many have to fight to retain their access to their own property as neighbours and opportunists seek to take advantage of their difficult situation. They live in constant fear about their future as they are grappling with huge responsibilities, without possessing the required skills and experiences.⁷⁴ The field assessment revealed that in some communities a lack of parental guidance and discipline is resulting in social and emotional problems for children and youth. Concerns were raised about anti-social behaviour, teenage pregnancies, drug and alcohol abuse and a lack of respect for elders. States should work toward the legal recognition and legal protection of the rights of child-headed households.

4.4.4. ALTERNATIVE CARE

Alternative care refers to orphanages, babies' homes, orphan villages, and other institutional care for children, as well as foster care and adoption. Institutional care is widely referred to as a 'last resort' in responding to the care needs of children, largely because of the negative impact on children of long-term institutionalisation. Some governments in the region, including Namibia and South Africa, support community-based alternative care for children, but also recognise the need for residential care as a last resort. Namibia's Ministry of Gender Equality and Child Welfare has introduced Minimum Standards for Residential Child Care Facilities (March 2009).

Whilst there are some such positive examples, residential care facilities for children continue to emerge across the region.⁷⁵ Many are unregistered, and as a result their services are unmonitored and unsupported by national social welfare/social services departments. Concerns have been raised by organisations including Save the Children, UNICEF, World Vision, and the UN General Assembly regarding the care received in such facilities. Policies establishing standards of care and monitoring mechanisms for institutional care are extremely weak or non-existent in most SADC Member States. There is a need to improve formal care systems, to define and monitor minimum standards of care, and to guard against protection violations. Such oversight should utilise UN-endorsed guidance on provision of alternative care arrangements for children without adequate parental care.

The field assessment found that fostering and adoption are not widespread in the region due to traditional and cultural beliefs that place importance on family and clan relations. South Africa is the only Member State to have signed the Hague Convention on International adoption. In the absence of formal alternative care arrangements, the burden of care usually falls on the extended family, in spite of poverty and other problems they may be facing themselves. The field assessment found that, as indicated in the literature, high numbers of children who have lost one or both parents in the region very often end up living with a grandparent or elderly relative. The majority of caregivers who participated in focus groups were over the age of 60, female, and few had more than primary education. Older carers lack regular income support, especially in countries with no state pension scheme. They may also have difficulties in accessing poverty alleviation programs or OVC assistance programmes, as they are not the legal parent of the child. The elderly also experience the challenge of maintaining their own health in order to care for the children. The majority of OVC & Y service providers highlighted the need for training for caregivers in parenting and childcare skills.

JLICA's final report on children and HIV and AIDS⁷⁶ calls for 'a bold change in approach' that builds policies and programmes that support extended family and community networks in caring for children; the evidence from the field assessment reaffirms this need.

⁷⁴ Bequele, A., 2007, 'The emerging challenges of children heading households: Some reflections'. *5th African Conference on Child Abuse and Neglect on HIV AND AIDS and Children: The Challenges of care for and protection of children in Africa*, ANPPCAN Uganda Chapter, Kampala, Uganda (27-29 March 2007)

⁷⁵ Keeping Children Out Of Harmful Institutions. Corinna Csaky, Save the Children UK and the Save the Children Child Protection Initiative.

⁷⁶ Home Truths, JLICA, February 2009, p.9

4.4.5. LEGAL PROTECTION

4.4.5.1. CIVIL REGISTRATION

Across SADC there is a lack of high-quality birth and death registration systems, making it difficult for orphans to obtain official records “proving” they are orphans.⁷⁷ Birth registration is a key legal tool that can protect children from a range of protection violations, entitle child or family access to services and, in some countries, access to social assistance grants.⁷⁸ A parent’s death certificate is of particular importance to upholding a child’s right to property and inheritance. Many children affected by conflict, migration or HIV do not have these documents. The SADC region is one of the regions with the lowest birth registration levels in the world.⁷⁹ Lack of birth registration also impacts on the ability of a country to keep accurate statistics on births, making it more difficult to monitor the situation of vulnerable children and plan effective programmes to support them.

Reasons for poor levels of birth registration include: Lack of awareness of laws for birth registration; lack of effective policies and strategies for implementation of laws; General lack of awareness of the importance of registration by parents or caregivers; Time consuming, bureaucratic processes, lengthy delays; Lack of assistance, inaccessible staff and complicated forms; High costs involved; Inaccessibility of registration offices for those living in rural areas; Parents themselves are not registered and therefore have difficulty registering their children - this is particularly complicated by high levels of migration in SADC and the assumption that undocumented adults are immigrants; In spite of laws to facilitate registration for refugees, children of foreign nationals who are not documented in a country may be reluctant to have contact with the authorities; In some countries it is not possible to register a child born outside of wedlock; It may not be possible to register a child without the father’s identity document and consent; Children have become separated from parents due to civil strife, conflict, or external migration.

All Member States recognise the importance of birth registration, and have put in place legal frameworks to ensure mandatory birth registration. However implementation is very weak, ranging from 8% to 78% in SADC Member States (average 44.5%), and with significantly lower registration in rural areas compared to urban areas.⁸⁰ Certain countries have undertaken massive registration campaigns (Angola, Mozambique, South Africa, Zimbabwe), including mobile units to reach rural, and often most needy, areas of the country. Although improvements have been achieved, it is difficult and costly to sustain such efforts. Provisions need to be made to support children and youth who were not registered at birth to be registered later in life, and civil registration must ensure the ability to register children born out wedlock, children of foreign nationals, unaccompanied migrant children, and children who are separated from their parents.

Within the focus groups a number of children stated that they did not have birth registration documents, 1/3 in one focus group and ½ of another, the common reasons cited include: stigma, living in remote areas and long distances to travel as well as a lack of information about how to register, and lack of appropriate documentation.

4.4.5.2. INHERITANCE

In many SADC Member States women and children have no legal right to claim wealth or property, and thus experience greater vulnerability and poverty. This, in turn, increases the likelihood of them engaging in risky behaviour in order to gain access to food and income, of being exploited, and of becoming infected with HIV. In addition, ‘property grabbing’ on the death of an adult is common practice, with widows and

⁷⁷ Save the Children (UK) South Africa Programme - *Legal and Policy Frameworks to Protect the Rights of Vulnerable Children in Southern Africa*. South Africa, 2006.

⁷⁸ PEPFAR, Plan International, United Nations Children’s Fund (UNICEF) & World Vision, 2008, *Strategic analysis on civil registration in the context of HIV and AIDS*.

⁷⁹ UNICEF, September 2009, *Progress for Children: A Report Card on Child Protection Number 8, September 2009*

⁸⁰ Data from <http://www.unicef.org/infobycountry/esaro.html>

children being thrown out of the family home by relatives of the deceased, and frequently left destitute.⁸¹ This is a serious issue in heavily HIV-affected communities.

Girls and children born out of wedlock typically experience greater difficulties in realising rights to inheritance. In several SADC Member States women have no rights to inherit land, wealth and property when their husbands die, meaning many widows are left destitute. With increasing numbers of women widowed by HIV and AIDS and in need of family property on which to live and raise their children, there are increasing calls for new inheritance laws.

In three Member States: Malawi, South Africa and Zambia, legislation exists that provides children with a portion of the deceased's estate in the case of a parent dying without a will. In Malawi, the Wills and Inheritance Act was amended in 1998 to criminalise property grabbing and to provide better protection for orphans, vulnerable children and widows. There are now provisions for children to inherit from the estates of their deceased parents, whether born in or out of wedlock⁸². In spite of progressive legal reforms, in practice, many women and children are not aware of their legal rights or lack the resources, skills and confidence to challenge accepted custom. Children generally need an adult to represent them in the contractual dealings related to owning property, but when children become orphaned, this is difficult. The expense and difficulties of bringing such issues to court means that many children and women are unable to protect their property rights.

In relation to programming responses for legal services, only three CSO respondents reported providing legal assistance for OVC & Y. In spite of the significant challenges faced by OVC & Y in accessing justice.

4.4.5.3. JUVENILE JUSTICE

The ACRWC states that children who are accused of breaking the law have the right to legal help and fair treatment in a justice system that respects their rights. Governments are required to set a minimum age below which children cannot be held criminally responsible and to provide minimum guarantees for the fairness and quick resolution of judicial or alternative proceedings. UNICEF/UNDOC indicators⁸³ provide a common way of measuring and presenting information to reveal whether international legal standards are being met which includes a range of specialist juvenile justice system, an effective oversight and complaints mechanism and existence of a national plan for the prevention of child involvement in crime.

There are numerous examples of new and draft laws relating to juvenile justice in SADC Member States. Much work has been done regionally to develop diversion programming, alternative sentencing, community service, alternatives to deprivation of liberty and to incorporate standards in legislation. However, in some SADC Member states there is still an absence of children's courts and no alternative sentencing procedures. There is a lack of consistency around the age of criminal responsibility, and in some countries children are sentenced to confinement with adults in detention centres. There is also a lack of gender sensitivity in juvenile justice systems.

Respondents in the field assessment reported that some criminal justice systems are slow, especially when dealing with cases of child abuse. A lack of professional workers, such as social workers and probation officers, further delays the time it takes for cases to get to court. One key informant from a national Ministry of Justice reported problems related to resources and logistics, resulting in children staying in government care shelters for too long, and delays in getting children into foster care placements. Children who have suffered abuse are faced with significant barriers in accessing justice and in going through the various steps involved in the justice system. It can take 2 to 3 years for a case to come to court, during which time children continue to live in the same area or even the same household as their abusers; children are forced to testify in open courts, thus facing intimidation, lack of confidentiality, and to come face to

⁸¹ Save the Children (UK) South Africa Programme - *Legal and Policy Frameworks to Protect the Rights of Vulnerable Children in Southern Africa*. South Africa, 2006.

⁸² Save the Children (UK), *Legal and Policy Frameworks to Protect the Rights of Vulnerable Children in Southern Africa*, South Africa, 2006

⁸³ *Manual for Measurement of Juvenile Justice Indicators*, UNICEF / UNCOD, New York, 2006

face with the perpetrator; cases are dismissed due to inconsistencies in the child's testimony, caused by (a) lengthy delays; (b) lack of legal professional trained to work with children.

In response to such challenges, the Ministry of Justice in Mauritius is developing a new law that will cover all aspects of protection of the child and should speed up proceedings as well as ironing out any contradictions in the laws with regard to children. Similarly, the Law of the Child Act (2009) in Tanzania should improve the legal protection of children, which was previously spread between many statutes. The new law lays out a comprehensive system for ensuring justice for children, whether they come into contact with the legal system as offenders, witnesses or victims.

4.4.6. EARLY MARRIAGE

The ACRWC explicitly prohibits harmful social and cultural practices including child marriage and specifies a minimum age of marriage of 18 years. Early marriage increases the vulnerability of children. Girls who are married early are often forced to withdraw from school thus denying them an education and increasing the likelihood of perpetuating the cycle of childhood deprivation. With early marriage also comes increased likelihood of early pregnancy, with increased risks for the mother. Girls who marry early are more likely to be married to men older than themselves, with unequal power relationships within the marriage and increased likelihood of domestic violence including rape.⁸⁴ Girls who are married young are disproportionately affected by violence by their husbands and less likely to have knowledge about how to protect their own sexual and reproductive health.⁸⁵

High percentages of girls are married before they are 18: an average of 27% of all girls⁸⁶. It is not known what percentage of these early marriages contained an element of coercion. Early marriages occur more frequently in the poorest 20% of society, thus involving the most vulnerable children⁸⁷. Reasons for early marriage include parents seeking to "marry off" their daughters in exchange for money or goods (such as cattle or household goods), or in order to relieve the household of the burden of supporting them. It is a coping mechanism for many poor families – they create an alliance through their married daughter with a better off family. In some cultures early marriage is seen as a way of protecting the girl from HIV infection and men often seek younger wives as a means of avoiding infection.

Most SADC Member States have formal laws that set the minimum age of marriage at between 18 and 21 years. However, with parental consent, the minimum age can be reduced to 15 or 16 years, and as low as 14 in one Member State. Even where legislation is in place to regulate the minimum age of marriage, customary laws and practice often take precedent, especially in rural areas. In all SADC Member States, early marriages have traditionally been and still are frequent. Ensuring protection of children will require harmonising the laws with customs and educating communities on the rights of children and the inherent risks of early marriage and child rearing.

Girls in one Member State were very vocal about early marriage during the focus group: *"I am frightened when I saw young girls forced to get married. I become angry to see mothers and fathers who violate child rights by forcing them for early marriage. I do not know whether the same might happen with me"* (14 yr old girl)

4.4.7. CHILD WORK AND CHILD LABOUR

Sub-Saharan Africa has the greatest incidence of economically active children – 26.4 per cent of all 5-14 year-olds, or 49.3 million children.⁸⁸ Child work is common in the SADC Member States. According to SADC's 'Strategic Framework and Programme of Action for OVC & Y', research shows that over 95% of child work takes place in and around private households in the forms of domestic chores, farm work or petty sales and services on behalf of the household. Societies in the SADC region place a high value on children working at home or on the family farm, and this is not perceived as harmful, rather as socially necessary

⁸⁴ UNICEF, 2005, *op cit*.

⁸⁵ Pinheiro, P.S, 2006, *op cit*.

⁸⁶ Data from State of the World's Children, UNICEF 2009. Data only available for 11 Member States.

⁸⁷ UNICEF, Early Marriage - a harmful traditional practice: a statistical exploration, 2005

⁸⁸ <http://www.ilo.org/ipec/Regionsandcountries/Africa/lang--en/index.htm>

work that is of benefit to the child. Work is problematic when it is hazardous, interferes with a child's education or is harmful to a child's physical, mental, psychological or social development. The term child labour is used to describe economic exploitation that is damaging to the child.

Poverty is a driving force behind children becoming engaged in child labour. Thousands of African girls and boys earn money to support their families or themselves, often in highly exploitative conditions. Gender differences exist to different extents in different countries. In addition to being denied an education, domestic workers face high levels of physical, sexual and psychological abuse.

Although the majority of the OVC & Y met with during the field assessment said they were not working, they undertake various tasks as part of everyday life such as looking after siblings, fetching water and firewood. Many also may have long distances to walk to and from school. Some of the children worry about being given hard physical labour such as digging pits for latrines or cutting firewood (which the girls refer to as boys work). Some children reported being sent to work on the rubbish dumps by their parents, to look for food and valuables. One boy reported that he is worried about "*being taken out of school to help the family survive*".

A critical gap is the lack of work opportunities for youth. Respondents in several Member States talked about this and some youth talked about being exploited in the labour market by being underpaid. Key informants agreed that vocational training skills are vital for youth to enable them to find employment in the formal or informal sector.

4.4.8. UNACCOMPANIED MIGRATION

Children often cross borders unaccompanied as a survival strategy. Reasons for unaccompanied migration between SADC Member States include seeking work opportunities and seeking out extended family following the death of a parent or caregiver.^{89,90} Children are extremely vulnerable when they migrate, particularly at border crossings and upon arrival in host countries. They are especially vulnerable to abuse, violence and exploitation due to their age and undocumented status in the host country. Research has also revealed that once they reach their destination country, children and youth face difficulties including exploitative labour, lack of protection, limited access to schools and health services, coercion of girls into the sex industry, discrimination and harassment - all related to their illegal status. Many of these children are not registered even in their country of origin and do not have identity documents, thus increasing their vulnerability further.⁹¹

Migrant children living outside their country of origin who participated in a focus group reported having crossed the border with no identity documents. Before staying at the centre where they are now, they reported sleeping on the streets, wary of 'thugs'. Some were involved in drug taking and theft. The boys were happy to now be attending school, but complained about being treated 'differently' because they are foreigners. They also worry about what happened to their brothers and sisters as they are unaware of their whereabouts.

Whilst all SADC Member States have ratified the CRC, ACRWC and the Convention on Refugees, national legislations do not cover all aspects of the Conventions. There is a need for better cross-border co-operation to protect all children at risk, and not only children who are trafficked; governments continue to devote most of their resources to child trafficking, even though much smaller numbers of children are involved.⁹²

South Africa, which is host to large numbers of migrant children, especially from Mozambique, Zimbabwe and Lesotho, is one of the few countries that makes provision for nonregistered, undocumented foreign children. The Child Care Act of 1983 states that 'foreign, unaccompanied children should be cared for by a

⁸⁹ Save the Children UK, 2007, *Children on the Move*

⁹⁰ Glynis Clacherty, 2003, *Poverty made this decision for me: Children in Musina: their experiences and needs*

⁹¹ Save the Children UK, 2006, *Visitors from Mozambique – a preliminary study outlining the risks and vulnerabilities facing Zimbabwean children who have crossed illegally into Mozambique*

⁹² *Regional Seminar on Children who Cross Borders in Southern Africa*, convened by Save the Children, Johannesburg, South Africa, May 2009.

social worker, placed in a place of safety and returned to parents or found a foster care alternative in South Africa'. However in practice, law enforcement officials often view these children as illegal minors to be deported as soon as possible.

4.4.9. SUBSTANCE ABUSE

Substance abuse was identified by some key informants as a risk facing vulnerable children and youth, though there is little evidence of preventive and responsive interventions targeting vulnerable youth. Substance abusers tend to be viewed as criminals, and sentenced accordingly, rather than rehabilitated. This underscores the need for psychosocial support. A comprehensive approach might integrate substance abuse awareness into in- and out-of-school lifeskills education for children and youth, target vulnerable groups with diversionary activities such as sport and recreation, livelihoods interventions, train social workers, teachers and health workers to recognise signs of substance abuse, and offer counselling and rehabilitation to substance abusers.

The Ministry of Youth in Mauritius is running a large scale pilot project targeting school drop-outs, children from the probation service, and other vulnerable children and youth. The programme offers beneficiaries lifeskills and leadership development, and teaches youth how to create their own small business, as well as engaging young people in community service. Youth Centres have been constructed (with full time trained youth officers) to provide a full range of educational and recreational activities. Special programmes are organised during school holidays for recreation, leisure and sports activities. There is also a Lifeskills Education Programme to equip young people with information and skills that are necessary to help them face the challenges of daily life (including a peer education component). Whilst not specifically aimed at preventing or responding to substance abuse, programmes such as this play an important role in preventing negative and anti-social behaviours amongst vulnerable children and youth.

4.5. SOCIAL PROTECTION

Social Protection represents a set of actions that address poverty, vulnerability and exclusion as well as provide means to cope with major risks throughout the life cycle. Social protection interventions can act as a safety net to assist the most needy during times of extreme stress, and can also increase the productivity of poor families and facilitate their participation in and contribution to the economy. Social protection systems may provide income or consumption transfers to the poor, protect the vulnerable against livelihood risks, and enhance the social status and rights of the marginalised'.⁹³

An estimated two thirds of the population in the SADC region live below the international poverty line,⁹⁴ and high levels of unemployment are experienced in the region ranging from 25% to above 80%.⁹⁵ Poverty is particularly acute for certain groups of children and youth, these include households headed by children, women, older people, people living with disabilities and/or HIV and AIDS and the unemployed. In many SADC Member States, extended families have assumed responsibility, with little or no support, for more than 90% of all orphans not living with a surviving parent.⁹⁶ These households experience disproportionate levels of household poverty often little or no support.

The SADC Regional Indicative Strategic Development Plan identifies gender as a cross-cutting issue in addressing poverty reduction in the region. Since women bear the greatest responsibility for children's care and protection, children can be more vulnerable in situations where women have limited access to independent livelihoods and/or the distribution of power and resources within the household is particularly

⁹³ Sebates-Wheeler, R. & Pelham, S., 2006, *Social Protection: How Important are the National Plans of Action for Orphans and Vulnerable Children?*

⁹⁴ SADC Strategic Framework and Programme of Action: Comprehensive Care and Support for OVC & Y, 2008-2010, P.3

⁹⁵ SADC Strategic Framework and Programme of Action: Comprehensive Care and Support for OVC & Y, 2008-2010, P.13

⁹⁶ UNICEF, 2006, *op cit*

inequitable. This is the case across the region as many women have limited access to land, security of tenure and credit. Furthermore, income generation and development are inhibited.⁹⁷ Land tenure is often controlled by customary law, and these laws often disadvantage women. This affects female and youth entrepreneurs and women and young people who want to start or expand their own businesses, thus further restricting opportunities for vulnerable female and youth-headed households to improve their situation.⁹⁸

Children's experiences of poverty and vulnerability differ from those of adults. Children are often more vulnerable to malnutrition, disease, abuse and exploitation than adults. Children also require different types of support. Interventions such as targeted school fee waivers, school feeding, integrated social welfare services and cash transfers can ensure that orphans and other vulnerable children and youth access their right to survival, education, health and protection, and in turn allow them to realise their full productive potential as adults.

Although the education, health, food security & nutrition and protection services and interventions help to address many challenges faced by vulnerable children and youth, they do not cover all. Among these are:

- nutrition beyond what is provided by clinic or school feeding programmes
- clothing needs beyond school uniforms provided by education programmes
- shelter needs for families
- human rights relating to privacy (i.e. freedom of choice of consumption) to reduce the risk of social exclusion and to enable vulnerable children and youth to live in the same way as non-vulnerable children and youth
- human rights relating to family life – ie continuing to live in a family rather than entering institutional care in order to meet basic needs

These needs can be addressed by the provision of **social transfers**, ideally in cash, but also in kind – and these will directly help to break the intergenerational transmission of poverty. The comprehensive review of the evidence base on children and AIDS consolidated by the Joint Learning Initiative on Children and AIDS (JLICA) argues that national social protection policies are the best tools to provide vulnerable families with basic economic security and shows that income transfers in particular can be an especially effective approach as the leading edge of a broader social protection agenda.⁹⁹

In the last 10 years a number of SADC Member States have introduced social protection systems, covering different groups of the population, particularly children, pensioners, persons with disabilities and the poor, though different countries have programmes for different population groups. Generally these programmes are state-funded. In some cases they are universal, intending to cover every member of the relevant group (e.g. pensions); in other cases they are targeted and entitlement depends on the family or individual's wealth status. In some countries social protection programmes exist in only some geographical areas.

There are several positive examples of social protection interventions that target OVC & Y in the SADC region. Under Botswana's 'Social Benefit Payment and Reconciliation System' orphans are registered and are eligible to receive monthly food baskets and a cash allowance. In some cases they also receive free school uniforms, housing, clothing and a waiver of school fee. Botswana's 'Revised National Policy on Destitute Persons' targets the poor and vulnerable, including children under the age of 18 without parental support and not receiving orphan support. Beneficiaries receive monthly cash support. Lesotho's 'Children's Protection and Welfare Bill' (2004) allows for exemption for orphans from fees for health and nutrition services. Malawi's 'National Safety Nets Strategy' (2002) provides grants to districts, which in turn target vulnerable households. Mozambique operates a 'Food Subsidy Programme' under the Ministry of Women and Social Action, whereby households where the head of the household is unable to work, is an older

⁹⁷ Save the Children (UK), *Legal and Policy Frameworks to Protect the Rights of Vulnerable Children in Southern Africa, South Africa, 2006*, P.12

⁹⁸ *SADC Gender Monitor 2009: Tracking Implementation of the SADC Protocol on Gender and Development*. SADC Gender Unit, Gaborone, Botswana, 2009, P.42

⁹⁹ JLICA < 2009, *Home Truths: Facing the Facts on Children, AIDS and Poverty*.

woman or man, is physically handicapped or chronically ill can access monthly cash transfer as a food subsidy. Malnourished pregnant women are also targeted. In Swaziland the 'Neighbourhood Care' Programme has been established by UNICEF and NGOs to provide social assistance to children with critical needs. Zambia's 'Social Assistance Scheme' aims to target the poorest 2% of the population.

4.5.1. SOCIAL TRANSFERS

Social transfers are regular, predictable transfers (cash or in kind, including fee waivers) from governments and community entities to individuals or households that can reduce child poverty and vulnerability, help ensure youth, children and caregiver's access to basic social services, and reduce the risk of child and youth exploitation and abuse.¹⁰⁰ Social transfers that benefit OVC & Y include unconditional cash transfers (where transfers of cash are made without condition to individuals or households identified as highly vulnerable, or poor), conditional cash transfers (where the receipt of the cash may be linked to the precondition to send a child to school, or to immunise a child), near cash transfers or in-kind material support to vulnerable households programmes. Examples of social transfers include old-age-pensions, disability grants, child support allowances, foster grants, exemptions from health user fees, education fee waivers, school feeding, agricultural inputs, assets and food distribution. There are nearly always strict criteria related to accessing benefits, such as poverty status, presence of a disability, chronic illness or age related criteria.

The field assessment revealed many examples of social transfer schemes across the region, including: material support for OVC in the form of clothing and food parcels and stipends and access to medical care; maintenance grants; food subsidies; and unconditional cash transfers. Key informants and focus group participants expressed widespread support for cash transfers, with respondents describing a marked difference between those families that receive cash grants and those that do not. *"Where the household is the beneficiary of cash grants, we are beginning to see some positive changes. Children have been able to return to school and have at least more than one meal per day"*. Cash transfers have enabled families to meet more of their basic needs.

In South Africa, the social cash transfer system has reduced the poverty gap by 45% and in Mozambique the urban cash transfer programme increased the household incomes in poor towns by 41%. Cash transfer programmes in Africa have led to improved nutritional status among children due to increased dietary diversity (e.g. Malawi) with less sickness among children, reduced child labour (also Malawi) and led to increased investment in productive assets (Zambia).

Context-specific needs-driven social transfers that benefit OVC & Y are being implemented in the majority of SADC Member States – either as part of the national development agenda (through National Poverty Reduction Strategies), in the form of a NPA for OVC, or through specific social protection policies and mechanisms. While some programmes do exist, there is a need to document examples of good practice in child-sensitive social protection to enable countries to scale up more quickly should they choose to do so. Some regional examples include Botswana's 'Social Benefit Payment and Reconciliation System', Lesotho's 'Children's Protection and Welfare Bill' (2004), Malawi's 'National Safety Nets Strategy' (2002), Mozambique's 'Food Subsidy Programme', Zambia's 'Social Assistance Scheme', Tanzania's 'National Costed Plan of Action for OVC' and South Africa's range of welfare grants. However, across the region such schemes are patchy and do not reach large numbers of OVC & Y and caregivers. Coverage is limited and many children face challenges in accessing support. Reasons include lack of identity documents, lack of awareness of available benefits, travel constraints and backlogs in processing applications.

No examples were found during the field assessment of social protection mechanisms that specifically target vulnerable youth.

¹⁰⁰ 'Joint Statement on Advancing Child Sensitive Social Protection', DFID, HelpAge International, Hope & Homes for Children, Institute of Development Studies, International Labour Organization, Overseas Development Institute, Save the Children UK, UNDP, UNICEF and the World Bank, June 2009, Page 3

4.5.2. LIVELIHOOD INTERVENTIONS

Livelihoods interventions are promotive programmes that build human capital and income earning capacity among the poor and marginalised, such as skills training, active labour market programmes, public works projects (cash for work or food for work schemes), and microcredit programmes. Of particular importance to OVC & Y are interventions that increase caregivers' access to employment or income generation, and preparing adolescents for their own livelihoods, taking account of their role as current and future workers and parents. Such interventions also play a vital role in reducing child labour.

The field assessment found several examples of small-scale income generating activities being implemented at community level to support OVC & Y and their caregivers – mostly food production. There is also a shift in thinking amongst CSOs away from hand-outs and towards an increased focus on economic strengthening of vulnerable households.

4.6. PSYCHOSOCIAL SUPPORT SERVICES

Psychosocial support is about helping children, families and communities to improve their social and emotional well-being. The growing numbers of OVC & Y in the SADC Region has focused attention on the need to provide support to children who slip through the cracks of increasingly stressed extended families. This has led to the development of programmes that target children affected by HIV and AIDS and OVC & Y with psychosocial interventions both standalone and alongside existing work. For a child, when psychosocial support is successfully mainstreamed the child will feel socially and emotionally supported in every aspect of their lives. The psychosocial needs of children vary by gender and age and across different social, economic and political contexts, therefore, an understanding of the culture is of fundamental importance in planning programmes.

When asked what made them happy, the majority of young respondents described every-day things that many people take for granted such as receiving food, going to school and receiving love and attention from parents or carers. Things that made them sad include loss of a parent or family member, and things that made them angry include being shouted at, beaten, denied food at home, when people say bad things or tell falsehoods about them, when they experience stigma and discrimination (for being 'orphans', HIV positive, having disabilities, etc.).

All key informants in the field assessment were asked to define psychosocial support, as they understand it in the context of the country and environment in which they work. Many respondents did not give definitions, but instead gave examples of services that they consider to be psychosocial support. Of those that did give definitions, no two definitions were the same. However there were common themes. Fifty-eight out of sixty-seven key informants said their organisation provides psychosocial support, mostly to children, with very few providing services for vulnerable youth and caregivers (although there is recognition of the need). Only one organisation reported providing services for children under the age of five years, revealing a gap in service provision for younger age groups. The research revealed a complete lack of gender-specific interventions. Not one respondent described services or activities that are designed to address the needs of particular gender-defined groups of vulnerable children and youth (e.g. married girls, girl mothers, unemployed male out of school youth, etc).

A range of services and activities are provided for OVC & Y under the auspices of psychosocial support – thirty-three different services in total. The most frequently provided services are support in the home through the training of caregivers to meet psychosocial needs, counselling, children and youth clubs, sport, recreation and play for children and youth - mostly as stand-alone activities. There are very few specialised psychosocial interventions by governments or CSOs, these require in-depth, long-term training and specific delivery and are relevant to those experiencing mental illness or extreme trauma. This is generally a small portion of the population, however in large emergencies this number will grow. 75% of interviewed CBOs that provide a range of psychosocial services for OVC & Y at the household and community level are not aware of any guidelines or frameworks that can support their work. The most commonly cited tool being

used is REPSSI's *Journey of Life*.¹⁰¹ Whilst it is acknowledged that psychosocial support should be needs based and culturally appropriate, there is an urgent need for some standard definitions and guidelines, as well as quality standards.

One of the most important aspects in promoting psychosocial wellbeing is to facilitate conditions for community mobilisation, ownership and control, in order to strengthen the family and community's ability to care for their children. In addition to this promotive approach, there is also a need for specialised referral services. Children who are struggling to cope within their existing care network, who are not progressing in terms of their development, or are unable to function as well as their peers may require specialised care that addresses their psychosocial needs more directly and is implemented by specialised staff. Specialised referral services are lacking / inaccessible in many Member States.

REPSSI started from a regional initiative which was meant to scale up psychosocial care and support for children affected by AIDS in 2001 in Masiye Camp Salvation Army, Zimbabwe by a diverse group of practitioners, children, youth, managers and academics from organizations responding to the orphan and vulnerable children crisis.

In May 2002, with financial support from a consortium of three donors i.e. the Swiss Agency for Development Cooperation (SDC), the Novartis Foundation for Sustainable Development (NFSD) and the Swedish International Development Agency (SIDA), the Regional Psychosocial Support Initiative (REPSSI) was formally launched as a project to improve and scale up psychosocial support for children affected by AIDS (CABA) in the East and Southern Africa (ESA) region.

The initiative soon evolved to include improving and scaling up psychosocial support to children affected by conflict as well as poverty. Using a successful partnerships model, REPSSI currently provides technical assistance for psychosocial care and support in 13 countries including Angola, Botswana, Kenya, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe.

OVC & Y who were consulted during the field assessment expressed the importance of socialising with other children and youth, especially in support groups for those sharing similar problems such as children who have lost one or both parents, and children living with HIV. Going to school appears to meet this need for many young people. Whilst some OVC & Y generally confide in family and friends, there were worryingly some who have no one to confide in. Caregivers, overstretched with household chores and trying to meet basic needs, were difficult to engage in serious discussions around the psychosocial needs of children and youth. The OVC & Y respondents belong to a variety of support groups and clubs, some of which provide for material needs and vocational training and others are recreational and social. All those belonging to groups perceive them as having value both in practical terms and for interpersonal relationships. Sometimes a group/NGO or club leader is the person that a child confides in.

5. CROSS SECTORAL ISSUES

There are a number of cross-cutting issues that affect the survival and wellbeing of orphans and other vulnerable children and youth. These issues are discussed individually below, but should be addressed in an integrated and holistic manner, using a multi-sectoral approach.

¹⁰¹ 'Journey of Life: A Community Workshop to Support Children'. REPSSI, Dr Jonathan Brakarsh and the Community Information and Inspiration Team, Bulawayo, Zimbabwe, 2004

5.1. HIV AND AIDS

There are huge variations in HIV prevalence and infection rates between and within countries. It is estimated that 3.0% of young men age 15-24 and 8.8% of young women age 15-24 living in the SADC Region are HIV positive. Only 37% and 35% of young men and women respectively in SADC Member States are reported to have comprehensive and correct knowledge about HIV and how to avoid transmission.¹⁰² The estimated number of children in the SADC Region in need of antiretroviral therapy is 297,600. Of these, nearly 150,000 are already receiving treatment – 50% of those in need.¹⁰³ Significant progress has been made in some SADC Member States in improving access to PMTCT for HIV-positive women.

HIV and AIDS have compounded existing vulnerabilities experienced by children and youth in the SADC Region and reversed human development gains scored in the past few decades. Children affected by AIDS face socio-economic challenges such as the lack of adequate food, money for school related expenses, poverty abuse and exploitation.

HIV and AIDS disproportionately affects women and girls compared to men and boys. Infection and prevalence rates are higher amongst girls and women, and the resultant hardships caused by the illness or death of a breadwinner hinders the development of girl children. Girls are hindered from accessing education and are frequently required to drop out of school to take care of ailing family members.¹⁰⁴

Interventions across all sectors need to ensure that they do not increase risk of infection and where possible look to help reduce the threat of infection.

5.2. GENDER

As highlighted throughout the previous sectoral reviews, girl children and women are at particular risk due to the threats of HIV, globalisation, human trafficking, the feminisation of poverty, gender based violence, as well as prejudicial and harmful social, cultural and religious practices, attitudes and mindsets.

Children's options are closely associated with the wellbeing and social position of women – women take primary responsibility for raising and caring for children and research has shown that the material condition, health and nutrition of children are positively associated with the skills, education and income of women.¹⁰⁵ The SADC region is premised on historical patriarchal values that tend to disadvantage women and result in women having diminished status and access to resources, and limited decision making powers. In a region where more than 34% of households are female-headed, the lack of legal protection for women has a critical impact on women's ability to protect their children. Women's lack of property rights and financial independence increases their vulnerability to poverty, exploitation, violence and ultimately, HIV infection.

Orphan girls face double discrimination. They may also be burdened with caregiving responsibilities for family members, resulting in school drop out. Several studies have shown that orphaned girls tend to engage in risky activities and behaviours as coping strategies, which may increase their vulnerability to HIV infection (e.g., working as domestic workers and commercial sex workers in exchange for food, clothing, and other basic survival necessities.)

There has been an alarming increase in the number of rape cases of young girls in some Southern African countries, some of which are motivated by the myth that having sex with a virgin is a cure for HIV. Studies done by UNICEF, UNAIDS and WHO in Malawi, United Republic of Tanzania, Zambia and Zimbabwe indicate that two thirds of all newly HIV infected 15-19 years old in the sub Saharan are females.

¹⁰² UNICEF/UNAIDS/WHO/UNFPA, 2009, *op cit*.

¹⁰³ *Towards Universal Access: Scaling up Priority HIV AND AIDS Interventions in the Health Sector, Progress Report 2009*. UNAIDS, UNICEF and WHO. WHO, Geneva, 2009. Annex 2, P.139

¹⁰⁴ SADC Gender Monitor 2009

¹⁰⁵ Save the Children UK, 2006, *op cit*

More work needs to be done to look at the role of boys and men in caring for children, and their role in reducing violence against girls and women.

5.3. CHILDREN AND YOUTH WITH DISABILITIES

Article 23 of the CRC states that children who have any kind of disability have the right to special care and support, as well as all the other rights in the Convention, so that they can live full and independent lives. The Charter of Fundamental Social Rights in SADC states that 'Member States shall create an enabling environment such that all persons with *disabilities*, whatever the origin and nature of their *disability*'. However it does not speak to the specific needs of children and youth with disabilities nor to the risks they face, risk mitigation or protection.

Children and youth with disabilities are extremely vulnerable to abuse, neglect and maltreatment, often because parents / caregivers lack support and do not know how to address their children's special needs. Children with physical disabilities are 3-4 times more likely to be abused than able-bodied children.¹⁰⁶ Children and youth with disabilities also face stigma, discrimination, marginalisation, and have diminished capacity to access their rights, survival and development. The Southern African Federation of the Disabled's Children and Youth Programme has identified the problems faced by young people with disabilities as lack of opportunities and chances to develop and lead a full social life, negative attitudes, vulnerability to abuse, limited employment opportunities, lack of access to information and social support.¹⁰⁷

Issues affecting children with disabilities are often marginalised or given inadequate consideration by lawmakers, and they are largely absent from NPAs. The SADC Strategic Framework and Programme of Action for OVC & Y does not identify disability as a specific vulnerability. In most SADC Member States children with disabilities have a constitutional right to social welfare services, but these services are currently not inclusive in the sense of being oriented towards children with disabilities having their needs met and their rights protected in society.¹⁰⁸ Children and youth living with disabilities are largely hidden and accurate data is not available for most SADC countries. In the 2010 State of the World's Children Report (UNICEF, 2009) data is only available for one Member State, where 14% of 2-9 year olds screen positive for at least one of the questions on disability in the DHS.

Children, youth and caregivers with disabilities need considerable support. Not only do they require specialist services related to disability, but also general services such as health promotion and education. To date, little has been done to provide such support.

5.4. CHILD AND YOUTH PARTICIPATION

Children's participation includes children being informed about their rights, being able to express their views freely in all matters affecting them, and having these views explicitly taken into account. It concerns matters affecting children as individuals, as well as collectively.¹⁰⁹ However, meaningful participation of children in affairs of state, society, community and family is extremely rare in SADC Member States, even though child and youth participation was cited by NGOs as the 3rd most common area in which they conduct advocacy.

Children can best articulate their own needs and desires. Some groups are more difficult to involve. Young children, children and youth living with disabilities, children who are separated from their parents, unemployed out-of-school youth, among others, find it particularly difficult to claim their right to be heard.

¹⁰⁶ 'From Sidelines to Centre Stage: The inclusion of children with disabilities in the Children's Act'. A children's Institute Case Study (Number 4, University of Cape Town, October 2009).

¹⁰⁷ http://www.safod.org/Programmes/children_youth.htm

¹⁰⁸ 'From Sidelines to Centre Stage: The inclusion of children with disabilities in the Children's Act'. A children's Institute Case Study (Number 4, University of Cape Town, October 2009).

¹⁰⁹ Save the Children Sweden, 2010, *Children's right to be heard and effective child protection. A guide for Governments and children rights advocates on involving children and young people in ending all forms of violence*

Often practitioners may be interested in involving children, but many in the child and youth sectors are not confident about how to practice the ideals of meaningful and well-informed participation of children and youth, and opinions vary widely regarding the specific objectives of young people's participation and thus appropriate approaches.

SADC Member States' reports to the Committee on the Rights of the Child and the Committee's concluding observations show common challenges and universal issues in the implementation of the child's right to be heard. Failure of meaningful child and youth participation is often attributable not to a deliberate denial of children's rights, but rather to existing ideas and attitudes about children. Adults do not question, challenge or seek to change beliefs they have grown up with because they have internalised them. Such attitudes include the need to not undermine parental authority, respect for elders, social attitudes about the role and capacities of "the young" and adults' lack of confidence about how to ascertain children's views or the fear that participation is risky, time-consuming and a diversion from "real" work. Ensuring meaningful child and youth participation is not just about changing laws and policies and creating opportunities; it has to involve behaviour change communication to address entrenched attitudes and traditional beliefs.

Several organisations interviewed during the field assessment said that children and youth need to be more involved in programmes that support them and in development itself. However few examples were reported. A recent review of child and youth participation by RIATT aims to offer guidelines to RIATT and SADC members as to how to extend thinking and practice in child and youth participation within the organisation and through implementing partnerships.¹¹⁰

5.5. EMERGENCIES

Emergency situations weaken the traditional social and security safety nets for children. Organised care and support has been relatively quick in responding to the material/physical and educational needs, which have more 'tangible' outputs. However, holistic child development demands more. Psychosocial interventions addressing post-humanitarian emergency recovery aim to assist children and their families who have experienced severe stress to restore their social and psychological health and prevent more long-term social and mental health problems.

Children are at increased risk of various problems in emergencies, in particular separated or unaccompanied children, children recruited or used by armed forces or groups, children who live or work on the streets and undernourished/under-stimulated children. Children may experience disruption of normal development, break up of families, threats to their security, their trust in humankind may be threatened, and their sense of hope for the future may be undermined. However, not everyone develops significant psychological problems in response to humanitarian emergencies. Many people, including children, show resilience and are able to cope relatively well in situations of adversity, especially if family and community structures have resources that offer protection and support. The primary focus of psychosocial interventions is on restoring as quickly as possible resilience in the face of challenging circumstances.

5.5.1. CONFLICT

The CRC stipulates that Governments must do everything they can to protect and care for children affected by war. Children under 15 should not be forced or recruited to take part in a war or join the armed forces. The Convention's Optional Protocol on the involvement of children in armed conflict further develops this right, raising the age for direct participation in armed conflict to 18 and establishing a ban on compulsory recruitment for children under 18.

War and political instability have severe negative impacts on children and have resulted in significant numbers of OVC & Y in the SADC Region. Conflict in Angola, DRC and Mozambique has left a legacy of children and youth with disabilities. Many more have experienced trauma, mental health and psychosocial

¹¹⁰ Child and youth participation in East and Southern Africa: Taking stock and moving forward. Rachel Bray, November 2009 (DRAFT)

problems caused by witnessing or experiencing violence and abuse. These challenges increase the vulnerability of children and youth and affect their ability to access their rights, including the right to survival and development, access to education and health, right to adequate food and shelter, and unmet psychosocial and emotional needs.

Post-war societies tend to exhibit high levels of trauma and violence, destructive relationships and work patterns, especially related to alcohol abuse and the proliferation of firearms, an increased risk of prostitution, child trafficking and suicide¹¹¹. Reports from different countries, including SADC Member States, recount a rise in post-conflict tensions relating to domestic violence, child abuse and a general rise in interpersonal violence and crime, especially in the families of the ex-military¹¹².

Wars are likely to result in population displacements. Eighty-two percent of ex-child soldiers interviewed in one SADC Member State and 44 percent in another¹¹³ were displaced at least once. Displacement increases the vulnerability of communities, family units, children and youth, and appears to contribute to increased gender based violence and exploitation. Displaced children are more likely to be victims of crime more likely to be beaten and robbed¹¹⁴. Children who have been separated from their families are extremely vulnerable to age and gender based violence. Separated boys are especially vulnerable for re-recruitment, especially if the political situation remains volatile.

Research in SADC Member States indicates that child soldiers and former child soldiers seem to be faring worse than other war affected children. They have more restricted access to clothing and footwear, have poorer nutritional status, and are less likely to attend school regularly. At the same time, they have a higher probability of starting their own households. This means that not only are they more disadvantaged but that they have an additional burden of supporting others.

Interviews with children suggest that they are exposed to greater hazards than adults during conflict. Children report that those who are sick or wounded are rarely given medical assistance and are often left to die. The use of rape and sexual abuse as weapons of war is well documented, increasing the risk of girls and women to contracting HIV and other sexually transmitted diseases. Girls have been abducted during conflicts and forced to fight, work as servants or become sexual slaves for combatants. There are reports of girls in refugee camps being abused by the people who should have been working to protect them. Testimonies from ex-child soldiers in one SADC Member State report that girl soldiers died from abortions, pregnancy and childbirth, and girl and boy soldiers died from injuries and wounds from attacks, punishments, arduous marches, exhaustion, anaemia, malnutrition, starvation, TB and STIs.

5.5.2. NATURAL DISASTERS AND CLIMATE CHANGE

In recent years, regional harvest failures resulting from flooding and droughts have led to a state of ongoing food insecurity in the SADC Region as well as some severe humanitarian crises.

The impact of natural disasters on children includes greater risk of injury, deteriorating nutritional status, water-borne diseases and a lack of sanitation. The psychosocial disruption and emotional turmoil experienced by children during a disaster can have long-term implications for their health and wellbeing. If children are displaced as a result of the disaster, they may be separated from their parents or carers, or even lose one or more members of their family. Children may also experience interruption to education. School age children are vulnerable to shocks, since a common coping strategy among the poor is to reduce investments in children's education.¹¹⁵

¹¹¹ Stavrou, V. 2007, *Literature Review and Analysis of GBV and Children Associated with Armed Forces and Groups*. UNICEF ESARO

¹¹² <http://www.un.org/Depts/dda/gender.htm>

¹¹³ International Research Network on Children and Armed Conflict, 2005, *Impact of Armed Conflict on Children: Recruitment and Displacement. The Comparative Report*

¹¹⁴ International Research Network on Children and Armed Conflict. May 2005.

¹¹⁵ UNICEF, 2008, *Social Protection in Eastern and Southern Africa: A Framework and Strategy for UNICEF*.

The increased frequency and intensity of natural disasters are a direct result of climate change. One of the largest groups to be affected will be children under the age of five.¹¹⁶ Climate change will accelerate the spread of malaria in various parts of the world. By making access to clean water even more difficult, it will be harder to tackle diarrhoea, one of the biggest killers of young children. Dirty water and unsafe sanitation is a major secondary cause of child mortality. While we have some knowledge of the impact of natural disasters on children and families, the effects of climate change on children are not well documented or recognised. Information is needed to enable identification of appropriate interventions to support children to adapt to climate change. Interventions to adapt to the effects of climate change must focus on children's needs.

6. CONVENTIONS, POLICIES, STRATEGIES AND GUIDELINES

This section identifies the key policies, strategies and guidelines that are relevant to an OVC & Y response and briefly indicates the reasons for their relevance. It then offers a summary of findings from the field, which subsequently inform the recommendations at the end of this report.

6.1. INTERNATIONAL POLICIES, INSTRUMENTS AND AGREEMENTS

The following are the key conventions and instruments that contribute to the realisation of children and youth's rights and underpin responses for OVC & Y:

- The **UN Convention on the Rights of the Child (CRC)** was adopted by the UN in November 1989. The CRC applies to all human beings under the age of 18 and covers virtually all the civil, political, social and cultural rights of children. It emphasises that children are holders of rights, and their rights cover all aspects of their lives. It makes special provision for children deprived of family environment, orphans, refugee children, children with disabilities, children in minorities/ indigenous groups, working children, children in conflict with the law, children affected by war, and child victims of abuse, neglect or exploitation. All governments in the world, except the United States of America and Somalia, have ratified the CRC. The CRC has been complemented more recently by two optional protocols to the CRC: the 'Optional Protocol on the involvement of children in armed conflict' and the 'Optional Protocol on the sale of children, child prostitution and child pornography'.¹¹⁷
- The **UN General Assembly Special Session on HIV and AIDS (UNGASS) Declaration of Commitment on HIV and AIDS (2001)** sets ambitious targets for addressing HIV and has been signed by all members of the UN. The Declaration commits signatories to a number of commitments and requires them to provide regular updates on progress. Of particular relevance to OVC & Y are commitments to reduce HIV prevalence among young people, to reduce the proportion of infants infected with HIV and to develop and implement national policies and strategies to build capacity and a supportive environment for orphans and other vulnerable children by 2010. All SADC Member States are signatories to the UN and most countries in the region provide regular updates.
- **ILO Convention 182 on the Worst Forms of Child Labour** provides for the prohibition and the elimination of the worst forms of child labour. This is of particular relevance in the SADC Region, where there are large numbers of migrant workers and increasing numbers of unaccompanied migrant children. All SADC Member States have ratified the Convention.
- **The Hague Convention on Protection of Children and Co-operation in Respect of Inter-country Adoption** is a multilateral treaty that serves to set internationally agreed upon norms and

¹¹⁶ Save the Children Alliance, November 2009, *Feeling the Heat: Child Survival in a Changing Climate*

¹¹⁷ A full list of the status of the international human rights instruments relevant to OVC, including the optional protocols, in SADC Member States, is available from the SADC Secretariat (OVC & Y Technical Advisor - dzirikure@sadc.int)

procedures for countries that participate in inter-country adoption. Within the SADC region, it has only been entered into force in by South Africa, Madagascar, Mauritius and Seychelles.

- The **Millennium Development Goals** promote poverty reduction, education, maternal health, gender equality and aim at combating child mortality. Goal 4 calls for the 2/3 reduction in the mortality rate for children under five, and Goal 6 calls for a halt and reversal of the spread of HIV by 2015. In SADC, the MDGs underpin many national development plans and Member States have used them as a context within which to report national progress on poverty alleviation. With the exception of MDG 2 on universal primary education, which is on track in many places, few other goals are near to being achieved.

The CRC and other international agreements set the standards that all countries should strive to achieve in meeting the rights and needs of children and youth. However, many countries, including SADC Member States, are failing to meet these standards. Reasons for failure include lack of political will; failure to domesticate international conventions and agreements into national legislation and policy frameworks; failure to recognise and prioritise the needs and rights of children and youth; cultural barriers; gender inequalities; lack of financial and technical resources; weak or non-existent health and social welfare systems; and the impact of HIV.

The SADC Minimum Package of Services for OVC & Y will acknowledge the limitations faced by SADC Member States in achieving the ideals set in international legislation and agreements, including the CRC, and the limitations of these instruments themselves in addressing the rights and needs of vulnerable children and youth in the local context. The SADC Minimum Package of Services for OVC & Y will not replace international goals and commitments but will be a stepping-stone toward achieving these.

Note: See Annex 3 for a summary of the status of ratification of international human rights instruments by SADC Member States

6.2. REGIONAL POLICIES, INSTRUMENTS AND GUIDELINES

There are a number of AU and SADC policy and strategy documents that are relevant to the situation of OVC & Y. Below is a summary of these policies, their relevance for OVC & Y and implications for OVC & Y programming and the development of a regional minimum package of services for OVC & Y.

- The **African Charter on the Rights and Welfare of the Child**¹¹⁸ (1990) reaffirms the principles of the UNCRC with a focus on the African context. There is specific reference to the equal rights and need for special protection of children with mental and physical disabilities, and the need for assistance and special protection of children who are permanently or temporarily separated from their parents. All SADC Member States have signed the Charter; all have ratified the Charter except Swaziland.
- The **SADC Protocol on Education and Skills Training** (1997) promotes 'implementation of coordinated comprehensive and integrated programmes of education and training that address the needs of the Region'. The Protocol calls on Member States to address gender inequalities, improve the quality and ensure the relevance of education and training, and provide universal basic education for at least nine years of schooling. It calls for socially disadvantaged groups to be given special support in admission to basic education. Little emphasis is placed on helping disadvantaged groups to access intermediate and higher education and training opportunities.
- The **SADC Protocol on Health** (1999) is underpinned by a commitment to Primary Health Care and the promotion of health care for all through better access to health services. It refers to child and adolescent health, but does not describe the particular vulnerabilities of children and youth, nor provide guidelines on what should be included in a healthcare package for children and adolescents and how to ensure access or child and youth friendly health services, including psychosocial health and support.

¹¹⁸ African Charter on the Rights and Welfare of the Child, Organisation of African Unity, 1999;

- **Charter of Fundamental Social Rights in SADC (2003)** lays down clear guidelines for the protection of children and youth in the working environment, especially protection from exploitative labour. It stipulates the State's responsibility to provide sufficient resources and social assistance to persons who have been unable to either enter or re-enter the labour market and have no means of subsistence.
- **SADC Declaration on Agriculture and Food Security (2004)** recognises that about 80% of the SADC population depend on agriculture for food, income and employment. Sustainable food security is a major challenge and a top priority in the SADC Agenda. The declaration reinforces SADC Member States' commitment to promote agriculture as a pillar of national and regional development strategies and programmes, defining 5 short-term and 9 medium term objectives on agriculture and food security. The Declaration is supported by a plan of action.
- **SADC Declaration on Poverty Eradication and Sustainable Development (2008)** reaffirms State Parties' commitment to the achievement of key international development goals aimed at sustainable social and economic development. The Declaration identifies regional level priorities in the areas of food security, climate change, power generation and transmission, higher economic growth through accelerated regional integration, pro-trade liberalisation and economic development; enhanced human capabilities through increased access to quality and appropriate education, training, welfare and social development, nutrition, health, and sporting services as well as information in all Member States. To address these priorities, SADC resolves to establish a Regional Poverty Observatory (RPO). The impact of poverty and of poverty eradication strategies on OVC & Y of different ages should be included as a cross-cutting issue to be monitored by the RPO.
- **The SADC Protocol on Gender and Development (2008)** aims to eliminate all gender inequalities in the SADC Region and to promote the full and equal enjoyment of rights. The protocol recognises that women and children are at particular risk due to the threats of HIV, globalisation, human trafficking, the feminisation of poverty; gender based violence, as well as prejudicial and harmful social, cultural and religious practices, attitudes and mindsets. The Protocol identifies gender-based violence as one of the key intervention areas that the SADC Region needs to address urgently and it stipulates that no person under the age of 18 shall marry. The Protocol is yet to be ratified by many member states.
- **The African Youth Charter¹¹⁹** came into force in 2009. The charter is intended to serve as a political and legal framework for action that takes stock of the current situation of the youth. The Charter takes into account the needs and aspirations of most vulnerable youth, including young displaced persons, refugees and youth with special needs. The AYC strongly promotes meaningful youth participation in all spheres of society, and recommends that State parties prioritise policies and programmes for marginalised youth, such as out-of-school and out-of-work youth. Signatories to the AYC are required to develop a comprehensive national youth policy to address the challenges facing young people in general and vulnerable groups in particular. Special attention is paid to elimination of discrimination against girls and young women, the protection and promotion of women's rights, the right of mentally and physically challenged youth to special care and equal and effective access to education, training, health care services, employment, sport, physical education and cultural and recreational activities. Amongst SADC Member States, Mauritius, Mozambique, Namibia, South Africa, Zambia and Zimbabwe have ratified the Charter.¹²⁰

SADC Codes and strategic frameworks: There are a number of SADC Codes that are relevant to OVC & Y, including the SADC Code on Social Security (2007), the SADC Code of Conduct on HIV and AIDS and Employment (1997), and the SADC Code of Conduct on Child Labour. SADC strategic frameworks and programmes of particular relevance to OVC & Y include the SADC Regional Indicative Strategic Development Plan (2003), the SADC HIV and AIDS Strategic Framework and Programme of Action 2010-2015, the Sexual and Reproductive Health Strategy for the SADC Region, 2006-2015, the 10-Year SADC

¹¹⁹ African Youth Charter, African Union, 2006;

¹²⁰ 'List of Countries Which Have Signed, Ratified/Acceded to the African Youth Charter', African Union, 3rd February 2010 <http://www.africa-union.org/root/au/Documents/Treaties/list/Youth%20Charter.pdf>

Strategic Plan of Action on Combating Trafficking in Persons, Especially Women and Children (2009-2019), the Strategic Framework and Programme of Action (2008-2015): Comprehensive Care and Support for Orphans, Vulnerable Children and Youth in SADC and the SADC Six-year Business Plan for Implementation of the Strategic Framework and Programme of Action for OVC & Y (April 2009 – March 2015).

An important framework at SADC level is the Strategic Framework and Programme of Action for OVC & Y. The Framework is built upon existing and emerging global, continental, regional and national policy and strategy frameworks, knowledge and experiences, and takes into account the particular socio-cultural, economic and political realities of the SADC region. The Minimum package of Services for OVC & Y will expand on the challenges and opportunities identified in the Framework. It will also add depth in terms of gender- and age-focused priorities and interventions.

Regional key informants were asked about the regional frameworks, policies and strategies that guide OVC & Y work, how these are being implemented, if there have been any capacity building efforts around them and how implementation is monitored. There were limited concrete responses from informants about examples of policies, strategies or frameworks at the regional level. Of those that did know of regional policies and frameworks, the following were mentioned: the UNCRC, the ACRWC, the SADC HIV and AIDS Strategic Framework and UNGASS goals and indicators. At a programmatic level, most were aware of psychosocial support guidelines (REPSI's), tools and action plans for OVC & Y and some were aware of the IASC guidelines on Mental Health and PSS in Emergencies. This increasing knowledge of psychosocial support tools is possibly indicative of the success of the regional approach by REPSI. This raises the potential for other regional level initiatives – notably cross-border movement, migration and public health issues.

The regional policy environment relating to the needs and rights of children and youth in general and to OVC & Y in particular is adequate. However, national field assessments found that regional policies and instruments are not well known at the national and sub-national levels resulting in a failure to translate them into national policies and strategies.

6.3. NATIONAL LEGISLATION, POLICIES, AND FRAMEWORKS

Ensuring that all domestic legislation is fully compatible with international and regional conventions and policies, and accordingly takes into account the special provisions that need to be made to address the needs of vulnerable children and youth is fundamental to achieving change. Law and legal reform have a key role in protecting and ensuring the fulfilment of the rights of orphans and other vulnerable children and youth. At national level, states must see their role as fulfilling clear legal obligations to each and every child and young person for which they can be held to account.

- **National Constitutions.** A number of Member States have elevated some rights to the constitutional level with the inclusion of a Bill of Rights. Increasingly, national Constitutions also include specific guarantees of children's rights. However not all are consistent with the provisions of the CRC and the ACRWC. In some member states the constitution defines a child as someone under the age of 16; others use the terms 'children and young people' without defining these terms.¹²¹
- **Customary Law:** The Committee on the Rights of the Child states that the UNCRC will prevail in situations where there is a conflict with domestic legislation or common practice, and that local or customary laws should be brought into compliance with the UNCRC. However, at a national level this recommendation has been hard to enforce either through lack of political will or the challenge of changing engrained social and cultural norms. This is a particular concern in relation to traditional practices relating to early marriage, inheritance rights of women and children, and

¹²¹ Refer to analysis of National Constitutions in Literature Review. Full document available from the SADC Secretariat (OVC & Y Technical Advisor - dzirikure@sadc.int)

abusive or exploitative behaviour towards children. Issues of marriage, inheritance and child custody are often handled outside of the judiciary, by traditional or religious courts.¹²²

- **Legislation:** Most SADC Member States have existing policy instruments and legislation that relate to the rights, protection, care and support of children. However, the RAAAP Effort Index found that legislative review is the weakest area in national responses to OVC & Y.¹²³ One reason is that children's issues tend to fall between several laws; there are inconsistencies in the definition of a child. Additionally, in spite of recent enactment of legislation for children in some countries, there is a lack of knowledge or awareness of these laws; they are not being fully implemented.

The process of legislative reform is essential to addressing the discrepancies between formal laws and customary or traditional laws. In thirteen out of fourteen SADC Member States a dual system operates, with recognition and practice of both formal and customary laws.¹²⁴ A 2004 study by UNICEF on the Impact of the Implementation of the CRC¹²⁵ highlights the link between law reform and improvements in access to and quality of programmes providing essential services to children and their families, especially in the health and education sectors. Legislative reform is proven to act as a catalyst for profound cultural changes concerning the role of children in society.

The African Child Policy Forum has developed a ranking system to compare how African governments fare relatively in terms of providing legal protection to their children against harm and exploitation.¹²⁶ SADC Member States rank from 2nd to 51st out of 52 African States, indicating hugely varying performance in appropriate legal and policy foundations for the protection of children. Significant achievements have been made in many countries. However there are still gaps and challenges in enforcing child protection and human rights laws, making orphans and vulnerable children more susceptible to poverty, stigma and discrimination.

- **Legal Protection for Women:** All SADC Member States are party to the 1979 UN Convention on the Elimination of all forms of Discrimination Against Women (CEDAW). The SADC Gender Monitor shows that all countries in the region have some provisions toward full constitutional rights for women and most Member States have made some progress in legislating against gender-based violence (GBV). However, it also notes that 'the prevalence of GBV remains high, and some countries in the region have reported an increase in cases of violence against women and children'.¹²⁷ In much of the SADC region, ingrained social and cultural norms relegate women to a lower social and economic status than men. Women may be treated as legal minors, barred from owning property and unable to make independent financial decisions. Women's lack of property rights and financial independence increases their vulnerability to poverty, exploitation, violence and HIV infection. In a region where more than 34% of households are female-headed, the lack of legal protection for women has a critical impact upon women's ability to protect their children.

The international and regional policy environment relating to the needs and rights of children and people in general and to OVC & Y in particular is adequate, yet many of these commitments have not been translated into national legislative and policy frameworks. Even at national level there is a noticeable gap between

¹²² Save the Children UK, 2006, *Legal and Policy Frameworks to Protect the Rights of Vulnerable Children in Southern Africa*; UNICEF, 2005, *Early Marriage - a harmful traditional practice: a statistical exploration*

¹²³ Policy Project, 2004, *OVC Programme Effort Index*

¹²⁴ *SADC Gender Monitor 2009: Tracking Implementation of the SADC Protocol on Gender and Development*. SADC Gender Unit, Gaborone, Botswana, 2009. P.19

¹²⁵ UNICEF, 2004, *Summary Report: Study on the Impact of the Implementation of the Convention on the Rights of the Child*

¹²⁶ The performance scores each government obtained with respect to the ratification of international and regional treaties; provisions made in national laws to protect children against abuse and exploitation; existence of a juvenile justice system; existence of a policy of free education; and existence of plans of action and coordinating bodies were aggregated to yield the index value for the dimension on protection (legal and policy framework). African Child Policy Forum, 2008.

¹²⁷ *SADC Gender Monitor 2009: Tracking Implementation of the SADC Protocol on Gender and Development*. SADC Gender Unit, Gaborone, Botswana, 2009, P.45.

policy development and commitment and the implementation of policies and effective and quality interventions. As a result there has been limited impact on the welfare and wellbeing of OVC & Y across the region. Extensive national and sub-national level advocacy and training will need to be done around the Minimum Package in order to ensure that it is prioritised as part of national development agendas and that the guidelines are incorporated into national OVC & Y policies and strategies.

The reasons for both non-compliance with regional commitments and weak implementation of national policies vary from country to country. The SADC Framework on OVC & Y and the literature review found the following main reasons:

- failure to domesticate the various regional commitments into national legislation and policy frameworks;
- failure to recognise and prioritise the needs and rights of children and youth;
- lack of political will;
- cultural barriers;
- gender inequalities;
- limited human resource capacity, especially at district and community levels;
- weak or non-existent health and social welfare systems;
- the immense combined impact of HIV and AIDS, poverty, conflict and climate change leading to very high number of OVC & Y across the region;
- vertical projects rather than a comprehensive approach to prevention, care and support;
- inadequate financial resources;
- unsustainable project approaches (e.g. large, once-off or limited-timeframe distribution programmes);
- interventions that are short term and donor driven.
- good practices are not shared or scaled up; fragmented approach;
- decision making, planning and monitoring and evaluation not based on adequate, reliable data.¹²⁸

There are glaring gaps in knowledge of and access to information about national legislative and policy frameworks. During the field assessment, key informants were asked about their knowledge and perceptions of policies and frameworks that guide their work. Whilst most governments and NGOs referred to adequate policies and frameworks being in place, the level of knowledge about national policies and frameworks varies; some government key informants were either able to provide no information or only that relevant to their particular ministries. For example, out of eleven Ministries of Education that were interviewed, three did not provide any information and of those that did five listed only national Education Acts and education-related policies. Out of the seven Ministries of Health interviewed, four listed the Health Act and associated policies and two included the Children's Act. At the NGO level, knowledge about guidelines and frameworks for OVC & Y is mainly limited to National Co-ordinating Committees (8 out of 12 countries) and National Plans of Action for OVC (9 out of 12 countries).

6.4. POLICIES AND LEGISLATION FOR OVC & Y

Within a national framework of laws to protect the rights of children, there need to be specific policies and legislation to protect OVC & Y. Some SADC Member States have National HIV and AIDS strategies and policies which make explicit provisions for OVC & Y.¹²⁹ In other Member States, issues relating to OVC & Y are implied within the concept of care and support for people infected and affected by HIV and AIDS. Some Member States specify OVC & Y in their national Poverty Reduction Strategies. Many countries have or are developing comprehensive National Action Plans for Children that will address a comprehensive approach

¹²⁸ Findings from Literature Review and from 'Strategic Framework and Programme of Action 2008-2015: Comprehensive Care and Support for OVC & Y in SADC'. SADC 2008.

¹²⁹ A comprehensive list of national legislation, policies and plans related to OVC & Y for all SADC Member States is available separately as an annexure to this report, is available from the SADC Secretariat (OVC & Y Technical Advisor - dzirikure@sadc.int)

to vulnerability, preferring to see this as a more comprehensive tool. Other Member States are phasing out NPAs and integrating vulnerability into new comprehensive Children's Acts. In most SADC Member States youth issues are handled separately from OVC, and fall under different ministries or a Youth Council. There is no equivalent to the NPAs that targets youth. Generally youth policies and programmes are much weaker and less resourced than those for OVC.

As an initial response following the 2001 UNGASS Declaration, the Rapid Assessment, Analysis and Action Planning initiative for OVC (RAAAP) was launched in 17 countries in sub-Saharan Africa including 10 SADC Member States in 2003.¹³⁰ The process consisted of an analysis of the situation of OVC according to the 5 strategies of the *Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS*.¹³¹ RAAAP country reports found that OVC policies are frequently not integrated into national poverty alleviation plans, national HIV strategic plans and policies, or human rights frameworks and that there are gaps in the domestication and enforcement of international laws.

Most SADC Member States now have a National Policy on Orphans and Vulnerable Children and a National Plan of Action. For those countries with more comprehensive children's plans, the future of the NPA is more likely to be at the level of a costed operational plan. Policies and plans for vulnerable youth are not being prioritised in the same way. Common priority areas for NPAs include: responses to OVC at family and community levels; access to services; government policy/legislative reform; advocacy/social mobilisation; monitoring and evaluation; coordination; and capacity building. NPAs are largely in line with the 2004 *Framework* referred to above.

However, in spite of the significant achievement of the development and rollout of NPAs, there are also a number of challenges still facing effective service delivery for orphans and other vulnerable children and youth. The key challenges identified through the literature review are:

- In the majority of NPAs the most hard to reach groups of OVC are not accorded sufficient attention. The needs and protection of children living on the street, children that have lost both parents, abandoned children, those that have been institutionalised, child soldiers, children with disabilities, abused children, marginalised groups and other categories who are likely to be more vulnerable than those being cared for in a community setting are not adequately addressed;¹³²
- The needs of children of pre-school age (0-6 years) are neglected; however more recently developed NPAs have more developmentally-informed interventions, and are not just restricted to health, nutrition and birth registration;¹³³
- Policies often dictate that care and support services end when a child turns 18; there is no continuum of care and support for vulnerable youth. Not only do OVC need continued support beyond the age of 18, for example in order to complete their education or gain vocational income-generating skills, but certain groups of youth between the ages of 18 and 24 are extremely vulnerable in their own right – unemployed out of school youth, youth care-givers and youth-headed households and unmarried mothers, to name a few. SADC has recognised this challenge through its OVC approach but this is not yet translated to national level policies and frameworks;
- There is a noticeable lack of attention to issues of child and youth participation and leadership development for OVC;
- The involvement of youth, caregivers and people living with HIV and AIDS in policy and programme development and in monitoring and evaluation of service delivery for OVC is minimal;

¹³⁰ Supported by USAID, UNICEF, UNAIDS and WFP in partnership with in-country donor offices, national OVC steering committees and the POLICY Project.

¹³¹ A Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS, UNICEF, May 2004

¹³² Sebates-Wheeler, R and Pelham, L., 2006. 'Social Protection: How Important are the National Plans of Action for OVC & Y?' Institute of Development Studies, Brighton, and UNICEF, P.9

¹³³ Engle, P., 2008, *National Plans of Action for OVC in Sub-Saharan Africa: Where are the youngest children?* Bernard Van Leer Foundation

- There is limited focus on social protection initiatives or linkages with national social protection frameworks. This may be due to limited understanding of the complexities of household coping responses, local care-giving practices and capacities over time and HIV-related stigma;
- In most of the NPAs the problems faced by OVC are seen as relatively homogenous; little or no attention is paid to gender, disability, ethnicity, class and wealth as well as indicators of vulnerability.
- NPAs in the region generally focus on providing for the immediate physical and material needs of OVC and do not take a holistic child-development approach. There is inadequate focus on reducing vulnerability or on meeting psychosocial needs and developing emotive and psychosocial competencies. There is also a risk that the current profusion of welfare-centred interventions may suppress innovation and entrepreneurship in communities and perpetuate chronic dependency on external support, concepts, philosophies on community care and facilitation of service delivery.¹³⁴

Note: See Annex 4 for a summary of national legislation and policies for OVC & Y

7. OVC & Y PROGRAMMING IN THE SADC REGION

All SADC Member States are implementing coordinated national-level responses for OVC, mostly under the strategic framework of a National Plan of Action for OVC. However the actual levels of coverage, the content of the package of services and the degree of coordination vary greatly between countries. Some countries are attempting to take a holistic approach to protection, care and support of OVC, whereas in other countries the NPA is essentially an emergency response package.¹³⁵

Services for youth are less comprehensive and less wide reaching than responses for vulnerable children, and are not integrated with services for OVC. Care and support for caregivers is also patchy and varied in terms of quality and scope. Most of the assistance being received as reported by children and youth in the focus groups is for health, food and education, some of which comes from families, relatives and/or NGOs. In general, the assistance is well received but does not meet all the children's needs.

A survey of 200 organisations involved in psychosocial support in the region¹³⁶ finds insufficient infrastructure in the SADC region. Although the majority of countries have a National Coordinating Committee for OVC (90%), only two Member States have a sub-committee focussing on psychosocial support. The lack of a sub-committee or task force in the government structure highlights the difficulty of getting psychosocial support issues on the government agenda. Civil society fares better with all Member States except one with at least one national network addressing OVC and PSS issues. Half of the countries reviewed have quality standards for OVC with a PSS component, though few have started to implement them. National advocacy groups for OVC and PSS are found in all countries. However, 50% lack child and youth-led advocacy groups.

7.1. COORDINATION OF THE RESPONSE

SADC Member State governments have made progress in terms of coordinating responses. Most of the SADC Member States have in place coordinating structures at national and regional levels, including OVC Technical Working Groups. However there are still issues around the capacity and effectiveness of these structures, and around coordination of responses for children and youth. In many SADC countries the efforts of national governments, international and national NGOs and community-level responses from

¹³⁴ SADC Strategic Framework and Programme of Action: Comprehensive Care and Support for OVC & Y, 2008-2010

¹³⁵ Findings from field assessment support those of the JLICA report. 'Home Truths: Facing the Facts on Children, AIDS and Poverty'. Joint Learning Initiative on Children and HIV and AIDS (JLICA) 2009.

¹³⁶ Brakarsh, J., 2008, *What's love got to do with it? The state of the response: PSS programming for children in the context HIV and AIDS in eastern and southern Africa*. Unpublished report: UNICEF ESARO / REPSI

CBOs and Faith Based Organisations (FBOs) lack coordination and systematisation. Although NPAs were intended to fulfil this role, in reality effective coordination remains limited for many reasons: lack of strong national-level leadership; failure to disseminate national plans and strategies to district and sub-district level; lack of human and financial resources; NGOs and CBOs having their own priorities and agendas; segregation of child and youth sectors and lack of focus on vulnerable youth.

During the field assessment several National AIDS Structures and other key informants reported that coordination is a challenge. OVC strategies and programmes (including NPAs) generally fall under Ministries of Social Welfare, youth strategies and programmes fall under Ministries of Youth and HIV prevention and treatment under Ministries of Health. There are various fora and mechanisms for coordination of NGOs within national frameworks, but none that are upheld as being very effective, especially in countries where there are several hundred different service providers working in the OVC & Y sector. It is difficult for service providers (be they government agencies, NGOs, CBOs, or FBOs) to effectively liaise and cooperate directly with one another in the absence of an effective national coordinating mechanism. This results in gaps and duplication of efforts, inadequate geographical coverage and a non-holistic approach to service delivery.

The field assessment complemented the literature that demonstrates that overall coordination of OVC & Y responses at both national and sub-national level is weak. In order to achieve comprehensive service delivery for OVC & Y, this coordination must be strengthened from the inter-ministerial level, to districts and community levels, including development of effective partnerships between the government, civil society and private sectors. There needs to be harmonisation between different structures and programmes that exist for OVC, children and youth in order to ensure (a) a continuum of services for OVC when they reach the age of 18, and (b) adequate support for vulnerable youth. In addition, functional referral mechanisms and defined linkages between service providers are vital when providing comprehensive care and support for OVC & Y.

7.2. ROLE OF GOVERNMENT AND CIVIL SOCIETY

The field assessment shows that all national governments play an important role in terms of developing national policies, legislation, frameworks and strategies for improving the lives of OVC & Y. Government and non-government service providers are expected to operate within the national frameworks and strategies. In some countries the government provides technical and financial support to non-government service providers for care and support of OVC & Y. Several government key informants said that NGOs should complement the work of governments. However in Member States that lack financial resources and government capacity, NGOs are doing social welfare work that governments should be undertaking.

For as many OVC & Y to be reached as possible there needs to be incorporation at all levels of civil society so that as many children and youth as possible can be assured of the basic inputs to secure a healthy and stimulating childhood.

7.3. IDENTIFICATION OF VULNERABLE CHILDREN

Whilst OVC programmes, of varying scales and scopes, exist in all SADC Member States, they are mostly focused on orphans and children affected by HIV and AIDS. Although children with disabilities fall under the 'vulnerable children' definition used in NPAs and children's policies, the NPAs do not spell out activities to specifically address their needs.

As is emphasised by the JLICA findings, the strong stigma still associated with HIV and AIDS must be recognised in devising community-based interventions. Thus the focus should be on all vulnerable children and not just those who are affected by AIDS. Communities need to develop their own criteria for identifying those children in need of support.

Youth and children age 0-6 years are generally excluded. They need to be specifically acknowledged in any vulnerability assessment.

7.4. NEEDS ASSESSMENT

The field assessment revealed that national governments and non-government service providers conduct needs assessments for OVC & Y and caregivers with varying degrees of regularity, usually through consultative processes. National assessments can be logistically difficult, time consuming and costly. By the time national assessments feed into policy development and strategies for national plans, there are long delays before beneficiaries see a roll out of services. Information collected by NGOs is utilised for internal planning purposes and/or fed into national databases. Some government and non-government service providers reported that after needs had been assessed there was insufficient capacity and/or resources to deliver services.

National monitoring and evaluation (M&E) systems need to be strengthened to provide information for governments on who is vulnerable and how many OVC & Y there are, so they can program and budget to address issue effectively. Governments need capacity building so they can better address this issue.

Data collection will be simplified by integrating indicators relating to OVC & Y into existing national data collection and reporting systems, such as health and education management information systems and demographic health surveys.

7.5. KNOWLEDGE MANAGEMENT

Respondents highlighted the need for better information sharing and knowledge management at national and regional levels. Some governments have dedicated databases for OVC, but no government-owned knowledge management systems appear to exist (though some countries are in the process of developing them). Where systems do exist, the information is not always widely shared, and there are issues with technology.

Key Informants expressed the need to gather the following information in a regional knowledge management system: OVC & Y studies, evaluations, reports, baselines, OVC & Y indicators, OVC & Y policies and frameworks, country profiles, numbers of OVC & Y per country, numbers accessing core services, types of core services available, numbers affected by poverty, HIV and AIDS, conflict, displacement and human trafficking.

National knowledge management systems should be easily accessible and kept current, should include data on OVC & Y and on service providers, share lessons learned, and should feed into a regional system to facilitate information sharing both within and between SADC Member States.

Such a system would make for easy access to data, relate to cost effectiveness, facilitate the tracking of emerging issues around OVC & Y and the sharing of regional practice and lessons learned. Information sharing should be through forums, websites, conferences, pamphlets, newsletters, network organisations in each country, internet/emails, reports.

Moreover, there must be community based management information systems to allow for data to be aggregated up to the national level as well as flow back down to the community. If communities are able to analyze the data they collect and measure the improvements, they will be able to use this data for advocacy purposes.

Lastly, it was suggested that SADC consider standardising the methodology and timing of national assessments across the region, so that information and lessons learned could be more easily shared and comparisons made within and across the region.

7.6. FAMILY AND COMMUNITY FOCUSED RESPONSES

Most guidelines and models for OVC programming stress the central role of mobilising community-based projects to keep affected children within the extended family. There is also substantial evidence of the valuable role of faith-based organisations in community responses to OVC.

While a comprehensive response to the needs of OVC requires a spectrum of options, including institutional care, there is widespread agreement that the intervention of choice (wherever possible) should be home-based community-supported care.¹³⁷ There needs to be a shift from a 'welfarist' approach to a more long-term developmental approach to work in this field. However, models need to be flexible, with a blend of capacity building/empowerment together with material support.¹³⁸

7.7. COMPREHENSIVE AND INTEGRATED OVC & Y INTERVENTIONS

The field assessment revealed that most of the CSOs that were interviewed do not provide a comprehensive range of services to OVC & Y and caregivers. Different organisations focus on different areas of care and support for OVC & Y, providing an average of 7.75 services to beneficiaries (between two and seventeen services per organisation). The range of services provided includes: health services, health service user fees, health education, education services, education fees, material support for education (books, uniforms, transport, etc.), food and nutrition, nutrition counselling, institutional care, shelter, building materials, bedding, mosquito nets, materials for IGAs, PSS, HIV and AIDS awareness, needs-based support for children and youth living with disabilities, referrals, water and sanitation, birth registration, child protection training and services, family reunification, and legal assistance. (N.B., This is not a statistically representative sample of service providers, and does not accurately reflect the national situation in terms of OVC & Y service provision). The three most frequently provided services are psychosocial support, food and nutrition support, and education fees. Forty-two out of sixty-six service providers reported that they refer OVC & Y to other service providers and institutions for services that they do not provide themselves. The three least frequently provided services, each provided by only 3 organisations, are birth registration, family reunification and legal assistance.

One sector in which a 'systems strengthening' approach is working is in education. There are many examples from across the region of attempts to provide comprehensive care and support for OVC & Y through the education system.¹³⁹ School-based interventions include health promotion, HIV and AIDS awareness and prevention, waiver of school-fees for OVC & Y, counselling and support, including peer education and peer support, child-friendly school initiatives, school feeding schemes and food gardens, and extra-curricular activities (sports and clubs) to promote a healthy lifestyle. While there is evidence that the school-based approach is effective, these programmes tend to be small-scale and fragmented, and their success and sustainability is often dependent on the personal commitment of a head teacher. Recent evidence from East and Southern Africa indicates that in order to accelerate momentum towards the goal of getting all children in schools of acceptable quality, responses must be gender sensitive, systemic and have rigorous monitoring and evaluation mechanisms built in from the outset.¹⁴⁰

7.8. SECTOR-SPECIFIC INTERVENTIONS

Respondents from CSOs reported that the most effective services for OVC & Y are those that are easiest to provide and for which outcomes are clearly measurable. In all countries education support was identified as an 'effective service'. School enrolment and school attendance are easily visible and measurable outcomes.

Food and nutrition support in the form of food parcels was identified as easy to provide and effective in the short term in meeting immediate nutritional needs, even though it is not sustainable. Yet ensuring food security was identified as one of the hardest needs to fulfil.

¹³⁷ JLICA, 2009, *op cit*.

¹³⁸ Strebel, A., 2004, *The Development, Implementation and Evaluation of Interventions for the Care of Orphans and Vulnerable Children in Botswana, South Africa and Zimbabwe: A Literature Review of Evidence-based Interventions for Home-based Child-centred Development*. Cape Town: Human Sciences Research Council

¹³⁹ Promoting Quality Education for OVC. UNICEF 2009. P.vi

¹⁴⁰ UNICEF, 2009, *Promoting Quality Education for OVC*.

Child-to-child and youth-to-youth interventions, such as peer support, peer education, and support groups were described as being particularly effective, along with participatory activities and interventions that are designed with the full consultation and participation of the community, OVC & Y and caregivers.

Many organisations felt that psychosocial support interventions are effective, meaningful and potentially very helpful in terms of equipping children and youth with coping skills, helping them deal with trauma and loss, improving self-esteem and independence, and building social skills and social networks. There is recognition that the effectiveness of interventions depends on a holistic approach – no one service or intervention can be effective in isolation.

Most respondents identified shelter as a difficult need to meet. It is expensive to renovate poor quality homes, or to build new homes. Community members are often unwilling to provide labour for home renovations for OVC & Y homes, even child-headed households. In urban areas there tends to be a shortage of housing and of land for building. Another need that is hard to provide for is legal protection. In many Member States respondents noted that it is harder to meet the needs of OVC & Y in rural areas than in urban areas, due to poor infrastructure and sparse distribution of essential services in rural areas – including schools, health facilities, and protection services (social workers, legal practitioners, child psychologists, birth registration, etc.). Overcoming household poverty and improving livelihoods of vulnerable households is reported to be particularly challenging, requiring medium to long-term support.

The JLICA report presents a body of evidence from Southern Africa to illustrate the benefits that income transfer programmes achieve for children.¹⁴¹ The report demonstrates that the cost of delivering universal benefits is not beyond the means of resource-poor countries, citing 3 SADC Member States that have domestically financed universal social pensions, which cost a maximum of 2% of GDP.¹⁴² As stated by JLICA (2009): 'The positive effects of income transfers are established. The critical factor now is national government leadership to take successful models to scale.'

7.9. CHILD INVOLVEMENT

As the children who participated in the field assessment showed, children and youth's perspectives are key for an effective OVC & Y response. Although adult perceptions may often be accurate, children identify priorities and have a nuanced understanding of the complex vulnerabilities that need addressing. As is also shown in this assessment, participation does not automatically happen but requires active commitment from adults.

7.10. QUALITY

There is a noticeable gap between policy development and commitment and the implementation of policies and effective and quality interventions. As a result there has been limited impact on the welfare and wellbeing of OVC & Y across the region. Some of the reasons include limited human resource capacity, especially at district and community levels, the immense combined impact of HIV and AIDS, poverty, conflict and climate change leading to very high numbers of OVC & Y across the region, vertical projects rather than a comprehensive approach to prevention, care and support, inadequate financial resources, unsustainable project approaches (e.g. large, once-off or limited-timeframe distribution programmes), interventions that are short term and donor driven, failure to share or scale-up good practices, fragmented approach and decision making, planning and M&E not based on adequate, reliable data.

The assessment revealed that quality interventions for OVC & Y are being defined, measured and improved at different levels: individual beneficiary, family, community, and system. It is important to recognise the interplay between defining, measuring and improving quality, and the need to involve all key stakeholders.

¹⁴¹ JLICA, 2009, *op cit*

¹⁴² Devereux S et al, Making cash count: Lessons from cash transfer schemes in east and southern Africa for supporting the most vulnerable children and households, Save the Children, HelpAge International and Institute of Development Studies, 2005.

Beneficiaries (children / youth / caregivers) have a role to play in defining quality from their own perspective and providing input into the measurement and ultimate improvement of quality services.

There was general agreement that regular monitoring is crucial to identify gaps and barriers to provision which can be corrected over time. Service providers reported that monitoring of service delivery and outcomes is done through the use of checklists, surveys and full scale evaluations. Monitoring and evaluation of interventions for OVC & Y and of their impact on the overall wellbeing of OVC & Y can be more easily accomplished if integrated into existing monitoring activities, e.g., integration of indicators into EMIS, HMIS and DHS data collection.

7.11. LOCAL TO NATIONAL

Whilst many NPAs and other reports and documents invoke ‘community-based care’ initiatives and idealise the ‘traditional’ ethos of community support, this may or may not reflect a reality that, in any case, varies from community to community and evolves over time.¹⁴³ There is a tendency to seize on successful experiences as ‘best practice’ models that should rapidly be scaled up from community to national level, without recognising that local success often depends on local conditions, such as a committed NGO team that has close relationships with the local PLHA community – advantages that would be lost if the approach goes ‘to scale’. In such circumstances, more appropriate would be replicating successful small-scale initiatives through supporting local NGOs to do similar work in other communities, rather than centralising the programme at national level.¹⁴⁴

7.12. WELLBEING ASSESSMENT TOOLS

A goal of OVC and youth programs, and of a lot of psychosocial interventions, is to improve wellbeing. Yet, measuring wellbeing has proven to be an elusive concept for many engaged in OVC programming. Various tools have been developed, including the Child Status Index (CSI), the Information and Action Tool (IAT) and the OVC Wellbeing Tool (OWT).¹⁴⁵ These are intended to provide information and propose actions on observed issues, unlike most other monitoring tools. The tools look at children within the context of family centred care, and can be used by people who have not had specific monitoring and evaluation training. The IAT is focused on children’s PS well-being within a holistic framework which includes physical, mental, emotional, social and spiritual indicators of wellbeing. The CSI toolkit is broader, assessing vulnerabilities, needs, and outcomes of orphaned and other children made vulnerable by HIV and AIDS. These two tools provide a systematic framework for identifying children’s needs, creating service plans, and assessing outcomes. Both the IAT and the CSI have been successfully field tested and are currently in trial use in several SADC countries. The OWT, used as a self-reported measure for OVC aged 13-18, was developed to serve as a fast, easy method of securing data about the overall wellbeing of children in OVC programs, and captures wellbeing from a child’s perspective. In the SADC region, the OWT has already been used in Malawi, Tanzania and Zambia.

7.13. PREVENTION

Most OVC & Y programmes in the SADC region fail to adequately address prevention: there is a lack of risk minimisation strategies and interventions to prevent vulnerable children and households from falling into a situation where they need direct support. It is acknowledged that “young people’s wellbeing can be most effectively achieved by strengthening their capabilities, enlarging their access to opportunities, and providing them with safe and supportive environments” (UNICEF 2001). Programmes focused on only

¹⁴³ Sabates-Wheeler, R. & Pelhan, L., 2006, *op cit*

¹⁴⁴ Sabates-Wheeler, R. & Pelhan, L., 2006, *op cit*

¹⁴⁵ Child Status Index – Measure Evaluation, 2008; Information and Action Tool – REPSSI and HSRC, 2008; OVC Wellbeing Tool – Catholic Relief Services

providing immediate services to children who are denied of their basic needs and rights are therefore inadequate as they lead to fragmented vertical responses only to those needs (e.g. feeding, treatment, literacy). Children come to be seen as a collection of problems, and the interconnectedness and underlying causes of their problems are overlooked. Interventions are essentially emergency responses and the factors that led to the deterioration of the child's care and support environment are not addressed. Adequate care and support should also focus on addressing vulnerabilities and providing sustainable coping options.

8. LINKING THE MINIMUM PACKAGE TO OTHER STANDARDS AND GUIDELINES

There is a need for a SADC Minimum Package of Services for OVC & Y to address the current policy-to-implementation gap and to provide an approach for effective coordination in addressing the pressing needs of growing numbers of OVC & Y in the region. The Minimum Package of Services is drawn from the response taking place across Member States. The Minimum Package will complement already existing regional and national initiatives and work toward ensuring a coordinated and comprehensive response for OVC & Y. There is a need for systems strengthening at all levels - national and local government, community, and family, to provide effective responses.

The underpinning principles for the OVC & Y Minimum Standards Package are the Guiding Principles that are outlined in the *SADC Framework & Plan of Action for Comprehensive Care & Support for Orphans, Vulnerable, Children & Youth 2008-2015*.

There are several other ongoing or planned initiatives identified during the assessment process. The two most significant are mentioned below.

8.1. DEVELOPMENT OF QUALITY STANDARDS

USAID PEPFAR is currently funding national programmes to develop quality standards for OVC in five SADC Member States: Malawi, Mozambique, Namibia, Tanzania and Zambia. National governments are working closely with NGOs and civil society organisations, to develop national standards and guidelines. This process does not, however, currently include vulnerable youth.

The field assessment revealed that service providers define and measure quality in a number of ways; for some organisations quality is measured, and for others it is evidence based, assessed using a variety of systems, tools and indicators. Some service providers reported that donors and/or national coordinating bodies require them to count services provided, but not to measure impact in terms of child wellbeing. Many organisations do not involve OVC & Y and caregivers in assessing quality.

The field assessment elicited perspectives on what elements would be necessary to provide quality services for OVC & Y and caregivers. Responses included:

- Provide children and youth with all their basic rights, including food, education, health, shelter, clothing and protection.
- Respond to different needs of children and youth of different ages and stages of development
- Provide comprehensive psychosocial support, including preventative interventions such as lifeskills development
- Provide specialised care and support for children and youth with specific needs (e.g. children and youth that are HIV positive, living with disabilities, living without parental care, etc.)
- Ensure all interventions are in the best interests of the child
- Interventions to be locally appropriate and relevant
- Interventions target all members of vulnerable households and not individual children
- Children, youth and caregivers should be consulted about their needs and involved in the design, implementation and assessment of interventions for which they are the beneficiaries

- Need for long-term livelihoods support, including economic strengthening, income generation opportunities, and social grants, to prevent dependency.
- An enabling environment: political will, an enabling legislative and policy framework, effective coordination from national to grassroots level, clearly defined roles and responsibilities, national guidelines and minimum standards, etc.
- Adequate and reliable long-term funding
- Technical support to Member States and service providers to define and implement locally-relevant quality programmes

Quality standards can help set guidelines for the types of services and the quantity of service - duration, frequency and amount provided. Conforming to a quality standard means that the service is effective and that the child/young person's life has improved in some way. Significantly, an intervention cannot be considered a quality intervention of national importance if it reaches only a very small number of beneficiaries.

8.2. DEVELOPMENT OF A PSYCHOSOCIAL SUPPORT FRAMEWORK

A parallel process to the development of a Minimum Package of Services for OVC & Y is the development of a psychosocial support framework for OVC & Y in the SADC Region. This is being developed in parallel with the minimum package because of the recognised need to focus on psychosocial care and support within the context of overall childcare and support.

The situation analysis has identified some key findings that will inform the PSS framework.

First, the assessment reinforced that there is a lack of clear understanding or consensus around the definition of psychosocial wellbeing and the meaning of psychosocial support.

Second, the field assessment showed that many psychosocial interventions in the region are stand-alone and there are very few specialised psychosocial interventions by governments or CSOs. Additionally they ignore some critical age groups. The overall goal of psychosocial interventions is to address children and youth's issues and needs in a holistic manner by placing psychosocial interventions inside wider developmental contexts such as education or health care to create an integrated developmental approach to promoting psychosocial wellbeing.

OVC & Y psychosocial standards are required to ensure that the basic principles and quality of care in the domain of psychosocial support are consistently applied and available to SADC residents. These should outline what is appropriate at different ages, as well as an examination of cultural influences on notions of psychosocial well-being, development, care and support across widely differing cultural and economic contexts.

LIST OF ANNEXES

- ANNEX 1 FULL BIBLIOGRAPHY FOR SADC OVC & Y SITUATION ANALYSIS
- ANNEX 2 LIST OF KEY INFORMANTS
- ANNEX 3 STATUS OF RATIFICATION OF INTERNATIONAL HUMAN RIGHTS INSTRUMENTS BY SADC MEMBER STATES
- ANNEX 4 SUMMARY OF NATIONAL LEGISLATION AND POLICIES FOR OVC & Y