NATIONAL PLAN OF ACTION

FOR

ORPHANS AND VULNERABLE CHILDREN

KENYA

2007 - 2010

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Department of Children Services,
Ministry of Gender, Children and Social Development,
P. O. Box 46205 – 00100,
Nairobi, Kenya
Telephone: +254 – 20 – 248411
Facsimile: +254 – 20 – 248827
Email: **children@gender.go.ke**

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FOREWORD

This is the Government of Kenya's **National Plan of Action on Orphans and Vulnerable Children (OVC).** The Ministry of Gender, Children and Social Development, through the Department of Children Services, found it necessary to develop this document as a response to the ever increasing orphans and vulnerable children country wide. It was estimated that by 2005, the number of orphans was 2.4 million, 48% of these being as a result of HIV/AIDS. This figure is besides a higher number of children rendered vulnerable by poverty, emergencies, insecurity, amidst other factors.

The government and other stakeholders have come up with several interventions to address the problem of OVC but this has remained inadequate in the face of the increasing number of OVC. A rapid assessment, analysis and action planning process (RAAAPP) conducted in 2004 identified the need to urgently develop a National Plan of Action (NPA) to address the needs of OVC and to guide OVC interventions in the country. The process of developing the NPA began in 2005 and this edition is an improvement of the first version which, among other things, has outlined the minimum package for OVC support. Although the original document was a 5 years programme, this edition covers 3 years within which the costing is done.

Orphans and vulnerable children require quality services that will significantly guarantee their transition to responsible adulthood. This NPA provides the framework for a well guided national response to OVC situation in the country. It provides crucial information on OVC support. It has a generic definition of OVC but highlights the need for specific OVC programmes to further define selection criteria that addresses the term vulnerability within their context of operation. The NPA has further identified some key strategic areas of focus for OVC interventions, the minimum requirements needed by OVC of different age-groups and the estimated cost of each of the component of the minimum requirement. It also explains coordination mechanisms and gives a general outline of monitoring and evaluation framework. It further suggests a pool of funding mechanism that would go a long way in ensuring transparency, accountability and a wider reach of OVC.

While the Department of Children Services plays a major role in supervising OVC interventions in the country, this NPA recognizes that there are other government Ministries/Departments that provide services for OVC. In addition, the civil societies, community based organizations (CBOs) and faith based organizations (FBOs) are expected to play their role in addressing OVC needs.

OVC make a considerable percentage of our population and if the plan is fully implemented, Kenya will have made a stride towards the achievement of the millennium development goals (MDGs) and the recently launched, including the upholding of the rights of children as spelt out in the UNCRC and the Children's Act. I advise all stakeholders to make maximum use of the provisions of this National Plan Action and closely work with the Department of Children Services to ensure that the rights of OVC are protected and respected. OVC are an investment to our country and lets all support them.

Director of Children Services, HSC
Ministry of Gender, Children and Social Development

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ACRONYMS

AAC	*Area Advisory Council*
AED	*Academy for Educational Development*
AIDS	*Acquired Immuno Deficiency Syndrome*
AJRM	*Annual Joint Review Meetings*
ART	*Anti - Retroviral Therapy*
ARV	*Anti - Retroviral Drugs*
ASAL	*Arid and Semi-Arid Lands*
CBO	*Community Based Organizations*
CCI	*Charitable Children Institutions*
CSO	*Civil Society Organizations*
CT – OVC	*Cash Transfer for Orphans and Vulnerable Children*
DCS	*Department of Children Services*
DHS	*Demographic Health Survey*
ECD	*Early Childhood Development*
FBO	*Faith Based Organizations*
FGM/C	*Female Genital Mutilation/Circumcision*
FPE	*Free Primary Education*
GBV	*Gender Based Violence*
GoK	*Government of Kenya*
HIV	*Human Immune Deficiency Virus*
HACI	*Hope for African Children Initiative*
IDP	*Internally Displaced Persons*
IEC	*Information, Education and Communication*
IGA	*Income Generating Activities*
IMCI	*Integrated Management of Childhood llness*
JFA	*Joint Financial Agreement*
KDHS	*Kenya Demographic and Health Survey*
KENAO	*Kenya National Audit Office*
KESSP	*Kenya Education Sector Support Programme*
KIHBS	*Kenya Integrated Household Budget Survey*
KNASP	*Kenya National HIV/AIDS Strategic Plan*
MDG	*Millennium Development Goals*
MEDI	*Micro-Enterprise Development Initiative*
MOEST	*Ministry of Education, Science and Technology*
MGCSD	*Ministry of Gender, Children and Social Development*
MOH	*Ministry of Health*
MTEF	*Medium Term Expenditure Framework*
NACC	*National AIDS Control Council*
NCCS	*National Council for Children Services*
NGO	*Non-Governmental Organizations*
NSC	*National Steering Committee on OVC*
OVC	*Orphans and Vulnerable Children*
PEPFAR	*Presidential Emergency Plan for HIV and AIDS Response*
PSA	*Priority Strategic Area*
RAAAPP	*Rapid Assessment, Analysis and Action Planning Process*
SOWC	*State of the World's Children Report (UNICEF)*
STI	*Sexually Transmitted Infections*
TB	*Tuberculosis*
TWG	*Technical Working Group*
UNCRC	*United Nations Convention on the Rights of the Child*
UNICEF	*United Nations Children's Fund*
UNGASS	*United Nations General Assembly Special Session*
USAID	*United States Agency for International Development*
VCT	*Voluntary Counselling and Testing*

DEFINITION OF TERMS

Caregiver	*A parent or guardian who is charged with the responsibility for a child's welfare*
Child	*Any human being under the age of 18 years*
Children affected by AIDS	*This refers to children and adolescents under 18 years old who are infected/affected by HIV; have lost one or both parents due to AIDS*
Discrimination	*An action based on a pre-existing stigma; a display of hostile or negative behaviour towards someone or people on account of an existing situation*
Double orphan	*A child who has lost both natural parents*
Duty bearer	*Any person or institution, including the State, with responsibility for the welfare of a child*
Gender	*A set of characteristics, roles and behaviour patterns that distinguish women from men – socially and culturally*
Morbidity	*This refers to sickness or illness*
A household Poverty	*Lack of a regular income that enables the household to access basic essentials needed by members of a household*
Orphan	*A child who has lost one or both parents (as a result of death)*
Orphan, maternal	*A child who has lost their natural mother (as a result of death)*
Orphan, paternal	*A child who has lost their natural father (as a result of death)*
Service provider	*An individual employed or attached to a formal institution that provides professional care or services*
Stigma	*The holding of derogatory social attitudes or beliefs, the expression of negative effect, or display of hostile or discriminatory behaviour towards members of a group, on account of their membership of that group*
Succession planning	*Mechanisms for parents to give instructions on economic, legal, emotional and practical matters that affect the lives of their children*
Vulnerability	*A heightened or increased exposure to risk as a result of one's circumstances*
Vulnerable child	*A child whose safety, wellbeing and development are, for various reasons, threatened, including children who are emotionally deprived or traumatized*

ACKNOWLEDGEMENT

The development of this National Plan of Action (NPA) for OVC was undertaken through a nationwide consultative and participatory process in which many stakeholders were involved. The stakeholders were drawn from a cross-section of the communities through Area Advisory Councils, Civil Societies, faith based organisations, international organizations and government ministries.

The Ministry of Gender, Children and Social Development; Department of Children Services wishes to acknowledge and express gratitude to the National Steering Committee on OVC for their leadership throughout this process.

The following organizations deserve special mention for having provided the bulk of the financial resources and technical support towards the development of this National Plan of Action: the **Policy Project** through **USAID**, **UNICEF Kenya Office**, **World Vision**, **Futures Group International**, **Academy for Educational Development, HACI** and **Pathfinder International,** including other key local and international organizations.

Special gratitude also goes to the Technical Working Group (TWG), which played a major role in facilitating the development and revision of this document (See back page for members of the TWG).

Since this National Plan of Action borrows a lot from the *Draft National Policy on OVC,* it can be surmised that there are many more who contributed directly or indirectly to the entire process. Gratitude therefore extends to those who have participated in the various consultative meetings, all those who availed information and those who provided their technical expertise in developing and finalizing this National Plan of Action for OVC.

CHAPTER 1: INTRODUCTION

1.1. SITUATION OF CHILDREN IN KENYA

1.1.1 Kenya: Some basic data

Kenya's population is estimated to be 35.5 million of which approximately 14.9 million are children below the age of 14 years *(Kenya Integrated Household Budget Survey - KIHBS 2005/2006)*. The mean size of a Kenyan household is 5.1; households in rural areas have an average household size of 5.5 members while those in urban areas have an average of 4.0 members *(KIBHS)*.
The national absolute poverty is estimated at 46%. In rural areas, overall poverty declined from 52.9% in 1997 to 49.1% while in urban overall poverty declined from 49.2 percent in 1997 to 33.7 % in 2005/2006. The ultra poor in Kenya are estimated to be 19.1%. Rural areas have the highest percentage (21.9%) while urban areas have lower percentage (8.3%) of the ultra poor *(KIHBS)*.
(National Bureau of Statistics – Basic report on wellbeing in Kenya April 2007)

Poverty impacts negatively on children as they are deprived their basic needs to survival, protection, participation and development. The Vision 2030 aims at making "Kenya a newly industrializing, middle income country providing high quality life to all its citizens in clean and secure environment by the year 2030". The Vision 2030, within its Social Pillar Sector, has indicated that the government will address needs of vulnerable groups, which include OVC, disabled, the aged, refugees and internally displaced persons through various strategies.

These strategies include reducing deaths through HIV and AIDS, enhancing support to orphans and vulnerable children through policy development and support of safety nets such as cash transfer scheme for OVC.

Map of Kenya 1

1.1.2 Health

The health status of children in Kenya has seen significant declines in recent years with infant mortality rates increasing from 30/1000 deaths in 1989 to 77/1000 in 2003 and under 5 mortality rates also worsening *(KDHS 2003).*

Only 65.9% of children aged between 12 and 23 months are fully immunized while malaria kills about 26,000 children every year *(KIHBS 2005/2006).* Most critically, the nutritional situation of children in Kenya has not improved in the past 20 years. Nutritional status indicators show that 33 percent of children under age 5 are chronically malnourished, while acute malnutrition rates stand at 6.1% and 20.2% are underweight with 4.0% being severely underweight. *(KIHBS 2005/06)*

1.1.3 Education and Birth Registration

After Free Primary Education (FPE) was introduced in 2003, the Net Enrolment Ratio increased from 77% in 2002 to nearly 85% in 2004 and the percentage of children dropping out of school fell from 5.4% to just over 2%. Despite FPE, 1.5 million children are still out of school. Further, considerable disparities remain across regions and gender, with enrolment particularly low in Arid and Semi-Arid Lands (ASAL) region for girls. While enrolment rates have increased, concerns have arisen regarding the quality of teaching and learning *(Draft National Policy on OVC 2005).*

Access to early childhood development (ECD) remains low. Nationally, only 28.2 % of children aged 3-5years are attending school. This is equivalent to about 549,000 children attending pre-school out of the estimated 1,950,000 children in this age group *(KIHBS 2005/6:47).* A report from the Department of Civil Registration (2007) indicates that there has been an upward trend in terms of birth registration from a national coverage of 39.35% in 2004 to 44.42 in 2007 a factor that is attributed to creation of awareness by the Department.

Nationally 1.3 million children (aged 5 to 17) were engaged in child labour in 1998/99. Most of these children were in commercial and subsistence agriculture, fishing, and domestic service. The majority of working children are aged 10–14 years, and the highest proportions are found in Coast, Eastern and Rift Valley Provinces (19–19.8%) *(Draft National Policy on OVC 2005)*.

1.1.4 HIV/AIDS and Children

The prevalence of HIV infection in adults appears to have peaked at 10% in the late 1990s and has since been declining in many parts of the country. The first national HIV prevalence survey in 2003 estimated that 7% of adults aged 15 to 49 years were infected with HIV, with rates in women nearly double those of men. Annual sentinel surveillance data of HIV prevalence in pregnant women and behavioural surveys suggest further declines, and the current prevalence is estimated to be 6.2%.

HIV/AIDS pandemic has impacted negatively on children and it was estimated that in 2005 there were about 156,000 children infected by HIV/AIDS and about 2.4 million orphans due to the epidemic. About 45% of these children, just over one million, have lost a parent to AIDS. Of the 2.4 million orphans, 1.5 million are maternal orphans, 1.4 million are paternal orphans and close to 0.5 million are double orphans *(NACC 2005).*

Besides children who are orphaned, an even greater number of children are made vulnerable due to factors such as poverty, diseases, abandonment, disasters and recently, the 2007 post election violence, among others causes. While it is estimated that between 30- 45% of the said orphans have ended in charitable children institutions (CCI), between 200,000- 300,000 children are estimated to be on the streets of major cities in the country.

The *Kenya Integrated Household Budget Survey (KIHBS) 2005/6* estimate that about 36% of children do not live with their parents. Nationally only 64% of children aged 0-14 years live with both of their parents, while 20.5% live with their mothers and not their fathers and 2.4% live with their fathers and not their mothers.

1.1.5 Justification for OVC intervention

Children of parents with HIV and AIDS become vulnerable long before their parents die. Girls, in particular, assume caring responsibilities for ailing parents and parenting responsibilities for their siblings. When primary bread-winners are unable to work, the entire family's food security is increasingly threatened, affecting adversely the nutritional status of children. Children from affected families may drop out of school while the quality of education of all children is affected by the impact of the pandemic on teachers.

Deteriorating circumstances due to the family's increasing poverty level and the impact of HIV/AIDS expose children to exploitation and abuse, while escalating crime and social disorganization are also contributing factors to the increasing numbers of OVC. A recent study undertaken jointly by government of Kenya and UNICEF on the extent of child sex exploitation in the coast region indicate that some 10,000 – 15,000 girls living in coastal areas are involved in casual sex work – up to 30% of all 12-18 year olds living in those areas. A further 2,000 – 3,000 girls and boys are involved in full-time year round commercial sex activity in the coast region. The study found out that sex workers include children whose basic needs cannot be met by family for reasons of unemployment, under-employment and loss of one or both parents.
(Source: The Extent and Effect of Sex Tourism and Sexual Exploitation of Children on the Kenyan Coast; A study conducted by UNICEF and Government of Kenya in 2006)

Other significant factors are the degree of psychosocial trauma suffered by OVC on losing their parents and the responsibilities they are left with, including the need to fend for younger siblings. When children lose their parents, often they lose their inheritance rights as well. Child abuse in Kenya takes different forms and there may be a lot of cases that go unreported.

Though there is no comprehensive data on child abuse, orphans are the major victims of child abuse which range from child neglect, abandonment, assault, sexual abuse, child prostitution, harmful cultural practices and exploitative labour, among others. Traditionally, OVC would have been absorbed into the extended family system; however, this traditional social safety net is under severe threat due to social and economic strains.

A RAAAPP undertaken by the Department of Children Services in 2004 indicated that although the Government, Civil Society, faith based organizations (FBOs) and community based organizations (CBOs) have come up with several responses, many OVC still remain unreached. Further, several gaps exist in OVC responses in Kenya. Lack of clear policies and empirical data that can be quoted to guide the development of programmes to respond to the issues is an immediate problem that need to be addressed. Coordination of OVC interventions and quality of services given to OVC remain a major area of concern.

Many development partners, NGOs, CBOs, FBOs and the Government are implementing more and more activities directed towards OVC programmes albeit in an uncoordinated manner. The National OVC Guidelines that were developed and adopted by National AIDS Control Council in 2003 were intended to give direction to organizations dealing with OVC issues. However, there has been no monitoring and evaluation on the implementation of these guidelines. This NPA attempts to address the existing gaps in OVC interventions and aims to increase the national response to ensure that more OVC are reached, given appropriate and quality care and protection.

1.2 Background to the National Plan of Action

1.2.1 Foundation and Development of the National Plan of Action

Kenya ratified the United Nations Convention on the Rights of Children (UNCRC) in 1990 and domesticated it through the Children Act, 2001. In June 2001, the United Nation General Assembly convened a Special Session on HIV/AIDS (UNGASS) and special attention was given to children orphaned and made vulnerable by HIV/AIDS. Kenya committed herself to the UNGASS goals whose key goal was aimed at addressing, as a priority, the vulnerabilities faced by children affected by and living with HIV.

Key commitments by countries attending UNGASS was that "by 2003 develop and by 2005, implement national policies and strategies to build and strengthen governmental, family, and community capacities to provide a supportive environment for orphans, both boys and girls infected and affected by HIV/AIDS".

Following the UNGASS commitments and the resultant increase of OVC in Kenya, a Rapid Assessment, Analysis and Action Planning Process (RAAAPP) was conducted in July 2004 to establish the nature and scope of the responses already existing in the country to address the OVC situation. The evidence from the RAAAPP process formed the basis for developing a National Policy for OVC and subsequently a National Plan of Action (NPA) for OVC that would catalyze a scale-up of national OVC responses against the impact of HIV/AIDS and other causes that make children vulnerable.

Seven Priority Strategic Areas (PSAs) were identified by the RAAAPP process and formed the basis for a national plan of action to be developed.

The 7 PSAs identified that form the basis of this NPA are:

1. **Strengthen the capacity of families to protect and care for OVC**
2. **Mobilize and support community based responses**
3. **Ensure access for OVC to essential services, including but not limited to education, health care, birth registration, psychosocial support and legal protection**
4. **Ensure that improved policy and legislation are put in place to protect the most vulnerable children**
5. **Create a supportive environment for children and families affected by HIV/AIDS**
6. **Strengthen and support national coordination and institutional structures**
7. **Strengthen national capacity to monitor and evaluate programme effectiveness and quality**

The above PSAs reflect the UNCRC provisions on rights of the child to survival, development, protection and participation. Based on RAAAPP recommendations a *Draft National policy on OVC* was developed to express and mobilize political will, provide a moral compass, offer a blueprint for activities and coordinate interventions and specify roles for all sectors.

After the development of the draft policy on OVC, the National Steering Committee on OVC spearheaded the development of the NPA on OVC that would actualize the policy. The process was broadly consultative and stakeholders were involved in every stage. The NPA is also informed by the Kenya National AIDS Strategic Plan under *priority strategic area 3* which provides for OVC interventions under the result of mitigation of social-economic impact of OVC. This NPA outlines the key interventions that are to be taken by the GoK and its national and international partners in addressing issues facing orphans and vulnerable children.

1.2.2 Goal

The goal of the National Plan of Action on OVC is;

To Ensure that all children in Kenya, who are orphaned or vulnerable, are protected and supported in order to achieve their full potential.

1.2.3 NPA Objectives:

- To increase family based care and retention of OVC within family/household set up.
- To increase care and support of OVC by communities
- To increase access by OVC to essential services including but not limited to education, health care, nutrition , birth registration, legal aid, and reproductive health
- To ensure that appropriate policies and legislation for protection and care of OVC are in place and operational
- To create a supportive environment for children and families affected by HIV/AIDS
- To increase the capacity of government and other institutional structures to coordinate OVC interventions

- To increase the capacity of the government to monitor and evaluate effectiveness of OVC structures and interventions

1.3 Definition of OVC

An orphan is defined as a child below 18 years whose parent or both parents have died. The definition of a vulnerable child is quite wide as causes of children vulnerability are many. In view of this, and for the purposes of monitoring progress, this NPA has narrowed its definition of OVC as orphaned children and children whose vulnerability is as a result of the parents/caregivers morbidity, mortality, household poverty or other socio-economic problems that render a child unable to receive basic needs. However, project specific interventions are advised to define their specific criteria of identification of OVC that at least encompasses the above definitions.

1.4 Guiding Principles on Program Planning and Implementation

All responses for OVC shall be developed and implemented in accordance with guiding principles provided in the *National Programme Guidelines on Orphans and other Children made Vulnerable by HIV/AIDS, March 2003* as listed below;

a. ***The family, extended family and the State shall remain the primary support structures for the care, protection and support of OVC***
b. ***Programmes for the care, support, protection and development of OVC shall respect cultural belief systems and ethical values – except where these are determined to cause harm to the child – and shall be guided by relevant national and international legal and policy instruments***
c. ***No child shall be discriminated against in regard to access and provision of care, support and protection***

d. ***Gender sensitivity and inclusiveness shall be emphasized and programming shall recognize and address the special needs of boys and girls***
e. ***Likewise, programming shall respond appropriately to the needs of children who are marginalized or who have special needs***
f. ***Institutional care shall be a last resort, when all other social safety nets are not available, or are not the best option for the child's care, support and protection.***

g. ***Transparency, accountability and good governance shall be required of all stakeholders providing care, support and protection to OVC***
h. ***The best interests of the child shall guide all decision making and child participation will be upheld at all levels***
i. ***Communities, families and children themselves will be empowered to cope with the challenges represented by the HIV/AIDS epidemic***

1.5 NPA Prioritizing Principles

In order to use the scarce resources dedicated for OVC efficiently and given the high number of OVC, there is need to have guiding principles for targeted OVC and the households taking care of them. The following principles shall guide programmers in prioritization;

Priority 1: Geographical Focus

HIV Prevalence and Number of OVC

Since the NPA is largely responding to OVC, especially as a result of HIV/AIDS pandemic, areas with the highest HIV prevalence will be given first consideration. In more cases than not, the number of OVC tend to be highest in areas with high HIV prevalence rates and as such, targeting areas with high HIV prevalence will be presumed to be reaching areas with highest number of OVC.

Poverty Levels

Accompanying decision on HIV prevalence, the number of OVC should be the poverty incidences within the identified provinces/districts. The *Kenya National Bureau of Statistics (KNBS)* provides data on poverty index across the country.

Special areas

Other areas that should be of priority either due to likelihood of high HIV prevalence, poverty and/or vulnerability of children will include

Areas with high prevalence of drug abuse

Urban slums

Arid and Semi Arid lands

Priority 2: OVC - Family based and those out of family

Since family based care is emphasized as the best option of bringing up children, first priority should be given to children who are out family (such as those in the streets and institutions with the aim of reintegrating them into family set ups). On interventions for children already in the family set up, priority should be given to children living within poorest families. However, a ranking criteria based on vulnerability should be worked out by specific programmes and projects.

Within the above priorities, this NPA further emphasizes the importance of giving first consideration to the families/individuals that are the poorest within defined groups. The poorest can be determined either through locally defined characteristics of poorest families or through use of nationally defined levels of poverty as provided by the Kenya National Bureau of Statistics (KNBS).

CHAPTER 2: PRIORITY STRATEGIC AREAS OF OVC INTERVENTION

This chapter provides further details on the 7 Priority Strategic Areas (PSAs) that provide the basis for OVC intervention. It provides the expected outcomes, outputs and some activities for each of the priority areas. However, the list of activities is not exhaustive and other activities can be drawn within each strategic area.

PSA 1: Strengthen the capacity of families to protect and care for OVC

A child in a family set up achieves holistic growth and development with values and ethos necessary for his/her ultimate adult life. Many OVC lack nuclear family set up and thus are cared for through extended family system. However, the extended family set up is often progressively unable to adequately provide for these OVC, mostly due to poverty or other hardships such as old age, unemployment, large household size, among other factors.

Due to this overwhelming state and ever increasing number of OVC, this priority area aims at strengthening the extended family set up as a priority way of reducing separation of children from their families to other options such as institutional care. Various studies, for instance from USAID, Save the Children, World Vision and UNICEF indicate that children can best be supported by providing services that enable them to remain within their own families and communities, complemented by systems to place them in safe and nurturing alternative family environment, when separation cannot be avoided.

The Government of Kenya is keen in promoting and encouraging the bringing up of children within family set ups and recommends that children should only be placed in institutional care as a last resort.

Expected Outcome: *Increased number of OVC taken care of within family set up and retained in these families throughout their childhood period*

Expected Outputs and Activities;

a. ***Increased number of households taking care of OVC enrolled in social safety net systems***
   - *Social safety net for families taking care of OVC in place*
   - *Establish and expanded cash transfer system to poor household taking care of OVC (already started in 2004)*
   - *Improve economic capacity of the household through increasing household income by: training on income generation activities, establishing/strengthening financial schemes, loans to families and other micro enterprise development systems for caregivers taking care of OVC*

b. Mechanisms for providing psychosocial support to OVC and their families in place

- *Develop standard guidelines on psychosocial support in Kenya*
- *Mainstream psychosocial support in OVC programmes*

c. Succession planning mainstreamed into interventions programs for OVC

- *Develop mechanisms for protecting inheritance rights of OVC through training on memory books, will writing and training on legal provisions such as the role of public trustees*
- *Sensitize ill parents to identify guardians for their children*
- *Develop training programmes for NGOs and other service delivery agencies on succession planning*

d. HIV positive OVC caregivers accessing treatment and support

- *Increase access of HIV + caregivers to VCT services*
- *Ensuring that HIV+ caregivers are accessing ARV/T*
- *Increase diagnosis and timely treatment of opportunistic infections*
- *Provide home-based care for HIV+ caregivers*
- *Promotion of preventive programmes*

e. Increased knowledge and skills of OVC care givers to care and protect OVC

- *Provide skills training programmes for care givers/child headed households on: parenting, financial management, nutrition and health, legal affairs, safe sex, gender concerns, etc*
- *Establish systems to monitor child-headed households*
- *Training older OVC and young people on vocational training*
- *Facilitate the formation and strengthening of support groups and networks of families with OVC*
- *Develop and disseminate IEC materials for OVC care and protection*
- *Integrate reproductive health and HIV/AIDS risks and prevention education in OVC programmes*

PSA 2: Mobilise and support community led responses for OVC care

When families cannot adequately meet the basic needs of their children, the community becomes a safety net that ensures the OVC are accessing these needs. In addition, the community becomes important in monitoring the situation of OVC within their immediate or extended families and also within non-family set ups.

In the Kenyan situation, communities in their various formal and non formal groups have given support and care to OVC within their communities and also assisted stakeholders who come into their communities to identify needy OVC and provide for their support. This strategic area

emphasizes the need to recognize the role of the community and provide them with support to facilitate their response to the needs of OVC when appropriate. This strategic area has major linkages with other strategic results and some activities outlined below are actually being implemented currently throughout the country.

Expected Outcome: ***Increased community based responses for OVC support, care and protection***

Expected Outputs and Activities;

a. ***Increased capacity of communities to respond to the needs of OVC***
   - *Mobilize and organize for early identification of OVC and develop monitoring systems for service provision*
   - *Develop the capacity of communities to respond to OVC through training of community leaders, community local committees like Area Advisory Councils (AAC), FBOs, CBOs, women groups, youth groups etc to respond to the needs of OVC*
   - *Support the establishment of OVC rescue centres and provide needed trainings and materials to community resource persons on OVC issues such as paralegals, teachers, counsellors and nutritionists, among others*
   - *Develop supplementary fortified food schemes and enhance food security initiatives at community level*
   - *Identify and support good practice models that support OVC*

b. ***Increased number of OVC taken up by families within their communities through formal processes (guardianship, foster care and adoption) and kinship foster care***
   - *Develop and enforce regulations that promote domestic guardianship, foster care and adoption of children as opposed to institutionalization of these children*
   - *Strengthen the capacity of social work systems, adoption organizations and societies to ensure adoption regulations are adequately followed*
   - *Strengthen the system for reintegration of children into their communities from charitable children institutions, statutory institutions and streets, among others*
   - *Increase public and community awareness on the benefits of children being raised in family set ups*

c. ***Increased co-ordination for OVC programmes at district level***
   - *Support the establishment of a community referral system*
   - *Strengthen linkages between community based initiatives and available government funds such as Community Development Fund (CDF), Local Authorities Trust Fund (LATF), Bursary Fund, HIV/AIDS funds, among others*
   - *Establish and maintain a database of OVC services at community level*

d. ***Increased mobilization of local resources to take care of OVC***

- *Support community based income generating activities (IGA) and micro enterprise development initiative (MEDI) programmes where the funds generated will be used for OVC support*
- *Initiate community banking and revolving funds*
- *Build the capacity of community committees (AAC, School Management Committee) to mobilize resources for OVC support, i.e., fund raising strategies*

PSA 3: Ensure access for OVC to essential services, including education, health care, nutrition, birth registration and other necessities

This strategic area therefore calls for establishment of mechanisms at all levels that ensure OVC have access to essential services.

The Government and other development partners are already offering some of the essential services such as the Free Primary Education (FPE), free health services to children below five years, provision of ARV, provision of free TB and malaria treatments, among others. Despite these efforts, many OVC are unable to access these services due to their difficult circumstances

Expected Outcome: ***Increased number of OVC accessing essential services***

Expected Outputs and Activities;

a. ***Increased school enrolment, attendance, retention and completion for OVC***

- *Support identification and address barriers that hinder OVC from accessing and completing FPE e.g. uniforms, shoes, school bags, food, books, etc*
- *Support OVC to access Early Childhood Development (ECD) services*
- *Support non-formal/special education for OVC who cannot attend formal education*
- *Support school feeding programmes*
- *Initiate and expand peer to peer interventions to encourage out of school OVC to re-enrol, and attend primary school*
- *Advocate for greater allocation of Bursary Fund to needy OVC*

b. ***Increased number of OVC accessing safe water and sanitation***

- *Support the installation of safe water points at schools and community levels*
- *Support the capacity of communities on water harvesting, water storing, water purifying and improving sanitation facility at the family level*
- *Increase access to sanitation and hygiene services for orphaned and vulnerable girls in and out of school, including provision of sanitary towels and sanitary ware (safe toilets/latrines)*

c. ***Increased number of OVC accessing reproductive health facilities and services***

- *Strengthen capacity of reproductive health providers to deal with OVC*
- *Support research on the situation of reproductive health for OVC to inform programs*
- *Support awareness strategies for older OVC on reproductive health and prevention of HIV infections*
- *Support development and dissemination of IEC and messages for OVC and youth on reproductive health*

d. ***Increased number of OVC accessing health and nutritional services***

- *Support health services systems within the communities to ensure OVC access health services*
- *Support sensitization of schools/communities on primary health care*
- *Support programmes within the community that promote nutritional status of OVC*
- *Support HIV + children to access paediatric ARV and treatment for opportunistic diseases*
- *Advocate for medical fee waiver for OVC*

e. ***Increased number of OVC that are legally protected within their families and communities***

- *Support the establishment of community level child protection committees*
- *Support the training of community level paralegals on legal issues impacting on OVC*
- *Support the establishment of community based paralegals structure*
- *Strengthen the capacity of law enforcing officers to protect OVC*
- *Support provision of legal aid to OVC*

f. ***Increased number of OVC obtaining birth registration certificates***

- *Support awareness strategies on importance of birth registration of OVC to attain birth certificates*
- *Support families to attain birth certificates for OVC*
- *Address barriers that hinder OVC from accessing their birth certificates*

g. ***Support programmes that ensure families caring for OVC have appropriate shelter***

- *Identify and support families caring for OVC that have inappropriate shelter*

h. ***Increased number of OVC receiving psychosocial support***

- *Develop national guidelines on psychosocial support to OVC*
- *Support set up of community based psychosocial interventions for OVC*
- *Integrate psychosocial support interventions into OVC programmes*
- *Train teachers on psychosocial support for OVC in school set up*

PSA 4: Ensure that improved policy and legislation are put in place to protect OVC

This strategic area aims at ensuring that the government develops policies and enacts laws that ensure protection of OVC and children from every form of abuse and exploitation such as child trafficking, child labour, sexual abuse and exploitation, recruitment into armed groups and disinheritance, among others.

It is recommended that laws should be reviewed to address the existing gaps in protection of OVC. While in Kenya some laws protecting and providing for OVC exist, enforcement still remains a challenge.

Expected Outcome: ***Comprehensive policies and legislations addressing the needs of OVC are in place and are functional***

Expected Outputs and Activities:

a. National policies, legislation, strategies and action plans that provide for support and protection of OVC in place and functional

- *Review current policies and legislation to identify gaps in addressing OVC welfare*
- *Support development of a national social protection policy that ensures incorporation of OVC*
- *Put in place mechanisms that measure progress in enactment of policy and legislation that incorporate responses for OVC*
- *Lobby for implementation of the Early Childhood Development Policy*
- *Support dissemination and implementation of existing laws/regulations that support care and protection of OVC*
- *Build the capacity of duty bearers to enhance their effective implementation of legislation for children as duty by various policy documents*
- *Develop and implement an advocacy strategy for OVC*
- *Advocate for adequate resource allocation for implementing policies/guidelines*
- *Develop and implement appropriate curricula and training programmes that address needs of OVC and their families developed and implemented*

b. OVC care and support incorporated in relevant institutions' curriculum

- *Review current training programmes, curriculum and materials of relevant institutions to establish coverage of OVC issues, e.g., higher learning institutions, police training, relevant tertiary training colleges, etc.*
- *Develop and support incorporation of OVC issues in these training programmes, curriculums and materials*

PSA 5: Create a supportive environment for children and families affected by HIV/AIDS, implement awareness raising campaigns at all levels through advocacy and social mobilisation

This strategic area seeks to address specifically stigma and discrimination related to HIV/AIDS that are experienced by OVC and their families. More needs to be done as different communities in Kenya are at different levels in terms knowledge, perceptions, attitudes and actions towards people living with HIV/AIDS and their families.
To reduce stigma and discrimination, this strategic area emphasizes on the need to increase access to information that challenges myths and transform public perception of HIV&AIDS. Further, this NPA has outlined one of the principles as ensuring that interventions do not, in whatever way, give a chance for promotion of stigma and discrimination of orphans and other children affected by HIV/AIDS.

This strategy focuses on developing a comprehensive stakeholder communication strategy; creating general awareness of OVC at every level and advocating for the rights of the child at every level of society.

Expected Outcome: ***A supportive environment for children and families affected by HIV and AIDS***

Expected Outputs and Activities:

a. ***Increased number of leaders engaged in campaigning for reduction of stigma and discrimination***

- *Support training and sensitizing leaders, including members of parliament on HIV/ AIDS, OVC issues and impact of stigma and discrimination to the families and the country as a whole*
- *Develop and disseminate IEC materials to leaders*
- *Disseminating the OVC policy, guidelines and other legislative provisions to leaders*

b. ***Increased public awareness on the situation of OVC and dangers of stigma and discrimination***

- *Develop and implement a comprehensive stakeholders communication strategy on HIV/AIDS*
- *Develop and implement dissemination mechanisms and strategies for essential OVC information and data (e.g. Situation Analysis findings, the HIV/AIDS indicators survey)*
- *Support community open forum discussions on HIV/AIDS and protection of OVC and their families*
- *Support the teaching of life skills for in and out of school children*

- *Support local actors i.e. teachers, health care workers, social welfare service providers, women groups, youth groups among others, to integrate into their work discussions of protection as it relates to HIV/AIDS*
- *Support partnership with the media to highlight issues of HIV/AIDS, stigma and discrimination*

PSA 6: Strengthen and support national and community coordination and institutional structure

Many development partners, NGOs, CBOs, FBOs and the Government are implementing more and more activities directed towards OVC programmes albeit in an uncoordinated manner. The National Council of Children Services (NCCS) at the national level and its community structures AAC are mandated to coordinate and monitor OVC interventions but its institutional structures requires to be enhanced to effectively undertake this role.

This strategic area is designed to facilitate an improved national and community coordination of OVC interventions. It cuts across all the other strategies by focusing on stakeholder joint ventures and resource mobilization initiatives.

Expected Outcome: ***Improved coordination of OVC interventions at national, district and community levels***

Expected Outputs and Activities:

a) Mechanisms for national, district, and community level coordination of OVC interventions developed and operational

- *Build capacity of National Steering Committee (NSC) members on advocacy, resource mobilization and coordination for OVC interventions*
- *Support and strengthen the capacity of the National Council for Children Services (NCCS) to review, develop and disseminate OVC agenda at national, district and community levels*
- *Support and strengthen capacity of Department of Children Services to coordinate and monitor OVC interventions*
- *Strengthen the capacity of AAC to coordinate OVC interventions at district and community levels*
- *Support multi-sector national and district annual work planning*
- *Establish an inventory of agencies dealing with OVC at national and district levels.*
- *Establish referral systems at community and district levels*
- *Support dissemination of the NPA for OVC at national and district levels to promote harmonization of interventions*

PSA 7: Strengthening national capacity to monitor and evaluate programme effectiveness and quality

Monitoring and evaluation acts as a guide in tracking the attainment of this NPA's objectives and also helps to rationalize the use of resources. The strategy helps programme implementers make informed decisions about programme operations; make the most effective and efficient use of resources; determine the extent to which the programmes/projects are on track; make any needed corrections accordingly; and ensure that OVC receive quality and timely services.

Expected Outcome: ***Improved services for OVC by all stakeholders***

Expected Output and Activities:

a. An integrated Monitoring and Evaluation Plan developed and implemented

- *Develop an integrated Monitoring and Evaluation Plan*
- *Define indicators for use by all OVC stakeholders to monitor national progress on responding on OVC*
- *Establish baseline data of agreed indicators*
- *Strengthen institutional capacity of the Department of Children Services to monitor OVC interventions*
- *Develop and disseminate monitoring tools*
- *Strengthen capacity of stakeholders implementing OVC interventions at all levels on monitoring progress of OVC*

b. OVC indicators incorporated and enshrined into national data/information systems

- *Lobby for mainstreaming of OVC agenda/indicators into periodic national data collection efforts such as national census, integrated household surveys and poverty surveys among others*
- *Lobby for generation and provision of OVC data by key social services ministries providing services to children, e.g., the school enrolment and retention data by Ministry of Education, immunization data by Ministry of Health and civil registration data by the Department of Civil Registrar, among others*

c. An OVC information sharing system/mechanism in place and functional

- *Review, strengthen and harmonize the existing information data base on children and OVC under the coordination of Department of Children Services*
- *Strengthen the capacity of stakeholders on information generation, analysis and utilization*
- *Support the development of a dissemination mechanism on OVC responses*
- *Support operational research on OVC issues*

CHAPTER 3: SUGGESTED MINIMUM PACKAGE

Various interventions for OVC have been way below meeting the basic needs of children they are meant to assist. Some of the interventions focus on some parts of the needs of children and not others. Those intervening for OVC have always regarded these interventions as making a difference in the lives of the beneficiary OVC even when the service is a-one-type handout given once or twice a year. There is thus need to ensure quantity, quality and frequency of these interventions.

This chapter is meant to address this concern and recommends a minimum package for various age groups of OVC (0-5, 6-13, 14 – under18). The chapter is based on and draws from the 7 Priority Strategic Areas discussed in the previous chapter; and especially the first three. The recommended minimum package takes cognisance of the fact that the development of a child's full potential – which is every child's right – is seriously threatened if the family environment deteriorates as a result of parental illness, extreme poverty or death. It is also threatened when the impact of HIV/AIDS undermines basic social services and safety nets such as health care, education, limited infrastructure, poor management, etc.

This Chapter presents a set of minimum interventions that are essential for meeting the basic needs of the OVC. This set of minimum interventions may be used to define which OVC has been reached and "the depth of reach" during the implementation of projects and programmes. "The depth of reach" will be defined as the percentage of overall minimum package that is made available to OVC in relation to the frequency that it is supplied. The minimum package may be viewed as the basic needs and rights of the OVC.

At the end of this chapter a set of extended interventions have been recommended that may follow once the minimum package has been provided for the majority of OVC. The costing of the minimum interventions is presented in Chapter Four.

3.1 A Developmental Approach

Children respond very differently to their experiences at different ages, depending on their level of physical, cognitive, emotional and psychosocial development. The illness or death of a parent or other family member has differing effects on children, depending in part, on a child's age and stage of development. For example, the effects of the illness or death of a key caregiver will be different for infants, young children, and children in the middle childhood years, and adolescents. The developmental level (including emotional maturity and level of understanding) of a child or adolescent will influence how he or she reacts to the death of a mother or father (or both), to separation from siblings, and to other possible consequences of parental death.

A young person's stage of development will also be a factor in determining the kinds of support and protection he or she needs to enhance the prospect of a healthy and productive future. OVC must not be regarded as a homogeneous and undifferentiated group. Policies, programs, information, and literature concerning OVC must be informed by a developmental, life cycle approach that recognize the physical, cognitive, emotional, and psychosocial differences that characterize children and adolescents in different stages of their development. The recommended minimum package takes these differences into account and recommends what is more relevant to the children of different ages.

Implementers of the recommended minimum package are advised to contact their district nutrition officers to get advice on proper nutritional diet as available within their localities which meet the needs of OVC of various ages. It is highly recommended that interveners work closely with relevant key ministries to get national recommended services and also to contextualize some interventions such as food available at particular geographical area that ensure recommended nutritional provision, messaging on reproductive health for adolescents with different cultural context, and recommended standards for various interventions, among others.

3.2 Minimum package for Infancy and Early Childhood: (0 – 5 year olds)

All children are most vulnerable during the first five years of life. Within this period, a child is at greatest risk of dying in the first year, especially during delivery and the first month after birth. The illness or death of a mother or guardian during a child's first year has life-threatening consequences. While the threat of such a loss to a child's survival gradually diminishes after the first year, it remains significant for several years.

In the first two years of life, young children need to feel emotionally close to at least one consistent and loving caregiver for their healthy development and, in fact, for their survival. In addition to the fulfilment of basic physical needs, the child needs touching, holding, emotional support and love from the consistent caregiver. When a young child loses such a caregiver, he or she is at risk of losing the ability to make close emotional bonds – to love and be loved – as well as at increased risk of illness and death. Children at this stage of life are sensitive to feelings of loss and stress in others and need reassurance.

HIV/AIDS heightens the vulnerability of infant children. While most children born to HIV-positive mothers do not become infected, their chances of survival are diminished if the mother becomes sick with AIDS and dies. Some infants acquire HIV infection from their mother during pregnancy and delivery or early in life, greatly reducing their chances of survival. Childhood diseases pose the most serious threat to the survival and development of young children in vulnerable households.

Boys and girls under age 5 – especially those whose families live in poverty in developing countries – are vulnerable to potentially fatal measles, diarrhoea, and pneumonia. Malnutrition increases the chances of children dying from these diseases. In addition, severe malnutrition during the first few years of life can cause irreversible stunting and impaired cognitive functioning. In settings where immunizations, treatment of childhood illness and adequate nutrition cannot always be assured, programs need to make concerted efforts to ensure that OVC under age 5 receive these key child survival interventions, because families with parents or other caregivers affected by HIV/AIDS may find it difficult to do so. Parents and caregivers also need support and training in providing the best care they can for these young children.

Between ages 3 and 6, young children remain vulnerable to diseases and malnutrition, but caregivers may neglect these children needs because they appear to be more independent. These children continue to need a sense of belonging and social and emotional support. They also need opportunities to learn, because this is the critical period for establishing curiosity, exploration, and motor skills.

Children of this age do not understand the finality of death and may expect a person who has died to reappear. They may fear that they have caused a loved one's death. Caregivers need to assure a child that this is not the case and also understand the child's anxiety, sadness, and possible outbursts of anger or regression to earlier forms of behaviour. Caregivers need to make the child feel safe and loved, be willing to talk about loss and the person who died, and provide clear information about death.

Long-term institutional care is particularly inappropriate for infants and young children, because the healthy emotional, cognitive, and even physical development of children in this age group requires that they have at least one consistent and loving caregiver with whom they can form a bond. There is a pressing need to ensure that family based care is available for these children, either through support for relatives, foster care, local adoptive placement, or community organizations that are integrally linked to the community.

Strategies that can help keep young children in families also include community-based child care and home visits. In response to demand, community-based child care centres are becoming more common in a number of countries. They provide children with food, access to health care,

and a place to learn and play. They may also enable older siblings to attend school and provide support for isolated caregivers, including the elderly. Home visits by community volunteers to caregivers who are elderly or children themselves can help them cope and promote good care and healthy practices such as positive discipline, preschool attendance and adequate nutrition for the children. Home-based care for an ill parent can help families as well as the affected adult.

Based on the above narration, a minimum package for this age group may be defined as follows:

- **Ensure that appropriate family/household based care is available to the child**
- **Ensure that the family and child have appropriate housing or shelter**
- **Ensure that the child has received all required immunizations as defined by Ministry of Health and indicated in the Ministry's immunization schedule**
- **Ensure that the child and caregiver visit the facility to receive health services under the Ministry of Health IMCI package/strategy**
- **Ensure that the child receives proper nutrition, and that the household is food secure**
- **Ensure that the child has obtained an official birth certificate**
- **Ensure that the child has appropriate clothing**
- **Ensure that a child aged 4-5 has access to early childhood development (ECD)**
- **Ensure that the child and caregiver receive psychosocial support when appropriate**
- **Ensure that the child's caregiver receives information on care of OVC including information on health issues of children, nutrition, foster care, acquisition of birth certificate, child development , child rights, child protection, child HIV status and treatment where appropriate, among others**

3.3 Minimum package for Middle Childhood (6 – 13 years)

Orphans in middle childhood are able to understand the finality of death and may have intense fears of further abandonment and loss. They may experience anxiety and regress to younger behaviours for a period of time. Others may not appear to react at all until months later. They can benefit from the opportunity to talk about death and loss, to participate in rituals related to the person they have lost, and to re-establish normal routines.

During middle childhood, school attendance is essential for progress in learning and problem solving. However, the impact of HIV/AIDS prevents some children from going to school and can affect their ability to study. Orphans are more likely than other children to be excluded from school, with household poverty, age, and relationship with the guardian all affecting school attendance. Ensuring access to quality education for orphans in middle childhood is an important program priority.

The experiences of a loving family life and group activities with siblings and friends are also important for healthy development during middle childhood. These children need a sense of security and belonging in a family or family-like environment. In addition to this family identity, a growing child needs to develop a positive self-identity and self-esteem.

Stigma and discrimination related to HIV/AIDS can negatively affect a child's social environment and relationships and can sometimes damage his or her self-esteem. Children in this age group should receive adequate protection and support to live with a surviving parent, or a member of the extended family, or with appropriate and well-monitored family-based care in their community. Programs must also ensure that children have access to age-appropriate education, health care, and other basic services.

Based on the above narration, a minimum package for this age group may be defined as follows:

- **Ensure that appropriate family/household based care is available to the child**
- **Ensure that the family and child has appropriate housing or shelter**
- **Ensure that the child has appropriate clothing, including school uniform**
- **Ensure that the child has obtained official birth certificate**
- **Ensure that the child attends primary school and support successful completion of a primary school**
- **Ensure that the child and caregiver visit a health facility to receive health service under the IMCI package/strategy**
- **Ensure that the child receives proper nutrition and that the household is food secure**
- **Sensitize the child on life skills, dangers of drug abuse and reproductive health issues at an appropriate age, including HIV/AIDS prevention and testing**
- **Ensure that the child and caregiver receive information on development and protection of the child including protection from early marriages, female genital mutilation (FGM), gender based violence (GBV), prevention of sexually transmitted infections, including HIV, among others**
- **Ensure that both the child and caregivers have psycho-social support**
- **Ensure the availability of sanitary ware as appropriate**

3.4 Minimum package for Adolescence: 14 to under 18 year olds

During adolescence, several key development experiences occur, including physical and sexual maturation, secondary school attendance, progress toward social and economic independence, and further development of identity. The transition from middle childhood to early adolescence is gradual, and some of the developmental tasks and concerns of middle childhood continue in

early adolescence. As the adolescent matures, some issues that were coming to the front during the latter stages of middle childhood become increasingly significant. These issues include prevention of sexual abuse and exploitation (and confronting it when it happens), the attainment of life skills (including those for HIV prevention) and the achievement of overall healthy and productive development.

Adolescents understand the nature of loss but may not directly express their worries and anxieties. They may feel resentment and anger at the death of a parent or close family member. They may seem to be coping, but at the same time they can experience depression, hopelessness and increased vulnerability. This can lead to a sense of alienation, desperation, risk-taking behaviour and withdrawal. Adolescents need to have someone to assist them with decision-making about future options and opportunities.

In many countries, adolescents have significantly less access to school than younger children. The economic impacts of HIV/AIDS on households jeopardize many adolescents' chances of staying in school, especially if they have to assume new responsibilities for supporting the family. Some become the head of the household if the alternative is for siblings to be separated or if siblings risk losing their inheritance after the death of their parents. Orphaned adolescents may be caught in the dilemma of having to work to support themselves and possibly younger siblings, which prevents them from attending school and receiving the education and training they need to obtain productive work.

Economic hardship can also deprive adolescents of much needed recreation and participation in community activities. Depression, hopelessness and risky behaviour can be common reactions to these circumstances; special attention and strong protective measures are needed. Even adolescent boys and girls whose families are intact may lack the information, skills, and youth-friendly services to support a positive transition through adolescent sexuality. Due to the fact that sexual activity (as well as substance abuse and other risky behaviours) often begins during adolescence, it is critical to provide comprehensive sexual health education and services to reduce the risks – often heightened for orphans – of unwanted pregnancies, coerced sex, exploitation in commercial sex and transmission of sexually transmitted infections. Programmes must provide information on health behaviours and the life skills that adolescents need to protect themselves.

Orphans may be particularly challenged by the developmental tasks of adolescence. Psychosocial and economic distress can lead to risk-taking behaviour linked with unsafe sexual practices and substance abuse. Adolescent orphans in HIV/AIDS-affected communities may be more vulnerable to HIV infection than young children or adults. Young people, especially girls, are becoming infected at younger ages, particularly in communities highly affected by HIV/AIDS. Ensuring that adolescents have access to education, job and life skills training and

health services are essential for policy and programme priorities. Strengthening the economic capacity of affected households caring for orphaned and vulnerable adolescents will also help keep future opportunities open to them. Connecting adolescents with caring or mentoring adults through participation in school, faith-based and other community organizations and activities will also promote healthy socialization and a sense of belonging as they approach adulthood.

Based on the above narration, a minimum package for this age group may be defined as follows:

- **Ensure that appropriate family/household based care is available to the child**
- **Ensure that the family and child have appropriate housing or shelter**
- **Ensure that the child has proper clothing, including school uniform**
- **Ensure that the child has obtained an official birth certificate**
- **Ensure that the child attains appropriate level of education**
- **Ensure that the child and caregiver visit a health facility to receive health services under the IMCI package/strategy**
- **Ensure that the child receives proper nutrition and the household is food secure**
- **Sensitise the child on life skills, dangers of drug abuse, and reproductive health issues at an appropriate age, including HIV/AIDS prevention and testing**
- **Ensure that the livelihood of the child is secured by providing future options such as vocational training and economic empowerment among others**
- **Ensure that the adolescent child and caregiver receive information on development and protection of the child including protection from early marriages, FGM, GBV, prevention from the infections, including HIV**
- **Ensure availability of sanitary ware as appropriate**
- **Provide an extended package or supportive interventions**

Additional support interventions that define an extended package may include the following: 0-18 years

- **Provision of ARV and drugs for opportunistic infections for HIV+ children**
- **Home visits by social workers**
- **Community based day-care centres for children whose head of household has to go to school**
- **Provision of insecticide treated bed-nets**
- **Sanitary towels for adolescent girls who are OVC**

Finally, it is important to note that once the child reaches the age of eighteen years old, coordination and referral mechanisms should be established to support those in need of assistance.

CHAPTER 4: COSTING OF THE MINIMUM PACKAGE

4.1 Introduction

This chapter provides estimate costs of minimum package of interventions for the OVC. The minimum packages as given for different age groups are presented in Tables 4.1.1, 4.1.2 and 4.1.3 for the age groups 0-5 years, 6-13 years and 14 - under 18 years, respectively. The interventions are given codes A, B and C corresponding to these age groups respectively. However, some interventions coded A for age group 0-5 years apply to the other two age groups and therefore same codes have been used. The same applies for interventions coded B for age group 6 – 13 years but applicable to age group 14-under 18 years, as well.

Table 4.1.1: Minimum Package for Infancy and Early Childhood (0-5 years)

Code of Intervention	*Description of Interventions of Minimum Package*
A1	Ensure that appropriate family/households based care is available to the child
A2	Ensure that the family and child have appropriate housing or shelter
A3	Ensure that the child has received all required immunizations as defined by the Ministry of Health
A4	Ensure that the child and caregiver visit a health facility to receive health services under the IMCI package/strategy
A5	Ensure that the child receives proper nutrition, and the household is food secure
A6	Ensure that the child has obtained an official birth certificate
A7	Ensure that the child has appropriate clothing
A8	Ensure that a child aged 4-5 has access to and completes ECDE
A9	Ensure that the child and caregiver receive psychosocial support when appropriate
A10	Ensure that the child's caregiver receives information on care of OVC, including information on health issues of children, nutrition, foster care, acquisition of a birth certificate, child development, child rights, child protection, and child HIV status and treatment where appropriate, among others

Table 4.1.2: Minimum Package for Middle Childhood (6-13 years)

Code of Intervention	*Description of Interventions of Minimum Package*
A1	Ensure that appropriate family/household based care is available to the child
A2	Ensure that the family and child have appropriate housing or shelter
B1	Ensure that the child has appropriate clothing, including school uniform
A6	Ensure that the child has obtained an official birth certificate
B2	Ensure that the child attends primary school and support successful completion of primary school
A4	Ensure that the child and caregiver visit a health facility to receive health services under the IMCI package/strategy
A5	Ensure that the child receives proper nutrition and that the household is food secure
B4	Sensitize the child on life skills, dangers of drug abuse and reproductive health issues at appropriate age, including HIV/AIDS prevention and testing
B5	Ensure that the child and caregiver receive information on development and protection of the child, including protection from early marriage, female genital mutilation, gender based violence, prevention of sexually transmitted infections, including HIV/AIDS
A9	Ensure that both child and caregivers have psycho-social support
B6	Ensure the availability of sanitary ware as appropriate

Table 4.1.3: Minimum Package for Adolescence (14- under 18 years)

Code of Intervention	*Description of Interventions of Minimum Package*
A1	Ensure that appropriate family/household based care is available to the child
A2	Ensure that the family and child have appropriate housing or shelter
B1	Ensure that the child has proper clothing, including school uniform
A6	Ensure that the child has obtained an official birth certificate
C1	Ensure that the child attains an appropriate level of education
A4	Ensure that the child and caregiver visit a health facility to receive health services under the IMCI package/strategy
A5	Ensure that the child receives proper nutrition and the household is food secure
B4	Sensitize the child on life skills, dangers of drug abuse, and reproductive health issues at an appropriate age, including HIV/AIDS prevention and testing
C4	Ensure that the livelihood of the child is secured by providing future options such as vocational training and economic empowerment
B5	Ensure that the adolescent child and caregiver receive information on development and protection of the child, including protection from early marriages, FGM/C, GBV, prevention of sexually transmitted infections, including HIV/AIDS
B6	Ensure the availability of sanitary ware as appropriate

4.2 Interventions derived from the Minimum Package

The minimum package was further classified in terms of specific interventions to allow costs estimation. The interventions consist of the following:

(a) *Education: the financial resources required in this intervention include school fees, uniforms, books and other supplies, and other fees*
(b) *Health: the resources required cover a full course of immunization, vitamin A supplementation, and routine health care services for children aged 0-5 years Resources to cover routine health care services for children aged 6- 17 years*
(c) *Sanitary pads: for girls aged 13-17 years*
(d) *Birth registration for all those in aged 0-5 years and those aged 6-17 who were not registered during early childhood*
(e) *Vocational training: for the children aged 10-17 years, who may miss to continue with formal schooling*

(f) *Family/home support: this intervention requires resources to cover financial stability (cash transfer), training in small business skills, strengthening life and survival skills, provision of psycho-social support, bed-nets, clothes, shoes and bedding, among others.*

In addition to the above interventions, programme costs were also estimated as proportion of the cost of interventions.

4.3 Costing Approach

The total cost of each intervention was estimated by multiplying the volume of services required by the unit costs, i.e.

Resources (Ksh) = Population in need X coverage target X unit cost

The *population in need* consists of the number of OVC in need of a given intervention, e.g., those OVC needing primary education. The *number of OVC* in need of each intervention was determined from the size of the relevant population of children in each of the three age groups. In terms of family support interventions, the number of households was used instead of the number of OVC. The *coverage target* is defined as the proportion of the population in need that will be reached by a given intervention in a specified time period of the NPA. Coverage rates indicate what is feasible. The *unit cost* is the amount of resources required per OVC per given intervention or per household per given intervention.

4.4 Determining the Number of OVC for the Purposes of Costing this NPA

Currently, there exist no data on the number of vulnerable children in the country. However, data on the number of orphans does exist from different sources including the *KDHS 2003, NACC 2005, KIHBS 2005/6 and the Children on the Brink Report 2004 by UNICEF.* Table 4.4.1 below presents the estimated and projected number of orphans as presented by *NACC:*

Table 4.4.1: Number of AIDS orphans 2007 - 2010

	Years			
Category	**2007**	**2008**	**2009(projected)**	**2010 (projected)**
Maternal Orphans				
AIDS	847,820	847,165	839,471	824,561
Non-AIDS	577,227	584,419	592,409	601,377
Total	1,425,047	1,431,584	1,431,881	1,425,938
Paternal Orphans				
AIDS	488,998	493,031	493,889	490,895
Non-AIDS	875,628	888,564	903,567	920,903
Total	1,364,626	1,381,595	1,397,456	1,411,797
Dual Orphans				
AIDS	342,975	341,485	336,624	328,370
Non-AIDS	96,709	97,096	97,632	98,371
Total	439,685	438,581	434,256	426,741
Total Orphans	2,349,989	2,374,598	2,395,081	2,410,995
All AIDS Orphans	1,048,356	1,052,727	1,049,937	1,039,130

Source: ***National AIDS Control Council, Nairobi: 2007***

Although a broad definition of OVC is embraced by the NPA, lack of data resulted in a decision by the Technical Working Group (TWG) overseeing the development of the NPA to adopt a narrow definition consisting of all orphans plus an additional 10% of all orphans, which is assumed to cater for other vulnerable children *(i.e. Total number of orphans + 10% of all orphans = total number of OVC).* These total numbers of OVC form a baseline upon which targeted populations of OVC for proposed interventions were calculated. Estimates of the number of orphans were generated from the Spectrum software model, as shown in Table 4.4.1 above.

Note that paternal and maternal orphans include the dual orphans. Total orphans consist of the total of maternal and paternal orphans less dual orphans. Using these numbers, the total number of OVC is calculated using the above formula given under 5.4 and is presented in Table 4.4.2 below.

Based on Table 4.4.1 above and using the formula given, i.e., an additional 10%, the estimated number of OVC in need has been calculated as presented in Table 4.4.2 below. This is considered to be the population of OVC in need.

Table 4.4.2: Estimated number of OVC (population in need)

	Years			
Age group	**2007**	**2008**	**2009**	**2010**
0-5	**399,298**	**403,372**	**406,658**	**409,071**
6-13 years	**1,366,812**	**1,380,758**	**1,392,007**	**1,400,266**
14-under 18 years	**688,715**	**695,741**	**701,410**	**705,571**
TOTAL OVC	**2,454,825**	**2,479,871**	**2,500,075**	**2,514,908**

Source*: *Data on orphans were generated by Spectrum at NACC, Nairobi

4.5: Coverage Targets Used in Costing

The coverage target represents the number of OVC that the NPA targets to reach in a given year. These different targets were based on information from a number of documents, specifically *Kenya National AIDS Strategic Plan 2005/06-2009/10, Kenya National Health Sector Strategic Plan II (2005-2010), and the Kenya Education Sector Support Programme (KESSP) (MOE, 2005 - Education)*. In addition, discussions with the TWG were useful in deriving coverage targets for some other interventions, such as household-based interventions. The targets used in the estimation are presented in Table 4.5.1, Table 4.5.2 and Table 4.5.3.

Table 4.5.1: OVC coverage targets for age groups 0-5 and 6-13 years

	2007/08	2008/09	2009/10	Target Population	Remarks
Age Group 0-5					
Accessing full course of childhood immunizations	72%	77%	85%	All OVC defined for this age group	Kenya Integrated Household Budget Survey 2005/06 gave a national coverage of 66%
Vitamin A, zinc and iron supplements	34%	42%	50%	All OVC defined for this age group	11% routine health care coverage based on RAAAPP 2004
Routine health care	34%	42%	50%	All OVC defined for this age group	11% routine health care coverage based on RAAAPP 2005
Birth registration	38%	44%	50%	All OVC defined for this age group but not registered	Note the RAAAPP gave a figure of 81.6% with registration documents, but KDHS (2003) gives 21%
Bednet	59%	69%	80%	All OVC defined for this age group	KIHBS 2005/06 gave a national coverage of 27%
Age Group 6-13					
Education: school fees	49%	64%	80%	All OVC defined for this age group	Based on discussion with TWG
Education: uniforms	49%	64%	80%	All OVC defined for this age group	Based on discussion with TWG
Education: books and supplies	49%	64%	80%	All OVC defined for this age group	Based on discussion with TWG
Education: special fees/assessments	49%	64%	80%	All OVC defined for this age group	Based on discussion with TWG
Routine health care	34%	42%	50%	All OVC defined for this age group	11% routine health care coverage based on RAAAPP 2005
Birth registration	38%	44%	50%	All OVC defined for this age group but not registered	Note the RAAAPP gave a figure of 81.6% with registration documents, but KDHS (2003) gives 21%

Table 4.5.2: OVC coverage targets for age group 14-less than 18 years

	2007/08	2008/09	2009/10	Target Population	Remarks
Age 14-below 18					
Education: school fees	20%	25%	29%	All OVC defined for this age group	Targets as for age group 6-13 but adjusted for transition to secondary from 47.3% in 2002 to 70% in 2008 (KESSP, 2005)
Education: uniforms	20%	25%	29%	All OVC defined for this age group	Targets as for age group 6-13 but adjusted for transition to secondary from 47.3% in 2002 to 70% in 2008 (KESSP, 2005)
Education: books and supplies	20%	25%	29%	All OVC defined for this age group	Targets as for age group 6-13 but adjusted for transition to secondary from 47.3% in 2002 to 70% in 2008 (KESSP, 2005)
Education: special fees/assessments	20%	25%	29%	All OVC defined for this age group	Targets as for age group 6-13 but adjusted for transition to secondary from 47.3% in 2002 to 70% in 2008 (KESSP, 2005)
Skills (vocational)	9%	10%	13%	All OVC defined for this age group	For those not in formal secondary schooling
Routine health care	34%	42%	50%	All OVC defined for this age group	11% routine health care coverage based on RAAAPP 2004
Birth registration	38%	44%	50%	All OVC defined for this age group but not registered	Note the RAAAPP gave a figure of 81.6% with registration documents, but KDHS (2003) gives 21%
Sanitary pads	30%	40%	50%	All female OVC defined for this age group	Based on discussion with TWG

Table 4.5.3: OVC coverage targets for households with OVC

Family/ Home	2007/08	2008/09	2009/10	Target Population	Remarks
Cash transfer	30,000	50,000	100,000	Households	Based on discussion with TWG and decision derived by using the national projections of CT-OVC reach.
Training in small business	30,000	50000	100,000	Households	Based on discussion with TWG and decision derived by using the national projections of CT-OVC reach.
Micro finance	30,000	50000	100,000	Households	Based on discussion with TWG and decision derived by using the national projections of CT-OVC reach.
Strengthening life and survival skills	30,000	50000	100,000	Households	Based on discussion with TWG and decision derived by using the national projections of CT
Provision of psycho-social support	30,000	50000	100,000	Households	Based on discussion with TWG and decision derived by using the national projections of CT
Shelter	30,000	50,000	100,000	Households	Based on discussion with TWG and decision derived by using the national projections of CT
Clothes	90,000	150,000	300,000	3 orphans multiplied with the number of households given above	Based on discussion with TWG. Target based on the assumption that each of the above household has 3 OVC.
Shoes	90,000	150,000	300,000	3 orphans multiplied with the number of households given above	Based on discussion with TWG. Target based on the assumption that each of the above household has 3 OVC.
Blanket and bedding	90,000	150,000	300,000	3 orphans multiplied by the number of households given above	Based on discussion with TWG. Target based on the assumption that each of the above household has 3 OVC.
Food	75,000	125,000	250,000	2.5 persons times the number of households given above	Based on discussion with TWG

4.6: Unit cost per each intervention

The unit costs for the costing exercise were obtained from various sources. However, two main sources of unit costs were the surveys carried out by Futures Group *"Financial Resources Required to Support Orphans and Children made vulnerable by HIV/AIDS Survey"*, May 2004 (***Futures Group, 2004***) and *Rapid Assessment, Analysis and Action Planning Process* (RAAAPP) for Orphans and Other Children Made Vulnerable by HIV/AIDS *(MOHA, 2004).* The unit costs used are presented in Table 4.6.1 and Table 4.6.2.

Table 4.6.1: Unit costs for different interventions

	Average unit cost per year (Kenya Shillings)	Source
AGE GROUP 0-5		
Accessing full course of childhood immunization	70	Futures Group, 2004
Vitamin A, zinc and iron supplements	1,543	Futures Group, 2004
Routine health care	4,569	Futures Group, 2004
Birth registration	550	Estimates based on Ksh 50 charged by Department of Civil Registrar for registration and discussion with TWG on average transport cost of Ksh. 500
AGE GROUP 6-13		
Education: school fees	-	
Education: uniforms	2,847	Futures Group, 2004
Education: books and supplies	-	
Education: special fees/assessments	-	
Routine health care	4,281	Futures Group, 2004
Birth registration	550	Estimates based on Ksh. 50 charged by Department of Civil Registrar for registration and discussion with TWG on average transport cost of Ksh. 500
AGE 14-under 18		
Education: school fees	20,900	Government fees guidelines
Education: uniforms	4,223	Futures Group, 2004
Education: books and supplies	5,974	Futures Group, 2004
Education: special fees/assessments	2,500	Government fees guidelines
Skills (vocational)	11,945	Futures Group, 2004
Routine health care	4,817	Futures Group, 2004
Birth registration	550	Estimated based on registration fee Ksh. 50 and transport cost of Ksh. 500
Sanitary pads	2400	Market price for year 2007

This table does not include costs already taken care of by the government, such as school fees, books and supplies for primary school.

Table 4.6.2: Unit costs for different interventions for household support

FAMILY SUPPORT	Average Unit Cost per year per household in Ksh.	Source
Cash transfer	18,000	MGCSD cash transfer to households of Ksh. 1,500.00 per month
Training in small business	15,875	Futures Group, 2004
Micro finance	16,305	Futures Group, 2004
Strengthening life and survival skills	1,000	Futures Group, 2004
Provision of psycho-social support	140	Futures Group, 2004
Shelter	1,500	Agreed by TWG
Bednet	683	Futures Group, 2004
Clothes	3,128	Futures Group, 2004
Shoes	2,179	Futures Group, 2004
Blanket and bedding	2,357	Futures Group, 2004
Food	12,802	KIHBS 2005/2006

The estimated costs of the different interventions based on the above information are presented in Table 4.7.1

4.7: Estimated Cost for the targeted OVC population covering 2007 - 2010

The estimated cost of OVC interventions is calculated by multiplying the *target population* with the unit cost and is presented in the table below.

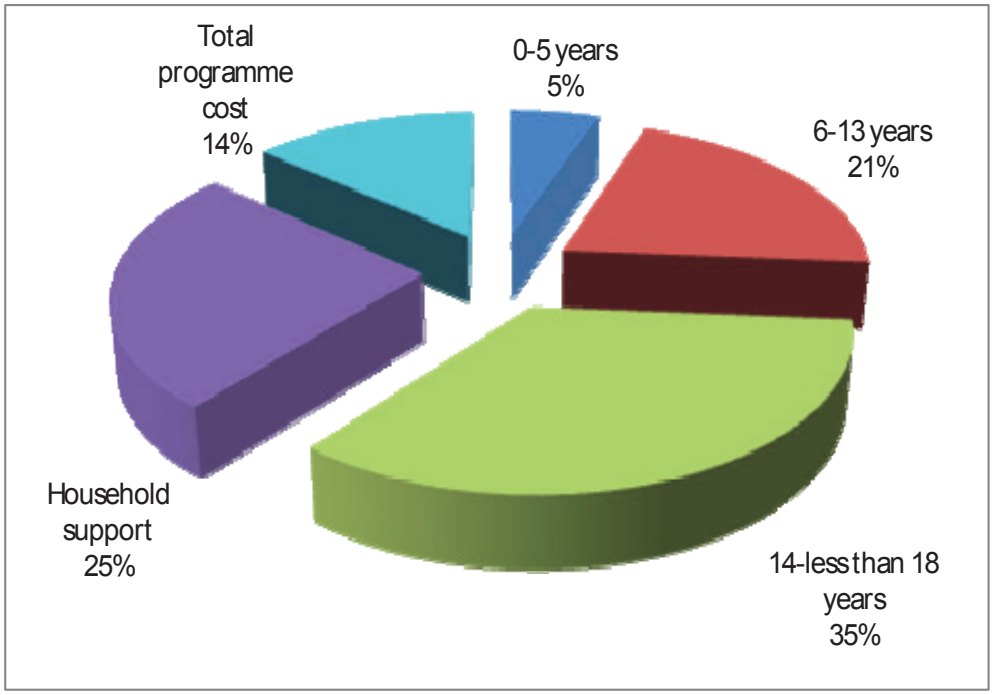
Table 4.7.1: Estimated cost (Ksh million) of OVC interventions

	2007/08 Ksh. 000,000.00	2008/09 Ksh. 000,000.00	2009/2010 Ksh. 000,000.00	2007/08-2009/10 Ksh. 000,000.00
AGE GROUP 0-5				
Accessing full course of childhood immunizations	24	27	31	81
Vitamin A, zinc and iron supplements	245	320	402	967
Routine health care	727	947	1,189	2,863
Birth registration	50	120	143	312
Bednet	186	233	284	703
Sub-total	**1,231**	**1,646**	**2,049**	**4,927**
AGE GROUP 6-13				
Education: school fees	-	-	-	
Education: uniforms	2,069	3,090	4,058	9,218
Education: books and supplies	-	-	-	
Education: special fees/assessments	-	-	-	
Routine health care	2,181	3,038	3,814	9,033
Birth registration	172	305	322	799
Sub-total	**4,422**	**6,434**	**8,194**	**19,050**
AGE GROUP 14- UNDER 18				
Education: school fees	3,420	4,497	5,402	13,319
Education: uniforms	691	909	1,092	2,691
Education: books and supplies	977	1,286	1,544	3,807
Education: special fees/assessments	409	538	646	1,593
Skills (vocational)	860	1,035	1,351	3,245
Routine health care	1,321	1,723	2,162	5,206
Birth registration	108	156	165	429
Sanitary pads	296	417	549	1,263
Sub-total	**8,082**	**10,560**	**12,912**	**31,554**
HOUSEHOLD SUPPORT				
Cash transfer	540	900	1,800	3,240
Training in small business	551	965	2,026	3,542
Micro finance	566	991	2,081	3,638
Strengthening life and survival skills	35	61	128	224
Provision of psycho-social support	5	9	18	32
Shelter	52	91	191	334
Clothes	326	570	1,198	2,094
Shoes	227	397	834	1,458
Blanket and bedding	246	430	902	1,578
Food	1,111	1,945	4,085	7,141
Sub total	**3,659**	**6,359**	**13,263**	**23,281**
Total Cost of All Interventions	**17,209**	**24,766**	**36,135**	**78,109**

PROGRAMME COSTS				
Management, Coordination & Networking (8%)	1,377	1,981	2,891	6,249
Monitoring and Evaluation (4%)	688	991	1,445	3,124
Research (2%)	344	495	723	1,562
Institutional Capacity Building (2%)	344	495	723	1,562
Total Programme Costs	**2,753**	**3,962**	**5,782**	**12,497**
TOTAL ANNUAL COSTS	**19,962**	**28,728**	**41,916**	**90,606**

Table 4.7.1 shows the overall cost of the minimum interventions would increase from Ksh. 19.96 billion in the year 2007/08 to Ksh. 28.73 billion in 2008/09 and Ksh. 41.92 billion in 2009/10. The highest proportion (33%) of the total cost for the three years is accounted by OVC aged between 14 – less than 18 years followed by those aged 6-13 years (24%), family support (23%), programme costs (14%) and lastly those aged 0-5 years (7%) as shown in Figure 4.7.2.

Figure 4.7.2: Shares of the different cost categories (2007/08-2009/10)



CHAPTER 5: IMPLEMENTATION AND COORDINATION OF NPA INTERVENTIONS

All stakeholders have the responsibility of implementing OVC interventions within the guidelines provided for in this NPA and other existing government policies and legislation. Proper coordination of OVC interventions remains key to ensuring concerted efforts that impact on the lives of OVC. The primary responsibility of overseeing and coordinating OVC activities in the country lies with the Ministry of Gender, Children and Social Development through the Department of Children Services (DCS). The DCS operates within the Children Act 2001.

5.1 Key Functions of the Department of Children Services include, among others;

- ***To identify priority areas for intervention in child welfare programmes***
- ***To identify root causes and interventions (curative and preventive) for Children in need of Care and Protection***
- ***To encourage community participation through networking***
- ***To facilitate the provision of children welfare services***
- ***To co-ordinate and monitor the provision of services by partners and other stakeholders in the OVC sector***

  Within the above mandate and with an ever increasing number of OVC, a National OVC Secretariat within the DCS has been put in place to oversee and coordinate OVC interventions, while a National Steering Committee for Orphans and Vulnerable Children (NSC – OVC) has been constituted to provide leadership in OVC interventions.

  The National Council for Children Services (NCCS). Established under Sect. 30 of the Children Act, 2001. is in charge of developing policies related to children in need of protection and care, among other functions. NCCS will ensure that Area Advisory Councils (AAC - which are a replication of NCCS at the district level) oversee the appropriate implementation of this NPA in all districts.
- ***The AAC shall replicate its functions at the division and location levels. The AAC will ensure that all OVC programs implement the minimum package. The role of AAC is complemented by existence of a network of community volunteers otherwise known as volunteer children officers and home visitors (secondary care givers). The ACC shall promote the involvement of community in all stages of OVC programmes in their areas.***

5.2 Roles of other key Ministries and other actors

The following Ministries, which are represented in both the National Council of Children Services (NCCS) and the National Steering Committee on OVC (NSC-OVC), will have the following functions within this NPA:

5.2.1 Ministry of Finance

The Ministry plays a major role in ensuring that the government allocates funds for OVC. The Ministry will provide guidelines and directives in terms of government funding, donor and other funding mechanisms.

5.2.2 Ministry of Planning and National Development

The Ministry of Planning and National Development will ensure that OVC concerns are catered for in the government's development plan. It will also ensure that OVC indicators are captured in the national surveys.

5.2.3 Ministry of Education

The Ministry will ensure that OVC access education, including ECD by addressing barriers met by OVC in accessing education. The Ministry through its extensive structure will be encouraged to identify and maintain data on OVC in schools and come up with interventions that will provide an enabling environment for OVC to access education. As much as possible, the Ministry will encourage counselling units in schools to address the psychosocial needs of OVC. The Ministry will ensure that education policy/Act incorporate the needs of OVC.

5.2.4 Ministry of Health

The MOH will provide OVC with the government's recommended minimum health service for children in Kenya. This includes provision of full child immunization, vitamin A supplementation, provision of ARV, and malaria and TB treatment among others.

The MOH will strive to establish a mechanism that makes it possible for OVC to access medical services. It will also provide information through its established structures to communities/caretakers that will improve the nutritional/health status of OVC. The Ministry will ensure that the health policy incorporates the health needs of OVC.

5.2.5 Department of Civil Registrar

The Department will raise awareness on the rights of birth registration for OVC and support OVC to acquire birth certificates. The Department will ensure that the Registration Act/Policy takes into consideration the special needs of OVC in terms of Registration and come up with mechanisms that address barriers to OVC registration.

5.2.6 Ministry of Labour

This Ministry will implement and raise awareness on existing legal provisions that protect OVC from child labour. In collaboration with other partners, the Ministry will protect children from exploitative child labour and further review the existing Laws to incorporate emerging trends in child labour.

5.2.7 National AIDS Control Council

The NACC will ensure that the Kenya National AIDS Strategic Plan is in line with this NPA as far as OVC interventions are concerned. It will also lobby for funding and support OVC interventions as per this NPA. NACC will also liaise with the DCS when approving funding for OVC interventions to NGOs, CBOs, FBOs, and the private sector to ensure that their programmes are in line with this NPA.

5.2.8 Civil Societies

Civil societies are agencies/institutions that are involved in supporting or implementing activities in specific priority areas of the NPA. The main ones are FBOs, CSOs and NGOs. These organizations are expected to work in close liaison with the District Children Officer and the AAC. They will adopt best practices in the OVC care and protection in line with the provisions of this NPA and other legal provisions. Civil societies will advocate and promote the rights of children and mobilise resources for OVC intervention.

5.2.9 Private Sector

The private sector includes institutions that are run privately for the purposes of profit making, such as industries, companies, among others. The private sector is represented at the NCCS, the AAC and the NSC for OVC. The private sector is expected to support communities within which they work as part of their social responsibility to support OVC.

5.2.10 Development partners

The development partners will be represented in National Steering Committee for OVC and any other thematic sub-committees and programme technical committees. The partners will also raise OVC concerns at international forums to leverage for international support. In addition, the development partners will provide funds for OVC interventions. They will help build the capacity of government and national civil societies to respond to OVC problems.

CHAPTER 6: RESOURCE MOBILIZATION AND FUNDING MECHANISM

The government acknowledges the already existing efforts by various stakeholders in resource mobilization towards responding to the needs of OVC in the country. The government would however, through modalities provided in this NPA, wish to consolidate its knowledge base on what resources come into the country for OVC response and ensure proper utilization of the same.

In this chapter, the government recommends a pool funding mechanism where willing development partners/donors are encouraged to put their contribution into a 'common basket account' that would facilitate a joint country response to OVC problems.

Proposed Pool Funding Mechanism

The Ministry of Gender, Children and Social Development (MGCSD) proposes to raise funds in support of this NPA according to a Joint Financial Agreement (JFA) made between the government and development partners/donors. The JFA will set forth provisions and procedures for financial support to the NPA on OVC; serve as a co-ordination framework for consultation between the development partners and other institutions willing to contribute funds towards this NPA; identify procedures relating to monitoring, decision-making, joint reviews of performance; and common procedures on disbursement, reporting and audit of financial statements.

The proposed fund raising strategy is based on Government of Kenya (GOK) and MGCSD commitment to the principles of effective, efficient and harmonised aid implementation. The funding will be aligned with the government financial management systems as provided for in the Constitution of Kenya (Section 99), the Exchequer and Audit Act (CAP 412), the Government of Kenya Financial Regulations and Procedures, the Public Audit Act 2003 and the Government Financial Management Act 2004. It will encourage joint planning and monitoring of implementation and utilization of funds.

The mechanism will maintain a financial management system that is adequate to reflect the transactions, resources, expenditures, assets and liabilities under the NPA, and that will ensure that the GOK is able to produce timely, relevant and reliable financial information for planning and implementation of the NPA.

It will ensure that the financial management system will support monitoring of progress toward NPA objectives, provide details of the degree of implementation of activities and allow the development partners to evaluate compliance with agreed procedures.

The coordination arrangements that apply to pool funding will be described in the JFA and form part of a broader consultation process that will include a wider group of development partners. These partners will be providing support, in one form or another, to the NPA on OVC.

Additional bilateral or multilateral agreements between GOK and each development partner may be developed to confirm the financial commitments of the partners.

Annual Joint Review Meetings (AJRM) will be held to review overall progress for the previous fiscal year based on reports provided by GoK and development partners. During this AJRM, development partners will provide indicative funding levels for the following fiscal year and will, where possible, indicate probable funding for the three-year medium-term expenditure framework (MTEF) period.

The GoK will ensure that, for each fiscal year for which JFA remains in force, an audit of MGCSD expenditure is undertaken in accordance with auditing standards and terms of reference as agreed between KENAO (Kenya National Audit Office) and the development partners.

Donors and development partners may request a performance-related audit to be carried out by the KENAO, or at its discretion, with the support of appropriately qualified auditors contracted under its authority. The selection of the auditors and timing for such audit will be done in close collaboration with the partners. The GoK and partners will jointly agree on the Terms of Reference of the audit. Based on the outcome of such audit, the partners may convey to GoK any corrective measures they consider necessary to be undertaken.

While the government recommends the above pooled funding mechanism, it recognizes the existences of other resource mobilization mechanisms as mentioned below:

Government funding

Government has always allocated funds for children in its fiscal years. In 2004/05, the government allocated funds specifically for OVC response. The amount of this allocation has increased over the years. This is indicative of government commitment to address OVC problems.

Bilateral funding from development partners

Development partners provide funds directly to civil societies, such as FBOs, CBOs and NGOs. A good example is the PEPFAR funding to civil societies in the country. In such cases, the development partner uses its criteria to identify those to fund. The funded agencies are accountable to the funding development donors. However, the government has the

responsibility to know the amounts of funding being provided for OVC intervention and ensure that they are properly utilized.

Faith-based giving

Opportunities for fundraising extend from local to international churches, mosques and temples to actual foundations and development operations within religious organizations, e.g., Catholic Relief Services, National Council of Churches (NCCK), and the Supreme Council of Kenya (SUPKEM), among others. These faith-based organizations are encouraged to report to the Department of Children Services on their support to OVC, including their area of coverage.

Individual donors

This includes generous individual contributions. While individual donor support tends to be smaller and more inconsistent, they are the easiest to obtain once a good network of supporters has been identified. This NPA encourages more individuals to support OVC that they come into contact with. While it is an individual choice on whether to make it known of their support, individuals are encouraged to register their support with the District Children Officer.

Charitable foundations

These are foundations created by individuals and corporations to provide funds and resources for charitable causes. They work closely with the recipients to develop projects and within a clearly defined funding priority.

Corporate giving

Cooperation contributes either directly or through corporate foundation, e.g. Safaricom, Kenya Commercial Bank and Barclays Bank. The majority of corporate funding is devoted to supporting community needs activities where a corporation has existing facilities/businesses.

Professional association and organizational funding

This includes bodies such as the Law Society of Kenya (LSK), Medical Association of Kenya (MAK) and others that can offer their free of charge services through mobilization of their members.

The above varied funding mechanisms suggest substantial resources mobilized to respond to OVC and their needs. It is therefore advisable that all those responding to the needs of OVC make a report on the same to the District Children Officer of their respective districts. This will ensure that the GoK is aware of OVC support, as well as promote smooth coordination and monitoring mechanisms. This strategy will also help in identifying where gaps exist. It is further advised that before funding is made to other stakeholders, donors should seek the recommendations of the government, through the Department of Children Services.

It is, however, hoped that if the above suggested pool funding mechanism is made operational, some of the current funding concerns will be addressed.

CHAPTER 7: MONITORING AND EVALUATION

It is important to institute an M & E framework for OVC programs that facilitates the stakeholders and the country to measure progress, promote accountability and enhance effectiveness in responding to the OVC crisis.

Information on the progress made in responding to the OVC crisis, the quality of services provided to the OVC and their effectiveness will be derived from consolidation of data from various projects implemented at community levels, through information obtained from various key ministries or through various assessments that may be carried out during the implementation period. These will be based on agreed national indicators that each of the actors will be expected to report on.

The Department of Children Services and the National Council for Children Services (NCCS), both within the Ministry of Gender, Children and Social Development, will be responsible for coordinating the national monitoring and evaluation of the OVC interventions. Through consultative processes, DCS will develop an M&E implementation plan and standard M & E tools. A national database for OVC will be established and stakeholders will be expected to feed into the database on agreed OVC indicators. The DCS will explore possibilities of linking the OVC database to other relevant national M & E systems in the Government such as Ministry of Health, NACC in the office of the President, Education, Planning, Labour, NACC in the Office of the President, among others, as well as other implementing agencies.

The draft OVC Policy Framework (2005) gives guidance by detailing that M&E functions shall be undertaken at all levels to enhance accountability and effectiveness and shall contain and ensure the following:

- Development of monitoring indicators for sectors/departments and aspects of HIV and AIDS programming for children that conform to internationally and nationally agreed standards
- Integration of specific indicators into strategic plans of government departments
- Effective co-ordination of policy formulation, programme/strategy development and implementation at national, provincial, district and local level. This will include levels of integrated planning and programme implementation between government departments for the care, support and protection of OVC.
- Evaluation of the implementation of the National Action Plan will be undertaken at agreed upon mid-term intervals from adoption of the NPA and commencement of implementation.
- Identification of activities towards strengthening of the capacity of all stakeholders in relation to programme planning, monitoring and evaluation and budget analysis.

- Mechanisms for reporting, feedback and communication with key stakeholders (with particular reference to children and communities) must be developed as an integral component of the strategy. This will include the preparation and submission of annual reports to relevant structures on impact of the OVC Policy Framework and the National Action Plan.
- Appropriate levels of resourcing and capacity exist or are secured for implementing monitoring and evaluation activities at the various levels. This will also include an annual assessment of resources used towards the care, protection and support of OVC and the impact of the resources used.
- It will be essential to ensure that there are adequately trained personnel at all levels to manage the M&E function.
- The National Department will define the core list of indicators consistent with this National Action Plan and with the delivery of OVC care and support.

Based on the above guidelines, this NPA proposes a list of indicators as presented in the matrix below that should be used to measure progress against each of the expected outputs in each of the key Priority Strategic Areas (PSAs). These indicators are a guide to the various stakeholders and have been drawn from, among others, UNGASS, NACC and from various ministries and civil societies responding to the OVC crisis. The M & E matrix provided below describes the strategic information that the program will gather and use for decision making, planning and assessing progress and impact of intervention with the aim of improving national responses to OVC issues.

7.1: PROPOSED MONITORING AND EVALUATION FRAMEWORK FOR OVC

OBJECTIVES	*ACTIVITIES*	*OUTPUT*	*INDICATORS*	*TARGET INSTITUTIONS*	*DATA SOURCE*
PSA 1: Strengthening capacity of families to protect and care for OVC *Expected outcomes: a) Enhanced OVC care and support within family set up, b) Improved economic capacity to respond to OVC needs, c) Improved nutritional status of OVC*					
Ensure social safety nets are in place for OVC	Develop and strengthen cash transfer mechanisms for households caring for OVC	A national cash transfer strategy for families caring for OVC in place by 2010	# of households taking care of OVC receiving funding from cash transfer system	MGCSD, other relevant ministries. Development partners. NGOs, CBOs	CT programme reports. NGO, FBO reports
	Build capacity and provide income generating activities and Micro Enterprise Development systems for caregiver/older OVC	Increased knowledge and skills on IGA and MEDI among OVC caregivers and older OVC	Households beneficiaries of CT program that have access to health , education and at least two meals a day % of trained caregivers and older OVC who have initiated and are managing IGA		

OBJECTIVES	*ACTIVITIES*	*OUTPUT*	*INDICATORS*	*TARGET INSTITUTIONS*	*DATA SOURCE*
Ensure food security systems for OVC and their families	Improve and expand school nutrition programmes to reach more vulnerable children	Increased number of schools providing nutritious feeding for OVC within schools	# of OVC and other vulnerable children receiving food at school	MOE, MOH, MOA, MGCSD, NGOs, CBOs, FBOs	MoE reports, National surveys
	Develop supplementary fortified food schemes at community level	Increased capacity of communities to provide adequate nutritious food to OVC	% of households that adequately feed their children		
	Expand and strengthen community food production schemes				
	Strengthen life skills programmes for OVC to incorporate IGAs				

OBJECTIVES	*ACTIVITIES*	*OUTPUT*	*INDICATORS*	*TARGET INSTITUTIONS*	*DATA SOURCE*
HIV+ OVC caregivers accessing treatment and support	Support the provision of comprehensive care for HIV+ caregivers including provision of ARV	Improve life through management for HIV+ caregivers including provision of ARV to primary caregivers	% of OVC caregivers who are HIV+ accessing ARV	NACC, MOH, MGCSD, NGOs, Development partners, NGOs, CBOs, FBOs	NACC, NGO, MoH reports, Surveys, reports
	Support establishment and strengthening of community support groups for HIV+ adults and children		# of support groups for HIV+ caregivers and children		
Increase knowledge and skills of adult care givers and young people to care and protect OVC	Provide skills training programmes for caregivers / older OVC on: parenting, financial management, nutrition and health, legal affairs, reproductive health , etc	OVC caregivers and older OVC have increased knowledge on care and protection on OVC	% of caregivers including older OVC in child-headed households expressing adequate knowledge on care of OVC	MGCSD, NGOs, CBOs, FBOs	Reports from NGOs, CBOs, FBOs National Surveys

OBJECTIVES	*ACTIVITIES*	*OUTPUT*	*INDICATORS*	*TARGET INSTITUTIONS*	*DATA SOURCE*
PSA 2: Mobilise and support community led responses for OVC care *Expected Outcomes: a) Increased capacity of communities to respond to the needs of OVC* *b) Improved quality of alternative care services for OVC*					
To increase the number of OVC taken up by families within communities through formal (guardianship, foster care and adoption) and kinship foster care	Support community awareness on alternative family based care Support the development and enforcement of laws and regulations on alternative family based care Strengthen capacity of institutions facilitating alternative care to deliver quality services for OVC Support and strengthen monitoring system for children in family based alternative care	Increased knowledge on alternative family based care among community members OVC within alternative family-based care are legally protected Improved capacity that promotes quality services for children in alternative care A social welfare system for children in alternative care established and functioning	# of children adopted within Kenya (domestic adoption) # of children put under guardianship and foster care # of children re-integrated back to the families from institutions, streets, statuary homes among others Proportion of children within alternative care families who receive adequate care and protection	MGCSD, Judiciary, Adoption Societies	Reports from MGCSD, Judiciary, Adoption Societies, Department of Social Services, Periodic Surveys

OBJECTIVES	*ACTIVITIES*	*OUTPUT*	*INDICATORS*	*TARGET INSTITUTIONS*	*DATA SOURCE*
PSA 3: Ensuring access to essential services (Education, health and nutrition, reproductive health, legal protection, water and sanitation and birth registration *Expected outcomes: a) Improved educational standards (increased enrolment, retention and completion rates), b) Improved health and nutritional status of OVC, c) Enhanced legal protection for OVC*					
To increase access of OVC to essential services	Review current essential services and service delivery mechanisms to ensure they incorporate the needs of OVC Conduct situational analysis and frequent research to ascertain accessibility of essential services to OVC	Delivery strategies for essential services for children capture OVC unique needs Increased knowledge on the status quo for access to essential services by OVC Essential services become more accessible to OVC	Proportion of orphans compared to non-orphans who are enrolled, attend and complete primary school education % of orphans aged 0-1 years who receive full immunization % of HIV+ children receiving paediatric ARV	MoE, MoH, MGCSD, CBOs, NGOs, FBOs	Reports from the relevant ministries, CSOs, Periodic Surveys
Develop /strengthen programmes that make essential services accessible to OVC	Support resource mobilization for the implementation of the programmes that make essential services accessible to OVC Support referral mechanisms that	Essential services become more accessible to OVC	Health care access ratio of orphans as compared to non-orphans Ratio of OVC compared to non-OVC who are		

	facilitate access to essential services by OVC	malnourished (underweight) Ratio of OVC compared to non-OVC who have knowledge on basic reproductive health and prevention of HIV infection % of OVC girls accessing sanitary towels once a month. % of OVC in need of legal services who received the service Proportion of children aged 0-4 whose births are reported registered Proportion of youth receiving training and utilizing life skills

OBJECTIVES	*ACTIVITIES*	*OUTPUT*	*INDICATORS*	*TARGET INSTITUTIONS*	*DATA SOURCE*
PSA 4: Ensure that improved policy and legislation are put in place to protect OVC *Expected Outcomes: a) Comprehensive policies and legislations addressing the needs of OVC in place and are functional by 2013 b) OVC receive quality care and support from practitioners, c) OVC and their families legally supported*					
To ensure that OVC care and support concerns are incorporated in relevant institutions' curriculum	Review current training programmes, curriculum and materials of relevant institutions to establish coverage of OVC issues Develop and support the incorporation of OVC issues in these training programmes, curriculums and materials Develop and enforce competencies for practitioners, providers and professional caregivers of OVC	Gaps and strengths identified and including opportunities for improvements Training materials and programmes of relevant institutions that incorporate OVC issues Existence of guidelines on Increased number of practitioners working for OVC obtaining minimum required qualifications	% of relevant institutions that have captured the issues of OVC in their training documents/ curriculumscurriculum Proportion of practitioners who have obtained minimum qualification	MGCSD, Judiciary, Kenya Police, CSOs	Reports, Police records, CSO reports

OBJECTIVES	*ACTIVITIES*	*OUTPUT*	*INDICATORS*	*TARGET INSTITUTIONS*	*DATA SOURCE*
To have in place, functional policies, legislations and action plans that provide for support and protection of OVC	Review current policies and legislation to identify gaps on OVC concerns Lobby for completion and approval of National Policy for OVC and the National Social Protection Policy Monitor the enactment of laws and legislation for OVC Build the capacity of duty bearers to enhance effective implementation of legislation for children Advocate for adequate resource allocation for implementing policies/guidelines related to OVC Develop national social protection policy for OVC	Gaps and strengths in existing legislation identified Policies on OVC and social protection approved Weaknesses in implementation of existing legislation identified and addressed Improved implementation policies and legislations for OVC	% of policies that have aspects of children that highlight OVC concerns/strategies # of policies approved that incorporate OVC concerns Increased # of OVC receiving services and protection	MGCSD, Judiciary, Kenya Police, CSOs	Reports, Police records, CSO reports

OBJECTIVES	*ACTIVITIES*	*OUTPUT*	*INDICATORS*	*TARGET INSTITUTIONS*	*DATA SOURCE*
PSA 5: Raising awareness to create a supportive environment for OVC *Expected Outcomes: a) A supportive environment for children and families affected by HIV and AIDS, b) Reduced stigma and discrimination against HIV + adults and children, OVC and their families, c) Increased number of OVC and their caregivers supported by their communities*					
To increase general public awareness on HIV/AIDS and dangers of stigma and discrimination	Support the development and implementation of comprehensive stakeholder communication strategy Support community open forum discussions on HIV/AIDS and protection of OVC and their families Support local actors to integrate HIV/AIDS and OVC protection into their work Support establishment of community support groups for HIV+ adults and children, OVC and their caregivers Support partnership with the media to highlight issues of HIV/AIDS, stigma and discrimination	Communication strategy on OVC issue in place Increased knowledge on HIV/AIDS, OVC issues and dangers of stigma and discrimination Increased responses for OVC among local actors Increased support and coping for HIV+ adults and children, OVC and their caregivers Increased coverage of HIV/AIDS issues, OVC concerns and dangers of stigma and discrimination in	% of adults expressing accepting attitudes towards people living with HIV/AIDS Proportion of OVC receiving support from their communities	NACC, Civil societies, MoE, MoH, MGCSD, FBOs, CBOs	Surveys Reports from listed stakeholders

OBJECTIVES	*ACTIVITIES*	*OUTPUT*	*INDICATORS*	*TARGET INSTITUTIONS*	*DATA SOURCE*
PSA 6: Strengthening and supporting national and community coordination and institutional structures *Expected outcomes: a) Improved coordination of OVC interventions at national, district and community levels, b) Increased coverage on responses for OVC in terms of numbers and geographical coverage*					
To improve coordination mechanism at national, district and community levels	Build the capacity of NSC, NCCS & AAC members on advocacy, resource mobilization and coordination for OVC interventions Support and strengthen capacity of Department of Children Service to coordinate and monitor OVC interventions Support a multi-sector national and district annual work planning Establish an inventory of agencies dealing with OVC at national and district levels Disseminate of the NPA for OVC at national and district levels to promote harmonious approach to OVC responses	Increased knowledge and skills among members of NSC, NCCS, AAC and staff of DCS on advocacy, resource mobilization and coordination of OVC interventions Harmonized work plans at all levels Existence of an inventory for agencies working for OVC at district and national levels Increased knowledge on the key responses for OVC among stakeholders	# of advocacy issues for OVC initiated and championed by NCCS and NCS % increase in resource allocation for OVC interventions both by the government and development partners % of districts with inventory for agencies implementing OVC interventions	MGCSD, related ministries, development partners	Surveys, Reports from listed stakeholders , district data banks

OBJECTIVES	*ACTIVITIES*	*OUTPUT*	*INDICATORS*	*TARGET INSTITUTIONS*	*DATA SOURCE*
PSA 7: Strengthening national capacity to monitor and evaluate OVC programmes **Expected outcomes:** *a) Improved programmes and services that positively impact on the lives of OVC, b) Improved planning and coordination on responses for OVC interventions among stakeholders, c) Civil society and private sectors strengthened*					
An integrated monitoring and evaluation plan developed and implemented by 2010	Define indicators for use by all stakeholders to monitor progress for OVC Establish baseline data with agreed indicators Strengthen institutional capacity of the Department of Children Services to coordinate the monitoring of OVC interventions Develop and disseminate monitoring tools Strengthen capacity of stakeholders implementing OVC interventions at all levels on monitoring progress for OVC.	Nationally acceptable indicators in place The situation of OVC scientifically verified Increased knowledge, skills and material capacity for monitoring within the Department of Children Services Existence of national monitoring tools Increased knowledge, skills and material capacity for monitoring within agencies implementing OVC interventions	% of agencies that are addressing critical areas identified in the baseline data % of reports that measure progress using agreed indicators	Relevant ministries, NGOs, FBO, CBO and private sector	Surveys Reports from listed stakeholders

OBJECTIVES	*ACTIVITIES*	*OUTPUT*	*INDICATORS*	*TARGET INSTITUTIONS*	*DATA SOURCE*
An OVC information sharing system/mechanism in place and functional by 2010	Review, strengthen and harmonize the existing information data base on children and OVC Strengthen the capacity of stakeholders on information generation, analysis and utilization Support the development of a dissemination mechanism on OVC responses Support operational research on OVC issues	Accessibility of reports on OVC concerns and responses Increased knowledge, skills and material capacity by implementing agencies on information management Clear guidelines on information flow and sharing Increase number of research conducted for OVC	% of districts with comprehensive OVC interventions # of research studies conducted on OVC # of forums for sharing OVC issues at various levels % of districts with inventory for agencies dealing with OVC	MGCSD, KNBS, MoP, other relevant ministries, civil societies, FBO, and private sector	Reports from MGCSD, KNBS, AACs, NGOs among others

CONCLUSION

The Ministry of Gender, Children and Social Development through this NPA has attempted to provide programme guidelines on OVC response from planning and implementation, costing, resource mobilization, coordination and evaluation. All interested stakeholders in the area of OVC, including policy makers, are encouraged to use this document to improve the lives of Orphans and Vulnerable Children within the country.

This plan has provided a platform for further development of supportive policies and plans to further better the lives of OVC. The Department of Children Services hopes that the resources generated out of these initiatives will be utilized well to give hope and a future to the lives of orphans and vulnerable children in Kenya.

References:

- *Futures Group International (2004), Rapid Response Analysis: Kenya: Nairobi: The Policy Project*
- *Ministry of Education, Kenya Education Sector Support Programme 2005, Nairobi*
- *Office of the Vice President and Ministry of Home Affairs (2004), Rapid Assessment, Analysis and Action Planning Process (RAAAPP) for Orphans and Other Children Made Vulnerable by HIV/AIDS in Kenya, Nairobi: MOHA*
- *Ministry of Health, (2005), Kenya National Health Sector Strategic Plan 2005-2010, Nairobi*
- *Ministry of Planning and National Development (2002), Analytical Report on Population Projections: Vol. 7. Nairobi: Central Bureau of Statistics*
- *Ministry of Planning and National Development, ORC Macro, Kenya Demographic and Health Survey 2003, Calverton, Maryland, USA: CBS, MOH, ORC Macro; 2004*
- *Ministry of Planning and National Development (2007), Kenya Integrated Household Budget Survey (KIHBS) 2005/06, Nairobi: Central Bureau of Statistics*
- *Office of the President (2004), Kenya National HIV/AIDS Strategic Plan 2005–2010, Nairobi: Office of the President; 2004*
- *Draft National Policy on Orphans and Vulnerable Children, MOHA, November 2005*
- *National Bureau of Statistics – Basic report on Wellbeing in Kenya, April 2007*
- *Kenya Demographic and Health Survey (KDHS), 2003*
- *The Extent and Effect of Sex Tourism and Sexual Exploitation of Children on the Kenyan Coast; A study conducted by UNICEF and Government of Kenya in 2006*
- *Children on the Brink Report 2004, UNICEF*
- *National AIDS Control Council, Nairobi; 2005*
- *National AIDS Control Council, Nairobi; 2007*
- *Futures Group, "Financial Resources Required to Support Orphans and Children made vulnerable by HIV/AIDS Survey", May 2004*

Names of the Technical Working Group (TWG):

Noah Sang'anyi	-	Department of Children Services
Mary Mbuga	-	Department of Children Services
Joseph Kajwang	-	Department of Children Services
Daniel Musembi	-	Department of Children Services
Catherine Kimotho	-	UNICEF
Jerusha Karuthiru	-	USAID
Dorothy Odhiambo	-	Health Policy Initiative (HPI)
Francis Kagwana	-	Health Policy Initiative (HPI)
Angeline Siparo	-	Health Policy Initiative (HPI)
Timothy Musombi	-	World Vision
Jennifer Otieno	-	Kenya OVC Network
Violent Wainaina	-	Pathfinder International
Lucas Barake	-	Hope for African Children Initiative (HACI)

"For the child,

There is no tomorrow;

For tomorrow will be too late;

***It is* TODAY!"**

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