CHAPTER 1: RESEARCH PROPOSAL

1. INTRODUCTION

1.1 Background of the Study

CARE South Africa-Lesotho's DELL project is a project aimed at increasing care and support to the HIV-infected/affected Orphaned and Vulnerable Children (OVC) living in poor and or marginalized communities. It is funded by the United States' President's Emergency Plan for AIDS Relief (PEPFAR). The project is well directed and based on the PERFAR core program areas for OVC as outlined in the FYO7 Reporting/ FY08 Planning Indicated Reference Guide pg 163-170.

CARE International ('CARE') is one of the world's largest private international relief and development organisations and a leader in sustainable development and emergency aid. Its programmes reach more than 30 million people each year in more than 60 countries in Africa, Asia, Europe, the Middle East and Latin America.

Established in Lesotho in 1968 and South Africa in 1994, the joint mission of CARE Lesotho was created in 2001 to promote integrated regional programming and lesson learning. CARE Lesotho-South Africa has head offices in Johannesburg, South Africa and in Maseru, Lesotho. In South Africa, CARE's areas of operation include the Limpopo, Mpumalanga and the Free State Provinces. In Lesotho, CARE implements programmes across the country.

In order to accomplish its mission of providing quality care to OVC, CARE SA-Lesotho has partnered with six NGOs in **Free State (Thabo Mofutsanyane District)** one of which is a technical partners which provide technical assistance to the five implementing partners.

- Child and Family Welfare Society Bethlehem (Technical Partner)
- Dihlabeng Development Initiative (Implementing Partner)
- Gethsemane Health Care Centre (Implementing Partner)
- Golden Gateway Hospice (Implementing Partner)
- Hlokomela Wa Heno (Implementing Partner)
- Ntsoanatsatsi EduCare Trust (Implementing Partner)

These partners operate mainly in the following towns Bethlehem, Clarence, Fouriesburg, Paul Roux, Rosendale, Kestle, Arlington, and QwaQwa. In all these towns partners work in both township and surrounding farm settlements.

1.1.1 Free State Province Overview

The Free State is the third-largest province in South Africa. Located in the centre of the country the Free State borders 6 of the 9 provinces in South Africa and is divided into 5 district municipalities with 20 local municipalities.

The 5 districts are: Northern Free State in the North; Thabo Mofutsanyane in the East; Motheo in the South-East; Xhariep in the South; and Lejweleputswa in the North-West

The Free State represents 10,6% of the total land area of South Africa.

The Free State has a population of 2 738 231. Population density is 21.1 people per square km. 47.5% of the Free State population is female and 52.5% male. 42% of the population is 19 years or younger, children according to the constitution, (The South African National Road Agency, 2007).

While the southern Free State is mainly an agricultural area, the Northern Free State is built on the gold industry. Important towns include Welkom (gold mining), Odendaalsrus (gold mining), Sasolburg, (which owes its existence to the petrol-from-coal installation), Kroonstad (agricultural, administrative and educational centre), Parys, Phuthaditjhaba (tourism and handcrafted items produced by the local people) and Bethlehem.

Approximately 37.3% or 1.09 million of the population is employed (PGDS: 2005). *In 2002, 55% of the population were classified as living in poverty (compared to 48% for South Africa).* Community Services comprises of (28%) of employment in the Free State Province.

Functional literacy for the province is approximately 69.2% while this figure for South Africa is 72.3%. Some 16% of people aged 20 years or older have received no schooling (Census 2001). Level of education is only measured in terms of people older than 20 years in the province (Census 2001). Level of education was not applicable to 42% of the Free State population. 23% received no education or schooling; 2% went on to higher education and training; 20% of the provincial population completed some primary school education; 7% completed primary school; 40% completed some of secondary school; and 8% completed Grade 12. More females (19%) than males (16%) received no schooling.

Child mortality rates are almost twice as much as that for the whole of South Africa. In terms of children dependent on adults for survival, the provincial average is 55%, approximately

10% less than the National average. 10% of all Free State adult deaths and 1% of child deaths were HIV AIDS related. 6% of female and 5% male deaths in 2001 could be attributed to AIDS.

1.1.2 Thabo Mofutsanyana District Overview

Thabo Mofutsanyane is one of the 5 districts of the Free State province of South Africa (Stats SA: 2001).

Thabo Mofutsanyana's area of jurisdiction is situated in the eastern parts of the Free State and borders Northern Free State and Mpumalanga to the north, KwaZulu Natal to the east, Lesotho to the south and Motheo and Lejweleputswa to the west.

1.1.3 Demographic Overview of Thabo Mofutsanyana District

Thabo Mofutsanyana has an estimated population of approximately 728 400 people with 310 600 (43 %) living in urban areas and 417 800 (57 %) living in rural areas.

These figures represent 25,97 % of the entire population of the Free State with a density of 25,76 people per square kilometer.

Ethnic groups represented in the district are mostly Black (95.17%) followed by White (4.16%) and Coloured people (0.50%). Indian or Asian people are the least represented in the District with only 0.18% of the population.

Females represent 53.62% of the district population and males 46.38%. 82% of the population speak Sesotho, 12% Zulu and 4% Afrikaans. English and Xhosa are respectively spoken by 1% of the population (Census, 2001).

47% of the population is below the age of 19 years. This means that almost half of the district municipality's population is either pre-school or of school-going age. Therefore there is an estimate of 342 348 children within this district. Research estimates that in 2002 48.9% of the people living in South Africa were residing in poverty, 54% of the Free State population lived in poverty and Thabo Mafutsanyana was estimated that 72% of its population was living in poverty District Economies (2002). We can then deduce that 72% of the 342 348 children living in the district, live in poverty therefore causing approximately 246 490 children to be vulnerable. According to the Statistics for the Thabo Mofutsanyane District Municipality (2001), 71 448 children are between the ages of 0-4yrs; on the same principal of 72% people living in poverty in the district we can equally estimate that there are 51 442 vulnerable children between these ages residing in the district.

Table 1: Population distribution per local municipal area, 2001

Area	Urban	Rural	Total	Percentage	Density (km²)
Setsoto	75463	50288	125751	17.26	21.14
Dihlabeng	79705	35400	115105	15.80	24.36
Maluti A Phofung	87585	305592	393177	53.98	87.97
Nketoana	41877	10755	52632	7.23	9.4
Phumelela	25971	15769	41740	5.73	5.54
Total / Average	**310601**	**417804**	**728405**	**100 %**	**25.76**

Most people within this region (57 %) are still living in rural areas and it can be expected that this proportion of the population will put a lot of pressure on development of infrastructure in future, IDP (2001).

1.1.4 ECONOMIC PROFILE

Thabo Mofutsanyana can be described as one of the most fertile agricultural regions in the Free State with a high gross income per hectare and a production capacity well above the average of the Free State. The area is also a well known tourism destination, because of its scenic environment.

A scenic view of Clarence

Considering the total population of the district municipality of 728405 the GGP per capita is calculated at R4 415 per capita and is the lowest compared to all other district municipalities. The economy of the district is primarily dependent on Agriculture and General Government while very little diversification is taking place. This places the area at tremendous economic risk, especially considering the decline in the agricultural sector during recent years.

Table 2: Employment summary per municipality

Municipality	Town	Employed	Unemployed, looking for work	Total labour force	Unemploy-ment rate (%)
SETSOTO	Clocolan	2534	1344	3878	34.66
	Ficksburg	**7151**	**3117**	**10268**	**30.36**
	Marquard	1703	1171	2874	40.74
	Senekal	3527	2071	5598	37
	Setsoto Rural	14839	1238	16076	7.7
	Subtotal	**29754**	**8941**	**38694**	**23.11**
DIHLABENG	**Bethlehem**	**16342**	**5913**	**22255**	**26.57**
	Clarens	587	249	836	29.78
	Fouriesburg	1136	1064	2200	48.36
	Paul Roux	646	674	1320	51.06
	Rosendal	**308**	**282**	**590**	**47.8**
	Dihlabeng Rural	8850	763	9612	7.94
	Subtotal	**27869**	**8945**	**36813**	**24.3**
MALUTI A PHOFUNG	Harrismith	8485	4689	13174	35.59
	Kestell	1005	532	1537	34.61
	Phuthaditjhaba	9811	5106	14917	34.23
	Maluti A Phofung Rural	35232	42965	78197	54.94
	Subtotal	54533	53292	107825	49.42
NKETOANA	Arlington	390	379	769	49.28
	Lindley	1273	1026	2299	44.63
	Petrus Steyn	1353	938	2291	40.94
	Reitz	3808	1601	5409	29.6
	Nketoana Rural	8567	900	9467	9.51
	Subtotal	**15391**	**4844**	**20235**	**23.94**
PHUMELELA	Memel	601	368	969	37.98
	Vrede	2700	1367	4067	33.61
	Warden	1048	621	1669	37.21
	Phumelela Rural	6468	1324	7792	16.99
	Subtotal	**10817**	**3680**	**14497**	**25.38**
THABO MOFUTSANYANA DM		**138364**	**79702**	**218064**	**36.55**

Source: STATS SA, 1996 (2001 statistics not available)

Research Areas

Areas in which DELL is implemented

The unemployment rates within this district municipality are the highest in the province, at an average of 36.55 % for the entire area. The unemployment levels vary considerably between the local municipalities, with Setsoto (23.11 %) and Nketoana (23.94 %) showing lower levels than others. Maluti a Phufong (49.42 %) is the municipality with the highest unemployment rate in the province while specifically the rural areas of this municipality constitute the highest unemployment rate in the district at 54.94 %.

It is, however, important to note that although the other rural areas seemingly has the lower unemployment rates, the decline in the agricultural sector over recent years has had an adverse effect on the employment potential of the rural areas and today it is expected that high levels of poverty occur, (Thabo Mofutsanyana District Municipality, 2001). This is mainly because agriculture provides the basic source of employment and income in most poor and rural families.

1.1.5 DEVELOPMENT PRIORITIES

During the LDO formulation processes within the region, the former TLCs, TRCs and District Councils identified several development priorities which were to be addressed within the next five years. The importance of these development priorities are summarized for the entire region in the figure below.

Source: Various LDO and IDP documents, 2001

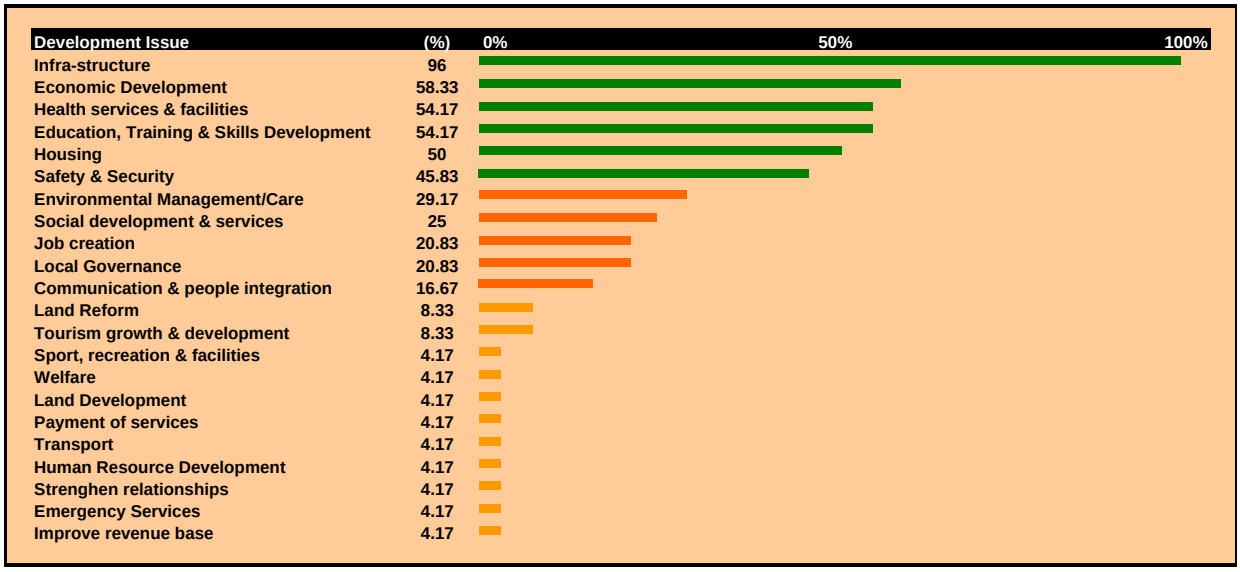


Figure 1: Summary of local development priorities for the region – 2001

1.2 Statement of the Problem

The HIV/AIDS epidemic is shattering children's lives and reversing many hard won children's rights gains. Following more than a decade of inadequate action, there is now an absolute imperative that the global community and every individual nation urgently mount large-scale, multifaceted responses to secure the future of all orphans and vulnerable children (OVC) Rose Smart (2003). The trends are showing an increase in the population of children being infected and affected by the pandemic hence, this baseline study seeks to explore the

situation of the OVCs being served by the DELL partners in Thabo Mofutsanyane District Municipality in the Free State.

1.3 Aim and Purpose of the Study

The purpose of this study was to conduct a household baseline study in 2 of the five partner organizations that are implementing DELL programme in Thabo Mofutsanyane.
To utilise this baseline study to identify meaningful information to inform and be used to devise interventions or measures to tackle the problems orphans and vulnerable children face. It is hoped that this study will bring about a better understanding of the essential elements and outcomes of the OVC in Thabo Mofutsanyane in order to promote realistic, effective, and feasible, interventions to protect and improve the well-being of the children and families who bear the greatest impact of the AIDS epidemic.

1.4 Objectives of the Study

The main objective of the study is to conduct a baseline study and examine the living situation and needs of the OVCs and their caregivers served by two of the DELL partners in Thabo Mofutsanyana District (Free State Province). This would be done by examining:

- The view of both the OVCs and their primary Caregivers on their living circumstances;
- Establish the capacity and capabilities of the community resources to respond to the needs of the OVC;
- Measure the capacity of the Partners;
- Identify possible factors contributing to the circumstances the OVC find themselves in these specific areas;
- Raise suggestions and recommendations to the identified challenges.

1.5 Hypothesis of the Study

The study departs from a hypothesis that; a lot has been done in assuring the human dignity and children's rights in South Africa, but a lot still needs to be done particularly with respect to care and protection of the most unfortunate OVC living in rural areas and townships Machenjedze, (2007). The very generation of people who were victims of discriminatory laws of apartheid system are parenting and bringing up another generation of discriminated children due to access….of the fruits of democracy Machenjedze, (2007).

1.6 Significance of the Study

There is a wide range of policies and strategies put in place in South Africa since the dawn of democracy to redress the imbalances in the distribution of the national wealth. However, children are still facing a lot of exclusion and challenges which threatens their chances of living to be to their full potential; mostly those living in the rural areas. The study seeks to examine the current circumstances these OVC are living under and possible means to provide a comprehensive care to cube.

The study will provide yard sticks against which the real progress can be measured in the near or long future. The study will also inform policy makers by identifying and addressing the gaps existing in the current strategies. In addition, it will add knowledge to better understanding of the circumstances befalling OVC. This study was undertaken with specific reference to the OVC being cared for by CARE Partners in Thabo Mofutsanyane in the Free State.

1.7 Delimitation of the Study

The study is limited to two of CARE partners implementing the DELL program within Thabo Mofutsanyana District in Free State. However, it must be noted that results will be analysed

with a broader picture of representation of the general circumstances facing the OVC and their care givers within this area. The study is specifically limited the OVC and caregivers in service of Gethsemane Health Care Centre in Ficksburg and Dihlabeng Development Initiative (Rosendale and Bethlehem).

1.8 Limitations of the study

- Time limitation has been a major constrain on this study due to the nature and purpose of the study. The study is expected to explore issues which had to inform planning of the project, hence the time pressure to have the study ready by planning time.
- In the care of children their right to participation is greatly emphasized, in this it is encouraged to have children as involved participants in matters which affect them. However, in this study children have only been involved as respondents (Children's Care Act 38 of 2005, Sec 2 (10)).
- The researcher's first language was not the common language to the respondents.

1.9 Conclusion

This chapter created the framework of this study by outlining the background to the research problem, the goals and objectives of the research. The delimitation and limitations of the study were also defined. This paved the way to reviewing the literature, which the following chapter is focused on. The second chapter unravels the existing knowledge and findings in this phenomenon of OVC internationally, in the African continent, in sub-Saharan Africa, in South Africa and in the Free State province.

CHAPTER 2: LITERATURE REVIEW

2. Introduction

This chapter will focus on literature review, looking at what has been said and done in this field of study by other researchers. The researcher generally focused on the attempt to expose what underlies the situation or circumstances of OVC and their caregivers. Firstly, working definitions for major concepts of the study were outlined. The researcher also reviewed related and competing ideas and theories on the concept. An evaluation of the general circumstances under which children affected and or infected by HIV/AIDS find themselves in South Africa will take centre stage.

When the democratic government assumed power in 1994, its aim was to establish a society based on the values of fundamental human rights, social justice, freedom, and equality. These values are entrenched in the Constitution of the Republic of South Africa of 1996. One of the key provisions in the Constitution is the one dealing with equality and non-discrimination, *Machenjedze, (2007);* Section 9(3) reads:

> "The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, **age**, disability, religion, conscience, belief, culture, language and birth, The Constitution of the Republic of South Africa, (1996).

In a research carried by John Williamson, *et al* (2004) indicates that, worldwide, the number of children under age 15 who have lost one or both parents stands at more than 14 million, and estimates predict this number will surpass 25 million by 2010. The vast majority – 11 million– of these children live in sub-Saharan Africa (*Children on the Brink, 2002*) in J. Williamson, A. Cox and B. Johnston, (2004). The impacts of HIV/AIDS on children, families, communities, and countries are products of many interrelated factors and require responses that vary by family, community, and country. These factors include the local pattern of the spread of HIV infection, economic activities, service availability, resources, public knowledge and awareness, the social environment, culture, the legal environment, and political leadership.

2.1 Definition of Terms

For the purpose of this study it is of paramount importance that, working terms be clearly defined at this stage. Among other terms the following terms shall be defined, Child, Orphan, Vulnerable and Caregiver.

2.1.1 Child

A child is primarily defined by age, and the most commonly agreed age is below 18years. A number of legal instruments define a child thus.

According to the African Charter on the Rights and Welfare of the Child is anybody under 18 years old, *African Charter on The Rights And Welfare Of The Child, (1999).*

This definition of a child is also in agreement with the South African Constitution definition, Section 28 (3) ……. "Child" means a person under the age of 18 years.

The *Children's Care Act 38 of 2005*, defines a child as "…a person under the age of 18 years". In some case however, the age is increased to 21 years mainly based on the reasons of dependence and extended schooling.

Age is a major factor in determining the extent of the state's obligation to provide the child's needs such as education, *University of Western Cape (1992).*

2.1.2 Orphan

An orphan is defined as "A child who has no surviving parent caring for him or her, *Department of Social Development, (2005).*

Other groups label any child that has lost one parent as an orphan. In this approach, a *maternal orphan* is a child whose mother has died, a *paternal orphan* is a child whose father has died, and a *double orphan* has lost both parents UNAIDS Global Report, (2008).

However, the most and commonly accept definition of an orphan is a child who has lost both parents through death, *Skinner et al, (2004).*

2.1.3 Vulnerable child

Skinner et al, (2004) defines a vulnerable child as a child who has no or very restricted access to basic needs.

The National Action Plan for Orphans and Other Children made Vulnerable by HIV/AIDS in South Africa 2009-2012 defines a vulnerable child as "A child whose survival, care,

protection, or development may be compromised due to a particular condition, situation or circumstance that prevents fulfillment of his or her rights.

2.1.4 Caregiver

Care giver means any person other than a parent or guardian, who factually cares for a child and includes-

- a foster parent;
- a person who cares for a child with the implied or express consent of a parent or guardian of the child;
- a person who cares for a child whilst the child is in temporary safe care;
- the person at the head of a child and youth care centre where a child has been placed;
- the person at the head of a shelter;
- a child and youth care worker who cares for a child who is without appropriate family care in the community; and
- the child at the head of a child-headed household, *Children's Act, (2005).*

2.1.5 Psychosocial Support

Psychosocial support has been defined as an ongoing process of meeting the emotional, social, mental and spiritual needs of the OVC; all of which are considered essential elements of meaningful and positive human development. It goes beyond simply meeting children's physical needs, and place great emphasis on children's psychosocial and emotional needs, and their need for social interaction *NAP-2008-2009.* Williamson *et al*, (2004), argues that in addition to their physical needs, children have critically important emotional, cognitive, social, developmental, and spiritual needs. Fulfilment of these needs is essential to positive human development, and the impacts of HIV/AIDS can impede this. These impacts may include social isolation, rejection, emotional stress from the suffering of a parent or family member, burdens and responsibilities of caring for an ill parent or raising younger siblings, and involuntary school dropout. In addition, some children are separated from their siblings or forced to live on their own after the death of their parents. During and after parent illness and death, a child experiences fear, anger and grief. A child's fear of the unknown may be compounded if adults do not share the truth about their illness and impending death. These emotions are too often overlooked. The psychological difficulties they create are less tangible than the material problems children suffer.

2.1.6 Succession Planning

Succession planning means putting plans in place for the eventuality of your death. These plans should include, but not necessarily be limited to inheritance of property; guardianship of children and disposal of mortal remains and should ensure that all vital documentation is available.

2.2 The General Living Circumstance of the OVC

It must be noted that the literature undertaking in this baseline study was widely informed by the National Action Plan for Orphans and other children made vulnerable by HIV/AIDS by the Department of Social Development (DoSD) 2009-2012.

The proportion of children in South Africa who have lost one or both their parents has increased over a period of five years (2002-2006) from 17% to 21% of all children. In 2006 the total number of children who had lost one or both parents amounted to 3,768,000. Sixteen per cent (16%) of them were maternal orphans, 66% paternal orphans and 18% double orphans. A big proportion of orphan-hood in South Africa is associated with the high HIV and AIDS prevalence among people in reproductive age, children orphaned due to AIDS are estimated to be around half of all orphans nationwide. It has to be noted that many children who have lost one or both parents enjoy the care and support of extended family. Yet, the estimated number of those children who have become orphaned and vulnerable stands at 1.5 million as at in October 2008. Typically Orphans in this context refers to Children below the age of 18 whose parents, either father or mother, or both, have died. Vulnerability in this context refers to a child whose survival, care, protection or development may be compromised due to the particular condition, situation or circumstance which prevents the fulfilment of his or her rights, as defined above, *National Action Plan for OVC, (2009).* The same documents continue to indicate that, the NAP 2009-2012 seeks to provide continued guidance to all government departments and sectors of civil society, building on work done in the NAP 2006-2008. It is informed by the state of children and families in South Africa, and how they are currently infected and affected by the AIDS epidemic. The Strategic Goals of the NAP 2009-2012 are:

- Strategy 1: Strengthen and support the capacity of families to protect and care for OVC

- Strategy 2: Mobilise and strengthen community-based responses for the care, support and protection of OVC
- Strategy 3: Ensure that legislation, policy, strategies and programmes are in place to protect the most vulnerable children
- Strategy 4: Ensure access of OVC to essential services
- Strategy 5: Raise awareness and advocate for the creation of a supportive environment for OVC
- Strategy 6: Strengthen mechanisms to drive and support the implementation of the NAP

The researcher also in this study utilized these strategic objectives of the NAP to see how much the programs of the CBO and NPOs partnering with CARE are aligned towards the fulfilling and or realization of these objectives.

2.3 Challenges facing the OVC in South Africa

Challenges which confront the daily lives of OVC, are wide and inter related in most cases. The literature on OVC identifies the following challenges as the most common and widely faced. For children in seriously affected communities, the whole nature of childhood is changing fundamentally. Children are at increased risk of losing opportunities for school, health care, growth, development, nutrition, and shelter. Moreover, with the death of a parent, children experience profound loss, grief, anxiety, fear, and hopelessness with long-term consequences such as psychosomatic disorders, chronic depression, low self-esteem, learning disabilities, and disturbed social behaviour. This is frequently compounded by "self-stigma" —children blaming themselves for their parents' illness and death and for the family's misfortune usually resulting from the community's attitude towards them Smart, (2003).

2.3.1 Care for OVC

Although the overwhelming majority of OVC are living with surviving parents or extended family, many of them are being cared for by a remaining parent who is sick or dying, elderly

grandparents- who themselves are often in need of care and support, or impoverished relatives struggling to meet the needs of their own children. Increasing numbers of children are living in child-headed households, with minimal or no adult supervision or support, Smart, (2003).

2.3.2 Stigma and Discrimination

Even in countries with well-established epidemics, HIV/AIDS-related stigma and discrimination are often pervasive. Typically, this is not restricted to individuals who are infected but affects their families as well. Children from HIV/AIDS affected households report experiencing stigma and discrimination on many levels and in all aspects of their lives. Within the extended family, children orphaned by HIV/AIDS tell of being expected to work harder than other children in the family and of being the last to get food or school fees. Discrimination at schools, in health services, and in other institutions compromises their rights and frequently limits their access to opportunities and benefits *Smart, (2003)*.

2.3.3 Poverty

There is evidence that there is an assumption that orphans are the most vulnerable children however, in many circumstances, children from poor families rather than double orphaned, are more vulnerable, for instance in a research carried by Filmer, in Smart, (2003) shows that there were most likely to be children from poor families not being enrolled or to be out of school than it was for orphans. Francis and Henderson, (1992:11) argues, poverty is not just a problem in itself; it is often associated with a number of other factors of disadvantages, such as poor housing, poor health, lower levels of educational achievements and powerlessness etc.

2.3.4 Deprivation of parental guidance

It has been evident, that disastrous consequences may also result from the separation or death of, one of the parents at a critical time in a child's life. Often however the child will adopt a "father-figure" or "mother-substitute", and work through to satisfactory adjustment Burns, (1955:7) , continues to indicate that when the child develops a strong ego or personality, the child is most likely to survive challenge and even strengthened by events that may be disastrous for other children.

2.3.5 Psychosocial Well-being

In addition to their physical needs, children have critically important emotional, cognitive, social, developmental, and spiritual needs. Fulfilment of these needs is essential to positive human development, and the impacts of HIV/AIDS can impede this. These impacts may include social isolation, rejection, emotional stress from the suffering of a parent or family member, burdens and responsibilities of caring for an ill parent or raising younger siblings, and involuntary school dropout. In addition, some children are separated from their siblings or forced to live on their own after the death of their parents. During and after parental illness and death, a child experiences fear, anger, and grief. A child's fear of the unknown may be compounded if adults do not share the truth about their illness and impending death. These emotions are too often overlooked. The psychological difficulties they create are less tangible than the material problems children suffer Williamson, *et al* (2004).

2.4 Review of current local government policies related to OVC and CBOs

2.4.1 South African Constitution Act 108 of 1996

The constitution of the Republic of South African opens in its preamble has a very important statement to the care of all citizens, which should always be kept in memory by those who care for the OVC.

"We therefore, through our freely elected representatives, adopt this Constitution as the supreme law of the Republic so as to-…….. Improve the quality of life of all citizens and free the potential of each person;……." Republic of South Africa Constitution, (1996).

As much as it is privilege for OVC to receive care and support, it is equally their constitutional right. The constitution provides that:

Chapter 1: The Republic of South Africa is one, sovereign, democratic state founded on the following values:

(a) Human dignity, the achievement of equality and the advancement of human rights and freedom,

The constitution also outlines the issue of citizenship in Chapter 1 (3)(a) that: All citizens are- equally entitled to the rights, privileges and benefits of citizenship.

Bill of Rights (ss 7-39)

7 Rights

(1) This Bill of Rights is a cornerstone of democracy in South Africa. It enshrines the rights of all people in our country and affirms the democratic values of human dignity, equality and freedom.

(2) The state must respect, protect, promote and fulfil the rights in the Bill of rights.

9 Equality

(3) The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth.

10 Human dignity

Everyone has inherent dignity and the right to have their dignity respected and protected.

11 Life

Everyone has the right to life.

12 Freedom and security of the person

(2) Everyone has the right to bodily and psychological integrity, which includes the right-

(a) to make decisions concerning reproduction;

(b) to security in and control over their body;

20 Citizenship

No citizen may be deprived of citizenship.

26 Housing

(1) Everyone has the right to have access to adequate housing.

(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of this right.

27 Health care, food, water and social security

(1) Everyone has the right to have access to-

(a) health care services, including reproductive health care;

(b) sufficient food and water; and

(c) social security, including, if they are unable to support themselves and their dependents, appropriate social assistance.

(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.

(3) No one may be refused emergency medical treatment.

28 Children

(1) Every child has the right-

(a) to a name and a nationality from birth;

(b) to family care or parental care, or to appropriate alternative care when removed from the family environment;

(c) to basic nutrition, shelter, basic health care services and social services;

(d) to be protected from maltreatment, neglect, abuse or degradation;

(e) to be protected from exploitative labour practices;

(f) not to be required or permitted to perform work or provide services that-

(i) are inappropriate for a person of that child's age; or

(ii) place at risk the child's well-being, education, physical or mental health or spiritual, moral or social development;

(g) not to be detained except as a measure of last resort, in which case, in addition to the rights a child enjoys under sections 12 and 35, the child may be detained only for the shortest appropriate period of time, and has the right to be-

(i) kept separately from detained persons over the age of 18 years; and

(ii) treated in a manner, and kept in conditions, that take account of the child's age;

(h) to have a legal practitioner assigned to the child by the state, and at state expense, in civil proceedings affecting the child, if substantial injustice would otherwise result; and

(i) not to be used directly in armed conflict, and to be protected in times of armed conflict.

(2) A child's best interests are of paramount importance in every matter concerning the child.

(3) In this section 'child' means a person under the age of 18 years.

29 Education

(1) Everyone has the right-

(a) to a basic education, including adult basic education;

2.4.2 Children's Act No. 38 of 2005

"Care", in relation to a child, includes, where appropriate-

(a) within available means, providing the child with-

(i) a suitable place to live;

(ii) living conditions that are conducive to the child's health, well-being and development; and

(iii) the necessary financial support;

(b) safeguarding and promoting the well-being of the child;

(c) protecting the child from maltreatment, abuse, neglect, degradation, discrimination, exploitation and any other physical, emotional or moral harm or hazards;

(*d)* respecting, protecting, promoting and securing the fulfilment of, and guarding against any infringement of, the child's rights set out in the Bill of Rights and the principles set out in Chapter 2 of this Act;

(e) guiding, directing and securing the child's education and upbringing, including religious and cultural education and upbringing, in a manner appropriate to the child's age, maturity and stage of development;

guiding, advising and assisting the child in decisions to be taken by the child in a manner appropriate to the child's age, maturity and stage of development;

(g) guiding the behaviour of the child in a humane manner;

(h) maintaining a sound relationship with the child;

(i) accommodating any special needs that the child may have; and

(j) generally, ensuring that the best interests of the child is the paramount concern in all matters affecting the child.

Chapter 13 on Child Youth Care Centres, Chapter 14 on Drop in centres, Chapter 15 on Partial Care need to be taken cognisance of by partners working with children in an institutional way.

2.4.3 National Action Plan For Orphans And Other Children Made Vulnerable By HIV And AIDS, 2009-2012

The National Plan of Action as designed by the Department of Social Development provides clear national objectives, which require all stakeholders to contribute in their own unique or similar way.

The Department of Social Development ("DoSD") is the lead sector department responsible for the implementation of the National Action Plan for Orphans and other Children Made Vulnerable by HIV and AIDS: 2006 – 2008 ("NAP"). The NAP developed by DoSD in collaboration with NACCA represents a response to the challenges faced by Orphans and other Children Made Vulnerable by HIV and AIDS ("OVC") NAP 2009-2012, (2009).

The NAP 2009-2012 seeks to provide continued guidance to all government departments and sectors of civil society, building on work done in the NAP 2006-2008. It is informed by the state of children and families in South Africa, and how they are currently infected and affected by the AIDS epidemic. The Strategic Goals of the NAP 2009-2012 are:

- Strategy 1: Strengthen and support the capacity of families to protect and care for OVC
- Strategy 2: Mobilise and strengthen community-based responses for the care, support and protection of OVC
- Strategy 3: Ensure that legislation, policy, strategies and programmes are in place to protect the most vulnerable children
- Strategy 4: Ensure access of OVC to essential services
- Strategy 5: Raise awareness and advocate for the creation of a supportive environment for OVC
- Strategy 6: Strengthen mechanisms to drive and support the implementation of the NAP

Also very crucial in the OVC care is the care and management of the carers themselves.

2.4.4 Community Care Worker Management Policy Framework: DRAFT VERSION 6.0

Social development services for Home and Community Based Care

Focus Services:

Home

- Assessment of individual and family needs
- Referrals, follow-up and follow through on behalf of beneficiaries.
- Facilitate access to social assistance including accompanying beneficiaries to relevant agencies
- Ensure attainment of vital documentation for beneficiaries for example, birth / death certificates and identity documents
- Early identification of Orphans and Children made Vulnerable (OVC) by HIV and AIDS and their families
- Psychosocial support to people on treatment for HIV and AIDS and other chronic conditions and affected families beyond medical care
- Psycho-social support services to Child and Youth headed households
- Provision of material assistance, for example food parcels and clothing
- Assist with issues pertaining inheritance and guardianship for children
- Assist with supervision of children and assistance with homework
- Assist when needed with household chores which could include washing, feeding children and preparing food.
- Assist with initiatives on sustainable livelihoods, for example food gardens

Community

- Raise awareness on succession planning issues to beneficiaries.
- Facilitate the establishment of support structures that build on traditional roles of families and communities to care and support such as:
    - Support groups- these groups are not only confined to people living with HIV and AIDS but may be established as needs arise, for example a support group for youth heading households, children, older persons
    - Community Care Centres

    - Child Care Forums
- Assist with conducting awareness campaigns on issues affecting individuals, families and communities
- Promote behaviour change through a life skills programme
- Commemoration of national and international days for example World AIDS Day and Human Rights Day
- Mapping services offered in the community
- Advocacy

Note: The aforementioned will include older persons and persons living with disabilities

CHAPTER 3: RESEARCH METHODOLOGY AND DESIGN

3 Introduction

In this chapter the research design and methodology employed throughout the process of research is outlined. This will include the case study research design; qualitative method as the main guiding method employed. Quantitative methodology is also outlined in a nutshell as some basic principles of quantitative methods are employed in converting the results into numerical percentage representation and finally, the descriptive research design, research population, sampling procedure and size. Research instruments, data analysis, validity and reliability of the research outcome are discussed as well.

3.1 Research Methodology

3.1.1 Qualitative research methodology

Qualitative research methodology is based on methodological traditions of enquiry that explores a social and human phenomenon, Creswell, (1998). Creswell further argues that qualitative research provides a rich source of information leading to theories, patterns and or policies that help to explain and inform the phenomenon under study. Another reason for selecting the qualitative method for this study is that the topic needed to be explored flexibly with the main aim of accessing specific information rather than a mere generalization of the findings. This study was done specifically to provide a measure of the situation of OVC and their Caregivers in these selected areas where DELL program is being implemented as a baseline study, and to create a yard stick against which progress can and will be measured in the future. In these approaches, the researcher strives to understand the meaning people have constructed about their own world and their experiences. The aim is to understand the nature of that setting, what their lives are like, what is going on for them, what their meanings are, and what the world looks like in their own particular setting. The goal of the researcher by using qualitative method is to be able to describe and understand rather than the mere explanation and prediction of human circumstances, Rembe, (2007) in Machenjedze, (2007). Qualitative research emphases the importance of social context for understanding the social world. When working from a qualitative perspective the researcher attempts to gain a first-hand, holistic understanding of phenomena and data collection gets shaped as the investigation proceeds De Vos *et al,* (2002).

The research seeks deep understanding of people's experiences and in this regard, to understand from their vantage point what they take to be the causes or factors perpetuating their living circumstances and what best could be done thereof. The research looks specifically at two of the five DELL implementing partners in Thabo Mofutsanyane District, namely Gethsemane Health Care Centre in Ficksburg and DDI (Bethlehem-town and Rosendale- nodal area).

3.1.2 Quantitative research methodology

A quantitative study may be defined as an inquiry into a social or human problems, based on testing a theory composed of variables, measured with numbers and analysed with statistical procedures in order to determine whether the predictive generalizations of the theory hold true (Creswell, 1994: 1-2) in De Vos *et al*, (2002). Quantitative approach is more highly formalized, as well as more explicitly controlled. Data collection procedures and types of measurement are constructed prior to the study and applied in a standardized manner. The researcher as an interviewer or observer is not expected to add their own impressions or interpretations; these are some of the main reasons why the researcher in this study choose to use the qualitative method as the main study guide, so as to provided a comprehensive logical frame of social reasoning of both the researcher and respondents.

3.1.3 Descriptive Research Design

The researcher's intent in a descriptive study is to observe and describe some segment of social reality, Babbie and Wagenaar (1992). The main purpose of descriptive research is to examine the relationship among variables and to provide an accurate description of a phenomenon that is being researched, Mouton and Marais, (1990).

A descriptive researcher believes that before solutions are sought, one needs to know what the existing facts and prevailing conditions are. While descriptive research is essentially concerned with conditions as they are, it nevertheless involves much more than mere fact gathering. Hence the researcher sought to conduct a descriptive research. The findings of this research assisted in developing possible solutions which are made in the form of recommendations, Machenjedze, (2007).

3.2 Research Design

Mouton, (1996) defines research design as a plan or blueprint of how one intends conducting the research. In a qualitative context, research design is the entire process of research from conceptualizing to writing the narrative, Creswell, (1998).

3.2.1 Case Study Design

Case study is studying social elements through a comprehensive description and analysis of a single situation or limited cases. Emphasis is placed on understanding the unit and the wholeness of a particular case, Rembe, (2007). In the desire to study a social group, community, system, organisation or a social event; it is convenient to pick one example or a small number of examples from the list to study them in detail within their own context, and make assessments and comparisons. These are called case studies, Walliman, (2006). The case being studied can refer to a process, activity, event, program, individual or multiple individuals. The description of the cases takes place through a detailed, in-depth data collection method of involving multiple sources of information that are rich in context. These can include interviews, document analysis, observations or archival records, De Vos, *et al.* (2002) in Machenjedze, (2007). Lastly, multiple sources and multiple methods; One of the strengths and the reasons why the researcher chose the utilization of a case study design in this research is because it allows and encourages the researcher to use a variety of sources, a variety of types of data and a variety of research methods as part of the investigation. Methods such as observation, interviews and document analysis can be utilised.

3.3 Research Population and Sampling Methods

3.3.1 Research Population

A research population refers to all those cases about whom the researcher wants to make a scientific conclusion, with respect to a certain attribute or social phenomenon. A research population is a term that sets boundaries on the study units and it refers to individuals who possess specific characteristics under study, Arkava, and Lane (1983). Specifically, in this study research population refers to:

All OVC and their caregivers receiving services from the selected **two** CARE partners implementing the DELL program; all other people as individuals and groups who are directly or indirectly involved in the provision of the services to the OVC. These include, *inter alia*,

parents; caregivers (secondary); and other stakeholders. The population may be too large, or simply unavailable for study. The researcher accordingly used a sample (a relatively small section) from within the population, Behr, (1983).

3.3.2 Sampling

A sample is a small portion of the total set of objects, events or persons that together comprise the subject of the study. It can be viewed as a subset of measurement drawn from a population in which the research is located. Most important is the sampling procedure and method one uses in qualitative research. Qualitative researchers usually work with small samples of people, nested in their context and studied in-depth. Qualitative samples tend to be purposive, rather than random, Matthew, and Huberman (1994); hence in this study participants where purposefully selected.

3.3.2.1 Purposive Sampling

This type of sampling is based entirely on the judgment of the researcher, in that a sample is composed of elements that contain the most characteristic, representative or typical attributes of the population. The judgment of the individual researcher is obviously too prominent a factor in this type of sample, De Vos, A.S *et al* (2002:208).

The researcher in this case selects cases with a specific purpose in mind. Purposive sampling is best when a researcher wants to identify particular types of cases for in-depth investigation. The purpose is less to generalize to a large population than it is to gain a deeper understanding of the phenomenon under study, Judd *et a,* (1991).

3.3.2.2 Sample Size

Beginning field researchers should start with a relatively small group (30 or fewer) who interact with each other formally or informally on a regular basis Neuman, (1997:47). The researcher purposively selected a small sample size in order to focus more on that small group and dig deeper into the search of all necessary information.

A round figure of 60 children respondents was decided for this baseline study. However the actual interviews were conducted with more than 60 respondents which comprised of:

- The children receiving services from the participating partners
- The children’s primary caregivers

- Organizational coordinators or managers

Based on the predilection of the qualitative researcher and his ability to dig deeper into the study, the whole sample of the study did not over exceed 30 from each site participating. A total of 74 children and their caregivers were interviewed, all divided among the 3 participating partner sites. The children selection was given preference to recently identified children, for the purpose of providing good progressive indicators.

3.4 Data Collection Methods

Descriptive research, based on a case study design, usually takes place through detailed, in-depth data collection methods, which are rich in context and involve multiple sources of information. These can include interviews, documents, observations or archival records. Please see Appendixes attached:

Appendix A: Partner Organisation Assessment Tool

Appendix B: Care OVC Programme Baseline Study – Interview Guide

3.4.1 Interviewing

Interviewing is the predominant mode of data or information collection in this qualitative research. Sewell in De Vos S *et al.* (2002) defines qualitative interviews as "attempts to understand the world from the participant's point of view, to unfold the meaning of peoples' experiences and to uncover their lived world prior to the scientific explanations". The main reasons why the researcher chose to use qualitative interviews include;

- First, the researcher's desire to find information in its total contextual relevance, that is inclusive of the *emotions, experiences and feelings* that accompanies it; rather than access to mere straight forward, distant and inhuman factual factors.
- The second reason why the researcher chose to use interviews in this study is to pursue what Denscombe, (2003) refers to as *privileged information*. This is the value of contact with key players in the field who can give privileged information. The depth of information provided by interviews in this regard can produce best value if the informants are willing to and able to give information that others could not, or the researcher could not know or access without getting in touch with them.

Field research uses unstructured, nondirective, in-depth interviews, which differ from formal survey research in many ways. The field interviews involve asking questions, listening,

expressing interest and recording what has been said. Interviews are a joint production of a researcher and a member. Members are active participants whose insight, feelings, and cooperation are essential parts of a discussion process that reveals subject meanings. The presence and involvement of the researcher, including how she or he listens, attends, encourages, interrupts, digresses, initiates topics, and terminates responses, is integral to the respondent's account Machenjedze, (2007).

3.4.2 Data gathering Assistance

The volunteers (community care workers) and OVC coordinators from the participating partners where utilized as data capturers, on their own sites. The main reason why the researcher choose this strategy was to keep the environment as normal as possible to the respondents to be interacting with people they are accustomed to. Door to door home visits were also done to some selected household for observational data gathering.

- **Observation** is a typical qualitative approach to data collection, which implies that data cannot really be reduced to figures. Therefore observation can be defined as a qualitative research procedure that studies the natural and everyday set-up in a particular community or situation.

3.5 Data Analysis

Steinberg, (2003) states that "qualitative analysis or analysis of words is referred to as content analysis and its basic task is to understand, interpret, and represent the meaning of what has been said by the respondents".

A thematic content analysis method was used in analyzing data gathered in the study. The analysis went through a number of stages. After each interview the researcher constructed a report on that interview, drawing out the essential ideas brought out.

- Themes where developed according to the core package of services expected to be rendered by the DELL implementing partners and in line with other developmental expectations
- These themes were used for analysis and give a baseline and have been also used to set the indicators against which progress could be measured against.

CHAPTER 4: PRESENTATION OF FINDINGS AND ANALYSIS

4 Introduction

Data analysis is the process of bringing order, structure and meaning to the mass of collected information and data. Therefore Chapter 4 will present and discuss the results generated from the family discussions and individual interviews with the OVC and their caregivers and other study participants. Chapter 4 also provides a brief description of the research site and research participants. As outlined in the Chapter 1; the researcher investigated the living circumstances of OVC and their Caregivers, as a baseline study for the DELL CARE programme.

A total of 74 individual separate and or joint interviews of OVC and their caregivers were conducted at the partner sites and at OVC homes.

4.1 Research Site and Participants

4.1.1 Research Site(s)

DELL program is being implemented in Thabo Mofutsanyane District in the Free State, mainly in the following towns:

- Alington
- Bethlehem
    - Clarens
    - Fouriesburg
    - Rosendale
    - Paul Roux
- Ficksburg,
- Kestel
- QwaQwa

It was decided that only two of the partners will participate in the baseline study. DDI (Bethlehem and Rosendale) and Gethsemane (Ficksburg) were selected. The main reasons why these two were selected was due to the diversified characteristics they represent.

- DDI; Bethlehem being a more urban area with a diversified and more service providers, while DDI- Rosendale, being classified as a nodal area, a place of greater need high levels of poverty and being a predominantly farm area. Gethsemane Ficksburg, being an area located on the national boarder region with Lesotho. Also

these areas generally make the widest geographical coverage of the area in which DELL is being implemented in Thabo Mofutsanyane District.

4.2 Data Presentation and Analysis

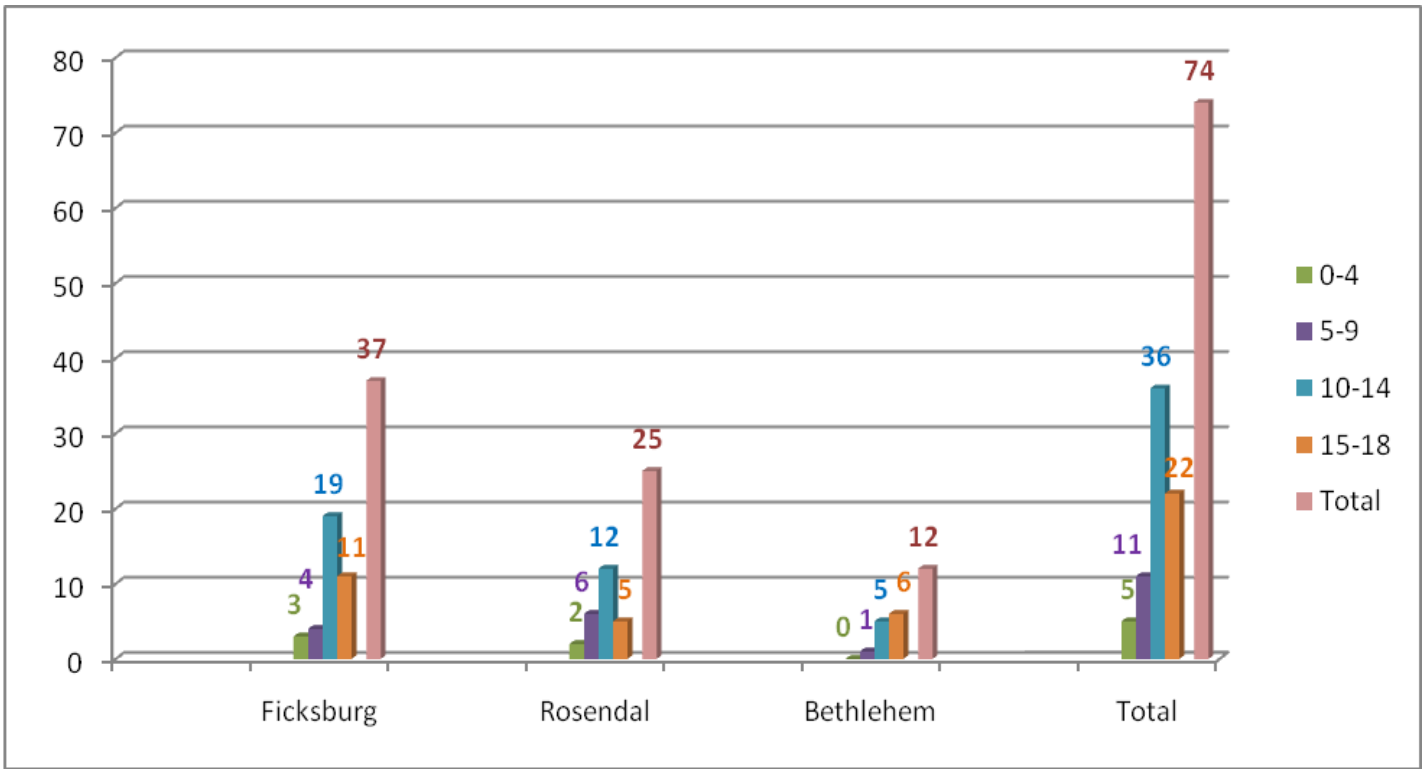
Steinberg, (2003) states that "qualitative analysis or analysis of words is referred to as content analysis and its basic task is to understand, interpret, and represent the meaning of what has been said by the respondents".

Qualitative data presentation and analysis is usually reduced into themes or categories and is evaluated subjectively. There are two primary sources for organizing qualitative data which are; the questions on the interview guide and or; the insights that emerge as you collect and analyze the data Sumbulu, (2005).

4.2.1 Age groups of participants

Children who participated in this study where all within the constitutional definition of a child; that is between 0 to 18 years of age.

Children per Age Group

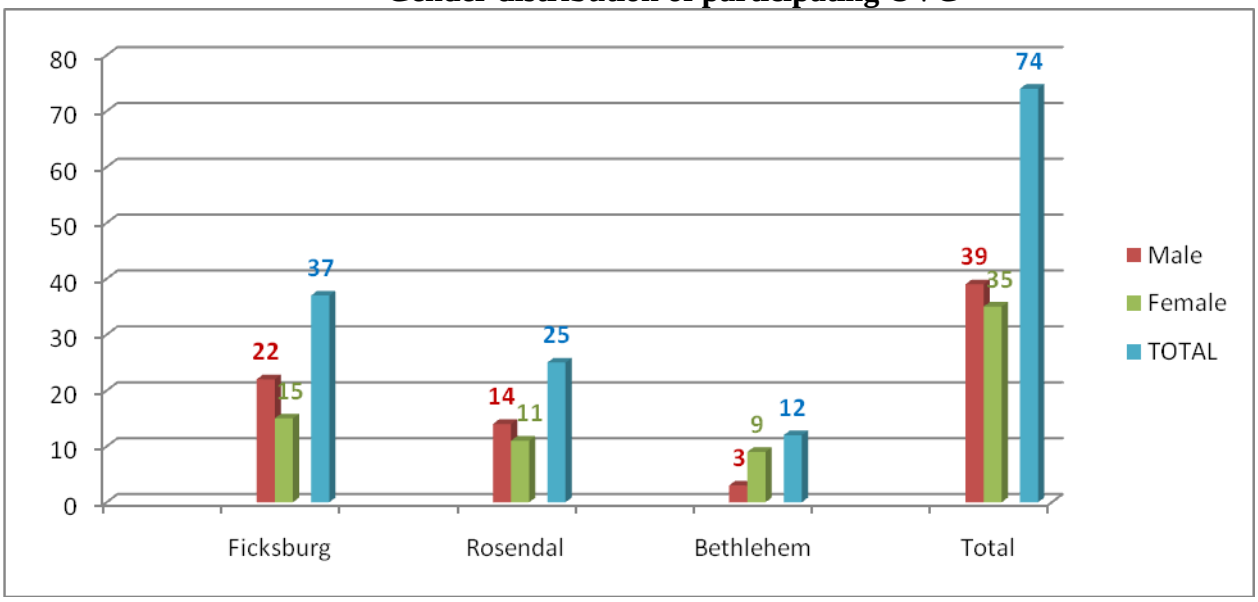


It was observable that the majority of children being served are between the age of 10 and 14 years. In most case this age group double or triple the other age groups.

- The research observed that in the first age group there were 5 children between 0-4 years. This could be an indication of a service gap in the partner's OVC programmes which could be a sign of no services or capacity at the partner level to render meaningful services to this age group. This could also imply that children in this age group are easily placed in family alternative care which results in them escaping the need for OVC services.
- There is an observable increase from the age 0-4years to 5-9years. This is most likely due to children becoming school going age and therefore increasing mobility which result in easy identification. When children become of school going age it becomes easier to identify who are vulnerable and can therefore be referred to different service providers.
- The research findings show a double plus increase of children in the 10 – 14 years. Possible explanations of this could be found in the programmes and services rendered to the OVC and also in the fact that at this age children become more vocal and are able to express their needs and are able to expect assistance.
- There is a significant decrease in the numbers of OVC being reached between the ages of 15-18years. This observation creates a huge concern as this age group, in the researcher's view, forms the critical stage between being a child and becoming an adult therefore lessons on responsibilities, sexuality, substance abuse, HIV/Aids, etc becomes of paramount importance and statistically there is an obvious gap. This age group also forms a considerable proportion of both single motherhood (children with children) and unwanted pregnancies. Another possible reason for such phenomena is that when programmes being offered do not speak to the specific needs of this age group, there is a filtering out tendency. Lastly, it is within this age group that children become 'Lost to Follow' which means that these children can no longer be found by the service providers. This can be due to them moving to other family members or friends, running away from their home environment, leaving school, living on the streets and even being coerced into prostitution.

4.2.2 Gender

Gender distribution of participating OVC



The study, found out that the numbers of boys, in OVC programs is growing significantly. Boys are becoming more willing to open up, look and ask for help. This gives an interesting comparison to the findings of services rendered to older people, which is predominantly utilised by females. The question is what could therefore, be the possible explanation for a higher number of boys than girls in an OVC program. The findings of this study established that, this is predominantly because of the influence of the female caregivers; who are living with the children who encourages them to look for and do ask for help when they can.

4.2.3 Siblings and other children in the same household

With a total of 74 children who participated in the study all combined they had either siblings or other children living in the same household who amounted to (269) excluding the 74 participants. This situation presents a picture that on average each household is caring for an approximately 5 children. This is despite their condition, circumstances and or status. The highest score was of 10 children in one household and it was more than one household with 10 children. On principle, based on these findings a single orphan or vulnerable child identified is a mirror reflection of 5 more.

4.3 Circumstances of the OVC

The living circumstances if the OVC is presented under different core needs of the children which are commonly referred to in DELL program as Core Package of Services (CPS). The themes of analysis are also driven out of the CPS.

4.3.1 Education and further training

The study looked into **5 aspects** of education to the OVC; which are: *enrollment, attendance, time and assistance with home work (school work at home), school fees and further training.*

Enrollment: It was identified that it was only a few children, about 2.5% of the participants, of the children of school going age who were not attending school and the main reasons mentioned were; *no birth certificates* and *child labour.* Child labour can be described as the situation when a child becomes the only bread winner or a contributor to the family income (doing piece jobs to support and help the single parents and other younger siblings).

Attendance: There was a good report of attendance from both the children and their caregivers. There is however an observed trend of absenteeism that was identified in most children living with grandparents as their caregivers; of not attending school on pension pay days in order to assist their grandparents to receive their pension. The main reasons for non-attendance which the research identified were:

- Assisting caregivers (grand-parents) at the pay points for the collection of their old age grants
- Caring for parents or other sick siblings at home
- No school uniforms
- Take up piece jobs to get money to assist parents and other siblings
- Going to collect treatment from clinics. 5% of children who participated in this research reported having missed school once or more in order to collect treatment from the clinic.

In support of the above research findings, Williamson *et al* (2004), also argues that; children may have to take time off from school due to the lack of school fees, school uniforms and or material (especially at the secondary level). He also further observes the similar phenomenon observed in the study about labour; due to the low productivity of the sick parent, workloads for children and extended family members increase. Children may begin to work in the formal or informal labour market to earn money for the household.

School fees: It was indicated that the issue of school fees has not been a major challenge towards children's school attendance. However, a form of indirect discrimination has been identified towards children who are not paying school fees, "for example one respondent (child) said that the teacher said to me when I asked to go to the toilet, ***"you want to go and use the toilet paper which you don't pay for."***

These same circumstances identified in this study as affecting attendance are similar to those identified in another research conducted by Machenjedze, (2007) as resulting in increased

school drop outs. He outlines that; the main cause of dropout in the rural schools was the issue of school fees, school uniforms and stationery. Although most schools claim that they did not send children home for fees or uniform, if a learner has not paid fees they are not allowed to play sport or to go for school trips. Some students enjoy going to school because they are good sports players so if they are deprived of what they like most at school they just stop going to school. When their fees get paid they realise they are so far behind in school work, they perform worse than they did before and they end up not coming to school at all.

Time and assistance with homework: A considerable number of children in this study indicated they had no one at home to assist them with their homework; hence they do the work by themselves. Another considerable number do receive assistance from their grandparents and in most cases they are just too old to provide the assistance effectively. All the eldest children from Child Headed Households (CHH) did not do their homework at all but did help their siblings with homework. The reason was they have so much to do at home that when they finish they are too tired to do their own homework.

School Uniforms: 53% of the participating children in this study had no school uniform or had an incomplete school uniform. The research has also found that not having a school uniform or having an incomplete uniform is one of the most commonly used discrimination in schools. Children with no or who have incomplete school uniforms feel lower than those with uniforms and those with uniforms feel better and more confident at school than those without. One child reported when asked how she feels about going to school without a uniform: ***"I know that the other girls don't want to play with me because I don't have a uniform"***. Not having school uniforms is also used in a more natural way in the formation of sub-cultures or sub-groups among children, i.e.: children with uniforms tend to play together whilst those without the correct uniforms stay together. The South African Schools Act 1996, Section 5 prohibits any form of discrimination against any child on any grounds, including the inability of a child's parents to pay fees, in Machenjedze, (2007). However, this does not stop children from discriminating against one another therefore these children are left at the mercy of the community's protection or lack thereof.

Children with and without School Uniforms

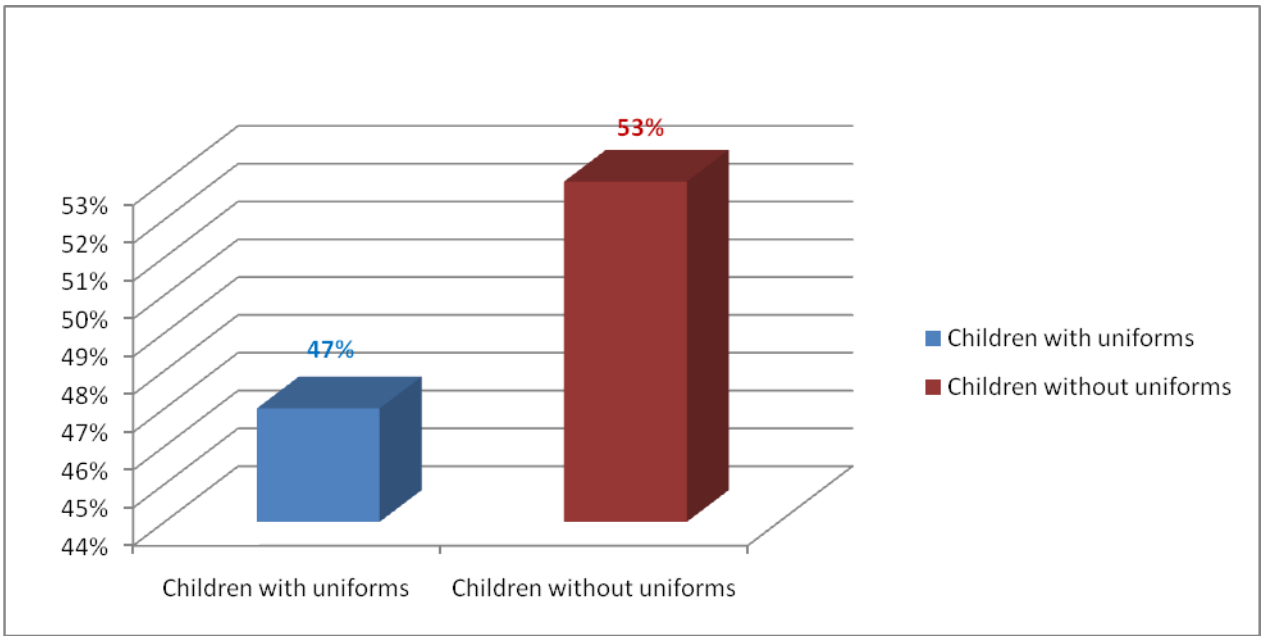


Photo taken by:
Golden Gateway Hospice, BETHLEHEM

A picture of a school going child not attending school on a school day – reasons unrevealed.

4.3.2 Child Protection

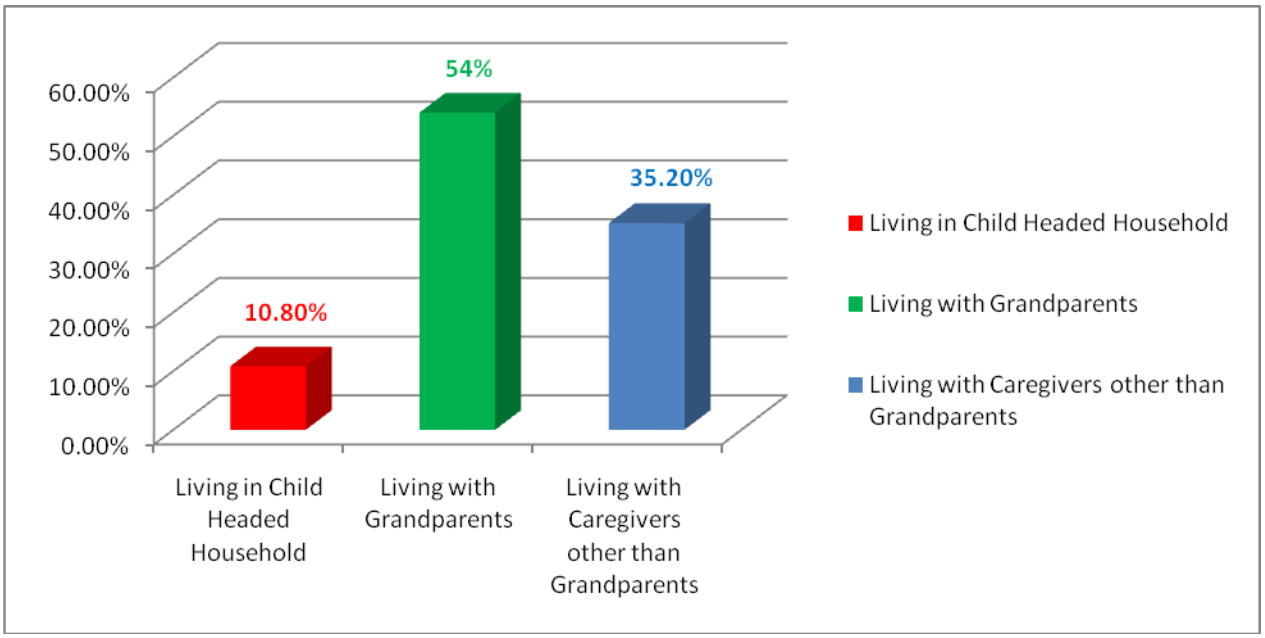
4.3.2.1 Primary Caregivers

The aspect of child protection is a crucial issue of a child's developmental process. This aspect plays a greater role in shaping children into becoming the people they become in their adult life. Hence, they need every support possible to protect them and bring them up in a safe environment, teaching them to be responsible citizens. Unfortunately, some children

have themselves to look up to for all the protection there is to need. For instance, in this study, out of 74 OVC who participated;

- 10.8% were from a child headed household
- 54% lived with grandmothers who were quite advanced in age to be a primary caregiver.
- Only 35.2% of the participating children lived with other caregivers, such as foster parents, aunts, etc; but being adult people not aged people.

OVC Protection



This is in no way a sentiment that grannies are not capable of providing care and protection to OVC, but the increasing numbers of young children in the care of only grandparents, is a phenomenon worth attention of social service organizations.

- In the researcher's analysis this is an indication of the impact the HIV/AIDS pandemic (which has hard hit the economically active age group leaving little children in the care of grannies) has had on the family structures.
- The huge age gap of parent-child relationship between the caregiver and the child is also further extended.

The above outlined phenomenon has created a huge gap that the CBOs providing assistance and help to these children needs to come closer than just a cooperate relationship to these children, in order to fill this gap.

Picture taken by:
Golden Gateway Hospice, BETHLEHEM

A child with his Grandmother
A complete family!!!

4.3.2.2 Birth Registrations and Identity Documents

The constitution chapter 1(ss 3(2)(a)) clearly outlines that all citizens are- equally entitled to the rights, privileges and benefits of citizenship; and one of such privileges and benefit is identity, through legal documentation such as birth certificate and identity book. However, 26% of all the children who participated and most of their represented siblings and children in the same household had no birth certificates. Almost all of them are school going children and some had already stopped attending school because they had no birth certificates.

- The majority of the 26% children who had no birth registrations and or Identity documents, 20% of them were from the Ficksburg partner. This is most likely due to the unique circumstances of the areas being located at the bordering region of South Africa and Lesotho. The research established that most of these children struggling with accessing birth registration have one of their parents originating from another country, particularly Lesotho in this case. This scenario is so extreme that it has kept hundreds of children out of school and if they do attend they can only go up to a certain point (*this is a matter of great concern*).

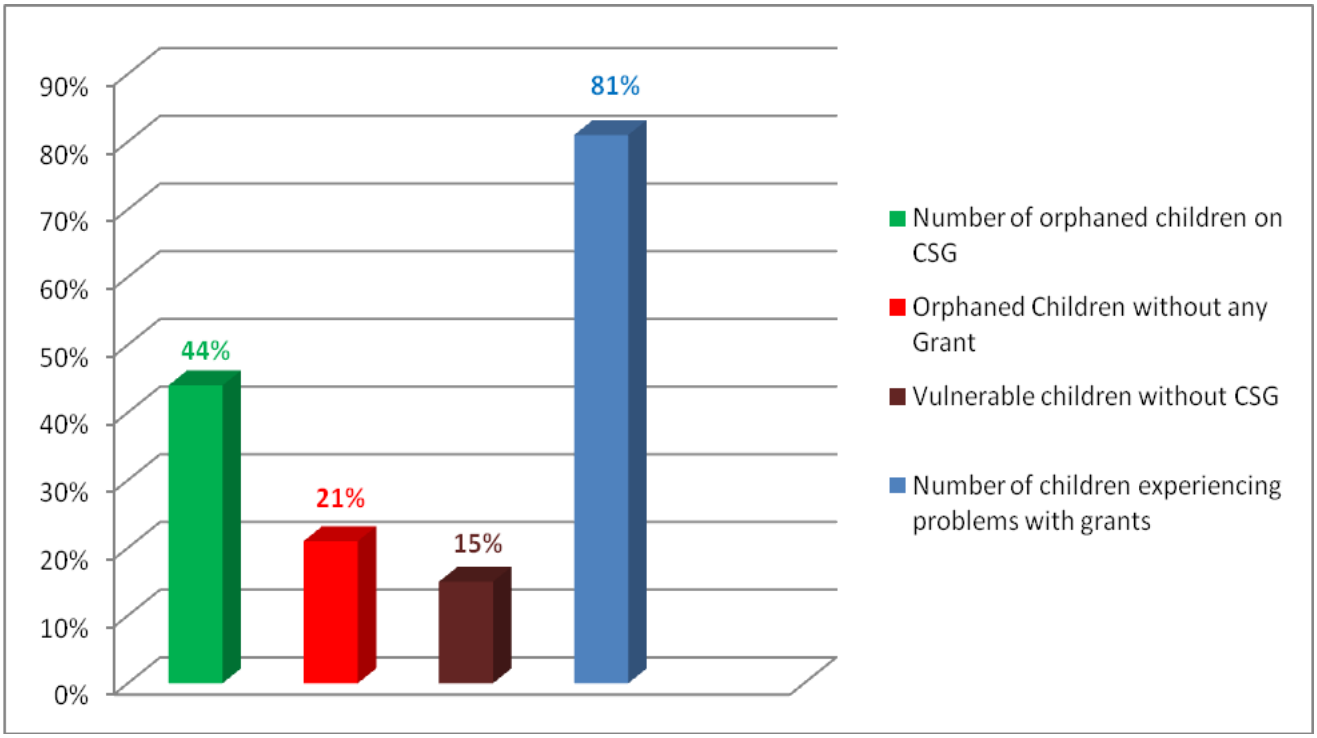
4.3.2.3 Social Security Grants

The majority of children who participated in the study were orphans in comparison to vulnerable children. However, it has been noted in the study that most of the orphans have not been placed in foster care placement either with their family caregivers (kinship) or non-family foster parents (non kinship). They therefore could receive social assistance in the form of a foster care grant (R680), but are only accessing a child support grant (R240). Orphaned children are eligible to receive Child Foster Grants (CFG) and vulnerable children, who are not placed in alternative care, are eligible to receive Child Support Grants (CSG). It

should be common knowledge to almost all citizens that children who are in need can access these government provided assistance but, findings revealed that this is not common knowledge to most caregivers particularly the elderly. The statistical findings were as follows; out of the total participants, 74 children:

- Number of Orphaned Children on CSG- 33 = 44%
- Orphaned Children without any grant- 16 = 21%
- Vulnerable Children without the CSG- 15 = 15%
- The total number of children with a problem regarding social security grant- 60 = 81%

Access to Social Security Grants



A wide range of circumstances have contributed to the above situation and have been identified as follows:

- Lack of knowledge by the primary caregivers
- Lack of birth registration documents for the children and or identity documents for the caregivers
- Delayed process of application for the grants
- Missing parent or parents
- Child headed household with no one to take the responsibility.

4.3.3 Food Security

Household food security is defined as access by all households **at all times** to adequate safe and nutritious food for a healthy and productive life Bonti-Ankomah, (2001).

Food security is one of the major elements of the core services that OVC and their caregivers need. On contrary the research has found out that this is the most unattended element of social services that community organizations are presently incapable to effectively respond to. This is mainly due to funding limitations and scope of funding as prescribed by the funders. The study discovered that food security is directly related to the family income. However, most families represented in this study had a social security grant as their sole income. 40% of all families who participated had only an Old Age Grant as their only source of income. The findings in this regard indicates that due to lack of food security most vulnerable children and families have resorted to cheap meals, which are highly innutritious and reduced number of meals per day.

In the Universal Declaration of Human Rights, there is one important article that clearly pin points the economic rights of many citizens of the world. Article 25.1 of the United Nation's Universal Declaration on Human Rights states that:

> *"Everyone has the right to a standard of living adequate for the health and wellbeing of himself and of his family, including food, clothing, housing, medical care, the necessary social services and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control".*

The study established that Poverty continues to be the main factor in household food insecurity. Given that there are not many viable livelihood strategies available (particularly in rural areas), most poor households are only dependent on social security grants income.

Employment levels are so low that only two families out of the 74 represented in the study had a form of income from employment; this therefore, influences poverty trends and hence food insecurity. The fewer the jobs, the lower the household income and the higher the vulnerability to food insecurity. There was no family which had any form of IGA (Income Generating Activity).

4.3.3.1 Nutrition

A nutritious diet is a very important element of every child's heath, physical and cognitive development. However, in this study 35% of the children who participated indicated that their most common and frequent main mail was pap (mielie meal) and water, while 16% have pap

and sour or fresh milk. This was mainly in those family where there was no income of any form, or who received only child support grants for a child as their only consistent form of monthly income.

4.3.4 Healthy Services

The HIV/AIDS epidemic presents a continuum of complex health issues ranging from protecting personal health to ensuring that a society has an adequate supply
of health care. In many developing countries, HIV/AIDS has reversed health gains achieved in the decades before the epidemic Williamson *et al,* (2004).

It is of paramount importance that each child has access to basic health care services. The study investigated if the children who participated did go to a clinic, hospital or doctor when sick.

- More than half of the children reported that they did not go to the clinic when they were sick. They just stayed at home until they were okay.
- 46% indicated that they always go to the clinic when sick.
- It was also observed that the children under the care of their grandparents were taken to the clinic most times they were sick than other children.
- 14% of the children indicated that they did not go to the clinic when they were sick because they had no one to take them.

4.4 Psychosocial Support

Children and youth in Africa confront myriad challenges due to the HIV/AIDS pandemic and other significant risk conditions such as poverty, hence the great need to attend to their psychosocial needs. The importance of attending to the psychosocial needs of OVC especially those left without the protection and nurturance provided by family and community support has been emphasized in a number of literature (Save the Children,
1996; Fox, 2001; Foster, 2002; World Health Organization, 2005 in Thurman, (2006).

In this baseline study, it was identified that psychosocial support is a very crucial service needed and valuable for and to the OVC. Although Partners (CBOs) do provide Psychosocial support in so many different ways to the OVC in the community and institutionally, there is:

- Less structure to the activities through which the psychosocial support is provided; hence the benefit of psychosocial support is not measurable or noticed.

- Emphasise has been given and focused in efforts to acquire resources to provide physical help such as food and clothing in more structured and systematic ways than it has been in psychosocial activities.

However, as identified by Thurman, (2006) DELL partners and any organisation servicing OVC need to recognise that 'in contexts of limited resources, psychosocial support may be the most important resource available in facilitating coping and resilience' (Maynard, 1999) in Thurman, (2006). Psychosocial support is essential for children to learn, develop life skills and to participate fully and have faith in the future in short, to become healthy, well-functioning and productive adults.

Psychosocial support when provided in more systematic, measurable and purposeful way it helps develop great resilience among the OVC.

The children who participated in this baseline study when asked " if they do talk to anyone when they have a problem"

- 12% indicated that they did not talk to anyone when they had a problem, not because they did not want to but because they had no one they could talk to; reasons that were more frequent among the children on why they do not talk to their guardians where;
    - The parents are sick and always in bed
    - Parents/ guardian always under the influence of drugs or alcohol
    - They live alone with younger siblings so they cannot tell their little siblings their problems and they are over burdened with parental duties

It was also identified in this study that the following groups of people form a very strong base of psychosocial support for children;

- Grandparents, mostly grandmothers, because more than 60% of the children reported that they confide in their grandmothers should they have a problem
- Parental figures next door (Neighbours)
- Siblings- it was discovered that in child headed household siblings talk to each other and confide in each other more than children do in family with parents or a guardian.

Previous studies on OVC has found out that, the trauma and grief associated with losing a close family member can be very stressful to children. They may lose interest in school if they are emotionally unable to focus on their studies or feel they will be discriminated against at school because their household is affected by HIV/AIDS. The circumstances of orphans can be further complicated by the dislocation or moving to a relative's home, separation

from siblings, placement in an institution, or abandonment to the street. As a result of these interrelated factors, children may not enrol in school at all, delay school entry until a later age, attend inconsistently, change schools often, repeat grades, or drop out of school altogether. Those who manage to remain in school may not have the success they once had because of poor emotional or physical health. Children in poor health have problems concentrating and learning in school, Williamson, *et al* (2004).

Picture taken by:
Golden Gateway Hospice, BETHLEHEM

A Social Worker spending quality time with OVC

Picture taken by:
DDI, BETHLEHEM

An example of OVC group outing

4.5 Community Response

There was a general consensus among most OVC coordinators in Partner organisations that there are unable to respond as quickly as possible to some needs that arise among OVC and their families. Particularly with regard to physical needs such as food, clothing and or shelter. Mainly so because the referral protocols to the relevant stakeholders are not well defined or officially arranged and agreed upon. It was however, highlighted that Hlokomela Wa Heno one of the CARE Partners has become the most reference for such services. It was understood that Hlokomela Wa Heno's ability to respond to the above mentioned needs is due to their open funding base they have acquired which has allowed them to respond to these needs

whereas other partners are experiencing far more prescriptive funding which inhibit their ability to respond to these particular needs.

Within Thabo Mofutsanyane District in areas that CARE- DELL program is being implemented there are a number of other different stakeholders operating at various levels. For instance, among the Partners who participated based in Bethlehem, Rosendale and Ficksburg, the following are also stakeholders operating within these same areas:

Bethlehem:

- With a wider Sphere of Influence in terms of area scope and technical support: Department of Social Development, Child and Family Welfare Society Bethlehem, Free State Care in Action
- NPOs/ CBOs: Hlokomela Wa Heno, DDI, Golden Gateway Hospice, CCFs, Youth Facilitators

Rosendale:

- Department of Social Development, Child and Family Welfare Society Bethlehem
- Istekeleng Jehova (DDI), CCFs, Hlokomela Wa Heno, Youth Facilitators (Save The Children)

Ficksburg:

- Department of Social Development, Free State Care in Action, Child and Family Welfare Society Bethlehem
- Gethsemane Health Care Centre, ILetsekang Disabled Centre, CCFs

With a number of organisations working in the same town, response is generally expected to be more prompt. However, this has not been the experience of the partners. Instead, the partners report that there has been a wide duplication of both statistics and services rendered to the same children due to lack of coordination of services between and among different stakeholders. Duplication of statistics is when a child has just been identified, recorded and reported on by more than one stakeholder particularly those being funded by the same funders, while duplication of services is when one or more specific children receives the similar service from two or more different stakeholders. A suitable example that the researcher has encountered in a community meeting, was a child who received 3 pairs of schools shoes from three different stakeholders working in the same area.

4.6 Organisational Capacity

4.6.1 Management/Leadership

The partner organisations which participated in this study have generally sound management systems in place. They both have a legally and constitutionally elected management board in place. Social Science writers also argue that a sound management for a welfare organisation goes a long way in determining the quality of services rendered to the beneficiary. Other management elements such as organisational policies apart from the constitution were explored as well and both the organisations had, in addition to their constitution, other policies like financial policies and volunteer policies. DDI, as a consortium, do have a number of these policies in place but focus needs to be given to its affiliates who operate in the different towns to develop and have policies such as, financial policies, in place as this will effectively capacitate sub-partners.

The organisations are lead by managers or directors who oversee all the programs of the organisations such as HBC, and or OVC and other community developments activities they engage in. Then OVC services are rendered at the site level, with a coordinator in-charge of OVC programme, and OVC field-workers, who receive stipend either from CARE or from the Department of Social Development. The field-workers are assigned to one of the specific programmes components: HBC or OVC.

4.6.2 Record Keeping/Information Storage

Records of any form - ranging from policy, financial, procedures and services rendered are of paramount importance in both the smooth day to day function and further planning and projections Lishman, (1994).

The baseline study, established that partners who are going to be implementing DELL program have not been effectively keeping records particularly records of services that they offer, services that they have rendered and the procedure through which they respond to the various needs.

Participating partner organisations did not have their programme activities written down in any form. Should there be turnover of implementing personnel who knows the programmes, continuity is very questionable. The situation points us to programmes and activities done unsystematically; hence difficulty to keep records thereafter.

However, it was identified that most organisations do keep their financial records more systematic in comparison to their programme records.

Lishman (1994), suggest that organisations rendering services to communities, should develop a culture of keeping every record. Some records maybe of no immediate use to the organisation but it has potential of forming an important “data bank” of client needs, agency resources and response to needs.

Where information was collected, little of it is about services, processes and outcomes that would help the practitioners in services rendering.

Another, major challenge identified was the issue of “unreliable data”. Data captured should be able to inform agency policy and practice in service delivery. Data would also be used for agency evaluation. Also, agency records allow for a statistical analysis of the work done.

Lishman, (1994) adds that, it is even more important for NGOs and CBOs whose projects and programmes rely on renewable funding which is usually contingent upon a favourable evaluation.

Also data collected can be utilised for individual personnel evaluation. Productivity of personnel can only be effectively measured based on the records of their activities.

CHAPTER 5: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5 Introduction

The concluding chapter gives a brief outline of the main findings. Conclusions are also drawn on the findings of the study on the current situation of OVC and their caregivers. The chapter also contains recommendations geared towards an effective and quality core package service to the OVC households.

5.1 Chapter Summaries

5.1.1 Chapter One

This chapter introduces the reader to the concept of baseline study in general. The chapter points out the problem statement of which the research seeks to explore. The reader is provided with the overview of the baseline study methodology (explained in chapter 3). The research explored the global, and local trends of the impact of HIV/AIDS on the children and their households. The case study focused on two CARE partners implementing the DELL program DDI in Bethlehem, Rosendale and Gethsemane Health Care Centre in Ficksburg. This chapter also outlined the research objectives, which the research sought to address, and the main objective was to: conduct a baseline study and examine the living situation and needs of the OVCs and their caregivers served by two named DELL partners.

5.1.2 Chapter Two

This chapter focused on the literature review which entailed looking at what has been done in the field of study. The researcher generally attempted to expose what underlies the living circumstances and challenges facing OVC households. First, the researcher outlined working definitions of the major concepts used in the baseline study. The study looked at the situation of OVC challenges in the South African context; these literature findings were used in reviewing the actual findings of the study. The researcher utilized relevant national policies in reviewing important elements of the study.

5.1.3 Chapter Three

Chapter three outlined the research design and methodology utilised throughout the process of research. Elements covered include the case study research design, qualitative and quantitative methods; the descriptive method of research, in particular, description of the research population, sampling procedure and size. Research instruments, data analysis procedure and the elements of validity and reliability of the research outcome were also outlined.

The study largely employed a qualitative descriptive research method, due to the nature of the phenomenon under study which the researcher desired to utilize a more open and flexible approach as suggested by Creswell, (1998). When working from a qualitative perspective the researcher attempts to gain a first-hand, holistic understanding of phenomena and data collection gets shaped as the investigation proceeds. Qualitative methodology is based on the assumption that valid understanding can be gained through accumulated knowledge acquired at first hand by a single researcher De Vos *et al,* (2002). The researcher's desire to conduct an in-depth inquiry into the living circumstances of the OVC serviced by the selected CARE Partners in Thabo Mofutsanyane District necessitated the use of a case study design. Methods such as participant observation and unstructured interviewing are used De Vos *et al,* (2002).. Individual or and family interviews were used in this research as a method for data collection, as this was deemed to be the most suitable method for the study. Participants were selected from the three participating towns as stated above. The data was analysed following the qualitative data analysis method suggested by Steinberg, (2001). The data was presented in identified themes and categories as outlined by Sumbulu, (2005).

5.1.4 Chapter Four

This chapter presented and gave a description of the findings, supported by direct and indirect quotations from the participants' own response, substantiated by applicable and relevant literature as a means of verification. The findings were presented in themes as identified by the researcher from the objectives of the study. The findings were presented and discussed under various themes.

Findings emanating from the themes as indicated can be summarized as follows:

5.2 Finding summary

5.2.1 Age

There are very few lower age group OVC identified in comparison to all the other age groups. In this study only 6.7% of children who participated were children between 0-4years. This cohort of OVC are more helpless and need much more care from OVC programs. The widely identified age group is children between the ages of 10-14years who consisted of 48% of the total OVC. 15-18years was 30% of the participants.

5.2.2 Sibling and other children in the same household: with a total of 74 children who participated in the study all combined they had either siblings or other children living in the same household who amounted to (269) excluding the 74 participants. This situation presents a picture that on average each household is caring for 5 children. This is despite their condition, circumstances and or status. The highest number was 10 children in one household and it was more than one household with 10 children. On principle, based on these findings a single orphan or vulnerable child identified is a mirror reflection of 5 more.

5.2.3 Education and further training

The study looked into **5 aspects** of education to the OVC; which are: *enrollment, attendance, time and assistance with home work (school work at home), school fees and further training.*

- It was identified that it was only a few children about 2.5% of the children of school going age were out of the school and the main reasons mentioned were *no birth certificates* and *child labour*, mostly when a child become the only bread winner.
- There was a good report from both children and the parents on school attendance. However, a pattern of absenteeism was observed among children living with older grandparents who require the assistance of the children on their pension pay day. Other reasons were caring for sick parents or other siblings at home, no school

uniform, taking up occasional piece jobs to help family and going to collect treatment at the clinic.

- It was indicated that the issue of school fees has not been a major challenge towards children's school attendance. However, a form of indirect discrimination has been identified towards children who are not paying school fees, "for example one respondent (child) said that the teacher said to me when I asked to go to the toilet, "***you want to go and use the toilet paper which you don't pay for."***
- Time and assistance with home work at home; a considerable number of children in this study indicated that they had no one at home to assist them with home work, hence they do the work by themselves. Another considerable number gets assists from their grandparents and in most case they are just too old to provide the assistance effectively. All the eldest children from CHH did not do their home works at all but did helped their siblings to do their homework. The reason was they have so much to do at home that when they finish they will be too tired to do homework.
- 53% of the children had no uniforms or had an incomplete school uniform.

5.2.4 Child protection: 10.8% of the children lived with no permanent adult support herein referred to Child Headed Household (CHH) except for the CCWs. 54% lived with a grandmothers. Only 35,2% had a physically fit adult.

5.2.5 Birth registration: 26% of the children who participated and most of their siblings at home had no birth certificates. 20% of these children were from Ficksburg. The searcher identified that most of the children struggling with documentation had one of their parents originating from another country not South Africa in this case predominantly Lesotho.

5.2.6 Social Security Grants: 44% of orphans who were eligible to be placed in foster care and receive FCG were only registered for Child Support Grant (CSG) and about 21% had no grant at all. 15% of vulnerable children had no form of financial support at all. Causes of this were:

- Lack of knowledge by the primary caregivers
- Lack of birth registration documents for the children and or identity documents for the caregivers
- Delayed process of application for the grants
- Child headed household with no one to take the responsibility.

5.2 .7 Food security: food security is identified to be the most threatening element of the OVC's wellbeing and it is the least quickly responded to by the organizations. (well discussed in chapter 4.3.3). 35% of children reported that their main meal was pap and water while 18% alternate pap with sour or fresh milk.

5.2.8 Health Care: More than half of the children indicated that they do not go to the clinic when sick. 46% indicated that they always go to the clinic when sick and it was observed that children under the care of the grandmothers were taken to the clinic , hospital or doctor always when they are sick more than other children.

5.2.9 Psychosocial support: The importance of attending to the psychosocial needs of OVC especially those left without the protection and nurturance provided by family and community support has been emphasized in the literature (Save the Children, 1996; Fox, 2001; Foster, 2002; World Health Organization, 2005 in Thurman, (2006).

In this baseline study, it was identified that psychosocial support is a very crucial service needed and valuable for and to the OVC. Although Partners (CBOs) do provide Psychosocial support in so many different ways to the OVC in the community and institutionally, there is:

- Less structure to the activities through which the psychosocial support is provided; hence the benefit of psychosocial support is not measurable or noticed.
- Emphasise has been given and focused in efforts to acquire resources to provide physical help such as food and clothing in more structured and systematic ways than it has been in psychosocial activities.

It was also identified in this study that the following groups of people form a very strong base of psychosocial support for OVC;

- Grandparents, parental figures next door and siblings (mostly in CHH).

5.2.10 Community Response: There was a general consensus among most OVC coordinators in Partner organisations that there are unable to respond as quickly as possible to

some needs that arise among OVC and their families. Particularly with regard to physical needs such as food, clothing or and shelter. Mainly so because the referral protocols to the relevant stakeholders are not well defined or officially arranged and agreed upon.

5.3 Recommendations

5.3.1 Sibling and other children in the same household

Realising that on average a family cares for 5 children with other households going as high as 10 children. It is highly recommended that attention be given to all the children in any identified household with an Orphan or a vulnerable child, though the other children might not be orphans nor appear vulnerable; but due to the number of children in the family, resources are most likely to be strained and expose all the children to some form and extent of vulnerability.

5.3.2 Education and further training

In addition to focus on the OVC's immediate and short term needs, CARE is recommended and encouraged to equally emphasise the long-term safety and stability for children by assisting them academically. This could be done through the activities such as 'after school support, schools programmes and kids clubs where children are helped with their homework and through holiday camps where lessons can be provided in English, mathematics, science and other subjects depending on the academic needs of the OVC. CARE partners should also look into providing other school necessities such uniforms and stationary in a more systematic and reliable manner. Partners should also work with local primary and secondary schools within their area of operation so that they can be in a position to be able to facilitates waiver of school fees for OVC, so that lack of finances is not a barrier to education; as this is a provision provided for in the Schools Act, Njaramba *et al*, (2008).
Provision of school material such as uniform and other accessories, has been identified to be playing a crucial role in boosting OVC confidence and acceptability.

5.3.3 Child protection

The study found and recommend the strategy and activities developed by the Family Health International (FHI) aimed at achieving the objective of improving the wellbeing and

protection of OVC and families and reducing the burden of HIV/AIDS on these children and their families. The activities suggest a useful framework that could be used by countries, ministries, and donors. They cover:

- Conducting assessments and supporting participatory strategic and program planning;
- Strengthening community mobilization to increase the capacity of communities to identify vulnerable children and to design, implement, and monitor their own OVC support activities;
- Fostering community-based care and support of OVC;
- *Integrating OVC support with home-based care, voluntary counselling and testing and mother-to-child transmission prevention activities;*
- Strengthening medical care, including home-based care, for children living with HIV/AIDS;
- Providing training and support for individual counselling and succession planning for children affected by HIV/AIDS;
- Supporting comprehensive, culturally appropriate psychosocial interventions for OVC;
- Assisting in the development of strategies and partnerships to create or maintain household resources and community safety nets;
- Supporting child-headed households and children as caregivers;
- Supporting interventions to reduce institutionalization and abandonment of children; and
- Monitoring and evaluating OVC programs.

5.3.4 Birth and I.D registration

The challenge with birth and I.D registration imaged as one of the major hindrance to a number of OVC to access any state assistance and continue with school. As reported the issues of effective referral protocol between and among the relevant government departments remains the major challenge. The study recommends that through the utilization of technical support, an effective and workable referral protocol be established among the partners working with the OVC, Department of Home Affairs and Department of Social Development. A more proactive approach is equally emphasized to reduce the increase of children growing up without birth certificates. It is recommended to promote awareness

among parents and caregivers to take birth certificates for children possibly few days after birth. This will in a long run reduce the number of OVC without any identity documents.

5.3.5 Food Security

Food is most often an immediate need that children encounters and very few organisations are able to provide the need adequately or consistently. Even though some community organisations through South African Social Security Agent (SASSA), Non-Governmental organisations and other corporate organisations manage to provide food assistance. However, the demand for food far outweighs supply, and food security issues remain unaddressed. One recommendation includes establishing food gardens which could provide food as well as generate income. Linked to food security is the need to establish sustainable income-generating activities within the communities. CARE through its partners will be highly recommended to utilise the VS&L as an economic strengthening strategy and a vehicle to the establishment of income generating activities (IGA).

VS&L has become an effective strategy of providing an economic safety net for OVC households and it also work well as a women empowerment strategy.

VS&L Empowers women with small business loans which is a proven and effective way to fight HIV/AIDS. Income generated from a small business provides women with the freedom to avoid no-win choices such as the commercial sex trade. Microenterprise investment is a multi-purpose investment, as profits from female entrepreneurs are used to feed, shelter, educate and provide health care for their children and often an ever growing population of AIDS orphans within their communities. VS&L provides a linkage between private and non-profit sectors with a business approach to reducing global poverty while mitigating the effects of HIV/AIDS, www.worldvision.org

5.3.6 Health Care

Having identified that the majority of the OVC are under the care of grandparents, who in most cases struggle themselves with need for health care support; it is here recommended that CARE through is partners in DELL initiate and promote “grandparents care”. These could be done through a support group system. A very good example of such a support framework is the “gogo care” program at Golden Gateway Hospice in Bethlehem. It is equally emphasized that the Community Care Workers (CCW) commonly refereed volunteers promote and monitor the OVC’s health records more often; and also to ensure that particularly younger children have clinic cards. Clinic cards have also become very important identity documents

for OVC, mostly in cases where biological parents have passed away. They are useful in applying for birth certificates and identity documents.

5.3.7 Psychosocial support

CARE and its partners are highly recommended to recognise that 'in contexts of limited resources, psychosocial support may be the most important resource available in facilitating coping and resilience' among OVC (Maynard, 1999) in Thurman, (2006). Psychosocial support is essential for children to learn, develop life skills and to participate fully and have faith in their future, to become healthy, well-functioning and productive adults. The reason for such an emphasis on psychosocial support is that apart from the physical absence of a parent, or the pain, suffering and poverty induced by AIDS related illness or deaths, far more difficult to deal with are the emotional wounds that are brought on by the impact of HIV/AIDS on OVC. The view above is well supported by other previous researchers such as Williamson *et al*, (2004) as argued in the literature of this study. As such psychosocial support (PSS) becomes an integral and important part of every OVC programme.

Other OVC programs have developed specific guidelines of providing PSS such as a compact disk on psychosocial support resources for children affected by HIV/AIDS available from the Regional Psychosocial Support Initiative in Bulawayo, Zimbabwe (info@repssi.org and http://www.repssi.org).

The study recommends that PSS be emphasised in DELL and be provided through the utilisation of a number of strategies as suggested below:

- **"Memory work"** through tools like "memory books or memory boxes" may be one strategy for creating openness between parents and children about a parent's illness, reducing the child's fear of the unknown, and maintaining the child's sense of family identity and belonging. In some countries, memory books list property inheritance, relatives, and documentation that can prove a child's legal rights to inheritance. Visits to extended family members while a sick parent is still alive can also be part of a coping strategy. Such visits can strengthen family connections that are a potential source of support after a parent has died. They can also give children an opportunity to express a preference about where and with whom they will live after the parent's death. One sad reality that children as human beings face is that they losses their loved ones through death and a worst situation their parents or caring guardians. In

such times children need no "food parcel" but help that helps them understand why "the sun still raises while my mother is no more"

- **"Grief and bereavement support"** as a psychosocial support strategy needs to be started where applicable or possible, while the parents or guardians still lives, just as memory work. It must be understood that children grieves like adults, but they expresses their grieve in different ways. Because of their emotional immaturity, they do not have the thinking abilities to make sense of it. They tend not to have words to describe their feelings, thoughts and memories. Therefore, their behaviour is the most reliable guide. Behaviours to look out for, in grieving children include;
    - Is the child irritable over every little setback?
    - Does he burst into tears every time he is thwarted?

  "Some children contain their pain for a very long time, perhaps unconsciously because they sense that you simply cannot help them yet". Usually, grieving children become very quiet and 'good' Couldrick, (1998). Those careering for a child at this stage they are encouraged to try and help the child to open up and share the feelings. OVC are bound to face grief and the following half truths are not helpful and may be Misinterpreted as follows:

    - *"Mummy has gone away"*

      Child's reaction- "Why didn't she take me with? I must have been bad to make her leave me"
    - *"God took Mummy because she was so good"*

      Child's reaction- anger against God " I needed her" fear of being good "I might be taken"
    - *"Daddy is sleeping forever"*

      Child's reaction- fear of going to sleep

  The guardian or someone closer to the child should tell him what happened, preferably at home where he feels safe.

  SINOMLANDO memory work training is highly recommended in this study for specifically equipping community care workers with a skill of rendering this paramount psychosocial service.

- **Play Groups and Kids Clubs**

  The OVC programme should ensure that children live like children, by creating space for them to play, spend time away from the daily worries in a more supportive

environment which helps them access other services they may need. This could be done through activities such as play groups and kids' clubs where children can gather for after school activities, that include assistance with home work, extra lessons, cultural games, and recreational activities. The clubs also facilitate psychosocial support for children who are able to meet and interact with other children in similar circumstances. however, previous studies have found evidence of elements of stigmatisation associated with gathering OVC in particular places or centres in the community. This does not therefore in my view warrant an arrest of the group activities for OVC in community but rather requires more education and awareness to be rendered to communities. Just as well put by Williamson, *et al* (2004) that community's knowledge and beliefs about HIV/AIDS can influence the community's response to affected children as much as factors related to the course of the epidemic and beliefs about how illness in general and HIV/AIDS in particular are caused can affect whether these children receive help from their extended families, communities, or service providers. These kind of groups provide great support to children in the same way an adult support group would do when well structure, with specific objectives and goals. Hence, it is highly recommended that children's (OVC) play groups should be conducted with specific goals and objectives. These objectives, therefore creates elements of measurement and evaluation.

- **Career Campus**

  In the same line of thinking, on providing psychosocial support, career campus which generally provide more than just psychosocial support but also provide a very crucial educational development guidance and insight should be provided for OVC. It has been observed and learnt though experience of working with OVC that most of them do not even proceed with education beyond high school (matric-for those privileged to get that far), not because they are not capable but it is mainly due to lack of exposure to possibilities available out there. Hence, creating a platform such as a career camp, which could be limited to higher graders (i.e. grade 10, 11 and 12) would be of amazing impact in opening a world of possibilities to OVC.

5.3.8 Community Network of Care (CNC)

The baseline has also proved that there are more than one service providers in each and every town that DELL programme is going to be implemented, with some towns such as Bethlehem with a range of Organisations providing services to OVC in one way or the other. That as it

may the study established that not one of these organisations have been able to provide a complete core package of services to the OVC. These includes Government Departments, NGOs, CBOs, FBOs. Based on the above findings it is highly recommended, that CARE should drive, through its DELL partners the establishment of Community Networks of Services in each town of operation. Community Network of Care is when a number of CBOs, other organisations and structures providing services of care to children in the same community come together, pooling their skills and resources together to strengthen their ability and capacity to effectively respond to the needs of OVC.

This is so because it is quite often the case that more than one community-based organisation is operating within an area. Realising that more can be achieved by amalgamating efforts, through effective referrals, coordination of services and case conferences. CCCFs and or Community Networks of Care have emerged as a means for communities to work together to fulfil common needs. CCCFs/CNC are a mechanism for discussing the issues of HIV/AIDS and its resulting problems, as well as proposed solutions Ching'andu, (2008). The Community Network of Care should at least meet once a month but can meet more frequent if there activity within their community to be organised. It is advised to promote wherever and whenever possible for OVC themselves to be part of the forums in order to promote the principle of child participation; as provided for in the new Children's Care Act 38 of 2005:

2 (10) " *Every child that is of such an age, maturity and stage of development as to be able to participate in any matter concerning that child has the right to participate in an more appropriate way and views expressed by the child must be given due consideration".*

5.4 Summative conclusion of DELL program

- increasing care and support services to OVC;
- strengthening the capacity of families/caregivers to care and support OVC;
- strengthening capacity of communities to care for OVC; and
- strengthening the capacity of child servicing organisations to care to OVC.

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APPENDIX A

BETHLEHEM CHILD AND FAMILY WELFARE SOCIETY

CARE OVC PROGRAMME--PARTNER ORGANISATION ASSESSMENT TOOL

This assessment tool is solely meant for the purpose of identify areas that would need focus in order to strengthen the capacity of the partner organisation in service delivery, record keeping and administration of the services.

	YES	NO
1. Is there a management committee specifically for the organisation ✓ Composition e.g. Male/Female ✓ Does the Organisation have names and contact list for the management	YES	NO
2. Is there any other form of a management committee or committees in place ✓ Composition: Gender ✓ Male: ✓ Female:	YES	NO
3. Does the organisation have a constitution	YES	NO
4. Any other policy(ies) ✓ Name:	YES	NO
5. Does the organisation have a computerised financial system in place	YES	NO
6. Is there a financial reporting system	YES	NO

7. Are the organisation's finances audited ✓ Frequency: ✓ By who? :	YES	NO
8. Does the organisation keep records of all the services it renders	YES	NO
9. Is there a database of children you serve (OVC Register)	YES	NO
10. The list is kept in the computer	YES	NO
11. The list is hand written in a book (register)	Yes	No
12. How often is the list updated	YES	NO
13. Does the organisation keep a file for every child/family	YES	NO
14. Does the organisation have cupboards to keep the files	YES	NO
15. Are the cupboards secured (are they confidentially kept)	YES	NO
16. Is there any referral system in place with other NGOs/Gvt Dpts ✓ Are the records of referrals kept? ✓ Are referrals followed up?	YES	NO
17. Which organisations/Dpts would you regard as having a good working relationship with your organisation ✓	YES	NO
18. Which Orgs/Dpts would you like your working relationship improved		

19. Was the staff trained-- In What..... ..... ✓ What are your training needs	YES	NO
20. What office equipments does the organisation have Offices Computer(s) Cupboards Furniture Security		
21. Is the your organisation registered as an NPO	YES	NO
22. Do you have the NPO Certificate	YES	NO
23. Is the organisation registered as a PBO ✓ UIF ✓ SARS ✓ Compensation Officer	YES	NO
24. Where does the organisation's funding come from a. b.	% %	
25. How many Staff members do you have		

✓ Staff: ✓ Volunteers:		
26. Do you have a Job descriptions for ✓ Staff ✓ Volunteers	 YES YES	 NO NO
27. Employment Contracts For Staff and Volunteers	YES	NO
28. Copy of the National Children's Bill (Child Care Act as amended)	YES	NO
29. How many children are the services delivered to		
30. What is your area of operation ✓ Geographically: ✓ Services:		

APPENDIX B

BETHLEHEM CHILD AND FAMILY WELFARE SOCIETY

CARE OVC PROGRAMME BASELINE STUDY-INTERVIEW GUIDE

The following study is conducted mainly for the purpose of monitoring and evaluating the DELL OVC programme. Basic research ethics such as confidentiality and respondent protection against harm are going to be upheld.

BIOGRAPHICAL INFORMATION

Name of child……

Age/D.O.B……

Family name……

Id number……

Name of parent(s)/caregiver……

Number of children in family……

Address:……

Circumstances of the child

EDUCATION

1. Do you go to school every day?.....
2. What grade are you in?.....
3. Do you sometimes miss school?.....if yes, it's mainly becauseof……
   ……
   ……
   …
4. Do you have a school uniform?.....
5. Who pays for your school fees?……
6. Who buys your school uniform?.....
7. How do you do your homework and does anyone help you?.....
   ……

CHILD PROTECTION

8. Who do you live with?.....
9. Do you have a birth certificate or id?.....
10. Do you receive any grant?.....

11. What is your grant used for?.....

FOOD SECURITY

12. Who is working at home?.....
13. Who buys food at home?.....
14. How many times do you eat in a day?.....
15. What do you usual eat in a day?.....

HEALTH SERVICES

16. Do you go to the clinic when you are sick?.....
17. Who takes you to the clinic when you have to go to clinic?
    .....

PSYCHO-SOCIAL SUPPORT

18. Do you talk with anyone when you have a problem?.....
    .....
19. Do you play with other children?.....
20. Do you a have toy / toys .....

CLOTHING

21. Do you have proper clothes?.....
22. Where did you get the nice clothes you have? .....
    .....
23. Do you have shoes?.....
24. Do you dress warmly to school?.....

General

25. What would you consider as the major pressing challenge you face on taking care of the Child.....
    .....
    .....