

**AN EXPLORATION OF THE NEEDS OF AND SERVICES PROVIDED TO  
ORPHANED AND VULNERABLE CHILDREN AFFECTED BY HIV AND AIDS  
IN RICHMOND, KWAZULU-NATAL, SOUTH AFRICA**

by

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## DECLARATION

I, declare that **AN EXPLORATION OF THE NEEDS OF AND SERVICES PROVIDED TO ORPHANED AND VULNERABLE CHILDREN AFFECTED BY HIV AND AIDS IN RICHMOND, KWAZULU-NATAL, SOUTH AFRICA** is my own work, and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

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## **SUMMARY**

The focus of this dissertation is on exploring the needs of and services provided to orphaned and vulnerable children (OVCs) in Richmond, KwaZulu-Natal. This research is based on the findings from in-depth face-to-face interviews, and the focus group discussion conducted with key informants and primary caregivers of OVCs, respectively. The findings underline that although the needs of OVCs are similar to those of all other children, OVCs face unique challenges. It further shows that the government of South Africa has been responsive in developing relevant legislation, policies, and programmes that attempt to address the needs of OVCs. The findings also revealed that the services provided are coordinated, to a limited extent, through the Flagship Project led by the office of the Premier and that coordination and integration of activities rendered by various stakeholders is crucial to a positive impact, and in increasing the accessibility of these services.

**KEY WORDS:** orphaned and vulnerable children, needs of OVCs, services provided to OVCs, community development approach, integrated development approach, child-headed households

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## LIST OF ACRONYMS AND ABBREVIATIONS

AFSA	AIDS Foundation South Africa
AIDS	Acquired Immuno Deficiency Syndrome
ART	Antiretroviral Treatment
CBOs	Community-Based Organisations
CCCs	Community Care Centres
CCFs	Child Care Forums
CCG	Community Caregivers
CDA	Community Development Approach
CHH	Child-Headed Households
CSG	Child Support Grant
DBE	Department of Basic Education
DIC	Drop-In Centres
DBE	Department of Basic Education
DOE	Department of Education
DOH	Department of Health
DOHA	Department of Home Affairs
DSD	Department of Social Development
FBOs	Faith-Based Organisations
FCG	Foster Care Grant
HIV	Human Immunodeficiency Virus
HSRC	Human Science Research Council
IDA	Integrated Development Approach
IDP	Integrated Development Planning
KZN	KwaZulu-Natal
MDGs	Millennium Development Goals
MRC	Medical Research Council
NAP	National Action Plan
NGOs	Non-Governmental Organisations
NIP	National Integrated Plan
NSP	National Strategic Plan
NSNP	National School Nutrition Programme
OVCs	Orphaned and Vulnerable Children

RAAAP	Rapid Country Assessment Analysis and Action Planning
RDP	Reconstruction and Development Programme
RSA	Republic of South Africa
SA	South Africa
SDF	Spatial Development Framework
SNT	Social Network Theory
STI	Sexual Transmission Infection
TB	Tuberculosis
TCF	Thandanani Children's Foundation
UN	United Nations
UNAIDS	United Nations Agency for International Development
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WFP	World Food Programme

# CHAPTER 1

## ORIENTATION TO THE STUDY

### 1.1 INTRODUCTION

The growing population of children who are orphaned mainly because of AIDS-related deaths, is a serious concern that presents major challenges. Millions of children have been orphaned or made vulnerable by Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). Children who have lost parents are not only affected because they have lost their parents; they are also vulnerable from the onset of their parents' illness, and they have to take care of the sick parents. These children are further made vulnerable when being discriminated against because a family member is living with HIV or AIDS; or because they themselves are living with HIV or AIDS (Salaam: 2005:10).

The majority of children who are orphaned due to AIDS-related deaths are raised by their relatives or by extended families. In most cases they live with their grandparents, who depend on their older-persons' grant to make ends meet. Grandparents face the problem of having to adjust to the extension of their own family and of again raising children. Grandparents are often unprepared for this emotionally, physically, and financially, they being in their old age (Tshenkeng 2009:20). In many cases, these grandparents face poverty and diminished physical and emotional health.

Some orphaned and vulnerable children find themselves in child-headed households (CHHs) in which they take care of themselves and live together as siblings without the direct supervision of an adult (Smart 2003:7). These children often are at risk of being exposed to exploitation by neighbours and family members. For example, they might be expected to perform duties for neighbours in exchange for food or money.

In response to the many challenges facing orphaned and vulnerable children (OVCs), the South African government and non-governmental organisations (NGOs) have initiated a number of programmes aiming at providing assistance to OVCs and their primary caregivers. However, these programmes are often not implemented in

an integrated or coordinated fashion. Often, providers of services to OVCs are operating in isolation, which results in services being duplicated and not reaching as many children as it would if service delivery were integrated and coordinated. In this study, the needs of and challenges faced by OVCs, as well as the extent to which the services rendered to OVCs are integrated and coordinated, will be explored.

This chapter presents the research problem of the study. The chapter first describes the research problem and the focus of the study, offering the research objectives and research questions. This chapter further presents the rationale for the study and describe the research setting. The research methods used in collecting and analysing the data is also briefly described, as well as the theoretical framework that guided this study. The chapter concludes by defining the key concepts used in the study.

## **1.2 THE RESEARCH PROBLEM**

This sub-section of the dissertation provides a brief introduction to the study. Secondly, it states the research problem and clarify the focus of this study.

### **1.2.1 Background of the study**

The number of orphaned children in most developing countries has increased dramatically since the onset of the AIDS pandemic. Before the onset of HIV and AIDS, it was not common for a child to have lost both parents. However, the AIDS pandemic has changed this scenario. The number of orphaned and vulnerable children has increased drastically with the increase in the number of people dying of AIDS-related diseases, before antiretroviral treatment (ART) was widely available. As a result, large numbers of children were left without either one or both parents. Estimates by the Joint United Nations' Programme on HIV and AIDS (UNAIDS), United Nations' Children's Emergency Fund (UNICEF) and the United States Agency for International Development (USAID) suggest that 2,2 million South African children (13% of all children) had lost one or both of their parents by the end of 2003 (Ndinga-Muvamba and Pharoah 2008:148). UNICEF states that in 2011, approximately 17,3 million children worldwide under the age of 18 had lost one or both parents to AIDS, with a vastly increased risk of poverty, homelessness, school

dropout, discrimination, and loss of life opportunities ([http://www.childinfo.org/hiv\\_aids.html](http://www.childinfo.org/hiv_aids.html)).

OVCs are generally regarded as those children who have no parents or who do not stay with their mothers and/or fathers and have become vulnerable due to the circumstances in which they find themselves (McKerrow, Smart and Snyman 1996). The Department of Social Development (DSD) defines a “vulnerable child” as a child whose survival, care, protection or development may be compromised due to a particular condition, situation or circumstance; and which prevents the fulfilment of his or her rights (DSD 2010: 9). Vulnerable children, according to the DSD include:

- Chronically and / or terminally ill children;
- Orphaned children;
- Children with physical disabilities and incurable diseases;
- Children infected and affected by HIV and AIDS;
- Children from dysfunctional families;
- Children in homes headed by other children;
- Children in poor households and communities

Smart (2003:7) refers to OVCs as those children who are at risk of orphanhood; are living in poverty; or who are abused, neglected, abandoned, displaced, or destitute. Definitions of vulnerability, and of OVCs in particular, vary from one country to another. Smart (2003, cited by Skinner et al. 2004:3) studied vulnerability in a number of African countries. Findings from this study are summarised in Table 1 below. The table indicates the factors relating to vulnerability.

Table 2 below indicates that the number of orphaned children in some sub-Saharan African countries is reported to be more than a million in 2009. In some countries, children who have been orphaned by AIDS-related deaths account for half or more of all orphaned children, nationally (<http://www.avert.org/-aids-orphans.htm> – accessed on 05/04/2011).

**Table 1: Definitions of vulnerability in different countries**

<b>COUNTRY</b>	<b>FACTORS RELATING TO VULNERABILITY</b>
South Africa	<p>Children who are neglected, destitute, and abandoned</p> <p>Children with terminally ill parents</p> <p>Children born to single mothers</p> <p>Children with unemployed caretakers</p> <p>Children abused or ill-treated by caretakers</p> <p>Disabled children</p>
Botswana	<p>Street children</p> <p>Child labourers</p> <p>Children who are sexually exploited</p> <p>Children who are neglected</p> <p>Children with handicaps</p>
Rwanda	<p>Children in child-headed households</p> <p>Children in foster care</p> <p>Street children</p> <p>Children in institutions</p> <p>Children in conflict with the law</p> <p>Disabled children</p> <p>Children affected by armed conflict</p> <p>Children who are sexually exploited or abused</p> <p>Working children</p> <p>Children with parents in prison</p> <p>Children in indigent households</p> <p>Refugee or displaced children</p> <p>Children who married before the age of majority</p>
Zambia	<p>Children not at school</p> <p>Children from female/disabled-headed households</p> <p>Children whose parents are ill</p> <p>Children from families where there is insufficient food</p> <p>Children who live in poor housing conditions</p>

Source: Smart (2003 cited by Skinner et al. 2004:3)

**Table 2: Number of children orphaned due to AIDS, in 2009**

<b>COUNTRY</b>	<b>NO OF ORPHANED CHILDREN</b>	<b>CHILDREN ORPHANED OWING TO AIDS AS PERCENTAGE OF ALL ORPHANED CHILDREN</b>
South Africa	1,900,000	56%
Uganda	1,200,000	44%
Kenya	1,200,000	46%
Zimbabwe	1,000,000	71%
Malawi	650,000	65%
Zambia	690,000	53%

Source: <http://www.avert.org/aids-orphans.htm> (accessed on 05/04/2011)

Table 2 above further indicates that in 2009 South Africa had the highest number of orphaned children (1.9 million children) compared with five other African countries. The table further indicates that 56% of these children were orphaned because of AIDS-related deaths; also, that in almost all of the above countries, more than 50% of children are orphaned because of AIDS-related deaths. Zimbabwe has the highest percentage of such children, who account for 71% of the total number of OVCs in Zimbabwe.

UNICEF states that in 2011 approximately 17,3 million children worldwide under the age of 18 have lost either one or both parents to AIDS, with a vastly increased risk of poverty, homelessness, school dropout, discrimination and loss of life opportunities ([http://www.childinfo.org/hiv\\_aids.html](http://www.childinfo.org/hiv_aids.html)). This UNICEF report further states that it is estimated that in 2011, 230,000 children under 15 years of age died of AIDS-related deaths worldwide. (The UNICEF site was last updated in November 2013).

A number of studies conducted on OVCs confirm that the majority of children who are orphaned or made vulnerable by HIV and AIDS are living with a surviving parent, or within their extended family, often with the grandmother. Most OVCs grow up with their grandparents, who use their older-persons grant to raise these children. Extended families have always been perceived as the traditional “social security system” in which family members are responsible for the protection of the vulnerable,

and care of the indigent and the sick (Ziver 2008:23). Although many orphaned and vulnerable children live with their extended family, they still face a number of challenges, such as securing funds to pay for essentials such as school fees, food and clothing. Furthermore, in some cases, CHHs do not receive support from extended families owing to the stigma associated with HIV and AIDS (Tshenkeng 2009:19).

Beard, Dimmock and Sthreshley (2001) describe how extended families are struggling to cope with problems related to orphaned children owing to the escalation in AIDS cases, AIDS-related deaths, and family disintegration. Due to social and economic challenges, some extended families are no longer coping or managing to take care of OVCs. This is because these extended families are also struggling with conditions of poverty and deprivation within their own families; for instance, they may have to provide for their biological children's needs. In some cases, families have been known to take on orphaned children merely to benefit from government social grants, such as the child support and foster care grants (<http://www.avert.-org/aids-orphans.htm>). The social grants received are then used to feed the whole family: in some cases the members of extended families themselves are unemployed, hence live under severe financial constraint.

However, it was estimated in 2005 that 5% of children affected by HIV and AIDS worldwide have no support, and are living on the street or in residential institutions (Salaam 2005:3). The DSD (2010:14) states that girl-children are especially vulnerable in the context of HIV and AIDS and child-headed households (CHH). Owing to gender-based discrimination, girl children are most likely to take care of a terminally ill parent or family member. This deprives them of the right to education. They may also be further subjected to child labour. Orphaned girls are also especially vulnerable to sexual exploitation and trafficking.

The effect of the AIDS epidemic on children and families is incremental, as cited by Munyathi (2005:2). He explains this view by pointing out that those OVCs worst hit by HIV and AIDS live in communities characterised by inadequate infrastructure and limited access to basic services. It is these children whose family and household conditions will further deteriorate under the impact of the AIDS epidemic. These

conditions have also resulted in the emergence of child-headed households. Ndinga-Muvamba (2008:151) argued that the death of parent(s) and migration of parents often result in the creation of CHHs.

Child-headed households are commonly defined as households in which all members are younger than 18 years of age (Maqoko and Dreyer 2007:723). Children in child-headed households live in conditions that are, on average, worse than those in mixed-generation households, having to provide for themselves with limited assistance or without any assistance from an adult. Children in child-headed households are less likely to live in formal dwellings, or to have access to adequate sanitation and water on site (Maqoko et al. 2007:724).

### **1.2.2 Problem Statement**

Due to changes in the social conditions in South Africa, such as a high unemployment rate, high levels of poverty, and an increase in the number of household dependants, some extended families cannot afford to raise and care for OVCs (UNICEF 2007). The question of who should bear the cost of raising OVCs and who should take the responsibility for OVCs, therefore, becomes critical. If the support that is provided to OVCs does not assist these children to have an opportunity to live a “normal life” with prospects of a brighter future, a vicious cycle could arise in which the children of OVCs will also grow up under similar conditions. This will result in greater numbers of children in distress.

Since many extended families are not managing to raise the OVCs in their care on their income, as indicated above, it is important that other measures are put in place to support OVCs. For instance, governments and civil society must strengthen the support they are providing to OVCs. Government departments should consider mainstreaming all their programmes, ensuring that they address issues of OVCs. This implies that the challenges faced by OVCs are to be prioritised, becoming an integral part of the various programmes implemented by all government departments. For example, the SA Department of Human Settlements could facilitate its systems and policies to allow OVCs access to Reconstruction Development Programme (RDP) houses. The SA Department of Home Affairs could ensure that

OVCs are given preference when processing applications for birth certificates and identity documents. Mainstreaming of OVC programmes could also ensure that the services provided to OVCs (such as social security grants in the form of child support grants and foster care grants) are provided to all eligible primary caregivers of OVCs (USAID 2005).

Gow & Desmond (2002:60) argued that by 2011, 56% of the population will live in households in which at least one person is living with HIV, or has died of AIDS-related illnesses. This will impact on the well-being of children in the affected households. This is because the financial burden of HIV and AIDS adversely affects the living standards and quality of life of all household members, leading to food insecurity, among other factors. Furthermore, competing priorities for limited resources in these families contributes to children in households with members living with HIV and AIDS often being unable to afford school uniforms, school fees, school books and stationery – the latter are prerequisites for school. The combined socio-economic consequences of HIV and AIDS on households with children living with HIV are far-reaching, which leads to these children having a reduced opportunity for personal growth and development.

Currently, there are a number of services provided by the SA government which aim at mitigating the impact of orphanhood. To mention a few, the Department of Social Development is providing various social security grants, such as the child support and foster care grants, to support OVCs. The Department of Health is providing nutritional supplements to OVCs, which includes fortified porridge and vitamin supplements. The Department of Education is implementing the school fee exemption policy, which is also targeting OVCs. (These will be discussed in detail in chapter 3). All these programmes aim at providing some sort of a relief in dealing with the challenges faced by the primary caregivers of OVCs.

However, a major challenge seems to be that the services provided by various government departments are not fully integrated and coordinated. Lack of, or limited integration of services, often results in the duplication of services, government departments and non-governmental organisations providing services to the same children. This result in services being available to only a few OVCs, usually those

who are easily accessible geographically; those in rural areas are usually not attended to.

### **1.2.3 Focus of the study**

This study focuses on exploring the needs of OVCs and their primary caregivers; and the services provided by government departments and non-governmental organisations (NGOs) to orphaned and vulnerable children. With regard to service provision, the study will, in particular, focus on services provided by (a) three government departments, that is, the Departments of Health, Social Development, and Basic Education (b) a non-governmental organisation known as the Thandanani Children's Foundation (TCF) and (c) the Richmond National Integrated Project (NIP) Site. This study further aims at investigating the degree to which the services rendered to orphaned and vulnerable children are provided in an integrated and coordinated fashion. In other words, it aims at exploring whether the services are implemented according to the principles of the Integrated Development Approach (IDA). An integrated development approach emphasises community participation in identifying the needs of the OVCs, and in developing long-term solutions to their problems (Beard, Dimmock and Sthreshley: 2001).

## **1.3 THE OBJECTIVES OF THE STUDY**

The main objectives of the study are:

1. To explore the needs of, and challenges faced by, children orphaned and made vulnerable by HIV and AIDS in Richmond, KwaZulu-Natal;
2. To explore services provided by key stakeholders rendering services to children orphaned and made vulnerable by HIV and AIDS in Richmond, KwaZulu-Natal;
3. To explore the extent to which the process used by service-providers in identifying children who are orphaned and made vulnerable by HIV and AIDS facilitates the inclusion of all affected children in Richmond, KwaZulu-Natal;
4. To explore the degree to which programmes implemented by various service providers targeting children who are orphaned and made vulnerable by HIV and AIDS, are integrated in Richmond, KwaZulu-Natal.

## **1.4 THE RESEARCH QUESTIONS**

The critical research questions to be answered by the study are:

1. What are the needs of children orphaned and made vulnerable by HIV and AIDS in Richmond, KwaZulu-Natal?
2. Which services are provided to children orphaned and made vulnerable by HIV and AIDS in Richmond, KwaZulu-Natal and by whom?
3. Does the process used by service-providers in identifying children orphaned and made vulnerable by HIV and AIDS facilitate the inclusion of all affected children in Richmond, KwaZulu-Natal?
4. In which ways do the various role-players work together to ensure that the outputs of their programmes are integrated?

## **1.5 RATIONALE FOR THE STUDY**

It is important to conduct this study because it should sensitise service-providers providing services to OVCs, such as government departments and NGOs, in terms of the needs of and existing challenges faced by OVCs and their primary caregivers. The study could also make these service providers aware of other providers who are working with OVCs, and with whom resources could be shared to support OVCs. This, should it not yet exist, could initiate a working relationship among the various service-providers. It should encourage the pooling of resources. The study could also provide such service-providers with information on where gaps exist, for instance, areas where services are not provided.

In addition, this study could increase the awareness levels of service providers about the importance of co-ordinating their activities and services. If the services rendered by service providers are co-ordinated and integrated, it could impact positively on service delivery and minimize the duplication of services. This is especially relevant in cases where two organizations are providing similar services to the same group of OVCs, while other OVCs are not receiving any support from any organisation.

It is therefore felt that the study's findings could enhance what can be considered an effective and efficient way of rendering services in an OVC domain and context, by

providing integrated services to OVCs. Furthermore, the recommendations made on the basis of the findings of the study could potentially impact on policy development, particularly if a model for integrated services is accepted as an innovative way to provide services to OVCs and their primary caregivers.

The value of this research, therefore, lies in the identification of the critical needs of OVCs, the challenges faced by OVCs and their caregivers, the key service providers that are rendering services to OVCs, as well as the manner in which these services are provided. The core objectives of this study are of significance because of their possible contribution to enhancing the care provided to OVCs. For instance, the study emphasises the community development approach in the provision of services to OVCs, which is based on the assumption that service providers should focus on building capacity within communities so that the latter are able to identify the challenges they face and develop their own strategies on how to address these challenges, in this case, the challenges faced by OVCs and their primary caregivers.

## **1.6 RESEARCH SETTING**

The study was conducted in the Richmond Local Municipality, which is one of seven local municipalities under the Umgungundlovu District Municipality. Richmond is a rural area situated approximately 45 kilometres south of Pietermaritzburg, which is a capital city of KwaZulu-Natal (KZN). The size of the Richmond Municipality is estimated at 1 232 square kilometres of land with an estimated population of 56 772 and 12 679 households (Richmond IDP 2010:15).

The majority of the population of Richmond resides in areas which are predominantly rural and are characterized by low levels of basic service provision, such as with regard to water and electricity (Richmond IDP 2010). The research setting of this study is described in detail in section 4.3 of chapter 4.

## **1.7 RESEARCH DESIGN AND METHODOLOGY**

A qualitative research design was used to conduct the study and qualitative methods were used to collect and analyse data. Qualitative research methods give the

researcher an opportunity to understand the research participant's experiences, interpretations, and the meanings s/he attaches to these experiences, by focusing on the context of people's everyday lives (Barbour 2008:12). A qualitative approach is appropriate in the case of this study as the study focuses on gaining deeper understanding how OVCs are defined by different service providers, as well as what is perceived as the needs of and challenges facing OVCs.

To collect data, individual interviews were conducted with five key informants who represented the Departments of Social Development, Basic Education and Health, the Thandanani Children's Foundations (TCF) and the Richmond NIP site. The TCF is a non-governmental organisation operating in the areas of Richmond and in some areas of Pietermaritzburg, in KwaZulu-Natal and the Richmond NIP site is situated in a rural area of Richmond called Ndaleni Mission. Data was also collected from thirteen primary caregivers, through individual in-depth interviews and focus group discussion.

Content analysis was used to analyse the collected data. The process of analysing data involved identifying relevant themes and sub-themes from the transcribed interviews and focus group discussion. The methodology of the study is discussed in detail in Chapter 4.

## **1.8 CONCEPTUAL FRAMEWORKS**

The theoretical frameworks that were used to guide this study are the Community Development Approach (CDA), the Integrated Development Approach (IDA) and the Social Network Theory and are discussed in detail in chapter 3. These three theoretical approaches define the role that communities need to play in order for their development to be effective.

The CDA aims at building active and sustainable communities by capacitating communities to address and respond to their own challenges. It states how community members can work together to deal with the challenges facing their community, and also define the role of other stakeholders. The CDA argues that the

role of government departments and NGOs is to provide resources and training so that communities take responsibility for their own development (Lombard 1990:73).

The integrated development approach (IDA) takes the community development approach to another level, since it argues that community development should be done in an integrated fashion. The IDA is based on the principles of Integrated Development Planning (IDP), which facilitate co-ordination and integration between a variety of role-players in order to set strategic priorities and specify how to deliver services to communities (Ambert 2004:9). For instance, according to the IDA, service providers that are supporting communities with resources and skills should integrate their services to avoid the duplication of services. The IDA therefore lobbies for the pooling of resources so that programmes and support are available to the greater community.

The Social Network Theory (SNT) on the other hand explains how networking within communities can stimulate new ideas and opportunities to bring about change and development. SNT argues that open networks are more likely to introduce positive change in the community. The SNT further regard propinquity and homophily as the strengths of the community, where propinquity is defined as being in the same place at the same time and homophily is defined as having one or more common social attributes (Kadushin 2004:6). The SNT is therefore relevant to community development as community members are in the proximity of each other and usually share the same goal.

## **1.9 DEFINITION OF KEY TERMS**

In the context of this study, the following definitions of key concepts will be used:

### **1.9.1 Orphaned Child**

The definition of an “orphaned child” varies from country to country. In South Africa there are two main criteria that are used when defining an orphaned child (Smart 2003:3). These variables are:

- (i) age, which refers to children who are below the age of 18 years, and

- (ii) parental loss, which refers to the loss of a mother, father, or both parents through death.

The DSD (2010:13) defines an orphan as a child who has lost one or both parents. Hunter et al. (1998:2) on the other hand, classify orphaned children into three types:

- (i) *Maternal orphaned children*, which refers to children under the age of 15 years whose mothers have died.
- (ii) *Paternal orphaned children*, which refers to children under the age of 15 years whose fathers have died.
- (iii) *Double orphaned children* are those children under the age of 15 years whose mothers and fathers have both died.

For the purposes of this study, an “orphaned child” is therefore defined as a child, under the age of 18 years, who has no surviving or present biological parent caring for him or her (Department of Social Development 2005:5).

### **1.9.2 Vulnerability**

“Vulnerability” is a complex concept to define, as it is used by different people in different ways. This term does not only refer to orphaned children only but often includes destitute and disabled children as well. According to Smart (2003:6), in South Africa, a child that is defined as “vulnerable” is one who:

- (i) is orphaned, neglected, destitute, or abandoned;
- (ii) has a terminally ill parent or guardian;
- (iii) is abused or ill-treated by a guardian or relatives;
- (iv) is living with a parent who does not have income-generating opportunities;
- (v) is born of a teenage or single mother.

### **1.9.3 Orphaned and Vulnerable Children**

For the purposes of this study, “orphaned and vulnerable children” will therefore be defined as children who have no parents or who do not stay with their maternal

parent and as a result have become vulnerable because of the negative circumstances in which they find themselves.

#### **1.9.4 Child**

According to the South African Constitution, a “child” is any person who is under the age of 18 years. In most international and national reports, children are defined as boys and girls up to the age of 18 years (Smart 2003:3). The age of 18 years relates primarily to the generally accepted age of being an adult, where for instance a person may be legally married without the consent of a parent/guardian or can consent to medical treatment without the presence of a parent or guardian.

The Children’s Amendment Act No 41 of 2007 allows for a child of 14 years of age to give consent to some types of medical treatment, such as taking an HIV test without getting permission from a parent or guardian. However, for the purposes of this study a “child” will refer to any person who is under the age of 18 years, which is in line with the Children’s Act No 38 of 2005.

#### **1.9.5 School-going children**

For the purposes of this study, “school-going children” refers to children who are still attending primary school, that is those who are in grades 1 to 7. This means that the focus will be on the services provided to children who are between the ages of about 7 and 15 years, but limited to those who are still in primary school.

#### **1.9.6 Child-headed households**

According to the amended Children’s Act 38 of 2005, Section 137 stipulates the following:

“The provincial head of Social Development may recognize a household as a Child headed household if –

- (i) the parent, guardian or caregiver of the household is terminally ill, has died or has abandoned the children in the household;

- (ii) no adult family member is available to provide care for children in the household;
- (iii) a child over the age of 16 years has assumed the role of caregiver in respect of the children in the household; and
- (iv) it is in the best interest of the children in the household” (Children’s Act 38 of 2005)”.

Maqoko et al. (2007:723) define child-headed households (CHH) in the following way, “CHH are generally considered to be those households where the main primary caregiver is younger than 18 years of age” (Maqoko et al. 2007:723). The former definition by Maqoko et al. will be used for the purposes of this study.

### **1.9.7 Primary Caregiver**

A “primary caregiver” is defined as “a person who has the parental responsibility or right to care for the child and who exercises that responsibility and right” (Department of Social Development 2005:5).

### **1.9.8 Community Caregiver**

A “community caregiver” is defined as “a person who regularly and voluntarily assists a household whose members are related or not related to him/her in terms of doing household chores, giving advice and giving spiritual, psycho-social and material support” (National Department of Health: 2002:15). A community caregiver is also defined as “an individual who provides most of the care to a person living with HIV and AIDS or to an OVC, usually a relative or someone who lives in the same residence” (USAID: 2006:5).

### **1.9.9 Service Provider**

For the purposes of this study, a “service provider” refers to the identified government departments, NGO and Richmond NIP site that participated as key informants in this study.

### **1.9.10 Residential Care**

“Residential care” is defined by the Department of Social Development (DSD) as the care of children that is provided in a children’s home (DSD 2000:20). The Children’s Amendment Bill (DSD 2006) defines “children’s home” as a residential care programme established in terms of the Child Care Act for children in need of care.

Naidoo (2007:37) defined “shelter” as a facility located at a specific place, which is managed for the purpose of providing basic services including overnight accommodation and food to children who attend the facility voluntarily.

### **1.9.11 Child Care Forums**

“Child Care Forums” are defined as community-based structures focusing on the needs of OVCs in the community, which ensure that these needs are met (Naidoo 2007:34).

### **1.9.12 Integrated Development Approach**

The “Integrated Development Approach” refers to the integrated planning that involves relevant stakeholders in finding the best solutions to achieve long-term development.

### **1.9.13 Community Development**

“Community development” is defined as a process of organisation, facilitation and action that allows people to create a community in which they want to live through a conscious process of self-determination (Maser 1997:101).

### **1.9.14 Social Assistance**

“Social Assistance” is defined as an income transfer in the form of grants or financial award provided by government. Grants in South Africa include the following: disability grant; a grant for the aged; war veteran's grant; grant-in-aid; foster child grant; care dependency grant and child support grant (DSD 2009).

## 1.10 OUTLINE OF THE STUDY

The outline of the study is as follows:

- **Chapter 1** aims at situating the research problem by contextualising the challenges and problems faced by children orphaned and made vulnerable by HIV and AIDS. The chapter starts by providing background on the OVC crisis and then sets out the problem statement and the focus of the study. Thereafter it presents the research objectives, the research questions, the rationale for doing this study, summarises the setting of where the research was conducted, the research methodology and the conceptual frameworks that guided this study. It also provides definitions of the key terms used in the study and finally presents the outline of the research.
- **Chapter 2** provides an overview of studies that have been conducted on the needs of and the challenges faced by OVCs, as well as the impact of HIV and AIDS on children, families and communities. This chapter concludes by attempting respond to questions such as who should take the responsibility of caring for OVCs. .
- **Chapter 3** presents policy and legislation that guides OVC programmes in South Africa as well as the support services available for OVCs. The chapter further discusses three theoretical frameworks that were used to guide the study, that is, the Community Development Approach, the Integrated Development Approach and Social Network Theory.
- **Chapter 4** describes the research design and methodology that was followed and used in this study. The processes that were followed to gather and analyse the data are described in detail. The themes and sub-themes that were identified during the analysis of the data gathered from the individual interviews and focus group discussion are also identified and described in this chapter.
- **Chapter 5** presents the findings of this study. It firstly describes the biographical characteristics of participants of this study, that is (a) the five key informants who

participated in the individual in-depth interviews and (b) the primary caregivers who participated in the focus group discussion as well as in the in the individual in-depth interviews. It also presents the findings of the research in terms of the themes and sub-themes identified during the analysis of the gathered data.

- **Chapter 6**, the final chapter of this dissertation, presents a summary of the research findings, and articulates the recommendations and limitations of the study.

## **1.11 CONCLUSION**

The increase in the number of orphaned and vulnerable children poses a major challenge to the growth and development of communities owing to the limited resources that are available to support these children. It is therefore critical that government departments and non-governmental organizations providing services to OVCs, work together to integrate the services they are rendering for OVCs to ensure that there is positive impact on the lives of OVCs and that services are not duplicated.

This chapter outlined the critical questions to be tackled by the study. It presented the research problem, objectives, and rationale for conducting the study. It further defined the research setting and the key terms that are used in the study.

In the next chapter the literature that is available on orphaned and vulnerable children is reviewed, by first looking at the extent of the OVC problem, focusing on the international, sub-Saharan African, and the South African contexts. Secondly, policy and legislation supporting the OVCs in South Africa is explored. Lastly, the chapter sets out the living conditions and main needs of OVCs, and challenges faced by OVCs.

## **CHAPTER 2**

### **LITERATURE REVIEW**

#### **2.1 INTRODUCTION**

The HIV and AIDS epidemics are creating orphaned children on an unrivalled scale. Orphaning caused by AIDS-related deaths is increasingly becoming a long-term problem, affecting mostly poor communities throughout Southern Africa and sub-Saharan Africa at large (Smart 2003:5). However, orphaning is not the only way that children may be affected by HIV and AIDS. A number of children are made vulnerable by HIV and AIDS when their parents suffer from HIV-related illnesses or when they are discriminated against because their parents have died of AIDS-related illnesses. Consequently, responses to HIV and AIDS should not only single out orphaned children, but should target both orphaned and vulnerable children (OVCs).

Although the overwhelming majority of OVCs are living with surviving parents or their extended family, many of them are being cared for by a remaining parent who is sick or dying; by elderly grandparents, who themselves are often in need of care and support; or by impoverished relatives who are struggling to meet the needs of their own children (Smart 2003:7). Increasing numbers of children are living in child-headed households (CHH), with minimal or no adult supervision or support. This results in children being at an increased risk of not having adequate shelter, not having the opportunity to attend school, and not receiving adequate health care and nutrition. Meeting these needs is important for the growth and development of children.

The chapter will focus on the extent of the OVC crisis, focusing on the international, sub-Saharan African and South African contexts. Furthermore, the impact of HIV and AIDS on children, families, and communities is discussed, as well as needs of and challenges faced by OVCs. The chapter concludes by exploring responsibility for taking care of OVCs.

## **2.2 EXTENT OF THE OVC CRISIS**

In order to discuss appropriate social responses to the needs of orphaned and vulnerable children, it is important that an assessment of the extent of the OVC crisis is conducted. The extent of the OVC crisis will therefore briefly be looked at in terms of three contexts, that is, the international, sub-Saharan African, and South African contexts.

### **2.2.1 International Context**

It is imperative that the number and profile of OVCs is understood if successful strategies for provision and care for them are to be developed. Globally, in 2011, 151 million children had lost either one or both parents owing to every possible cause; 17.3 million children under the age of 15 years had lost either one or both parents (UNICEF 2013). UNICEF (2013) further states that in 2011 there were 3.5 million children whose parents had died because of AIDS: 2011 ([www.childinfo.org/hiv - aids.html](http://www.childinfo.org/hiv_aids.html)). Despite a modest decline in the adult HIV prevalence rate worldwide, and despite increasing access to treatment, the total number of children aged 0–17 years who have lost their parents owing to AIDS-related illnesses has not yet declined (UNAIDS 2010:112). According to this global report prepared by UNAIDS, the number of orphaned children has increased from 14.6 million in 2005, to 16.6 million in 2009, the majority (90%) of these children living in sub-Saharan Africa. The figure for children (under 18 years of age) who have lost one or both parents due to AIDS globally in 2012 is estimated at 17,8 million, according to a UNICEF report published in 2013 (UNICEF 2013).

A strategic framework for the protection, care and support of OVCs was developed to target action areas and provide operational guidelines to governments and other key stakeholders in this regard. This strategic framework was developed during the first Global Partners' Forum, which was convened by United Nations Children's Fund (UNICEF), and supported by UNAIDS in 2003. It identified the following five key strategies for accelerating the response to the OVC crisis (UNICEF 2004:5):

- Strengthening the capacity of families to protect and care for OVCs by prolonging the lives of parents and providing support to OVCs and their families;

- Mobilising and strengthening community-based responses, to provide assistance to vulnerable households;
- Ensuring access to essential services for OVCs, which includes health care and education;
- Ensuring that government protects the most vulnerable children through improved, relevant policy and legislation; and
- Raising awareness to create a supportive environment for children affected by HIV and AIDS.

**Table 3: Summary of the actions identified by the Interagency Task Team**

<b>BROAD STRATEGIES</b>	<b>POSSIBLE INTERVENTIONS</b>
Policy and strategies	<ul style="list-style-type: none"> <li>• Laws protecting the rights of children, which will promote equality and prohibit discrimination and stigma</li> <li>• National policy and guidelines for OVCs, which will define the problem; putting in place structures for overseeing the planning, implementation, and monitoring of the services and support available for OVCs</li> <li>• National HIV and AIDS strategies that include an explicit focus on OVCs</li> <li>• Clear support from national government</li> </ul>
Advocacy	<ul style="list-style-type: none"> <li>• Targeted issues-based advocacy, to raise awareness and identify policy actions that are essential in supporting OVCs; and to address stigma and discrimination</li> </ul>
Multi-sectoral structure	<ul style="list-style-type: none"> <li>• A multi-sectoral OVC structure, which includes representation of all relevant stakeholders, and with clearly defined roles and an official mandate</li> <li>• Regular consultation with relevant stakeholders</li> </ul>
Monitoring	<ul style="list-style-type: none"> <li>• Monitoring of policy implementation</li> </ul>

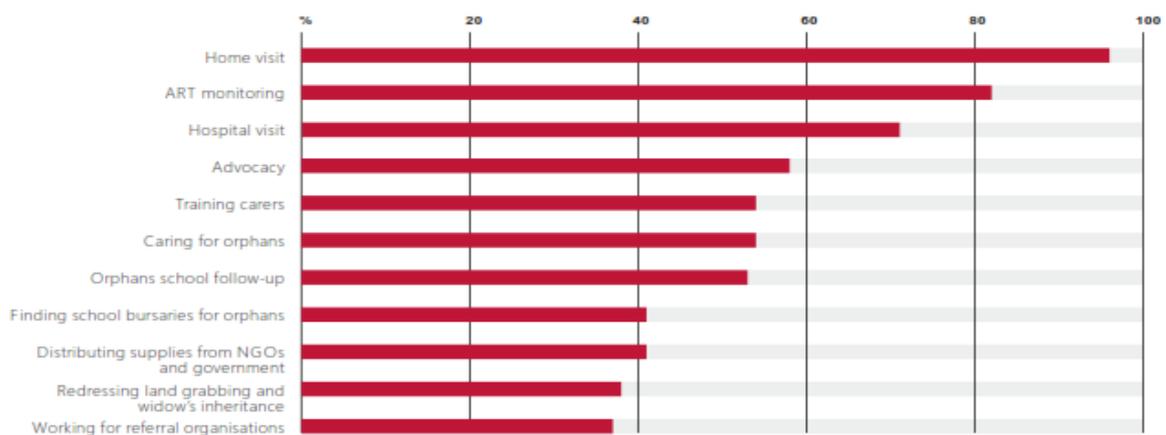
Source: Smart 2003

The Interagency Task Team (ITT) on OVCs was convened by UNICEF. It comprised representatives from UNAIDS, UNDP, UNFPA, World Food Programme, Save the Children Alliance, USAID, and the International Federation of Red Cross and Red Crescent Societies (IFRC). This task team met for the first time in 2002 to deliberate on possible interventions and support for OVCs made vulnerable by HIV and AIDS. This task team further identified several practical actions (refer to table 3 above) which aimed at providing assistance to various countries on how to move forward the policy process of addressing OVC issues (Smart 2003:14).

In addition to the above, there are remarkable interventions aiming to respond to HIV-related challenges globally. These interventions include the development of systems and networks, both formal and informal, that support children orphaned by the epidemic (UNAIDS 2012:112). Figure 1 below indicates that in 2009 more than 50% of caregivers interviewed in Cameroon, Kenya, Malawi, Nigeria, South Africa and Uganda were caring for and providing school-related support to orphaned children. More than 40% of caregivers in the mentioned countries assisted orphaned children to elicit bursaries which would pay school fees.

**Figure 1: Types of care and support work for people living with HIV**

*Source: Compensation for Contributions: report on interviews with volunteer caregivers in six countries. Human Rights Commission and Community Agency for Social Enquiry, Sept 2009.*



Source UNAIDS 2010:113

The UNAIDS Global Report on the AIDS Epidemic also reported a narrowing of the difference in school attendance between orphaned and non-orphaned children, as

one main achievement of this response. The report further indicates that most households caring for children affected by HIV still do not have access to any external care and support services (UNAIDS 2012:112).

A United Nations General Assembly high-level meeting, held in June 2011, mandated the UNAIDS to support countries in reporting on progress made in the implementation of the 2011 UN Political Declaration on HIV and AIDS (UNAIDS 2013:7). In this regard, the United Nations (UN) General Assembly convened a special session on HIV and AIDS at which 189 UN member states signed a Declaration of Commitment towards achieving a set of goals and targets in order to intensify international action to fight the AIDS pandemic, mobilising the necessary resources (UNICEF 2005:25). The Declaration reflects global consensus on a comprehensive framework to reverse the HIV and AIDS epidemics by 2015.

It further states that special attention must be paid to children orphaned and made vulnerable by HIV and AIDS. The member states of the UN agreed to review and regularly report by 2015 against a set of standardised core indicators, on their progress in realising universal access to HIV prevention, treatment, care and support. The number of countries providing reports on the implementation of the Declaration of Commitment increased to 186 (96% of UN Member States) in 2012 from 53% in 2004. The percentage of countries reporting on support for children affected by HIV and AIDS also increased from 8 in 2006 to 42 in 2010 (UNAIDS 2013:9).

Table 4 below further indicates the progress made by these countries with regard to two general population indicators relevant to OVCs, which are (a) support provided to households caring for orphaned and vulnerable children aged 0 to 18; and (b) school attendance by orphaned and vulnerable children.

The table below shows that the number of responding countries reporting on support provided for children affected by HIV and AIDS increased from 8 in 2006 to 42 countries in 2010. There was also an increase in the response rate from 4% in 2004 to 22% in 2010. It further shows that in 2008, 50 countries started reporting on

school attendance by OVC and non-OVCs, although in 2010 there was a decrease to 46 countries.

**Table 4: Response rates on general population indicators related to OVCs (2004 - 2010)**

<b>Indicators</b>	<b>Measurement</b>	<b>2006</b>	<b>2008</b>	<b>2010</b>
Support provided for children affected by HIV and AIDS	Number of responding countries	8	36	42
	Response rate	4%	19%	22%
School attendance by Orphaned and Vulnerable Children	Number of responding countries	N/A	50	46
	Response rate	N/A	26%	24%

Source: UNAIDS 2010

## **2.2.2 Sub-Saharan African Context**

In response to the AIDS epidemic, the “First Ladies” of the African Countries established an organisation called the Organization of African First Ladies against HIV/AIDS (OAFLA) in partnership with UNAIDS, in 2002. The aim of the OAFLA is to address HIV and AIDS related issues in Africa (UNAIDS 2013:33). The organisation started with 37 First Ladies in Africa in 2002, and the membership has increased to 40 by 2013. The 37 African countries include Algeria, Botswana, South Africa, Cameroon, Mozambique, Swaziland, etc. OAFLA members advocate for programmes to eliminate new HIV infections among children, promote efforts to mobilize resources for the AIDS response and to improve access to HIV treatment, care and support services on the continent. The OAFLA has further launched many high-impact campaigns, including “FLAME”, in nine countries in 2011 to promote both the virtual elimination of new HIV infections among children and keeping their mothers alive (UNAIDS 2013:33).

In November 2003, the USAID, UNICEF, UNAIDS and the World Food Program (WFP) launched a Rapid Country Assessment, Analysis and Action Planning (RAAAP) initiative for OVCs in 17 sub-Saharan countries (Policy Project 2005:1).

These countries included Botswana, Central African Republic, Côte d' Ivoire, Ethiopia, Malawi, Kenya, Lesotho, South Africa, Swaziland, Zambia, Mozambique, Namibia, Nigeria, Rwanda, Tanzania, Uganda and Zimbabwe. The aim of the RAAAP project was to assess the levels of support and care provided to OVCs. The report indicated that in 11 of the 17 countries, more than 15% of all children under 18 years of age, could be classified as OVCs. RAAAP refers to OVCs as children who are below the age of 18 years and who have lost either one or both parents (Policy Project 2005:1).

Given the high estimated numbers of OVCs, all role players should consider the level and extent of the need for support for OVCs, as well as the capacity required for addressing the challenges faced by OVCs when designing relevant programmes, so that these will be able to cater for the increase in the number of OVCs.

The OVC RAAAP initiative was developed to provide a policy and programmatic framework which would unify and scale-up multi-sectoral national responses to the OVC crisis in each of the 17 identified countries in sub-Saharan Africa (Policy Project 2005:2). This initiative involved the development of assessment tools that were used for a rapid assessment of current levels of care and support for OVCs in the 17 countries. The findings of these assessments were analysed, and plans of action developed on the basis of these analyses. The assessment tools included the following:

- A situational analysis of the OVC crisis, which included an analysis and summary of existing quantitative data on OVCs in the 17 countries;
- A contextual assessment, which provided an overview of the needs and issues affecting the lives of OVCs and families. It also highlighted the challenges facing the government, communities, and families, in responding to the needs of OVCs;
- A response assessment, which identified (a) the various service providers rendering services to OVCs, and (b) the services they provide to OVCs. It also highlighted current OVC interventions afforded by the identified service providers in rendering services to OVCs; and
- An assessment of community responses, which offered information on the existing community responses to OVCs, including support provided by extended families, neighbours, and the community at large.

The data collected through the above assessment tools was then analysed by the national OVC steering committees of the 17 countries. Reports on the findings were compiled and used to prepare national OVC action plans. The national OVC action plans identified the financial and technical support required to scale up the implementation of OVC programmes in these countries. The recommendations of the RAAAP initiative, which correspond to the strategies developed by UNICEF indicated in section 2.2.1 above, included the following strategy frameworks and key activities:

**Table 5: Summary of the RAAAP Initiative Recommendations**

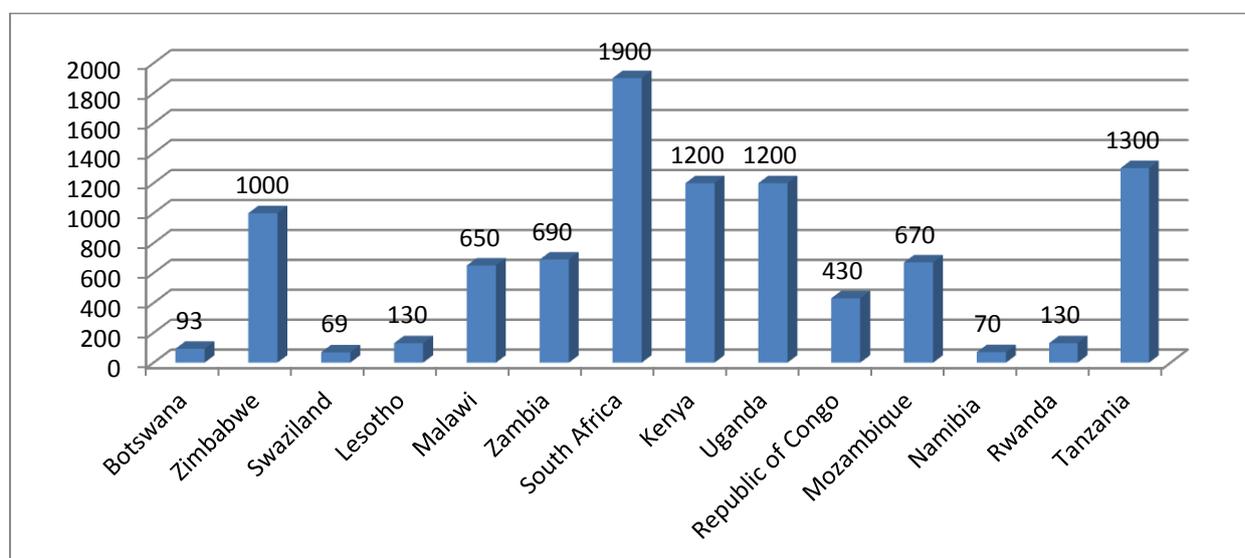
Framework strategy	Key activities to be conducted
Strengthen the capacity of families to protect and care for OVCs	<ul style="list-style-type: none"> <li>• Prevention of HIV infection and progression to AIDS, to avoid increase in the number of children orphaned owing to AIDS-related deaths</li> <li>• Establish and implement age-specific HIV prevention programmes, which should be accessible to the most vulnerable youth</li> </ul>
Mobilise and support community-based responses	<ul style="list-style-type: none"> <li>• National OVC strategic planning and resource allocation needs to be centred on the community level</li> <li>• Integrating poverty reduction strategies (focusing on community economic vitality) with an OVC policy and goals that recognise communities as principal beneficiaries and implementing forces</li> </ul>
Ensure access to essential services for OVCs	<ul style="list-style-type: none"> <li>• Establish monitoring and evaluation systems to track OVCs receiving support, which will facilitate an increase in access to essential services</li> </ul>

Development of policy and legislation for OVCs and channelling of resources	<ul style="list-style-type: none"> <li>Funding should be linked to systems that can be replicated rapidly, which also reinforce a shared learning environment among service-providers for OVCs</li> </ul>
<b>Framework strategy</b>	<b>Key activities to be conducted</b>
Create supportive environment for OVCs through awareness campaigns	<ul style="list-style-type: none"> <li>Establishment of national OVC ministry to be responsible for establishment of clear advocacy and mobilisation plan</li> </ul>

Source: Policy Project (2005)

However, no significant decline in the number of OVCs seems to have occurred. According to the United Nations (2010) (<http://www.avert.org/aidsorphans.htm>) the number of orphaned children living in sub-Saharan Africa in 2009 was estimated at 14,8 million. It further states that the highest numbers of orphaned children are found in countries with the highest HIV prevalence or those that have recently been involved in armed conflict, for instance, Zimbabwe.

**Figure 2: Number of orphaned children in sub-Saharan Africa, in 2011 (in 1000)**



Source: The Stephen Lewis Foundation: 2012 ([www.stephenlewisfoundation.org](http://www.stephenlewisfoundation.org))

The number of children orphaned owing to AIDS-related deaths in six African countries (that is, Kenya, Nigeria, South Africa, Uganda, United Republic of

Tanzania, and Zimbabwe) was recorded in 2009 as more than 9 million, with Nigeria alone counting 2.5 million orphaned children owing to AIDS-related deaths (UNAIDS 2010:112). The report further states that more than 10% of all children aged 0 –17 years have lost either one or two parents owing to AIDS-related illnesses in Zimbabwe (16%), Lesotho (13%), and Botswana (12%) and Swaziland (12%) (UNAIDS 2010:112).

Figure 2 above indicates that in 2011, Southern African countries such as South Africa, Tanzania, Kenya and Uganda had the highest number of orphaned children in sub-Saharan Africa. The figure shows that the lowest number of orphaned children were found in Swaziland, Namibia and Botswana (The Stephen Lewis Foundation 2012: <http://www.stephenlewisfoundation.org>).

### 2.2.3 South African Context

The National Strategic Plan for HIV and AIDS and STI 2007 – 2011 (NSP) (2007:34) reported that in 2007 in South Africa, children under the age of 18 years accounted for 40% of the population. Table 6 below shows that in 2011, the total number of children in South Africa was 18, 541 million (Stats SA 2012).

**Table 6: Distribution of children in South Africa, by province: 2011**

Province	2011	%
Eastern Cape	2 687 000	14%
Free State	1 060 000	7%
Gauteng	3 336 000	18%
KwaZulu-Natal	4 2 13 000	23%
Limpopo	2 241 000	12%
Mpumalanga	1 473 000	8%
Northern Cape	435 000	2%
North West	1 282 000	7%
Western Cape	1 814 000	10%
<b>Total</b>	<b>18 541 000</b>	<b>100%</b>

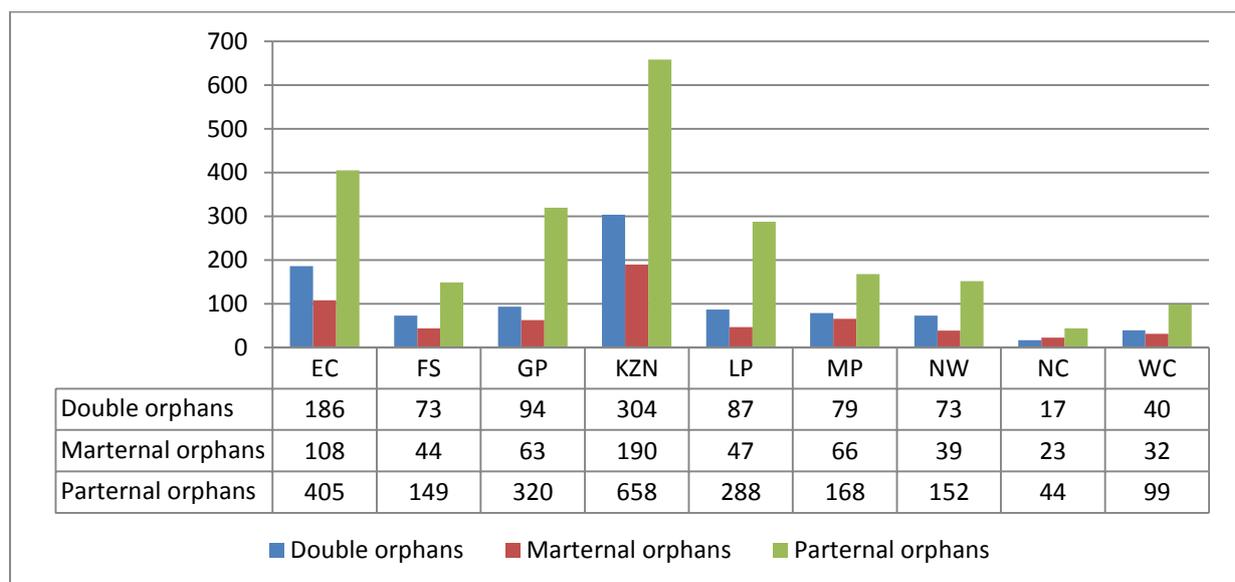
Source: Children’s Institute (2013)

The table above shows that the majority of children are found in the provinces of KwaZulu-Natal (4.2 million), followed by Gauteng (3.3 million) and the Eastern Cape (2.6 million).

Half of the children in South Africa live in three of the nine provinces, that is KwaZulu-Natal (23%), Gauteng (18%) and Eastern Cape (14%). Provinces with the lowest number of children include Northern Cape (2%), Free State (7%), North West (7%), and Mpumalanga (8%).

The NSP 2007 - 2011 (SANAC 2007:34), developed by the South African National AIDS Council (SANAC) indicates that in 2004, it was estimated that there were 2.2 million orphaned children, meaning 13% of all children under 18 years had lost either a mother, a father or both parents. The NSP 2007 – 2011 further states that nearly half of all orphaned children in SA were estimated to have lost parents as a result of AIDS-related illnesses. In 2009, the number of orphaned children in South Africa was estimated by UNICEF (2010) to be 3.7 million. This UNICEF report indicates that half of these orphaned children have lost either one or both parents to AIDS-related deaths; and 150,000 children are believed to be living in child-headed households ([http://www.unicef.org/south-africa/protection\\_6633.html](http://www.unicef.org/south-africa/protection_6633.html)).

**Figure 3: South African orphaned children count by Province: 2011 (in 1000)**



Source: Children’s Institute (2013)

Figure 3 above indicates statistics on the number of orphaned children in 2011 in South Africa, as indicated in the Children’s Institute (2013). The figure shows that the majority of orphaned children in South Africa are from KwaZulu-Natal with 304 000 children who are double-orphaned; followed by the Eastern Cape with 186 000 double-orphaned children. The two provinces had 190 000 and 108 000 maternal-orphaned children, respectively. The provinces with the lowest number of double-orphaned children are Northern Cape with 17 000, and Western Cape with 40 000 (Children’s Institute 2013: 88).

Table 7 below and Figure 3 above further show that in all the provinces orphaned children have lost paternal parents more than maternal parents. For instance, in KZN there are 658 000 paternal-orphaned children compared with 190 000 maternal-orphaned children.

**Table 7: South African orphaned children count by Province: 2011 (in 1000)**

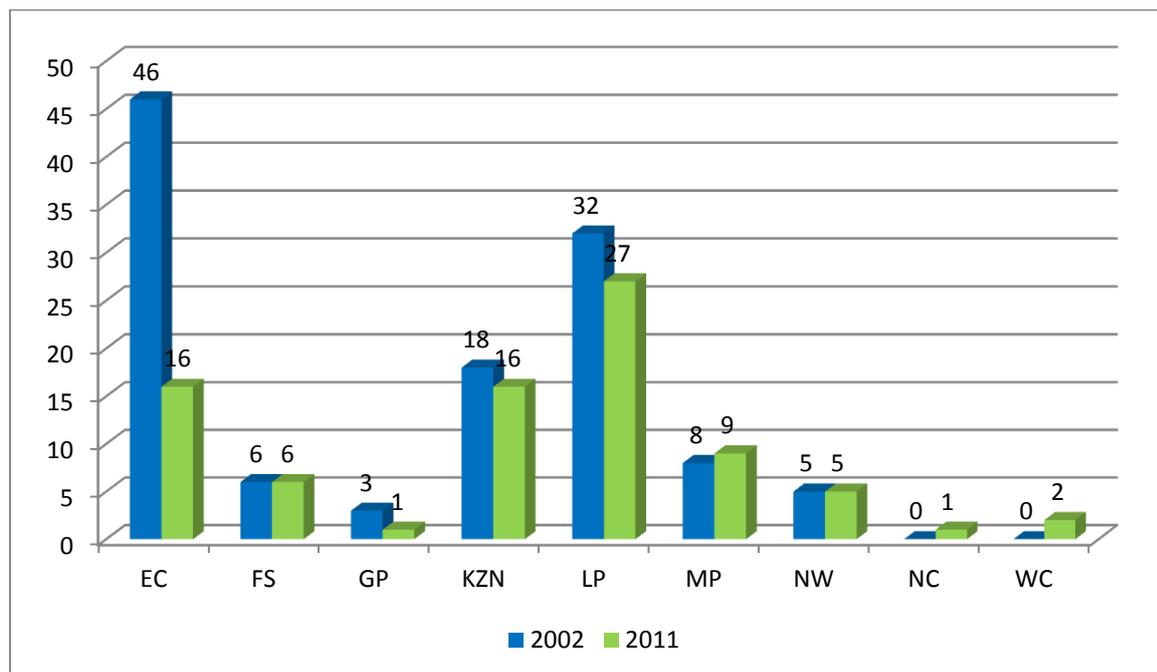
<b>PROVINCE</b>	<b>MATERNAL</b>	<b>PARTENAL</b>	<b>DOUBLE</b>
Eastern Cape	186	108	405
Free State	73	44	149
Gauteng	94	63	320
Kwa-Zulu Natal	304	190	658
Limpopo	87	47	288
Mpumalanga	79	66	168
Northern Cape	73	39	152
North West	17	23	44
Western Cape	40	32	99
<b>TOTAL</b>	<b>953</b>	<b>612</b>	<b>2 283</b>

Source: Children’s Institute (2013)

Furthermore, the SA government and civil society are concerned about the number of children living in child-headed households. This figure is escalating as the number of orphaned children increases owing to the AIDS-related deaths of their parents (Children’s Institute 2013:89). Child-headed households are generally defined as those households in which the main caregiver is younger than 18 years of age

(Maqoko et al. 2007:723). Figure 4 below indicates the number of child-headed households (CHHs) in South Africa from 2002 – 2011, per province. The total number of children living in child-headed households in South Africa decreased from 118 000 in 2002 to 82 000 in 2011 (Children’s Institute 2013: 89).

**Figure 4: Number of children living in child-headed households in South Africa by Province: 2002 and 2011 (in 1000)**



Source: Children’s Institute (2013)

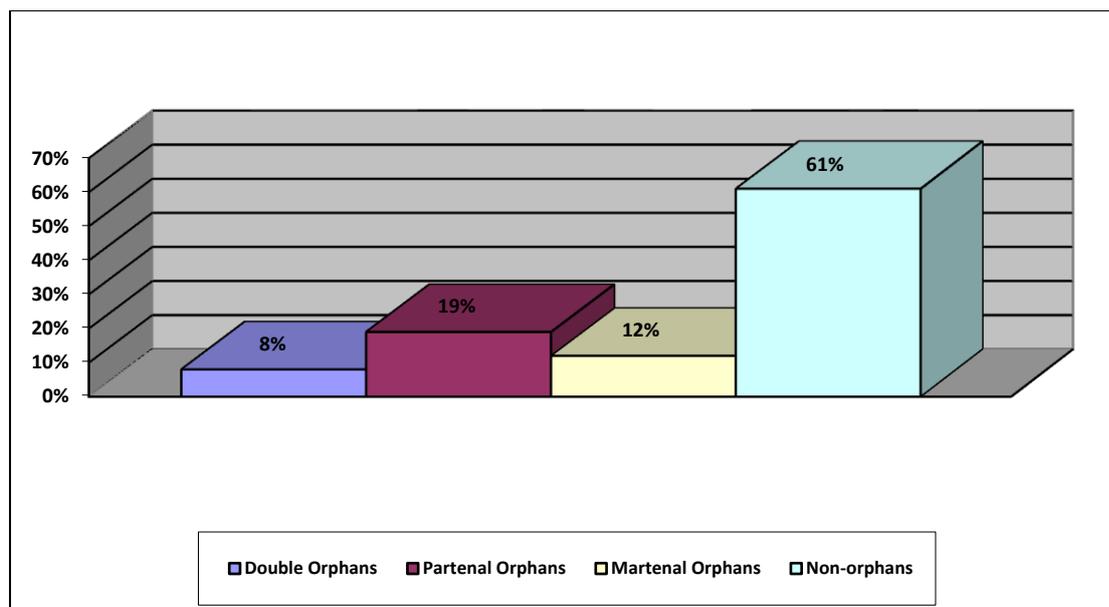
This figure further indicates that the numbers of children in CHH declined in all provinces, with the exception of Mpumalanga, which had an increase from 8 000 to 9 000. The numbers dropped from 46 000 to 16 000 in Eastern Cape, and from 18 000 to 16 000 in KwaZulu-Natal. The drop in the figures may indicate that the interventions on OVCs are yielding positive results. For instance, the OVCs could be living with relatives or have been placed in orphanages. The above figure shows that the number of children living in CHH dropped in 2011, compared with 2002.

According to the Children’s Institute (2006), the majority of children living in CHH are not orphaned children; their parents are alive but are living elsewhere ([www.buanews.gov.za/dsd.htm](http://www.buanews.gov.za/dsd.htm)). The Children’s Institute further states that about

90% of the total number of children in CHH in 2009 were located in three provinces of SA, which are KwaZulu-Natal, Limpopo, and the Eastern Cape. The report also indicates that the majority (88%) of CHH have at least one child older than 15 years of age.

Figure 5 below indicates that the majority (61%) of children living in CHH have two living parents; 80% having a living mother. According to the Household Survey conducted by the Children’s Institute (2006), 8% of the children in CHH have lost both parents, and 12% have lost their mothers ([www.buanews.gov.za/-dsd.htm](http://www.buanews.gov.za/-dsd.htm)). The majority of children living in CHH are therefore not orphaned children, as the study above indicates that the parents are still alive. These children may have been abandoned by their parents.

**Figure 5: Status of orphaned children living in child-headed households**



Source: Children’s Institute (2006)

### **2.3 THE IMPACT OF HIV AND AIDS ON CHILDREN, FAMILIES AND COMMUNITIES**

The impact of HIV and AIDS on children is complex when their parents become ill and die, as children are affected and made vulnerable by HIV and AIDS long before they are orphaned. When a parent develops HIV infection-related symptoms,

children often take on the role of a caregiver. Caring for, and the death of sick parents, costs of funerals and loss of inheritance may result in financial problems and psychosocial distress. The challenges faced by OVCs and the possible absence of adequate adult care may also lead to an increased risk of discrimination and exploitation.

When a family member becomes infected with HIV, the family often rapidly descends into poverty (Govender 2007:14). Additional funds are required to care for the sick person, pay for their medication, the transport costs of travelling to health facilities, and the expense of providing them with nutritious food.

**Table 8: Impact of HIV and AIDS on Children, Families, and Communities**

<b>IMPACT OF HIV AND AIDS ON</b>		
<b>CHILDREN</b>	<b>FAMILIES</b>	<b>COMMUNITIES</b>
Loss of family and identity	Loss of family members	Labour pool is reduced
Psychosocial distress	Changes in households and family structure	Poverty increases
Increased malnutrition	Family dissolution	Infrastructure deteriorates
Loss of health care, including immunisation	Lost income	Access to health and education is reduced
Increased demands for labour	Impoverishment	Mortality is elevated
Fewer opportunities for schooling and education	Lost labour	Community has fewer resources
Loss of inheritance	Forced migration	Communities suffer a general loss of resilience
Forced migration	Grief	
Homelessness	Stress	
Exposure to HIV infection	Reduced ability to care for children and elderly household members	

Source: HSRC (1996)

Once these adults start suffering from AIDS-related illnesses, and cannot work, healthy adults have to divert their productive energy, becoming caregivers and looking after the sick. Walker et al. (2004) state that the loss of income owing to prolonged illness and medical and funeral expenses, often depletes the resources of an already destitute family. This is because the family has to spend most of the little money that they have on medical expenses.

Table 8 above, compiled by the HSRC, indicates the impact of HIV and AIDS on children themselves, their families, and the community at large. It shows that children are placed in vulnerable situations, whereby their chances of a brighter future are minimised. Again, because of poverty, they are at risk of HIV infection, for instance, should they become sexually involved with older partners as a means of survival.

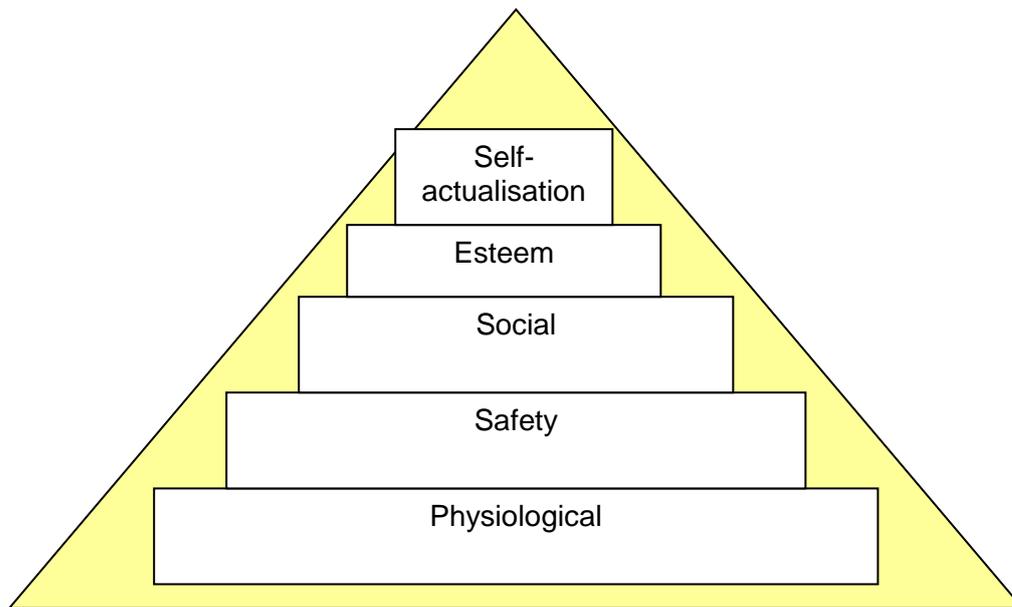
## **2.4 THE NEEDS OF AND CHALLENGES FACED BY OVCS**

The main needs of OVCs, as indicated in a study conducted by the HSRC, include food, shelter, and clothing (HSRC 2007:12). This study indicates that poor families have found it challenging to provide for the basic needs of OVCs, such as food, clothing, shelter and education. In most cases, taking care of OVCs is an additional responsibility, the families having their own dependants in their care.

Maslow's theory of a hierarchy of needs identifies the needs of individuals, categorising them into five levels, which are set in a hierarchical order (see figure 6 below) (<http://www.netmba.com/mgmt/ob/motivation/maslow>). This theory states that basic needs, that is, **physiological needs**, must be satisfied first before the higher-level needs can be satisfied. The same theory may be applied to OVCs, their needs being similar to those of all other people.

Figure 6 below indicates that physiological needs are the most critical, in that these are required for sustaining life. Such needs include food and water; these must be fulfilled first, before the following needs are met.

**Figure 6: Maslow's Hierarchy of Needs**



Source: <http://www.netmba.com/mgmt/ob/motivation/maslow>

The next level in the hierarchy refers to the **safety needs**, meaning the need to live in a safe area, and to have medical insurance and job security. Next in the hierarchy are **social needs**, which include the need for interacting with other people, such as belonging to a group, and having friends. According to Maslow's theory, it is only when these first three essential levels of needs are met, that the esteem and self-actualisation needs can be met. The **esteem needs** refer to a person's self-respect, and a need to be recognised, whereas the **self-actualisation need** is the need to reach one's full potential as a person (<http://www.netmba.com/mgmt/ob/motivation/maslow>).

Although it can be argued that OVCs have the same needs as other people, they often experienced severe challenges when attempting to meet their needs. The challenges that are experienced by OVCs may be explained in terms of three broad categories, which are social, psychosocial, and financial challenges.

#### **2.4.1 Social Challenges**

The illness or death of a mother or caregiver can jeopardise the meeting of a child's most basic needs, such as access to adequate health care, sanitation, and nutrition. Stigma associated with HIV and AIDS may put children at risk of further

discrimination, isolating them from their communities. Often OVCs themselves are perceived by their peers and community members to be living with HIV, which may not necessarily be the case. Other children from their communities and schools may not feel comfortable playing with them, fearing becoming infected with HIV. Some children are teased by other children and community members; others lose their friends, who assume that when they get close to such children they will become infected with HIV. Stigma and discrimination thus also contribute to the challenges experienced by OVCs. The rejection starts as early as when their parents fall ill with AIDS-related illnesses (Salaam: 2005:10).

Furthermore, when parents have died, and there is no support from others, the burden of running the household falls on the children. In such instances children live alone in 'child-headed households', without the supervision of any adults. In some cases there are adult caregivers in these households, who are terminally ill, and unable to take care of themselves or their families. In these instances, the older child often takes the responsibility of heading the family; hence these households are regarded as child-headed households. There are also cases in which the heads of CHH are school-going older siblings, who are supported by an adult from another household (Maqoko et al. 2007:723).

Walker et al. (2004) state that in CHH, children as young as five years old perform household chores such as cooking meals, taking care of crops, and collecting water and firewood. The older children often leave school early to support their siblings. They bring in money by begging or by performing menial tasks such as washing cars and cleaning neighbours' houses. These children still have to carry out the tasks of managing the family resources and running the home, however, their ability to maintain and repair their homes is minimal. This has resulted in these children being exposed to the risk of losing schooling opportunities, proper and adequate shelter, as well as other possibilities for growth and development.

OVCs are also made more vulnerable by HIV and AIDS because they may become exposed to abuse and exploitation. OVCs can easily be abused or exploited, having no one to protect or defend them, thus they are easily targeted. The report on the research conducted on OVCs in Botswana, edited by Tsheko (2007:18), revealed

that OVCs were generally subjected to physical and sexual abuse by older community members, whether or not relatives. It further states that OVCs were forced to do all the undesirable jobs at home, such as making and selling beer.

Maqoko et al. (2007) further state that the heads of CHH have the same responsibility as all other heads of families. They have to work to financially support the family and siblings; they have to provide food, clothing and shelter for the siblings, and to deal with the emotional well-being of their siblings. OVCs in CHH, therefore, are faced with a serious challenge or threat to loss of education if they have to drop out of school to find “piecework”. They are also faced with the psychological trauma of witnessing a parent’s illness, or dealing with the death of a parent and then the absence of adult guidance and mentoring.

#### **2.4.2 Psychological Challenges**

The loss of a parent can deprive a child of a family environment crucial to the development of a positive self-identity and self-esteem. Separation from biological parents and family at a young age leaves children with unfulfilled psychological and emotional needs. Psychological support is defined by Naidoo (2007:11) as: “the interventions and methods that enhance children’s families’ and communities’ ability to cope in their own context, and to achieve personal and social well-being”.

OVCs experience many negative changes in their lives; and, as a result, are victims of neglect, which includes emotional neglect. In a study conducted in Uganda in 2005, high levels of psychological distress were found in orphaned and vulnerable children (<http://www.avert.org/aids-orphans.htm>). The report shows that anxiety, depression, and anger were more common among OVCs than among other children. The report further shows that 12% of the OVCs interviewed affirmed that they wished they were dead, compared with 3% of other children. These psychological problems threaten to become more severe if they are not addressed, for instance, through counselling.

On a psychological level, children become traumatised by the illness of their parents, which is also exacerbated by the stigma and discrimination attached to such a

circumstance. Because the burden of care and responsibility is likely to fall onto the children in the case of a sick parent or death of a parent, these children experience a loss of childhood (Maqoko et al. 2007:719). Moreover, with the death of their parents they suffer profound loss, hopelessness, grief, fear, and anxiety, which may also not be dealt with appropriately (Smart 2003:8). This exposes them to various forms of trauma. In other words, they can no longer play or rest, and they lose the opportunity of participating in community, religious, and cultural activities, and in sport. Children who have lost one or more parents experience grief and loss that may not be adequately dealt with in an environment lacking psychosocial support.

Dropping out of school can result in emotional distress and social isolation: interaction with peers will become limited. Emotional distress and isolation is worsened by the shame, fear, and rejection that often surrounds people affected by HIV and AIDS (Maqoko et al. 2007:720). Mponshane (2008:13) argues that being a child living in poverty often means having no access to health services, education, and shelter, often being exposed to abuse, exploitation, and discrimination, which all result in emotional distress.

Psychosocial distress also results from economic and financial challenges owing to the death of parents. Because of these financial challenges, OVCs often end up withdrawing from school, no longer being able to pay school fees or to buy necessary school materials.

### **2.4.3 Financial Challenges**

Financial challenges result mainly from the loss of income when parents or caregivers become sick or die because of HIV. The cost of AIDS-related illnesses and death can be high enough to send a household into permanent poverty, or from poverty to destitution (Naidoo 2007:9). HIV can therefore be regarded as perpetuating a cycle of poverty, which results in an inability to access food, clothing, and shelter. Because of this, children have to forego education; instead assuming the adult role of providing for their families. Further pressure may be exerted by increased health-care costs, and eventually funeral costs.

Owing to HIV and AIDS, OVCs are increasingly pressured to contribute financially to their homes. This forces them to go onto the streets, to seek food for their families, and to escape their daily challenges. Whilst on the streets, they are exposed to many forms of exploitation, such as drug-abuse, child labour, child prostitution and rape, which makes them more vulnerable to contracting HIV.

The report (Tsheko 2007:18) further indicates that a number of OVCs are exploited by the local business community, who hire them as labourers to do various heavy and hazardous jobs. OVCs are then often grossly underpaid at the end of the job, or in some cases are given food as a form of payment. Usually, business people engage OVCs as daily-paid labourers instead of appointing them as permanent staff (Tsheko 2007:18).

The results of the study conducted by Kuo and Operario in KwaZulu-Natal (date unknown) indicates that HIV perpetuates a cycle of poverty and unemployment, linked to an inability to access food, clothing, and shelter (Kuo et al. [sa]: 4). The study also indicated that parental deaths result in changes in households, which may exacerbate financial challenges. For instance, this occurs when the income that was brought in by parents disappears after the death of the parents, particularly when they were doing “piecework” or other informal work.

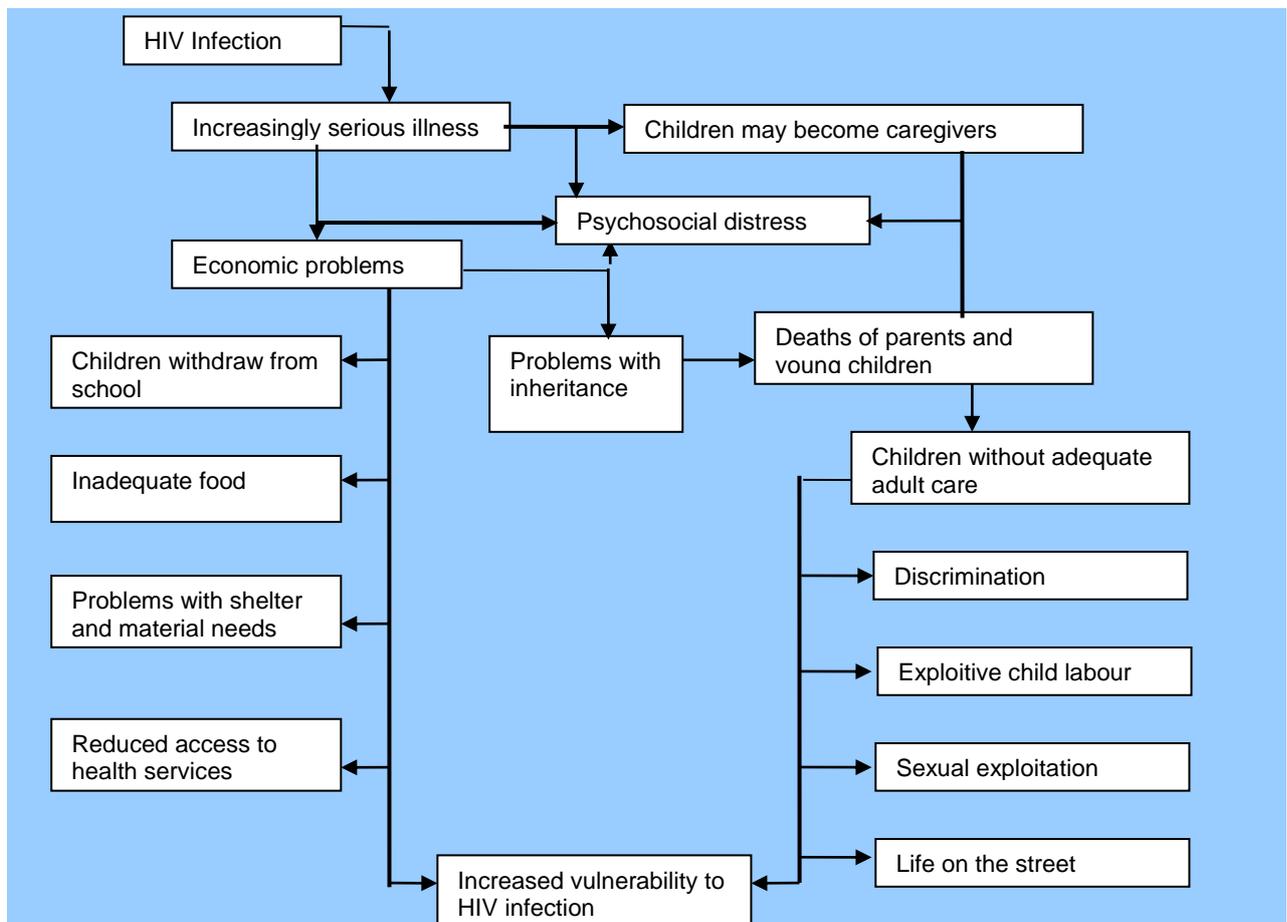
Some of the factors contributing to financial challenges were reported in this study as administrative and eligibility barriers in the state-supported social grant system (Kuo et al. [sa]:4). The documents required by the Department of Home Affairs and the Department of Social Development for processing applications for social security grants, are not always available. For instance, in some cases, the caregivers or guardians do not have parents’ death certificates; or the children themselves do not have birth certificates, which are required by the DSD for the processing of social grant applications.

Furthermore, socio-economic consequences include HIV and AIDS-related illnesses and deaths among adults in their productive years, which impacts on the economy through a high rate of absenteeism and reduced productivity.

Children between the ages of 6 and 14 years old are supposed to be at school, however, owing to the living conditions of OVCs in CHH, this is not always possible. It is anticipated that, for approximately 5% of these children, obtaining sufficient basic resources will be a significant challenge (TCF 2003). For instance, they do not have money to buy school uniforms or stationery, nor to pay school fees. This is indicated in the unpublished research which was conducted by the Thandanani Children’s Foundation in 2003 in South Africa. Their findings indicated that OVCs lack basic resources such as clothing, school uniforms, and food (TCF: 2003).

In another study conducted by Mahati et al. (2006:26) in two districts of Zimbabwe (Bulilimangwe and Chimanimani), it was found that the housing conditions of OVCs were generally fairly good, most of them living with their extended families or neighbours.

**Figure 7: Problems among children and families affected by HIV and AIDS**



Source: Smart 2003:8

Figure 7 above indicates various problems and challenges experienced by children and families affected by HIV and AIDS. It also shows the way in which the impact of living with HIV causes social, psychological, and financial distress.

By contrast, the research conducted in 2007 by the HSRC in Central Eastern Botswana indicates that the majority of households consisting of OVCs were reported to lack necessities such as housing, proper sanitation, and water. The house structure was also reported as of concern, housing being an important factor in caring for OVCs. Some OVCs were reportedly living in incomplete housing structures or in overcrowded houses or in houses lacking hygienic conditions (HSRC 2007:14). Often homes leak during heavy rains: it could be unsafe to live in these houses. The death of parents was cited as the key factor which impacts negatively on the living conditions of these children. The HSRC study (2007:15) also found that there is a significant number of OVCs living under difficult conditions, with no food, proper clothing, and other necessities of life. In these cases the OVCs looked malnourished and wore ragged clothing (HSRC 2007:15).

In such situations it is unlikely that many of the needs of the OVCs will be met. It is therefore essential that appropriate social and material support for these families and their communities is provided, if the needs of orphaned and vulnerable children are to be adequately addressed.

HIV and AIDS and poverty are placing the extended family network traditionally existing in Africa and South Africa under severe strain (Smart 2003:7). As indicated above, after the death of their parent(s), OVCs are likely to be cared for by their grandmothers, a situation which has led to an increase in the number and size of extended families.

## **2.5 RESPONSIBILITY FOR TAKING CARE OF OVCS**

As stated above, children affected by HIV and AIDS are at an increased risk of losing the care of their parents, even before one or both parents have died. They are more likely than other children to be living with a step-parent, within an extended family or with a biologically unrelated family. While these traditional community coping

mechanisms are often protective, studies have shown that children living in these arrangements are less likely to receive an equal share of the household resources, the biological children of the primary caregivers often being favoured (UNICEF 2007:16). This is particularly the case when resources are scarce and are not sufficient to cater for the direct family of the primary caregivers.

The task of caring of OVCs is affected negatively during and after a parent's illness, the OVCs being expected to take the responsibility of caring for their sick parents or their siblings. Girls often take on significant responsibilities in the running the household when their parents become ill. Boys are taken out of school in order to take piecework from community members, such as washing cars and helping in the local shops. Children who have lost their parents are also more likely to be separated from their siblings, compounding their sense of loss, displacement and emotional distress, often being placed in some or other form of institutional care (UNICEF 2007:16).

The question of who should bear the cost of raising OVCs and who should take care of them therefore becomes critical. However, there is no convergence of views on the most appropriate approach to this matter. While there are many perspectives, they generally fall within two broad categories, the first being that OVCs should be the responsibility of the government; the alternative view being that extended families should shoulder the responsibility of taking care of OVCs. There is also a belief that OVCs should grow up in their communities of origin, and that supporting a community-based approach could be cost-effective (Salaam et al. 2005:3).

After the death of the parents, OVCs are often "informally" adopted by relatives or neighbours. The extended family generally constitutes the major resource for caring of OVCs (Foster et al. 2005:241). The role that is played by extended families is often overlooked, this being an informal and spontaneous form of fostering. The studies conducted by several researchers indicate that living with extended families is often preferred by OVCs themselves, as they are usually not isolated, but "informally adopted" and accepted as part of the "whole family" (Foster et al. 2005:243).

In a study conducted in Zimbabwe (Mahati et al. 1996), the caregivers (most of whom were not related to OVCs) mentioned two main reasons for taking care of OVCs. The first reason was that their parents were deceased, and therefore the children had no one else to take care of them. Secondly, these children were being neglected as their extended families could not provide care for them. As a result of poverty, relatives fail to adequately provide the children with basic necessities such as food and clothing.

In sub-Saharan African societies and communities, the role of women as primary providers of care within the family and community is prominent, a role that is often underestimated (Muller 2005:53). Muller points out that the roles of women in the household include collecting wood for fire and water, food production and preparation, cleaning the house, taking care of children and socialising with community members. Within the HIV and AIDS context, there are additional activities that women are expected to do, which include bathing the affected person, cleaning up after him/her, feeding those who are too ill to feed themselves, escorting the sick person to and from the toilet or clinic, and providing emotional support.

Furthermore, it appears that the majority of OVCs are accommodated within their communities; very few are housed in places of safety, owing to lack of sufficient resources. However, the traditional extended family system that used to take care of orphaned children is in many instances disintegrating; households are becoming more nuclear-family centred. This has at times led to children being forced to take care of their own siblings in CHH, after losing their parents, not having adult relatives to care for them (Muller 2005:55).

## **2.6 CONCLUSION**

Children who are orphaned and vulnerable are faced with number of challenges. The various studies discussed above have highlighted the immediate needs of OVCs as being food, clothing, and shelter. However, most OVCs are struggling to meet their needs. They are growing up in difficult conditions, which results in some of them having no access to food at least once a week. The increase in numbers of orphaned children has also resulted in a number of children living in child-headed

households. The death of parents, owing to AIDS-related illnesses and poverty has augmented the number of children who are orphaned, as well as those who live in CHHs.

The following chapter will focus on the policies developed and implemented by various government departments, aimed at addressing the challenges faced by OVCs; also the various services provided by government departments and civil society. The chapter will further discuss three theoretical frameworks that will guide the focus of the research, that is, Integrated Development Approach, Community Development Approach, and Social Network Theory.

## **CHAPTER 3**

### **SERVICE PROVISION TO OVCs**

#### **3.1 INTRODUCTION**

The South African government, through its departments as well as non-governmental organisations (NGOs), has developed a number of policies aimed at addressing the AIDS epidemic. In addition, a number of services are rendered by the government departments and NGOs which tackle the needs of, and the challenges faced by OVCs. The services rendered include providing material, financial, and psychosocial support to OVCs and their primary caregivers. However, these services are not always integrated or coordinated, which hinders their effectiveness at community level. Often, service providers target the same communities, and the same OVCs, duplicating the services.

There are several theoretical frameworks that guide qualitative research, depending on the focus of the research. For the purposes of this study, the conceptual frameworks that will be discussed, which are relevant to the study, are the Community Development Approach, the Integrated Development Approach, and the Social Network Theory.

This chapter will therefore focus on various policies and legislations guiding the implementation of OVC programmes in South Africa. It further examines services provided by government departments and civil society to OVCs and their primary caregivers. The chapter concludes by outlining the three theoretical frameworks that will guide the study.

#### **3.2 POLICY AND LEGISLATION SUPPORTING OVCs IN SOUTH AFRICA**

##### **3.2.1 Policies supporting OVCs in South Africa**

The South African government has put in place a number of policies and certain legislation which provide guidance on the way in which issues affecting OVCs in the country should be addressed. These include guidelines on the response of organisations and government departments providing services to OVCs to the

challenges faced by OVCs. Each of these policies has built-in mechanisms to ensure that the rights of children in general, and OVCs in particular, are protected (DSD 2005:27).

### **3.2.1.1 Department of Social Development National Action Plan (2009 –2012)**

The aim of the National Action Plan for the Department of Social Development (2009 – 2012) (NAP) is to define the roles of various stakeholders (which includes government departments and civil society) in addressing the social impact of HIV and AIDS in general (DSD 2009:3). This National Action Plan also stipulates interventions to reduce the impact of HIV and AIDS on OVCs. The NAP articulates clearly the key interventions for each of its strategic goals, and the monitoring indicators for each intervention. The six strategic goals of the NAP, which overlap with the RAAAP's strategy framework and the UNICEF's strategy discussed in 2.2.2 of chapter 2, are as follows:

- *Strategic Goal 1: Strengthen and support the capacity of families to protect and care for OVCs*

The NAP intends to enhance the early identification of OVCs, child-headed households and their families who qualify for care and support services. The identification process should involve harmonising and standardising the database of OVCs receiving care and support services from government departments and the NGO sector. The NAP stipulates the care and support services that are to be offered to OVCs, which should include nutritional support, material support, psychosocial support, social security, educational support, and shelter (DSD: 2009).

The NAP further identifies interventions regarding the improvement of psychosocial support provided to OVCs, which include training community caregivers (CCGs), health-care providers, educators and primary caregivers on psychosocial issues. The NAP also intends to strengthen household economic capacity through food security by strengthening school nutritional programmes and by linking households to sustainable development (DSD 2009:20).

- *Strategic goal 2: Mobilise and strengthen community-based responses for the care, support, and protection of OVCs*

The NAP aims at increasing the mobilisation of community-based responses for the care, support, and protection of OVCs, in order to develop competent communities able to provide support, protection, and care to OVCs. This also involves facilitating the participation of local authorities in the care and support of OVCs and strengthening the capacity of NGOs, FBOs, and CBOs, so that they are able to provide improved services to OVCs (DSD 2009:21).

- *Strategic goal 3: Ensure that relevant legislation, policy, strategies, and programmes are in place to protect the most vulnerable children*

The NAP aims at enhancing the comprehensive protection of OVCs through policy and legislation by reviewing current policies, developing relevant guidelines, and by the dissemination of these policies and guidelines to all government departments and organisations providing services to OVCs. Strategic goal 3 further seeks to strengthen the referral system that will result in OVCs' accessing relevant services and support (DSD 2009:22).

- *Strategic goal 4: Ensure that OVCs have access to essential services*

This goal seeks to increase OVCs' access to essential services through capacitating educators and other community structures with regard to the identification of OVCs and the provision of care and support programmes targeting OVCs (DSD 2009:23).

- *Strategic goal 5: Raise awareness about and advocate for the creation of a supportive environment for OVCs*

The NAP intends to facilitate awareness of the rights of OVCs at every level of society through the implementation of a communication and advocacy strategy. The aim of awareness campaigns is to increase the number of organisations and community members who will be aware of the rights of the OVCs (DSD 2009:24).

This will result in community members being able to take OVCs in their own communities.

- *Strategic goal 6: Strengthen mechanisms which drive and support the implementation of the NAP*

This goal aims to improve the evaluation of OVC programmes through conducting operational research on programmes implemented for OVCs, conducting impact evaluations that will inform policies guiding programmes for OVCs (DSD 2009:25).

### **3.2.1.2 The National Integrated Plan for Children and Youth Infected and Affected by HIV and AIDS, 2000**

The National Integrated Plan for Children and Youth infected and affected by HIV and AIDS (NIP) (DSD 2005:32) was launched in 2000, with the aim of ensuring that individuals (especially children), households, and communities affected by HIV and AIDS, have access to an appropriate and effective integrated system of prevention, care, and support services at community level. The NIP is a joint venture between the Department of Health (DOH), the Department of Social Development (DSD) and the Department of Education (DOE). Services rendered to OVCs as a result of this venture are provided at NIP sites – also known as “drop-in centres”. The objectives of the NIP sites are to strengthen the capacity of families by providing support services to families and communities. These services include the identification and referral of OVCs to appropriate government departments such as Department of Home Affairs (in the case of those children who do not have birth certificates) and assisting primary caregivers of OVCs to obtain social security grants (AFSA [sa]:8)

The DSD is responsible for coordinating the operations of the NIP sites. The coordination of the efforts and expertise of government departments and civil society is critical in addressing the needs of and reaching the majority of OVCs, avoiding duplication, and ensuring the optimal use of available resources (DSD 2005:16).

The NIP further facilitates the provision of relevant services to OVCs by each of the three mentioned government departments. For instance, the DOH is tasked with the

provision of HIV and AIDS counselling and testing (HCT), basic health care which includes health education, bathing of patients at home, and assisting patients at home with taking medication. The DOE is tasked with providing life skills and HIV and AIDS education in primary and secondary schools. The DSD, on the other hand, has been mandated to assist families with social-grant applications, psychosocial support and capacitating community members so that they are able to deal with challenges related to OVCs. The DSD also has to facilitate the development and growth of community-based organisations through training sessions and workshops (DSD 2005:32).

The NIP facilitates the provision of relevant services to OVCs by the three departments through providing financial, material, and human resources to NGOs or CBOs. Services provided at the NIP sites are implemented by local NGOs. For instance, the DOH provides funding to NGOs which covers the salaries of staff, the purchasing of groceries to feed OVCs and which covers administrative costs. The funding provided by the DSD is set aside for the procurement of furniture and equipment for the NIP site, the salaries of staff, and the purchasing of food parcels to be distributed to OVCs (AFSA [sa]:8).

The NIP aims at ensuring that structures of coordination are developed at all levels, that is at provincial, district and local level. For instance, it suggests that forums be established that consist of representatives from the DSD, the DOH, the DBE, civil society, and the community. Through these forums, the participation of representatives from the three above-mentioned government departments, as well as relevant community organisations and leaders, are to be regulated and coordinated (AFSA 2004:11). In other words, the role of these coordination structures is to oversee the operation of the NIP sites, ensuring that all the planned services are available.

### **3.2.1.3 The National HIV and AIDS and STI Strategic Plan for South Africa (2007 - 2011) and the National HIV and AIDS, STI and TB Strategic Plan for South Africa (2012 – 2016)**

In response to the HIV and AIDS epidemics, in 2007, the SA government launched the National Strategic Plan for HIV and AIDS and STI 2007 – 2011 for South Africa (NSP 2007 - 2011), which aimed at providing guidance to relevant stakeholders such as government departments and civil society, on the way in which to address issues relating to HIV and AIDS. The development of NSP 2007 - 2011 is led by the South African National AIDS Council (SANAC) under the supervision of the Deputy President of South Africa. The Department of Health provides secretariat services to SANAC.

The NSP 2007 - 2011 has allocated various tasks and activities to different stakeholders. It clearly identifies relevant stakeholders in the management of HIV and AIDS, as well as the roles and responsibilities of all role players. There are two primary aims of the NSP 2007 – 2011. The first aim is to reduce the number of new infections by 50% by 2011. Secondly, it aims at reducing the impact of HIV and AIDS on individuals, families, communities, and society, by expanding access to treatment, care and support by 2011 to 80% of people infected with HIV (SANAC 2007:10). The NSP 2007 – 2011 has structured possible interventions in terms of four priority areas: many of the important issues related to OVCs are covered under key priority area 2: treatment, care, and support.

The NSP 2007 – 2011 (SANAC 2007:83) identifies the DSD as the leading government department in issues concerning OVCs; thus tasking this department with facilitating the strengthening of the implementation of OVC policy and programmes. For instance, the DSD is tasked with developing mechanisms for identifying, tracking, and linking OVCs to available support services, as well as with monitoring the implementation of the National Action Plan for OVCs. The aim of this intervention is to increase the proportion of OVCs who are able to access social grants and other support services.

Goal eight of the NSP 2007 – 2011 addresses the mitigation of the impact of HIV and AIDS and the creation of an enabling social environment for treatment, care, and support, through strengthening the implementation of OVC policy and programmes. The interventions indicated in the NSP 2007 – 2011 include the monitoring of the NAP as it relates to the OVCs, identification of OVCs and CHH, and increasing access to services targeting OVCs.

After the expiry of the NSP 2007 – 2011, SANAC led and coordinated the process of developing the National Strategic Plan for HIV and AIDS, STI and TB 2012 – 2016 (NSP 2012 - 2016), which was launched in December 2011 by the President of South Africa. This plan is driven by a long-term vision for the country with respect to the HIV and TB epidemics. The NSP (2012 - 2016) is based on a twenty-year vision, with the following objectives:

- Zero new HIV and TB infections;
- Zero deaths associated with HIV and TB; and
- Zero discrimination associated with HIV and TB

The NSP 2012 – 2016 has included TB in its mandate. This stemmed from the high co-infection rate (co-infection rate refers to people who are infected with both HIV and TB) (SANAC 2011: 9). The NSP 2012 – 2016 further identifies OVCs and youth as among the key population groups targeted for HIV and TB interventions. These interventions aim at mitigating the impact of HIV and TB, as well as breaking the cycle of ongoing vulnerability (SANAC 2011:24).

The NSP 2012 – 2016 defines specific interventions aimed at mitigating the impact of HIV and AIDS on those people who are infected and affected by HIV and AIDS. These interventions are critical in providing relevant support to the affected individuals and communities, and in breaking down the vicious cycle of ongoing vulnerability and infection from generation to generation (SANAC 2011:30).

The strategic objectives and interventions relevant to OVCs, as indicated in the NSP 2012 – 2016, may be summarised as follows:

**Table 9: Summary of strategic objectives, interventions, and key activities targeting OVCs in the NSP 2012 – 2016**

<b>STRATEGIC OBJECTIVES 1: Address Social and Structural Drivers of HIV, STI and TB Prevention, Care and Impact</b>	
<b>KEY INTERVENTIONS</b>	<b>KEY ACTIVITIES</b>
Mitigate the impact of HIV, STIs and TB on orphans, vulnerable children, and youth	<ul style="list-style-type: none"> <li>• Scale up interventions targeting OVCs and youth</li> <li>• Strengthen community initiatives for the protection of rights of OVCs</li> <li>• Involvement and participation of mental health in the provision of support services targeting OVCs</li> </ul>
Reduce HIV- and TB-related stigma and discrimination	<ul style="list-style-type: none"> <li>• NSP 2012 – 2016 proposes the implementation of a stigma-mitigation framework, which provides guidance to government departments, civil society and communities on how to reduce stigma</li> </ul>
Strengthen community systems so as to expand access to services	<ul style="list-style-type: none"> <li>• Tasking provinces to implement strategies by which to support municipalities and local communities, stating that these strategies should be reflected in the Integrated Development Plans (IDPs)</li> </ul>
Support efforts aimed at poverty alleviation and the enhancing of food security programmes	<ul style="list-style-type: none"> <li>• CHH to be prioritised for poverty alleviation programmes, ensuring that needs such as food, shelter, and access to health and social services are fast-tracked</li> </ul>
<b>Strategic Objective 2: Prevent New HIV, STI and TB Infections</b>	
Reduce by 2016, the transmission of HIV from mother to child to less than 2% at six weeks after birth and less than 5% at 18 months of age	<ul style="list-style-type: none"> <li>• To facilitate provision of appropriate treatment, care, and support to mothers and their infants living with HIV</li> <li>• To establish appropriate referral mechanisms for care services to OVCs and women</li> </ul>

Source: SANAC 2011

Table 10 below indicates the core indicators, relevant to OVCs, which will be implemented and monitored under the NSP 2012 – 2016. The table further identifies key indicators that will be used at national level to measure the implementation and outcomes of programmes and services aimed at OVCs.

**Table 10: Indicators monitoring OVC programmes, identified by the NSP**

<b>Strategic Objectives</b>	<b>Core Indicators</b>	<b>Definition</b>	<b>Target for 2016</b>
Address Social and Structural Drivers of HIV and TB Prevention, Care and Impact	% OVCs aged 0-17 whose households received free basic external support in caring for the child	Coverage of OVC Programmes	90%
	Current school attendance among both OVCs and non-OVCs aged 10-14	Progress towards preventing relative disadvantage in school attendance among OVCs, versus non-OVCs	100%
Ensure the protection of Human Rights, improving access to Justice	Human rights and equality violations	Proportion of cases on abuses of human rights and gender equality finalised by the relevant body	Not specified
	Number of people accessing legal services targeted at women and children, and victims of sexual violence	Progress in accessibility to legal supports	Not specified

Source: SANAC 2011

#### **3.2.1.4 National Guidelines for Social Services to Children infected and affected by HIV and AIDS**

The National guidelines for social services to children infected and affected by HIV and AIDS were developed by the Department of Social Development in the year 2000. The aim of these guidelines is to assist relevant organisations and individuals providing services to children infected and affected by HIV and AIDS. These guidelines assure that the provision of community-based care and support takes into account community needs and cultural practices, and that the rights of children are protected (DSD 2005:33). The guidelines provide information on the way in which to establish and implement special programmes, including home and community-based care and support which also caters for OVCs. It therefore serves as a step-by-step guide on how to develop community-based structures, which will also strengthen poverty-alleviation programmes in affected areas.

These national guidelines (DSD 2000:1) are used as an instrument for:

- the development and implementation of approaches that mobilise and capacitate children, families, and communities to address the effects of the HIV and AIDS epidemics;
- strengthening access to integrated services that address the basic needs of OVCs, which include basic health care, education, protection from abuse and exploitation; and
- the development of an inter-sectoral strategy facilitating proactive responses, which focuses on the rights and needs of children infected and affected by HIV and AIDS.

#### **3.2.1.5 The National Policy on HIV and AIDS for Learners and Educators in Public Schools**

In September 1999, the then Department of Education (DOE) launched a national policy on HIV and AIDS for learners and educators in public schools. The policy emphasised non-discrimination and the equality of learners, stipulating that learners living with HIV may not be unfairly discriminated against, but should be treated in a

just manner (DOE 1999:7). This means that learners and students who are living with HIV and AIDS have the right to attend any school, as is the case for any other child.

The policy further states that learners living with HIV may not be denied admission to or continued attendance at school on account of their HIV status (DOE 1999:7). The policy also prohibits the HIV testing of a learner as a prerequisite for admission or continued attendance at school. No learner is compelled to disclose his or her HIV status to the school.

### **3.2.1.6 HIV and AIDS strategy for the Department of Basic Education**

The Draft Integrated Strategy on HIV and AIDS 2012 – 2016 of the Department of Basic Education (2010:19) proposes that the Department's policies targeting vulnerable children aim at mitigating barriers to retention of learners, and achievement in school for learners infected with and affected by HIV and AIDS. The Department of Basic Education argues that policies targeting vulnerable children could have a positive impact in that such policies could ensure that OVCs remain in school.

This strategy document further aims at facilitating access to universal primary education, which is the target of the Millennium Development Goals (MDGs). This MDG aims at instituting care and support programmes for OVCs, such as school feeding and no-school-fee programmes. The school feeding and no-school-fee programmes are expected to improve enrolment numbers and the retention of learners (DBE 2010:19).

### **3.2.1.7 National Health Insurance in South Africa – Policy Paper (DOH 2011)**

The aim of the National Health Insurance (NHI) is to provide improved access to quality health services of all South Africans irrespective of whether they are employed or not (DOH 2011:18). The DOH (2011: 4) indicates that the NHI will be phased-in over a period of 14 years, and that implementation of the NHI will result to all members of the community accessing a defined comprehensive package of

health services at all levels of care. This also includes orphaned and vulnerable children, as members of the community.

The NHI will be implemented in three phases as follows:

- Phase 1: Pilot phase in 10 districts (2012-2015), this phase also include the strengthening of the health system
- Phase 2: Phasing-In of National Health Insurance – Second Phase (2016-2020)
- Phase 3: Phasing-In of National Health Insurance – Third Phase (2021-2025)

The NHI (DOH 2011:24) further indicates that primary health care services shall be delivered according to the following three streams:

a) District Clinical Specialist Teams

District-based clinical specialist support teams are responsible for supporting the delivery of priority health care programmes at a district level. The role of the District Clinical Specialist Teams is to provide clinical support and oversight particularly in those districts with a high disease burden

b) School-based Primary Health Care services

The NHI (DOH 2011:25) indicates that school health services will be delivered by a team that is headed by a professional nurse. The services will include health promotion, prevention and curative health services that address the health needs of school-going children, including those children who have missed the opportunity to access services such as child immunization services during their pre-school years.

The other areas of the school health programme will include a focus on child and sex abuse, oral health services, vision screening services, eradication of parasites, nutritional services, substance abuse, sexual and reproductive health rights including family planning services, and HIV and AIDS related programmes (DOH 2011).

### c) Municipal Ward-based Primary Health Care Agents

The NHI will further facilitate that health services are available at a ward level. A team of health workers, called PHC agents will be deployed in every municipal ward to provide health care services to allocated families in the community. At least 10 people will be deployed per ward, which will be led by the health professional depending on availability. Each member of the team will be allocated a certain number of families (DOH 2011).

The teams will collectively facilitate community involvement and participation in identifying health problems and behaviours that place individuals at risk of disease or injury; vulnerable individuals and groups; and implementing appropriate interventions from the service package to address the behaviours or health problems (DOH 2011).

### **3.2.2 Legislation supporting OVCs in SA**

The following legislation contains sections that protect the rights of children in South Africa.

#### **3.2.2.1 The Constitution of the Republic of South Africa, 108 of 1996**

The Constitution of the Republic of South Africa (RSA), as the supreme law of South Africa, has been founded on the values of freedom, equality, non-racism, and human dignity. Section 28 of the Constitution of RSA focuses on rights that children have in addition to all other rights contained in the Bill of Rights. The Constitution of the RSA (1996:13) defines the rights of the children as including:

- a name and nationality from birth;
- family care, parental care, or appropriate alternatives of care when removed from the family environment;
- protection from maltreatment, neglect, abuse, or degradation;
- access to basic nutrition, shelter, and basic health care and social services;
- protection from exploitative labour practices.

### **3.2.2.2 The Children's Act No 38 of 2005**

The parliament of the RSA passed the first Children's Bill in December 2005, signed into law in June 2006, by the former president of South Africa, Mr Thabo Mbeki. The Children's Act No 38 of 2005 sets out principles relating to the care and protection of children. It defines parental responsibilities and rights, and makes provision for matters such as children's courts, adoption, and methods of dealing with child abduction (The Children's Act No 38 of 2005:40).

The Children's Act No 38 (2005:96) further specifies that children in need of care include those who are abandoned, orphaned, who live on the street, or who beg for a living, as well as children who are exploited or who are in a physical state of neglect.

### **3.2.2.3 The South African Schools Act No 84 of 1996**

The South African Schools Act No 84 of 1996 makes school attendance compulsory for children between the ages of 7 and 15 years of age. It states that learners may, under certain conditions, be exempted from the payment of school fees. This Act further stresses the need for all public schools to provide equal education to all learners regardless of their differences, such as those based on race and gender. It further states that schools must admit all children and meet their educational requirements without unfairly discriminating against them in any way (DBE 1996).

### **3.2.2.4 The National Health Act No 61 of 2003**

The National Health Act No 61 of 2003 recognises children as a group of people who require special attention, allowing for the provision of free primary health care to children under the age of six years who are not members or beneficiaries of a medical aid scheme. This Act further states that the Minister of Health should provide health services to vulnerable groups, which include women, children, disabled persons, and pensioners (Department of Health 2004:18).

### **3.2.2.5 The Social Assistance Act No 13 of 2004**

The Social Assistance Act No 13 of 2004 provides for the rendering of social assistance to needy people. This Act was amended in 2004 to further regulate the provision of social grants and financial awards to certain categories of persons and bodies. The Social Assistance Act No 13 of 2004 (DSD 2004:10) stipulates, for example, the criteria for eligibility for child-support grants, which allows for primary caregivers to receive a Child Support Grant (CSG) amounting to R300 per month until the child reaches the age of 18 years.

The Act specifies that for a primary caregiver to qualify for the CCG, the child (i) must have been born after the 31<sup>st</sup> December 1993, (ii) must not be cared for by a state institution, and (iii) must reside with a primary caregiver who is not paid to look after the child. (<http://www.services.gov.za/services/content/home/servicesfor-people/socialbenefits>).

### **3.2.2.6 Local Government: Municipal Systems Act No 32 of 2000**

The Municipal Systems Act 32 of 2000 is the foundation of development in the local government sphere in terms of setting out core systems, principles and processes for the alleviation of poverty. This Act focuses on, amongst others, community participation, integrated development planning and performance management. Part 3 of Chapter 5 of this Act stipulate that the each district municipality must adopt a framework for integrated development planning in the area as a whole. This should be a consultative process with all relevant stakeholders in the area, including community members.

This Act, chapter 8, further requires that municipalities give effect to the provision of the Constitution and:

- give priority to the basic needs of the local community
- promote the development of the local community, and
- ensure that all members of the local community have access to basic municipal services.

In obtaining the critical development priorities, municipalities are guided by the development framework through which its development strategies are aligned with those of provincial and national development plans in order to provide appropriate services to the communities.

### **3.3 SUPPORT SERVICES FOR OVCs**

Children affected by HIV and AIDS need support in a wide range of areas, which include material, psychological, and legal support and protection. The type of support that is provided to children affected by HIV and AIDS, either by individuals, community members or service-providers is both material and non-material assistance (Gumede 2009:30). Various service-providers, also the SA government, such as government departments, NGOs, CBOs and FBOs, are rendering diverse services to OVCs. Services provided to OVCs are generally provided by community-based organisations. These are usually supported by government departments, in some respects enhancing community development.

#### **3.3.1 Community-based support for OVCs**

Community development is defined as a process of organisation, facilitation, and action allowing people to create a community in which they want to live, through a conscious process of self-determination (Maser 1997:101). Maser further states that community development is a process by which the ideals of sustainable development may be implemented, by both allowing and encouraging people to act as catalysts for sustainable social change at community level.

Further, community-based care and support enables community members, families, and individuals to have access to services nearest to home, encouraging community participation. The aim of providing community-based care and support services is to facilitate the provision of continued services to OVCs, ensuring that OVCs have access to basic services, such education and basic health care (DSD 2000:11).

The types of support provided to OVCs and their caregivers by communities may be categorised in terms of (i) material and financial support; (ii) education and skills training; and (iii) protection and legal support.

### **3.3.1.1 Material and financial support**

Material and financial support refers to the type of support provided by organisations supporting OVCs by, for instance, issuing of stipends, financial assistance, and food parcels to families who care for OVCs. Salaam (2005:14) argues, however, that providing OVCs with material support can result in these children being exploited. For example, people who provide material support to OVCs may expect that the OVCs repay them in kind, which might include sexual favours.

Further, it is possible that NGOs, CBOs and FBOs provide OVCs with materials that are sub-standard. OVCs will accept these, being they are in need of support. Nevertheless, this problem can be minimised if communities are involved in these projects, and are empowered in terms of how to monitor the care and support that is provided to OVCs. Salaam (2005:14) further states that school feeding programmes and community cooperatives have been found to be effective strategies for supplementing the care provided by individual members of the community; and that these minimise the likelihood of abuse.

### **3.3.1.2 Education and skills training**

One of the key strategies in breaking the cycle of poverty and vulnerability to HIV infections is the providing of education and skills training (Salaam 2005:15). Some organisations provide educational support to OVCs, such as school uniforms and stationery, thus ensuring that OVCs remain in school.

Other organisations provide vocational skills training to OVCs, with the idea of assisting children to obtain a source of income. These training programmes can have additional benefits, particularly for girls, as it is expected that those who have participated in the vocational skills training will be exposed to various opportunities. This is because vocational training programmes empower children with a variety of skills, such as sewing, cooking, baking, etc. With the relevant support the children can, for example, once they have been trained, bake and sell to their communities.

### **3.3.1.3 Protection and legal support**

In households headed by children who are solely responsible for their sibling(s), either in CHH or where parent(s) are ill, OVCs struggle not only to support the household but also to keep their homes. In an effort to help OVCs and their parents living with HIV, and to prevent their properties being taken away by relatives or community members, USAID supports organisations working with parents living with HIV to plan for the future of their children through will-writing and other succession-planning initiatives (Salaam 2005:16).

### **3.3.2 Government-based support for OVCs**

Government-based support refers to the support that is provided by the government to communities and to OVCs in particular, which include:

#### **3.3.2.1 Social Assistance**

Social assistance refers to the provision of income transfer in the form of grants. The South African Department of Social Development (DSD) offers support to needy people, which includes OVCs, by providing social and financial assistance to qualifying people in the form of social grants (DSD 2005). The DSD is obligated by law to provide social security for children in need of care, including those children whose parents are unable to provide for their children's needs (Richter et al. 2010: 20). The grants that are available and appropriate to OVCs in this regard include:

##### *3.3.2.1.1 The Child Support Grant (CSG)*

The CSG is given to a primary caregiver responsible for looking after a child younger than 18 years of age. A primary caregiver – this could be a parent, grandparent, or anyone mainly responsible for the needs of the child. is a person seeing to the daily needs of the child.. The grant of R300 per month is given to primary caregivers whose financial situation is below a certain level, determined by a means test. In other words, a means test is used to decide whether one qualifies for the grant.

### 3.3.2.1.2 *The Foster Care Grant (FCG)*

The FCG is provided to primary caregivers who are fostering a child below 18 years of age. A foster child is a child removed from his/her parents or guardian, or whose parents have died, the child being legally placed in the care of a foster parent, in terms of Child Care Act no 74 of 1983 (DSD 2005). The FCG amounts to R800 per month. The main aim of this grant is to assist foster parents in providing basic needs such as food and clothing to OVCs, aiming to reduce the burden to the primary caregiver. The FCG is paid to a foster parent, who is appointed by a court, for as long as the child is under the custody and care of that foster parent (Ritchter et al. 2010: 27).

### 3.3.2.1.3 *Social Relief Grant (SRG)*

The SRG is paid to those persons who have absolutely no money and would not survive without immediate help from the government (DSD 2000:27). It is paid to persons living in poverty, who are in need of immediate temporary assistance (Ritchter et al. 2010: 29). This grant is paid in the form of a money voucher or food parcel, which is given for a period of three months. The amount varies according to the situation at hand. For instance, people who qualify for this grant include those who have applied for another grant which is being processed. The amount of the grant will then be equivalent to the grant being processed (DSD 2000:17).

The report prepared by a social worker working with a particular family or OVCs will determine whether or not an OVC or primary caregiver qualifies for a food parcel or money voucher. The criteria used include assessing whether there is food in the home, and whether the caregiver is able to work (DSD 2000:27). This grant can only be issued for a period of three consecutive months. It can only be extended for a further three months on the recommendation of the social worker (DSD 2000:27).

Even though the government has initiated the above social assistance programmes to address the basic needs of vulnerable children, many OVCs cannot access these social grants (Mponshane 2008:18) as they lack the relevant and required documentation, such as birth certificates and identity documents. Money to pay for

transport fees also becomes a challenge when OVCs and primary caregivers have to go to the offices of the DSD to apply for grants, particularly in rural areas. In many instances it becomes difficult or impossible for OVCs to access social grants, as indicated by Mpontshane (2008:18).

### **3.3.2.2 Child Care Forums**

Child Care Forums (CCFs) are community-based structures focusing on the needs of OVCs in the community, ensuring that these are met (Naidoo 2007:34). The Department of Social Development has the responsibility of developing the CCFs in the communities and ensuring that these are functional. Relevant service-providers such as the Departments of Home Affairs, Health and Education are linked to the CCFs, facilitating relevant support to OVCs and the community (DSD date unknown:66). For example, the CCFs assist guardians or primary caregivers to access child support and foster care grants, by seeing that they obtain the relevant documentation. They then assist them with preparing and submitting applications for social grants to the DSD. Once the application has been successful, the CCFs assist the DSD with the screening and monitoring of foster-care parents seeing to it that children are properly taken care of.

The CCFs usually consist of a group of prominent community-based adults (for instance, retired social workers, teachers, nurses, councillors, and Izinduna) working together to take responsibility for organising support for orphaned and vulnerable children in their community. Izinduna refers to counsellors who act as advisors to traditional Amakhosi (local Chiefs). Members of CCFs provide their services on a voluntary basis, without receiving a stipend or any form of remuneration from the government. The DSD, however, conducts relevant training for the members of CCFs, which includes training on services that are provided by the department to OVCs (Ritchter et al. 2010: 60).

The responsibility of the CCFs is to ensure early identification of OVCs who need support, referring them to relevant role-players for appropriate service provision (Ritchter et al. 2010: 60).

### **3.3.2.3 National Integrated Projects**

The Department of Social Development, in conjunction with the Department of Health and the Department of Education is also implementing the National Integrated Plan (NIP) sites, also known as Drop-in Centres (DICs) or Community Care Centres (CCCs). An NIP site is defined by Ritchter et al. (2010: 62) as “a facility providing services aimed at meeting the emotional, physical, and social development needs of vulnerable children”. As stipulated in the National Integrated Plan for Children and Youth infected and affected by HIV and AIDS, three government departments, that is the DSD, the DOH, and the DOE provide funding to non-governmental organisations (NGOs) for providing services at the NIP sites. The objective of the NIP site is to strengthen the capacity of families, by providing a variety of caring and supportive services to OVCs and their families (AIDS Foundation for South Africa [sa]:3). The services rendered at the NIP sites include Home Community Based Care (HCBC), OVC support interventions, HIV and AIDS awareness and treatment support, as well as poverty alleviation projects.

AFSA ([sa]:18) further reported on the gaps and limitations that hamper effective NIP implementation. Lack of capacity was identified as the main limitation, when funded NGOs had limited knowledge and skills with regard to project management. The report indicates that the three above-mentioned government departments did not provide appropriate project management training to the NIP staff so as to ensure effective and successful programme implementation. The training sessions that were provided targeted only caregivers and not the management staff of the NGO or the NIP site.

The second challenge experienced by the NIP sites, as reported by AFSA ([sa]:51), is inflexibility with regard to delays in procurement. The report indicates that funding by the DSD is usually delayed by two to three months, which makes it difficult for the NIP sites to provide food parcels in time. The DOH is expecting the sites to pay for the first month and then claim for a reimbursement. This means that they have to use their own funds, which are not always available, for the initial purchase.

### **3.3.2.4 Nutrition supplementation programme**

#### *3.3.2.4.1 Nutrition Supplementation Programme*

The objective of the Nutrition Supplementation Programme (NSP), which is led by the Department of Health, is to identify and treat undernourished children and adults at a clinic, also known as a primary health care (PHC) clinic (Ritchter et al. 2010: 89). The Nutrition Supplementation Programme provides vulnerable beneficiaries with food supplements, which include fortified maize meal, high-energy drinks and vitamin A. Children that are targeted for the Nutrition Supplementation Programme, include those under the age of 5 years, who are experiencing growth faltering. Growth faltering occurs when the child's growth curve drops over two consecutive months on their growth monitoring *Road to Health Card* (Ritchter et al. 2010:89).

In cases in which the children are severe malnourished, they are admitted to hospitals, where they are treated and provided with an intensive diet until they recover.

#### *3.3.2.4.2 National School Nutrition Programme*

To address the issues of poverty and malnutrition in children, the Department of Basic Education is also implementing the National School Nutrition Programme (NSNP). The NSNP provides nutrition education, parasite control, and micronutrient and food in the form of one cooked meal per day (Ritchter et al. 2010: 27).

### **3.3.2.5 School support programmes**

The Department of Basic Education is implementing various programmes aiming to retain children in schools, particularly vulnerable children. The DBE has identified schools in poor communities, in which learners may not be charged school or registration fees, these schools having been listed as "no-fee" schools by the Minister of Basic Education in the Government Gazette at end of September of each year. These are schools found in quintiles 1, 2 and 3 (quintiles refer to poverty ranking of the community in which the school is situated) (Ritchter et al. 2010:168).

In addition, the DBE makes provision for the exemption of primary caregivers regarding paying school fees at public schools that are not classified as “no-fee” schools (Ritchter et al. 2010:159). Ritchter et al. (2010:159) identify the following primary caregivers as automatically exempted from paying school fees:

- A primary caregiver who has the responsibility of taking care of a child, including relatives and foster-care parents.
- A person who is in receipt of a social security grant on behalf of a child.
- A child who heads a household or who is part of a child-headed household.

### **3.3.2.6 Residential Care**

Generally, in some communities group housing for OVCs is provided, which may be in residential care or in orphanages. The DSD defines “residential care” as the care of children that is provided in a children’s home (DSD 2000:20). Residential care provides accommodation to more than six children of different ages and gender. In this case, a number of children who are orphaned or vulnerable live in a house with an adult who looks after them. Naidoo (2007:37) regards shelters as a facility located at a specific place, which is managed for the purpose of providing basic services, including overnight accommodation and food, to children who attend the facility voluntarily.

Residential care is generally regarded as an expensive way of looking after OVCs, requiring as it does infrastructure, staff to care for children and services, which are all costly. This is also considered not very beneficial for children, it often being too impersonal, and affording too little contact with adults (<http://www.etu.org.za/-toolbox/-docs/aids/care.html>). UNICEF (2004:19) also states that residential care for OVCs can affect the development of OVCs negatively, as they generally fail to provide for the emotional and psychological needs of OVCs. UNICEF (2004:19) argues that such institutions may be appealing because they can provide food, shelter and education to OVCs.

Research over the past years has confirmed the above view, demonstrating that residential care has a negative effect on children (UNICEF 2007:16). In some instances OVCs from one family are separated and placed in different institutions, or

each member is fostered by a different family. This means that OVCs of the same family often grow up in different places. Widespread stigma also impacts negatively on the well-being of OVCs, for example, stigma often causes workers from hospitals or institutions to treat children living with HIV and AIDS differently from other children, not providing adequate attention to and treatment for them for long periods of time. Once institutionalised, children are often separated from other children in the communities, leading to further stigmatization (UNICEF 2007:17).

### **3.4 THE NEED FOR THE COORDINATION OF ACTIVITIES AND AN INTEGRATED DEVELOPMENT APPROACH.**

The idea of one organisation or role-player as the sole entity that should take responsibility for OVCs, is in contrast to the principles of an integrated development approach in which aid and assistance to the orphaned and vulnerable children and their families are proposed to be provided by a combination of community contributions, and through the involvement of various governmental departments and NGOs (Muller 2005:55).

There are a number of non-governmental organisations, community-based, and faith-based organisations, as well as government departments rendering services to orphaned and vulnerable children, as discussed above in section 3. The coordination of the efforts and expertise of these role-players is needed in reaching all OVCs, avoiding duplication of services, and ensuring the optimal use of resources.

In KwaZulu-Natal, the Office of the Premier plays the role of coordinating services rendered by government departments and civil society. According to the National Department of Social Development (2005:16) the objectives of coordinating services include:

- promoting coordination between all stakeholders at all levels;
- sharing information with regard to issues relating to OVCs and relevant programmes;
- promoting collaboration between stakeholders to improve services and programmes for OVCs; and
- mobilising and disbursing resources to OVCs.

Table 11 below summarises the roles that key service providers are supposed to play in rendering services to orphaned and vulnerable children (DSD 2005). According to an integrated development approach, all the services provided by the above-mentioned service-providers should be available to all OVCs. The service-providers could be divided into two main categories, that is, government departments, and civil society.

**Table 11: Roles of Key Service-Providers**

KEY SERVICE-PROVIDERS		ROLES AND RESPONSIBILITIES
<b>Civil Society Stakeholders</b>	National and Provincial NGOs, CBOs and FBOs	<ul style="list-style-type: none"> <li>• Mobilise and disperse resources</li> <li>• Advocate and lobby for the rights of OVCs</li> <li>• Capacity-building for CBOs, FBOs and other organizations</li> <li>• Develop and manage community-based care and support programmes for OVCs</li> </ul>
	Local NGOs, FBOs and CBOs	<ul style="list-style-type: none"> <li>• Identify OVCs</li> <li>• Strengthen families and community coping systems</li> <li>• Mobilise resources</li> <li>• Provide psychosocial support, spiritual guidance and material assistance</li> <li>• Develop and implement community-based care and support programmes for OVCs</li> <li>• Assist with succession and will-planning</li> </ul>
<b>Government</b>	Department of Education	<ul style="list-style-type: none"> <li>• Educate learners about HIV and AIDS so as to reduce stigma and discrimination</li> <li>• Develop school-based support systems</li> <li>• Develop capacity-building programmes for educators</li> <li>• Develop and ensure referral system to other relevant service-providers</li> <li>• Develop appropriate life-skills programmes for OVCs</li> <li>• Provide primary school nutrition programmes and food fortification</li> </ul>

		<ul style="list-style-type: none"> <li>• Develop and implement Early Childhood Development programme</li> </ul>
	Department of Health	<ul style="list-style-type: none"> <li>• Provide comprehensive treatment, care, and support programme for the management of HIV and AIDS</li> <li>• Implementation of the Protein Energy Malnutrition Programme (PEM) for malnourished children</li> <li>• Implementation of the Expanded Programme for Immunisation which would administer vaccines</li> <li>• Coordinate and facilitate access of all communities to health services</li> </ul>
	Department of Agriculture	<ul style="list-style-type: none"> <li>• Promote and facilitate food security</li> <li>• Provide training to child-headed households and community members regarding food production</li> </ul>
	Department of Housing	<ul style="list-style-type: none"> <li>• Ensure that the housing needs of households affected by HIV and AIDS are addressed</li> </ul>

Source: National Department of Social Development (2005)

An example of an integrated development approach in action is the project of Community Care Centres as discussed in section 2.5 above. Currently the DSD, DOH and DBE are joint implementers of the National Integrated Project, which involves the establishment of Community Care Centres focusing on providing services to OVCs. In these centres the DSD and DOH identify and provide funding jointly so as to enable the rendering of services to OVCs.

### 3.5 CONCEPTUAL FRAMEWORKS

Conceptual frameworks are structured from a set of broad ideas and theories that help a researcher to properly identify the problem they are looking at, frame their questions and find suitable literature. (<http://www.ehow.com/about6664512meaning-conceptual-framework-research.html>). This section deals with the conceptual frameworks which provided guidance to this study.

### **3.5.1 Community Development Approach**

This sub-section highlights three community-based approaches, serving as examples of how individuals and communities can improve the state and lives of orphaned and vulnerable children. The approaches discussed are (i) Community Development (ii) Social Network Theory and (iii) Integrated Development Approach.

#### **3.5.1.1 Community Development**

Community development is defined as “a planned effort to produce assets that increase the capacity of residents to improve their quality of life” (Green and Haines 2007, cited in Phillips 2009:38). It is also defined by some as a long-term approach to the building of active and sustainable communities based on social justice and mutual respect (<http://www.peopleandparticipation.net/display/methods/community+-development.htm>). Furthermore, some theorists argue that community development is about changing power structures, removing the barriers that prevent people from participating in issues that affect their lives, allowing the community to develop solutions on their own.

Community Development is known as a dynamic process which involves diverse social groups (Weil 2013:496). Weil (2013:496) further defines community development as “a self-help economic, physical and social process that involves diverse individuals and groups with the targeted community, engaging community members in decision making and implementation for the benefit of the entire community”.

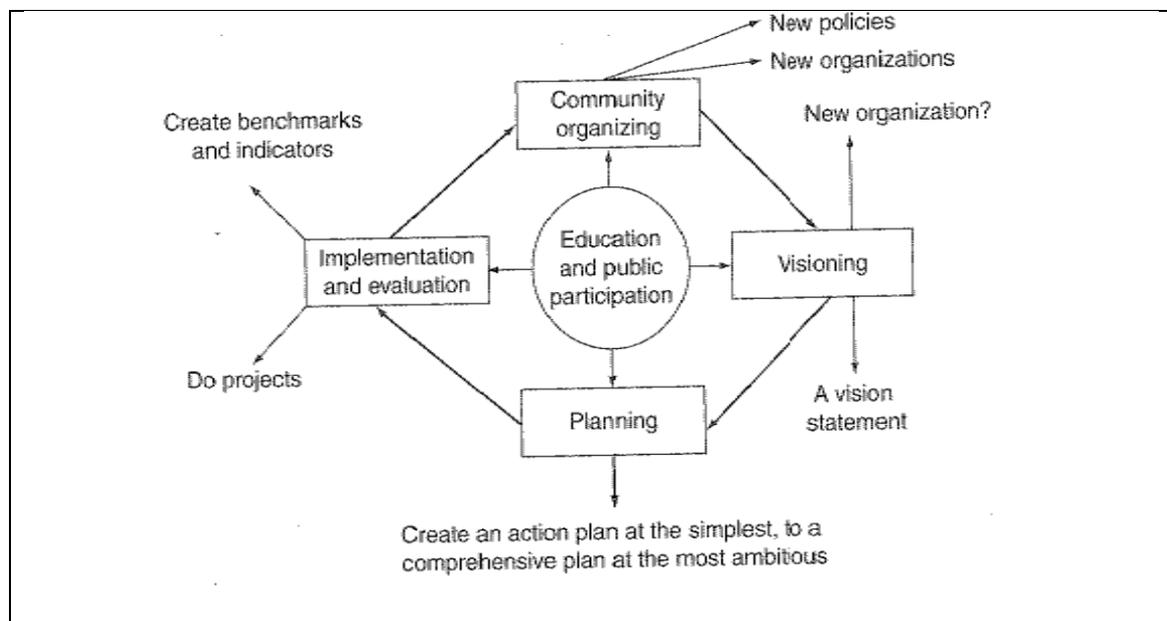
Phillips et al. (2009:6) argue that community development needs to be considered both as a process and an outcome. Community development as a process involves teaching community members how to work together to solve problems, whereas community development as an outcome refers to taking collective action and deriving a result from that action (Phillips et al. 2009:6). Community development can be seen as a mechanism through which community members may empower themselves, learning to take control of their lives in order to create a more fulfilling existence through mutual efforts to resolve shared problems. A community-based

development approach could therefore allow community members to identify the issues of concern related to OVCs, addressing these as a collective.

As a *process*, community development may be described as a collective effort undertaken by a community on its own to identify needs and to formulate specific objectives in order to satisfy these needs. Asset-based community development is one approach to community development, which focuses on building capacity within a community. It looks at the resources available in the community, which could include community members, infrastructure, and communal gardens. By focusing on these assets, members could see the positive aspects of their community and could therefore work together to further develop these assets (Phillips et al. 2009:39).

Some theorists argue that the process of community development starts from community organising, to envisioning, leading on to planning, then to implementation and evaluation, and then back to organising again (Phillips et al.: 2009:42).

**Figure 8: Community development as a process**



Source: Phillips et al. (2009:43)

Figure 8 above indicates the critical components of community development as a process. The process begins with community organising. This focuses on mobilising key community members who could be part of a particular activity. This is followed

by envisioning that which would assist in establishing the future of a community. The vision for the community is developed through consensus among community members. Once this is accomplished, the community can develop an action plan specifying all critical activities to be conducted. Lastly, the process involves implementing activities that are indicated in the action plan. As part of implementation, the activities conducted should be monitored closely (Phillips 2009:43).

**Table 12: Elements of community development**

<b>COMPONENTS</b>	<b>DESCRIPTON</b>
Build on community assets	This focuses on the resources available in the community, e.g. skills and knowledge of community members, and community structures and leadership.
Increase skills of community members	Through community development, it is anticipated that members of the community will gain more skills such as facilitation, organising and fund-raising skills, depending on the activities on which they are embarking.
Community participation	The development of the potential and abilities of community members, in relation to participation, collaboration and self-directedness. This also refers to the involvement of individuals, groups and organisations.
Foster community self-reliance and confidence	Community development helps a community to believe in itself and its abilities. This will assist communities to confront any challenges that they encounter in the future.
Resources	Provision of resources and the equal distribution of resources.
Integration and collaboration	The integration and encouragement of action systems which would collaborate and coordinate activities.

Source: Homan (2004:55).

The table above describes the critical elements of community development as described by Homan (2004:55).

The community work elements, indicated below by Homan (2004) are critical for any community project to succeed. This sets out the way in which a community can work together in addressing its own challenges, starting from identifying a common challenge, finding to a process which addresses that challenge. It highlights the importance of having a common objective and the importance of involving all relevant stakeholders in addressing the challenge. It further emphasises that community development projects require the involvement of community workers, who will lead and guide the process (Homan 2004:55).

### **3.5.1.1 Principles of community work**

The principles of community work provide direction. Wetherell (2009:26) argues that effective community work leads to an integrated society, and that this work consists of three essential features. Firstly, equality; which refers to every community member being treated equally, and all members having the right to a fair outcome. Secondly, community members should be free to participate in any community activities. Lastly, there should be interaction amongst various groups in the communities.

Lombard (1990:73) states that “the principles of community work provide a fundamental basis and the philosophical point for the implementation of the method”. He further identifies the key principles in the execution of community work to include respect for human dignity. This refers to respecting the opinions and the abilities of individual community members. The principle of self-determination promotes the taking of responsibility by the community members in improving their lives. It further encourages involvement and participation of all key stakeholders, including community members (Lombard 1990:73).

The strength of community development lies in communities being assisted to find ways of working together, which will enable them to make changes to their own lives. This means that community members can then work together in addressing the challenges they are facing with regard to OVCs. This is achieved through the

understanding that each community member is unique, and can participate and contribute towards the process of caring for the OVCs in the community (Wetherell 2009:26).

### **3.5.2 Integrated Development Approach**

Similar to the community development approach (CDA), the integrated development approach (IDA) refers to a process whereby key stakeholders plan together with the intention of finding best solutions to achieve long-term community development. It aims at coordinating the work of government and other service providers, recorded in a coherent plan to improve the quality of life of all community members. For the IDA to be effective, planning should take into account the existing conditions in the community, challenges facing communities, and internal and external resources that are available for development (USAID 2005:3).

An IDA is crucial to any community development. (An IDA usually fails because of top-down approaches, where in policies are developed by government without consulting relevant stakeholders. In this case the government and donors are not only focused on the formulation and implementation of policies but have become implementers of those policies. For the IDA to be effective, the roles and responsibilities of all the role players should be clearly defined. For instance, if government departments uphold their responsibility of developing policies and making resources available, communities can assume greater responsibility and become the focal centres of development. An IDA leads to communities taking responsibility and ownership of the development.

An IDA is relevant to addressing challenges faced by OVCs, as the communities can work together with government departments and donors, in responding positively to challenges. The role of government departments and donors could be to provide direction in terms of developing relevant policies and guidelines, and the provision of resources and relevant skills. The community, on the other hand, could be capacitated and empowered with regard to the ways in which challenges faced by OVCs could be addressed; and the way in which OVCs could be assisted with the relevant resources and skills.

One of the strengths of an IDA is that it allows for the pooling of resources by various service providers, which could enhance community development. The pooling of resources could ensure that the government departments who play a critical role in providing support to OVCs do not duplicate services, leaving some communities unattended to. This could enhance the impact of the services provided, and could make it possible for service-providers to also provide services to other communities.

### **3.5.3 Social network theory**

The effectiveness and sustainability of an IDA is also linked to the creation of an effective social network in a particular community. A strong social network could facilitate collective action that could result in integrated and sustainable community development. Social networks also facilitate the flow of information and the exercising of influence among network members (Bruggerman 2007:2). This implies that existing social networks in communities may be used to pass on information and to educate community members on issues related to OVCs.

The SNT states that any social network consists of two elements, that is, nodes and ties. Nodes are the elements of the network that act, whereas the ties are the way nodes relate to one another, or the relationships between the nodes. There can be many kinds of ties between the nodes. In other words, the SNT may be regarded as a map representing all of the relevant ties between the nodes ([http://www.experiencefestival.com/a/Social\\_network-Introduction\\_to\\_social\\_net-works/id/211-3785](http://www.experiencefestival.com/a/Social_network-Introduction_to_social_net-works/id/211-3785)). It is further stated that the shape of the social network determines the usefulness of the network to its individuals. If the networks are smaller and tighter, this means that they are less useful to the members than when they are open and have loose connections; open networks being more likely to introduce new ideas and opportunities, involving as they do more people and connections.

Social networks hold members together, which prevents the community from breaking up (Bruggerman 2007:12). Social networks exist when there are interactions between two or more people, for instance, in families, communities, or the workplace. The SNT states that if there are relations among network members, cohesion is supposedly strong, whereas if there are gaps in the network then

cohesion is presumably weak. Social networks may therefore be used to sensitise and mobilise community members, so that they are able to address the challenges faced by OVCs. Once the information has reached some members of the community, it is transferred amongst members through existing social networks.

Generally, in communities, particularly in African communities, “everyone knows everyone else” therefore there are a number of connections between one person and other community members, which means that information usually moves fast from one area to another. On the other hand, the smaller and more confined the community is, the more limited is the number of people who can be directly reached. The larger and more open social networks are more receptive to and more likely to lead to the development of new ideas and opportunities because they involve more people and connections. Community networks therefore act as cheap and user-friendly referral systems, supplying informal help at times of crisis. They are often resorted to before professional help is requested from the appropriate service-providers (Gilchrist 2009:15).

According to Kadushin (2004:6), at all levels of analysis nodes are more likely to be connected with one another, other conditions being equal, if they are geographically near to one another. He further states that individuals are more likely to be friends or to tolerate one another if they are geographically close. This implies that people from the same community may be more tolerant and sympathetic to OVCs coming from the same community than those coming from other communities.

The SNT is also defined in terms of propinquity and homophily. The SNT defines propinquity as being in the same place at the same time. Studies of elites show that persons are more likely to have a connection, relationship, or friendship if they went to the same school at the same time (Domhoff 1967 cited by Kadushin 2004). In the context of this study propinquity therefore refers to people who are living in the same community at the same time. Community members are more likely to have some connection and to form relationships, particularly African communities. African people generally believe in the adage ‘Umuntu ngumuntu ngabantu’ which means that “you are what you are because of other people”. It is possible therefore for these communities to develop community projects addressing the challenges of OVCs, and

as a result provide a safe and nurturing environment to OVCs. This is because social networks supply to community members informal care and a sense of belonging (Gilchrist 2009:15).

Homophily is defined as having one or more common social attributes, such as being a member of the same social class. Common norms may bring nodes with common attributes together, or the reverse: common attributes and contact may lead to common norms. This holds true for both individuals and collectives (Domhoff 1967 cited by Kadushin 2004). The implications of this are that it could be easier for OVCs to connect with each other and to be able to support and share experiences with one another. The OVCs are likely to connect and feel comfortable with each other as they share similar experiences and challenges.

### **3.6 CONCLUSION**

Government departments, NGOs, FBOs and CBOs, in response to the HIV and AIDS epidemics, have developed relevant legislation and policies and are implementing a number of programmes aimed at addressing the challenges faced by and needs of OVCs. Government policies and legislation is critical in the implementation of any OVC programme, providing guidance on the way in which these programmes and services should be provided to OVCs and their primary caregivers.

The support services provided to OVCs and their primary caregivers are both government and community based. This shows that the two structures are designed to complement each other in the provision of OVC services. The support that is rendered ranges from material support to educational support, to legal support. This indicate that services are generally provided by a number of organisations and government departments, however, this does not necessarily mean that they are accessible to all OVCs. As a result, the question arose about the degree to which services rendered are integrated and coordinated. Non-integration could result in the duplication of services; the support provided by various service-providers is available to only a few OVCs. The research is therefore conducted mainly to assess whether the support provided, whether government or community based, is accessible to

OVCs and their primary caregivers. It will further assess whether the policies are known to and implemented by the government departments and civil society.

There are a number of theories that may be used to define and analyse the issues relating to OVCs. Community development shows that community members can work together to address the challenges faced by OVCs and their families. It shows that communities can organise themselves, once they have a similar goal and can design their own strategies. Various service providers can therefore provide support to communities by capacitating them with relevant skills and knowledge, in order for them to be able to address their own problems.

The following chapter will focus on the research design and methodology that was used to collect the data for this study.

## **CHAPTER 4**

### **RESEARCH METHODOLOGY**

#### **4.1 INTRODUCTION**

This chapter presents the research methodology that was followed when conducting this study. Firstly, Chapter Four aims at defining and explaining the research design that was used, namely a qualitative research design. Secondly, this chapter describes the research setting, and sets out the sampling techniques and methods of data collection that were employed. Thirdly, it explains how the gathered data was analysed and interpreted, identifying the themes and sub-themes that emerged during these processes. Finally, ethical issues that were taken into consideration when the study was being conducted are discussed.

#### **4.2 RESEARCH DESIGN**

The research design is used to guide the researcher through the process of collecting, analysing and interpreting data (Rugg and Petre 2007:62). There are a number of research methods that can be used when conducting various types of research. Owing to the nature of this study, this research was conducted by using a qualitative research design. Qualitative research focuses on the meaning and motivations that underlie cultural symbols, personal experiences and phenomena, and on detailed understandings of processes in the social world (Kalof, Dan and Dietz 2008:79). Qualitative research designs are used to generate rich understandings of research participants' experiences and beliefs. The advantage of using this type of design is that it focuses on fostering a relationship of trust and empathy between the researcher and the research participants, which is important in accessing sensitive and personal information from research participants.

Qualitative research methods give the researcher an opportunity of understanding the research participant's experiences, interpretations, and the meanings he or she attaches to these experiences by focusing on the context of people's everyday lives (Barbour 2008:12). This means that qualitative researchers attempt to understand the experiences and views of their research participants, arguing that people attach different meanings to their and others' behaviour in different settings.

A qualitative approach is appropriate in the case of this study, focuses as it does on understanding the way in which OVCs are defined by various service providers, as well as what is perceived as the needs of and challenges facing OVCs, among other factors. The study is not aiming at focusing on the number of OVCs in need of services. It is rather aimed at gaining an understanding of the context of issues affecting OVCs.

The qualitative research design of this study is informed by ideas that are often expressed from the perspectives of postmodernism and social constructionism as set out below.

#### **4.2.1 Postmodernism**

Qualitative research is usually informed by ideas put forward by postmodernism, which seeks to deconstruct or tear apart the concepts of the “subject” and the “field” to reveal the internal hidden structure (Silverman 2005:98). Unlike modernism, which relies on logical reasoning, postmodernism distrusts all systematic, “objective”, empirical observation and doubts that knowledge is generalizable or accumulates over time. It rejects the assumptions of “universal truths” and “objective knowledge” and takes into consideration the ideas of a multi-verse of reality with multiple meanings and contexts (Tshenkeng 2009:41).

This approach allows for the expression of different perspectives and views, also with regard to the uncovering of the meanings attached to a person’s experiences. The experiences and opinions of the primary caregivers who participated in this study differ in many ways and to subject them to only “one truth” might amount to rejecting one or more individuals’ derived meaning and knowledge. A postmodernist framework fits well with the research design of this study, allowing as it does for the expression of different voices, which is what the study intended to achieve. This allows participants to fully express their experiences and derived meanings without being subjected to or measured against a specific objective view.

#### **4.2.2 Social Constructionism**

Social constructionism is based on understanding of the way in which people construct and make sense of the world they live in and the world of other people who live in it (Kalof et al. 2008:81). It examines the way ideas and attitudes have developed over time within a particular social or community context. A social constructionist perspective is relevant to the methodology of this study in that it emphasises the socially constructed nature of reality, highlighting a person's lived experiences rather than expert knowledge. This study is based on the premise that primary caregivers of OVCs have different experiences with regard to raising OVCs; therefore it is important to understand how their attitudes have developed over time within the environment to which they were exposed.

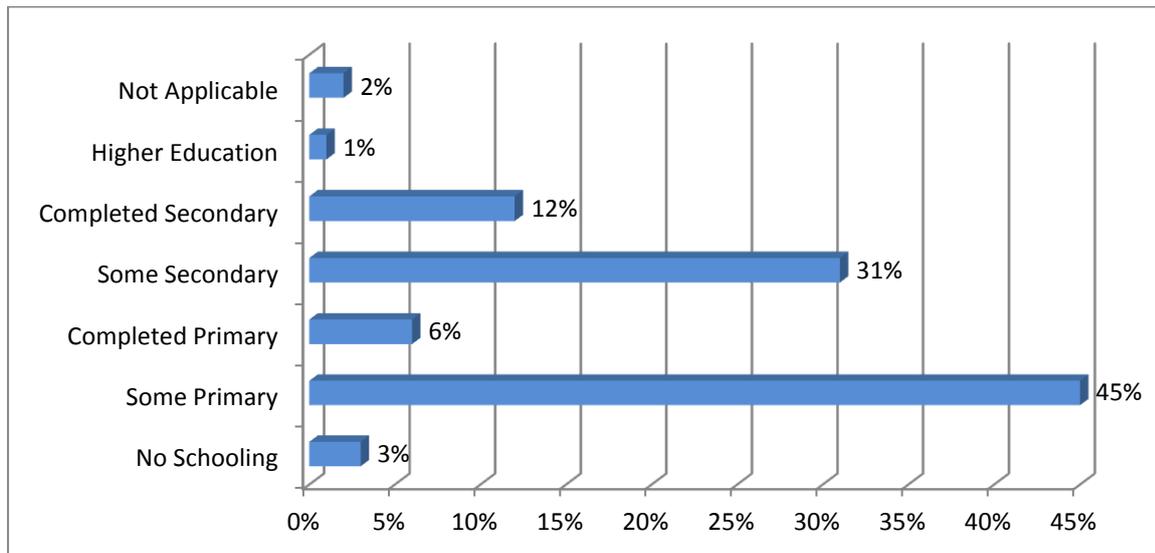
#### **4.3 RESEARCH SETTING**

This study was conducted in the Richmond area, which is one of the seven local municipalities constituting the Umgungundlovu District Municipality. Richmond is situated approximately 45km south of Pietermaritzburg, which is the capital city of KwaZulu-Natal. Pietermaritzburg is the second biggest city in KwaZulu-Natal after Durban, with a population estimated at 521 805 people. It is situated between Durban and Ladysmith and it is located on the national road, the N3. Its population comprises all race groups, that is, Africans, Whites, Indians, and Coloureds. The three main languages that are spoken in Pietermaritzburg are isiZulu, English, and Afrikaans. The area comprises both formal and informal settlements, and poverty-stricken areas (Msunduzi Municipality 2009). The majority of the population of the Umgungundlovu District Municipality is Africans who speak isiZulu.

The Richmond Local Municipality has a population of 65,793 (Stats SA 2011). The majority of the population reside in areas which are predominantly rural and which are characterized by low levels of basic services and facilities, and by substantial unemployment.

Figure 9 below indicates that the majority (45%) of the population in Richmond have some level of primary school, followed by 31% who have some level of secondary school.

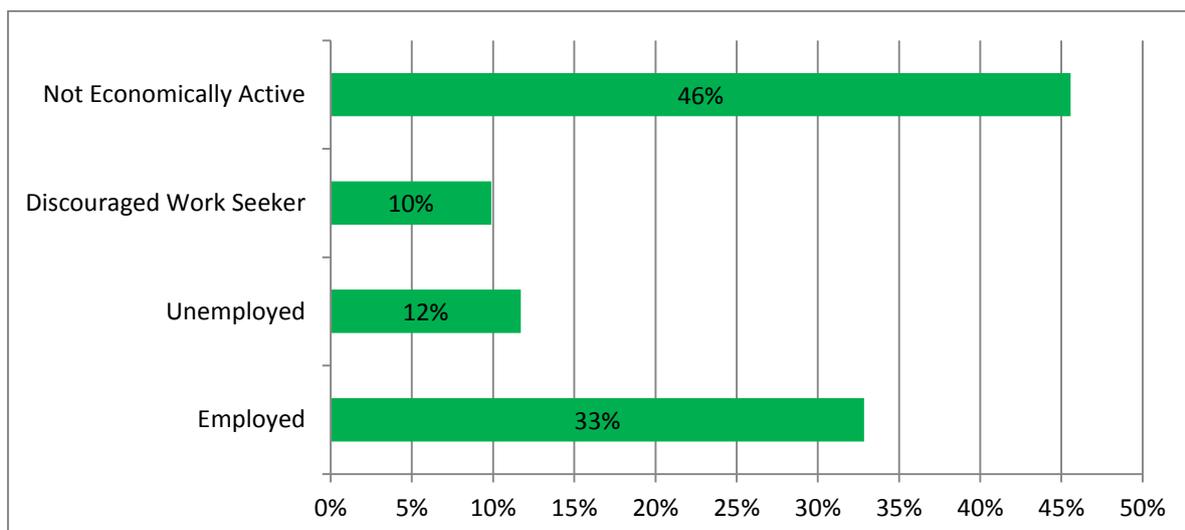
**Figure 9: Highest Educational Level**



Source: Statistics SA 2011

Only 12% of Richmond population have completed secondary school and only 1% reported to have higher education. This indicates that only a few people in Richmond have educational levels that are sufficient for better employment opportunities. The figure further indicates that 3% have no schooling. Figure 9, in conclusion, indicates that literacy levels are low in this area.

**Figure 10: Employment for those aged 15 – 64**

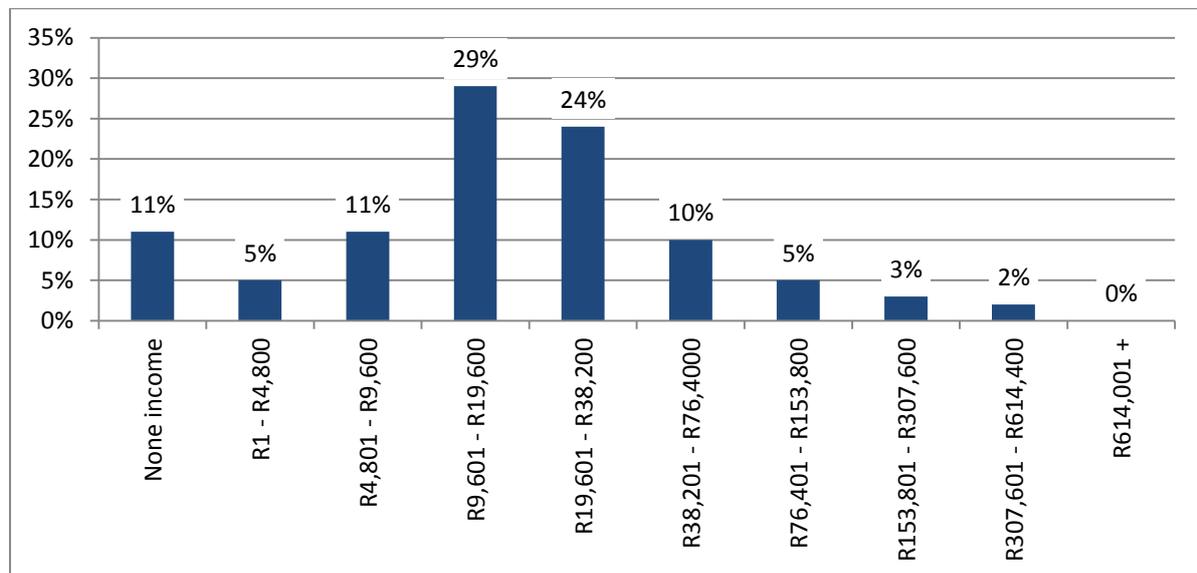


Source: Statistics SA 2011

Figure 10 above indicates that unemployment rate is very high in Richmond, sitting at 68%, where figures for not economically active and discouraged work seekers are included. The figure further shows that the majority (46%) of the unemployed are not economically active and that 10% of the unemployed are discouraged work seekers. Only 33% of the Richmond population is employed. The high figures of unemployment in the area contribute to high levels of poverty.

Figure 11 below indicates that a significant number of people (27%) in Richmond municipalities earn less than R800 per month, and 11% of these have no income. The figure further shows that the majority (53%) of the people in Richmond earns between R9 600 and R38 200 per annum. The highest paid people, which are only 5% of the total employed people in the area, earn between R12 000 and R51 200 per month.

**Figure 11: Average household income per annum**



Source: Statistics SA 2011

The Msunduzi Spatial Development Framework (SDF) Review (2009) states that KwaZulu-Natal is estimated to have the third-largest incidence of poverty in the whole of South Africa. Sixty per cent of the population lives below the poverty datum line, not having access to basic services and facilities (Msunduzi SDF 2009). The rate of illiteracy is very high. This problem is more pronounced in rural and peri-

urban areas such as Richmond, affecting mostly women, who are predominantly Africans.

The SDF Review (2009) further states that there are high numbers of low-income earners in the Richmond area, and that most of the residents work in the factories and industries situated in both Richmond and Pietermaritzburg. The majority of the population is poverty stricken, depending on social grants and pensions that are received from the government. The rate of school drop-outs is high, leading to escalating rates of unemployment in the area.

#### **4.4 SAMPLING DESIGN AND TECHNIQUES**

Sampling is a process of systematically selecting cases or a sub-group of people from the population for inclusion in a research project (Kalof et al. 2008:41). Sampling designs may be grouped into two categories, namely, probability and non-probability sampling. For the purposes of this study, a non-probability sampling technique, specifically judgmental sampling, was used. Judgmental sampling, also known as purposive sampling, relies on the judgment of the researcher in the selection of research participants. In other words, research participants are selected within specific categories, with a specific purpose in mind (Kalof et al. 2008:45). Purposive sampling allows the researcher to identify and target individuals who are believed to match the characteristics of the population being studied.

In the case of this study, service providers rendering services to OVCs, and primary caregivers who are taking care of OVCs in the area of Richmond were purposely identified, they having first-hand information on issues related to OVCs.

The research participants of this study may be categorised into two groups, namely, those who provide services to OVCs such as government officials – the key informants – and those who provide care to OVCs, namely, the primary caregivers of OVCs. The former included representatives from the Departments of Social Development, Basic Education, and Health; and non-governmental organizations such as the Thandanani Children's Foundation (TCF) and the Richmond NIP site. These key informants were actively involved in the programmes rendered to OVCs in

their respective departments or organizations in the Richmond area. The TCF and the Richmond NIP site were identified as the two main organisations that work directly with OVCs and their primary caregivers in this area. The primary caregivers who participated in the focus group discussion were identified through the Thandanani Children's Foundation. The Richmond NIP site was requested to assist with the identification of a second set of primary caregivers who participated in the in-depth individual interviews.

## **4.5 DATA COLLECTION METHODS**

There are a number of different data-collection methods that may be used in qualitative research. For the purposes of this study, individual face-to-face semi-structured interviews and a focus group discussion were conducted. In-depth individual interviews were conducted with key informants, consisting of (a) representatives from departments of Health, Social Development and Basic Education, (b) representatives from the Thandanani Children's Foundation and Richmond NIP site. In-depth interviews were also conducted with six primary caregivers. The participants in the focus group discussion consisted of another set of eight primary caregivers.

### **4.5.1 Service Providers: In-depth, semi-structured, individual interviews**

An "interview" is defined as "an interactive process whereby two or more people are communicating or working together" (Rugg et al. 2007). When interviews are used as a data-collection technique, information is obtained in either a structured or semi-structured manner in which the interviewer asks prearranged questions, the participant responds to the questions, and the interviewer records answers. The structured interview refers to an interview in which the researcher asks the questions in a specific prearranged order; whereas in a semi-structured interview the interview schedule is used as a guide and the researcher can rephrase questions, probing where necessary (Rugg et al. 2007).

Semi-structured, in-depth, individual, face-to-face interviews with representatives from the Department of Health, the Department of Social Development, the Department of Education, the Thandanani Children's Foundation and the Richmond

NIP site were conducted, based on the questions set out in the attached interview schedule (attached as Annexure F). An in-depth interview is defined as “a series of mostly open-ended questions that is used to obtain detailed or descriptive information from individuals about research topic” (Kalof et al. 2008:120). This data-collection technique was used because it allowed the researcher to gather in-depth information from the research participants, at the same time ascertaining that the same topics and sub-topics were covered during the interviews.

Written permission to interview the representatives of government departments was obtained from the heads of the research units of the three departments, i.e. the DOH, the DOE and the DSD, before appointments were made with the identified representatives. A letter requesting permission to interview the particular representatives from the government departments was sent to the respective heads of the departments (attached as Annexure B). Once written approval had been obtained (attached as Annexure C), each department was requested to provide the name of a person to be interviewed, preferably an official working on their OVC programme. Thereafter, appointments were made with the identified representatives, at which the purpose of the interview was explained. Permission was obtained from the prospective participant, before the interview took place. Research participants were requested to sign the informed consent form, indicating that they understood that participation was voluntary (attached as Annexure D).

Permission to tape-record the interviews was also obtained before the interviews took place. The interviews were conducted in English, being transcribed within two days after the conducting of the interviews. The transcripts of all the interviews were kept in a file and securely locked away at the home of the researcher.

#### **4.5.2 Primary Caregivers: Focus-group discussion and in-depth semi-structured individual interviews**

Primary caregivers were also identified as a critical source of information. This is because primary caregivers take care of OVCs and hence have first-hand information with regard to the experiences of, challenges faced by, and the needs of

OVCs. For the purposes of this study, eight primary caregivers participated in a focus-group discussion, another six participating in the in-depth individual interviews.

A focus-group discussion is another technique used for data-collection in qualitative research. In focus-group discussions emphasis is placed on the interaction between the research participants, with the researcher taking a less active role in directing the discussion (Barbour 2008:18). Focus group discussions involve gathering about six to twelve people in a room to discuss a particular issue. The role of the interviewer in the focus group is to facilitate group discussion. The interviewer thus plays the role of a facilitator in ensuring that all the research participants participate fully in the discussion. The advantage of using focus-group discussions is that this may generate a rich understanding of the research participants' experiences and beliefs. It may also afford the participants an opportunity for sharing information and experiences. This was important in the case of this study, caregivers themselves often experiencing challenges with regard to raising OVCs. They were then given the opportunity of learning from one another how to deal with challenges related to OVCs.

The TCF was requested to identify caregivers taking care of OVCs in the area of Pietermaritzburg, including Richmond, working as they do directly with OVCs. Eight caregivers were in this way identified and requested to participate in a focus-group discussion, which took approximately two hours. This session was held in the Pietermaritzburg Central Business District (CBD), at TCF's offices, so that it was easily accessible to all. The research participants were reimbursed for the travelling costs. The cost of travelling to and from the venue was ascertained by the researcher from the TCF before the focus group discussion was conducted. The TCF reimburses the caregivers of OVCs if they have to attend workshops or meetings in their offices. The researcher reimbursed the research participants for the cost of fares to and from the venue, using the rate that is paid by the TCF. Refreshments were provided for the research participants.

A consent form was prepared prior to the focus-group session. The wording was explained to participants before they were requested to sign it (attached as Annexure D). To guide the focus-group discussion, a discussion guide was prepared and used

during the discussion (attached as Annexure E). The discussion was conducted in isiZulu, as this was the home language of all research participants who participated in the discussion. Permission to tape-record the discussion was obtained from the participants. Thereafter it was transcribed verbatim and translated into English. The transcripts were printed and were filed and locked away in a secure place at the home of the researcher.

For the in-depth individual interviews, the Richmond NIP site was requested to assist with identifying six primary caregivers to participate in the individual interviews. The Richmond NIP site was requested to assist with the identification of primary caregivers, working with them, as does TCF. These interviews were conducted in the boardroom of the Richmond NIP site, this location being central to all of the identified primary caregivers. Although these primary caregivers did not use transport to the NIP site, the researcher paid them a minimum amount of R20 each, as a token of appreciation of their time and contribution to the study.

An interview schedule was prepared prior to the interviews. This was used during the individual interviews with the primary caregivers to gather the data (attached as Annexure F). After explaining the purpose of the interviews and obtaining permission from the primary caregivers, they were requested to sign the informed consent forms, indicating that they understood that participation was voluntary. The consent form was similar to the one used for service providers (attached as Annexure D).

#### **4.6 DATA ANALYSIS AND INTERPRETATION**

Data analysis is defined as breaking data into small components, which involves (a) carving data into manageable units, (b) filtering out units which can be used, (c) creating categories and/or identifying patterns which can and cannot be used to make sense of the data, and (d) attempting to subsume subsequent units of data under these provisional categories (Wellington and Szczerbinski 2007:103). In this study, content analysis was used to analyse the data. Content analysis is the process of identifying, coding and categorising the primary and secondary themes that emerge from the data. Coding is defined as “an attempt to fix meaning, constructing a particular vision of the world that excludes other possible viewpoints”

(Barbour 2008:196). The coding of data includes sorting concepts into groups so that concepts in the same group are as similar as possible, and those in different groups are as different as possible. Meaning is therefore derived from identifying critical themes; categorising them prior to coding, responses reflecting similar meanings being grouped together. Coding also allows for the sorting and re-sorting of data, for instance, through the cutting and pasting of information into separate documents.

In other words, during coding, the researcher organises the raw data into conceptual categories, identifying emerging themes or concepts. The data was analysed in the following way:

#### **4.6.1 Preparing data for coding**

A coding frame was developed during the process of working through the transcripts. Selective coding was used. This concept refers to working through the data and identifying cases that illustrate particular themes. Critical themes were identified which included the identification and definitions of OVCs, needs, and challenges of the OVCs; best place for OVCs to grow up; who should provide for OVCs; services provided to OVCs and their primary caregivers; as well as the extent to which the services rendered are coordinated and integrated.

The transcript of each interview was analysed in order to identify responses that demonstrate similar themes and sub-themes. These were highlighted using different colours, each colour representing a certain theme, to allow for comparisons and to contrast data gathered from the in-depth interviews and focus group discussion.

Responses in the transcripts were also colour-coded; responses from each participant were coded in one colour. Responses from the DOH were coded in orange, the DBE in pink, the DSD in bright green, the TCF in sky blue and the focus group in brown. These were then used to analyse the data.

#### **4.6.2 Coding the data**

After reading the transcripts of the interviews and the focus-group discussion several times, the data were sorted into the following coding categories:

**Theme 1: Definitions of orphaned children**

- a. Age
- b. Presence of biological parents

**Theme 2: Definition of vulnerability**

- a. Children suffering because of poverty
- b. Social issues

**Theme 3: Identification of orphaned and vulnerable children**

- a. Who identifies the OVCs?
- b. How do the service providers identify OVCs?

**Theme 4: The needs of orphaned and vulnerable children**

- a. Food
- b. Clothing
- c. Shelter
- d. Caring
- e. Educational support
- f. Emotional support

**Theme 5: Challenges faced by OVCs and responses to challenges**

- a. Lack of belonging
- b. OVCs having to assume adult's responsibilities
- c. Stigma, discrimination and exploitation
- d. How can these challenges be addressed?

**Theme 6: The best place for OVCs to grow up**

- a. Within their communities
- b. Shelters / places of safety / children's homes

**Theme 7: Who should provide for OVCs?**

- a. Government departments
- b. Non-governmental organisations
- c. Relatives

- d. Communities, including neighbours

**Theme 8: Services provided to OVCs by various government departments and NGOs**

- a. In this theme, services listed by the identified service providers were compared with those actually received by the primary caregivers

**Theme 9: Challenges faced by NGOs and government departments regarding service provision to OVCs**

- a. Insufficient resources
- b. Cooperation of government officials

**Theme 10: Integration and coordination of services provided to OVCs by the NGOs and government departments**

- a. The importance of integration and the extent to which services are integrated
- b. Key departments to integrate with
- c. Who should lead the integration and how to strengthen or improve the integration?

**4.6.3 Analysing the gathered data**

Content analysis is a technique used to analyse texts, whether written, spoken, or visual. The main goal of content analysis is to systematically classify words, phrases, sentences and other units of text into a series of meaningful categories (Kalof et al. 2008:105). This method was used because it allowed the researcher to compare content across the transcripts of the various interviews (cases). Cross-case analysis was conducted by grouping together different themes that emerged from the research participants' responses. Interpretative analysis was used to interpret data with the aim of identifying possible causal linkages, making inferences, and uncovering meanings contained in the data. The responses from the research participants were then compared in illustrating similarities and differences in viewpoints.

## **4.7 TRUSTWORTHINESS OF THE DATA**

The trustworthiness of data refers to the extent to which data obtained from the study may be considered credible. Trustworthiness is assessed by measuring the reliability and the validity of the gathered data. The data is considered trustworthy if it is reliable and valid. Validity and reliability are two factors which both quantitative and qualitative researchers should concern themselves when designing a study, analysing results, and judging the quality of the study (<http://www.nova.edu/ssss/QR/QR8-4/golafshani.pdf> December 2010).

### **4.7.1 Reliability**

Golafshani (2003:601) explains trustworthiness as referring to the researcher's credibility and neutrality when conducting research. Reliability refers to the consistency of a finding across repeated tests. If iterated tests demonstrate the same result, the procedure is said to be reliable. Gerring (2012:83). Kalof et al. (2008:163), however, argued that reliability is not a fair way of judging qualitative research. They stated that dependability reflects the extent of the researcher's truthfulness. The researcher has the responsibility of accurately presenting the data, being honest in the collection and presentation of data, and of conducting the research thoroughly. This was maintained in this study during data collection. The views of the researcher were not shared with the research participants during either the interviews or the focus-group discussion. The researcher was mainly facilitating the focus-group session and interviews, as well as ensuring that there was active participation among caregivers.

### **4.7.2 Validity**

Validity refers to the degree to which a scale or measure reflects the phenomenon under study. Davies (2007:243) indicated that validity in qualitative research relates to the question of whether the end results of the analysis are accurate representations of the psychological and the textual reality claimed by the researcher. In other words, validity in qualitative research refers to the extent to which the data is plausible, credible, and trustworthy, and thus can be defensible when challenged.

To enhance validity, triangulation and reflexivity were conducted in this study. Triangulation is a multi-faceted approach to studying a topic (Kalof 2008:209). It involves the use of multiple-data sources in providing a well-rounded understanding of a topic. Various types of data-collection techniques were employed in this study, that is, the focus group discussion, and the in-depth semi-structured individual interviews. Engaging multiple methods of data-collection facilitates more valid and diverse construction of realities.

Furthermore, two different types of sources were used to collect data: caregivers of the OVCs, and organizations rendering services to OVCs. Utilising various types of data-collection tools and various sources, allowed the researcher to enhance the validity of the data.

Reflexivity, on the other hand, refers to the process of acknowledging and critically examining one's own characteristics and biases, as these influence participants and findings (Mathison 2005:370). The researcher had to ensure that she remained aware of her own views and beliefs throughout, not imposing her own beliefs on the research participants. This is also an important procedure for establishing credibility. This was done by extensively quoting the research participants when the gathered data was presented.

#### **4.8 ETHICAL CONSIDERATIONS**

The ethics of research defines what is and is not permissible in conducting research (Kalf et al. 2008:46). Kalf et al. (2008:26) further state that a research study conducted in an ethical manner maximises benefits to both the scientists and the study participants, respecting participants' rights, and minimising the risk to participants. In other words, ethics guide the researcher with regard to the moral or legitimate manner of conducting research, thus protecting the research participants.

Ethical clearance was obtained from the University of South Africa (attached as Annexure A) before the interviews and the focus-group discussion were conducted. The following ethical issues were taken into consideration, and were explained to research participants.

#### **4.8.1 Informed consent**

A fundamental ethical principle of social research is never to coerce anyone into participating in the research, in other words, participation should always be voluntary (Kalf et al. 2008:47). It is the duty of the researcher to explain to research participants that their participation in the study is voluntary, and that they may withdraw from the study at any stage, should they wish to do so. Researchers must also inform potential participants of what they are being asked to do, so that they can make an informed decision about whether or not to participate in the study. Wellington et al. (2007:62) emphasise that participants should give written, informed consent prior to taking part in the research study.

In ensuring that participation was voluntary, and that participants made an informed decision, the researcher first explained to the research participants the aims and objectives of the study, and the way in which the study was to be conducted. All the research participants were thereafter requested to sign informed consent forms if they agreed to participate in the study (attached as Annexure D).

#### **4.8.2 Privacy, anonymity, and confidentiality**

Researchers must take precautions in protecting the research participants' privacy and identity. Researchers protect privacy by maintaining confidentiality. Confidentiality is maintained by removing all identifying information about individuals from research records and reports (Kalf et al. 2008:49). When reporting the data in this study, the researcher does not indicate the names and identities of the participants. In ensuring that privacy and confidentiality was maintained in this study, the names of the primary caregivers who participated in focus-group discussions and in in-depth individual interviews were not captured. Instead, participants allocated numbers, and referred to as "participant 1", "participant 2", and so forth. Furthermore, no information was released in such a way that would allow the public to link specific responses to particular participants.

Anonymity means that research participants remain anonymous or nameless: names of research participants were not mentioned. Kalf et al. (2008:50) state that anonymous research means that there is no link between individuals' data and their

contact information. Although anonymity cannot be guaranteed in most studies, research participants were assured that the personal information obtained from participants was going to be treated with confidentiality. It was explained that information was to be used for the purposes of this study. No other person, except for the supervisor of this study, would have access to the interview data.

#### **4.8.3 No harm**

The personal nature of qualitative research implies that researchers must be very sensitive to the possible harm their work might cause to participants (Gibbs 2007:8). The possible harm to participants could be either physical or psychological harm. Psychological harm refers to stressful and/or embarrassing conditions the research might cause to participants. Physical harm, on the other hand, refers to danger of injury or physical attack on research participants. It is important that researchers protect research participants from any possible form of harm. To ensure that participants were not exposed to any form of risk in this study, ethical clearance was obtained from the University of South Africa (attached as Annexure G) prior to the conducting of the in-depth individual interviews and the focus-group session.

The interviews and the focus group session were conducted in a safe place, in the boardrooms of the Richmond NIP and TCF. Utilising the boardrooms of the two organisations during the interviews also ensured that participants were not exposed to humiliation and embarrassment from passers-by.

#### **4.8.4 Special populations and coercion**

Social research can also coerce groups of participants to take part in the study, who are incapable of giving true, voluntary, informed consent. The participants must therefore be recruited in such a way that does not subject them to any pressure to participate (Wellington 2007:62). The researcher must explicitly inform participants at the beginning of the study that they have the right to withdraw at any time from participating in the study. This was explained to the participants of this study before they signed the consent form. To protect vulnerable groups (which is children in this case), interviewing children in this study was avoided. Instead, information was collected from the children's primary caregivers.

#### **4.9 PILOT STUDY**

Pilot testing, also known as pre-testing, refers to administering a survey or schedule of questions with the aim of assessing how well the questions are constructed, thus ensuring that they will obtain the information they are seeking (Kalof et al. 2008:203). Piloting the research instruments allows the researcher to assess the reliability of the measure. For instance, before the data-collection tools were used to conduct the interviews, the pilot interview schedules were tested with two participants, one for primary caregivers and another for service providers. The interview schedules for the focus group discussion were tested on two primary caregivers. The interview schedule for the in-depth individual interviews with the service providers was tested with an official from the Department of Health. The drafted interview schedules were tested on the three participants to ensure that questions were clear and unambiguous.

During the pilot study, two questions in the service provider's interview schedule were identified as enquiring about the same issue. One question was then eliminated.

#### **4.10 CONCLUSION**

The nature of this study required the use of a qualitative research design, the study aiming to collect information based on the experiences and beliefs of people working with OVCs and those taking care of OVCs. The study goal was to collect rich, in-depth data through interacting, by conducting in-depth interviews with people who were directly involved with OVCs. In-depth, semi-structured interviews were held with three representatives of various government departments, one from a non-governmental organisation, a representative from an NIP site, as well as with six primary caregivers. A focus group session was further conducted with an additional eight primary caregivers who lived with and took care of OVCs. The discussions were all taped-recorded and transcribed at a later stage for analysis purposes.

Furthermore, ten key themes with their sub-themes were identified and set out within this chapter from the data that was collected both from the in-depth interviews and the focus-group discussion. This chapter further attempted to assess trustworthiness

of data collected by accepting the concept of reliability and validity. The chapter also reported on the ethical principles guiding this study.

The focus of the next chapter will be on the presentation of research findings and a discussion thereof. Chapter 5 will present a brief description of the biographical characteristics of the research participants, and thereafter the research findings will be presented in terms of the ten identified themes highlighted in section 4.6.2 above.

## CHAPTER 5

### DATA ANALYSIS AND INTERPRETATION

#### 5.1 INTRODUCTION

The data presented in this section was gathered by means of individual face-to-face interviews and a focus group discussion session. The face-to-face interviews were held with representatives of the departments of Basic Education (DBE), Health (DOH) and Social Development (DSD); the Thandanani Children's Foundation (TCF); the Richmond Day Care Centre (also known as the Richmond NIP Site); as well as with six primary caregivers of OVCs. In addition, another eight primary caregivers who are taking care of OVCs participated in a focus-group session.

Chapter 5 will firstly present a brief description of the research participants. The findings from the study will be presented according to ten identified themes. The following are the themes and sub-themes identified from the analysis of the transcripts of the interviews and the focus-group session: (i) definition of orphaned children; (ii) definition of vulnerability; (iii) identification of the needs of OVCs; challenges faced by OVCs; (iv) best place in which OVCs should be raised; (v) who should provide for OVCs; (vi) services provided to OVCs by various government departments; (vii) challenges faced by NGOs and government departments; and lastly, (viii) the integration and coordination of services provided to OVCs by the NGOs and government departments.

**Theme 1: Definition of orphaned children.** The first sub-theme that emerged under this theme focused on the age parameters of orphaned children, and the presence of biological parents, as used by the identified service providers rendering services to OVCs.

**Theme 2: Definition of vulnerability.** The sub-themes identified under this theme are children suffering because of poverty; social issues affecting children (for instance, children affected by HIV and AIDS), children who are affected psychologically and emotionally (for instance, children who are taking care of sick parents), as well as children living with a sick parent.

**Theme 3: Identification of orphaned and vulnerable children.** The sub-themes identified for this theme focus on who identifies OVCs, and how the various service providers identify OVCs.

**Theme 4: Needs of orphaned and vulnerable children.** The sub-themes identified under this theme are food, clothing, shelter, educational support, emotional support, and persons who should take the responsibility of meeting the identified needs of OVCs.

**Theme 5: Challenges faced by orphaned and vulnerable children.** The sub-themes identified under this theme include lack of belonging, OVCs taking on responsibilities of adults, stigma, discrimination, and exploitation. Another sub-theme explored possible ways of addressing these challenges.

**Theme 6: Best place in which OVCs should be raised.** The sub-themes identified under this theme are whether the right place for OVCs to grow up is within their communities or at shelters / places of safety / children's homes.

**Theme 7: Who should provide for OVCs?** The identified sub-themes in this case are government departments, non-governmental organizations, relatives, and communities, including neighbours.

**Theme 8: Services provided to OVCs by the various government departments and NGOs.** Under this theme, services listed by the identified service providers are compared with those received by the primary caregivers, with the aim of ascertaining whether these services reach the OVCs. The sub-themes focused on the departments of Social Development, Health, and Basic Education; the Thandanani Children's Foundation; as well as the Richmond Day Care Centre.

**Theme 9: Challenges faced by NGOs and government departments that are providing services to OVCs.** The sub-themes identified under this theme are insufficient resources and the level of commitment of civil servants.

**Theme 10: Relevant legislation used by service providers.** The sub-themes for this theme focused on various legislation identified by the service providers.

**Theme 11: Integration and coordination of services provided to OVCs by the NGOs and government departments.** The sub-themes included (i) the importance of and the extent to which integration was taking place within the services provided by the identified government departments, (ii) the key government departments that should integrate their services, (iii) who should lead this integration and (iv) how to strengthen or improve the integration of services provided by the identified service providers.

## **5.2 DESCRIPTION OF RESEARCH PARTICIPANTS**

The participants for this study were categorised according to their responsibilities in caring for OVCs. The first group of participants consisted of key informants who were representing the identified service providers, such as government departments and NGOs. The identified service providers consisted of three government departments. Three government officials participated in this study, each representing either the Department of Social Development, the Department of Basic Education or the Department of Health. One NGO representative working for the Thandanani Children's Foundation and one working at the Richmond NIP were the other two key informants of this study. These key informants participated in individual, face-to-face interviews.

The second group of participants consisted of primary caregivers who provided direct care to OVCs. Eight of these primary caregivers participated in a focus-group discussion, and an additional six primary caregivers participated in in-depth individual interviews.

### **5.2.1 Service providers**

The five key informants were the HIV and AIDS coordinators of their respective departments/organisations whose responsibilities included managing the programmes dealing with OVCs. The representatives of the departments of Social

Development and Basic Education were based in their respective head offices in Pietermaritzburg. This office was responsible for the services rendered in the uMgungundlovu District Municipality. The uMgungundlovu District Municipality is one of eleven municipal districts in KwaZulu-Natal. The Richmond Local Municipality is one of the seven municipalities constituting the uMgungundlovu District Municipality. The representative of the Department of Health was based at the Umgungundlovu District Office and was responsible for activities provided at the district municipality, including the Richmond area.

The main office of TCF is in Pietermaritzburg. However, the TCF also has a satellite office in the town of Richmond, which is responsible for the services provided in the area of Richmond. The Richmond NIP site, on the other hand, is located in an area called the Ndaleni Mission in Richmond. This NIP site is situated next to a primary health-care facility and three government schools, of which two are primary schools and one is a high school. There is also a Methodist church in the vicinity of the Richmond NIP site.

### **5.2.2 Primary caregivers**

The eight primary caregivers who participated in the focus group (primary caregivers 1 – 8) were all females taking care of and living with OVCs, together with their own children. All these eight primary caregivers indicated that they were unemployed, with the exception of two, of whom one had temporary work and the other was engaged in sewing and selling her garments.

The six primary caregivers who participated in the individual in-depth interviews (primary caregivers 9 – 14) were also all females ranging between the ages of 32 to 65 years, who were responsible for, and taking care of OVCs. Furthermore, all primary caregivers were unemployed, with the exception of one primary caregiver who had temporary jobs. One primary caregiver was the recipient of the grant for older persons.

**Table 13: Profile of the primary caregivers**

	<b>GENDER</b>	<b>AGE GROUP (YEARS)</b>	<b>EMPLOYMENT STATUS</b>	<b>RELATIONSHIP WITH OVC</b>	<b>INCOME STATUS</b>	<b>NO OF OWN CHILDREN</b>	<b>NO OF OVCS IN CARE</b>
<b>Primary Caregiver 1</b>	Female	50 – 60	Unemployed	Grandmother	No	2	3
<b>Primary Caregiver 2</b>	Female	30 – 40	Unemployed	Grandmother	No	0	2
<b>Primary Caregiver 3</b>	Female	40 – 50	Unemployed	Grandmother	No	2	2
<b>Primary Caregiver 4</b>	Female	60 – 70	Unemployed	Grandmother	No	2	2
<b>Primary Caregiver 5</b>	Female	30 – 40	Unemployed	Grandmother	No	1	7
<b>Primary Caregiver 6</b>	Female	30 – 40	Unemployed	Sister	No	5	4
<b>Primary Caregiver 7</b>	Female	40 – 50	Unemployed but does sewing	Grandmother	Yes	3	2
<b>Primary Caregiver 8</b>	Female	60 – 70	Temporary jobs	Grandmother	Yes	0	1
<b>Primary Caregiver 9</b>	Female	50 – 60	Unemployed	Grandmother	No	5	1
<b>Primary Caregiver 10</b>	Female	60 – 70	Unemployed	Grandmother	No	2	1
<b>Primary Caregiver 11</b>	Female	30 – 40	Unemployed	Sister	No	3	1
<b>Primary Caregiver 12</b>	Female	50 – 60	Unemployed	Grandmother	No	4	11
<b>Primary Caregiver 13</b>	Female	40 – 50	Unemployed	Grandmother	No	2	2
<b>Primary Caregiver 14</b>	Female	60 – 70	Unemployed	Great grandmother	No	4	1

Table 15 above indicates that the ages of the primary caregivers ranged between 30 and 70 years, with four primary caregivers being between 30 and 40 years of age, four were between 40 and 50 years, three between 50 and 60 years of age, and three primary caregivers between 60 and 70 years of age.

The above table further shows that twelve of the primary caregivers, translating to 86%, have their own children. Two primary caregivers have no children of their own. The table also indicate that five primary caregivers were each taking care of either one or two OVCs, while the other primary caregivers were taking care of 3, 4, 7, and 11 OVCs, respectively. The number of OVCs in the care of these primary caregivers excludes their own children.

These primary caregivers were selected because they were taking care of OVCs, and hence had first-hand experience and knowledge on issues affecting OVCs.

### **5.3 PRESENTATION OF RESEARCH FINDINGS**

The findings of the study are presented according to the ten themes identified during the analysis of the transcribed interviews and focus group discussion.

#### **5.3.1 Theme 1: Definition of orphaned children**

The representatives of service providers working with OVCs were asked to define “orphaned children” as defined by their respective government departments and organisations.

##### **5.3.1.1 Age**

The age limit for OVCs used by the Department of Social Development differs from that of the Department of Health. According to the DSD representative, the age of OVCs ranges from 0 to 18 years, as stated by its representative:

*“We link it [age] with the definition of ‘child’ in terms of the Child Act of 1983 No 74.”*

The representative from the DOH indicated that no age limit is applied with regard to OVCs or any other person who would like to access the programmes of the Department. However, in terms of the services provided to OVCs at the NIP sites, the DOH representative indicated that the age limit of 15 years was applicable.

*“It is approximately 15 years in the NIP sites that we have when feeding the children and seeing to the health and the social environment of the child, but in terms of the health aspect of the people affected by HIV and AIDS we do not have age limits.”*

### **5.3.1.2 Presence of biological parents**

The service providers who participated in the study also defined an “orphaned child” in terms of whether his/her parents were still alive. The Department of Social Development defined an “orphaned and vulnerable child” as a child who had lost either one or both parents. This also includes cases where only one parent was known to a child, while the other was not known. In cases where the known parent had died, the child would be considered an orphaned child. The DSD representative further explained that:

*“In most cases children are born out of wedlock and they are raised by a single parent. And then if that parent dies that child becomes an orphan and can be taken to Court for placement.”*

According to the DBE representative a child is orphaned when either one or both parents die:

*“The definition of an orphan then is when both parents have passed away or one parent.”*

The representative from the TCF also defined an orphaned child as one who had lost either one or both parents, but expatiated that, in the case of one parent dying and the other parent not being traceable, the child is also categorised as an orphaned child.

*“An orphan is someone who has lost both parents or lost one parent and the other one cannot be traceable.”*

The manager of the NIP site defined orphaned children as:

*“Those children who have lost both parents, I am talking about a case where both parents have died.”*

### **5.3.2 Theme 2: Definition of vulnerability**

#### **5.3.2.1 Poverty**

The DOH representative defined “vulnerability” in terms of poverty, the DOH indicating that all children suffering because of poverty are vulnerable, as stated by its representative:

*“Poverty could result from the fact that the children do not have parents or there is nobody working in the family or there is abuse within the family.”*

#### **5.3.2.2 Poverty, unemployment and living with sick parent(s)**

On the other hand, in defining “vulnerability”, the DBE and TCF used social challenges, such as poverty, unemployment and living with sick parent(s) to define a vulnerable child. The representative from the DBE stated that:

*“There are learners who are vulnerable because they are affected or infected, and there would be children who are vulnerable because they are coming from families who are affected psychologically.”*

For the DOH, vulnerability also refers to the situation of children who are affected and/or infected by HIV and AIDS, or those children who are vulnerable because they come from families who are affected psychologically by their home conditions, for example, in the case of abuse. They also referred to those children who are not coping academically as vulnerable, in that they need more attention in school.

The DOH representative mentioned that:

*“There will be learners who are vulnerable because they are infected or affected, there will be learners who are vulnerable because they are coming from the families who are affected psychologically.”*

The DSD representative defined “vulnerable children” as those who are affected by HIV and AIDS. Furthermore, the department takes into consideration the situation at home. The representative from the DSD reported:

*“Vulnerable children are all those children affected by HIV and AIDS, either that child is living with a parent who is sick or is vulnerable because of the condition or background of the family.”*

Similarly, the TCF representative stated that:

*“A vulnerable child could be, let us say, a mother or one of the parents who is caring for a child, who is either mentally challenged or they are incapable of caring for a child, maybe because of things such as substance abuse or any other form of child neglect.”*

In other words, the TCF representative defined a “vulnerable child” as one who lives with a sick parent, either physically sick or mentally challenged, (as the latter is incapable of caring for a child) or as a child who is neglected by his/her parents.

The NIP site manager defined a “vulnerable child” as:

*“Those children where you find that a mother has died and the father is sick and bed-ridden, are called vulnerable children. Also where both parents are sick and taking treatment or those who have mental illnesses.”*

### **5.3.3 Theme 3: Identification of OVCs**

Theme 3 looks at the way in which the identified service providers select orphaned and vulnerable children. These key informants have indicated that the service providers use community caregivers and teachers to identify OVCs. In some instances community members themselves identify OVCs.

#### **5.3.3.1 Community caregivers (CCGs)**

The representatives from both the departments of Health and Social Development indicated that they use volunteers, known as “community caregivers” (CCGs) from the communities to identify both orphaned and vulnerable children in their respective communities. The DOH representative explained:

*“Community caregivers do house-to-house visits, identifying the families that need assistance in all aspects.”*

Primary caregiver 13 echoed the comments of the DOH representative by stating that:

*“They [the community caregivers] conduct home visits, and they all work in their home areas which makes it easy for them to know immediately when the children are left without parents, then they can come in to assist.”*

Primary caregiver 9 stated that:

*“They [TCF] have community volunteers who conduct house-to-house visits and they identify children who are orphaned.”*

Meanwhile, the DSD representative indicated that:

*“OVCs are identified by community caregivers by looking at the vulnerability of those children as well as family background, including social and economic aspects of the children.”*

The DSD representative further explained that the CCGs are not part of the department’s staff; they are volunteers from the community. The department pays them a stipend in return for the services rendered in the community through non-governmental organisations registered as non-profit organisations (NPOs). The DSD representative indicated that:

*“The community caregivers are the extended arm of the Department in providing services to the vulnerable group.”*

The representative from the TCF also uses CCGs to identify OVCs and, as with the DOH and the DSD, the TCF pays the CCGs a stipend in return for work done. The TCF participant stated that:

*“It would be very difficult to go and identify OVCs in the communities but it is easier for the CCGs as they are from the communities”.*

The NIP site manager stated that:

*“The community caregivers work in their areas where they come from because everybody knows his/her area very well and what is happening in their area.”*

### **5.3.3.2 Teachers**

For the DBE, on the other hand, OVCs are identified by teachers in the schools, using a vulnerability assessment form which takes into consideration all the details of the learner, for instance, age, home situation, and information about his/her parents. It is on this basis that a decision is taken whether the child is vulnerable. The DBE participant indicated that:

*“Identification is done by teachers... we do not prescribe because they (teachers) are going to look at the enrolment and say how many OVCs do they have and they will prioritise.”*

Three of the primary caregivers (primary caregivers 9, 10 and 11) also stated that the teachers at school identify children who are in need of support. Primary caregiver 9 described a case in which local taxi owners utilised teachers to identify children who could benefit from the taxi owners’ community outreach programme: taxi owners purchased and distributed school uniforms to vulnerable children. Primary caregiver 9 mentioned that:

*“The teachers chose children who are needy, they knew that he is an orphan so they gave him uniforms.”*

There was also a case in which a teacher identified an orphaned child who had tried to commit suicide. Primary caregiver 11 stated:

*“The teacher called me and told me that she has drunk lot of pills.”*

### **5.3.3.3 Community members**

The DOH representative also indicated that in some cases community members identify OVCs and refer them to the NIP site. She explained that:

*“Most of our children are identified by caregivers but sometimes you find that the community leaders or community members are aware of the project [NIP Site]. They then come to talk to the project manager and say that there is a family there that needs assistance... we make the community aware of the project so that if there is anyone in need of the services we are providing they can refer.”*

### 5.3.4 Theme 4: The Needs of the OVCs

This section aims at identifying the basic needs of OVCs. The key informants and primary caregivers were further asked to identify the needs of the OVCs, as well as who should provide for these needs.

#### 5.3.4.1 Food

All the participants considered food the most critical need of OVCs. The TCF representative argued that:

*“For them [OVCs] to grasp what they are learning, they need something on their stomach.”*

The representative from the DBE also stated that OVCs need nutritious food to survive, which should be available both in and out of school. One of the participants of the focus group discussion (Primary caregiver 7) also mentioned that:

*“If they [OVCs] can be assisted with food... that will be appreciated.”*

When the DSD representative was asked to list the needs of the OVCs, she indicated that:

*“The OVCs are facing challenges as the Province is faced by poverty, so I would say it is food and shelter.”*

Primary caregivers also sourced food from vegetable gardens that they have started at home. All the primary caregivers that participated in the in-depth interviews, with the exception of primary caregiver 11, indicated that they had their own vegetable gardens at home. Primary caregiver 12 indicated that:

*“It [vegetable garden] helps a lot, sometimes I don’t go to the shops but just go to the garden and get something to cook.”*

Primary caregiver 9 reported that:

*“It helps me a lot because I plant some vegetables and we all have food from the garden.”*

The primary caregiver 14 indicated that she had assisted her neighbours with seedlings from her garden, stating that:

*“Because I always plough and I harvest a lot, they [neighbours] will always come to me and ask for seedlings.”*

She further indicated:

*“The garden helps a lot because I don’t buy these from the shops, I get it from the garden and we prepare our meals from the food that we get from the garden.”*

Although primary caregiver 11 indicated that she did not have a vegetable garden, she stated that she would like to have one. She indicated:

*“Because of lack of funds I cannot fence the garden and then the livestock easily get to my garden and eat everything. I would like to have a garden because I like ploughing.”*

#### **5.3.4.2 Clothing**

The DOH and DSD representatives identified clothing as one of the critical needs of OVCs. The primary caregivers also mentioned that clothes are an important need of the OVCs. Primary caregiver 8 indicated:

*“I can afford to buy clothes for the younger ones but the older ones wants expensive clothes and I cannot afford.”*

Primary caregiver 7 mentioned:

*“It is mainly clothing and school clothes as it is cold.”*

Primary caregiver 5 stated:

*“I would say its clothes and school uniforms, because they are many, and I am taking care of 8 children.”*

Furthermore, only one of the primary caregivers, primary caregiver 9, indicated that she had received support in terms of clothing, stating that:

*“Sometimes Thandanani gives us clothes, maybe once a year ... t-shirts, pants and a blanket.”*

#### **5.3.4.3 Shelter**

The representatives from the DSD, DOH and TCF also identified shelter as one of the critical needs of the OVCs. The DSD representative stated that:

*“I would say it is food and shelter.”*

The TCF representative indicated that in some cases the houses that the OVCs live in are in a terrible condition, indicating that:

*“There are times when we can’t even repair the houses because the poles inside have been eaten by termites and we end up having to build the structure.”*

The primary caregivers also identified shelter as an important need for the OVCs. Primary caregiver 3 indicated that:

*“I need proper shelter as currently our house is chocolate, meaning that it is built of mud. I would like to see all these children sleeping on the bed not on the floor and they can be warm.”*

Primary caregiver 2 stated that:

*“... and also shelter because we only have one room, dining room and a kitchen. They all sleep in the dining room.”*

Primary caregiver 5 also indicated that:

*“I am taking care of 8 children and I am trying to extend the house that we are living in because we are many and we live in a 2-roomed house.”*

Primary caregiver 11 also stated that the house they were living in was not sufficient for all of them:

*“There are two-bedrooms because our house is four-roomed house ... we are many, we are ten in total.”*

The other four primary caregivers, that is, primary caregivers 9, 10, 12, 13 indicated that they had 5, 4, 8 and 4 bedrooms in their houses, respectively.

#### **5.3.4.4 School support**

School support is also a critical need of OVCs, as identified by the representatives from the DBE and the TCF. The DBE representative stated that:

*“The support that they need is academically, and food during school hours, although the Department has a nutrition programme in schools.”*

The TCF representative mentioned:

*“It is school uniform so that they are not being stigmatized because of their uniform which is in a bad condition.”*

Primary caregiver 7 identified school support as an important need, indicating that:

*“If school fees could be halved ... School clothes as it is cold.”*

Similar to primary caregiver 7, the DSD representative also felt that school support is important. She indicated that:

*“...if the OVCs do not have parents or parents are illiterate, when the children are at school they need support with school so that they will be able to face the world.”*

The NIP site manager stated:

*“Most children here need school uniforms, you would see that their uniforms are old but due to limited funding we only buy uniforms for those children coming from child-headed households.”*

The NIP site manager further mentioned:

*“The OVCs need support with school fees, they [OVCs] need to be exempted from paying school fees even though they receive social grants from the government, since the grant is used for food, clothing and in some cases to feed everyone in the household.”*

#### **5.3.4.5 Emotional support**

The DOH participant indicated that emotional support for OVCs is critical:

*“Emotional support is important as they [OVCs] have lost their parents. Some of them have seen their parents going through all the stages [of AIDS] before they die and those are painful experiences.”*

Primary caregiver 3, who stated that OVCs were finding it difficult to show emotion, supported the need for emotional support:

*“They become confused as they grow up without parents. Even when you try to love them and show that you care, they do not show any emotions of love. You never know when they are happy or sad.”*

The DOH representative further stated that:

*“There is a need for continuously caring for OVCs, ... there is a need for an adult who will be teaching these children family values and caring for them.”*

The NIP site manager stated in this regard:

*“These children are left with their aunts who are also young and do not have experience in raising a child. You will find that they end up being frustrated and some of them turn to drugs.”*

In addition, the DBE participant mentioned love and caring as an important need of the OVCs:

*“You need somebody who will be continuously caring for them because you find that the caregiver only comes today and will come next month and there is no continuous caring, monitoring of the family and teaching values. In the child-headed households you find that there is really a need for an adult who will be teaching these children family values and caring for them.”*

### **5.3.5 Theme 5: Challenges faced by OVCs and responses to challenges**

Theme five examined the challenges facing OVCs, as identified by the participants, also the way in which these can be addressed.

#### **5.3.5.1 Lack of belonging and love**

The representative from the DOH identified lack of belonging as the main challenge facing OVCs. The DOH participant in the study stated that:

*“Lack of belonging affects the OVCs as they do not belong in a neat family, that way they lack guidance on what to do and not to do.”*

The participant further stated:

*“A child can have a family but if there is no love in that family there is a problem and these children do not feel loved.”*

The DBE representative emphasised the importance of OVCs experiencing love and being cared for at home. He stated that:

*“From home they [OVCs] need to experience love and being cared for, mostly because some of them you find that they are heads of the family at the age when they still need to be cared for.”*

To assess whether OVCs perceived their primary caregivers as parents in the absence of their biological parents, the primary caregivers were asked whom did the child considered as playing a mother-figure role in his/her life. All the individually interviewed primary caregivers indicated that the children considered them as their mothers in the absence of their biological mothers. This indicates that, according to the primary caregivers, the OVCs' needs for belonging and love are met to some degree.

In this regard, primary caregiver 9 stated:

*“He knows that this is his home, but he also knows that he has another home, his father's family.”*

Primary caregiver 10 also indicated that the child was part of the family, stating:

*“I am the only person she knows, she has aunts but she considers me as her primary caregiver. If she needs something, she comes to me.”*

Primary caregiver 11 mentioned that:

*“She talks to me about most of the things and even if you ask her who does she respect as a parent, she always says that it is me. She also tells me if there is something that is worrying her.”*

Primary caregiver 12 said:

*“When she comes home, I am the first person she talks to, she would look for me wherever I am. She regards me as her mother.”*

Primary caregiver 14 indicated that:

*“I think it is his Aunt because he goes to her if she needs something.”*

### **5.3.5.2 Assuming responsibilities of adults**

The participant from the DBE mentioned that the main challenge faced by OVCs is that they have to assume responsibilities of adults, such as taking care of their siblings. The DBE representative indicated that:

*“Some of them have to act as parents to the young ones they are living with, the lack of love and guidance by the elders make them vulnerable to other people who are unable to help them. Even at home they don’t have someone to help with academic work or homework.”*

To assess whether the OVCs were overburdened with household-chores, the primary caregivers were asked to indicate the household chores that were the responsibility of children in their care. Primary caregiver 14 indicated that:

*“He does not do anything, the only thing that he does is to fetch water when he comes back from school.”*

Primary caregiver 13 said in this regard:

*“I have trained them, they fetch water, wash their own underwear and clothing, and sweep the floor although you have to do it again. I try to teach them how to do house chores.”*

Primary caregiver 12 made a similar comment, and indicated that:

*“Every school day she washes her clothes, then fetches water before she goes to play. I try to teach her all the house duties, sometimes I go with her to fetch fire wood.”*

Primary caregiver 11, on the other hand, indicated that her child was not helping with any of the household-chores, stating that:

*“I don’t know why she is not helping, but the problem is that I am afraid to force her to do things because we will end up not getting along. I asked her to do things but if she doesn’t want to, I leave her.”*

### **5.3.5.3 Stigma, discrimination and exploitation**

According to the DSD participant, the main challenges faced by OVCs are stigma, discrimination and crime. The DSD also stated that OVCs are vulnerable and can easily be exploited by other people, especially those in child-headed households (CHH) where neighbours abuse girls sexually and emotionally. She indicated that:

*“In most cases communities are not educated about OVCs, so they [OVCs] end up being exposed to stigma, discrimination and crime.”*

The DSD participant further stated that this occurs because the OVCs are not aware of their rights and they do not have people to protect and defend them. She further stated that OVCs are being discriminated against by neighbours.

The participant representing the TCF echoed this and stated:

*“OVCs become easy targets for child abusers, people taking advantage of them because they see that they are in need of financial support. You will find that some people will abuse them sexually and say that I will give you R5 to buy something that you like or bread.”*

The NIP site manager indicated that:

*“Even though the primary caregivers are getting grants on behalf of the children, there are cases where children are not taken care of properly, you will find these children with torn clothes.”*

Primary caregiver 7 mentioned that OVCs are easily blamed for things they did not do, as they do not have anyone to defend them.

*“A year ago, the children were playing outside and this child was accused of raping an 8 year old girl. Because they do not have parents they are easy targets and they are blamed for things they did not do.”*

Primary caregiver 10 stated that sometimes the neighbours did not want her child to come to their houses. She reported that:

*“Because the neighbours know her and they know that she is naughty, so sometimes they don’t want her to come to their homes. For instance they know that she sometimes steals money.”*

Primary caregiver 12 mentioned that:

*“I don’t think it [abuse and exploitation] ever happened to her as she has never said anything about it.”*

However, primary caregiver 12 further stated that:

*“Sometimes when they are playing with other children and they will tell her that they are going to beat her because she doesn’t have a mother to defend her.”*

Another challenge facing OVCs as identified by the representative from the DBE, is evident where there are no proper plans in place before the death of the parents as to whom should take the responsibility of the children. This occurs especially in cases where there are valuable assets such houses, and extended families are interested in inheriting these assets.

*“Because some people see these children as a source of income, if a child is living with me then I can apply for a grant and get money.”*

#### **5.3.5.4 Possible ways of addressing the identified challenges**

When the key informants were asked to identify possible ways of addressing challenges faced by OVC, the DSD representative argued that the government has to conduct awareness campaigns and educate communities on issues affecting OVCs. Once communities are educated, they can take responsibility for the upbringing and nurturing of OVCs.

Primary caregiver 2 identified counselling as the most possible solution to the challenges faced by the OVCs. She believed that counselling would address the challenge of being emotionless, stating that:

*“Maybe the social workers can counsel them, so that they will get to terms with the fact that their parents are gone, and they will learn to accept their caregivers and listen to us.”*

Primary caregiver 5 supported the idea of counselling, mentioning:

*“I agree with her that they need to be counselled, because they think you are abusing them when you ask them to do something for you, and when you punish them they think you do that because you are not their biological parent.”*

Primary caregiver 11 indicated that she sometimes did not know how to handle or talk to OVCs in her care, saying:

*“I feel that I also needed somebody to tell me what I have to do, how I should talk to her because she is a teenager and sometimes I do not even know how to talk to her or discipline her if she does something wrong.”*

The TCF participant argued that the response to the challenges faced by OVCs must be initiated by communities, since OVCs form part of the communities and the community knows what is happening to the children on a daily basis:

*“Members of the community are the ones who are always there in a child’s life, they know what is happening with a child on a daily basis.”*

Almost similar to what was identified by the TCF representative as a solution, the NIP site manager felt that there should be support groups for the OVCs, stating that:

*“I think we should assist them to form support groups so that they can share with each other on how can they deal with this situation. The social workers should be involved in these support groups so that they can guide them.”*

The DSD representative felt that the solution might be educating communities and the OVCs, so that they are aware of their rights and services that are available for OVCs. She further indicated that stigma and discrimination occurs because

communities are not educated about issues relating to OVCs. The DSD representative stated in this regard:

*“You will find that they [OVCs] end up being abused either sexually or emotionally by the neighbours and maybe the children are not even aware of their rights.”*

The representative from DOH argued that expansion of the National Integrated Plan (NIP) sites would address the challenge of belonging, stating that:

*“The OVCs have the sense of belonging in the NIP sites as they are being taken care of and are assisted with homework and taught life skills.”*

The DBE participant also agreed with the participant from the DOH that NIP sites are responding to the challenges faced by OVCs. He stated that:

*“At these sites the OVCs are offered breakfast before going to school and are assisted with homework after school... Also, community leadership should be able to identify all those children at risk and in need of care so that their challenges can be addressed.”*

### **5.3.6 Theme 6: Best place in which OVCs should be raised**

This section intended to elicit further information regarding the research participants' opinions on the best place in which OVCs should be raised. The DSD representative argued that the best place for OVCs to grow up is in their **communities**. The representative from the DSD mentioned:

*“Communities are the best place because if you take a child away from their community they lose the values and principles of their families. Then you are breaking the ties of the child and of the community. Also the DSD is doing away with institutions which promote the institutional approach and we are now rendering a developmental approach.”*

The TCF participant agreed that the best place for OVCs to grow up is in the community:

*“You find that to remove a child and place him/her in an institution is traumatic to a child no matter how beautiful the place is, because you remove the child from the environment they are used to, a place where they feel free to be children.”*

The representative of the DBE also argued that:

*“If foster parents have children at heart, living with relatives in the communities is the best place, because this is where the family structure is, rather than having them institutionalized in one place, they may be taken care of but they need to interact with their elders.”*

The DOH participant agreed that the best place for OVCs to grow up is in their communities, however, he indicated that:

*“In reality the institutions are the better places, particularly because of the things that are happening in the child-headed households. The OVCs can be provided with the material support but nobody is responsible for the day-to-day living of those OVCs.”*

**Shelters** were also considered good places in which OVCs should be raised, if these are located in the communities. Therefore, the DOH representative suggested:

*“Institutions should be there and maybe we should advocate that within those institutions the communities adopt these OVCs and maybe visit the families once a month. Because there are many challenges in the communities that they are exposed to, there is rape, abuse within the families they are staying with by their uncles, whereas in the homes you will not find that.”*

The NIP site manager also indicated the importance of shelters when stating that:

*“It is better if they stay in the shelters but these shelters should not be far from communities, so that the children are not separated from their communities and the children that they grew up with because it will give them identity and a sense of belonging.”*

In the focus-group discussion, the primary caregivers did not agree with one another on the issue of the best place in which OVCs should be raised. Five of the primary caregivers believed that the best place for the OVCs to grow up is with **relatives**. This, in their opinion, did not mean that OVCs would necessarily be well-treated by relatives. Primary caregiver 5 mentioned that:

*“The relatives are better because even in the homes [shelters] they take children to live with strangers and they [strangers] abuse them [OVCs]. I think it is better for them to live with relatives than be ill-treated by strangers.”*

This view was supported by primary caregivers 1 and 6, who respectively argued that:

*“I support her, it is better for them to go to relatives.”*

*and*

*“It is always better for OVCs to live with relatives.”*

Primary caregiver 8 felt that **orphanages** are the best place at which OVCs should be raised. She responded by mentioning that:

*“I think orphanages are the best place for OVCs to grow up.”*

Primary caregiver 3 felt that this was a difficult issue, as the child might not want to live with relatives or in an orphanage. The caregiver must then decide on behalf of the child the best place in which he should be raised.

### 5.3.7 Theme 7: Who should provide for OVCs

The representative from the DSD felt that the government should provide for OVCs, specifically, food should be provided by the DSD, as food security is a mandate of the Department of Social Development. According to the DBE representative, the provision of **food** should be and is the responsibility of the government. The participant representing the DBE stated in this regard:

*“There is a programme of fighting the war on poverty driven by the Premier’s Office, which is called the Flagship Project, which encourages every household to have at least a food garden. The government is also reinforcing the school nutrition programme and feeding of children whilst at school.”*

The DOH representative also indicated that food provision should be the mandate of the DSD.

Similar to the DSD representative, the NIP site manager also felt that the DSD should take the responsibility for OVCs, especially with regard to the provision of food:

*“Social Development should take the responsibility, the NGOs does not have enough budget to provide food for the children. Even though the Departments give us budgets for cooked meals and food parcels but it is not enough, we only receive a budget for 65 children.”*

The NIP site manager further stated with regard to providing for **educational needs** that:

*“[The Department of] Education should provide all school materials and exempt all OVCs from paying school fees, and Social Development should provide school uniforms.”*

The representative from the DSD further indicated that local government should also intervene by compiling a database of all OVCs in all the municipalities, and then facilitate that **shelter** is available for all OVCs.

*“The local government should prioritise these OVCs and build RDP [Reconstruction and Development Programme] houses, especially for the child-headed households.”*

The DOH representative further mentioned that various government departments should provide for OVCs:

*“There should be a multi-stakeholder forum that can sit around the table and discuss who can provide what. Because even with other Departments that are not involved at the moment, you may find that they can do something. I don’t think it should be just three or four Departments that are involved because it is a national problem and it affects everyone, it could affect my family tomorrow.”*

The DSD representative felt that the government is already providing OVCs with social security grants, indicating that the OVCs or primary caregivers should use the grants to buy clothes and school material.

Other participants felt that communities should also play a critical role in the upbringing of OVCs. For instance, the representative from the DOH indicated that communities should also provide for OVCs, by:

*“Adopting these OVCs by, say once a month ..., giving them cans of fish and some vegetables and things like that.”*

The TCF representative agreed with the three representatives from the government departments that the government should provide for OVCs, noting, however, that:

*“You don’t want to create a dependant society but if we are being realistic there needs to be a limited support for a minimal period of time, while we are busy developing people so that they can get to the*

*point where they can support themselves, that is where the government comes in and the NGOs.”*

The participant from the TCF further argued that the DSD should also take responsibility for providing school uniforms and shelter to OVCs, but only for a limited time. Thereafter, the communities should take over this responsibility, ensuring that school uniforms and shelter are available to the OVCs. With regard to the provision of **emotional support**, this participant stated that NGOs have vast experience and skills in this area; and that they should be responsible for this aspect. However, the DSD should provide financial support to these NGOs.

Primary caregiver 5 indicated that the government should take the responsibility for OVCs, stating that:

*“The government should house them, especially when there are no relative /es.”*

Primary caregiver 2 also felt that OVCs are the responsibility of the government, mentioning that:

*“It is the government, but working with the relatives who will live with the child.”*

Primary caregivers 5 and 6 felt that the Department of Social Development, through the social workers, should ensure that the needs of OVCs are met, by providing financial assistance to the guardians of OVCs. Primary caregiver 5 stated that:

*“I also think the social workers should make sure that they [OVCs] get clothes, food and all those things.”*

Primary caregiver 7 felt that primary caregivers should take the responsibility of providing for the OVCs, arguing that:

*“Yes, as a primary caregiver I should be responsible because I agreed to take care of them [OVCs].”*

Primary caregiver 1 stated that the government should work together with the primary caregivers to provide for OVCs:

*“We as guardians should also assist to make sure that the children go to school and they eat”.*

### **5.3.8 Theme 8: Services provided to OVCs by the various government departments and NGOs.**

This section examines the programmes targeting the OVCs which identified service providers are implementing, as mentioned by the representatives of the participating departments and organisations:

#### **5.3.8.1 The Department of Social Development**

One of the programmes that the Department of Social Development is implementing and that is targeting OVCs, is the Home- and Community-Based Care Programme (HCBC). The HCBC uses a structure called a Child Care Forum to identify OVCs in the communities and protect the children’s rights as set out in the Constitution of South Africa. The DSD representative defined a Child Care Forum as:

*“The Child Care Forum is a structure that is at a local level, which is responsible for the identification of OVCs, protecting children’s rights as stipulated in the constitution of South Africa.”*

The Department of Social Development is also providing services to OVCs through the NIP Sites, under the HCBC programme, by means of which OVCs are provided with meals before and after school. At the NIP sites children are also provided with homework supervision, counselling and food parcels. The NIP site manager described the services rendered at the NIP sites in the following way:

*“In those sites we provide services to OVCs, provide them with meals, sometimes we also provide them with school uniforms, we assist OVCs with homework supervision, as well as counselling and we also facilitate support groups for these OVCs.”*

Although the DSD is implementing these programmes which target OVCs through the NIP sites, the services appear not to be available to all the eligible children. Half of the primary caregivers individually interviewed indicated that they had never received support from the NIP site. Primary caregiver 10 stated:

*“I have never received food from this Centre, I’ve seen people with wheel barrows full of food but I have never received anything... if I can say that they have helped me with anything I would be lying.”*

Primary caregiver 14, who is the great-grandmother of the child, stated that:

*“I came here immediately after the death of my granddaughter and I gave them all the details of my great grandchild and my late granddaughter, and they said they will put her name on the list. I waited but nothing happened.”*

Nevertheless, primary caregiver 13 indicated that the food provided at the NIP site was of great assistance to the OVCs:

*“It helps them because they like coming to this centre and they enjoy the meals that they get from here.”*

Primary caregiver 11 affirmed this when she mentioned:

*“It helps to get something after school when the child is hungry.”*

The DSD also ensures that OVCs access the social security grants, such as the child-support grant and the foster-care grant. All the primary caregivers individually interviewed indicated that they were receiving social-security grants from the

Department of Social Development. Primary caregivers 2, 4, and 8 confirmed that they were receiving grants from the department.

Primary caregiver 8 stated:

*“The Department assists with grants and I also get a pension from the government.”*

Primary caregiver 12 mentioned that:

*“The grant helps a lot, especially because I am unemployed and I manage to feed them from this money and buy them things that they need. If you look at them you will not tell that they do not have parents because they have everything they need, like all other children.”*

Primary caregivers 10 and 13 also indicated that they use the money they receive from the grant to buy school uniforms, clothes and food.

Although all the primary caregivers were receiving the foster-care grant, three of the primary caregivers, (primary caregiver 10, 11 and 14), indicated that they have encountered challenges during the process of applying for social security grants. Primary caregiver 10 indicated that it took her two years; and primary caregiver 11 that it took her five months to receive the grant, from the day they submitted applications to the DSD. Primary caregiver 10 explained that:

*“I was about to give up, as every time I went to the social worker, she will speak on the phone for a long time and when she is done she would say I must come back the following day.”*

The same primary caregiver also experienced a challenge with accessing the social security grant for the other grandchild she is taking care of, because the grant was cut off without any explanation.

The stipulations of the Social Assistance Act No 13 of 2004 are that only people who are directly taking care of the children should receive the Child Support Grant. However, this is not always the case, because primary caregiver 14, who lives with her great grandchild, is not in receipt of the grant. In this case the grant is paid out to her daughter (who is the child's grandmother), who does not live with them. She mentioned that:

*“By the time the money gets to us it is too little as she will tell us that most of it is taken by the bank charges. Sometimes we don't even get this money, she would tell us that she got mugged and they took all the money.”*

When this great grandmother was asked what the total amount was that she was receiving from her daughter on monthly basis, she indicated that it was not more than R200 per month. This differs from the amount stipulated in the Social Assistance Act No 13 of 2004, namely that of R740 per month. This amount is given to primary caregivers who are taking care of children who are not their biological children.

Primary caregiver 11, who is taking care of her younger sibling, also indicated that she had experienced challenges when she submitted an application to the DSD, requesting to receive the child support grant that was paid to her mother before she died. She stated that:

*“For the whole year we struggled as there was no source of income, and the application to change only succeeded after 13 months.”*

She further explained that:

*“They told me that they were still waiting for the head office to process it [application]. I did not even get the back pay for the months that I was not paid.”*

### 5.3.8.2 The Department of Health

The representative of the DOH mentioned that the department also supports the NIP sites, in collaboration with the DSD, the DOH being responsible for the procurement of groceries for OVCs and for paying the salaries of some of the staff working at the NIP sites. She narrated as follows:

*“In the NIP sites we contract an NGO, in the contract the Department pays the NGO for the provision of services to OVCs. Those services that are contracted by the Department include providing food, we buy groceries and we pay the staff within the NIP sites but it is not only us, some of the staff is paid by Department of Social Development.”*

She further explained:

*“The caregivers are supposed to cook breakfast for the children in the morning before going to school, and they assess them before going to school whether they are fit to go to school. If they suspect something is wrong they do home visits to find out what the problem is at home and then they refer accordingly ... we follow them up and if there is a health problem, we refer them to clinics or they request the mobile clinic to come to the NIP site. They check their immunization cards to see if they are up to date and the health in general and social aspects as well.”*

The DOH also facilitates the immunisation of OVCs by first checking the immunisation cards to ensure that they are up to date. Those that are not up to date are referred to the nearest primary health-care (PHC) facility.

Primary caregivers 13, 12 and 9 indicated that they had received some support with health issues, where primary caregivers 13 and 9 received health support from the community caregivers, and primary caregiver 12 received health information from the school nurses. Primary Caregiver 13 mentioned that:

*“They remind us when it is time for immunisation, they make sure that we take the children to the clinic when it is time for immunisation. They also check the child’s “road to health card” to see if it is up to date and weigh children to see if they are growing properly.”*

There are also cases in which community outreach nurses provide health education in schools. Primary Caregiver 12 stated that:

*“They are checked by the school nurses at school, if it happens that the child is not immunised, they will tell you to take the child to clinic.”*

Primary caregiver 9 also stated that they had received assistance from the TCF, indicating that:

*“They [TCF] have sent the child to the dentist, check if the eyesight is ok and if the child is well health wise.”*

Primary caregivers 10, 11 and 14 indicated that they had never received any form of support in relation to health issues. When primary caregiver 11 was asked whether she had received support from community caregivers working with the DOH, she stated that:

*“I don’t think we have them [community caregivers] in our area, I have never seen them.”*

Primary caregiver 10 also stated she had never received any assistance with health issues, further indicating that:

*“I don’t take her to the clinic if she is sick, I take her to the doctor in town.”*

### 5.3.8.3 The Department of Basic Education

The Care and Support Programme of the Department of Basic Education offers support to OVCs by purchasing and supplying OVCs with school uniforms, stationery and facilitating the school-fee exemption policy for eligible children. The DBE representative described the services rendered by this department in the following way:

*“The Department assists with buying of school uniforms, grant school-fee exemptions, if the learner qualifies for a fee exemption, because the policy of the Department says that learners who cannot afford to pay for school fees can be exempted through the governing body from paying the school fees.”*

The six individually interviewed primary caregivers indicated that they were not paying any school fees for their children. Primary caregiver 10 explained that:

*“I was told that they do not pay school fees anymore.”*

Primary caregiver 11 also mentioned that:

*“They don’t pay school fees in the school that she goes to.”*

Primary caregiver 14 stated that:

*“All the children in this school do not pay school fees.”*

The primary caregivers mentioned that all the children attending local schools were exempted from paying school fees. Primary caregiver 13 indicated that:

*“We were told to stop paying the school fees, as the Department said we must stop paying the school fees ... we all do not pay school fees, all the learners in all the schools.”*

However, there is confusion with regard to whether the school fees are exempted for all the children in the local schools. As indicated above, six primary caregivers stated that learners do not pay school fees. On the other hand, the NIP site manager stated that all other children do pay school fees, and only those who have been exempted from paying school fees do not pay the school fees:

*“In some cases we have to write letters for the primary caregivers requesting the school to exempt them from paying school fees. Then they will grant them permission, but once the school discovers that they receive a foster care grant the school will demand school fees.”*

The NIP site manager further explained that:

*“Maybe they just decided to stop paying the school fees but the schools will demand payments at the end of the year. They will not get their reports if they have are not up-to-date with their school fees.”*

The DBE is also implementing a school feeding programme, in which the Department allocates a budget to qualifying schools for the provision of cooked meals for OVCs. The primary caregivers indicated that their children were benefiting from the school feeding programme. The school feeding programme was considered very beneficial to the OVCs in school. Primary caregiver 11 indicated in this regard:

*“They now get cooked meals at school ... every learner in the school gets this food.”*

She further stated:

*“It helps them a lot, because there are many children who suffer because of poverty even though they are not orphaned, some children come to school without any food from home.”*

Primary caregiver 9 mentioned that:

*“They have a school feeding programme, and they only give food to those children who do not have lunch for the day.”*

Primary caregiver 12 explained in this regard:

*“They eat every day during the week.”*

#### **5.3.8.4 The Thandanani Children’s Foundation**

The TCF representative described one of the purposes of this organisation as that of facilitating the OVCs in school by providing them with school uniforms, and ensuring that all eligible children are exempted from paying school fees. The TCF representative explained the services rendered to OVCs as follows:

*“We recruit volunteers from these communities, what we do is that we develop the volunteers so that they are able to identify orphaned children, and that they support children in those communities.”*

The TCF also ensures that OVCs are provided with clothing and are referred to PHC facilities when they are sick or when they need medical attention. Primary caregiver 9 indicated that the TCF also arrange for dental and eye-care services for those children in need of these services, who are accordingly referred to the various government departments.

The TCF representative stated:

*“Thandanani made arrangements with the dentist and the optician, we had to send children to a central place to be seen by a dentist and the optician.”*

In cases where the houses are not in good repair, the TCF representative stated that they assist the OVCs with either repairing the house or re-building the house, depending on the availability of funds and resources, such as labour and material:

*“We first look at the physical structure of the house where the OVCs live, is it secure enough in terms of stability? Is it secure enough in terms of them being safe from intruders? As well as looking at hygiene within that household, is it hygienic.”*

The NIP site manager described the services rendered by the TCF as:

*“Their services are not that different from what we are providing, except that they have an office, and also they have a nurse who goes with them when they conduct home visits, particularly for those people who are bed-ridden.”*

The TCF was also known to two primary caregivers, that is, primary caregiver 9 and 12. Primary caregiver 9 defined the duties of the TCF caregivers as follows:

*“They look at the well-being of the child, the challenges experienced by primary caregivers, check if children are supported, as well as to see if we do not mismanage the grants that we receive for the children.”*

Primary caregiver 9 further explained that the TCF had assisted her with applying for a social grant, as well as with obtaining the school-fee exemption. She also stated that they receive clothing for the children from the TCF at least once a year.

Primary caregiver 12 also explained that:

*“There is this boy who helped me, I can’t remember his name but he used to visit us at home to check how we are coping. He was coming from town working for this organisation... Thandanani.”*

Primary caregiver 1 indicated:

*“They [Thandanani] gave us pots and blankets.”*

All the primary caregivers who participated in the focus group discussion also knew the TCF. Primary caregiver 3 mentioned that:

*“Social workers from Thandanani used to call us and give us food vouchers.”*

Primary caregiver 5 stated in this regard that:

*“Because these children are under Thandanani, the social workers should make sure that they provide clothes, food and all those things.”*

#### **5.3.8.5 The Richmond Day Care Centre (NIP site)**

The Richmond Day Care Centre, which is an NIP site as pointed out above, provides various services to OVCs. The NIP site manager explained the services rendered at the site as follows:

*“We help children who are orphaned and those who live alone in their homes, called child-headed households. We have volunteers who work in the communities and identify them [OVCs] during the home visits that they conduct.”*

The NIP site manager indicated that they use community caregivers to identify OVCs in the communities and to facilitate the OVCs receiving appropriate services from the various government departments. The NIP site manager further explained that:

*“Once identified, we then refer them to government departments as per their needs. For instance, you find that there are orphaned children without birth certificates so we will help them to get birth certificates with Home Affairs and refer them to Social Development for the child*

*support grant and foster care grants. Those who are from child-headed households, we help them find foster parents.”*

The NIP site manager further mentioned that the identified OVCs received cooked meals twice a day, in the mornings before going to school, as well as after school; and they also assist these children with their school work.

*“We help them with homework after school and we give them cooked meals every day. In the morning before school we give them breakfast and when they come back from school, we give them a cooked meal for lunch.”*

The DBE representative emphasised the importance of OVCs’ receiving assistance with school work, stating that:

*“Even at home they don’t have someone who can help them with their academic work or homework. So those are challenges they find themselves in not on par with other learners at school.”*

However, the primary caregivers individually interviewed indicated that the children under their care had never received any support with homework.

Primary caregiver 11 mentioned that:

*“I help her with the homework when I can, as there is nobody who can help her ... sometimes she goes to her classmates and they help each other.”*

Primary caregiver 13 also indicated that:

*“I help them at home with their homework, we do it ourselves.”*

Primary caregiver 12 explained that she never receives support from anyone, by stating that:

*“I don’t get help, not even from a single person, it is my responsibility alone.”*

The NIP site also utilises the funds that it receives from the government to purchase food parcels and school uniforms which are distributed to the most needy children. She further indicated that they also prepare cooked meals, which they take to needy families. The NIP site manager stated in this regard:

*“We have a soup kitchen programme where we cook soup in the Centre and take it to those people who are sick at home. In some cases you find that there are people who are sick at home and they have no one taking care of them and we give them soup.”*

Primary caregiver 11 indicated that she has received support with school uniforms and clothing from the Centre, stating that:

*“The Centre once gave us uniforms, they buy it for people who have not yet received the grant from Social Development.”*

Although primary caregiver 13 indicated that she never received support with school uniforms, she stated:

*“I know that sometimes this Centre will buy them [OVCs] school uniforms and distribute to the most needy children.”*

The NIP site manager indicated that they receive funding from both the DSD and DOH, mentioning that:

*“Most of the funding comes from the DSD, they fund us for many services such as food parcels, school uniforms, salaries for staff. [The Department of] Health bought us this park home that we are using, they pay for groceries for daily cooked meals and salaries for some of the staff.”*

### 5.3.9 Theme 9: Challenges faced by the identified service providers

The key informants were also asked to identify the challenges faced by the organisations providing services to OVCs.

#### 5.3.9.1 Insufficient resources

Four of the service providers identified funding as the main challenge facing organisations providing services to OVCs, that is, representatives from the DOH, DSD, TCF and the NIP site. The DSD representative identified the main challenge faced by the department as:

*“The first challenge is that there is not enough money to provide for the OVCs.”*

The DSD representative further explained that, owing to lack of funding, the department has established one service office per municipality. OVCs have to travel to these service offices, which are not always close to where the OVCs live, to get assistance. She stated that:

*“The distance that is there between our service offices and communities ... although we have a service office in each municipality, the OVCs still have to travel very long distances to our offices.”*

The DOH representative also felt that, because of the challenge of insufficient funds for the OVC programmes, the department is failing to establish additional NIP sites offering services to OVCs. The DOH representative stated that:

*“Because of lack of funding ... we only have 9 NIP sites and we have 7 municipalities, so you can imagine that it is not enough. Even in one municipality, we need more, maybe 5 NIP sites, because the distance between these NIP sites is just too much. There are many OVCs that are not cared for.”*

The DOH representative further explained that:

*“The organizations are there and most of them are now aware of what to do and things like that but they cannot do what they want to do because of lack of funding.”*

The NIP site manager also alluded to their budgets being the main challenge facing the organisations, illustrating that:

*“The major challenge is funding, it is very limited and you cannot use it for anything else that you think is important for the OVCs in that particular time. The contract specifies that you can only use funds for this and that, and you cannot deviate from the contract.”*

Another challenge with the budget that the NIP site receives from the government, as mentioned by the site manager, is the following:

*“It takes a long time for the Departments to reimburse us after we have submitted claims, sometimes it even takes three months to get the money. This is very demotivating to the staff, you can imagine what it does to a person not to get your salary for three months.”*

The TCF representative indicated that they also experienced financial challenges, stating that:

*“We have come out from a crisis whereby, as staff, from October 2009 to March 2010 we had to sacrifice 20% of our salaries as well as our annual bonuses and that is a decision that was made voluntarily by the staff.”*

The TCF representative further stated:

*“Because of the recession, some of our donors have cut down on the amount that they promise to give us and some just withdrew because*

*they did not have budget, they were also struggling. We realized that we were going to run out of funds six months before the end of the financial year and for us to be able to continue to the end of the financial we had to sacrifice a portion of our salaries.”*

### **5.3.9.2 Lack of cooperation of government officials**

The DBE representative identified a lack of cooperation from some government officials as another challenge facing the DBE. The official indicated that:

*“The kind of role that is played by the educators is hindered by a lack of cooperation by different Departments.”*

He further indicated that the lack of cooperation sometimes is caused by fear, stating that:

*“If you are living in a community and there is a case of child abuse, the educator will find it difficult to report the case in fear of being victimised.”*

However, when the representative was asked what possible solutions to the above-mentioned challenge can be found, he stated that:

*“The Department tries to capacitate and encourage the educators to refer these cases to relevant Departments.”*

The TCF representative also alluded to the issue of non-cooperative government officials, indicating that in some cases documents go missing from certain government offices. The TCF representative explained that:

*“Another challenge would be civil servants, I have been trying for more than 3 years to secure a building site from them. These are community projects and you find that when you look at the map the site is marked*

*as an early learning centre or crèche. It has taken me more than 3 years and to date I have not secured those pieces of land.”*

The TCF representative further stated:

*“I have submitted several applications for the lease of that piece of land and have never been successful and at the end of the day they will say we have lost the application, please resubmit, and I have to start afresh. I have just submitted another one in March because they have lost the previous one.”*

### **5.3.10 Theme 10: Relevant legislation used by service providers**

The service providers were asked to mention pieces of legislation relevant to their areas of work. The representative from the DBE identified the following:

*“In our Directorate the issues of child care at schools are guided by the Child’s Act. Also the strategy on HIV and AIDS and treatment, care and support, which is priority number 2.”*

The representative from the DSD identified three documents, which are as follows:

*“Action Plan for OVCs ... the Children’s Act, as well as guidelines for establishing community care centres.”*

The DOH representative identified only the National Strategic Plan, further explaining that:

*“In the National Strategic Plan there are clauses that talk about OVCs and who should be caring for the OVCs, but in the DOH legislation, really there is not much. Maybe with the DSD there are legislations.”*

The TCF representative mentioned that:

*“Most of the child support issues are covered in the Child’s Act, because it goes as far as providing guidance in terms of prevention of child abuse, child trafficking and all those things are about rendering services to a vulnerable child. It covers it all.”*

The NIP site manager also mentioned the Children’s Act No 38 of 2005, stating that:

*“Although I don’t know the acts but I have heard of the Child Care Act, yes only.”*

### **5.3.11 Theme 11: Integration and coordination of services provided to OVCs by the NGOs and government departments**

This section aimed at viewing the importance of integration of services rendered to OVCs as perceived by the service providers, as well as the extent of the integration of these services provided by the various service providers to OVCs.

#### **5.3.11.1 The importance of and the extent to which integration is taking place**

According to the representative of the Department of Basic Education, the service providers rendering services to OVCs have been integrating the services that are offered to OVCs. He indicated in this regard that:

*“We have been doing it for a long time, it is just that us, the officials, were not conscious about it. The good thing that has been started by the Operation Sukuma Sakhe, was to see this integration happening at a provincial level.”*

The DOH representative also emphasised the importance of Operation Sukuma Sakhe (OSS), also known the Flagship Project, in the integration of services, explaining the aim of this project as being:

*“To deliver the services at a household level in an integrated fashion ... If the community caregiver goes to the household they cover everything, they identify a problem and will know exactly what to do and will operate in an integrated manner so that not many community caregivers will visit the [same] household.”*

In appreciation of the OSS, the DOH representative further stated that:

*“In the time of Flagship Programme it [integration] is happening perfectly, to me the Flagship Project is like a dream come true. Because we have been trying this integration for years and we have been doing it in a small scale.”*

The representative from the DOH further explained that:

*“The aim of the Operation Sukuma Sakhe is to deliver services at a household level and in an integrated fashion. In most Departments that have community cadres, you find that the DOH has got a cadre, the DBE has a cadre, the DSD also has a cadre and the municipality also has a cadre. All these four cadres are going to the same household, delivering services, so what the Flagship is doing, is to train all these cadres in everything so that when they each go to a household they cover everything, and will also train them on everything. If the cadre goes to this household and identify a problem, this cadre will know exactly what to do in a household and will operate in an integrated fashion so that not many cadres will visit the [same] household.”*

The NIP site manager also felt that the OSS has had a positive impact on the services provided by organisations in communities, stating that:

*“It [Flagship] helps a lot as each Department has to indicate how they will assist organisations that are experiencing problems in the communities. Each Department is expected to respond to their relevant cases in the meeting.”*

Elaborating on what is expected from the government departments, the NIP site manager narrated that:

*“The Departments have to address issues there and there or else they have to give feedback in the next meeting, which pushes them to perform.”*

The participant from the DSD explained the importance of integrating services among the service providers as follows:

*“Not one Department can be able to provide all services to the OVCs.”*

The primary caregivers who participated in the focus group discussion were asked whether it was important for the service providers to integrate their services. Primary caregiver 1 indicated that:

*“I think it [not integrating] is not good because they do not communicate with each other.”*

Primary caregiver 2 also felt it was important for various service providers to work together in the provision of services to OVC. She explained that:

*“I think if they can work together and they will know how many children need assistance and will make sure that they all receive something.”*

On the other hand, primary caregiver 7 stated that it was up to the organisations to decide whether to integrate the services, mentioning that:

*“I think it is fine because it is up to them and it depends on what they have. For us this is like a gift and we cannot choose or tell them how they should do it.”*

The NIP site manager felt that, although integration is important, in some cases it is not possible to integrate all the services, different organisations sometimes offering different services:

*“Although we are all working with the OVCs, the services that we provide as organisations are not exactly the same, so it is better to work together and give frequent reports to each other.”*

#### **5.3.11.2 Key government departments in the integration of services provided for the OVCs**

The participants were further asked to identify key organisations that should integrate their services. The DSD representative indicated that:

*“We need the Department of Health to come in with the health aspects, we need [the Department of] Education to look at the education aspects of a child and then [the Department of] Social Development to come with the social aspect of the child, because we need to render a holistic approach to these children.”*

She further added the following:

*“We also need local government to provide housing for the OVCs and also the municipality because these people are staying in their areas. As well as the Department of Agriculture to be part and parcel since in the province there is a push of “one-home-one-garden”. And yes, the NGOs.”*

The TCF representative identified the DBE, DSD, and the Department of Home Affairs (DOHA) as some of the government departments that ought to integrate their services, stating that:

*“Department of Basic Education, Department of Health, Department of Social Development, Department of Home Affairs, and Justice,*

*because these are all the doors that you have to go through in terms of supporting a child.”*

The primary caregivers that participated in the focus group discussion mentioned only organisations that provide support to OVCs, and in some cases they were not aware of the names of those organisations. Primary caregiver 1 stated:

*“I don’t know the name of that organization but they took my sisters children and live with them. They give them groceries when they come home during holidays.”*

Primary caregiver 8 mentioned:

*“There is another place which assists [OVCs] with vouchers; it is an Indian shop in East Street.”*

### **5.3.11.3 Who should lead the integration?**

When asked who should take the responsibility for ensuring that services are integrated, three of the five participants indicated that the Office of the Premier should play the leading role in facilitating that the services rendered to OVCs are integrated. These respondents indicated that the Office of the Premier is playing the role of coordinating services rendered to OVCs through the OSS.

Meanwhile, the TCF representative stated that the DSD should take the responsibility for ensuring that integration takes place among the service providers, stating that:

*“Social Development, it is their primary responsibility to care for OVCs, therefore they should take the lead.”*

The representative from the DOH felt that the Office of the Premier should lead the integration of services provided to OVCs, by explaining that:

*“According to the Flagship Project, which is hosted at the Office of the Premier, the Heads of Departments have been allocated with districts to lead. So it is the office of the Premier.”*

The DSD representative also shared a similar view, stating:

*“Lucky for us we have the Office of the Premier, which have the responsibility of co-ordinating all the activities conducted by government departments.”*

The DBE representative identified both the Office of the Premier, as well as district municipalities, to lead integration:

*“The Premier’s Office, as it is happening now, I think they are doing well. But then at a local level district municipality should take a leading role, because those are the people that can draw in different stakeholders.”*

#### **5.3.11.4 How to improve integration of services provided to OVCs**

One way of improving the integration, as mentioned by the TCF representative, is to ensure that the relevant representatives from the government departments attend the Flagship Project meetings:

*“We need to have a forum where all these service providers will come together and have discussions and see where they can collaborate. Not that it has not happened before, it has been happening but the problem is you attend those forums and representatives from state departments are not decision makers. They come there and they listen and you ask questions, they are still going to refer to superiors and get back to you with the response and they do not come back.”*

According to the DSD representative, integration can be improved by having regular meetings with all the service providers. She stated that:

*“We need to have frequent meetings as well as to be able to plan closely together and be able to monitor the progress together. And also to form a task team that is going to represent government departments.”*

#### **5.4 CONCLUSION**

In conclusion, the findings of this study indicate that there are similarities with regard to the way in which the research participants viewed issues relating to OVCs. The key informants were representatives from the DSD, DOH, DBE and the TCF, as well as the NIP site. The research participants also included primary caregivers, who were taking care of OVCs. The chapter also presented the findings of the study under eleven themes, which included the manner in which the participants defined and identified the OVCs: their needs and challenges. The chapter further highlighted the services provided to the OVCs by the key government departments; the importance of integrating these services, as well as who should lead the process of integrating services rendered to OVCs.

The next chapter will conclude the dissertation by reviewing the foregoing chapters together with a summary of research objectives. Furthermore, interpretations of the research findings will be presented in relation to the research objectives. Lastly, chapter 6 will discuss the limitations of the study and recommendations for further studies.

## **CHAPTER 6**

### **CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS**

#### **6.1 INTRODUCTION**

This study focused on the services rendered to OVCs, with the aim of ascertaining the degree to which these services are accessible to OVCs and the extent to which they are integrated. This chapter concludes the dissertation. Firstly, it provides a summary of the chapters constituting this dissertation. Secondly, it summarises the research findings in terms of the research objectives. It further identifies the limitations of the study, making recommendations for future research and programme implementation.

#### **6.2 SUMMARY OF CHAPTERS**

The dissertation consists of six chapters. The first chapter focused on contextualising the issues related to OVCs. Chapter 1 outlines the rationale and objectives of the study, followed by definitions of the key terms used throughout the document. The chapter further outlines the key research questions that formed the basis of the study. The research methodology that was used in data collection and analysis is briefly described; this includes the research setting. The chapter concludes with a summary of the theoretical framework.

Chapter 2 presents various studies conducted by several researchers on issues related to OVCs in different countries. The chapter begins by describing the extent of the problem of OVCs worldwide; then in sub-Saharan Africa; and in South Africa, in particular. Issues relating to the needs and challenges of OVCs - who should take responsibility for the care for OVCs - are discussed in depth, together with the impact of HIV and AIDS on children, families, and communities. The chapter concludes by discussing the need for coordination of services provided for OVCs.

Chapter 3 presents the policies and legislation supporting OVCs in South Africa by exploring various policies and guidelines used by identified government departments and civil society organisations rendering services to OVCs, which guide the

implementation of OVC programmes. Secondly, the chapter reviews the services rendered to OVCs, which are both community- and government-based. The chapter concludes with a discussion on three theoretical frameworks guiding the study, that is, the community development theory, the social network theory, and the integrated development approach.

Chapter 4 of the dissertation presents a detailed discussion of the research methodology that followed in conducting the study. The chapter opens by defining the qualitative research design used, going on to describe the research setting at which the study was conducted. Chapter 4 also reports on the data-collection methods used to gather data, that is, in-depth individual face-to-face interviews. To assess the trustworthiness of the study, the chapter reviews the pilot testing, reliability, and validity. The chapter concludes with a discussion on ethical considerations, such as informed consent, privacy, anonymity and confidentiality.

Chapter 5 reports on the findings of the study. The findings are reported in detail according to ten themes, which were identified in Chapter 4.

The final chapter of the dissertation concludes the dissertation by first providing a brief review of the chapters, followed by summarising the findings of the research. Secondly, limitations of the study, and recommendations for future studies are presented. Lastly, the chapter concludes with the suggestions for the implementation of OVC programmes.

### **6.3 SUMMARY OF RESEARCH FINDINGS**

This section will briefly summarise the research findings presented in detail in the previous chapter, in relation to the research objectives stated in Chapter 1. The study had four critical research objectives, which were as follows:

1. To explore the needs of and challenges faced by children orphaned and made vulnerable by HIV and AIDS in Richmond, KwaZulu-Natal;

2. To explore services provided by key stakeholders rendering services to children orphaned and made vulnerable by HIV and AIDS in Richmond, KwaZulu-Natal;
3. To explore the extent to which the process used by service providers to identify children who are orphaned and made vulnerable by HIV and AIDS facilitate the inclusion of all affected children in Richmond, KwaZulu-Natal;
4. To explore the degree to which programmes implemented by different service providers targeting children who are orphaned and made vulnerable by HIV and AIDS are integrated in Richmond, KwaZulu-Natal.

In the remainder of this section, a summary of the research findings is given.

### **6.3.1 Research Objective 1: To explore the needs of and challenges faced by children orphaned and made vulnerable by HIV and AIDS in Richmond, KwaZulu-Natal**

#### **6.3.1.1 The needs of children orphaned and made vulnerable by HIV and AIDS**

The needs of the OVCs are similar to the needs of all other children, as indicated in section 2.5 of Chapter 2 and as per findings of this research. All participants identified food, clothing, and shelter as the main needs of OVCs. This is similar to the findings of a study conducted by the HSRC, in which shelter, food, and clothing, were identified as the major needs of OVCs (HSRC 2007:12). The HSRC study also indicated that indigent families find it difficult to provide for the basic needs of OVCs, which is similar to concerns mentioned by the primary caregivers in this study. Taking care of and providing for OVCs is often an additional responsibility for the primary caregivers, who also have their biological children to take care of. The needs that were identified by the participants are summarised as follows:

##### *6.3.1.1.1 Food provision*

Food is one of the basic needs fundamental for any person to survive. It is one of the basic physiological needs, as per Maslow's theory of the hierarchy of needs

<http://www.netmba.com/mgmt/ob/motivation/maslow>). The findings of the research indicated that the provision of food to OVCs is a challenge to primary caregivers, owing to high levels of poverty in the communities, the primary caregivers still having to provide for their own families. This is in line with the study findings of the two researches that were conducted previously, one by Kuo and Operario in KwaZulu-Natal (date unknown) and another by HSRC in 2007. Kuo et al. ([sa]:4) indicate that HIV perpetuates a cycle of poverty and unemployment, which is linked to an inability to access food, clothing and shelter. The HSRC study (2007:15) also found that there are a significant number of OVCs living under difficult conditions, with no food, proper clothing, and shelter. In these cases, the OVCs appeared malnourished, and wore ragged clothing.

The research findings further highlighted that the departments of Health, Social Development and Basic Education, and the Office of the Premier have introduced a number of programmes aimed at providing food in particular to vulnerable children, which includes programmes such as the NIP, the NSP and the Flagship Programme.

The research findings in Chapter 3 indicate that the DSD, the DBE, and the Richmond NIP site provide food to OVCs. Both the literature review and research findings indicated that the DBE provides cooked meals to children in schools, as does the Richmond NIP site, which is also providing cooked meals at the centre. The DSD, on the other hand, provides food parcels to those families who have lodged applications for social-security grants and are still waiting for the grants to be approved. However, 29% of the primary caregivers indicated that their children have never received cooked meals at the NIP centre, and 43% have never received food parcels from the DSD. All primary caregivers were aware of the school nutrition programme, which is implemented by the DBE, by means of which children are provided with cooked meals at school. The primary caregivers indicated that all children in the schools were benefiting from this programme, including children who are neither orphaned nor vulnerable.

The Flagship Programme promotes a “one-house-one-garden” policy to fight poverty in communities. A number (36%) of primary caregivers indicated that they have vegetable gardens at their homes. However, these primary caregivers indicated that

they do not receive any support from any of the government departments or from the local municipality. Although the research findings indicate that various civil society organisations and government departments do provide food to OVCs, the majority of the primary caregivers stated that the availability of food to OVCs remains a challenge. They indicated that it is the responsibility of the Department of Social Development to ensure that there is food for the OVCs.

#### *6.3.1.1.2 Clothing needs*

Provision of clothing to OVCs is also critical. However, some of the primary caregivers indicated that it was sometimes a challenge to provide clothing for the OVCs. Similarly, a study conducted by the HSRC, indicates that the main needs of OVCs include food, shelter and clothing (HSRC 2007:12). This study further indicates that indigent families found it challenging to provide for the basic needs of OVCs, such as food, clothing, shelter, and education. Most of the primary caregivers who were unemployed indicated that they cannot always afford to buy clothes. The primary caregivers indicated that they use the social security grants that they receive from the DSD to buy clothes. However, they stated that the grants were not always sufficient to meet all the needs of the OVCs. Some of the primary caregivers mentioned that the social grants are supplemented by the support they receive from the TCF which includes provision of clothing for children in need. However, funding is not always available as the TCF also relies on donations.

Furthermore, some of the primary caregivers indicated that they had only once received clothes from the NIP site, which also relied on clothes donated by community members.

#### *6.3.1.1.3 Shelter needs*

Security is the second-most important need that must be satisfied for the survival of humans, according to Maslow's theory of the hierarchy of needs (<http://www.netmba.com/mgmt/ob/motivation/maslow>). The study conducted by Mahati et al. (2006:26) indicates that the OVCs, and particularly those in CHH, live in houses that are in a bad condition. The TCF concurred with Mahati et al. (2006)

stating that in some cases they build or renovate houses for OVCs and CHHs. The other key informants also indicated that it is critical that the Department of Human Settlement be involved in the programmes for OVCs to facilitate the allocation of RDP houses to OVCs, especially to the CHHs.

Shelter was also identified by the primary caregivers as of crucial importance. This was identified by the primary caregivers as a challenge and a dire need. One primary caregiver raised the challenge of shelter, indicating that she and her OVCs lived in a two-bedroomed house built of mud and mortar.

Although Mahati et al. (2006:26) showed that OVCs live in houses that are structurally in a bad condition, 43% of the primary caregivers have houses with, on average, six bedrooms. The study conducted by HSRC (2007:14) also confirmed that shelter is a challenge to OVCs, indicating that some of the OVCs were reported to be living in incomplete housing structures or in overcrowded houses, under unhygienic conditions. However, the primary caregivers were not asked to elaborate on the conditions of their houses, as in indicating whether their houses were in a good or bad condition.

#### *6.3.1.1.4 Educational needs*

This study found that the HIV and AIDS strategy of the DBE (DBE 2010:19) seeks to ensure that the OVCs are kept in school, through the programmes such as school-fee exemption, and the feeding-scheme programmes, also known as the National School Nutrition Programme (NSNP). The research findings confirmed the implementation of the DBE's strategy, indicating that six of the primary caregivers were not paying school fees. In addition to school-fee exemption, the research findings indicated that OVCs also received support from the TCF and other community members with school uniforms and stationery. One primary caregiver mentioned a case of taxi owners who had initiated a community outreach programme, in which they purchased and distributed school uniforms to vulnerable children in the communities.

The participants further indicated that, once the children were receiving the grant, they were expected to pay school fees. The participants, however, gave contradictory information on this matter; the primary caregivers indicated that none of the children in the area were paying school fees, yet the NIP representative indicated that the primary caregivers were expected to pay the school fees. The Department of Education (2010:19) indicates that the department intends to implement a “no-school-fee programme”, which aims at improving school enrolment and retention of learners.

#### *6.3.1.1.5 Emotional needs*

Emotional support contributes to the development of self-esteem in children. Studies have shown that in most cases, children who grow up without parents lack emotional support (<http://www.avert.org/aids-orphans.htm>). The TCF agreed with the findings of these studies. They had initiated programmes for OVCs that addressed the challenge of lack of emotional support, such as therapeutic camps that they conduct during school holidays. This study’s findings further confirms that emotional needs must be addressed. Two primary caregivers also mentioned that emotional support was critical, some OVCs having lost both parents, while other OVCs had seen their parents become terminally ill. There was also a case of a child trying to commit suicide because she was not coping with the death of her parents. She had to be offered counselling.

### **6.3.1.2 Challenges faced by children orphaned and made vulnerable by HIV and AIDS**

In addition to the needs of the OVCs, section 2.7 of Chapter 2, and the research findings identified challenges faced by OVCs, which are grouped into three categories, i.e. social, psychological, and economic challenges.

#### *6.3.1.2.1 Social challenges*

One of the social challenges raised by the research participants included the issue of OVCs taking on adults’ responsibilities. Maqoko et al. (2007) found that when

parents became sick or died, children were forced to take on the responsibilities of a parent. However, this was not the case in this study all of the primary caregivers indicated that the children were doing minimal house chores, such as fetching water, and washing their own underwear.

Salaam (2005:10) also mentions that rejection of orphaned children by peers or neighbours starts as early as when the parents fall ill with HIV-related illnesses. The elder child has then to take the responsibility of heading the family and providing care to younger siblings. This has contributed to an increase in the number of child-headed households, as stated by Maqoko et al. (2007). This was not the case with the participants in this study, as the OVCs were all living with their primary caregivers, who were adults. The study could also not find any cases of rejection by either peers or neighbours.

Other social challenges faced by OVCs include stigma, discrimination, exploitation and crime. Salaam (2005:10) states that stigma associated with HIV and AIDS can put children at further risk of discrimination, particularly when children are perceived to be infected with HIV. This results in OVCs being isolated and discriminated against, particularly when their peers refuse to play with them, for fear of being infected. The participants in this study in this regard stated that other people easily exploited the OVCs - neighbours, in particular, often abused girls sexually and emotionally.

Tsheko (2007:18) also states that older community members often subject the OVCs to physical and sexual abuse. Tsheko mentioned that OVCs are easily abused or exploited, having no one to protect or defend them. The DSD representative stated during the interview that OVCs and community members were not aware of their rights. This contributes to exploitation and abuse by other community members. Only 14% of the primary caregivers indicated cases in which OVCs were exploited or discriminated against.

#### 6.3.1.2.2 *Psychological challenges*

The participants in this study identified psychological challenges faced by OVCs. These included a loss of positive self-identity and self-esteem owing to lack of love and a sense of belonging. This finding confirms the research conducted in Uganda in 2005, which concluded that high levels of psychological distress were found in orphaned and vulnerable children (<http://www.avert.org/aids-orphans.htm>). The report shows that anxiety, depression, and anger, were more common among OVCs than in other children. These research findings concur with this study, which indicates that, although some of the OVCs grew up with their relatives, they still felt the loss of growing up without parents. Naidoo (2007:11) states that if this need for belonging and love is not fulfilled, these children often grow up with low levels of confidence and self-esteem, which will affect their self-actualisation.

The participants in this study were in support of this, indicating that the OVCs were unable to show emotion or love because of the trauma that came with their parents' death. However, 57% of the primary caregivers indicated that the OVCs they are taking care of felt part of their families, and considered the caregivers their parents. All interviewed primary caregivers indicated that the OVCs had not received bereavement or trauma counselling, after the death of their parents.

#### 6.3.1.2.3 *Financial challenges*

This study found that financial challenges resulted from the need for the OVCs to contribute financially to their homes. Naidoo (2007:9) states that costs of HIV and AIDS-related illnesses and death can lead households to poverty or destitution. Likewise, the participants in this study mentioned that primary caregivers need money to buy food, clothes, and for general maintenance of the household. Tshenko (2007:18) indicates that the local business people tend to exploit OVCs when they employ them to work as labourers for various heavy and hazardous jobs; the OVCs being grossly underpaid. This study's findings supported this, in that the TCF representative indicated that there are cases where OVCs were paid a paltry R5 for sex.

Furthermore, the findings of this study also indicated that, in some cases, the primary caregivers used the social-security grant money for their own needs, which left the needs of the OVCs unattended. The DSD (2005) indicates that the grant is paid to the primary caregiver, who is supposed to be taking care of the OVC. However, this study found that this is not always the case. One participant was not receiving a grant. The grant was instead paid to someone who was not living with the child. This shows that there are instances in which social grants are not reaching those who are taking care of the children. The grant beneficiaries in this particular case used the grant for their own needs.

To respond to these challenges, the research findings identified strengthening existing NIP sites while establishing more such sites. This will ultimately result in more OVCs receiving financial and material support. The participants in this study indicated that OVCs did not only find support such as food, clothing and assistance with homework at the NIP sites, but they also got an opportunity to socialise with other children with similar experiences and circumstances. The DSD policy (2000) state that OVCs should be provided with material support such as assistance with schoolwork, food, and washing of uniforms at the NIP site. The participants in this study also confirmed that they had received support at the site.

The participants in this study also identified capacity-building programmes as a possible solution to the challenges faced by the OVCs. They stated that government departments should provide communities with more information on issues related to OVCs. This is in line with the principles of the Community Development Approach and Integrated Development Approach, as discussed in Chapter 3, which emphasised building capacities to communities, enabling them to address the challenges on their own (Green and Haines 2007, cited in Phillips 2009:38). This will further equip communities with strategies for interventions in addressing challenges faced by OVCs.

### **6.3.2 Research Objective 2: To explore services provided by key stakeholders rendering services to children orphaned and made vulnerable by HIV and AIDS Richmond, KwaZulu-Natal**

The research findings showed that various service providers are providing services to orphaned and vulnerable children in Richmond. During the interviews with the key informants, these participants indicated that they provide direct services to OVCs. The services provided by these service providers may be summarised as follows:

#### **6.3.2.1 Food provision**

The support rendered by the DBE to OVCs includes provision of cooked meals, as stated by the DBE representative. The DBE representative mentioned that the DBE provides cooked meals to schools through the National School Nutrition Programme. The primary caregivers indicated that all vulnerable children in schools were provided with a cooked meal per school day. This is similar to the National School Nutrition Programme, which provides children with cooked meals at school (Ritchter et al. 2010: 27). A significant number of primary caregivers (43%) indicated that their children were benefiting from the school feeding programme. The school feeding programme provided by the DBE was considered beneficial to the OVC schoolchildren. The findings of this study confirm that the DBE is adhering to its policies of ensuring that children receive a cooked meal at least once a day: the OVCs in this study were all receiving a cooked meal in school.

However, one primary caregiver indicated that the cooked meals were small portions - children were still hungry when they got home. The other primary caregivers, however, felt this food was of assistance, as sometimes they did not have enough money to buy food for the OVCs.

The NIP site is supposed to provide cooked meals to the identified OVCs in the community (AFSA [sa]:3). This was confirmed by the Richmond NIP manager, who indicated that the centre provides cooked meals for the OVCs in the mornings before children go to school, and again in the afternoons. One of the interviewed primary caregivers indicated that the OVCs were receiving meals from the centre until they

receive the social grants from the DSD. One can therefore conclude that the NIP site is providing cooked meals to OVCs.

Furthermore, the findings of this study indicated that the DSD, TCF, and the NIP centre provide food parcels to vulnerable children and their primary caregivers. However, all primary caregivers indicated that they had never received food parcels from the DSD.

### **6.3.2.2 Financial assistance**

The findings of this study indicate that primary caregivers receive financial assistance both directly and indirectly for the care of OVCs. The type of financial assistance that the primary caregivers should receive directly includes the social-security grant, provided by the DSD, through SASSA (DSD 2005). The DSD is supposed to provide social assistance in the form of social-security grants, such as child-support grants and foster-care grants to primary caregivers of OVCs (DSD 2005). All primary caregivers who participated in the study, barring one, confirmed that they were in receipt of foster-care grants for taking care of the OVCs, as per DSD policies. However, the research findings of this study showed that, in some instances, the grant did not reach the intended beneficiaries.

The DSD and the DOH are supposed to jointly provide funding to the NIP site, which in turn provides OVCs with support such as cooked meals before and after school, and support with homework (Ritchter et al. 2010). This was also confirmed in this study by the NIP site manager, who indicated that the centre was funded by both the DSD and the DOH. Furthermore, all participants in this study were aware of this centre, which was described by them as providing support to OVCs.

### **6.3.2.3 Provision of health services**

The research findings of this study indicated that health services are provided by the Department of Health and the Thandanani Children's Foundation. The DOH representative indicated that they use CCGs to provide training to the communities on health-related issues, identifying those in need of health care. The DOH further is

supposed to provide services to undernourished children through the NSP, these children being provided with food supplements (Richter et al. 2010:89). However, only one primary caregiver confirmed that she had received support from CCGs on health-related issues. Two PCs confirmed that TCF provides health services to OVCs, stating that children in their care had been referred to the dentist and an optician, respectively.

#### **6.3.2.4 School-related support**

The Department of Education is supposed to provide support to orphaned and vulnerable children in its school-fee exemption programme, which targets primary caregivers who cannot afford to pay school fees (Richter et al. 2010). This study found that the stipulated acts of DBE are being adhered to, a number of primary caregivers (43%) confirming that learners of the schools in the area of Ndaleni were not paying school fees. However, this was disputed by the representative of the Richmond NIP site, who indicated that it was only those children who qualified for school-fee exemption who were not paying the school fees.

The TCF is also supposed to provide OVCs with school uniforms and to assist the eligible primary caregivers to apply for school-fee exemption. None of the primary caregivers confirmed this to have occurred.

The centre is also supposed to assist OVCs with homework after school. This was, however, disputed by all the primary caregivers, who indicated that they had never received support from the centre with homework, the focus-groups participants did not mention anything in this regard. The primary caregivers, both from the individual interviews and the focus-group discussion have indicated they had received food and clothing from the centre.

### **6.3.3 Research Objective 3: To explore the extent to which the process used by service providers to identify children who are orphaned and made vulnerable by HIV and AIDS facilitate the inclusion of all affected children in Richmond, KwaZulu-Natal**

The research findings of this study indicated that all the identified service providers, with the exception of the DBE, used community caregivers to identify OVCs in the community. The key informants from the departments of Health and Social Development and the TCF stated that they recruit community caregivers who worked as volunteers for their organisations in return for a stipend. Although in most contexts services are provided by the mentioned government departments and civil society organisations, it is members of local communities who play a critical role in providing support to these children.

The findings of this study also indicated that the CCGs are known in the communities, and that the primary caregivers of OVCs acknowledge the assistance they receive from the CCGs. The key informants further stated that it was easier to identify OVCs using CCGs, as the CCGs are placed within and work in their communities, which makes it easier for them to identify children immediately when they are in need of care. As mentioned by the key informants, the CCGs conduct home visits in their allocated households, provide health education to household members, and refer accordingly. This study also found that all primary caregivers indicated that they are aware of the community caregivers who work in their communities and have received support from these CCGs. These findings confirm the strength of the Integrated Development Approach, which allows and encourages the pooling of resources by the various service providers.

However, the key informants identified the challenge of insufficient resources as a hindrance to the provision of services to OVCs. The research participants indicated that funding is not always available to all the OVCs, whose primary caregivers do not always have funds to travel to where they can get assistance, for instance, to apply for social-security grants in the offices of the DSD. The challenge with financial resources is in line with what is highlighted in a study conducted by AFSA ([sa]). The AFSA report indicates that funding by the DSD is usually delayed by two to three

months, which makes it difficult for NIP sites to provide food parcels in time. Also, the DOH is expecting the sites to pay for the first month and then claim for a reimbursement. This means that the departments have to use their own funds, which are not always available, for the first purchase.

The DBE, on the other hand, is supposed to use a different method to the DSD and the DOH of identifying OVCs in need of care. Its representative indicated that they use teachers to identify vulnerable children in schools. This is convenient and feasible for the DBE, because educators are in constant contact with learners during school hours – they constantly observe and assess children during school sessions. This study confirms that the DBE does, through its teachers, identify children in need of care. There was a case reported by one of the study participants of one of the school teachers referring an OVC for counselling.

This study therefore found that the identified service providers have put systems in place to identify OVCs at a community level, as well as in schools. The two processes, wherein OVCs are identified in schools and in a community, allow for those children who were not identified at a community level to be identified by teachers in schools and therefore to be linked to relevant services.

The issue of who should take the responsibility for the care of OVCs is always debatable and critical, even after the OVCs have been identified by the service providers. Some authors argue that this responsibility should lie with the government; while other authors state that the OVCs should be the responsibility of the extended families. For instance, Salaam et al. (2005) argue that OVCs should grow up in their communities of origin. UNICEF (2004) argues that residential care may be appealing because it can provide food, shelter, and education to OVCs. This study found that the majority (57%) of the primary caregivers indicated that the provision of care for OVCs should be the responsibility of the government, specifically of the Department of Social Development, about the provision of food, clothing and shelter. The findings of this study confirm the statement of the NSP (2007 – 2011), which also identified the DSD as playing a leading role on issues relating to OVCs. On the other hand, 43% of primary caregivers indicated that other government departments, NGOs and communities should all work together to

provide services to OVCs. For instance, the participants indicated that the Department of Human Settlement should provide shelter for OVCs, and NGOs were identified as experts in the provision of emotional support.

The majority of the research participants indicated that the best place for the OVCs to grow up is in their familiar communities, in other words, in their places of origin. This would ensure that OVCs are always in touch with their families' principles and values. The participants emphasised that, even after the death of their parents, the community members provided guidance to the affected children. This is in line with an African saying: "*it takes the whole village to raise a child*", which means that the child is not only raised by its biological parents; the community members contribute to the upbringing of the child. These findings are confirmed by Salaam et al. (2005) who maintain that OVCs should grow up in their communities of origin. This is supported by the Community Development Approach, which states that community members should be involved in the implementation of the OVC programmes in their community, which will then benefit the entire community.

However, previous studies have indicated that, owing to high levels of poverty within communities, the relatives or neighbours find it difficult to care for OVCs in their homes (Smart 2003:7). Shelters and orphanages are therefore an alternative, in cases where relatives and neighbours cannot take care of OVCs (Naidoo 2997). Naidoo (2007:37) argues that shelters and orphanages may at least be able to offer most of the material support to OVCs, such as food, clothing and shelter, however, they are often not able to give the children emotional support and a sense of belonging. The research participants in this study that were in favour of shelters and orphanages proposed that the shelters should be in the areas in which where the communities are situated. This would allow for the OVCs to reside in the shelters, however, to continue having close contact with their familiar friends and people, such as community and family members. In other words, the findings of this study confirm that orphanages are an alternative accommodation for OVCs, in cases where relatives are unable to take care of OVCs. However, this study further recommended that these orphanages should be situated within the communities of the OVCs.

#### **6.3.4 Research Objective 4: To explore the degree to which programmes implemented by the various service providers targeting children orphaned and made vulnerable by HIV and AIDS are integrated in Richmond, KwaZulu-Natal**

The findings of this research indicated that the services rendered to OVCs were coordinated and integrated to a limited extent. However, there is still a need for strengthening the integration of services provided to OVCs. The research findings indicated that the work conducted by the CCGs is of a fragmented manner, seeming to be not coordinated within the departments providing services to OVCs. This contradicts the principles of the National Action Plan for the Department of Social Development (2009 – 2012). The NAP stipulates that coordination of services is critical to addressing the needs of, and reaching the majority of OVCs, avoiding duplication and ensuring the optimal use of available resources (DSD 2005:16).

This study found that the provision of services in a non-coordinated manner resulted in the same households being visited by a number of CCGs from different departments, each focusing on different aspect of the work.

The provision of services in an integrated manner is crucial to the success of the programme. Muller (2005:55) states that assistance to orphaned and vulnerable children and their families is to be provided by a combination of community contributions and through the involvement of various governmental departments and NGOs. This was confirmed by one of the key informants, who stated that coordination of activities conducted by different government departments and civil society is critical in avoiding duplication, and in ensure the optimal use of resources.

This study found that all five key informants confirmed that they are working with one another in an attempt to coordinate their activities. They further indicated that this was currently done to a limited extent and in an disorganized manner. The research participants further indicated that the lack of integration or coordination of services led to the same services being provided to the same OVCs, while other OVCs were left without any form of assistance.

The DBE representative indicated that they had a good working relationship with the DSD and the DOH, which allowed them to refer prospective clients to the DSD for social-security grants, and to the DOH for any health-related issues. These study findings are in line with the stipulations of DSD prescripts (DSD 2005:16) which have identified the objectives of coordinating for OVCs as promoting coordination between all stakeholders, sharing information relating to OVCs, promoting collaboration between stakeholders to improve services and programmes for OVCs, as well as mobilising and disbursing services to OVCs at large.

The four key informants, with the exception of the representative of the NIP site, concurred with the above, stating that through the Flagship Project and Child Care Forums they met, as service providers rendering services to OVCs in the area, to deliberate on issues relating to OVCs. These forums were also used for the sharing of information, and for referring cases to relevant service providers. The findings of the study are in line with the Integrated Development Approach, which emphasises key stakeholders planning together to achieve long-term community development.

The key informants further identified strategies for strengthening integration and coordination of services. These included (i) the strengthening of the flagship project; (ii) integration of community caregivers, ensuring that community caregivers work together and provide support to all service providers in the area; (iii) full participation in the meetings of the service providers and cooperation from officials of government departments in particular; as well as (iv) the mainstreaming and prioritisation of matters relating to OVCs by all government departments. These findings confirm the importance of and the objectives of coordinating services provided to OVCs, as outlined by the DSD policies.

The key informants of this study have further indicated that the KZN provincial government has realised that provision of services in a non-integrated manner is causing a problem and confusion at a community level. The Flagship Project, as a result, is aiming at integrating the services provided by the CCGs. These are in line with what was identified by Muller (2205:55), who also emphasised the importance of using an integrated development approach when organisations are providing

services to OVCs. The integrated development approach is similar to the Flagship Project.

This study found that the implementation of the flagship project ensured that once a CCG visit a particular household, it would not be necessary for another CCG to visit the same household. The findings of this study also identify that government departments and other service providers respond timeously to the challenges identified in the communities. This is because each service provider (government department or civil society organisation) attends the set meetings, which addresses service delivery issues. These are in line with Child Care Forums as indicated in chapter 3, section 3.3.2.2. CCFs are supposed to consist of prominent community members whose main responsibility is to facilitate that the needs of OVCs in the community are met (Naidoo 2007:34).

This study highlighted that the DSD, the DBE, the DOH and DOHA were identified by the participants as the key government departments that should integrate the services they provide to OVCs. The four departments were identified by primary caregivers as they render services that are fundamental to the survival of a child. The DSD (2005) states that the integrated approach calls for the Departments of Health, Social Development, Agriculture, Education and Housing to work together and ensure that their respective services are available to all vulnerable children.

## **6.4 LIMITATIONS OF THE STUDY**

There are a number of limitations to this study, which should be taken into consideration when future studies are conducted. These limitations relate to the research design, recruitment of primary caregivers and cost factors.

### **6.4.1 Limitations related to the research design**

The study was conducted mainly as one of the requirements of Masters Degree and the scope of the study is therefore limited. The aims and objectives of this research led to the researcher choosing a qualitative approach, which focused on gaining an in-depth understanding on the needs of and services provided to OVCs in Richmond

(KZN). Participants were therefore limited to representatives of the identified key stakeholders, consisting of service providers and primary caregivers. This study focused on OVCs, and information was only collected from three government departments and two civil society organizations, which provides services to OVCs, as well as from fourteen primary caregivers who takes care of OVCs. As such, the findings cannot be generalized to all OVCs and primary caregivers.

The result of this research should not be seen as representative of the experiences of all primary caregivers. However, further studies can be done in order to generalize the findings to a larger scale.

#### **6.4.2 Limitations related to the recruitment of the primary caregivers**

Primary caregivers were recruited through the organisations that participated in the research, that is the Thandanani Children’s Foundation and the Richmond NIP Site. This poses some level of bias as only primary caregivers that are associated with the two organisations were selected, and those that are not linked with these organisations were excluded. Recruitment of the primary caregivers was limited to the two organisations mainly because of the time factor and also because they were relatively easily accessible through these organisations.

#### **6.4.3 Cost factor**

There were several costs attached to conducting the study, which limited the researcher to focus on a limited number of participants. The costs incurred included traveling to areas where primary caregivers were residing, as well as to the offices of the representatives of the identified government departments and civil society organisations. The cost of conducting a focus group session included travelling back and forth the venue, for both the primary caregivers and the researcher, as well as for the refreshments, provided for the focus group participants.

### **6.5 RECOMMENDATIONS**

The following recommendations are made based on the findings of this study.

### **6.5.1 Recommendations for policy and implementation**

Recommendations for policy formulation and implementation, as emerged from the research findings, are as follows:

- An inter-sectoral OVC Forum should be established, which should consist of all relevant stakeholders from the different sectors, such as government, civil society and the community. The representatives of the key stakeholders with decision-making powers in their own organisations should sit in the Forum. The Forum should provide a platform for all relevant service providers to share lessons learnt as well as information, which should ensure that the duplication of services is minimized while the integration of services is strengthened. The office of the Premier should lead this inter-sectoral OVC Forum, as one of its responsibilities is to co-ordinate services rendered by various government departments in KZN.
- Definitions of OVCs need to be standardized so that all service providers use similar terminology and hence have a similar understanding of the issues affecting OVCs.
- The Flagship Programme must be strengthened, with all service providers participating in the weekly meetings. This should result in the duplication of services being either minimised or eliminated. Roles and responsibilities of each service provider should be clearly defined to avoid role confusion.
- The services provided to OVCs must be strengthened and expanded to include psychosocial support, which currently is offered on a very small scale. The aspects of psychosocial support that need strengthening should include:
  - intensive ongoing counselling, which should include trauma and bereavement counselling;

- the strengthening or establishment of support groups targeting OVCs and primary caregivers, encouraging and helping one another through their shared experiences; and
  - “memory-box” projects which would allow children to remember their parents who have died, enhancing the process of healing.
- Integrated monitoring and evaluation systems should be developed and implemented to monitor progress on the implementation as well as the impact of OVC programmes. Lessons learnt from implementing OVC programmes by different service providers should be documented. These may then be replicated in other areas.
  - The activities rendered by CCGs working with the various government departments should be integrated, and their activities standardised, so as to minimise duplication of services. The training provided to the CCGs should also be standardised, ensuring that CCGs are trained in all services provided by the four key departments, i.e. DOH, DSD, DBE, and DOHA.
  - Capacity-building programmes should be developed, allowing community members to build their capacities, ensuring that they are able to address challenges facing OVCs. This will also ensure that communities are aware of and are able to access all the services available to OVCs and their primary caregivers.
  - Programmes targeting OVCs must be:
    - Must be included and recorded in the IDPs of relevant municipalities to ensure that they are implemented and budgeted for by municipalities. This will also ensure ownership and accountability by service providers, including the municipality.
    - Mainstreamed by all government departments, so that challenges faced by OVCs are prioritised and attended to by all government departments. This will also ensure that all services rendered by government departments and civil society are accessible to all eligible

OVCs. Policy documents developed by government departments should be aligned so that there is harmony in all policies addressing issues of OVCs.

- Capacity-building programmes should be developed for the NIP sites, which should include providing training to the NIP management team on fundraising strategies, so that they are able to write proposals and raise funds, independent of government departments.

### **6.5.2 Recommendations for future research**

The recommendations for future studies on issues relating to orphaned and vulnerable children are as follows:

- More studies focusing on the challenges facing OVCs discussed in this research study must be conducted, assessing possible intervention strategies on ways of addressing the challenges faced by both the OVCs and primary caregivers. Such studies would be an important step in addressing the challenges faced by OVCs.
- Future studies should also include service providers not part of this research, such the departments of Home Affairs, Human Settlement and the Department of Women, Children, and People with Disability.
- It is also recommended that similar research be conducted using a larger sample. For instance, research may include traditional councils, more primary caregivers, and OVCs themselves, accessing a more profound understanding of the experiences of all OVCs and primary caregivers taking care of OVCs.

## 6.6 CONCLUSION

The extent of the HIV and AIDS epidemics is evidenced, among other factors, by the increase in the number of orphaned and vulnerable children in the world, including sub-Saharan Africa and South Africa. The AIDS epidemic is a challenge that will continue to face South Africa, in particular, for decades to come. This study has shown that families and communities are finding it difficult to provide care and support to OVCs, mainly because of high poverty and unemployment levels. In most cases the OVCs are living with their grandparents, who themselves are struggling to support their direct families with the old age pension. Therefore new ways of providing services to the OVCs must be found. These could include integrating and coordinating existing services already provided by various service providers, which could then strengthen the support offered to OVCs.

This study indicates that the needs of the OVCs are similar to those of all other children, however, OVCs are more desperate. The critical needs for OVCs include food, shelter, and educational support. Various service providers are, however, implementing a number of programmes that aim at responding to the needs of and challenges faced by OVCs. These programmes include the school nutrition programme, the no-school-fee programme, and the HCBC programme, as implemented by the DSD and the DOH. The findings of this study, however, indicate that these services are not available to all OVCs in the Richmond area of KZN. There were cases reported by primary caregivers in which services were not reaching their children or families. These include programmes which provide support with vegetable gardens, clothing, and food parcels, mainly from the Richmond NIP site.

This study further indicates that service providers utilise community caregivers to identify OVCs in their communities, while using teachers to identify OVCs in school. The model of community caregivers is perceived as the best model with which to identify OVCs in the communities, the CCGs working in their areas of origin. The CCGs immediately become aware of children in need of care. However, for the model to be effective, CCGs must be capacitated and supported by the relevant service providers.

The study has also shown that the services provided to OVCs are neither fully integrated nor coordinated. This results in the duplication of services, which leads to some areas being neglected, usually those located in the rural areas. However, the findings of this study indicated that the services provided to OVCs are integrated to a certain extent through the government's Flagship Programme. The principles of Integrated Development Approach and Community Development Approach show that, for development to be effective and sustainable, it should be driven and owned by the community itself. The role of service providers should be that of capacitating communities, enabling them to identify their challenges, and assisting them in developing strategies for addressing these challenges.

In conclusion, it is crucial for service providers to integrate and coordinate services provided to OVCs. The involvement of communities in the provision of these services is paramount, so that the support provided can be sustainable, even after the service providers have exited the communities. Programmes targeting OVCs should be mainstreamed and prioritised by all government departments. This will ensure that the support received by OVCs is holistic, and is not limited to the three government departments participating in the NIP sites (i.e. DSD, DOH and DBE).

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## ANNEXURE A: ETHICAL CLEARANCE

UNISA

Department of Sociology  
College of Human Sciences  
15 March 2010

**Proposed title:** *An assessment of the use of an integrated developmental approach in providing services to school-going orphans and vulnerable children affected by HIV and AIDS*

**Principal investigator:** Zanele Priscilla Maseko (student number 32358318)

**Reviewed and processed as:** Class approval (see paragraph 10.7 of the UNISA Guidelines for Ethics Review)

**Approval status recommended by reviewers:** Approved

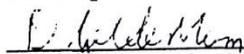
The Higher Degrees Committee of the Department of Sociology has reviewed the application for ethical review and considers the methodological, technical and ethical aspects of the request to be appropriate to the tasks proposed. Approval is hereby granted for the candidate to proceed with the study in strict accordance with the approved proposal and the ethics policy of the University of South Africa.

In addition, the candidate should heed the following guidelines:

- To only start this research study after obtaining informed consent from your research participants
- To carry out the research according to good research practice and in an ethical manner
- To maintain the confidentiality of all data collected from or about research participants, and maintain security procedures for the protection of privacy
- To work in close collaboration with your supervisor(s) and to record the way in which the ethical guidelines as suggested in your proposal has been implemented in your research
- To notify the Higher Degrees Committee of the Department of Sociology in writing immediately if any change to the study is proposed and await approval before proceeding with the proposed change
- To notify the Higher Degrees Committee of the Department of Sociology in writing immediately if any adverse event occurs.

Approvals are valid for ONE academic year after which a request for a continuation of the approval must be submitted to your supervisor(s).

Kind regards



D. Gelderblom (Prof)  
Chair: Department of Sociology  
Tel + 27 12 429 6301

www.unisa

**ANNEXURE B: LETTER TO SERVICE PROVIDERS REQUESTING PERMISSION  
TO CONDUCT STUDY**

P.O. Box 100276  
SCOTTSVILLE  
3209  
21 April 2010

The Manager  
Department of Health  
Health Research and Knowledge Unit  
PIETERMARITZBURG  
3000

**RE: PERMISSION TO CONDUCT AN INTERVIEW**

Dear Sir/Madam

I am registered for the degree of Master of Arts in the subject of Sociology (Social Behaviour Studies in HIV/AIDS) with the University of South Africa (UNISA). As part of the requirements for completing this degree, one is expected to complete a research project. The study will be focusing on investigating the degree to which an integrated developmental approach (IDA) is used in the implementation of HIV and AIDS programmes **for school-going orphans and vulnerable children (OVCs)**. The study will also look at the needs and challenges faced by OVCs. It will also identify different stakeholders working in this field, and the services they are rendering, and look at what extent are these services co-ordinated.

The proposed methodology for this study is to conduct a focus group session with the caregivers and also to interview representatives from different service providers working with OVCs.

I therefore request permission to interview a person managing/co-ordinating the programme for Orphans and Vulnerable Children in the Department of Health. The interview will take almost forty-five minutes and could be held in any place that will be convenient to the interviewee.

The information obtained will solely be used for this research project and confidentiality will be kept at all times. Participation in the study will be voluntary and participants can opt out at any time. I have attached the following documents:

- Research proposal approved by UNISA
- Copy of ethical clearance
- Interview Schedule

Thank you in advance for your co-operation

Yours sincerely

---

**Zanele Maseko**  
**082 457 6146**

## ANNEXURE C: APPROVAL LETTERS FROM SERVICE PROVIDERS



**kzn education**

Department:  
Education  
KWAZULU-NATAL

**PZ MASEKO  
P O BOX 100276  
SCOTTSVILLE  
3209**

Enquiries: Sibusiso Alwar

Date: 08/02/2010

Reference: 0014/2010

### **RESEARCH PROPOSAL: AN ASSESSMENT OF THE USE OF AN INTEGRATED DEVELOPMENT, APPROACH IN PROVIDING SERVICES TO SCHOOL GOING ORPHANS AND VULNERABLE CHILDREN AFFECTED BY HIV AND AIDS**

Your application to conduct the above-mentioned research at the departmental institutions has been approved subject to the following conditions:

1. The Departmental officials are under no obligation to assist you in your investigation.
2. Departmental officials should not be identifiable in any way from the results of the investigation.
3. You make all the arrangements concerning your investigation.
4. Work programmes are not to be interrupted.
5. The investigation is to be conducted from 08 February 2010 to 08 February 2011.
6. Should you wish to extend the period of your survey please contact Mr Sibusiso Alwar at the contact numbers above.
7. A photocopy of this letter is submitted to the principal of the school where the intended research is to be conducted.
8. Your research will be limited to the province of KwaZulu Natal
9. A brief summary of the content, findings and recommendations is provided to the Director: Resource Planning.

...dedicated to service and performance  
beyond the call of duty.

KWAZULU-NATAL DEPARTMENT OF EDUCATION

POSTAL Private Bag 99137, Pietermaritzburg, 3209, KwaZulu-Natal, Republic of South Africa

PHYSICAL Office Q29, 160 Pietermaritzburg Street, Metropolitan Building, PIETERMARITZBURG 3201

TEL: +27 33 341 8610/8611 | Fax: +27 33 341 8612 | E-mail



**kzn education**

Department:  
Education  
KWAZULU-NATAL

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10. The Department receives a copy of the completed report/dissertation/thesis addressed to:

The Director: Resource Planning  
Private Bag X9137  
Pletemmaritzburg  
3200

We wish you success in your research.

Kind regards

**R. Cassius Lubisi (PhD)**  
**Superintendent-General**



**HEALTH**

KwaZulu-Natal

Health Research & Knowledge Management sub-component

10 – 103 Natalia Building, 330 Langalibalele Street

Private Bag x9051

Pietermaritzburg

3200

Tel.: 033 – 3953189

Fax.: 033 – 394 3782

Email: [hrkm@kznhealth.gov.za](mailto:hrkm@kznhealth.gov.za)

[www.kznhealth.gov.za](http://www.kznhealth.gov.za)

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**Reference** : HRKM062/10  
**Enquiries** : Mrs G Khumalo  
**Telephone** : 033 – 3953189

05 May 2010

Dear Ms Z Maseko

**Subject: Approval of a Research Proposal**

1. The research proposal titled '**An assessment of the use of an integrated developmental approach in providing services to school-going orphans and vulnerable children (OVC) affected by HIV and AIDS**' was reviewed by the KwaZulu-Natal Department of Health.

The proposal is hereby **approved** for research to be undertaken at the Department of Health, Umgungundlovu District with the OVC Programme Manager and caregivers.

2. You are requested to take note of the following:
  - a. Make the necessary arrangement with the identified persons before commencing with your research project.
  - b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.
3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to [hrkm@kznhealth.gov.za](mailto:hrkm@kznhealth.gov.za)

For any additional information please contact Mrs G Khumalo on 033-3953189.

Yours Sincerely

Dr S.S.S. Buthelezi

Date: 12.5.10

Chairperson, Health Research Committee

KwaZulu-Natal Department of Health

---

uMnyango Wezempilo . Departement van Gesondheid

*Fighting Disease, Fighting Poverty, Giving Hope*



## PROVINCE OF KWAZULU-NATAL

UMNYANGO  
WEZENHLALAKAHLE  
NOKUTHUTHUKISWA  
KOMPHAKATHI

DEPARTMENT OF WELFARE  
AND POPULATION  
DEVELOPMENT

DEPARTMENT VAN WELSYN EN  
BEVOLKINGSONTWIKKELING

FAX : 033 – 264 2083  
Telephone/ Ucingo /Telefoon : 033 – 264 2000  
Enquiries / Imibuzo / Navroes : Ms Z.G. Gumede  
Reference / Inkombani / Namba : 1011r  
E-mail : Genevieve.Gumede@kznsocdev.gov.za

DEPARTMENT OF SOCIAL DEV  
Private Bag X9144  
Pietermaritzburg  
3200

Dear Ms Z. Maseko

**APPROVAL: RESEARCH PROJECT – ASSESSMENT OF THE USE OF AN  
INTEGRATED DEVELOPMENTAL APPROACH IN PROVIDING SERVICES TO  
SCHOOL-GOING OPRHANS AND VULNERABLE CHILDREN AFFECTED BY HIV  
AND AIDS  
INTERVIEW OF DEPARTMENTAL OFFICIAL**

Receipt of your correspondence in this matter dated 21 April 2010 refers.  
Regret the delay in response.

The Department herein provides an approval to interview an official  
responsible for the coordination of the orphaned and vulnerable children  
programme in the Directorate HIV and AIDS. Ms N. Nala will be the official  
concerned.

It is requested that you undertake the following:

- a) Make the necessary arrangements with the identified person before commencing with your research project
- b) Provide an interim progress report and final report (electronic and hard copies) when your research is complete.

Your final report must be posted to the Department. The Department's  
address is as follows:

Department of Social Development  
Private Bag X 9144  
Pietermaritzburg  
3200

An electronic copy to be forwarded to [Bheki.Nkosi@kznsocdev.gov.za](mailto:Bheki.Nkosi@kznsocdev.gov.za) cc  
[Thobi.Mhlongo@kznsocdev.gov.za](mailto:Thobi.Mhlongo@kznsocdev.gov.za).

Do not hesitate to contact Ms Gumede or Mr Msikinya should you require any additional information. They are contactable at (033) 264 2069 / 2010 respectively.



**SUPERINTENDENT-GENERAL**  
**DEPARTMENT OF SOCIAL DEVELOPMENT**  
DATE: 02 SEPTEMBER 2010

## ANNEXURE D: INFORMED CONSENT

### INFORMED CONSENT FORM

*This questionnaire forms part of the research project carried out in partial fulfilment of the requirements for the degree of Master of Arts in the subject of Sociology (Social Behaviour Studies in HIV/AIDS) at the University of South Africa (UNISA).*

*The main aim of the study is to investigate the degree to which an integrated developmental approach (IDA) is used in the implementation of HIV and AIDS programmes for school-going orphans and vulnerable children (OVCs). The study will look at the needs and challenges faced by OVCs. It will also identify different stakeholders working in this field, and the services they are rendering, and look at what extent are their services co-ordinated.*

*Your cooperation will be highly appreciated, and the information that you provide will be treated in strictly confidential manner. Participation in the study is voluntary, and you can withdraw from the interview at any time you feel uncomfortable and do not wish to continue. The information obtained will be used for this study only. You are therefore requested to participate in the study and respond to the questions as best as you can.*

*Any information that you consider relevant for the study, but not covered in the interview schedule will be appreciated. I am available for any questions that you may have about the study. My contact number is 082 457 6146.*

I, \_\_\_\_\_ hereby give consent to participate in the research. I understand that my participation is voluntary and that I can withdraw from participating in the interview at any time. I understand that the information I provide will be confidential and that my identity will not be revealed at any time.

\_\_\_\_\_  
SIGNATURE OF PARTICIPANT

\_\_\_\_\_  
DATE

Thank you

Yours sincerely

\_\_\_\_\_  
**Zanele Maseko**

## ANNEXURE E: FOCUS GROUP DISCUSSION GUIDE

### 1. PROFILE OF THE CAREGIVERS

*This information will be collected from all eight caregivers that will be participating in the focus group discussion.*

#### 1.1 Gender:

Male	
Female	

#### 1.2 Age group:

20 – 30 years	
31 – 40 years	
41 – 50 years	
51 – 60 years	
61 year and more	

#### 1.3 Employment Status:

Full-time employed	
Part-time employed	
Unemployed	
Pensioner	
Self-employed	
Receiving stipend	
Other: Specify	

#### 1.4 Do you have your own children?

Yes	
No	

#### 1.5 If yes, how many

One	
Two	
Three	
Four	
Five and more	

#### 1.6 How many school-going OVCs are you taking care of?

#### 1.7 How are you related to the OVC that you are taking care of?

#### 1.8 What are the reasons for taking care of school-going OVC?

1.9 What are the challenges you are experiencing in relation to taking care of school-going OVCs?

1.10 How do think should the above challenges (in 1.8 above) be addressed?

## **2. PROFILE OF THE OVCs**

2.1 What is the age group of the OVCs you are taking care of?

2.2 What happened to the parents and relatives of the OVC you are taking care of?

2.3 What do you think are the needs of school-going OVCs?

2.4 Who do you think should provide for these?

2.5 What are the challenges experienced by the school-going OVCs?

2.6 In your opinion, how can the above challenges (in 2.6 above) be addressed?

## **3. SUPPORT**

3.1 What type of support do you provide to the OVC?

3.2 What type of support do you get from NGOs and/or government departments?

3.3 Where do you usually get that support (mentioned in 3.2 above) from, to provide for the OVCs?

3.4 What kind of support do you think are most critical for the caregivers?

## **4. NEEDS OF SCHOOL-GOING OVC**

4.1 In your opinion and experience, what are the immediate needs of school-going OVCs?

4.2 Who do you think should take care of the OVCs?

4.3 Where do you think is the best place for the OVCs to grow up?

## **5. SERVICE PROVIDERS AND INTEGRATION OF SERVICES**

5.1 Which organizations do you know that provide support to caregivers?

5.2 What type of support is provided by organizations in 5.1 above?

5.3 Which organizations do you know that provide support to school-going OVCs?

5.4 What type of support is provided by organizations in 5.2 above?

- 5.5 In your opinion how do these organizations work together in providing support to OVCs?
- 5.6 How can service providers improve the services that they are providing to OVCs?
- 5.7 How do you think service provider should work together in providing services to school-going OVCs?
- 5.8 Which other organizations that you know of that could provide services to school-going OVCs?
- 5.9 With whom in the community should you as the caregiver integrate services to assist yourself as a caregiver?
- 5.10 With whom in the community should you as the caregiver integrate services to assist school-going OVCs?
- 5.11 How can caregivers co-operate with each other to assist each other?

## **ANNEXURE G: SCHEDULE OF QUESTIONS FOR INDIVIDUAL INTERVIEWS WITH PRIMARY CAREGIVERS**

### **1. Identification of Orphaned and Vulnerable Children**

- Who identified the children you are taking of, for services and support?
- Please explain how these children were identified by the person mentioned above.
- Are there any community caregivers in your area?
- In your understanding, what do the community caregivers do in your community? In your explanation please include the following:
  - Who are they linked with?
  - What activities do they conduct?
- How long did it take to get support from these community caregivers, starting from the day the process started?
- Were there any challenges encountered? If yes please describe.
- How were these challenges resolved?

### **2. Needs of OVCs**

#### **2.1 Food**

##### **a) NIP site**

- What do you know about the NIP sites in your area?
- How did you get to know it?
- What services do you, or children that you are taking care of, receive from the NIP site?
- And how often?

##### **b) School feeding programme**

- What do you know about school feeding programme?
- Does the children that you are taking of benefit from this programme?
- Please explain why and how you were selected to benefit from this programme.

##### **c) Support with vegetable garden**

- Have you ever received support with vegetable garden? If yes, please explain
- In your understanding, why and how were you selected to receive this support?
- How does the vegetable garden assist you and your family?
- Do you currently have a vegetable garden?
- If yes, who is assisting you?
- If not, how come you are not having it?

- 2.1 Clothes
- a) School uniforms
- How do you get school uniforms for the children you are taking care of?
  - Please indicate the support in relation to school uniforms, that you have received from any other person and from whom?
- b) Casual clothes
- How do you get casual clothes for the children you are taking care of?
  - Please indicate the support in relation to casual clothes, that you have received from any other person and from whom?
- 2.3 Shelter
- Please describe the house that you live by indicating the number of bedrooms
  - Who owns the house?
- 2.4 Education
- a) School fees or school-fee exemption
- Do you pay school fees for these children?
  - If yes, how do you get the money you are using for paying school fees?
  - How much are you paying?
  - Please explain why you are not getting school-fee exemption, in your knowledge?
  - If not, please explain the process you followed to get to be exempted from paying school fees.
  - How does getting school-fee exemption assist you?
- b) Stationery and books
- How do you get stationery and school books for these children?
- c) Support with homework
- Who assist these children with homework?
  - Please indicate other type of support that you receive with regards to homework?
- 2.5 Emotional support
- a) Counselling
- Did any of these children get help in the form of counselling?
  - Where did you get support for counselling for these children?
  - Please describe cases where the children had to go for counselling?
  - Please describe how was a need for counselling identified.
  - How often do the child or children go for counselling?

- b) Bereavement counselling
    - Did the children get bereavement counselling?
    - Please explain how did they access this counselling?
- 2.5 Medical and health
- Is there anybody helping you with immunization of the children?
  - How do they assist you?
  - Who takes the responsibility of ensuring that the child is immunised?
  - What happens when the child gets sick, is there anyone who helps you?
  - What type of assistance do you get from them?
- 3. Challenges faced by and support for OVCs**
- 3.1 Belonging
- Whom does the child identify with as part of his/her family? Please provide more information about that person.
  - Do you think the child feels part of your family? What makes you think that?
  - Do you think it is important that the child feels part of this family? Why do you think so?
  - What could be done to make sure that the child feels part your family?
- 3.2 Continuous caring
- Is there a person that the child considers close family? Please give details of that person
  - If the child needs anything, who is the first person s/he will go to?
  - How long have you been living with the child?
  - How did you get to leave with the child?
- 3.3 Taking adult's responsibilities
- Does the child help you with the house chores?
  - What does s/he help you with? Please describe type of chores, times of doing those chores and how frequent do they do it?
- 3.4 Abuse, exploitation, discrimination and violence
- How are these children made aware of issues of abuse, violence and exploitation?
  - How are they protected from the above?
  - Please describe cases where they were exposed to the above, and how it was addressed?
- 3.5 Obtaining official documents
- Do the children have birth certificates or identity documents?
  - Please describe the process that was followed to obtain the above documents, including who assisted you and how did they help you?

- Please describe the challenges encountered and how were they were addressed?

### 3.6 Application for social grants

- Do you get social security grants from the Department of Social Development?
- Please describe the process that was followed, indicating type of support that you received.
- Please describe challenges encountered in the process and how these were addressed.

### 3.7 General

- What other services that are targeting OVCs, which you are aware of?
- Do you use any of these services? Please explain
- What makes it difficult for you to access these services?
- How did you as a primary caregiver become aware of these services?

## **ANNEXURE F: INTERVIEW SCHEDULE FOR SERVICE PROVIDERS**

### **1. OVCs**

#### **1.1 Definition of OVCs**

How do you define an OVC?

.....  
.....  
.....

Is there a difference in a way that you define an OVC with other service providers, if so please explain

.....  
.....

#### **1.2 Identification of OVCs**

How do you identify OVCs?

.....  
.....  
.....

#### **1.3 Immediate needs of OVCs and whose responsibility**

From your experience, what are the immediate needs of OVCs? (List 5 in terms of importance)

1. ....
2. ....
3. ....
4. ....
5. ....

In your opinion, who should take the responsibility of the OVCs? (If more than one person / sector is mentioned, indicate who should be responsible for what)

.....  
.....  
.....

#### **1.4 Challenges of OVCs**

What are the main challenges faced by the OVCs? (List them in terms of importance)

.....  
.....  
.....

### **2. SERVICE PROVIDERS**

#### **2.1 Relevant service providers and services offered for OVCs**

Do you know any other organizations / departments providing services to OVC?  
Please list them and the services they are providing

.....  
.....

.....  
.....  
.....

**2.2 Programmes relevant and types of support available to OVCs**  
Please list all the programmes available in your organization targeting OVC

.....  
.....  
.....

**2.3 Relevant policies and legislations**  
Do you know any policies / legislations relecant to OVCs? Please list them

.....  
.....  
.....

**2.4 Integration of Services**  
Do you have scheduled meetings with other service providers to discuss OVCs, if so how often do you meet?

.....

In your opinion how can we strengthen the integration of services between the service providers?

.....  
.....  
.....

## **ANNEXURE G: INTERVIEW SCHEDULE FOR PRIMARY CAREGIVERS**

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- How were these challenges resolved?

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- And how often?

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