

# OVC Programmes in South Africa Funded by the U.S. President's Emergency Plan for AIDS Relief

Summary Report for 32 Case Studies



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- Child Welfare South Africa Asibavikele
- Child Welfare Tshwane HIV Project
- Civil Society Development Initiatives
- CHoiCe Comprehensive Health Care Trust OVC Programme
- Hands @ Work Masoyi Home-Based Care OVC Programme
- Heartbeat
- HOPE *worldwide*/South Africa OVC Programmes
- Ikwezi Lomso Child & Family Welfare
- Inkwanca Home Based Care Programmes
- Isibindi King Williams Town
- Khanyiselani Development Trust
- Makhuduthamaga Home/Community Based Care Umbrella Programme
- Makotse Women's Club
- Masaskhane Women's Organisation
- Motswadibe Home Based Care
- Nhlayiso Community Health & Counselling Centre

- Nurturing Orphans of AIDS for Humanity
- Salvation Army Matsoho A Thuso OVC Programme
- Save the Children UK Community-based Care & Protection of Children Affected by HIV/AIDS and Poverty Programme
- Sekhukhune Educare Project
- Senzakwenzeke
- Sizanani Home Based Care OVC Programme
- South African Catholic Bishops Conference OVC Projects
- The Valley Trust OVC Project
- Vongani Child & Youth Care Development Project
- Winterveldt HIV/AIDS Project
- World Vision/South Africa Networks of Hope Project
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## TABLE OF CONTENTS

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<b>ACKNOWLEDGEMENTS .....</b>	<b>III</b>
<b>LIST OF ACRONYMS .....</b>	<b>V</b>
<b>EXECUTIVE SUMMARY .....</b>	<b>6</b>
Beneficiaries .....	6
Programme Activities .....	6
Programme Services.....	7
Unmet Needs .....	8
Resources.....	9
Programme Challenges .....	9
Conclusion.....	9
<b>INTRODUCTION .....</b>	<b>10</b>
OVC in South Africa and the South African Government’s Approach .....	11
The US Government’s OVC Approach in South Africa .....	12
<b>OVC CASE STUDY METHODOLOGY.....</b>	<b>13</b>
<b>BENEFICIARIES OF OVC PROGRAMMES.....</b>	<b>15</b>
OVC Aged 17 Years or Younger .....	16
OVC Aged 18 Years or Over .....	17
OVC Parents/Guardians/Caregivers .....	18
Communities .....	18
Community-Based Organisations.....	18
Identification of OVC .....	19
Exit from OVC Programmes .....	20
<b>KEY PROGRAMME ACTIVITIES .....</b>	<b>21</b>
Networking .....	21
Home Visits .....	23
Capacity Building .....	23
Drop-in Centres .....	25
Community Sensitisation.....	26
Childcare Forums.....	26
<b>KEY SERVICES PROVIDED.....</b>	<b>28</b>
Food and Nutritional Support.....	28
Psychosocial Support .....	30
General Education .....	32
Child Protection.....	33
General Healthcare.....	34
Economic Strengthening .....	34
HIV Prevention Education or Interventions.....	36
Shelter .....	37
Clinical Nutrition Interventions.....	37
Vocational Training .....	38
Healthcare for HIV-Positive Children.....	38
<b>UNMET NEEDS.....</b>	<b>39</b>
Psychosocial Support .....	39
On-going Food and Nutrition Support .....	40
Shelter .....	40
Education .....	41
Economic Support.....	41
ART for HIV-Positive OVC .....	41
<b>RESOURCES.....</b>	<b>42</b>
<b>PROGRAMME CHALLENGES .....</b>	<b>43</b>
Insufficient Resources.....	43
High Staff Turnover.....	44
Stigma and Discrimination .....	44
Monitoring and Evaluation .....	44
<b>CONCLUSIONS.....</b>	<b>45</b>
Additional Recommendations.....	46
<b>REFERENCES.....</b>	<b>47</b>
<b>APPENDICES.....</b>	<b>49</b>

## LIST OF ACRONYMS

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AI	appreciative inquiry	M&E	monitoring and evaluation
AIDS	acquired immune deficiency syndrome	MK HCBC	Makhuduthamaga Home/Community Based Care
AMREF	African Medical and Research Foundation	NAP	National Action Plan
ART	antiretroviral treatment	NGO	nongovernmental organisation
ARV	antiretroviral	Noah	Nurturing Orphans of AIDS for Humanity
CBO	community-based organisation	NOH	Networks of Hope
CCC	childcare committee	OVC	orphans and vulnerable children
CCC	community care coalition	PLHA	people living with HIV/AIDS
CCCF	community childcare forum	PSS	psychosocial support
CCF	childcare forum	SACBC	South African Catholic Bishops Conference
CHH	child-headed households	SACIN	Sponsor a Child in Need
CPC	Centre for Positive Care	SANCO	South African National Civic Organisation
CWSA	Child Welfare South Africa	SAPS	South African Police Service
DoA	Department of Agriculture	SAWSO	Salvation Army World Service Office
DoE	Department of Education	SCUK	Save The Children UK
DoH	Department of Health	SEP	Sekhukhune Educare Project
DoSD	Department of Social Development	TB DOTS	Tuberculosis Direct Observed Therapy Short Course
ECD	Early Childhood Development	TSA	The Salvation Army
emergency plan	U.S. President's Emergency Plan for AIDS Relief	UNICEF	United Nations Children's Fund
EU	European Union	USG	United States government
FBO	faith-based organisation	USAID	U.S. Agency for International Development
HBC	home-based care	VCT	voluntary counselling and testing
HIV	human immunodeficiency virus	VS&L	voluntary savings and loan
HWWSA	Hope <i>worldwide</i> South Africa	WVSA	World Vision/South Africa
IGA	income-generating activity		

## EXECUTIVE SUMMARY

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Despite the magnitude and dire consequences of the growing number of orphans and vulnerable children (OVC) in South Africa, and elsewhere in sub-Saharan Africa, there is insufficient documentation of the strategies deployed to improve the well-being of these children.

In an attempt to fill these knowledge gaps, the U.S. President's Emergency Plan for AIDS Relief (emergency plan)/South Africa commissioned Khulisa Management Services to research and write 32 case studies of emergency plan-funded OVC programmes in South Africa. The case studies along with this summary report were written to impart better understanding of the important contributions of South African programmes supporting the needs of OVC.

This report summarises the characteristics of the 32 OVC programmes for which individual case studies were written.

### BENEFICIARIES

The main beneficiaries of the 32 programmes studied are OVC themselves, although the definitions of OVC are not standardised across the programmes. OVC are most often identified through home visits and door-to-door campaigns, through schools, by community members, or through self-referrals by OVC themselves.

A secondary group of beneficiaries includes caregivers, parents, and guardians of OVC, as well as the general community. The OVC programmes provide a variety of services to these groups, including HIV counselling, testing and disclosure; referral to clinical services, such as antiretroviral treatment (ART); psychosocial support; and, at times, vocational training.

Finally, a third beneficiary group are community-based organisations (CBOs) working with OVC. Some of the 32 programmes build the capacity of these CBOs to strengthen their work with OVC.

### PROGRAMME ACTIVITIES

Programme activities are the vehicle for providing important services to HIV-affected families, communities, and most importantly to OVC. Across the 32 programmes, several key activities were identified including networking, home visits, drop-in centres, childcare forums (CCFs), community sensitisation, and capacity building of communities, as well as community-based organisations.

Networking and forming partnerships is the most common activity undertaken by the 32 programmes. Alliances typically include those with CBOs, nongovernmental organisations (NGOs), local businesses and various departments of the South African government. Indeed, most programmes rely on linkages with various government

departments for services, such as obtaining important legal documents, applying for social grants, and accessing shelter, food, and healthcare.

Home visits are a common means to identifying and supporting OVC. Most programmes conduct home visits, although the frequency varies widely – from once-a-day to once-a-quarter. The frequency and duration of home visits is often dependent on the size of the programme’s volunteer staff, its caseloads, and the amount of care a specific household or OVC requires.

Drop-in-centres, another means of delivering OVC care and support, are also commonly used by the 32 programmes. The centres serve as structured places where beneficiaries (OVC and their caregivers) come together to access a range of support services including psychosocial support (PSS), income-generating activities (IGA), homework assistance, and recreation. However, some centres are more formal than others, which may consist of an open space in the village.

Community and CBO capacity building is a further common activity for these programmes. The focus of capacity building is generally to improve OVC identification, advocacy, and delivery of support services. Capacity building leverages existing resources, knowledge, and skills at a community level for extending care and support to OVC. Community capacity building also helps to address economic, social, and political bottlenecks to OVC care and support.

## PROGRAMME SERVICES

The emergency plan delineates 11 services to meet the basic needs of OVC and their families. Each of the 32 OVC programmes in this study provides a different mix of these 11 services to achieve their overall aim of supporting OVC.

The most common service provided by all 32 programmes is some form of food or nutritional support. While many programmes distribute food parcels or prepare meals for OVC, some promote food gardens or donate livestock. On average, most programmes provide two food/nutrition services in the same community – usually food gardens and food parcels.

Psychosocial support is another very common service provided by the 32 programmes, including “memory box” therapy, *Journey of Life* workshops, lay counselling, child and adult support groups, art therapy, recreational activities, and debriefing sessions for care workers/volunteers. However, the quality of the PSS service can vary widely, to the extent that the real value of some PSS is unclear.

Many programmes offer child protection services through neighbourhood watches, safe houses, referrals to the South Africa Police Service (SAPS) or other relevant authorities, and workshops/training of relevant staff in child protection policies and strategies.

Support for keeping OVC in formal schooling is a further common service. This service generally involves negotiating with school authorities for fee exemptions for OVC; providing free or discounted uniforms, stationery, and supplies; and, in some cases, sponsoring bursaries.

Vocational training is less common among the 32 programmes. Among those that provide this service, the focus is on training beneficiaries in hairdressing, beadwork, tissue box making, sewing, building/construction, or cooking.

Support in health often takes the form of transporting ill OVC (or family members) to health facilities. Some programmes help OVC to access their antiretroviral (ARV) medication from local clinics as well. Many of the programmes organise and run HIV prevention campaigns and training workshops within their various communities.

Economic strengthening services often focus on facilitating access to social grants for OVC or their guardians. Some programmes also train beneficiaries in income generating activities (such as sewing, beading, and raising chickens), or establish savings and loans schemes for OVC and their families.

Only a few programmes address the shelter needs of OVC through construction/refurbishment of houses. These are usually focused on OVC found in child-headed households (CHHs). A few programmes also

offer clinical nutritional interventions. These interventions involve the distribution of fortified meals to OVC that are malnourished.

## UNMET NEEDS

Most programmes featured are only able to address a portion of the overall needs of OVC. Unmet needs reflect gaps in service provision such as a lack of comprehensiveness of particular services, low frequency of services, or poor quality of services. These gaps occur mainly because of limited resources (human, financial, and infrastructural), limited skills, inadequate quality assurance of OVC programmes, or a lack of appropriate regulations and policies.

From the specific experiences of the 32 OVC programmes, several common unmet needs emerge. Psychosocial support is one such area. Whilst some OVC programmes provide excellent PSS services through well-trained and experienced counsellors, others have either no PSS services at all, or fledgling efforts that lack trained counsellors and knowledgeable professional guidance.

Food and nutritional support is another area of unmet need. All 32 programmes reportedly supply food to OVC but this does not accurately reflect the reality that some programmes only provide such assistance in emergency situations or very occasionally.



Very few programmes offer shelter support services to OVC, ARV care for HIV-positive OVC, or vocational training for OVC or their guardians.

## RESOURCES

All 32 programmes receive funding either directly or indirectly from the emergency plan. Most programmes receive both financial and in-kind support from various South African government departments, such as the Department of Social Development, the Department of Health, and the Department of Agriculture. Some programmes also receive funding (either directly or indirectly) from other donors including the Global Fund to Fight AIDS, TB, and Malaria; the World Bank; and the European Union (EU). Most programmes receive support from private companies that provide financial contributions, donations of food parcels, donations of buildings, skills development, and transportation. Community members also actively contribute their time, often working as volunteers to deliver door-to-door services or work at drop-in centres.

## PROGRAMME CHALLENGES

The 32 OVC programmes in this study have faced a wide variety of programmatic challenges in their efforts to reach and serve South Africa's expanding OVC population. The problem of limited resources — financial and human — not commensurate with growth in OVC is the most common challenge facing these programmes. Resource limits affect staff and volunteer placements constraining the implementation

of programme activities and services. In some programmes, volunteers and staff work without sufficient training, thereby limiting their effectiveness. Turnover of staff and volunteers is high in many programmes, due to low remuneration, burnout, or better job offers.

Another important programmatic challenge concerns high levels of stigma and discriminatory practices towards OVC, which seriously constrains the effectiveness of programme efforts.

Finally, per emergency plan requirements, monitoring of OVC programme activities is routine; however, many programmes have insufficient resources to effectively implement their monitoring and evaluation (M&E) systems. This includes skilled staff, appropriately designed systems, and necessary equipment.

## CONCLUSION

Overall, the 32 programmes do tremendous work for OVC, some with meagre resources complemented by a lot of goodwill from individuals and the communities in which they work. Continued support is imperative as the HIV epidemic renders more and more children vulnerable. Safeguarding these children to give them a chance at a normal life is not an option but a moral obligation for all.

## INTRODUCTION

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This report summarises the characteristics of 32 programmes implementing orphan and vulnerable children (OVC) services and activities in South Africa. These 32 programmes were documented in individual case studies as part of a larger initiative to document and research OVC interventions in South Africa.

The U.S. Agency for International Development (USAID) in South Africa commissioned the 32 case studies and this summary report to gain further insight into OVC programmes that receive financial support through the U.S. President's Emergency Plan for AIDS Relief (emergency plan). USAID purposefully selected the 32 OVC programmes, and the case studies for each programme were researched and written by Khulisa Management Services (Johannesburg) with technical support from the MEASURE Evaluation project. Production of the 32 case studies as well as this summary report was further made possible with USAID/South Africa funding through the Support for Economic Growth and Analysis II project (SEGA II) project.

Despite the magnitude and dire consequences of the growing number of OVC in South Africa and elsewhere in sub-Saharan Africa, there is insufficient documentation of the strategies deployed to improve the well-being of these children. There is urgent need to learn more about how to improve the effectiveness, quality, and reach of efforts designed

to address the needs of OVC, as well as to replicate programmatic approaches that work well in the African context. Government and nongovernmental organisation (NGO) programme managers alike require more information on how to effectively reach growing numbers of OVC with services to improve their well-being. Within the South African context, there is also need to implement more successfully the government's National OVC Framework and Plan of Action.

In an attempt to fill these knowledge gaps, the 32 case studies and this summary report were written to impart better understanding of the important contributions of South African NGOs in supporting the needs of OVC and in designing and delivering effective OVC programming. The overall purpose of the exercise was to answer partially the question, *“What interventions are most effective in terms of models, components, costs, and outcomes in improving the well-being of OVC in South Africa?”*

The primary audience for the 32 case studies and this summary report include OVC programme implementers, policy-makers, and funding agencies addressing OVC needs in South Africa and elsewhere in sub-Saharan Africa. It is hoped that the specific examples from the 32 programmes will offer detailed information about the variety of programmatic approaches undertaken, the range of services offered, as well as the programmes' major challenges and unmet needs. The specific examples from the 32 programmes will further help to inform

current programming, as well as enable wider replication of successful OVC-related initiatives within South Africa and across the region.

## OVC IN SOUTH AFRICA AND THE SOUTH AFRICAN GOVERNMENT'S APPROACH

South Africa has an estimated 5.5 million people living with HIV, the highest number of people living with HIV of any country in the world. As a result, the epidemic is creating a large number of children living without adult protection, nurturing, or financial support.

Of South Africa's more than 18 million children, about 3.8 million children have lost one or both parents (21% of all children), half of whom live in KwaZulu-Natal (26%) and the Eastern Cape (22%). More than 668,000 children have lost both parents, and some 122,000 children are estimated to be living in child-headed households (CHHs). Most CHHs can be found in Limpopo (33%), KwaZulu-Natal (30%), and the Eastern Cape (25%) provinces (Proudlock, Dutschke, Jamieson et al., 2008).

Income poverty, which affects 55% of children, is most prevalent in rural disadvantaged provinces, and is experienced most extensively by African children in South Africa. The HIV and AIDS epidemic destroys children's lives by forcing them to assume caregiver and provider roles. Most OVC live with and are cared for by a grandparent or a great-grandparent, more than 81% according to the United Nations Children's

Fund (UNICEF). Without adequate protection and care, OVC are more susceptible to child labour and sexual or other forms of exploitation, increasing their risk of acquiring HIV infection.

In response to the magnitude of the problem in the country, the South African government issued a Policy Framework for OVC in 2005, a blueprint for the care of OVC. The Policy Framework, along with the National Action Plan (NAP) issued in 2006, provide a clear path for addressing the social impacts of HIV and AIDS and for providing services to OVC. The NAP's six key strategies are:

1. strengthen the capacity of families to care for OVC
2. mobilise community-based responses for care, support, and protection of OVC
3. ensure that legislation, policy, and programmes are in place to protect the most vulnerable children
4. ensure access to essential services for OVC
5. increase awareness and advocacy regarding OVC issues
6. engage the business community to actively support OVC.

In all instances, family and community care is prioritised, and institutional care is viewed as a last resort.

## THE US GOVERNMENT'S OVC APPROACH IN SOUTH AFRICA

The United States government's (USG) multi-faceted OVC approach is consistent with South Africa's OVC Policy Framework. Through the emergency plan, the USG provides direct support to the South Africa Department of Social Development (DoSD) and to diverse local and international NGOs to scale-up existing OVC programmes that complement and support the DoSD efforts.

Emergency plan OVC partners focus on innovative ways to scale-up OVC services through integrating systemic interventions; supporting and training volunteers, caregivers, and community-based organisations; and by addressing service delivery issues. The USG emphasises quality improvements in the delivery of OVC services and works to ensure a standard-based approach to quality in programme planning and implementation among emergency plan partners. To ensure high quality, the USG defines "direct OVC service provision" as when an OVC receives at least three out of the following 11 services:

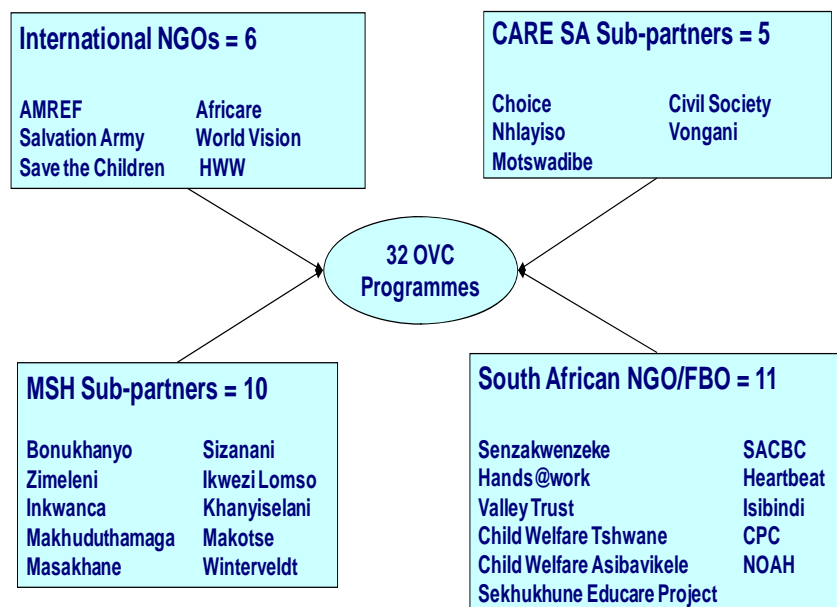
1. **clinical nutrition interventions;**
2. provision of targeted, short-term **food and nutritional support** and leveraging food and/or food parcels from other sources such as the DoSD, private sector companies, and churches;
3. **shelter and care;**
4. **child protection** (i.e. birth registration, identification, and inheritance issues);
5. **psychosocial support;**
6. assistance in accessing **general healthcare;**
7. healthcare support specifically for **antiretroviral therapy (ART);**
8. **HIV prevention education** or interventions (e.g., life skills, etc.);
9. **vocational training;**
10. increased access to **education** (including the provision of school uniforms, after-school tutoring, etc.); and
11. assistance in accessing **economic support** (social grants, income-generating activities, etc.).

The USG assistance in South Africa aims to build the capacity of local organisations and encourage sustainable interventions for OVC. In this regard, several smaller organisations that previously received USG funding through an intermediate emergency plan partner have graduated and now receive direct USG funding and manage their programmes directly.

## OVC CASE STUDY METHODOLOGY

To document the strengths of the 32 emergency plan-funded OVC programmes selected for these case studies, Khulisa conducted (i) document reviews; (ii) key informant interviews; (iii) workshops with local staff, volunteers, beneficiaries, and community members; and (iv) site visits to observe programme activities.

USAID/South Africa selected the 32 OVC programmes to be studied based on a cross section of sizes and maturity of programming. Below is a breakdown of the OVC programmes covered by this set of case studies by organisation type.



Khulisa designed this study using an appreciative inquiry (AI) approach. AI was chosen as the overarching approach because it seeks out and identifies “the best” in an organisation and its work. In other words, applying AI in research inquires into what works within an organisation and what it does well, rather than the conventional approach of looking at what is broken and needs to be fixed.

*“Appreciative Inquiry is about the co-evolutionary search for the best in people, their organisations, and the relevant world around them. In its broadest focus, it involves systematic discovery of what gives “life” to a living system when it is most alive, most effective, and most constructively capable in economic, ecological, and human terms. AI involves, in a central way, the art and practice of asking questions that strengthen a system’s capacity to apprehend, anticipate, and heighten positive potential”*

*David Cooperrider, co-founder of appreciative inquiry*

Based on AI methodology, a variety of respondents from each programme (staff, volunteers, beneficiaries, and community members) were randomly paired to interview one another using an interview guide that explored the best aspects of their OVC programme. One member of the pair later re-told the other’s story to the larger group. Unfortunately, this approach proved to be challenging due to community level participants’ low literacy levels and a lack of experience in interviewing. These participants found the evaluation-focused questions to be complex and, therefore, their “stories” lacked descriptive detail. After

eight workshops where the initial approach was used, it was clear that the expected high-quality information was not being obtained through this method.

Consequently, the tools and the interviewing methodology were revised toward conducting AI-oriented group interviews. From there on out, each OVC programme underwent two group interviews – one with programme staff/volunteers, and another with beneficiaries/community members. Khulisa researchers facilitated the group interviews using the new AI-oriented tools. The facilitators were able to rephrase the AI terminology (e.g., “extraordinary”), which participants did not always understand, and to better explain the questions. This allowed for more probing and, thus, stories with greater detail. Translations were also conducted when necessary (South Africa has 11 official languages). Participants were encouraged to tell their stories to the whole group, rather than just to a fellow participant. After the group interviews, which functioned much like focus group discussions, any outstanding questions were submitted to the participating programmes via telephone calls and e-mail, which helped to round-out the picture of each organisation and its OVC programming.

The modified approach led to a better understanding of, and responses to, the AI questions as it allowed for specific probing and gathering of richer stories. Additionally, the participants found the emotional telling of and listening to stories to be informative and cathartic; service

providers felt more encouraged in their work; and the beneficiaries and stakeholders gained better understanding of their OVC programmes. The revised approach also resulted in positive organisational development spill-over effects, useful to many of the programmes as a whole. The revised AI approach was also successful in identifying good practices, local innovations, and common challenges, which can be shared across OVC programmes in sub-Saharan Africa and worldwide.

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*“For me, I learned about what is happening on the ground – I learned about the challenges field-workers are facing on the ground. I know the impact of not being able to debrief, the psychological effect one goes through due to overwork. This workshop was like a debriefing session.”*

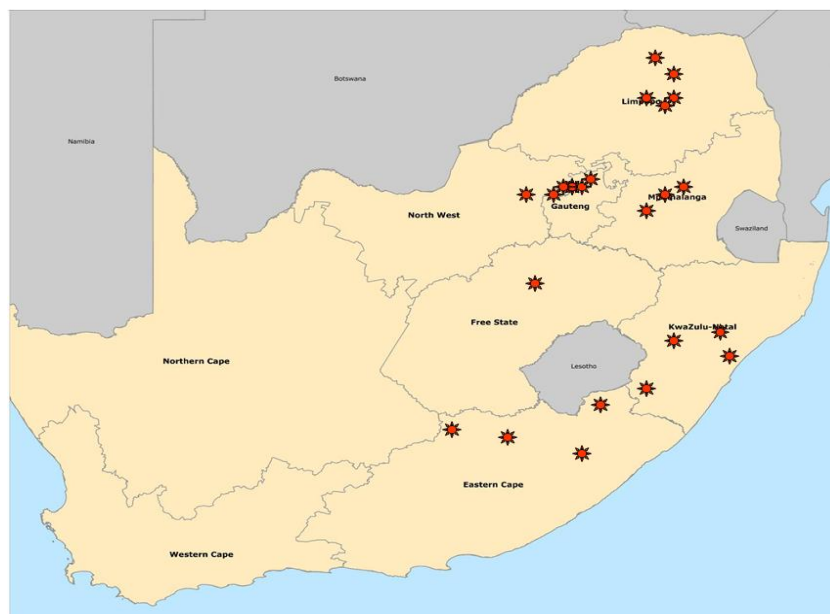
**AI workshop participant**

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Within the 32 individual case studies, the OVC programmatic approaches are described in depth, including methods of beneficiary selection, descriptions of the key programme activities, and the various services delivered. Programme innovations, challenges, and unmet needs are also detailed.

It is our hope that these individual case studies, along with this summary report, will stimulate the emergence of improved approaches and more comprehensive coverage in the effort to support OVC in resource-constrained environments.

**Figure 1: Location of Khulisa site visits to the 32 OVC programmes in South Africa**



## **BENEFICIARIES OF OVC PROGRAMMES**

Organisations working in the field of OVC do so primarily to improve the lives of these children, either through providing services to them directly or through capacitating others working on the grassroots level to provide them with an array of services. Thus, OVC can either benefit directly from the services provided to them, or indirectly, when activities and services are initially delivered at an organisational level before filtering down to them.

Children who benefit from these interventions are those deemed vulnerable due to the conditions in which they live. These could be children who are either single or double orphans after the death of one or both parents; children whose parent/guardian or caregiver is ill; children who lack proper shelter; or children who are at risk of abuse or neglect. The exact definition of an OVC differs from one programme to the next, as the social ills that put children at risk as well as the direct impact of the HIV and AIDS epidemic vary from one locality to the next.

Most beneficiaries within the 32 programmes are children who, according to programmatic definitions, are either “orphans” and/or are deemed “vulnerable.” Typically in OVC programmes, accurate tracking of children by age is rarely an organisational priority or, in some instances, such tracking is beyond the capacity of the programme. Thus, reliable information on numbers of OVC served by age could not

be obtained from all of the programmes. Children served were more easily classified into two broad categories, those 17 years of age or younger, and youth 18 years of age or older. Some programmes break this down further into pre-school-, primary school-, and secondary school-aged children.

In addition to benefiting OVC, activities and services offered by OVC-focused programmes also tend to benefit OVC parents/guardians/care givers; communities; as well as other organisations working with OVC that are strengthened through capacity-building activities.

### **OVC AGED 17 YEARS OR YOUNGER**

The South African government's policy is to target and serve OVC below 18 years of age. Most donors take their lead from the South African government and, thus, the majority of programme funding is restricted to activities and services for children younger than 18 years of age.

Indeed, all 32 programmes either directly or indirectly give services to OVC below 18 years of age, and the majority of OVC beneficiaries in these programmes are 17 years of age or younger. Only a few programmes extend their services to orphaned and vulnerable youth 18 years of age or older.

Within the birth-to-17 years of age group, children in the formative years (5 years or younger) have additional vulnerabilities, as events such as

malnutrition, or the lack of mental stimulation can have lasting negative effects on their cognitive development that may later hinder their academic capacity. In a country such as South Africa where personal success is often linked to good academic performance, these children face an uphill battle toward financial independence and a life free of the poverty in which most of them find themselves when they are young.

Cognisant of this situation, programmes such as Hands @ Work Masoyi Home-Based Care OVC Programme (Hands @ Work) put special emphasis on helping children 6 years old or younger in order to give them a better chance of succeeding in life. This point was put across simply yet powerfully by the one of the Hands @ Work staff members:

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*"If children do not have the necessary development in place by this age, they will be playing catch-up for the rest of their lives."*

**CEO, Hands @ Work, key informant interview**

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Though activities and services are primarily aimed at OVC, some programmes such as Nhlayiso Community Health and Counselling Centre's OVC Programme (Nhlayiso), Salvation Army's Matsoho A Thuso OVC Programme (Salvation Army), Save the Children-UK's Community-Based Care and Protection of Children Affected by HIV/AIDS and Poverty Programme (SC-UK), and Sekhukhune Educare Project (SEP) allow other



children access to their services (such as after-school activities at kids clubs) in an attempt to prevent stigmatising OVC. These programmes believe that opening their services to all children make OVC less vulnerable to discrimination from their communities. A member of the community where SC-UK is active had this to say about their targeting approach:

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*“SC-UK taught us to identify vulnerable children, but it provides for all the children in the household and doesn’t discriminate. The services offered are reliable and relevant according to the needs of the community.”*

**Community member, AI workshop**

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## **OVC AGED 18 YEARS OR OVER**

Despite the South African government’s policy and the associated limited funding for OVC 18 and older, 10 of the 32 programmes also extend services to this older age group.

This is especially helpful for youth who, even though they are over 18 years of age, are still school. By 18 years, most children in South Africa are expected to have completed secondary school (i.e., matriculated), and be preparing to begin tertiary education. However, in the case of OVC, many fall behind in their education due to factors such as taking time off from school to care for sick parents/guardians, or because they

lack finances to pay the necessary fees. In recognition of this, some OVC programmes make exceptions to the age-limit and continue to support OVC beyond their 18<sup>th</sup> birthday, especially in supporting continued education.

Beyond support for secondary school education, vocational training services for youth over 17 years of age provide them with an opportunity and the skills to be self-sustaining and financially independent. Where the programme is unable to provide this service directly, it often refers youths to other organisations that can. For example, CHoiCe Comprehensive Health Care Trust’s OVC Programme (CHoiCe) refers youth 18 or older to loveLife, and World Vision/South Africa Networks of Hope Project (NOH) links these adolescents to a sponsor that can help fund their continuing education.

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*“Children of all ages benefit. We also include youth in this. Youth, however, get involved in other activities. They graduate from being OVC, they then volunteer, and specialize in the different areas. They have the possibility of becoming staff members at a later stage.”*

**Project director, Sekhukune Educare Project, key informant interview**

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## OVC PARENTS/GUARDIANS/CAREGIVERS

It is well recognised among the 32 OVC programmes that children individually targeted cannot be helped in isolation. Thus, where resources allow services are also extended to their parents or guardians. These adults are often assisted with psychosocial support and counselling (including counselling on HIV voluntary counselling, testing, and disclosure), referral to clinical services such as ART, and assistance with navigating the DoSD for access to social grants. By ensuring that those who care for OVC are in good health and are capacitated, these programmes help to ensure that these children are well cared for by capable individuals in safe and familiar environments.

## COMMUNITIES

Communities also directly benefit from activities carried out by OVC programmes. Community sensitisation on issues such as the vulnerability of children, identifying OVC, signs to look for related to child abuse, and HIV prevention awareness reportedly result in increased knowledge levels in recipient communities. In some communities, the community-wide benefits have become so common that OVC identification and referral is done by members of the community, as they have been made aware of the services available to help these children.

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*“Community members can also be looked at as beneficiaries, since we also do door-to-door activities, where we educate them on human rights and/or how to deal with orphans in order to get past the stigma and pertaining issues.”*

**OVC/HBC coordinator, Vongani Child and Youth Development Project**

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## COMMUNITY-BASED ORGANISATIONS

Some OVC programmes realise that more can be achieved for OVC by working through established organisations in communities. By working through local community-based organisations (CBOs), these programmes attain a reach far beyond what they could with their own resources. Thus, OVC programmes such as the South African Catholic Bishops Conference OVC Projects (SACBC) and Makhuduthamaga Home/Community-Based Care Umbrella Programme (MKHCBC) primarily gear their programmes toward building partnerships with CBOs working with OVC to capacitate them to be more efficient and effective in serving OVC.

This is usually done through strengthening the CBO’s financial and human resources management as well as improving their monitoring and evaluation systems. The CBOs then deliver the required services to OVC at ground level. In these instances, CBOs are regarded as the prime beneficiaries with OVC as the secondary beneficiaries. Four of the 32 programmes included in this study give direct organisational development services to other organisations working with OVC.

## IDENTIFICATION OF OVC

Most of the 32 OVC programmes identify OVC through home visits conducted by staff or volunteers or via door-to-door campaigns in targeted areas. Some OVC are also identified when home-based care is given to ailing parents or guardians.

Schools and drop-in centres are also important entry points for many OVC. They provide unique environments where children can be monitored on a regular basis. Indicators such as declining academic performance, declining personal hygiene, absenteeism, and withdrawal from group activities are all signs that can be easily detected and followed up by teachers. Twenty of the 32 programmes (63%) reported that schools and drop-in centres are places where they primarily identify OVC.

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*“The schools are an important source of recruitment of children because of the ongoing feedback given by teachers and principals. They can see firsthand when there are improvements or declines in behaviour and school marks.”*

**HOPE worldwide staff AI interview**

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OVC also are identified by community members, who direct staff members and volunteers to the locations of OVC. In areas where childcare forums (CCFs) have been formed, the forums also identify

OVC. Community leaders, such as village headmen, nurses in hospitals and clinics, policemen, and religious leaders also help to identify and to refer OVC to organisations or centres where they know vulnerable children can be helped. At times, OVC also self-refer when they know other children who are part of the programme.

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*“We have 169 community child-welfare member organisations .... The programme trains members within the community to identify vulnerable children (i.e, children who have been orphaned or who are living in child headed households). The programme builds on relationships with the community to encourage referrals of vulnerable children.”*

**Child Welfare South Africa national programme manager for child protection,  
key informant interview**

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After OVC have been identified, enrolment into a programme is usually followed by a structured needs assessment, which can include an evaluation of household head status, living conditions, and an individual’s nutritional, educational, and financial requirements. The needs assessment usually informs the range of services the individual OVC requires.

Most of the 32 OVC programmes strive to provide a comprehensive package of services to holistically meet the needs of OVC. The services range from meeting immediate physical needs (such as food provision) to more intrinsic needs (such as emotional, spiritual, and psychosocial

counselling). Some programmes require consent from parents, guardians or caregivers before an OVC can be enrolled into the programme. However, the range of services that programmes offer is more often limited by financial and human resources. Some OVC programmes strive to begin service delivery with the OVC with the greatest needs, mirroring the triage system used in emergency medical care.

### **EXIT FROM OVC PROGRAMMES**

Inevitably, children leave OVC programmes. The most commonly cited reasons for exiting a programme include migration to other parts of the country where the specific programme is not active or reaching 18 years of age. Other reasons include an OVC being taken-in by a family member, adoption, an OVC becoming recipient of a social grant, or completion of secondary school.

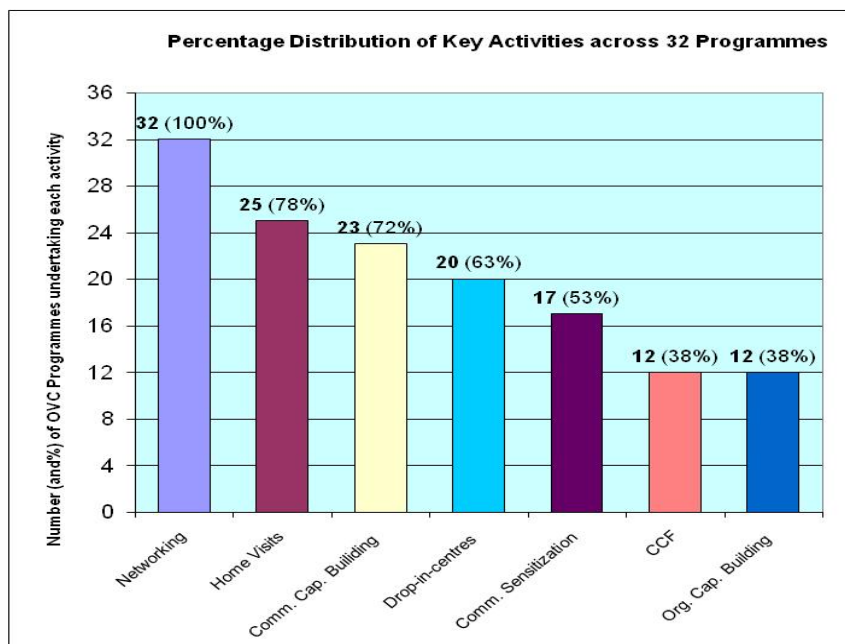
Some programmes try to prepare OVC for their eventual exit from the programme. They encourage them to learn income generating skills or join the OVC programme itself as a volunteer where they can then benefit from the training and later use it to secure a job.

The reality is that, as OVC grow older, it is imperative that the programmes establish exit plans for all activities and services, lest children exit the programmes only to be made even more vulnerable than before due to a total lack of support.

## KEY PROGRAMME ACTIVITIES



Programme activities are the vehicle for providing important services to HIV-affected families, communities, and most importantly to OVC. Across the 32 programmes several key activities were identified and investigated, including CCFs; home visits; drop-in centres; organisational capacity building; community sensitisation; community capacity building; and networking. Although most of the programmes conduct



similar activities, many are modified to cater for specific programme requirements. This section summarises these activities utilising examples from the programmes.



### NETWORKING

Networking is crucial to the success of OVC programmes because it identifies complementary service points, promotes the development of referral systems, identifies duplication of effort across NGOs and CBOs, and serves as a crucial step to cementing partnerships and thus offering a full array of services to communities and vulnerable groups.

Networking was the most common activity mentioned by the OVC programmes studied. All 32 OVC programmes (100%) report that they network with an array of stakeholders to facilitate the implementation of their programmes. Networking was common with groups from the public sector (such as local government departments, ward councillors, local government officials, public health clinics, and schools) as well as the private sector (such as other NGOs, CBOs, faith-based organisations [FBOs], and businesses).

Other important stakeholders include traditional healers and community leaders. Informal and formal gatherings, such as community meetings, provide valuable opportunities for dialogue and subsequent development of partnerships. Some programmes use this avenue to

network. For example, the African Medical and Research Foundation (AMREF) hosts large meetings called “jamborees” where CBOs, FBOs, and government departments get together to enable OVC to access services on site and to educate communities about the support structures generally available to OVC.

The large majority of the 32 programmes (29 or 91%) collaborate with formal partners. Alliances typically include those with CBOs, NGOs, local businesses, and various government departments. These alliances are essential as they increase the resource base of programmes to better serve OVC. For example, HOPE *worldwide* South Africa (HWWSA) has established relationships with the Department of Home Affairs (DoHA) to ensure OVC receive legal documentation, such as birth certificates and identity documents; with the Department of Housing (DoH) to promote the allocation of Reconstruction and Development Programme (RDP) houses to OVC; and with several companies for the supply of regular material or financial assistance such as food, transportation for staff, school fees, vocational training, technical assistance, and educational materials.

Programmes use various strategies when cementing partnerships, ranging from the development of informal relationships to drawing up and signing formal agreements. For example, AMREF/South Africa Sekhukhune and Umkhanyakude OVC Project collaboratively develops

implementation plans with its local level partners and, following this, signs “service-level agreements” with them.

Another form of networking is building referral linkages with complementary services. Seventeen of the 32 programmes (53%) refer OVC for additional services they themselves cannot provide. Numerous programmes refer beneficiaries to social workers to support them with specific issues, including dealing with cases of child abuse, accessing shelter, and assisting with applications for grants. Beneficiaries are also referred to clinics for healthcare needs, including ART, and to partner organisations, which CHoiCe does, for specific services, such as psychosocial support, which they cannot provide.

Some programmes, including SC-UK and SACBC, partner at the national level to influence policy positively for OVC care on a nationwide scale. SC-UK and SACBC achieve such scale through their alliance with the inter-ministerial Steering Committee of the National Action Committee for Children Affected by HIV and AIDS (NACCA). Through NACCA, these programmes played an active role in the national effort to roll out CCFs to all municipalities. They also played a role in the development of the National Strategic Plan (NSP) on HIV and AIDS which highlights the responsibility of schools to be more actively involved in OVC care.



## HOME VISITS

Home visits are the second most common activity used by the 32 OVC programmes. Home visits are used to provide home-based care (HBC) to individuals living with HIV/AIDS, specifically palliative care; to supply essential services, such as food and nutritional support, psychosocial care, and assistance with applications for legal documentation, such as birth certificates and support grants; to support children in doing their homework; and, to monitor and evaluate OVC well-being.

Twenty-five of the 32 programmes (78%) send either trained volunteers or staff members to conduct home visits. The frequency and duration of visits varies widely from once-a-day to once-a-quarter. This is due to the wide range in the numbers of programme staff or volunteers, their case loads, and the amount of care or services an OVC or household requires.

Two examples of programmes conducting home visits include SEP and Isibindi King William's Town (Isibindi). SEP, in similar fashion to most of the programmes, uses volunteers to provide HBC and to identify, assess, and deliver services to OVC. The services comprise psychosocial support, homework assistance, material support, and making referrals for any other services needed. The regularity of SEP's home visits is based on the needs of each household, but they commonly range from once-a-week to five-times-a-week.

Isibindi, on the other hand, is unusual in its approach in that its volunteers are encouraged to form relationships with specific families that are visited each and every day for up to three hours at a time. Isibindi's volunteers are encouraged to ensure each day is special by making children feel loved and important. They do this by performing a range of services, including the provision of psychosocial support, cooking, washing and ironing school uniforms, conducting life skills training to increase children's competency and independence, and, assisting children with their homework.

HBC services are often offered during home visits. However, such services primarily are offered in the form of palliative care for ill adults. Nonetheless, a few programmes offer children HBC services, for example, CHoiCe. Several programmes, such as Inkwezi Lomso Child and Family Welfare, have HBC programmes that provide ongoing support to those infected with HIV and their families, including children. Generally, HBC providers are trained in antiretroviral (ARV) treatment for adults and children, TB treatment through Directly Observed Treatment Short-course (DOTS) therapy, HIV prevention and care awareness, palliative care, and one-on-one counselling.



## CAPACITY BUILDING

Building capacity (specifically of communities) is the third most common activity mentioned among the 32 OVC programmes. Most capacity

building is conducted directly with communities, although a few programmes focus on building the capacity of local CBOs as described below.

### *Capacity Building of Communities*

Building the capacity of communities to support the needs of its OVC is an international best practice executed by 23 of the OVC programmes (72%). Most community capacity building is central to the OVC programme because it uplifts and advances the status of impoverished and vulnerable communities and individuals, and helps to ensure the survival, sustainability, and future of these communities and vulnerable groups within them.

Common community-level capacity building initiatives involve building the skills of influential members of the community to better identify and care for OVC (for example through community child care forums), providing vocational skills training and support to community members to make them more employable, or establishing income generating programmes to improve households' economic status.

Among the many community capacity building efforts of the 32 OVC programmes are some interesting examples:

- Vongani Child and Youth Care Development Project (Vongani) has established voluntary savings and loaning (VS&L) groups to build economic support within the community.
- Senzakwenzeke facilitates the training of traditional healers in the Department of Health's accredited HIV/AIDS course so as to strengthen their response to the pandemic and to tackle stigmatisation of OVC in their communities.
- Isibindi's vocational skills training and support to community members avails the unemployed with marketable skills to make them more employable.
- Child Welfare South Africa Asibavikele (among many programmes) trains key community stakeholders to identify and refer OVC. This enables otherwise neglected children to benefit from a range of OVC services available in their communities.

In addition to addressing current community needs, capacity building brings the difficulties faced by OVC on a daily basis to the fore. In so doing, this activity promotes and preserves the necessary care of OVC within communities in South Africa on a sustainable basis.

### *Organisational Capacity Building*

Strengthening the professional development of local CBOs and NGOs is a significant activity for improving the scope and quality of services to



OVC. Of the 32 programmes, 12 (38%) build the capacity of local CBOs/NGOs. The scale of interventions varies considerably, with some programmes providing only limited support to their partners (such as Khanyiselani Development Trust (Khanyiselani)) whilst others (such as MKHCBC) provide capacity-building activities as their core business. Khanyiselani offers fledgling projects advice and invitations to training workshops they provide to their own staff, whilst MKHCBC supplies its 28 member organisations with on-going support and training on a range of topics for improving the member organisations' operating structures to better serve OVC.

Organisational capacity-building interventions also vary considerably. Some, such as CHoiCe, which is accredited with the South African Health and Welfare Sector Education Training Authority, provide accredited training courses on key service topics, including psychosocial support, and establishing and running CCFs. Others offer formal and informal instruction on an array of operational topics, such as financial management, human resource management, and the establishment of monitoring and evaluating (M&E) systems. For example, SACBC strengthens the capacity of its 32 sub-partners via workshops on various topics, such as financial and project management.

Heartbeat's 22-month training programme (the *Tswelopele Mentorship Programme*) consists of three training blocks involving academic learning, internships, and practical implementation support. It teaches

participants about the Heartbeat model for OVC care/support, encouraging them to adapt it for use in the context of their own communities. To maximise success, Heartbeat deploys a mentor to participants over the duration of their training. This mentor supports and monitors the participant's efforts to implement the OVC care/support programme. Apart from the lengthy *Tswelopele Mentorship Programme*, Heartbeat also provides shorter ad hoc training modules as requested.

As part of organisational capacity building, five OVC programmes (16%) provide sub-grants to other NGOs, CBOs, or FBOs to assist in the delivery of key services. This is significant as a lack of resources remains an outstanding issue in OVC programming across South Africa.

The SACBC, a sub-grantee of Family Health International through the emergency plan and USAID/South Africa funding, provides its 32 sub-sub-grantees with funding and training to improve their responsiveness to OVC in their communities, resulting in increased OVC programme capacity in eight of the nine provinces in South Africa.



### **DROP-IN CENTRES**

Drop-in centres serve as structured places where beneficiaries come together, usually Monday through Friday, to access services. Drop-in-centres generally provide psychosocial support, homework assistance,

and a safe space where OVC can play with other children. Many centres also provide food; however, the frequency of this provision varies across programmes. For example, Bonukhanyo Youth Organisation's OVC Project (Bonukhanyo) offers one meal per child during school days, whereas Masakhane Women's Organisation supplies three meals per day, seven days a week.

Some centres have been set-up to serve a specific group. World Vision/South Africa (WVSA) NOH Project is one such example. It has a centre specifically for disabled children, where they can receive special care. Centres allow programme staff/volunteers to monitor the beneficiaries and, if appropriate, to intervene and provide additional services, or refer the children for further support.

Twenty programmes (63%) have drop-in-centres; making it the fourth most common activity among the 32 programmes. However, some centres are more formal than others. For example, Nhlaysi creates village centres that are informal spaces, under trees or in yards around volunteers' homes. It is here that volunteers offer counselling and a safe and nurturing environment to play. Kids clubs are other mechanisms used, for example, by Salvation Army's Matsoho A Thuso Programme and HWWSA. In the kids clubs, children spend time in a supportive environment where some of their needs can be met. Informal centres such as these generally do not provide food or nutritional support given their lack of structure or funding to do so.

These centres are, in most cases, open to all children from the surrounding community.



## COMMUNITY SENSITISATION

Seventeen of the 32 programmes (53%) mobilise communities through sensitising local stakeholders and the general public to OVC-related issues and the local programming activities available. Grassroots mobilisation contributes to community ownership, builds advocacy and raises awareness of OVC, all of which contribute to the sustainability of programmes and continued care and support of OVC.

Sensitising the community is an activity undertaken by many programmes. For example, WVSA NOH Project engages with civil society to form community care coalitions (CCC); MKHCBC continually communicates with the communities it (and its member organisations) serves, resulting in the provision of information about specific OVC in need; and, Nhlaysi successfully campaign, educate, and dialogue with the community about child abuse and, in so doing, increase the protection of children.



## CHILDCARE FORUMS

Childcare forums are an international best practice embraced in the South African context. The DoSD's 2003 *Guidelines on the*

*Establishment of Childcare Forums* outlines the importance of the forums in caring for OVC. According to the guidelines, the mission of the CCF is to “mobilise communities for early identification of children and families in need to provide comprehensive care, including physical, emotional, social, economic, and spiritual care, which is sensitive to culture, religion, and value systems in order to maximize the quality of life for OVC.”

Twelve (38%) of the 32 OVC programmes study utilise CCFs to reach OVC. The CCFs help to identify OVC, ensure they have access to essential services, and monitor and evaluate the provision of services to OVC. Membership in CCFs typically includes influential individuals from the community and involves capacitating them through training sessions. Representation can include staff members of the South African Police Service (SAPS), teachers, local clinic staff, traditional healers, traditional leaders, and local government officials, predominantly from the Department of Health and Department of Social Development. All CCF members volunteer their time to undergo training, meet on a regular basis, and assist OVC in their community.

While some programmes use alternative naming conventions for their forums, all essentially perform similar functions. For example WWSA NOH Project uses the term community care coalitions, whereas Heartbeat refers to community childcare forums.

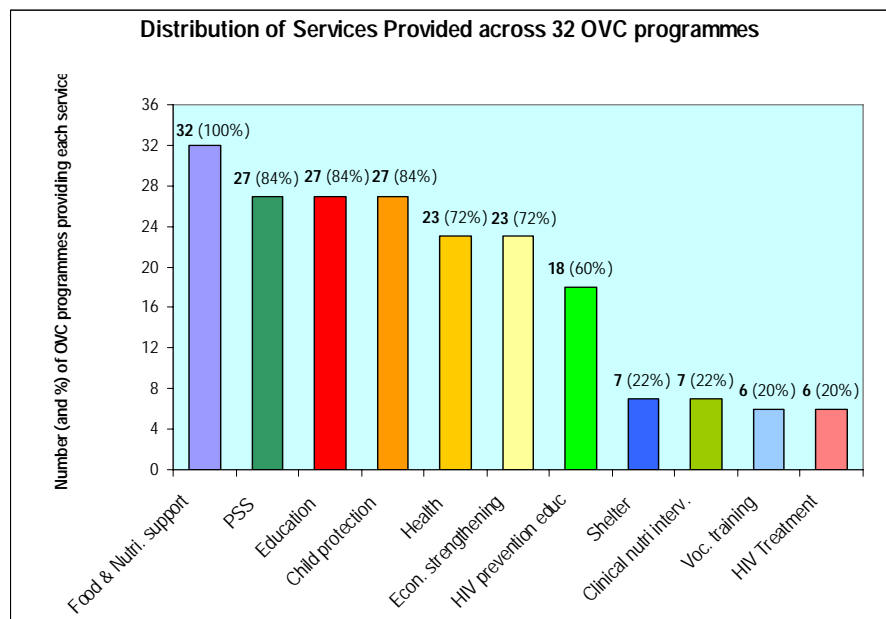
Some CCFs perform unique functions in addition to those outlined above. For example, CCF members of Inkhwezi Lomso Child and Family Welfare frequently come together to discuss challenges facing children and, following this, participate in advocating for protection and enforcement of the rights of OVC on the local level. Civil Society Development Initiatives (CSDI), on the other hand, uses its forums to prevent duplication of effort by NGOs, to monitor cases of abuse, and assist children in need after hours.

CCFs are vital structures for improving the lives of OVC. They identify and ensure OVC gain access to essential services. This might be done by a CCF member referring a child (or in some cases even escorting the child) to the appropriate person for assistance within a school, clinic, government department or local organisation and then following-up to ensure the child’s needs were met sufficiently. Furthermore, and most importantly, these forums promote community involvement that is imperative for the long-term sustainability of support and care of OVC.

## KEY SERVICES PROVIDED



The loss of a parent or illness in the family is extremely disruptive to children, placing them at a distinct disadvantage in obtaining the support necessary for their welfare, or in securing their long-term survival. Therefore, meeting the basic needs of children and young people made vulnerable by HIV/AIDS is not only vital for ensuring their current well-being, but it is also critical to their future. The emergency plan delineates 11 services to meet the basic needs of these children,



as highlighted on page 12. Each of the 32 OVC programmes provides a different potpourri of these services to OVC with the overall aim of meeting their basic needs. Their efforts are thus tailored into a package that is as comprehensive and cross-cutting as available resources will allow. The end result is that the OVC whom these programmes reach, either directly or indirectly, get access to services they otherwise would not have. Furthermore, based on the “stories” told by the beneficiaries themselves, their lives are changing for the better, thanks to the programmes reaching out to them in their communities.

The following section summarises these OVC services with accompanying stories from those whose lives have been most affected.



### FOOD AND NUTRITIONAL SUPPORT

Sadly, for children orphaned by AIDS or who have parents or guardians suffering the ravages of the illness, hunger is a stark reality that they face on a daily basis. Fortunately, however, all 32 OVC programmes (100%) in this study provide some form of food and nutrition support. The type of food and nutritional support that are provided to OVC varies across programmes – from food parcels, to prepared meals, to food gardens or livestock donations. On average, most programmes provide two food and nutrition services in the same community – usually food gardens and food parcels.

### *Food Gardens*

Promotion of gardens is the most common food and nutrition service provided by the programmes. Twenty-seven programmes (84%) have either established have their own gardens or encourage OVC and their families to grow food gardens. These gardens aim to sustain OVC and their families, as well as to generate income when excess harvest is sold.

South Africa's Department of Agriculture (DoA) is often a prime resource to many OVC programmes that promote and manage food gardens, providing seedlings, fencing materials, and agricultural expertise. Examples of programmes managing food gardens include Noah, Africare/South Africa Injongo Yethu HIV/AIDS Project (Africare), and CHoiCe.

One innovative garden programme, implemented through Africare, encourages beneficiaries to produce medicinal herbs in their gardens for personal use. Traditional healers assist in labelling plants in terms of their nutritional value, as well as their medicinal properties.

### *Food Parcels*

Twenty-two of the 32 programmes (69%) distribute food parcels, which usually consist of maize meal, beans, canned fish, cooking oil, and fortified porridge. South Africa's DoSD is one of the main sources for these food parcels, but other donors, such as Tiger Brands and Shoprite

(two private-sector food-related companies), often make contributions to OVC programmes.

Typically, food parcels are distributed at drop-in centres or by caregivers during home visits. Heartbeat distributes food parcels to OVC on a relatively frequent basis, i.e. monthly, while other programmes (e.g. Bonukhanyo and Child Welfare-Tshwane HIV Project) can only afford to do so in emergencies; that is, when volunteers or caregivers identify OVC in dire need of food and then send food parcels to the affected households.

### *Prepared Meals*

Sixteen programmes (50%) are involved in preparing meals for OVC; although, again the frequency varies among the programmes. While most programmes prepare meals once a day (usually lunch on Mondays to Fridays), some like Masakhane Women's Organisation prepares meals for OVC three times a day, seven days a week. OVC generally access these meals before and/or after school; at soup kitchens, drop-in centres, after-school centres, resource centres, or feeding centres. One programme, Inkwanca HBC Programmes, operates a "meals-on-wheels" programme and distributes cooked meals to needy children and bed-ridden people once a day, three times a week.

## Livestock

Three OVC programmes (9%) provide OVC and their guardians with livestock, such as chickens or goats. These animals and their by products (e.g., eggs and milk) are then used by the OVC either for consumption or sold to generate income.

Food and nutrition support is one of the most powerful services provided by OVC programmes, as seen by the stories below from beneficiaries:

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*“There was a family where two boys from a CHH were begging for food by going house to house. Since Heartbeat came into their lives, they have changed and are no longer begging. They are fat because they are getting the help they need. They are getting Morvite [a vitamin-rich porridge] now.”*

**Beneficiary, Heartbeat**

*“I had six children but two of them and their father died. The programme started helping us after the death of my husband and the home visitors came to check on us. Three of my children are going to school and the programme gave them two chickens each. The chickens are now laying eggs. The children get something to eat in the morning before they go to school and during short breaks they come home and I quickly fry eggs for them to eat”.*

**Beneficiary, World Vision**

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## PSYCHOSOCIAL SUPPORT

The impacts of HIV/AIDS on children can be devastating. Children often witness the decline of their parent’s health and eventual death. Many OVC struggle to understand such loss and may blame themselves for their parent’s death, or believe they are being punished. Furthermore, some of those that support OVC, such as grandparents, care workers/volunteers, live with the trauma of HIV/AIDS in their own lives. Recognising that psychosocial support (PSS) for OVC and their carers is therefore crucial, it is one of the most common services offered by the 32 programmes.

Twenty-seven programmes (84%) provide some form of PSS. This support includes, but is not limited to, activities such as “memory box” therapy, *Journey of Life* workshops, lay counselling, one-on-one counselling, child and adult support groups, art therapy, recreational activities, and debriefing sessions for care workers/volunteers. These activities usually take place at OVC homes (during home visits), at drop-in centres, resource centres, workshop venues, or at playgrounds.

One-on-one counselling to OVC during home visits is the most common form of PSS delivered by the programmes. Through repeated visits, care workers and volunteers become confidantes to OVC and can monitor their emotional status to provide counselling, as needed. Home visits also provide an avenue for “memory box” therapy, one of the most

common types of formal therapy provided. In “memory box” activities, caregivers act as memory facilitators to assist children in remembering their parents and reaffirming their memories by preserving items belonging to their parents (such as souvenirs, letters, photographs, and clothing) in a box.

Other forms of psychosocial support include group therapy sessions. Programmes such as CHoiCe and Nhlayiso run weekly group therapy sessions over a 10-12 week period for OVC. The average size group consists of about 15 children and one or more facilitators/ counsellors. As much as possible, support group sessions are interactive and provide a non-threatening and non-discriminatory atmosphere where OVC share their experiences.

Adult support groups are less common among the 32 programmes. When organised, they focus mostly on OVC household members, such as grandparents or care workers. However where adult support groups are organised, such as at Heartbeat, these sessions usually entail debriefing of participants to help them cope with the challenges of caring for OVC.

Several programmes also ensure that OVC are involved in recreational activities, such as sports, music, drama, and other activities offered at drop-in centres. These programmes (e.g. Hands @ Work, Centre for Positive Care [CPC], Noah, and CSDI) generally believe that group-based

recreational activities help OVC to cope with their bereavement and to recover faster.

Other programmes employ the services of experts who specialize in psychosocial support. These experts either train care workers/ volunteers or facilitate workshops for the OVC themselves. For example, SACBC partners with the Regional Psychosocial Support Initiative (REPSSI) which facilitates *Journey of Life* workshops for the programmes’ care workers. SC-UK trains its CCF members in “play skills” by the Rob Smetherheam Bereavement Centre, based in Bloemfontein, South Africa. CHoiCe goes a step further by referring OVC who “fail to heal” or fail to benefit from their PSS to other counselling institutions.

The impact of psychosocial support on the lives of its beneficiaries is captured in the statements below:

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*“I have learned...how to take care of myself as an orphan...and [to] have respect [for] other people, and we [also] get the educational camps and the outings. I experienced that I am not the only one with a problem. The respect that I get from the project, and also the help that I get, and support I get from the care givers...I don’t feel like an orphan anymore.”*

**Beneficiary, Salvation Army**

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*“They also guide us....like when I heard (my) kid was positive, I was crying all the time, but Mpho [care giver] came and talked to me. Within three months, I was happy, and the child is doing well up ‘till today.”*

**Beneficiary, Heartbeat**

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## GENERAL EDUCATION

For most OVC in South Africa, a good education is beyond their financial means. Fortunately, most of the 32 OVC programmes (27 or 84%) provide some form of educational support, such as negotiation with school authorities for school fee exemptions; provision of free or discounted uniforms, stationery, and supplies such as pens, pencils, and schoolbooks; and, in some cases, bursaries.

Caregivers or volunteers in these programmes also assist OVC with their homework, either during home visits or at after-school centres. One programme, Vongani, actually helps OVC prepare for examinations and follows up on report forms to assess OVC school performance. SC-UK works with youth facilitators (two per school) in the programme’s service areas. These youth facilitators help OVC with homework and follow up on OVC who are frequently absent from school to determine the cause of their absenteeism. Another programme, CPC, operates a back-to-school campaign at the beginning of the school year to ensure that all OVC return to school for the new academic year.

For younger OVC, some programmes (e.g., Noah) specialise in early childhood development (ECD) methodologies, which they apply to children attending day-care centres. Noah specifically reports that OVC who have participated in the ECD programme adjust better to formal education.

To keep the OVC positively engaged during the holiday seasons, some programmes, such as Heartbeat, organise holiday classes at camping sites where they teach OVC other skills that extend beyond academia, such as bush survival and camping skills.

Most programmes stop supporting OVC once they graduate from high school. However, Hands @ Work and Heartbeat have programmes in place to ensure that graduating OVC can either further their education at tertiary level or gain vocational skills. For example, Hands @ Work runs a forward education programme, which is directed at OVC who have performed well in their high school matriculation exams and require financial assistance to continue to the tertiary level. Heartbeat has a similar tertiary education fund for OVC who are high academic performers.



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*“When I received a uniform I felt proud because they supported me. Before this, I did not have [a] uniform or food. There was a sense of relief from then, and a feeling of belonging because I no longer felt different from other children. Before this, I was not seen as the same as other children because I did not have a school uniform. Now there is knowledge that someone cares, and through this I was able to develop myself at school.”*

**Beneficiary, AMREF**

*“I want to thank Zimeleni. I was staying with my grandmother and not attending school. There was no food and no soap to wash. I was delayed at school because I have no parents. Because of Zimeleni, I attend school like other children. I am proud to be a scholar. I love education. I am very thankful to Zimeleni because I wear a uniform to school like other children.”*

**Beneficiary, Zimeleni**

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## CHILD PROTECTION

Recognising that OVC are at risk of various forms of abuse, the majority of the 32 programmes (27 or 84%) have established various initiatives and mechanisms to protect the children. OVC face the reality of social neglect and stigma, which often places them at risk for physical, sexual, or emotional abuse; exploitation (including trafficking); and seizure of inherited property by unscrupulous relatives. The range of child protection support offered by these programmes includes neighbourhood watches, safe houses, referrals to SAPS or other

relevant authorities, and workshops and/or training of relevant staff in child protection policies and strategies.

In most programmes, caregivers and CCF members play a vital role in identifying abused children. Hence, programmes such as SACBC and AMREF facilitate training workshops on child protection for their staff. Other programmes, such as Motswadibe HBC, go so far as conducting anti-stigma and child protection campaigns in their communities.

Inkwanca HBC and Hands @ Work form neighbourhood watches or child protection committees within their communities. These consist of volunteer community members whose responsibility it is to seek, identify, and report cases of child abuse in their communities. Cases of abuse are then be reported to SAPS or other programmes, such as the Greater Nelspruit Rape Intervention Programme (GRIP), which provides emotional and medical assistance to sexually-abused children, or the South African National Civic Organisation (SANCO), which addresses physical abuse situations. Inkwanca HBC goes a step further by running 16 safe houses at strategic locations in the community, locations where children and women can take refuge from abusive domestic situations. These houses belong to good-natured families or individuals in the community who volunteer their homes to be used as safe houses whenever the need may arise. On average, these safe houses can accommodate as many as 12 children at a time.

Such initiatives, as those mentioned above, are highly commendable because the threat of abuse, as captured in the following statements, is ever present with OVC:

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*“Last March, they received a letter indicating there were plans to abduct children and then prepare them sexually for the forthcoming 2010 Soccer World Cup. Since OVC have meagre resources and less social networks and supervision, they were likely to be targets of this abduction strategy. Consequently, Vongani and partners decided to host anti-child abduction campaigns. The campaigns were held at Vongani Centre and at Siyandhani Primary School. Each campaign reaches about 750 or more children, among them OVC.”*

**Advocacy facilitator, Vongani Child and Youth Development Organisation**

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## GENERAL HEALTHCARE

Twenty three of the 32 programmes (72%) provide general healthcare services which mainly consist of assisting OVC to access health facilities when they are ill. Care workers/volunteers identify sick OVC during home visits and accompany them to the nearest health facility or mobile clinic. Some programmes, such as Africare and SC-UK, train their care workers/volunteers to check the OVC’s “Road to Health” cards to monitor their growth and developmental progress, as well as their immunization status. When required, OVC are accompanied to health facilities for immunizations.

A few programmes, such as Hands @ Work and Ikwanca HBC, have a dedicated nurse that accompanies care workers during home visits or attends to OVC at the drop-in centres. Generally, programme care workers/volunteers are so well known in their communities that they often are the first people to be asked for help when there is a health emergency, providing a valuable service to the community as a whole.

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*“I am the mother of a sick son. We were sitting at home, my son was very ill, and I was taking care of him. We had no help, and life was difficult. Then Motswadibe HBC came to visit me at home. They took my child to the hospital. There was a strike at the time, so they gave him some medication.”*

**Beneficiaries, Motswadibe HBC**

*“We work with the local clinic. We have a mobile clinic [from the South African Department of Health], which comes here once in two weeks. We manage to take all the children to this mobile clinic. There is this story about an OVC whose mother passed away with HIV/AIDS. The child was also affected with this virus. Then the care worker was able to take this child to the clinic every week for TB treatment. Then the child was referred to the hospital for more medication. This is only possible with collaboration with the clinic – this works very well.”*

**Caregiver, Makotse Women's Club**

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## ECONOMIC STRENGTHENING

Virtually all the programmes in this report operate in economically disadvantaged parts of South Africa where unemployment rates are high – often over the national average of 33%. More so, OVC and their

caretakers often experience diminished cash resources and productive capacity owing to the burden of illness and/or death of family breadwinners.

Against this backdrop, 23 of the programmes (72%) provide some form of economic strengthening for OVC and their families. These include enabling OVC or their guardians, to access social grants, training them in income-generating activities (IGA), participating in savings and loans schemes, etc.

While various social grants are available to South Africans, many OVC and their caretakers are too impoverished, illiterate, or unaware of the grants for which they may be eligible. OVC and their caretakers also experience difficulties accessing identity documents, mostly due the lengthy processes and backlogs at DoHA. Most programmes have developed linkages with the DoHA to ease the process of acquiring identity documents, a prerequisite for accessing social grants.

Furthermore, many programmes actually send their staff to the relevant government departments to process the grants for the OVC or their caretakers. The types of social grants available to OVC and their families or caretakers include child support grants, foster care grants, and disability grants. Often these grants form the bulk of income for many OVC, if not their entire income, especially in child- or granny-headed households.

Aside from assistance in accessing social grants, some OVC programmes such as Inkwanca, Noah, and CPC also provide training in such IGAs as sewing, beading, and raising chickens. These activities, targeted to OVC, their caretakers, as well as programme staff, serve to provide alternative revenue for self-sustenance. For example, Heartbeat supported an OVC throughout the child's schooling and subsequently trained and then employed the OVC to run their garden project. This not only strengthened the OVC economically, but provided succour to several other impoverished families in that community. Care workers and volunteers are not left out – they also receive training in IGA as they are often not remunerated (or only minimally remunerated) for their services.

Other OVC programmes use VS&L groups as another approach to economic strengthening. Programmes such as Vongani, Motswadibe HBC, and Nhlayiso encourage OVC and their family members to join VS&L as a means of saving money, investing their grants, and spending funds wisely. The VS&L initiatives are reportedly highly successful in easing the burden of poverty in their communities.

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*"I learnt life doesn't start and end here because I don't have parents myself. If I have problems, I can go to Heartbeat. They are a shoulder to cry on. They help us with many things, like to get grants for the children, get ID [identification documents] for them from home affairs."*

**Participant, beneficiary AI workshop**

*"I was staying home doing nothing, and I had children. I was wondering what to do. I was lonely. I came to FCC. They helped me. They gave me clothes and food. I started beadwork, and at month end I have money. I buy my children food. I have something I did not have before. I can take my children to the cinema. Now I am living like others. When I joined the support group, they gave beads, and at month end they give food parcels."*

**Beneficiary, Child Welfare Tshwane**

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## **HIV PREVENTION EDUCATION OR INTERVENTIONS**

To create awareness of issues surrounding HIV and AIDS and related illnesses, 18 of the programmes (60%) design and run prevention campaigns and training workshops within their various communities to provide basic HIV/AIDS information and to correct myths and stereotypes surrounding HIV and AIDS. The main target group of these campaigns and workshops are the programmes' staff, volunteers, OVC, and the community as a whole. Recognising the potential influence of highly respected community leaders in South Africa (such as local pastors and *Indunas* or chiefs), programmes such as Zimeleni HBC OVC

Project (Zimeleni) involve these individuals in delivering prevention messages so as to increase the probability that the community will accept the message. Prevention education is also delivered by care givers during home visits to OVC and their family members.

Because it is essential that HIV prevention interventions for OVC are age-appropriate, several programmes use approaches such as peer education to reach children. Noah, for example, has piloted the "Soul Buddyz" club for primary-school children and "Dance4Life," which uses dance to communicate messages about sexual behaviour and HIV/AIDS. Noah also collaborates with the Centre for Support of Peer Education (CSPE), an initiative of the Harvard School of Public Health, on the development, design, and testing of a peer education curriculum for OVC.

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*"The training I received is special for me and the children because they are benefiting from my skills. I used to be very ignorant about HIV/AIDS, but I have gained a lot from the training. Dealing with infected people [with respect and care] is one thing I learnt from attending the workshops."*

**Volunteer, Noah**

*"I think Vongani has educated me a lot, especially when it comes to social issues such as HIV/AIDS, early pregnancy, just to mention a few. They also encourage abstaining rather than 'condomizing,' when we're talking about the issue."*

**Beneficiary, Vongani**

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## SHELTER

Because many OVC are left in unsafe environments or without suitable shelter, seven programmes (22%) address the shelter needs of OVC in their areas. SACBC and Hands @ Work construct and refurbish houses for OVC, especially CHHs in dire situations. Child Welfare Asibavikele also runs houses for OVC, which they call *Thokomala* (“comfort” in Zulu) houses. Children in *Thokomala* houses are cared for by a foster mother. Child Welfare Asibavikele also assists families interested in fostering OVC, helping them to legalise such relationships through the court system. Other programmes, including SEP and SC-UK, refer OVC in dire need of shelter to the local government councillors, or local municipalities, for assistance with acquiring RDP houses, i.e. government housing. Child Welfare Tshwane goes as far as negotiating with municipal rental offices for reasonable rental rates and utility bills on the behalf of OVC.

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*“Motswadibe brought change in the community. They help vulnerable children apply for RDP houses. Around 50 vulnerable families are waiting for RDP houses that are under construction. About 80 have acquired RDP houses.”*

**Social Worker, Motswadibe**

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*“I told them my story about how I didn’t have a place to stay with my six-year-old daughter. A Thokomala house was built here in Wattville, where needy children can stay. My daughter now stays there in a healthy environment, safe, and warm, and also attends preschool now. I visit her once or twice a week. I am very happy about the reward I got from the project.”*

**Beneficiary, Child Welfare Asibavikele**

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## CLINICAL NUTRITION INTERVENTIONS

Clinical nutritional interventions are among the least-common service delivered by the 32 OVC programmes. Only seven programmes (22%) report offering clinical nutrition interventions; most of them involving the distribution of fortified meals to OVC, especially to those who are malnourished. For example, Noah, Child Welfare Tshwane, CPC, CHoiCe, and Winterveldt HIV/AIDS Project (Winterveldt) provide instant fortified porridge (also known as e-pap) to very ill and malnourished children. E-pap is usually obtained directly from the Department of Health. Winterveldt also negotiates with local clinics to provide free formula milk to HIV-positive mothers unable to breastfeed. Yet another programme, Hands @ Work, provides OVC with multivitamins when available, and ensures that children are de-wormed twice yearly to improve nutritional absorption.

In developing countries, malnutrition underlies more than 50% of deaths among children under five years of age. The interventions mentioned above, albeit limited in scope and reach, serve to ensure that OVC do not succumb to this potentially deadly, but not uncommon, condition in South Africa.

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*"I am proud of Sizanani because it gives nutritious food to the children and to the sick."*

**Beneficiary, Sinzanani**

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## VOCATIONAL TRAINING

Vocational skills training is the least common service provided by the 32 programmes. Only six programmes (20%) offer vocational training, and these provide to a wide range of beneficiaries (including OVC, grannies, and care workers) with skills training in areas such as hairdressing, beadwork, tissue box making, sewing, building/construction skills, and cooking. Programmes involved in vocational training, such as Hands @ Work and CHoiCe, place significant value on teaching these skills, as they are seen as a means of future income generation. Most skills training are conducted by staff members of the programmes, or even volunteers from the community with relevant skills.

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*"One of the most amazing things about this project is the volunteers' determination to improve their skills for job creation. There is a lot of unemployment in the community, and volunteers also want to teach people skills so that they can generate their own income. The volunteers are very concerned about the community and are determined to make a difference."*

**Area manager, Child Welfare, Asibavikele**

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## HEALTHCARE FOR HIV-POSITIVE CHILDREN

Only six of the 32 programmes (20%) support ART services to OVC who are HIV-infected. Winterveldt and Masakhane Women's Organisation help OVC to access their ARV medication from local clinics. Care workers either accompanying the children to collect ARV medications or actually receive the medication on the child's behalf. Care workers who are appropriately trained, such as those working at Noah and Khanyiselani, also monitor ARV adherence by OVC to ensure effective treatment. Hands @ Work runs a separate shelter at their drop-in centre where HIV-positive OVC can sleep undisturbed and receive extra medical attention when necessary. Child Welfare Tshwane goes a step further by assisting OVC from foreign families, mostly refugees from neighbouring Zimbabwe and Mozambique, to acquire temporary identification papers needed to access ART at government health facilities.

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*“Isolabantwana looks at children’s “Road to Health” cards. They also look at medication dosage schedules. When Isolabantwana workers go to homes and find parents have no money to take kids for medication, no transport, or no ID documents, and they are needed for OVC from foreign families who need ARV, Child Welfare gives us money for photos, and transport money, and also [to] look for temporary ID books. We look after all the children, even if they are non-South Africans.”*

**Participant, Child Welfare Tshwane**

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## UNMET NEEDS

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Given the growing number of OVC in South Africa over the last five years, more programmes have been established by NGOs, CBOs, FBOs, and other local entities to provide services to OVC and their communities. Yet, many of these programmes only address small parts of the overall need and few programmes offer a fully-comprehensive range of services to OVC due to limited resources – both human and financial.

Unmet needs reflect gaps in services provision, including lack of comprehensiveness of particular services; low frequency of services; or poor quality of services. Often these gaps result from limited resources (human, financial, or infrastructural), limited skills in managing or delivering OVC programmes, inadequate quality assurance of OVC programmes, or lack of appropriate regulations and policies.

From the specific experiences of the 32 OVC programmes, a few areas emerge as common unmet needs, as described below.

### PSYCHOSOCIAL SUPPORT

Among the 32 programmes included in this study, there is recognition of the need for more in-depth PSS services. And although 27 programmes (84%) report that they provide PSS, the quality of the service is often

weak; so much so that the real value of the psychosocial support in the lives of these children is unclear.

PSS is one of the greatest ongoing needs of OVC and their families, but few programmes provide PSS to care givers/parents/guardians, who often face difficult circumstances of their own illnesses or the overwhelming burden of providing child care with only limited resources. For OVC, the death of a parent can be the most traumatic experience they suffer, creating a profound need for PSS before and after such events. While some OVC programmes provide excellent PSS services, such as one-on-one counselling and support groups run by well trained, experienced counsellors, others have either no services in place at all, or the efforts are fledgling with neither trained counsellors nor knowledgeable professional guidance.

### ON-GOING FOOD AND NUTRITION SUPPORT

Although all 32 programmes (100%) report support food and nutrition for OVC, this does not accurately illustrate the wide variance in the frequency of this support. For example, some programmes only provide food support once every six months or once each year. Furthermore, the establishment of food gardens in some areas is quite limited due to a lack of skills, cultivatable space, water, and other inputs.

The single greatest need of OVC is access to enough food on a daily basis to keep a growing child healthy. Without such access, their

physical health at risk, as well as their emotional well-being. Under the constant worry of where the next meal is coming from, the OVC could resort to using sex as a commodity in exchange for food.

Another largely unmet need related to food is clinical nutrition interventions. This whole arena needs significantly more attention and support, especially for older children who do not always qualify for clinical nutrition. Because of the difficulty in accessing food, there are OVC of all ages in extreme need of clinical nutritional support, based on malnutrition guidelines from the World Health Organisation.

### SHELTER

Another area of intensive need within the OVC population in South Africa is shelter interventions. Only seven programmes (22%) provide support related to shelter and this is very small-scale. The current orphan crisis is stretching the capacity of the traditional African extended family system, both in urban and rural areas. In some areas, this system is simply exhausted due to the number of OVC in the community. Emergency shelter responses do exist in some communities, but children need to live under solid roofs every day. The situation is exacerbated by high rental and utility rates as well as long queues for RDP houses. Thus, additional attention must be given to how to solve this growing problem in South Africa, where the need for shelter by growing numbers of OVC remains largely unmet.



## EDUCATION

A solid education is the best foundation for a self-sufficient and secure life. However, for many OVC in South Africa, a good education is beyond their financial means. Despite the government's efforts to achieve universal primary education, basic education remains an unmet need for many OVC, due to lack of uniforms, books and stationary; lack of funds for school fees and for adequate transportation; or a failure in linking these learners with homework assistance.

## ECONOMIC SUPPORT

Delayed processing of social grants leaves many OVC and their care givers without much-needed finances to make ends meet. Eventually, OVC must support themselves and find jobs in a country a relatively high unemployment rate. Yet vocational training for OVC as they grow older is largely lacking among the 32 programmes. Because only six programmes (20%) support some form of vocational training, there is need to expand efforts that build the marketable skills of OVC, with attention to providing these children, when they are ready, with access to job fairs, conferences, businesses, and NGOs beyond their localities where they might find a potential gainful employment.

## ART FOR HIV-POSITIVE OVC

Finally, and not insignificantly, only six programmes (20%) support linkages to, or the provision of, ART for OVC living with HIV. Even these programmes face obstacles to the delivery of this service, such as a lack of functioning referral systems and long distances required to travel to clinics dispensing ARV medications. Prevention of mother-to-child transmission of HIV and, more recently, paediatric treatment have been expanded significantly in South Africa, and there is scope for OVC programmes to do more to link OVC with paediatric treatment programmes.

## RESOURCES

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It goes without saying that most programmes involved in the provision of services to OVC rely heavily on donations and goodwill to carry-out their work. All 32 programmes receive monetary support from the emergency plan to deliver services to OVC. And most have other multiple funding sources, with the emergency plan providing only a portion of the resources directed to their OVC services.

Emergency plan funds are accessed either directly from the USG in South Africa (making the recipient a “prime partner”) or through an intermediary organisation that receives emergency plan funding (making the recipient a “sub-partner” or a “sub-sub-partner”). Prime partners with direct access to emergency plan funds often use the funds to provide technical and financial support to other, often smaller organisations working with OVC.

Aside from the emergency plan, some of the programmes also receive funding (either directly or indirectly) from other donors including the Global Fund to Fight AIDS, TB, and Malaria; the World Bank; and the European Union.

Most programmes receive support from various departments of the South African government: the Department of Social Development provides funding for volunteer stipends, food parcels, and assistance

with applying for social grants; the Department of Health provides training to various community stakeholders, such as traditional healers; and the Department of Agriculture provides several OVC programmes with seedlings, fencing materials, and agricultural expertise for food gardens.

Some programmes also receive support from businesses, both large and small. Private companies help in many ways, including direct financial contributions, money, donations of food parcels, donations of buildings, skills development, and transportation.

Heartbeat runs a Sponsor a Child in Need (SACIN) programme, which encourages individuals to donate money for OVC programming. The programme is open to anyone who would like to sponsor a child for an entire year, similar to programmes developed in the United States decades ago.

These programmes also have active participation from the communities themselves. Many programmes use campaigns and awareness drives to mobilise community members volunteer their time for a wide range of activities associated with the OVC programme. This includes conducting home visits, working at drop-in centres, conducting situational assessments before launching the OVC programme, assisting with building projects, and conducting awareness raising campaigns. Community members also participate in activities which help sustain

OVC care such as communal gardens and in raising material and financial support from local businesses. Community in-kind contributions are instrumental in ensuring the success OVC programmes and also promote sustainability and longevity of the OVC programme.

Without donor aid, government support and community contributions, OVC programmes would undoubtedly be hard put to deliver meaningful services.

## PROGRAMME CHALLENGES

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In working to meet the enormous and growing OVC population in South Africa, the largest in the world at some 3.8 million, most programmes face a wide variety of challenges, including, but not limited to, the following:

### INSUFFICIENT RESOURCES

Despite significant increases in emergency plan/South Africa and in the government of South Africa's funding for OVC programmes and services, these increases have not been sufficient to meet the needs comprehensively of the rapidly growing OVC population.

Insufficient funding means insufficient staffing, because many skilled professionals choose not to work in the sector due to its relatively low salaries. Too little funding means limited or no evaluations of OVC programming and, thus, inadequate learning and dissemination of good OVC approaches. Too little funding means that OVC in South Africa tend not to receive all the support they need, despite the best of intentions of many programmes and individuals.

Insufficient funding means too little training for programme staff and volunteers, and this is manifested in too much learning “on the job” for adequate delivery of OVC services. For example, some PSS interventions or methods are really far too casual to be categorized as

such. Also, the frequency of debriefing after field/home visits by staff members or volunteers is scant in regularity, as well as in its depth, and could do more harm than good when not appropriately undertaken.

Insufficient funding means logistical problems, such as inadequate or a total lack of transportation, computers, telephones, fax machines, etc. Insufficient transportation resources in particular can limit staff or volunteers home visits to home-based care clients or OVC because some are far afield.

Volunteer stipends are generally quite small and often do not arrive on a regular basis, creating low morale, as well as limiting the ability of the volunteers to do the work for which they have signed up. When volunteers cannot “get by” in their own lives financially, they simply are not in the position to assist OVC.

### **HIGH STAFF TURNOVER**

Staff turnover at many programmes is high, partly because of burnout, partly because of insufficient qualifications and training, and partly because some staff members are offered better jobs based on the experience they have gained working with programme.

Some volunteers believe that, after a specific length of time as volunteers, they should be hired as permanent staff by the organisation to which they volunteered. When this doesn't happen (for whatever

reason), these volunteers often leave the programme, sometimes resentfully. This can damage a programme's efforts to build support and advocacy, for both the programme and to deliver services to OVC themselves.

### **STIGMA AND DISCRIMINATION**

Stigma and discriminatory practices towards OVC and people living with HIV and AIDS (PLHA) are widespread in South Africa (and elsewhere) and are believed to be caused by a general lack of understanding of HIV. Between 1998 and 2008, five South African women openly living with HIV were murdered due to their HIV status. In such an environment, it is difficult to stimulate an environment supportive of HIV-affected OVC by communities where negative attitudes and discriminatory practices towards PLHA and OVC are entrenched.

This major programmatic challenge prevents OVC from coming forward and accessing much needed services. It requires all the stops to be pulled out politically, socially, and legally, so as to advance the lives of PLHA and OVC.

### **MONITORING AND EVALUATION**

Monitoring of OVC programme activities is routine, per emergency plan requirements; however, many programmes do not have sufficient resources to implement their M&E systems effectively. These necessary

resources include skilled staff, appropriately designed data management systems, and necessary equipment.

As a result, many programmes could not readily provide the exact number of OVC they serve or have served. Some programmes count all children who attend drop-in centres, regardless of their OVC status, in an attempt to minimise stigmatising OVC. While understandable, this could lead to possible over-counting of OVC. Also, because few programmes carry out evaluations of their OVC programmes, this restrains the necessary learning and sharing that is necessary for improving OVC programming.

## CONCLUSIONS

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Although the 32 programmes in this study are similar in their ultimate goal of improving the lives of OVC, they differ immensely in the manner in which they approach their OVC programming. The programmes range from high-level technical and financial assistance at the organisational level to grassroots, door-to-door work. Despite differences in scale and mode of service delivery, a number of cross-cutting findings emerged upon which the following conclusions were drawn.

Food insufficiency is an immediate and pressing need that is common to most OVC and their families. Recent studies (Weiser, Leiter, Bangsberg et al., 2007) have found that food insufficiency is associated with multiple (often interdependent) risky sexual practices among women. These findings suggest that protecting and promoting access to food can decrease the vulnerability of women to HIV infection and, thus, safeguard their children from the ravages of the HIV epidemic. Unfortunately, not all of the 32 OVC programmes have the capacity to produce their own food or to purchase and distribute food regularly to their beneficiaries. Thus, income-generating activities and food gardens are needed in conjunction with other forms of food assistance to increase OVCs' and their caregivers' access to food. Unless urgent food needs are met, investments in the other programmatic areas (such as education, PSS, etc.) may be wasted.

All OVC have been emotionally scarred by the trauma of caring for and losing a parent to AIDS, others from abandonment or abuse. Thus, quality PSS services delivered by well-trained counsellors need to be offered on a much larger scale.

Very young children (six years of age or younger) are often not adequately covered in OVC programmes, due to the fact that many programmes are designed to be delivered around school-age children. Most OVC under the age of two years are unable to get to drop-in centres or kids clubs to benefit from OVC programmes. Early childhood development (ECD) initiatives delivered in the homes or in neighbourhoods of communities should be considered. In this regard, OVC programmes may wish to liaise with the ECD directorate within the national Department of Education.

Providing services to older OVC (age 18 years and older) appears to be an additional stumbling block for most of the 32 programmes. This stems largely from the South African government's cut-off age (18 years) for support to OVC, which has also been applied by most international donors.

## **ADDITIONAL RECOMMENDATIONS**

Based on Khulisa researchers' observations, as well as the sentiments expressed by respondents at the 32 OVC programmes, the following

short-term and long-term interventions may further help to streamline and improve OVC service delivery in South Africa.

### *Short-Term Recommendations*

- Strengthen partnerships with government departments such that they can be relied upon to assist OVC programmes consistently when needed.
- Expand efforts to mobilize communities and private businesses to support OVC interventions.
- Encourage food gardens to include the production of medicinal herbs.
- Encourage the Department of Agriculture to provide more OVC with livestock for consumption and income generation.

### *Long-Term Recommendations*

- Widely replicate childcare forums in alignment with the South African government's policy and framework.
- Establish a CCF network so that CCFs can learn from each other and provide each other with support.
- Hold national meetings on an annual basis where OVC programmatic good practices and challenges can be tabled. Participation in these meetings should include government, organisations serving OVC, and donors.

- Train community workers as mid-level social work professionals to ease the caseload of social workers.
- Build linkages with the Department of Labour to create job initiatives for young people out of work with special emphasis on adolescent OVC.
- Standardise the training for OVC care givers. Aim to have the training accredited by the sector education training authorities, such that quality of care given to OVC is maintained at a high and consistent level.
- Develop quality-assurance approaches, mechanisms, and evaluation tools for OVC programming. Such tools would aid programmes in the development of programming objectives and implementation standards they can work toward, monitor regularly, and refine as needed.
- Provide OVC programmes and organisations with capacity building in “social entrepreneurship,” emphasising the knowledge and skills required for generating sustained income.

Overall, these 32 programmes do tremendous work for OVC, some of them with meagre resources complemented by a lot of goodwill from individuals and the communities in which they work. Continued support is imperative as the HIV epidemic renders more and more children

vulnerable. Safeguarding these children to give them a chance at a normal life is not an option but a moral obligation for all.

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## APPENDICES

### Appendix A: OVC Programme by Key activities

AGENCY	Networking	Child Care Forums	Home Visits	Community Sensitization	Drop-in Centres (incl after school activities)	Capacity Building	
						Community Capacity Building	Organisational Capacity Building
Africare	X	X	X	X		X	
AMREF	X	X					X
Bonukhanyo	X		X	X	X		
Child Welfare SA: Asibavikele	X		X			X	
Child Welfare Tshwane	X		X		X	X	
Choice Trust	X		X		X		X
Civil Society	X		X		X	X	
CPC	X	X	X		X	X	
Hands at Work	X	X	X	X	X	X	X
Heartbeat	X	X	X		X	X	X
Hope worldwide	X			X	X	X	X
Ikhwezi Lomso	X	X					
Inkwanca	X	X	X		X		
Isbindi	X		X	X		X	X
Khanyiselani	X		X			X	X
Makhuduthamaga	X	X		X	X		X
Makotse	X		X	X	X	X	X
Masakhane Women's Organisation	X		X		X		
Motswadibe	X		X	X		X	
Nhlayiso	X		X	X	X		
NOAH	X		X	X	X	X	
SACBC	X	X		X			X
Salvation Army	X		X	X	X	X	
Save the Children UK	X	X	X			X	X
Sekhukhune	X		X		X	X	X
Senzakwenzeke	X	X	X	X		X	
Sizanani	X		X	X	X	X	
Valley Trust	X					X	
Vongani	X		X	X	X	X	
Winterveldt	X		X			X	
World Vision	X	X	X	X	X	X	
Zimeleni	X			X	X	X	

## Appendix B: OVC Programme by Key Services Delivered

AGENCY	Clinical Nutrition	Food/ Food Parcels	Shelter	Child Protection	General Healthcare	Healthcare for ART	HIV Prevention Education	PSS	General Education	Vocational Training	Economic Strengthening
Africare		X			X			X		X	X
AMREF		X		X					X		
Bonukhanyo		X		X	X		X		X	X	
Child Welfare SA: Asibavikele		X	X	X				X	X		X
Child Welfare Tshwane	X	X	X	X	X	X	X	X	X		X
Choice Trust	X	X			X		X	X	X	X	X
Civil Society		X		X			X	X	X		X
CPC	X	X		X	X		X	X	X		X
Hands at Work	X	X	X	X	X			X	X	X	X
Heartbeat		X		X	X			X	X		X
Hope worldwide		X						X	X	X	X
Ikhwezi Lomso		X		X	X			X			
Inkwanca		X		X	X				X		X
Isbindi		X			X			X	X		X
Khanyiselani		X		X	X	X		X	X		
Makhuduthamaga		X		X				X			
Makotse		X		X	X			X	X		
Masakhane Women's Organisation		X		X	X	X	X				
Motswadibe		X	X	X	X		X	X	X		X
Nhlayiso		X		X			X	X	X		X
NOAH	X	X		X	X	X	X	X	X		X
SACBC		X	X	X	X	X		X	X		X
Salvation Army		X		X	X		X	X	X		X
Save the Children UK	X	X	X	X	X			X	X		X
Sekhukhune		X	X	X	X		X	X	X		X
Senzakwenzeke		X		X			X	X			X
Sizanani		X			X		X	X	X		X
Valley Trust		X		X	X		X	X	X		
Vongani		X		X	X		X	X	X		X
Winterveldt	X	X		X	X	X	X	X	X		X
World Vision		X		X			X	X	X	X	X
Zimleni		X		X			X	X	X		