

AREA: Children orphaned by AIDS

COUNTRY: Republic of South Africa

TITLE: Approaches to caring for children orphaned by AIDS and other vulnerable children.

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APPROACHES TO CARING FOR CHILDREN ORPHANED BY AIDS AND OTHER VULNERABLE CHILDREN

ESSENTIAL ELEMENTS FOR A QUALITY SERVICE

Heidi Loening-Voysey
Theresa Wilson

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IUPHC
PO Box 67
Bergvlei
2012

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ACRONYMS AND TERMINOLOGY USED

Child	Person under the age of 18, unless by law majority is attained at an earlier age (CRC)
Children living with AIDS	Children who are either themselves infected with HIV or who are AIDS-ill and/or who live in families where members are either infected with HIV, are AIDS-ill or have died of AIDS
CRC	Convention on the Rights of the Child
Orphan	<p>In the absence of an official definition in South Africa, the definition in this instance is a child who has lost one or both of his or her parents. In the context of the HIV/AIDS epidemic in South Africa, which is predominantly heterosexually transmitted, a child who has lost a parent due to HIV/AIDS is likely to have an infected remaining parent.</p> <p>A child orphaned by HIV/AIDS is not always easy to distinguish from other orphans due to the fact that cause of death and parent's whereabouts are often unknown and records are often not available. The number of orphans has increased in South Africa and it is assumed this is due to the escalating AIDS-related mortality rates.</p>
OVC	<p>Orphaned and Vulnerable Children.</p> <p>In the context of HIV/AIDS, <i>vulnerability</i> refers to children living in a household where the duty bearer is ill with AIDS. It also refers to children living in a household that takes in orphaned children.</p>
UNICEF	United Nations Children's Fund
NGO	Non government organization
CBO	Community based organization
HEARD	Health Economics and Research Division
MPSA	Mpumalanga Project Support Association
SMME	Small, medium and micro enterprise

CHAPTER 1: INTRODUCTION

RATIONALE FOR THE STUDY

The growing numbers of orphaned and vulnerable children in South Africa represent a grave concern for education, health, and social development organizations. The HIV/AIDS epidemic is the primary contributing factor to these increasing numbers as South Africa experiences one of the worst HIV/AIDS epidemics in the world.

While statistics on orphans are not always reliable, they are consistently alarming. The number of children orphaned by HIV/AIDS increased by 400% between 1994 and 1997. It has been estimated that by 2015, when the epidemic should have reached its peak, orphans will comprise 9-12 % of the total population i.e. 3.6-4.8 million children (Smart, 2000:16). Before HIV, the care of orphans in developing countries was mostly absorbed by the communities. Now, the increasing numbers are rapidly moving beyond coping capacities of many communities.

It is well documented that AIDS illnesses and deaths adversely affect households. Principle income earners who are HIV positive are likely to lose their sources of income and medical expenses represent a significant strain on household income as does their death. Children are orphaned and the majority of them lose their right to a decent and humane existence. Without the protection of parents, or an appointed caregiver, children are more likely to lose the opportunity for schooling, nutrition, shelter, health care and the love, affection and guidance required for growth into responsible adulthood.

Traditional means of caring for children have had to adapt. In addition, other indigenous responses have emerged and continue to evolve as the numbers of orphaned and vulnerable children (OVC) increase and their needs intensify. However, it is clear that responses to the plight of these children are struggling to cope with the escalating HIV/AIDS epidemic.

In South Africa research into models of care and the cost of this care for orphaned and vulnerable children is scarce (Smart, 2000; McKerrow, 1995; McKerrow, 1996). While recent studies provide useful insights into the nature of care provided in these various contexts, there is an imperative to develop a framework for evaluating the quality of service and for assessing the feasibility of each approach.

For the purposes of this study, quality care has been defined as: " Care which meets the needs of children in a culturally acceptable way and enables them to realise their rights".

GOAL AND OBJECTIVES OF THE STUDY

The main goal of this study was to develop policy recommendations for the care of orphaned and vulnerable children in South Africa.

The objectives towards this goal were as follows:

- To develop essential elements for assessing the quality of care of HIV/AIDS orphaned and vulnerable children;
- To provide a typology of approaches to the care and support of children and determine the options within these different approaches;
- To evaluate the extent to which the different approaches meet the needs of children living with AIDS and enable children to attain their rights;
- To present information on the feasibility and cost-effectiveness of the different approaches to enable children living with AIDS to realise their rights;
- Make recommendations for policy choices; and
- To offer information for lobbying and advocacy around enabling children living with AIDS to attain their rights.

This report is one part of a combined study. This part provides a detailed study of the quality of care provided by each approach. The cost-effectiveness part of the study has been prepared by the Health Economics and HIV/AIDS Research Division, University of Natal (HEARD, 2000).

GUIDING PRINCIPLES

The following principles informed the design and analysis of this study:

- The nature and causes of children's circumstances were seen in a systemic way -i.e. non-linear, co-operative and integrated approaches were taken when assessing how children's rights were not being realised. In terms of this framework, the family, the community, the churches, NGOs and CBOs and the state formed an integral part of the analysis;
- Children's needs have to be met. This is best done synergistically or holistically;
- Children's rights, as stipulated in the Convention on the Rights of the Child, are non-hierarchical, universal and are informed by children's needs. If unattained, claims must be made against the responsible duty bearers.

RESEARCH CONTEXT

Research on models of care of orphaned children in Zambia revealed a four-tier response to children's needs (McKerrow, 1996) in the quest for upholding their rights. This is useful in providing a framework for understanding the South African situation.

The family who must identify vulnerable children and orphans and provide the basic day to day needs of the children as well as emotional support.

The community which must support both the children and their caretakers as well as act as a forum for lobbying authorities to assist in providing an affective response to their needs and rights.

The churches/NGOs/CBOs who should co-ordinate all responses whilst also providing material support and support services.

Finally the state must develop local infrastructure, empower state personnel, create an enabling environment at all levels, modify state services and facilitate funding for grassroots responses.

McKerrow, 1996:3

Rights have correlative duties, which have to be carried out by identified and accountable duty bearers. The child's mother or father represents the first level of duty bearers and there are a number of responsibilities for which this prime caregiver is responsible. The extended family, community, district and state have duties owed to the child too. In terms of the International Human Rights Law the state has three obligations: to respect, to protect and to fulfil the realisation and enjoyment of rights (UNICEF, 2000).

This study examines the delivery of services to OVC within this four-tier context.

RESEARCH PROCESS

A rapid appraisal of children living with HIV/AIDS in South Africa was completed early 2000 (Smart, 2000). This present study takes the research process into the next phase, which was to identify the policy options, assess them and look at their feasibility. Based on the findings, recommendations are made for policy development for OVC.

Actions taken in the research process

The following steps are a summary of the research process, (details of which are in separate sections hereafter):

1. A review of literature and websites was done with the purpose of identifying relevant issues, practices, policies, data, principles and guidelines;
2. A reference group of key informants was formed and communicated with directly and electronically several times throughout the study. They provided up-to-date information from their respective fields and were thus able to guide the researchers with relevant details;
3. Based on the information gained from step one and two, interview guidelines, participatory exercises and observational checklists were designed for the field visits;
4. Sites were selected from a broad database search to represent the various approaches to childcare;

5. Data was then collected by one of the researchers who visited each of the selected facilities, for up to three days. Detailed case studies were written on each site;
6. Data was then coded and analysed by the researchers in terms of organisational features as well as in terms of children's needs and rights ;
7. The findings were then presented to representatives from the sites who all convened in Johannesburg. Some adjustments were made to the findings and the list of essential elements to caring for the OVC was compiled.
8. The reference team was called together again to refine the list of essential elements and to gain consensus on which duty bearers should be accountable for each essential element.
9. This report was then compiled.

This study was undertaken by two researchers who collaborated with each other and a researcher from HEARD throughout the process.

Data Collection

Throughout the data collection processes, the two researchers collaborated - checking and confirming each other's work. The following processes were used to collect information:

- Literature review - A review of relevant and referenced literature was used to outline the findings, proposals and debates regarding the care of HIV/AIDS OVC.
- Reference group - Two meetings were held with role-players involved in this field. The first meeting served to gain consensus on the assumptions of the study, reach agreement on options to be studied as samples of approaches and to develop essential elements (indicators) of good quality care to be used in the evaluation of the different approaches. At the second meeting, reference group members reflected on the analysis of the data collected, gave further meaning to it and ratified it.
- Multiple case studies - Each case served the purpose of representing an approach to childcare and was therefore purposefully selected. Information was gathered through interviews, participatory exercises, group discussions with caregivers, children and associated people, such as a social worker from a child welfare agency. Checklists, based on children's needs and rights, and guidelines to participatory exercises, based on participatory rural appraisal approach, were used. Observations and researchers' experiences were also documented in the case studies. Three days were spent at each of the ten sites.
- Multiple sources of information - Each site offered insights from different sources. Not only were diverse people from the sites used as informants, but also literature and external people were accessed for information. Secondary data studies included annual reports, media clippings, referral forms, administrative records, evaluation reports and training material. On completion of the site visits, key people from the sites were called together for a meeting where the data gathered for each site was presented. They verified the information on their services and contributed to the analysis of data. This group of people also contributed to a discussion on the essential elements to caring for the OVC.

- Costing related information was collected by the researchers in conjunction with the researchers from HEARD.

Site Selection

Sites were selected as the lenses through which the different approaches could be viewed.

The first step to site selection was identifying the different approaches to caring for OVC in South Africa. This was done with the help of the reference team, discussion with key people in the field of child welfare and referring to past studies in this field.

Secondly, sites were identified to represent each approach. This was done through reviewing literature on models and approaches to care of the OVC in South Africa and through discussions with service providers and experts working in the field of childcare (see Annexure A for the detailed selection criteria and site selection matrix).

Sites were selected on the basis of their availability and willingness to participate in the study as well as the following criteria and factors (see Appendix A for detailed site selection matrix):

- Services were operational for at least one year;
- Sites to reflect the provincial HIV infection spread (KwaZulu-Natal, Mpumalanga and Gauteng have the highest HIV infection rates);
- Organizations to clearly stipulate that they provide a service to children either infected or affected by HIV/AIDS;
- Site selection to represent rural and urban settings;
- Site selection to represent formal structures and informal community-based structures; and,
- Sites to reflect services from the span of four financing policy levels vs. those that focus on one level only (i.e. Dept of Social Development policy)
 - Level 1: Prevention e.g. income generation, training
 - Level 2: Early Intervention e.g. home visits, support groups, material relief; informal child care arrangements
 - Level 3: Statutory Services e.g. formal placement in foster care and adoption; accessing foster care grants
 - Level 4: Continuum of Care - the full range of service offered in a residential care setting e.g. 100% care; respite care; day-care.

Table 1. Sites chosen to represent the different approaches to caring for the OVC.

APPROCAH	SITE SELECTED
Informal Fostering/Non-statutory Foster Care	➤ Nceba Village, Transkei (E. Cape)
Community Based Support Structures	➤ Pin Project
Home-Based Care and Support	<ul style="list-style-type: none"> ➤ Centre for Positive Care, Thoyandou ➤ Mpumalanga Project Support Association, Nelspruit ➤ Sinosizo, Durban Metropolitan Area ➤ St Nicholas Hospice, Bloemfontein
Unregistered residential care	<ul style="list-style-type: none"> ➤ Nkosi's Haven, Johannesburg ➤ Jardim's Home, Barberton
Statutory Adoption and Foster Care	➤ Durban Children's Society, Durban
Statutory Residential Care	➤ Nazareth House, Cape Town

Data Analysis

- Data gathered at sites was reported in the form of case studies
- Matrixes were then used to organise and inductively analyse comparative material collected at the sites on the following two areas:
 - Approaches to childcare. i.e. how the children's' needs were/ were not being met and how their rights were/ were not being upheld; and
 - How the organisation was structured and supported, who it served, who provided the service and how it functioned (see Appendix A)
- Essential elements to caring for the OVC were established from the discussions held with childcare workers and the reference team. These were then used in reflecting on the approaches and assessing the extent to which their services meet the children's needs and uphold their rights. The strengths and weaknesses of each organisation were established.
- Childcare services do not operate in isolation. It was therefore important to analyse each approach in terms of constraining and enabling external factors as well.

Limitations to the study

Organizations providing social services are affected by many variables, both internally and externally. Comparing approaches to childcare was therefore limited to qualitative descriptions without any control over contextual variables. The only constant variable was the policy framework, but even that varied between provinces on some points (for example, street children's shelters). In addition, the implementation of policies varied from province to province. Sites varied regarding demographics, disease prevalence, available resources and networking possibilities.

Whilst multiple sources of information at each site served to ensure reliability, this in reality was not always feasible. One of the limitations was language. Although the researchers worked with translators, it was felt that this removed the researchers from the reality and sometimes influenced, or biased, the information provided. Furthermore, time with children alone, without the caregiver was difficult to arrange. Firstly, because it takes time to develop trust with children and therefore discussions with them were often limited to superficialities. Secondly, some caregivers seemed to feel threatened by the research and wanted to influence the children's communication.

A further influencing factor that must to be taken into account in this study and future studies, is that the hardship and pain experienced by the respondents is so enormous. Their communication was affected by the imploring necessity for assistance. Not only did this leave the researchers feeling helpless and abusive of the respondents, but discussions of their reality were regularly punctuated with quests for something better - something that the researchers could not promise, even with the information they were providing.

Time was a limiting factor. Participatory exercises required a lot more time for them to effectively impact on the organizations' ability to review their services.

The stigma attached to HIV/AIDS and the taboo associated with the subject prevented open discussions, particularly in the rural areas.

OUTLINE OF REPORT

The report is divided into the following sections:

- Chapter 1:** Rationale, goal and objectives of the study and research methodology.
- Chapter 2:** Rights and needs of Children Orphaned by AIDS and other Vulnerable Children. This provides a theoretical framework as well as an analysis of the rights and needs of children and an essential element framework for quality childcare.
- Chapter 3:** Approaches to caring for the OVC. This includes an overview of the South African legal framework as well as a typology of approaches to caring for OVC.
- Chapter 4:** Analysis of the quality of care provided by the different approaches to caring for the OVC.
- Chapter 5:** Recommendations for policy and service delivery to the OVC.

CHAPTER 2: RIGHTS AND NEEDS OF CHILDREN ORPHANED BY AIDS AND OTHER VULNERABLE CHILDREN

INTRODUCTION

"All children have physical, emotional, social and intellectual needs which must be met if they are to enjoy life, develop their full potential and develop into participating, contributing adults. If any one of these basic needs remains unmet - or inadequately met - then development may become stunted or distorted" (Pringle, 1980)

In order to meet the objective of ascertaining the essential elements of care (and thereby develop indicators for assessing the quality of care) for children orphaned by AIDS and other vulnerable children, a consensus on the rights and needs of these children had to be reached. This consensus was reached by referring to local and international literature reviews, discussing and observing in the field and consulting with the reference team. In this chapter a theoretical framework for understanding the common developmental needs and rights of children is presented after which the specific needs of OVC are outlined. Finally, the essential elements for meeting needs and realising rights are presented.

COMMON DEVELOPMENTAL NEEDS AND RIGHTS OF CHILDREN

Manfred Max-Neef's theory on human scale development (1991) is used as a framework for understanding children's fundamental needs, which in this study are seen as basis for understanding children's rights. In terms of this theory, human needs are seen as an interactive and interrelated system and not as a hierarchy. Needs, which are identified as subsistence, protection, affection, creation, idleness, identity, participation and understanding are best met synergistically by satisfiers that respond to more than one need at a time. Examples would be: active feeding, whereby bonding relationships are nurtured whilst children are being fed; and, community building activities, that satisfy the need for participation, identity, understanding and leisure simultaneously.

For the purpose of presenting the findings of this research, needs and rights are clustered into the following broad categories:

<i>Survival</i>	- food, clothing, shelter and health care
<i>Security</i>	- love; affection; protection against abuse, neglect and exploitation
<i>Socialisation</i>	- understanding; identity; participation and basic psycho-social services
<i>Self-actualisation</i>	- recreation ; leisure and freedom of expression

Although survival needs and rights are recognised as a priority, it must be noted that without affection, protection and understanding, children are less likely to grow up into well functioning adults. The categories of needs and rights may appear to be in a hierarchy, but this is not intended. In terms of human scale development theory and the rights based approach to meeting needs, all needs are of equal importance and are non- negotiable.

The following table provides an overview of rights and needs, their satisfiers² and the possible implications of not satisfying these needs and neglecting their rights.

Table 2: Common developmental needs and rights of children

RIGHT/NEED	MANIFESTATION OF REALIZED RIGHTS & SATISFIERS	RIGHTS AT RISK & IMPLICATIONS OF IMPAIRED NEED SATISFACTION
SURVIVAL		
<i>Subsistence</i> Survival as a human being	Adequate nutritious food, Secure dwelling, Appropriate clothes, Accessible health care, Social security	Malnutrition and stunted growth High mortality and morbidity rate Common disabilities not prevented
SECURITY		
<i>Protection</i> From exploitation, abuse and neglect	A caregiver who knows the child's whereabouts and protects the child's rights Consistent and healthy discipline Familiar place and known routine Law and law enforcement	Troubled and disturbed children Dysfunctional families Homeless children Children live in harmful environments
<i>Love Affection</i>	Stable, continuous, dependable and loving relationships Unconditional love Friendships Intimacy	Lack of concern for others and lack of conscience are probable reactions to being unloved and rejected Vandalism, violence and delinquency are not infrequently an outward expression of these feelings and of the need for love
SOCIALISATION		
<i>Identity</i> Uniqueness as person Sense of personal continuity	Name and kinship Customs and traditions Memories and knowledge of personal and family origin Sense of future and direction	Sense of alienation Apathy Low self esteem Lack of direction
<i>Understanding</i> Insight, direction and knowledge	Information Positive communication Schooling/education Cultural guidance Mentoring	Illiteracy and poor employment prospects Ill-informed Disempowered Lack of self direction
<i>Participation</i> Valued as a contributor to society, Considered a person with own rights	Community, neighbourhood and cultural activities Discussions involving children Positive communication Opportunities to exercise responsibility Equality of opportunity	Isolation Lack of concern and respect for communal good Lack of confidence in tackling new situations, tasks or relationships Lack of sense of responsibility for self, others and material objects

1. ² Satisfiers refers to the ways in which needs are met whether in individual, group or environmental contexts. It is emphasised that these should not be reduced to economic goods only. There is no linear relationship between needs and satisfiers.

RIGHT/NEED	MANIFESTATION OF REALIZED RIGHTS & SATISFIERS	RIGHTS AT RISK & IMPLICATIONS OF IMPAIRED NEED SATISFACTION
SELF-ACTUALISATION		
<i>Recreation/</i> Leisure New experiences	Time and space to play Stimulation Recreational facilities	Inertia and apathy Low morale Unresponsive to environmental stimuli
<i>Freedom of</i> <i>expression</i> Expression as individual	Flexibility/space for children's exploration and expression of different views Opportunities to exercise independence and to explore thoughts, views , ways of doing things and philosophies	Disempowerment Voicelessness Apathy Stereotypical views

(Drawn from Max-Neef, 1991 and Pringle, 1980)

SPECIAL CHALLENGES AND RESOURCE GAPS FACING CHILDREN ORPHANED BY AIDS AND OTHER VULNERABLE CHILDREN

Experience has shown that children orphaned by AIDS should not be separated out from other children in need of care for fear of stigmatising the former group and neglecting the latter group. However, an objective of this study was to assess the different approaches to the care of children affected by HIV/AIDS. This required an understanding of their expressed needs. Most of these needs have already been documented³ and were confirmed through the course of this study.

Before the HIV virus, orphans, who were mostly taken care of by communities, comprised about 2,5% of the child population in developing countries. Now, as a result of the HIV virus this proportion has shifted beyond communities coping capacities - up to 11% in some areas, such as Uganda. The picture is likely to be as bleak in South Africa (Bartholet, 2000; Harber,1998: 48-50; McKerrow et al, 1995:35 and UNDP, 1998: 68 -69).

Insight gained from lived experience explains why childcare facilities need to cater for OVCs specific needs. The experiences most commonly spoken of in this study were the following:

- Trauma associated with losing a parent, which is in most cases exacerbated by the threat of losing the second parent;
- Witnessing the parent's physical deterioration, pain and death;
- Having cared for the parent in their terminal phase and often being blamed for causing pain;
- Anxiety about their source of livelihood and their ability to retain the family home after the parent's death;
- Keeping out of school and other activities with peers in order to take responsibility in the household; and

³ Smart (2000); McKerrow (1995; 1996) ; World Bank (1999)

- Approximately one third of AIDS orphans are themselves infected with the HIV (World Bank, 1999: 37) - palliative care has therefore been added as a separate category to this list of rights and needs.

A considerably more detailed discussion of these specific needs and rights is contained in Annexure B. The following table presents a summary of Annexure B.

Table 3: Special Challenges and Resource Gaps Facing the HIV/AIDS OVC

RIGHT	SPECIFIC TO ORPHANED AND VULNERABLE CHILDREN
SURVIVAL	
<i>Subsistence</i> Survival as a human being	Balanced, nutritious and regular meals especially for HIV positive children With the death of household's breadwinner, food supply and clothing is threatened Maintenance and security of shelter Infection control and health information
SECURITY	
<i>Protection</i> From exploitation, abuse and neglect	Protection of inheritance and property Protection from stigmatisation due to HIV positive status Protection from exploitation by surrogate parents and/or extended family Protection from physical and sexual abuse
<i>Affection</i> Unconditional love	Caring, consistent, affectionate, considerate and available caregiver Assurance of care before and after the trauma of a parent death
SOCIALISATION	
<i>Identity</i> Uniqueness as person Sense of personal continuity	Birth certificates Memories, family stories and personal articles Space to keep own things (especially for residential care) Keep siblings together Kinship care and family continuity Socialisation into cultural norms and values of community
<i>Understanding</i> Insight, direction and knowledge	Free schooling from 7 years to 15 years School attendance without a uniform required Vocational training Understand imminent death of parent, future plans and who will take care of them Understand implications of HIV positive status Information on how they can look after their own health and protect themselves against HIV and STD's
<i>Participation</i> Valued as a contributor to society	Involve children in plans regarding their care
SELF-ACTUALISATION	
<i>Recreation/Leisure</i> New experiences	Children need relief from domestic and nursing responsibilities to be able to play
<i>Freedom of expression</i> Expression as individual	Children need to develop and express own opinions within substitute care setting

RIGHT	SPECIFIC TO ORPHANED AND VULNERABLE CHILDREN
PALLIATIVE CARE	Pain relief Presence of caring adult during dying phase Reliable adult to administer medication and supplements as prescribed Pre and post bereavement counselling Change of bedding Nappies

ESSENTIAL ELEMENTS FOR REALISING ORPHANS & VULNERABLE CHILDREN'S RIGHTS

For the purpose of assessing whether services provided to OVC met their needs and enabled them to realise their rights, essential elements to the care of OVC were developed by this study. An iterative process was used to devise this list. First, an observational checklist was compiled from the list of specific needs and rights with reference to the researchers' past experiences, the Convention on the Rights of the Child, the Minimum Standards of Foster Care, UNICEF's guidelines for Integrated Management of Childhood Illnesses and other relevant literature. Second, the researchers then adjusted the list after their field visits. Finally, the researchers presented it to the reference teams who helped to refine the list further.

The compilation of this list raised several debatable issues. The following points summarize these dilemmas.

- In order to cost essential elements, HEARD had to focus on aspects which have a monetary value i.e. food, clothing, fuel/light/washing/cleaning and household costs (HEARD, 2001: Appendix A2.1). This study has extended this list to include aspects which cannot be costed, but which are vital for children's development such as affection, positive regard and mentoring. These dimensions are difficult to measure. A quantitative assessment of care given to children would be inappropriate. Table 3 therefore provides a qualitative framework as a point of reference, or a checklist for childcare providers.
- The discrepancy between the availability of resources and children's rights presented a dilemma in this study - particularly for the reference team. The gap between what the majority of children actually have and what they are eligible to have in terms of the Convention on the Rights of the Child is vast. For example, the Convention (article 28) recognises the right to free education for all children and yet children are often excluded from schools because they have not paid fees, have no school shoes or unable to purchase school books. A less obvious example would be the right to freedom of expression, which is seldom seen as a matter of survival. The discussion on essential elements was therefore often confused by caregivers' experiences of children surviving despite their rights not being realised. This study adopted a rights-based perspective where the essential elements reflect what children have the right to, and not so much what is good enough for survival.

- The differentiation between what was considered essential varied in different contexts and provided a further dilemma in this study. For example, in the statutory residential settings a bed per child would be expected, whilst grass mats and a shared blanket would be acceptable in a rural household. The list of essential elements is not specific, and has to be applied in relation to what is considered the norm of the child's context.
- The discussion on essential elements often debated whether the more intangible dimensions to childcare are essential. For example, in one situation the children were physically well cared for and were given many educational and recreational opportunities, but lacked attachment to a parent figure; in the other the children's physical needs were barely met, but they were attached to a member of kin and participated in community activities. The former displayed clingy, petulant and aggressive behaviour, whilst the latter were generally jovial, respectful and spontaneous. This study worked from the premise that a child's physical being cannot be separated from its social and spiritual being - the one contributes to the other. It was therefore impossible to separate tangible from intangible elements. The list of essential elements is divided into separate categories which may imply a hierarchy. However, it is imperative that these essential elements are not applied as such.
- The application of these essential elements (Table 3) should to be guided by the unique and individual characteristics of each child, such as HIV status, stage of development, cultural context and life experiences. Children of different age groups, from infants to teenagers have different needs. For example, infants and toddlers require constant care and regular meals while teenagers may be able to do a number of things by themselves and can go longer without food. Even within age groups needs may differ, some orphans may be able to attend school while others are unable to because of domestic responsibilities, financial constraints or illness. In addition, some of the orphaned and vulnerable children may be HIV positive and others not. Given these variations, there can and should never be a rigid approach to addressing the rights and needs of OVC.

Table 4: Essential elements for realising orphans & vulnerable children's rights

ESSENTIAL ELEMENT
<p>SURVIVAL</p> <p><i>Food</i></p> <ul style="list-style-type: none"> • Nutritious and balanced diet with 3 meals a day as an absolute minimum • Involve children in the preparation and choice of food <p><i>Involving children in preparation of food is a synergistic way of meeting a number of needs & honouring their rights - survival, participation and identity as well as teaching the child important life skills</i></p>
<p><i>Clothing</i></p> <ul style="list-style-type: none"> • At least one change of clothing that offer protection against the weather • Nappies <p><i>Nappies were not always considered a necessity - in rural settings toddlers were seldom seen with nappies. Whereas in residential settings, some preferred cloth nappies because they were less likely to cause skin irritations, whilst others preferred disposable nappies and received large amounts of them from foreign donors</i></p>

ESSENTIAL ELEMENT
<p>Home environment</p> <ul style="list-style-type: none"> • Shelter against the weather • Protection against environmental hazards, pests and intruders • A personal and safe sleeping space which allows for provides privacy for older children • Basic household amenities - access to running water and sanitation and access to fuel for boiling water and for warmth • Cleanliness • Spare bedding <p><i>Spare bedding was especially needed for HIV+ children and for bed-wetters, which was common in residential settings.</i></p>
<p>Hygiene/infection control</p> <ul style="list-style-type: none"> • Positive personal hygiene practices • Use of universal precaution guidelines where there is risk of infection • Access to water and sanitation <p><i>Without close adult supervision, water and sanitation, children are unlikely to learn healthy habits. In some settings the adults themselves were unaware of hygienic practices - for example a child with diarrhoea was seen to defecate at the threshold of the household. The dog ate the faeces. In another instance the caregiver gave a child unboiled water, collected from the river, to drink out of a communal cup.</i></p>
<p>Treatment and health care</p> <ul style="list-style-type: none"> • Full immunisation and record of Road to Health Card • Access to basic treatment and health care • Reliable caregiver to administer medicines, dietary supplements and home remedies • Awareness of, and response to indications of illness as well as basic first aid <p><i>Access to health care was particularly difficult for sites in rural areas</i></p>
SECURITY
<p>Protection</p> <ul style="list-style-type: none"> • Protection from abuse, neglect and exploitation • Acceptance of the HIV positive child • Protection against discrimination, and stigmatisation • Arrangements to be made for the care of the child before the parent dies, including drawing up of a will / expressed wish nominating a legal guardian for the child and stipulating the child's inheritance • A caring, constant and reliable adult presence with whom the child can disclose abuse, and who can access help for the child • Healthy discipline practices including setting rules and limits <p><i>While not mentioned as a right or need by participants in the study, theory and experience confirms that children should have healthy discipline practices to help them behave in culturally and socially appropriate ways.</i></p>
<p>Affection</p> <ul style="list-style-type: none"> • A caring, constant and reliable adult presence who offers security and continuity and with whom the child can communicate openly • The adult caregiver to have a positive communication style which includes "being there" for the child, taking time to listen, and communicating at the child's level <p><i>The caring and constant adult upholds many of the other rights of the child, including protection and identity. In addition, open communication at the child's level provides the basis for meeting other needs relating to understanding and participation.</i></p>
SOCIALISATION

ESSENTIAL ELEMENT
<p>Identity</p> <ul style="list-style-type: none"> • Birth registration • Retention and respect for the child's name, kinship and identity • Captured memories for the child such as photos, artefacts, details of significant others and cultural connections • Acknowledgement of the individuality of the child, for example celebration of birthdays <p><i>Legal identity, personal identity and cultural/social identity are all important.</i></p>
<p>Education/Schooling</p> <ul style="list-style-type: none"> • Free and accessible primary and secondary education • Advocacy for and protection of children's rights to free schooling • Time to go to school and time and space to do homework • An adult caregiver or older child to be available to do homework with the child • Entrepreneurship skills to increase capacity for self-sufficiency <p><i>For many sites, school fees and school uniforms were viewed as essential elements, without which a child could not go to school. However, in terms of the Constitution, schools may not discriminate or exclude against any learner and therefore a school uniform should not be an essential element. Rather, what is essential is for the child to have someone who can advocate on his or her behalf and ensure their right to free education is realised.</i></p> <p><i>Children at sites visited requested help with homework.</i></p>
<p>Participation</p> <ul style="list-style-type: none"> • Children to contribute to their own care plans - their views are to be sought and listened to • Children are given opportunities to participate in all decisions affecting their lives • Children to participate in social, cultural and kinship activities and occasions <p><i>Involving the child in decision-making around their care plan provides a sense of security and protection as well as a sense of future.</i></p>
<p>Understanding, Information and Communication</p> <ul style="list-style-type: none"> • Training for children in basic survival skills and life skills • Caregivers to communicate, at least on a basic level, with children in the language of their community of origin • Information and open communication with children about their own health status if HIV positive • Information and open communication with children on health issues, including sexuality and relationships <p><i>Being able to communicate with a child in the language of their community of origin has important implications for providing a sense of belonging, cultural connection and identity for the child.</i></p>
<p>Counselling/supportive services</p> <ul style="list-style-type: none"> • Support and guidance for children who are experiencing social and emotional difficulties. Where caregivers are unable to do this, to access appropriate assistance. • Communicate openly with children about death, of a parent, family member, friend or their own death and provide emotional and spiritual support. • Caregivers need to understand implications of loss and children's expression of grief. <p><i>Children are particularly vulnerable after the death of a parent - the right and need for protection, affection, support and understanding could be met synergistically by a caring responsible adult</i></p>
SELF-ACTUALISATION

ESSENTIAL ELEMENT
<p>Recreation/Idleness</p> <ul style="list-style-type: none"> • Balance between household chores, recreation and leisure time • Time to play and to be children • Recreational opportunities with peers <p><i>One of the worst scenarios depicted in this study was a girl child having to take responsibility for nursing her AIDS ill mother, a baby with disability and a toddler. When asked how she could be helped - her reply was - "I just want to be able to play".</i></p> <p><i>Children and teenagers learn, socialize and form sense of self through play/recreational activities with peers.</i></p>
<p>Freedom of Expression</p> <ul style="list-style-type: none"> • Time and opportunities for children to question and discuss values, ethics and morals • Time and opportunities for children to be able to freely seek information and express their ideas <p><i>Some site representatives felt that children should be allowed freedom of expression, but within cultural and age appropriate boundaries. However, the Convention on the Rights of the Child gives the child the right to freedom of expression without boundaries</i></p>
<p>PALLIATIVE CARE</p> <ul style="list-style-type: none"> • A caring presence and pain relief during the transitional phase • Acknowledgement of death to children • Provision of opportunities for closure when a child, parent, family member or friend dies • After-death services including transport of body to mortuary and a dignified burial <p><i>All sites visited in this study expressed difficulty in discussing death with children - whether it related to the death of the child him/herself or the parent or another child. It was often said that the adults themselves struggled with this and therefore found it difficult to help children to cope with death.</i></p>

CONCLUDING COMMENTS:

This study confirmed the fact that HIV/AIDS vulnerable and orphaned children have rights and needs peculiar to their situation. The main reason for this is that approximately one third of these children are infected themselves and many of them have witnessed the death of their parent(s). A human rights perspective was crucial in looking for what was essential for the care of children. What was observed as essential in the field, was very often a far cry from what was ratified by the government in the signing of the Convention on the Rights of the Child.

A list of essential elements for the care of HIV/AIDS OVC was compiled in this study and presented in this chapter. This list should not be seen as exhaustive, but more as a reference point, or a checklist, for caregivers to use in assessing how effective substitute care is in meeting the children's needs and honouring their rights. It must be noted that this list ought to be applied flexibly in the light of the child's unique context and life experiences. In addition, these essential elements should be applied holistically within each site.

CHAPTER 3: APPROACHES TO THE CARE OF CHILDREN ORPHANED BY AIDS AND OTHER VULNERABLE CHILDREN

INTRODUCTION

This chapter provides a typology of approaches to the care and support of children, particularly OVC. Each approach is discussed in terms of organizational features as well as constraints and facilitating factors. A summary of the legal context is given to provide a broader understanding of how children are found in need of care and then committed to substitute care. The shift from residual welfare to developmental welfare in South Africa has meant that residential care is discouraged and community based care is the preferred approach. Social assistance is nevertheless still offered and this chapter gives details on what children are eligible for.

Information on existing care facilities was obtained from past research reports and existing service providers. Co-ordinating bodies, such as the South African National Council for Child Welfare, National Association of Childcare Workers (NACCW), Children in Distress (CINDI), Children's HIV/AIDS Network (CHAIN), AIDS consortium and the National Association of People living with AIDS (NAPWA) were also approached for information.

The approaches to caring for OVC are predominantly needs based. Many of the people drawn to this work feel called to it and say they do not have the personalities or skills to do the advocacy and lobbying required for the rights based approach (Loening-Voysey,2000).

THE RANGE OF APPROACHES TO THE CARE OF CHILDREN ORPHANED BY AIDS AND OTHER VULNERABLE CHILDREN

Approaches span across a continuum, with statutory substitute care at the one end and non-statutory substitute care at the other. Statutory services involve the committal of the child through the courts to some form of supervised substitute care such as residential or foster care. Non-statutory substitute care does not go through the courts and refers largely to extended family and kinship care.

With the growing numbers of children in need of care, especially those with special needs such as HIV/AIDS, a range of modifications and combinations of statutory and non-statutory approaches have emerged.

The non-profit sector plays a pivotal role in providing services to children found in need of care in South Africa. The care of OVC is provided almost entirely by non-governmental organizations (NGOs), which can be divided into formal and informal welfare sectors. The formal welfare sector is long established, has developed infrastructures, employs professional staff and receives government subsidies. Many formal welfare organizations are contracted by government, and receive subsidies, to implement statutory childcare provisions. Informal NGOs tend to be more closely aligned with the new developmental

approach and rely more on donor funding than government subsidies. Furthermore, many less structured and more indigenous responses to the swelling numbers of children living with HIV/AIDS have evolved in communities, without the support of state subsidies and without being registered as NGOs. These are more difficult to track and to include in any form of classification.

The growing numbers of children in need of care as a result of the HIV/AIDS pandemic has exceeded the capacity of established systems of care. The extent of this shortfall is difficult to ascertain, because there are no reliable statistics on the prevalence and impact of the pandemic, nor is there a record of how the effects of this pandemic are being addressed. For example, a comprehensive database of services to children in South Africa does not exist. Central co-ordination and planning of services are hampered for the following reasons:

- The majority of services provided to children are non-governmental and are not legally obliged to register with the Department of Social Development, although it is to their advantage to do so; and
- Many of the indigenous, less structured ways of caring for the children are unknown, unacknowledged, unsupported and not co-ordinated and therefore more difficult to track and to include in any form of classification.

LEGAL FRAMEWORK

The Child Care Act (74 of 1983) provides information on how children can be found to be in need of care legally as well as on the responsibilities of children's courts. The test for whether a child needs intervention has moved from assessing the fitness of parents to a more child-centred evaluation (Child Care Amendment Act,1996).

The United Nations Convention on the Rights of the Child and the South African Constitution further protects the child and ensures that:

- In matters affecting the child, the child's views be heard and given due weight in accordance with the age and maturity of the child;
- The child has the right to family or parental care or to appropriate alternative care when removed from the family environment; and
- The child's best interests are considered paramount in every matter concerning the child (Skelton, 1998).

A Child is found in **need of care**, by the Children's court, if the child is:

- Neglected or abused;
- Orphaned and there is no-one to care for him or her; and
- Behaving in an uncontrollable manner.

A child can be placed in a place of safety pending the outcome of a children's court enquiry. The maximum duration of a child's stay in an identified place of safety is meant to be twelve weeks, but in reality this is often extended.

According to the Child Care Amendment Act No. 96 of 1996, **the following persons and processes identify a child as being in need of care and protection.**

a) A child may be identified as being in need of short term emergency care (place of safety) pending a children's court enquiry by:

- i) A court of law during proceedings;
- ii) A commissioner of child welfare on information given by any person on oath; and
- ii) A policeman, social worker, or authorised officer.

b) A child who has been removed to a place of safety may be brought to the children's court in order to determine whether that child is in need of care, by a policeman, social worker or authorised officer.

c) A child whom the children's court assistant believes to be a child in need of care may be brought before the children's court by a policeman, social worker or authorised officer.

d) A children's court enquiry makes a final determination regarding whether a child is in need of care (Barret et al, 1999: 6-17).

Options for the placement of children found in need of care at a children's court enquiry include the following:

- Remaining with the parent or guardian, but with the supervision of a social worker;
- Removal to a residential setting such as a children's home, place of safety, school of industries;
- Removal to foster care, supervised by a social worker; or
- Adopted, which formally ascribes the duties of a parent to a new person other than the natural parent or guardian and must be consented to by parents of a child born in wedlock or the mother of a child born out of wedlock.

The difficulty with the identification and placement of children in need of care, is that:

- Many children in need of care go unnoticed;
- Many communities do not have access to welfare services and are not informed of social security and legal processes which protect children in need of care;
- A court based approach requires people who are not familiar with the child's circumstances to make decisions in the child's best interest;
- Court proceedings are clumsy and labour intensive, an unrealistic requirement with the sheer numbers of children in need of care due to the impact of HIV/AIDS; and
- Rural areas are under-serviced by welfare and judicial systems (Barrett et al, 2000:18-19).

The Child Care Act (no 774 of 1983) is in the process of being altered again to be more conducive to local conditions and to cater for the increasing demand created by the effects of HIV/AIDS on vulnerable children and to be in line with the developmental approach of the welfare sector. "Research to inform feasible and sustainable policy options for statutory services is needed, particularly in relation to child protection services, juvenile justice and the protection of women against abuse" (Patel 1998: 21).

COMMUNITY- BASED STRATEGIES

With social welfare's shift from a residual to a developmental approach in South Africa, institutional care has been discouraged and the focus is now more on community development and community based strategies. Regional welfare departments are no longer registering new children's homes and financing is being steered towards sustainable, community-owned initiatives. It is important however, at this point, to differentiate between community development, which aims to enhance socio- economic conditions, and community care, which may involve community development but is not incumbent upon it.

Community care strategies support informal, indigenous and traditional ways of caring for children in need of care, most commonly by extended family or kinship members, usually a granny or aunt. This form of informal care is widespread and a practice acceptable in most cultures. However, increasingly, the capacity of families to take in extended family orphans is diminishing. The assumption of community care is that communities have families, or, capable women, who are willing and able to provide the care. This assumption is questionable. "While community care can certainly give individuals a better quality of life than they would have in an institution, community care can equally be a convenient cover for the neglect by the state" (Harber, 1998:24).

Informal care is often supported by strategies such as home-based care projects, income generation projects for caregivers and community child care committees. While these strategies bolster impoverished communities they also serve to disguise the gaps left by duty bearers. This approach therefore merely relieves the immediate crisis and does not advocate for accountability on the part of the state.

SOCIAL ASSISTANCE

Despite the shift to developmental principles, South African welfare policies acknowledge the importance of social security. "Social security and welfare services form an integral part of the government's response to poverty and to the promotion of human capital development and social well-being. Most of the welfare budget is allocated to social security..." (Patel, 1998:15). The Social Assistance Policy is presently being reviewed. Eligibility criteria and administration procedures are being revised to improve the chances for children affected by HIV/AIDS, chronic illnesses and disabilities of attaining their rights.

In the past social security grants were seen as a way to help vulnerable and impoverished people meet basic needs. The review has suggested that social assistance should enable children lead a dignified and full life and ought to promote full participation and development.

The range of grants presently available to support families caring for children in need, include:

Child support grant: R100 per month up to the child's 7th birthday. A simple means test is applied;

Foster-care-grant:	R375 per month up to child's 18 th birthday. Foster parents into whose care the child has been committed can apply for this grant; and
Place-of-safety grant:	R12.50 per day Place-of-safety parents into whose care a child has been committed can apply for this grant. It is generally supposed to be a short-term grant (12 weeks to 6 months).

TYOLOGY OF APPROACHES TO THE CARE OF CHILDREN ORPHANED BY AIDS AND OTHER VULNERABLE CHILDREN

The following categories provide a summary of the kinds of services available to HIV/AIDS orphaned and vulnerable children.

1. Independent orphan household: orphan children living on their own, without any formal help.
2. Informal /Non-statutory foster care: informal care offered by community members to vulnerable children in their area. This can also be seen as indigenous care.
3. Community based support structures: income generation or awareness programmes, which identify and support children and their caregivers.
4. Home-based care and support: care offered to chronically ill people (adults and children) is extended to the dependants of the patients.
5. Statutory adoption and foster care: services provided by the Child Welfare Services and particular residential settings, such as Cotlands in Johannesburg.
6. Non-statutory residential care: private homes opened to vulnerable children.
7. Statutory residential care: street children's shelters, government places-of-safety and children's homes either in cottage formation or dormitory style.

Apart from the first category i.e. independent orphan households, the above categories were used in selecting sites to represent the different approaches to caring for children living with HIV/AIDS in South Africa for this study (refer to chapter one for more details on selection criteria). Although independent, unsupported orphan-headed households are frequently identified and spoken about, this study did not include them as a model of child care. The reason being that children find themselves in this untenable position and it is not a replicable form of care.

It should be noted that short-term options for the care of children have not been included in this study, these refer largely to shelters for street children and places-of-safety.

IDENTIFYING FEATURES OF EACH APPROACH

The following section describes the identifying features, constraints and facilitating factors of each approach. Sites visited are used as illustrations. Appendix C.1 and C.2 presents detailed information of the following discussion. The case studies, which were done on each site, are available from UNICEF.

1. **Informal Fostering/Non-Statutory Foster Care: Site Visited - Nceba (Eastern Cape)**

In this approach, community members assume the responsibility of caring for vulnerable children in their midst. Children cared for in this approach are external to any welfare support or system. The children are not placed in homes with a court order and the caregivers do not receive a place-of-safety grant or foster care grant. Caregivers are motivated by kinship obligations, community preservation and a sense of personal calling. Community structures, or individual community members offer support to caregivers, but generally these caregivers go unnoticed. There is no organizational structure, and networking depends on available resources. Support to indigenous caregivers is sometimes bolstered by donations, monetary and/or goods. This form of care is very common in rural areas where access to services, government and non-government, is more difficult than in urban areas.

The number of children in informal care is difficult to quantify, but without it, the official substitute care system would be completely overwhelmed.

Constraining factors to this approach are that the caregivers are not officially appointed and there is no record of them as duty bearers. They are then not eligible for state support and the child has no avenue to claim his/her rights. This form of care is poorly supported and often appears in areas where health, educational and welfare services are inaccessible, unreliable and ill informed.

HEARD (2000: 28) found this approach could not be costed in terms of "minimum standards of care" because the care did not meet with the criteria used for minimum standards.

Facilitating factors include community support, maintenance of kinship ties and identity, and, the reinforcement of indigenous strengths and coping mechanisms. Support from local religious groups, NGOs and people with altruistic interests provide charitable support, without which the caregivers would be destitute.

Nceba is an example of the support given to indigenous caregivers. Deon Mulder, an ex-teacher and ex-missionary from that area, living in an old mission out post, identified the need of the children when he was teaching them. He realised that these children were being taken care of by women in the community in their own homes, but that their means were very limited. They are dependent on their own pension. The exact number of children being taken care of in this manner is unknown, because children tend to wander in and out. However, each woman cares for at least ten children at any given time. The women were phenomenal in the way they supported each other and in their role as caregivers, even though they were not officially appointed as such. Deon's support connected them and

he provided opportunities for fellowship. Some children also lived with him in very rudimentary circumstances until the cyclone destroyed the dwellings in 1999. The children then moved to the caregiver living closest to him.

Deon began supporting them with food parcels, transport to collect water and to get to clinics, hospitals and government departments. He is a trained nurse and could therefore give health information and nursing help. He was himself supported very minimally by friends, a local minister and his family and a group of students (Stellenbosch University) who volunteered their services once a year. Most of the facilities attached to the mission outpost were built very simply and inexpensively by the students - including a pit latrine, a crèche, a multi-purpose "chapel" , a vegetable garden and a little office. A young woman operated the crèche voluntarily - but struggled without training and resources.

Overseas and local friends committed themselves to regular donations, which together amounted to about R2000pm. With this he paid the expenses for four households, fuel for his vehicle, school fees and a security guard. He kept clear records of expenses and trained one of the caregivers to do the same. Other donations included clothing and material for the crèche.

The health, education and welfare services in the area are very inadequate. Schools seem to close at arbitrary times, school reports are standardised forms with very little individualised information and teachers are overwhelmed with the numbers of children in one class.

The clinics and hospitals in the area could not test for HIV. Sending away for the test took up to three months for the results. All the children in Deon's care were fully immunised - Deon kept clinic cards and trained the other caregivers to do the same. The local clinic was operational and supportive of the women caring for children, but their services were hampered by lack of facilities and backup services such as laboratories, dispensaries and ambulances.

Most children do not have birth certificates and therefore cannot get child support grants. Travel to government offices alone is costly, hazardous and time consuming, and then when they get there, they are required to wait for hours. If applications are made they are often lost. Women complained of having to wait so long for the child support grant that the child reached 7 years of age and no longer qualified without there being any evidence of a grant.

The stigma attached to HIV/AIDS in the area is still very strong, but Deon has nevertheless raised awareness and advocated for safe sex behaviour - the functionary and utilitarian role of women in the area however, has mitigated against this campaign.

When asked what he felt was the most important thing he gave the people, Deon said "hope and transport".

2. Community Based Support Structures: Site Visited - Pin Project (Kwa-Zulu/Natal

Organisations in this category offer support to indigenous, informal caregivers. Their focus varies between emotional support, information provision, advice, advocacy, and liaison with income generation activities. Key functions of these organizations, however, are the support they give to caregivers and networking they do with related services and resources.

Orphaned and vulnerable children stay in their communities of origin and are cared for by family and members of the same community.

Within this approach a variety of organizational structures exist. Some organizations have a constitution, a board of management, a staff structure and are registered as non-government organizations with the Department of Social Development. Others are completely voluntary, often associated with religious groups and tend to be more charity oriented and are unlikely to be registered in any way. Combinations of the above configurations also exist.

Funding for organizations within this approach generally comes from donors - sometimes through the National Development Agency, and sometimes directly to the organizations. Some local churches have established trusts for organizations supporting caregivers.

Many community-based initiatives have evolved in various pockets and of varying forms in South Africa. Two examples of very different approaches are presented.

a) Thanadanani, (operating in the Pietermaritzburg district of KwaZulu Natal) which has established community child care committees through local elections. The committees do community profiles, identify vulnerable children, post them to caregivers in the community, oversee the children and advocate on their behalf. They lead campaigns in the area, e.g. mobilising birth registration. They regularly negotiate with schools for children's entry and for their reports and for protection against discrimination.

b) Sunflower, (operating in the Empangeni district) was initiated by a strong, visionary woman. Motivated by her faith and sense of social development, she has co-ordinated income generation projects, vegetable gardening, educational meetings, pre-school education, vocational skills for youth and education on AIDS related issues. OVC benefit from any one of these initiatives. She has no funding, works off her own meagre pension as a retired teacher and motivates others into action. She visits these groups regularly and wherever possible liaises with outside resources.

Constraints: Generally caregivers within this approach are only supported by the organisation, but are not employed by them. Although they are playing the role of primary caregiver they are not officially appointed as such as and are therefore not necessarily eligible for state support. Because organisations are not required to register with the State, constitutions and boards of management are not obligatory, mismanagement is less likely to be detected and their services would not form part of a central registry and database.

Facilitating factors: Well run organisations are potentially good conduits for donor funding to reach the people who really need it - provided the organisation itself does not siphon off large amounts for operational costs. Organisations within this category are rooted in the community and are potentially more developmental in approach, facilitating the realisation of human rights. Community-based care assumes the availability of willing and capable indigenous caregivers, which is often not the case. This approach helps to make community-based care a fraction more viable by allowing caregivers to be in contact with proximal support, thus preventing them from total isolation and destitution.

The site visited in this category was the **PIN Project**, initiated by Alice Searle, a voluntary service organization (VSO) delegate. She works with the Zululand Crafters Association in facilitating income generation activities with grandmothers. This provides an opportunity for pensioners to supplement their income and simultaneously establish a fund from the profit of the sale of their craft for AIDS orphans' grandmothers.

The organization was in its embryonic stage when visited by the researcher. It has since become a registered NGO with a constitution and bank account. Detailed records are kept of all meetings and financial transactions.

Their craft consists primarily of bead brooches with the design of the AIDS ribbon woven into it. Alice has established a market for the brooches at local conferences and overseas outlets. Kushu Dlamini from the Zululand Crafters Association sources the beads and manages the quality control.

The management committee manages the fund and all the applications for assistance. The only criteria to qualify for assistance are that the grannies need to be pensioners and have AIDS orphans in their care. The PIN project relies entirely on volunteer workers.

Networking is done with other service providers, particularly NGOs operating from the Zululand Chamber of Business Foundation Community Park. They refer out for AIDS counselling and to the Department of Social Development for social assistance. They attempted working with the Department of Social Development in establishing protocols and organizational procedures, but after waiting three months for a reply from them, Alice and the committee decided to go it alone.

PIN project has been facilitated by the association with other organizations in the Community Park, Richard's Bay and by the support of VSO in the form of Alice's time, expertise and commitment. The grandmothers' fellowship and mutual support provides an incentive for all of them (and anyone associated with them!). VSO's connection with market possibilities in Britain has been a particularly strong lubricant in establishing the fund. The committee was formed primarily from community representatives, people skilled in management functions and knowledgeable in the field of AIDS.

Constraints have been experienced with accessing assistance from the Department of Social Development. All the services provided to this organization have been voluntary - should these services fall away, the PIN project would not be able to sustain itself (HEARD 2000).

A comment of one of the grandmothers in this project captured the advantage of this approach-
" Tell the government to give us the subsidy and we will take care of the children. We know best how to do that! Not even the teachers can teach them morals like we can."

3. Home-Based Care and Support: Sites Visited - Centre for Positive Care (Northern Province), Mpumalanga Project Support Association (Mpumalanga) Sinosizo (Durban Metropolitan) and St Nicholas Hospice (Bloemfontein)

Home-based care initiatives provide services to households of people living with AIDS, TB, disabilities and injuries or other chronic illness. All the sites visited provided home care services to anyone in need of care, however the bulk of their patients were AIDS-ill. The

sites selected were those that are also identifying and supporting orphaned and vulnerable children, but not all home-based care organizations are extending their services to children.

There are no minimum standards for home-based care programmes- not for the service offered by the workers and volunteers, nor for the training level of the service rendered. Most of them are independent organizations registered as NGOs and are therefore guided by a constitution and board of management and are able to access donor funding. Some are part of a holding body and others are independent organizations. Examples of a holding body is Hospice for St. Nicholas, which does set minimum standards for their services. Their staff and volunteers undergo specialised training courses. The standard of care and the number of cases carried by a volunteer therefore varies from one organization to the other. One of the ways in which standards are maintained is through the evaluations done by/for the donors. Sinosizo is one such example - the external evaluation provided clear, rigorous indicators to use in their evaluation and their management priorities became clearer (Liz Towell, Personal communication, July 2000).

Home-based care models can either have a community base or an institutional base. Community home-based care models recruit community members to visit and care for needy people in their homes. Emphasis is placed on collaborating with community leaders in enlisting community members to be trained as voluntary home-based care workers in order to create a comprehensive, community-owned service. Institutional based care uses experts or professionals from a health care facility to go out into the community to provide care to people in their homes (Mpumalanga Department of Health, undated). Variations of both these models are found in South Africa. It would, however, be rare to find an institutionally based model that relies solely on professionals to do the work, as volunteers form the backbone of all home-based care programmes.

Examples of community home-based care models are the Centre for Positive Care in Thoyandou, Sinosizo in Durban Metropolitan, Mpumalanga Project Support Association and Tateni Home Based Care in Mamelodi. Home-based care models, which have an institutional base, include St Nicholas Hospice, Bloemfontein.

There is a minimum package of care that is commonly provided by all home- based care initiatives (Russel et al, 2000:24):

- Basic nursing care taught to family members equipping them to care for the patient. The patient is also taught how to care for him/herself.
- Information on health care and related matters such as good nutrition and preventative measures.
- Supportive visiting with patient.
- Counselling and support to caregiver.
- Accompanying patient on visits to hospital or clinic.
- Provision of food and other material support when possible.
- Basic dressing and wound care.
- House cleaning, bathing and dressing of patient.
- Undertaking minor errands.
- Referring to resources in the community.

In addition to the minimum care package, **St Nicholas** offers day care and short term in-patient palliative care. Home care workers can call on the expertise of professional nurses who are available 24hour 7 days a week. A co-ordinator was appointed to identify children at risk and make arrangements for their care.

Sinosizo offers poverty alleviation projects for caregivers. They also identify orphans and arrange guardianship through their employed social worker, which is a unique feature of this organization.

Initially, the focus of many home-based care projects was the care of sick people, however as the numbers of vulnerable children have increased they have found their services extending to orphan related care. For most projects, this service is limited to the identification of vulnerable children, providing material relief when available and finding a possible caregiver in the community and/or referring to a welfare placement agency to formalise guardianship. The home-based care worker would oversee the care of vulnerable children and upon their own sense of responsibility respond to any urgent needs.

Constraints of this approach include poor access to remote areas, particularly bad roads and poor transport system. Volunteers from this approach also spoke about crime and political strife as deterrents to their work. Many home-based care programmes operate in poverty stricken communities, the worst of which are in rural areas. State health systems are inadequately resourced and sparse in the rural areas, which makes networking and referring to professionals difficult. After-death services are expensive and inaccessible. Home-based care workers spoke about the difficulties they have once vulnerable children are identified - where do they have to turn to for assistance? As the co-ordinator of MPSA in Shogwe district said **"We are sitting on a crisis and have nowhere to go"**. They had identified 700 orphans in one month, who were all starving and apart from teaching them trench gardening, the home-based care project had nothing to give them.

In terms of meeting the "minimum standards of care" this approach was costed as the most cost effective. However, this has to be seen in the light of the heavy dependency on volunteerism and the high rate of burnout amongst home care workers.

Facilitating factors essentially lie in the fact that it is very often the home-based care worker who is first on the scene and therefore able to identify vulnerable children before they become destitute. But, as Kevin Bellinghurst (MPSA) said, "If we do not get to the children within eight hours of their parent's death, they are likely to loose their home and all their goods". So desperate are some of the poor communities in the rural areas. Some organizations within this approach have been established for sometime, as they responded when AIDS-ill patients first started needing care. They are, therefore, able to be more resourceful in picking up children in need of care. **"We have made plenty of mistakes. We have leant from our mistakes and are much better organised now,"** said Liz Towell from Sinosizo.

4. Unregistered Residential Care: Sites Visited - Jardim's House (Barberton) and Nkosi's Haven (Johannesburg)

Non-statutory residential care provides residential care outside the child's community of origin. As with statutory residential care, these homes care for children who are abandoned, abused and who have no family who can care for them. In some cases the children are even placed in these homes by court order. However, unlike statutory residential care, these homes are not registered and are therefore not under the supervision of the Department of Social Development. This is the defining feature of the homes in this category.

How children are cared for, who cares for them and how they end up in this type of care varies from home to home. Examples are the two homes visited for this study.

Nkosi's Haven was set up as a home for HIV-positive mothers and their children. Women get to know about the place through the media, social workers at hospitals and word of mouth. The only criterion for entry is HIV-positive status of the mother. Nkosi's Haven does not easily fit into any of the existing legislative categories and as a result cannot be registered.

On the other hand,

Jardim's House caters for abused, abandoned and neglected children some of whom are HIV-positive. They have all been placed in the home with a court order. However, the house does not meet the requirements set out by the Department of Health for residential settings, and the Department of Social Development is no longer registering new children's homes (see section on community care strategies in this report). The irony of this, is that even though Jardim House cannot be registered, the social workers from the regional welfare office and the local child welfare society are recommending Sophie Jardim as a foster mother to the commissioner, who in turn is committing the children to her care, but she is not able to access financial support from the state for all the children in her care.

The **carrying capacity** of homes in this category varies, however given their informal nature they tend to be small. Nkosi's Haven currently accommodates a total of 18, with 7 mothers and 11 children, while Jardim's House has 14 children. The ratio of staff to children in these homes also varies. In Nkosi's Haven mothers look after their own children, while in Jardim's Home there are about 4 children to an adult.

Staff working in these homes may or may not have training and are usually inspired by a personal calling. Financial reimbursement of staff depends largely on donor money, the availability of state subsidies where eligibility requirements can be met, and income-generation projects. In these informal and difficult-to-classify situations, accessing state subsidies is clumsy as the following case highlights.

There are 14 children living at Jardim's House. Of these, 8 are receiving some form of state subsidy - 7 foster care grants and 1 place-of-safety grant. In order to get around the regulation of maximum of six children per foster care home, some of these children are

formally placed with the neighbour but are actually living with Sophie. Three children were placed in the home as a place-of-safety when they were abandoned as babies 2 years ago. Birth certificates were applied for at the time and have still not been received. As birth certificates are a requirement for a foster care grant they cannot receive this grant. Neither are they able to receive a place of safety grant because the maximum duration for this grant is 12 weeks.

Constraints of this approach are inherent in the regulations pertaining to residential care. Children in these settings are not in their communities of origin, but are not as removed from community activities and household chores as children in large statutory residential settings are. Other constraints have been the delay in getting birth certificates for abandoned children in their care.

Facilitating factors arise out of their personal contacts with donors and supportive people. Both sites visited have had a lot of media coverage and are supported by various people and organizations. Sophie and Gail both have dynamic personalities and have done something unusual, they are sometimes unpopular, but have managed to carry it off with a lot of enthusiasm and public attention.

5. Statutory Adoption and Foster Care: Site Visited - Durban Children's Society (Durban)

All children in statutory adoption and foster care are committed to this form of care by a court order.

Adoption (see section on adoption in this section of the report) is an option, albeit rare, for children living with AIDS. For orphaned children and economically stable surrogate parents it is the most secure option. There are reported incidences of HIV positive children being adopted, for example Nkosi who was adopted by Gail Johnson, Cotlands have made their first adoption placement and Kerux/Mohaou have found adoptive parents in America for two of their children. Adoption is an option that requires further research and resources. It is potentially a viable option to child care that requires awareness raising, campaigning and recruitment (Brink, 1999).

Fostering requires a person appointed by the court to perform the role of a surrogate parent and to take full custody of the child. The place of abode is the home of the foster parent. Traditionally, Child Welfare Societies are the state-appointed authorities managing adoption and foster placements: recruiting and screening the parents; and matching and placing the children. Foster care requires further monitoring and reporting by social workers, whilst adoption places the child out of the system.

This category of childcare is inclusive of all forms of foster care. However, it is important to understand that, because of the varying circumstances requiring statutory intervention, there are several kinds of foster care.

For the purposes of this study, it is useful to differentiate between foster care for children found in need-of-care because of neglect, abuse or abandonment, and foster care for orphaned children because of AIDS illnesses. A child removed because of abuse or neglect and placed with an unrelated person (ostensibly until the child is either adopted or returned to the parent after rehabilitation/reconstruction) is likely to come with other difficulties such as disruptive parents, and behavioural problems. The state, having made the removal and the committal is obliged: to ensure the protection of the child; to monitor the placement; and to support the person taking the parental responsibility on their behalf.

On the other hand, kinship care of orphans, need not require the same court proceedings nor state monitoring and protection. The majority of orphans are taken care of by family, most commonly the maternal grandmother, who need not be subjected to the lengthy enquiry and time consuming application for the foster care grant. Nor is it cost-effective for professional social workers to have these increasingly enormous numbers added to their already large caseloads. However, many of these related caregivers require financial assistance, which a state subsidy provides - hence the foster care committals within the system as it functions to date.

In response to the growing numbers of children in need of care, Child Welfare Societies have been exploring a **range of alternative approaches to the provision of statutory foster care**. For example, Crisis Care and the Community-Family model at Durban Children's Society, and, Cluster Foster Care and Collective Foster Care at Pietermaritzburg Child Welfare.

Traditional foster care: Up to six children are placed in the home of a foster parent/s. Foster parents are not reimbursed for taking care of the children, however the child is eligible for the foster care grant which can be used to cover expenses. Extended family members can be appointed as foster parents.

Crisis Care: Essentially, crisis care is a temporary placement for "hard-to-place" HIV-positive babies. Some of the babies die in crisis care and others are placed in permanent care. Strictly speaking, crisis care is a place-of-safety placement rather than foster care. Crisis care mothers can receive a place-of-safety grant for the duration of the placement, which theoretically should not be longer than 12 weeks to 6 months, however can go on for over a year.

Community Family Model: Up to six children are placed with a foster mother in a home that is purchased, equipped and owned by the organization. The foster mother is paid a small allowance in addition to receiving foster care grants for each of the children. The mother is assisted by a relief parent who is also given a small allowance. The home is in the community and community leaderships structure are involved in the process of developing and implementing the community family home. This model provides a way of keeping siblings together and keeping children integrated in their communities of origin.

Cluster Foster Care: Volunteer women and couples are recruited and trained in the basics of childcare. Up to six children are placed with each volunteer who receives foster care grants and material support. Community workers link these volunteers to other resources such as day care centres which relieve foster parents of childcare duties in order to undertake income-generating activities (McKerrow, 1996:14).

Collective Foster Care: Instead of being placed with a volunteer, woman or couple, children are placed in the collective care of a social, religious or work-related body whose members undertake to collectively act as surrogate carers for the children. Children remain in the homes of their parents. This approach is commonly used to support child-headed households (McKerrow, 1996:14).

All the above approaches require the recruitment and selection of suitable foster care parents, court reports and procedures and supervision of placements. All these approaches require **organisational structures**, staff systems, professional protocols and funding other than the state subsidies which Child Welfare Societies receive.

Some child welfare societies, such as Durban Children's Society, are moving away from professional foster care, to **community or developmental foster care**. Community foster care is really about involving the community in determining the criteria for the care of children, rather than the criteria set by professionals removed from community life. Professional criteria have tended to emphasise the physical conditions of the home, income levels and value-laden personal characteristics such as age and sexual orientation. When Durban Children's Society piloted the community foster care approach with two communities, the criteria set by community members was that people who care for children should not have committed a crime and should love children (personal communication with Dorothy Nielson, Orphan and Vulnerable Children Co-ordinator, Durban Children's Society, July 2000).

Social workers are required to **supervise** all foster care placements and submit a report to the Department of Social Development every two years, and in so doing offer children the protection of a monitoring system. The efficacy of this system is yet to be evaluated.

It was reported that a couple of foster parents are applying to have their homes registered with the NGO desk of the National Department of Social Development and are thereby becoming eligible to **raise funds**. Registering children's homes is the function of regional social development departments. As their directive is to not register any new homes, foster parents are circumventing this by registering as a non-profit organization (Jackie Loffel, personal communication, 27/11/00).

Constraints of this approach are incumbent in the time consuming, expensive and cumbersome statutory procedures. Kinship care and community care do not necessarily require statutory supervision and yet the law, at this stage, requires all foster care to follow these procedures. HEARD (2000) reports that social workers generally spend about 15 hours per annum per foster care placement, that is for the placement and the supervision of the child. Whilst this provides some form of protection for the child, it hardly warrants the delay and frustration experienced by potential surrogate parents of OVC.

Facilitating factors are found in the variety of manifestations of foster care derived by innovative Child Welfare Societies. Foster care and adoption placements are facilitated by an objective person who can manage the expressed wish of the parents, when available, and discuss the acceptance of responsibility for the care of the child. This approach was costed as a relatively inexpensive form of care, but the cost of caring for HIV-positive children would push this figure up.

6. Statutory Residential Care: Site visited - Nazareth House (Cape Town)

All children placed in statutory residential care have been found in need of care and are statutorily placed with a court order. For each child the home receives a state subsidy of R824 a month, but this amount proves to be 1/3 of what it costs Nazareth House to care for their children. This is usually an **"end of the road" option** for children in need of care, often abandoned or abused children for whom return to community and family of origin is not an option.

Traditional children's homes, reform schools and places-of-safety all fit into this category, all of which have had to consider how they can adapt to the needs of children living with AIDS - whether they are infected themselves or have family members who are infected. These facilities faced the difficulty of being constitutionally obliged to accept HIV-positive children, not being able to test for HIV and not being equipped to cope with the consequences of having HIV-positive children in their care.

Some, like Nazareth House, have completely **adapted to cater only for HIV-positive** children, while others have incorporated HIV-positive children with uninfected children. Very often these homes are inspired by religious commitments - *God's Golden Acre* in KwaZulu Natal, *St John's* in Barberton and *Beautiful Gates* in the Cape are examples. Specialised care requires appropriately trained staff, 24 hour care, carefully planned diets and medical attention.

The **carrying capacity** of residential care settings varies. Currently those facilities caring solely for HIV-positive children tend to care for a limited number of children, i.e. less than 50. Nazareth House can care for a maximum of 40 children; *God's Golden Acre* in Cato Ridge - 31, *Kerux/Mohau* in Pretoria - 30; *Cotlands Hospice* - 18; *St John's* in Barberton - 15. The ratio of staff to child at Nazareth House is 1 - 4. This appears to be the norm in most of the homes.

Mixed children's homes can cater for many more children, however once HIV-positive children become AIDS-ill they are moved over to hospice settings whether in the home or elsewhere. For example, *William Clarke Gardens/Othendweni Children's Home*, in Durban can cater for up to 200 healthy children, HIV-positive or not. Children who become ill are moved to their special care unit with a capacity of 16.

Children can be cared for in family-type cottages with housemothers or parents, or they can be cared for in dormitory-style accommodation. Some of the cottages are in the community, for example, *St George's*. Others, such as the *SOS Children's Village*, are clustered together in one complex. Nazareth House has dormitory-style accommodation, however they have recently built a cottage for their school-going children. These children have outlived their expected life-span and require a more family-type setting.

All the homes are registered and therefore have to have a Constitution and a Board of Directors. Some of them fall under an external holding body. For example, Nazareth House is

part of the International Order of the Sisters of Nazareth. Most of the homes, particularly the larger ones, have routines, are structured and have a management hierarchy.

Constraints: As stated previously in this report, this model is expensive and is not favoured by the government. Furthermore, children in this form of care are often found to be clingy and lacking in relationship skills. Attachments with significant adults are difficult to form in large residential settings and are therefore scarce. This has implications for children's socio-emotional development.

Facilitating factors: residential settings are generally well resourced - they easily attract donors and altruistic interest. Children who would otherwise be destitute are able to realise the inherent right to life.

SUMMARY OF APPROACHES

The following table provides a summary of the key features of the different approaches to caring for OVC. The site chosen may not reflect all of the features listed and this is indicative of the wide range of options within each approach (see Annexure D for a more detailed analysis).

Table 5: Summary of Approaches to the care of orphaned and vulnerable children.

APPROACHES	KEY FEATURES
Informal fostering (non-statutory foster care) Site chosen: Nceba Village	<ul style="list-style-type: none"> ▪ Child is not committed by court order ▪ No statutory supervision or accountability ▪ Caregiver could access R100 per month child support grant ▪ Care is commonly provided by extended family or member of community
Community Support Site chosen: <i>Pin Project</i>	<ul style="list-style-type: none"> • Support is given to indigenous/informal/kinship care of OVC • Support can be of varying forms for example, income-generation projects, advice and information, community support structures, advocacy on their behalf, networking and referring • Indirect care of the child • No statutory intervention or accountability' • May or may not be registered as an NGO
Home Based Care and Support Sites chosen: <i>Centre for Positive Care</i> <i>MPSA</i> <i>Sinosizo</i> <i>St Nicholas Hospice</i>	<ul style="list-style-type: none"> ▪ Core function is to equip the family to care for sick and dying person in the home ▪ Support to AIDS-ill parent to continue caring for their child in their home, whether the child is AIDS-ill or not ▪ Assistance to AIDS-ill parent to arrange for guardianship of the child with extended family or neighbours ▪ Where no family exists, referral of case to social worker for statutory intervention ▪ In the absence of social work intervention, visit child-headed households and provide support ▪ Child is not committed to the care of the home care worker or organization ▪ On the whole, no statutory supervision or accountability ▪ Generally registered as an NGO

APPROACHES	KEY FEATURES
Unregistered / Non-Statutory Residential Care Sites chosen: <i>Jardim Home</i> <i>Nkosi's Haven</i>	<ul style="list-style-type: none"> ▪ Home is not registered as children's home; may be registered as an NGO - not registered either because DOSD is no longer registering children's homes or because they don't meet health requirements ▪ Child may or may not be committed by court order for foster care or place of safety ▪ If child is committed then placement is supervised and accountable to DOSD ▪ If committed then will have access to foster care grant (R375pm) or place of safety grant (R12.82 per day) ▪ If means test is passed then could access child support grant (R100 pm) ▪ Commonly cares for children for whom there is no available statutory residential setting
Statutory Foster Care Site chosen: <i>Durban Children's Society</i>	<ul style="list-style-type: none"> ▪ Child is committed by court order to the care of a foster parent ▪ Access to R375 foster care grant ▪ Statutory supervision and accountability to DOSD <ul style="list-style-type: none"> ▪ Commonly used for children who require state intervention for their protection such as abused or neglected children ▪ Commonly used as a way of supporting kinship care ▪ A range of models have emerged such as cluster foster care for child-headed households
Statutory Residential Care Site chosen: <i>Nazareth House</i>	<ul style="list-style-type: none"> ▪ Home is registered as children's home with DOSD ▪ Child is committed by court order ▪ Statutory supervision and accountability to DOSD ▪ Access to R824 grant per month ▪ Last resort for child in need of care ▪ Commonly used for HIV+ children found in need of care ▪ Generally not situated in community of origin ▪ Expensive ▪ Discouraged by DOSD - no longer registering new homes

CONCLUDING COMMENTS

This chapter has outlined the different approaches on the continuum of care offered to OVC in South Africa. The nature of care and the required organisational features are discussed, using the sites visited as examples of each approach. Constraints and facilitating features of each approach were illuminated. This revealed that each approach has advantages and disadvantages in terms of how they function and in terms of how they are able to care for OVC. Statutory residential care is the most expensive and is used as an "end of the road" option. Non-statutory foster care is the least expensive, but caregivers in this approach have the least access to resources and services and quality control is potentially a challenge..

CHAPTER 4: ASSESSMENT OF QUALITY OF CARE

INTRODUCTION

This chapter assesses the extent to which the various approaches described in Chapter Three realise the rights of OVC. The checklist of essential elements, provided in Chapter Two, is used as a framework for the analysis (see Appendix D for a detailed assessment of each site visited). The analysis focuses on the extent to which rights are upheld by each approach. Each analysis concludes with reasons for and against it being a policy option.

ASSESSMENT OF APPROACHES

INFORMAL/NON-STATUTORY FOSTERING

Survival: For children being cared for at Nceba, meals tended to be sporadic, unbalanced and dependent on what was available. The children looked underfed and malnourished. For many informal caregivers, subsistence farming could supplement food requirements and provide an income, however this was dependent on weather conditions and access to water. In the Eastern Cape maize plantations were destroyed by the tornado in 1999, while in some areas of the Northern Province floods washed away water distribution systems and cutting off supplies to small subsistence farms.

The living conditions at Nceba Village were in keeping with those of the poorer provinces in South Africa, where 29% of households have no form of toilet and approximately 90% have no regular refuse removal (Statistics South Africa 1996).

Nceba had no form of sanitation. Children used the bush. Refuse was buried and burnt, but would often be seen littering the surroundings. Water was collected from the river and children were seen carrying large plastic containers on their heads or pushing wheelbarrows with water filled drums. Water storage was limited and hygiene standards were not observed. For example, one bucket with one dispensing cup served everyone's needs. Hands would seldom be washed and bathing would happen in the river or in a tub. Water was boiled in a black pot over a wood fire at the centre of the huts, depending on the availability of fuel. Drinking water was not boiled. When asked why so many people are ill and dying in the area, a caregiver said "I don't know- maybe it's the water". An awareness of the potential dangers of unpurified water was therefore there, but a denial of HIV/AIDS was also obvious.

In principle, the state offers free health care to children and lactating mothers, but in reality fees were charged, particularly in cash strapped provinces. Furthermore, services in the remote areas were scarce and inadequately supplied and equipped. For example, the Pilani clinic (in the Canzibe district where Nceba is located) could not do HIV testing. They did not have phones, radios or transport. Medication supplies were limited and irregularly restocked. Solar power and gas were used for fuel. The nursing sisters travelled by taxi to do home visits, primarily to assist with birth deliveries. No home-based care programmes were

established and there was no collaboration with welfare services. Condoms were provided, but education on safe sex apparently had little impact. "They (men) do not want to use them...", said a young woman, with four children. Another woman with a disability, with four children, an obviously ill baby and five orphaned nieces and nephews and no regular income, said she did not want any more children, but did not know how to prevent herself falling pregnant again.

Social welfare services were provided at some distance away - a R16.00 taxi ride away, which is more than anyone there could afford. Most people were unaware of how they could benefit from social services. If they were aware, they said it was useless applying for anything, because it took time and money and they were told to come back a few months later, by which time applications were lost or staff had changed.

In 1998, the government introduced the child support grant for children under the age of 7 years living in impoverished households. It was intended that 3 million children would access the grant within five years. However, after the first year, less than 30 000, or a meagre 1% of people were accessing the grant (Department of Social Welfare 1999). These slow take-up rates were attributed, by the Department of Social Development, to stringent information requirements and inadequate capacity in their own department. Throughout the study, caregivers who were clearly eligible for the grant were not receiving it for various reasons including:

- Difficulties in registering births, especially in rural areas where home births are common. For some households the costs of getting to a state office to register births or apply for an ID book were beyond their means. A grant application cannot be processed without a birth certificate for the child and an identity document for the primary caregiver.
- Applications not being processed by welfare officials. In the Northern Province, caregivers were turned away by officials saying that the province did not have money to pay for this grant. In other areas, grant applications were accepted but caregivers never received the grants for reasons which were never explained, or it took so long to process the applications the child had grown beyond the eligible age of seven years.

The economic costing exercise revealed that informal caregivers needed R276 a month, per child to adequately provide for their basic survival needs. Caregivers at Nceba Village were caring for an entire household on less than this amount.

Security: At Nceba Village, children were cared for by a constant and reliable adult who was willing to take responsibility for their care. The arrangement was informal (in other words there was no legal status), and was known to community members who would bring orphaned children to the households. However, these same community members did not assist the households nor did they oversee or monitor the care. There was only one concerned community member who did the best he could to access food, water and health care as well as friendly visits to the households. State social services were not aware of their existence as they never visited the area. In addition, there were no NGOs or CBOs that could facilitate access to resources and strengthen household efforts to care.

In the event of any of the informal caregivers at Nceba falling ill or dying, it was unclear who would take responsibility for the care of the children. It was also unclear how these households would cope with more children being placed into their care and what would happen to the OVC they were unable to accommodate.

Socialisation: Education services at Nceba, as in many parts of South Africa, were under-resourced and inadequate. According to the clinic sister, the local primary school near Nceba had 1000 pupils and up until very recently had only four classrooms. Teaching was sporadic and unreliable, and some days classes were not offered at all. Last year, the school closed for the December holidays early in November. Within the home, the attitude to learning was casual. If the children were needed to collect water or assist with other household chores they were kept back from school. Community members identified education of the children as a priority, however there was no mobilisation within the community to improve the education offered. Nor were there efforts to promote a culture of learning amongst adults and children.

Despite harsh living circumstances and the limited access to resources, children at Nceba were jovial, friendly, welcoming and for the most part energetic and interested in life. They were observed to be very caring towards each other and responsible with duties ascribed to them. The smallest treat was equitably shared out amongst them. If a child was upset there would always be someone to attend to him/her. This positive communal attitude could possibly be attributed to the fact that these children were being cared for in their communities of origin within culturally sanctioned kinship ties and networks. They participated in all the household and community rituals, traditions and activities. This appeared to give them a strong sense of belonging and bonding which nurtured and sustained them.

Self-actualisation: There was no awareness of the right of children to play, if their chores and other household responsibilities were completed, such as collecting water, thrashing corn and herding the cattle, they were free to play. It is a culturally sanctioned practice for children to assist adults with work in the home. There seemed to be no awareness on the part of caregivers that children could possibly be over-worked and even exploited through this cultural practice. Freedom of expression was a foreign concept to caregivers.

Palliative Care: No pain relief medication was available to give to children dying at home at Nceba. Clinics were poorly stocked and there were no home-based care programmes. A concerned community member assisted with transporting ill children and corpses to the hospital, if and when his car was working. No bereavement counselling was available and death was not spoken about in the homes. Because there was no HIV testing it was difficult to establish whether children were dying of AIDS or other causes. Growing numbers of children and adults were dying but HIV/AIDS was not spoken about.

Informal Fostering: An Option?

Poverty is the backdrop against which care is provided to many children in South Africa and was the overwhelming feature of the informal care provided at Nceba Village: "There is no hope here. Its not only AIDS. People are permanently hungry" (concerned community member, Nceba Village).

A defining feature of poverty is lack of access to resources. In terms of the commonly accepted definition of poverty (the poorest 40% of households), six out of every 10 children in South Africa live in poverty. Children living in rural areas are more likely to be poor than their rural counterparts, as seven out of every 10 people live in rural areas. Provincial differences further highlight the discrepancy between rural areas and poverty. In the Eastern Cape 78 of children live in poor households, compared with 35% in the Western Cape and 20% in Gauteng (Robinson et al, 1999, p. vii).

Informal fostering by extended family and community members meets some of the basic requirements for the care of OVC, such as constant and reliable adult presence which provides support and care to children in their community of origin.

However, while these caregivers may be willing to take responsibility for the care of OVC in the community, without access to resources the quality of the care they provide is inadequate in terms of meeting survival needs. The long-term protection of the children is also not assured, particularly where adult caregivers may themselves be HIV positive and not have long to live. Socialisation needs are addressed quite effectively by informal fostering, however this is within cultural norms and traditions which are not based on children's rights. The same applies to Self-actualisation needs, where cultural practices determine the extent to which children have time to play and their views elicited and considered, again with no awareness of their rights. The special physical and psycho-social needs of AIDS-ill children and the other children living in the household were not recognised nor were there resources to address them.

Informal fostering which has no access to established, functioning and reliable support networks, both public and private, is clearly not a viable option of care for needy OVC. While it provides the basis from which to care for OVC in the community, it needs targeted support programmes in the form of income-generation projects and home-based care and support programmes. It also needs access to functioning social, health and education services and a legal framework within which to operate.

COMMUNITY SUPPORT

The Pin Project is an income-generating community support structure. Its intention is to assist the growing numbers of grannies who are caring for their grandchildren without any support from parent's income, largely because of the increasing number of adults dying from AIDS-related diseases. The project is still in the early stages of development and is still far from being able to provide potential beneficiaries with a reliable and significant source of income. To date, a few needy grannies have been given a once-off payment to assist with schools fees or uniforms. The economic costing exercise revealed that the project itself is essentially running at a loss. The material support offered by the Pin Project is limited and unreliable. Grannies continue to rely on their monthly pension payments of R580 per month to support themselves and their households.

Apart from income-generation opportunities, the Pin Project does not offer any other direct service to its members. Members gain emotionally and spiritually from being part of a support

group, which in turn encourages and sustains their caregiving efforts. The benefit to the children is indirect. There is no awareness raising or information sharing around HIV/AIDS in spite of the fact that the primary product of the Pin project is beaded broaches designed with the AIDS ribbon. As in many parts of South Africa, AIDS and sex are taboo topics.

When the Pin Project was visited for this research it was very much in an embryonic phase. The researchers are aware that a number of developments have taken place since the visit including networking, structure and organizational procedures. These developments are indicative of their potential.

Community Support: An Option?

Community support is an option which needs to be supported and strengthened. Through supporting income-generating activities, these projects attempt to go beyond the charitable "hand-out" response to promoting economic empowerment opportunities for its members. It encourages an attitude of self-help and community support. However, as with all SMME enterprises it is not an easy solution, requiring access to credit facilities, markets and business acumen in order to be a viable operation. These projects could benefit from strengthening its networks with care and support organizations and facilitating access on the part of its members to home-based care organisations.

HOME-BASED CARE AND SUPPORT

Survival: Home-based care and support organisations aimed to support and strengthen families and households, including informal fostering and kinship arrangements, to care for an ill person in their home. The core business of most of these programmes was to provide primary health care assistance to families, which included raising awareness on nutrition issues. However, organizations recognised that it is pointless to educate patients and their families about good nutrition when families have nothing to eat. Therefore, all of the sites visited provided some form of material relief. The nature and extent of this relief depended on the ability of the organization to access funds and donations. For organizations in the under-resourced rural areas, such as the Mpumalanga Project Support Association and Centre for Positive Care, this assistance was limited and amounted to no more than a small food parcel consisting of samp, beans or soya and one or two items of clothes for the most needy families. St Nicholas Hospice on the other hand, was extremely well networked in Bloemfontein and received regular and generous donations of food, clothes and toys from churches, businesses and community members. In addition, they provided a day care centre three days a week which served nutritious and balanced meals to HIV positive children.

While basic material relief probably saved many families from starvation, home care workers and staff at these organizations cited many cases of malnutrition and hunger. Some home care workers encouraged families to grow their own vegetables, and in a few cases supplied seeds. They all tried to assist families to obtain the child support grant, however in most cases this was unsuccessful, once more this was particularly the case in the poor rural provinces. St Nicholas and Sinosizo, used their contacts with the Department Social Development to secure grants for patients and their families.

In meeting material needs, the sites focused at the level of finding solutions to meeting the needs of individuals and families, reflecting more of a needs-based than rights-based approach. Community mobilisation and community development responses were not explored, including advocacy and lobbying for social justice. One site planned an income-generating project, not for the families but as a means of supplementing the income of home care workers. While home care organizations need to stay focused on what they do best, which is caring of sick people at home, there is scope for forming linkages with non-governmental and community-based organizations that have the capacity and expertise in community development and poverty alleviation. Families of patients could be linked to these projects. In addition, communities could be encouraged to organise themselves and establish community gardens.

Home care organizations stressed that the capacity of extended families and communities to take care of needy OVC was limited due to wide-spread impoverished circumstances: "In five years time we will need a children's home. All the people here are struggling. They cannot take more children into their homes" (Home Based Care Co-ordinator, Centre for Positive Care).

Security: An identified strength of home-based care projects was that, when visiting ill patients, care supporters were well placed to assess whether fundamental rights of the children in the home were being honoured. They were further in an excellent position to identify those children who were vulnerable and in need of care or who, on the death of their parent would require alternative care. In some cases these children were referred to social workers, however staff commented that follow-up of social workers was either slow or non-existent.

For children living in child-headed households, care supporters and orphan co-ordinators provided an important link with external resources as well as the reassurance of an adult presence. However, because children are not legally placed in the care of these organizations their long-term care prospects are not ensured. Many home care organizations reported high caseloads which included a mixture of chronically and terminally ill adults as well as healthy orphans. The capacity of care supporters to provide a constant and reliable presence, especially for child-headed households was clearly constrained.

Socialisation: Home care workers played an important advocacy role in securing the child's right to attend school when fees could not be paid. However there appeared to be varying degrees of awareness about the right of the child to attend school regardless of whether they could afford to pay fees or purchase a uniform. As a result, some organizations directed their efforts at securing resources to pay for school fees and purchase uniforms when what was really required was for school administrators to be obliged to meet Constitutional obligations.

All the organizations visited attempted to hear the views of children regarding their care situation and their preferences for alternative care placements.

Self-Actualization: Some home-based care organizations were aware of the child's right to play and those with access to welfare services were, in some instances, able to remove children from situations of exploitation.

Palliative Care: Care supporters received training in caring for chronically and terminally ill adults and children. However, because of poorly stocked clinics with indifferent staff, they were often unable to provide the necessary medication. One home care facilitator spoke of having to smuggle morphine out of the local hospital to give to an AIDS patient who was dying in agony at home. There was clearly reluctance on the part of many care supporters to talk to children about death and the reasons for their parent's death. This stemmed largely from their own perceptions of what was culturally acceptable and their own personal comfort levels.

St Nicholas Hospice was an exception in this regard. All their staff received specialised training in either palliative care or bereavement counselling. In addition, 24-hour access to trained nurses and an in-patient centre ensured that patients had access to the necessary pain relief medication at all times. As a result, they were able to provide a quality palliative care service to AIDS-ill OVC.

Home-Based Care and Support: An Option?

Home-based care and support programmes play a vital role in strengthening the capacity of families and communities to care for OVC. Care supporters play a facilitating role in terms of accessing material and other resources for families. The home-based care programme, which was best placed to uphold the protection rights of children was Sinosizo as they had employed their own social worker who could undertake statutory placements and supervision. The cost of this model of home-based care was R506 per child per month. St Nicholas was also better placed to respond to children in-need-of-substitute-care because of their strong networks with a functioning social welfare system in Bloemfontein.

Home-based care organisations would benefit from linking with community development projects and adopting a stronger advocacy and lobbying stance to ensure that the rights of children are upheld by families, communities and state service providers.

UNREGISTERED RESIDENTIAL CARE

Survival : As identified in the previous chapter this is a category that doesn't meet government's regulatory requirements and can be regarded as illegal. Some of the homes may not comply with: designated space per child; kitchen facilities and number of toilets and basins. This was clearly the case for both sites visited. However, none of the children in these settings complained about space or living conditions, as this comment indicates for some it was just the opposite: "Its nice here. People donate food and clothes. It seems we live better than people in houses" (11 year old resident at Nkosi's Haven).

Access to resources, and the distribution of these resources in the home, determined the quality of material care. Jardim's Home for example had access to foster care grants and a small income-generating project. Nkosi's Haven, on the other hand, relied entirely on local and international donations, including donations of food, clothes and disposable nappies.

Within the context of poverty, all forms of residential care, whether registered or unregistered, are well placed to meet the basic survival needs of orphaned and vulnerable children. In some cases, without this level of support, the child would not survive.

A residential care environment can provide the necessary structure to implement and monitor hygiene and infection control measures. However, especially with unregistered homes this is not guaranteed and depends on the awareness and inclination of the housemother. Nkosi's Haven had very clear and stringent guidelines on hygiene practices, and residence in the home was contingent on these being adhered to, while in Jardim's Home, children shared toothbrushes and facecloths and there was a more casual approach to hygiene.

Security: Unregistered residential care can provide children with some level of security as the housemother provides constant care, living on the premises with the children.

Nkosi's Haven presented an unusual model where mother and child were accommodated together in the home and the child could remain in the home in the event of the mother's death. This arrangement provided the child with continuity and additional security, which is less likely to be the case where a child is removed from home, is a crisis situation and placed in an unfamiliar environment with strange adults. Children at Nkosi's Haven, including the orphaned children, were observed to be confident and at ease with all the adults in the home. From their comments about the home, it was clear that they felt loved, cared for and secure: "I love Gail and Jane - they take care of us as their kids"; "I love to be here"; and "Nkosi's Haven takes care of me" (children aged between 9 and 13 years).

For those children who are committed to the care of the housemother by the court, this placement requires the supervision of a social worker, which, if carried out correctly, could provide additional protection (see discussion in section on statutory adoption and foster care).

Socialisation: Both the unregistered residential care facilities visited were situated in urban areas removed from many of the children's community of origin. However, given the small and informal nature of these facilities, children were exposed to the day-to-day functioning of the household, assisted with household chores and accompanied adults on trips to shops and community amenities.

The smaller numbers of children living in unregistered homes (Nkosi's Haven had 11 and Jardim's Home - 14) provided staff with more opportunities for building individual and personalised relationships between themselves and the children. Children were seen as entities in their own right and had their own clothing and space to keep personal belongings. In keeping with the focus on the child as an individual, both homes made an effort to keep the personal histories of the children in tact. Nkosi's Haven introduced a photo project for the mothers and encouraged them to write memoirs and letters for their children. Jardim's Home kept individualised scrapbooks for each child, documenting milestones and personal achievements. Other ways of recognising individuality and personal identity included the celebration of children's birthdays.

Self-Actualization: While children in these homes were allocated responsibility for some household chores, these were not excessive and children had time and opportunities to play. The different views of children were respected.

Palliative Care: Both the homes visited, depended on the state health care system to meet the palliative care needs of AIDS-ill children. At Jardim's House, children died at home rather than in the hospital as the housemother felt they would be better cared for at home.

Unregistered Residential Care: An Option?

This approach clearly fills a gap in the need for substitute care and is used as a resource by social workers even though these homes do not meet prescribed regulations for providing care. The monthly cost of caring for one child at Jardim's House was R931, which makes this a relatively costly approach, however at least one-third of the cost of statutory residential care. The legal status of these homes is unclear. Oversight and monitoring of care in the homes is not legally required unless a child has been placed there by a court order. The role of the state becomes less clear if the home functions entirely independently from the statutory welfare system. In some respects, the care offered by unregistered homes was preferable to many statutory residential care settings, as the homes had one constant primary caregiver, were smaller and offered a more "normal" family-type experience for children. Regulatory mechanisms to register and supervise this form of care need to be explored.

STATUTORY ADOPTION AND FOSTER CARE

Survival: Foster parents have access to the foster care grant and can therefore afford to meet basic survival needs. The quality and quantity of material support will however vary depending on the personal economic status of the foster parent. The practice of requiring foster parents to meet traditional westernised nuclear family standards is gradually being replaced by community-determined criteria, which removes the guarantee that the survival rights of children in foster care will be met at comparable levels. Children living in Community-Family foster care arrangements, where the home is owned by Durban Children's Society, are assured an adequate level of shelter.

The following case study provides insight into the experiences of a foster mother in an informal settlement. She provides a form of group foster care for a mixture of children. Only one of the children has been legally placed in her care.

Mrs Ndlovu currently looks after 8 children, aged between 3 years and 17 years, in her 4-roomed shack in the informal settlement area of Cato Crest. Six of these children are grandchildren, one is a neighbour's child (3 years old) and the other was formally placed in her care by Durban Children's Society. It is suspected that the neighbour's child is HIV positive as she is constantly sickly and her mother died of AIDS.

Mrs Ndlovu started looking after other people's children from 1994 on an informal basis. She got "very cross" seeing children staying out in the streets and suffering and wanted to do something about it. She receives no grants for any of the children but is currently making an application through the social workers for one of the children. She complained that social workers "dump the children at my home with nothing, maybe only three dresses". She required assistance with food and clothes. Her current sources of income are her husband's old age pension and remittances from her daughter who works in town and lives with her. Mrs Ndlovu also tries to earn an extra income by selling fruit outside the house.

In 1997 Mrs Ndlovu trained as a home-based care worker (a Nompilo) at Cato Crest with Durban Children's Society and nursed a neighbour who had AIDS. She is not afraid of people who are HIV+ "in my mind they are the same like these who haven't got the disease".

Mrs Ndlovu dreams about building a "proper house" for the children with enough room for them to sleep. She has started to build the foundations for this house in her backyard. Her yard doesn't have a fence around it and she worries that the children may wander out and get hurt by a car. She also worries about the health of the child with HIV who doesn't have long to live and that the "day when God will visit us will be soon". Mrs Ndlovu would like training on how to look after the children properly. She doesn't know if they are satisfied (Foster mother, Durban Children's Society).

The following issues are highlighted by this case:

- Mrs Ndlovu started out as an unsupported informal caregiver. Through her contact with Durban Children's Society (DCS) she was able to access training and limited material resources.
- The physical conditions of her home are clearly not adequate in terms of space and safety, however she lacks the resources to upgrade her home. In spite of the inadequacy of the home environment, given the large number of children requiring substitute care and limited resources, DCS recognises her as a viable substitute child care resource but are unable to access the necessary resources to enable her to provide quality care.
- Mrs Ndlovu is caring for her grandchildren (kinship care) as well as un-related children. She does not meet regulatory requirements for a statutory residential care setting. In addition the number of children in her care exceed the number allowed in terms of the foster care regulations. Theoretically, she could access a maximum of six foster care grants if these children were to go through the statutory process. Alternatively she could try to access Child Support Grants for the children in her care under the age of seven years.
- The legal status of the children who have been placed in her care informally by family and community members is unclear.

Security: Children are committed to foster care by a court order. Therefore all foster care placements require social work supervision. However, social work supervision does not necessarily guarantee protection. Social workers at Durban Children's society estimated that only 5.6 hours was spent per child over a two-year period in the supervision of a foster care placement (Desmond, 2000). Given the limited supervision of placements, it would be difficult for a social worker to detect abusive situations or unhealthy discipline practices identified by

foster children's comments: "I feel angry when "granny" beats me", and "I hate it when my mother and brother beat me" (comments from foster children, DCS).

Because statutory foster care are found in need of care by a court, foster parents care for children who very often are removed from traumatic and abusive family situations. The mothers interviewed said they lacked the skills to deal with these problems on their own as the following case illustrates.

"My child had to go to school without a lunch box and he was angry with me about this. When he came home from school he locked me out of the house. I tried to get in through the back door, but he hit me on the head with a stick and then with his belt. When he is angry he takes anything to hit me. I fell down, faint and dizzy. I called the police and my social worker. The policeman came and said we must try to live together nicely, but I could not get hold of my social worker". Community-Family foster mother. The foster child is 10 years old.

Support groups and regular contact with their social worker were cited as needs by this group of foster parents.

A strength of statutory foster care is that children live with a legally designated parental figure who can provide reliable and constant care until the child reaches the age of 18 or completes school. If for whatever reason, this arrangement breaks down, the child remains the responsibility of the state or their agent who is then obliged to find an alternative foster parent or care arrangement. Comments from foster children reflected contentment with their care situation, in spite of some unhappiness with excessive discipline: "I feel wonderful when I am with 'granny'"; "My family is a nice, caring and kind family"; and "I feel wonderful when I am with my family".

Socialisation: Children in foster care are generally kept in their community of origin and as a result retain their cultural identity. They attend local schools and have friends from similar socio-economic backgrounds. A further advantage is that children are incorporated into the daily living of the family and are exposed to every-day household issues, which facilitates socialisation and equips them with basic life skills.

Cross-cultural foster care presents its own unique challenges with respect to retaining a child's cultural identity. At Durban Children's Society, many abandoned HIV-positive babies end up in cross-cultural crisis-care placements because recruitment drives for crisis care parents are most successful amongst white middle-class parents (Nielson, personal communication, 4/7/2000). Crisis care parents did not see a need to talk Zulu to the babies; the children were being socialised into their culture and English formed the basis of that culture (group interview with crisis care parents, 7/4/2000).

The supervisory agency and foster parent are required to keep identifying records. This is one way of preserving their history. Not all children, especially abandoned babies, are told the details of how they ended up in alternative care. As one social worker said: " Would you really want to know that your mother threw you down the pit latrine because she didn't want

you?" Children may, however, have access to their records when they reach the age of 18 years.

Self-actualisation: The safeguarding of the child's right for self-actualisation depends on the vision, insight, resources and capacity of caregivers. However, regular supervision is required to ensure that children have time to play and are not being used as cheap labour.

Palliative care: Apart from a few isolated (and often publicised) cases, childcare agencies find it difficult to place HIV positive children in foster care or adoption. Nazareth House reported that they have yet to find a foster care or adoptive placement for one of their HIV-positive children. As a result, few foster parents are aware of or have training in meeting the special palliative care needs of HIV-positive children. At Durban Children's Society, crisis care parents take the children to their special care unit at William Clarke Gardens/Othendweni Children's Home when they get ill. Foster mothers involved with DCS's community-family project said they would not be prepared to care for HIV-positive children for reasons largely related to fear and ignorance.

Statutory Adoption and Foster Care: An Option?

The cost of the community-family foster care model is R609 per child per month, roughly R100 more than the Home-based care and support model. This model addresses the shortcomings of informal fostering and home-based care models in terms of providing a long-term legal framework for the OVC. In order to improve supervision of statutory placements, social workers need to move away from individual casework and include, for example, monthly support groups for foster mothers and foster children. In this way, group problem solving and information sharing would be encouraged.

A continuum of foster care approaches, with accompanying training and financial support, needs to be developed. This continuum would include traditional foster care, specialised foster care - for children who are HIV positive for example - and therapeutic foster care - for children who have been sexually or physically abused. Specialised and therapeutic foster parents require additional training and additional financial support. In addition, these difficult placements need greater supervision and support.

STATUTORY RESIDENTIAL CARE

Survival: Statutory residential care facilities are able to access state funds for each child. Because of this they are, theoretically at least, well placed to satisfy the children's need for survival. Nazareth House was particularly well-equipped and maintained, providing a comfortable, child-friendly and healthy environment. There are, however, homes which do not match this standard.

The minimum economic cost of providing for the survival needs at the home amounted to R2950 per month per child. This amount excludes medical costs. With medical costs it would be R3525 per child per month. The Home receives around R800 per month per child from the state subsidy. Nazareth House, through its relationship with the Catholic Church and an aggressive marketing campaign, was able to access international and local donor funds. In

addition, extensive donations in kind of clothes, food and volunteer time compensated for deficits in direct financial assistance.

Security: In residential care, a child experiences security in having a routine and being associated with children like themselves. Discipline records are a statutory requirement and annual reports need to be submitted to the courts by the social worker. Although the statutory residential care sites visited did not display obvious cases of child abuse, reported cases of abuse in children's homes are well known (Michael, 1994).

Adults are always in attendance of children in a residential setting, however a consistent, caring and affectionate adult is not guaranteed. Staff work on a shift system and high rates of staff turnover are common in childcare settings. Attention-seeking behaviour, with clinging and whining, was observed in a number of the children at Nazareth House and this could be attributed to not having a consistent relationship with a parental figure.

Statutory residential settings are legally obliged to maintain records of all the children which offers some protection against getting lost in the system as well as preserving the personal history and identity of the child.

Socialisation: A weakness to this approach is the exclusion of children from every-day household and community functioning with very few residential settings being based in the community from which the children originate. The trend for some time in statutory residential care of children has been to maintain contact with family and community members. However, many of the children visited in these sites were abandoned and therefore family members were unknown.

In the homes visited, volunteers to the zoo or aquarium arranged numerous outings and children were showered with "treats" on these occasions. However, normal, mundane experiences like going to buy bread from the *spaza* shop or taking a taxi were foreign events for many children who have grown up in a residential care setting.

In some cases, Nazareth House being one example, special attention was paid to maintaining personal items and memories, while in other homes children form an amorphous mass and don't have their own personal items, such as clothes, special books or toys, let alone space to keep these items.

In this setting, childcare plans are required to be prepared for each child but are not always discussed with the children. At Nazareth House childcare plans were discussed with the older children, it was not feasible with babies or toddlers. Childcare workers usually receive training on communicating appropriately with children, but a gap, which was identified was the capacity of caregivers to communicate with children on sensitive issues such as death, sexuality and relationships. In addition, these types of discussions require a trusting relationship with an adult and time, which can often be lacking in a residential care setting. For those children who are HIV-positive, there is a need to find ways to inform them of their status and be able to sensitively yet truthfully answer questions children may have.

The following case highlights the potential for HIV+ children to be "used", with or without their knowledge, as fund-raising mascots for organizations providing services for children with AIDS. It is clear that, in a context of secrecy, fear and stigmatisation, AIDS needs a "face". However, using an AIDS-ill child in a fund-raising exercise without their knowledge or consent violates their right to understanding and participation.

A nine-year old HIV+ child living at the Special Care Unit is regularly involved in awareness raising and fund-raising activities for William Clarke Gardens/Othendweni Children's Home. However, the researcher could find no one amongst either the staff or volunteers who knew if she was aware of her HIV+ status. The professional nurse thought that the head of the Unit may have told the child about her condition, but she wasn't sure. A care worker said, "No-one tells us we can tell the child". The child has been on an aeroplane to an AIDS awareness function, her picture has been in the newspapers as an AIDS orphan, the "face of the AIDS generation". When she is ill, she weeps and says she is going to die, the care worker responds by saying "Don't worry, you aren't going to die. Look at me, when I get sick I always get better". The Special Care Unit has a mortuary on the premises, but death is not spoken about to the children as they don't want to upset them. When children are very ill they are taken to hospital. If they die there, children in the home are not told of their death. If they ask, they are told "the child has gone to another hospital".

Self-actualisation: Some homes offer children structured recreational facilities and activities. While structure offers children security and ensures these opportunities, too rigid a routine can numb creativity and individuality. Without the guidance and inspiration provided by an interested and concerned adult figure in the child's life, self-actualisation is impaired.

Palliative Care: For HIV-positive children requiring specialised 24hour health care, this approach is well-placed to cater for those needs. However, as the previous case demonstrated, palliative care needs to be understood as encompassing more than just 24hour medical care and requires from caregivers a level of awareness of and sensitivity to the psycho-social needs of the AIDS-ill child.

Statutory Residential Care: An Option?

The cost of Statutory Residential Care renders it a prohibitive option of care for large numbers of OVC - R2590 per month per child excluding palliative care costs and R3525 per month including palliative care. It is clear that there will always be children for whom no other community-based substitute care alternatives are available. In communities that, through fear and ignorance, stigmatise and discriminate against those living with HIV/AIDS, abandoned HIV-positive babies will remain a common feature of the epidemic.

There is clearly a need for a network of state supported statutory residential care facilities that could be used as a last resort for children requiring substitute care. Efforts should be made by these facilities to create a "normal" family-type setting through, for example, establishing cottage-style homes either within a complex or decentralised into communities. A further possibility for exploration is to make the facility available for short-term respite and day-care programmes for needy HIV-positive children who are being cared for in their communities of origin. This would support and strengthen the capacity of families to continue to care for their child at home.

CROSS-CUTTING ISSUES

From the analysis of each approach against the essential element guidelines, it was clear that the efficacy of each approach depended on the extent to which it was able to either address or compensate for the following critical capacity constraints at household and community levels.

- Pervasive poverty stemming from, and compounded by, lack of access to resources including food sources and a basic income, potable water, sanitation, functioning clinics and schools. Poverty weakened the capacity of households and communities to provide adequate levels of care for OVC. In some instances, lack of access to resources resulted in extended family and kinship networks unwilling to take responsibility for the care of OVC.
- Unjust administrative practices on the part of some social security officials who used a range of methods to deny the Child Support Grant to caregivers of children under the age of seven.
- Denial of the right to education by some school administrators who refused entry to those children who were either unable to afford school fees or a school uniform.
- Inability of existing state statutory services to detect, identify, respond to and monitor OVC needing and receiving substitute care.
- Limited, inaccurate and often absent information on HIV/AIDS issues in communities. In some instances, lack of awareness and understanding led to stigma and discrimination against HIV/AIDS OVC and an unwillingness to care for these children.
- Taboo topics within communities, linked to cultural norms, traditions and rules hindered efforts to raise awareness on HIV/AIDS prevention and care issues. In addition, these taboo topics limited the extent to which the special psycho-social needs of OVC were responded to. A commonly cited example was that of acknowledging and talking to children about the death of a parent.

The following factors undermined the ability of organizations to respond to capacity constraints within households and communities:

- Community development was an under-utilised and under-acknowledged response. The focus of most organizations was on caring and supporting OVC at the household or individual level. Reasons for this focus included:
 - Large caseloads and limited/insecure financial resources which kept organizations focused on crisis management and meeting survival needs of households on a day-to-day basis;
 - Philosophy of charity and benevolence that is needs-based as opposed to rights-based. Emphasis was not on empowering claim-holders to claim their rights through, for example, advocacy and lobbying campaigns that challenge and respond to the underlying structural causes of access to resources. Instead, efforts were directed towards "doing the best we can" within difficult circumstances;
 - Lack of knowledge and skills in implementing community development responses. Issues raised included whom to network with, how to tap into existing development initiatives and how to access poverty alleviation funds.

- Lack of awareness and information on the rights of children, both within the Convention of the Rights of the Child and the Constitution of the Republic of South Africa, as well as integrating children's rights issues into programmes to ensure the progressive realisation of these rights.

Factors which supported organizations' efforts to manage capacity constraints included:

- Presence of community support structures, especially churches and women's groups, and the willingness of these community members to take responsibility for the care of OVC. These groups were used by NGOs as points of entry into communities for mobilisation around the care and support of OVC.
- Acceptance by communities and households of home-based care programmes, without which NGOs would not be able to provide care and support. This acceptance appeared to be based on two elements: the perceived "neutrality" of programmes (in other words, the programme was not seen to be assisting AIDS patients only); and the "status" of care supporters.
- Ability to build personal relationships and contacts with "sympathetic" state employees for example local clinic sisters or social security officials. These relationships enabled NGOs to negotiate for access to these services on behalf of their clients.
- Access to the statutory child welfare system either through an internally employed social worker or a dedicated OVC co-ordinator with strong linkages to a functioning statutory welfare system ensured that children in need of care were identified and protected.
- Ability to access state grants for the care of OVC. State grants provided some form of financial security either for the facility or for the primary caregiver and ensured that basic survival rights could be maintained.
- Ability to access specialised or therapeutic services to address the special psycho-social needs of HIV/AIDS OVC.

CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

INTRODUCTION

This chapter summarises the findings of the study. The information is organised into four categories - the continuum of approaches for the care of OVC, the capacity of households to care for OVC, mobilising communities to care for OVC and providing a safety net for OVC. Recommendations are made for improved functioning in each category. The chapter ends with a table of the essential elements and suggested duties of the four levels of role players and duty bearers - household, community, NGO/CBO and the state.

CONTINUUM OF APPROACHES FOR THE CARE AND SUPPORT OF OVC

Given the spectrum of needs of OVC, it is clear that a multi-layered and integrated response to their care and support is required, involving households, communities, non-governmental and community-based organizations and the state.

This study confirms the conclusions of other investigations, namely, that the care-giving efforts of extended families and kinship networks be supported and strengthened, ensuring they have the necessary resources to care and protect OVC. The costing part of the study also confirmed the potential of community-based models of care to provide care at a significantly lower cost than residential-based models of care.

While fully supporting the call to strengthen household and community-based approaches, the study confirms the imperative for alternative substitute care options where extended family members are not willing or available to care, or where it is not in the best interest of the child to remain within the extended family. These substitute care options range from least restrictive (such as adoption and community foster-care options) to most restrictive in the form of statutory residential care. Statutory residential care, as the most restrictive and expensive form of substitute care is clearly a last resort. However, the increasing demand for this type of care to cope with the growing number of abandoned HIV-positive OVC poses a serious challenge to the state.

Currently, there is a tendency for service providers to work in isolation from each other, with little networking and cross-pollination between approaches. In addition, the current regulatory framework does not make provision for emerging responses. As a result, many services, which are filling a gap in service delivery, are operating outside the legal framework and are not eligible for any state assistance. A further concern is the lack of standardised training, guidelines and standards for the provision of services for OVC that results in highly variable levels of quality within and between approaches to service provision.

Recommendations:

- The Department of Social Development to review the existing regulatory framework for the registration of organizations either supporting households in caring for OVC or providing a direct service to OVC. The review must address accountability and funding issues.

- Service providers to identify, recognise and acknowledge the continuum of approaches to care and support and to explore ways in which partnerships and networks can be built between services so as to optimise the utilisation of human and financial resources.
- Provincial, district and local level workshops to be held with key stakeholders, including as far as possible OVC and their primary caregivers, to establish the duties and obligations of each duty bearer, identify unmet needs and capacity constraints and agree on a plan of action to ensure the realisation of the rights of OVC. At the end of this chapter, a matrix of duties and duty bearers is provided. This matrix was developed in consultation with key informants and OVC service providers and could be used as a point of departure for the clarification of roles and responsibilities. It must be borne in mind that the different duty bearers and role players often do not have the capacity to fulfil their obligations. These capacity gaps needs to be addressed.

STRENGTHENING THE CAPACITY OF HOUSEHOLDS TO CARE FOR OVC

At the heart of all community-based responses lies the availability and willingness of households to take responsibility for the care of OVC. A recurring theme throughout this study shows how poverty, specifically lack of access to resources, weakens the capacity of the household to care for OVC. Currently, many households do not have access to the necessary financial or human resources to enable them to provide adequate care for their own children, let alone OVC. Because of the nature and extent of poverty in South Africa and the challenges facing government in delivering basic services, the burden of care currently falls primarily on households. This results, in many instances, in inadequate, poor quality care for OVC. It was clear from the study that for many of these households, simply having access to basic services including: potable water; sanitation; primary health care; education; and a basic income or livelihood had the potential to significantly improve their capacity to care for OVC.

Key areas of concern in relation to access to basic services were:

- The exclusion of children from schools because of lack of funds for school fees and uniforms. This is in direct contravention of their Constitutional right to an education.
- The difficulties faced by caregivers in securing the Child Support Grant. In addition, the amount of the grant is clearly not sufficient to enable caregiver to adequately meet the basic survival needs of OVC, particularly those with special needs.
- The poorly equipped primary health care clinics which were unable or unwilling to support local home-based care programmes.
- The court proceedings for appointing a legal guardian who would be eligible for state support are clumsy, time-consuming and unrealistic for the number of HIV/AIDS OVC.

Many communities, including NGOs working within these communities, were not aware of the full extent of their rights to basic services in terms of the Constitution and other legislation. Information and practical skills were also required by many households to enable them to prepare nutritious food, apply basic hygiene and infection control measures, use healthy discipline practices and respond appropriately to the psycho-social concerns of OVC.

Strengthening the capacity of households to care clearly requires the burden and cost of care to be shared between the household, community, service organization and the state.

Recommendations

- Government departments, particularly at provincial and local levels, to speed up service delivery, especially in under-resourced rural areas. It is important that the provision of basic services be driven by community-identified priorities and not nationally determined priorities.
- The Department of Social Development to simplify processes for placing OVC in substitute care so that an official duty bearer can be speedily appointed and be eligible for state support as soon as the children are taken into their care.
- The Department of Social Development, through its review of social security, to explore the possibility of increasing the Child Support Grant to cover at least the basic survival costs (R267 per month) and to extend this grant to cover all needy children up to the age of 18 years.
- The Department of Education to ensure that children who cannot afford to pay school fees or a uniform are not denied access to an education. This requires close monitoring of schools admission policies and practices as well as providing clear communication channels should a dispute arise,
- The Department of Social Development to ensure that provincial departments are not denying eligible caregivers access to the Child Support Grant. Administration procedures must be streamlined and access improved, particularly in rural areas.
- The Department of Health to ensure that primary health care clinics are equipped with supplies required for home-based nursing care and that clinic personnel have a positive and accepting attitude towards home-based care programmes.
- Where access to services is problematic, one-stop multi-purpose centres to be established in communities, at clinics for example. Social security officials could work together with Home Affairs officials registering births and processing social security applications. Social auxiliary workers could provide information on community development projects, and legal assistance could be provided.
- NGO service providers to apply community development approaches and encourage collective problem solving and mutual support amongst caregivers and OVC.
- NGO's to familiarise themselves with the policy and legislative framework within which services for the care of OVC are provided, particularly in relation to the Constitutional rights of children and to inform and educate service recipients. Efforts should be made to advocate and lobby for the provision of functioning basic services.
- Relevant government departments to develop an integrated training programme that locates the provision of care and support services to OVC within the context of children's rights. This training programme could be supported by UNICEF and UNAIDS and should be co-ordinated with other NGO/CBO initiatives. Training workshops to be convened by at the service delivery level, including all stakeholders to build relationships, identify areas of common ground, clarify roles and responsibilities, acknowledge capacity constraints and explore practical means to overcome these.

MOBILISING COMMUNITY SUPPORT FOR THE CARE OF OVC

Stigma and discrimination of people living with AIDS poses one of the greatest threats to the successful scaling-up of community-based responses. HIV-positive mothers who are themselves rejected and unsupported, abandon their HIV-positive babies. For many of these abandoned children, statutory residential care settings are the only option. Extended family and community members refuse to take care of OVC whose parents died of AIDS resulting in growing number of orphan-headed households or an over-burdening of the statutory child-care system. At the root of stigma and discrimination lies fear and ignorance about HIV/AIDS. Home-based care programmes reported little success in linking care efforts with prevention efforts largely due to sex and AIDS being taboos topic in many cultures. Tackling stigma and discrimination requires a response from national leadership as well as at programmatic levels.

Recommendations:

- Politicians to raise awareness at every public appearance about the impact of HIV/AIDS and the importance of caring and supporting OVC in communities.
- Government to promote positive images of caring for OVC and to acknowledge and recognise the vast numbers of volunteer workers throughout the country who devote time and energy to assist OVC.
- NGO's to raise awareness in communities of the existence of OVC as well as the role of community members, including churches and youth groups in becoming part of the solution.
- Practical guidelines for community-based programmes to care for OVC to be developed encompassing the selection, training, supervision/nurturing of informal caregivers and care supporters; networking; financing; advocacy and community development.

PROVIDING A COMPREHENSIVE SAFETY-NET

A comprehensive safety net is needed to identify and "pick-up" OVC who are in need of care, identify appropriate service providers and link children to these services, regulate and monitor the quality of care provided to these children, and track the progression of the child through the various systems of care. There is limited information on the prevalence and incidence of OVC which impedes proper planning. A comprehensive service provider database, which spans the continuum of approaches, is also lacking. In addition, the supervision and monitoring of childcare services are largely absent and where they exist tend to be ineffectual.

Recommendations:

- The Department of Social Development to compile a comprehensive data-base of service providers spanning the continuum of approaches. This data-base to be updated regularly and to be made freely available on the Internet. Census data to be used to pinpoint areas of highest need.
- An integrated response to service provision to be developed based on the identification and mapping of services as well as high-need areas. Geographical information systems to be used.
- The comprehensive review of the Child Care Act to make provision:

- For a range of long-term and permanent substitute care options, using the typology of approaches as a framework;
- For the registration and supervision/monitoring of organizations caring for OVC; and
- For the protection of children's inheritance, including their homes.
- Community monitoring systems, such as "the eyes of the child" to be developed and implemented as a first step in a comprehensive monitoring and supervision system.
- The Department of Social Development, at national and provincial levels, needs to strengthen its monitoring and evaluation capacity. The Department's quality assurance programme provides a mechanism for the continuous improvement of services and this needs to be introduced with speed to all state-owned and state-funded childcare services. The quality assurance methodology needs to ensure that children are involved in the evaluation of the service and that the focus is on realising the rights of the child (the matrix at the end of this chapter provides a framework for a right-based approach to monitoring and evaluation).

The reference team at the start of the study identified poverty and political leadership as being the critical stumbling blocks to quality care for orphaned and vulnerable children. The clarion call of most of the respondents in this study was for the alleviation of hunger and the need for functioning state services - only then could they begin to talk about quality services.

TABLE 6: ESSENTIAL ELEMENTS OF QUALITY CARE: DUTY BEARERS (HOUSEHOLD, COMMUNITY, NGO AND STATE) AND THEIR SUGGESTED DUTIES

RIGHT	HOUSEHOLD	COMMUNITY	NGO	STATE
SURVIVAL				
Food	<ul style="list-style-type: none"> Provide a nutritious and balanced diet with 3 meals a day as an absolute minimum. Ideally children should get at least 5 meals a day (breakfast, mid-morning snack, lunch, mid-afternoon snack and support) Involve children in the preparation of food and in the choice of food, balanced with nutritious input of adults 	<ul style="list-style-type: none"> Establish collective gardens in communities/villages 	<ul style="list-style-type: none"> Link caregivers to food source e.g. welfare grant, food parcel, vegetable gardening. Link caregivers to low cost cooking method e.g. the "hotbox". Provide a food distribution system - for relief Establish community gardens Provide training in providing a nutritious and balanced diet and involving children in choice and preparation Monitor school feeding schemes Lobby and advocate for access 	<ul style="list-style-type: none"> Child support grant and foster care grant to cover food needs (DOW) Provide a food distribution system - for relief (DOH clinics) Provide feeding schemes at schools (DOE) Provide seed money for community gardens and subsistence farming (DOW and DOA)
<i>Clothing</i>	<ul style="list-style-type: none"> Provide clothing relevant to the elements Provide enough clothes to have one set being washed while wearing another one Provide school uniform and shoes 	<ul style="list-style-type: none"> Establish a system to collect and distribute unused clothing 	<ul style="list-style-type: none"> Provide a clothing bank and clothing distribution system 	<ul style="list-style-type: none"> Child support grant or foster care grant to cover clothing needs (DOW) Ensure that children are not being turned away from school because they do not have a uniform (DOE)
<i>Home environment</i>	<ul style="list-style-type: none"> Provide shelter against the elements and security from other people and the environment Provide a personal and safe sleeping space. Older children need privacy and all children need protection Provide basic household cleanliness Provide spare bedding for changing wet or soiled bed clothes 	<ul style="list-style-type: none"> Traditional leaders to provide shelter to those children who have nothing Monitor the safety and cleanliness of the home environment Raise awareness of environmental issues 	<ul style="list-style-type: none"> Monitor the safety and cleanliness of the home environment Provide awareness, knowledge and skills for caregivers and children on a safe home environment 	<ul style="list-style-type: none"> Provide and subsidise basic household infrastructure - at least communal standpipes, ventilated improved pit latrines, electricity, graded roads, storm water drainage, communal refuse removal (Local government, DWAF) Provide legal protection for children to retain their own homes (DOW) Provide shelter to those children who have nothing (DOW, DOH) Monitor the safety and cleanliness of the home environment (DOW, DOH) Provide awareness, knowledge and skills for caregivers and children on a safe home environment(DOH clinics)
<i>Hygiene/ Infection control</i>	<ul style="list-style-type: none"> Apply basic hygienic practices Use universal precaution guidelines Ensure personal hygiene practices 	<ul style="list-style-type: none"> Promote awareness in the community 	<ul style="list-style-type: none"> Provide awareness, knowledge and skills for caregivers and children on hygiene and infection control Provide materials for basic hygiene 	<ul style="list-style-type: none"> Provide materials for basic hygiene practices including soap, bleach, containers, a means to boil water and gloves or some form of protection

RIGHT	HOUSEHOLD	COMMUNITY	NGO	STATE
	are followed		practices including soap, bleach, containers, a means to boil water, and gloves or some form of protection especially for child carers	especially for child carers (DOH clinics) <ul style="list-style-type: none"> • Provide awareness, knowledge and skills for caregivers and children on hygiene and infection control (DOH clinics) • Child support grant or foster grant to cover hygiene and infection control costs (DOW)
<i>Treatment and Health Care</i>	<ul style="list-style-type: none"> • Ensure the child receives required immunisations and keep the Road to Health Card • Apply knowledge of basic first aid • Be aware of and respond to indications of illness • Administer medicines, dietary supplements and home remedies as prescribed 	<ul style="list-style-type: none"> • Report notifiable diseases • Traditional healers to provide awareness, knowledge and skills on AIDS related illnesses and on helpful remedies • Tradition healers to promote safe sex practices • Promote awareness in the community 	<ul style="list-style-type: none"> • Provide awareness, knowledge and skills for caregivers on identifying and responding to illness - including home remedies and pain relief • Provide training in basic first and First Aid Kits • Provide basic home care kits • Provide a referral system between the caregiver, care supporter, clinic and hospital • Monitor treatment and health care 	<ul style="list-style-type: none"> • Provide functional clinics for immunisations and a system for ensuring all children are immunised (DOH, DOE) • Provide vitamin supplements, cotrimoxazole, treatment for opportunistic infections and pain alleviation medication (DOH clinics and hospitals) • Provide awareness, knowledge and skills for caregivers on identifying and responding to illness - including home remedies and pain relief (DOH clinics) • Provide training in basic first aid and First Aid Kits (DOH clinics) • Provide basic home care kit (DOH clinics) • Provide a referral system between the caregiver, care supporter, clinic and hospital (DOH) • Monitor treatment and health care (DOH) • Wide-spread awareness campaigns
<i>Poverty Alleviation/ Social Security</i>	<ul style="list-style-type: none"> • Caregivers to initiate and participate in income-generation activities and projects • Caregivers to demonstrate self-sufficiency (vs. dependency) to children 	<ul style="list-style-type: none"> • Community to actively engage in poverty alleviation programmes and income generation activities • Community to actively participate in informal support systems such as stokvels and burial societies 	<ul style="list-style-type: none"> • Provide information on social security grants and how to apply • Facilitate caregivers access to and receipt of social security, including the child support grant, foster care grant, disability grant and care dependency grant • Link caregivers to state and NGO poverty alleviation programmes • Promote and support small and micro business development including access to 	<ul style="list-style-type: none"> • Provide an accessible, efficient and functional social security system - a one-stop-shop (DOW) • Improve access to social security in rural areas • Promote and support income generation projects and small and micro business development, including access to micro finance and loans DOW, Poverty Alleviation Fund) • Work within a developmental and

RIGHT	HOUSEHOLD	COMMUNITY	NGO	STATE
			micro finance and loans <ul style="list-style-type: none"> Work within a developmental and holistic approach 	holistic approach
SECURITY				
<i>Protection against abuse and neglect</i>	<ul style="list-style-type: none"> Provide a caring, constant and reliable adult presence with whom the child can communicate openly and report abuse to, and who can access help for the child Respond to reports of abuse and neglect Apply healthy discipline practices, setting rules and limits which help children to behave in a socially and culturally appropriate way Parents to draw up a will before they die nominating a guardian and protecting the child's home 	<ul style="list-style-type: none"> Report abuse and neglect of children in terms of the law to a social worker, children's court or police station Provide a referral, reporting and communication system for tracking children in need of care, for example "eyes of the child", community child care committees and CINDI Provide "safe houses" for children Accept HIV positive people and protect them from stigma and attack Protect orphaned children from having their homes vandalised and confiscated Protect orphaned children's right to their heritage in their kinship 	<ul style="list-style-type: none"> Report abuse and neglect of children in terms of the law to a social worker, children's court or police station Provide a referral, reporting and communication system for tracking children in need of care, for example "eyes of the child", community child care committees and CINDI Advocate against traditional practices that are not in the best interests of the child Provide alternatives to caring for children where a child cannot be cared for by their family/extended family Closely supervise child placements, whether statutory or non-statutory Provide life skills for children to equip with knowledge and skills to protect themselves Train caregivers and care supporters in identifying and recognising signs of abuse Provide awareness, knowledge and skills to caregivers in positive discipline practices Assist with drawing up will and appointing a guardian Be at child's home within 8 hours of parent's death to ensure security of the property and home Advocate against the discrimination of children living with HIV/AIDS Develop a long-term care plans for the child Ensure effective communication systems between role-players, including referral systems Provide a system for tracking children 	<ul style="list-style-type: none"> Provide a referral, reporting and communication system for tracking children in need of care, for example "eyes of the child", community child care committees and CINDI Advocate against the discrimination of children living with HIV/AIDS Provide a streamlined and effective legislative system to protect children from abuse and neglect Provide legal protection for orphans losing their property Provide accessible and effective guardianship systems Provide a legal framework for a system which provides a range of long-term and permanent substitute care approaches (DOW)

RIGHT	HOUSEHOLD	COMMUNITY	NGO	STATE
			<p>who are in need of care</p> <ul style="list-style-type: none"> Advocate and lobby for the care and protection of children 	
<i>Affection</i>	<ul style="list-style-type: none"> Provide a caring, constant and reliable adult presence, who offers security and continuity and with whom the child can communicate openly Provide unconditional affection The adult caregiver to have a positive communication style with the child, to "be there" for the child, take time to listen and communicate on their level 	<ul style="list-style-type: none"> Provide positive role models for children Screen and monitor caregivers in terms of their ability to provide unconditional affection to children Provide on-going support for caregivers Provide opportunities for positive interaction between adults and children for example clubs and youth groups 	<ul style="list-style-type: none"> Screen and monitor caregivers in terms of their ability to provide unconditional affection to children Provide a supportive environment for caregivers (the less stressed they are the more available they are to children) Provide awareness, knowledge and skills for caregivers on children's need for affection and how to build a child's self esteem 	<ul style="list-style-type: none"> Provide awareness, knowledge and skills for caregivers on children's need for affection and how to build a child's self esteem (DOW) Provide a supportive environment for caregivers (DOW)
SOCIALISATION				
<i>Identity</i>	<ul style="list-style-type: none"> Register the child's birth Ensure that a child's kinship, name and identity is retained and respected Identify family members who can care for the child and create a family setting for the child Recognise the individuality of the child through, for example, celebrating birthdays Capture memories for the child such as photos, artefacts, details of significant others, cultural connections and linkages 	<ul style="list-style-type: none"> Identify family members to care for the child and create a family setting for the child Promote a sense of community identity Inform orphaned children of their heritage Protect children's right to their heritage 	<ul style="list-style-type: none"> Apply the principle of caring for the child in own community as far as possible and ensure some kind of continuation of lifestyle. Identify family members to care for the child and create a family setting for the child Provide awareness raising for caregivers on how to make children feel an important part of their family and community Provide a system to prevent the loss of identity of the child for example memory boxes/books, information on the child and significant others 	<ul style="list-style-type: none"> Provide an effective and accessible system to register children's births, paying particular attention to children in rural areas and abandoned children (DHA, DOH) Provide legal protection against changing a child's name, unless requested by the child Apply the principle of caring for the child in own community as far as possible and ensure some kind of continuation of lifestyle (DOW)
<i>Education/ Schooling</i>	<ul style="list-style-type: none"> Ensure the child has the space and time to go to school, do homework and to read Instil a learning environment in the home with an interactive and interpretative communication style between an adult caregiver and the child An adult caregiver or older child to be available to do homework 	<ul style="list-style-type: none"> Monitor school attendance and advocate for those children not attending school Promote culture of learning in the community 	<ul style="list-style-type: none"> Monitor school attendance and advocate for those children not attending school Provide awareness, knowledge and skills for caregivers and children on building a learning environment in the home and in the community Provide home-based early childhood education 	<ul style="list-style-type: none"> Provide access to free education, from pre school (ECD) to primary and secondary levels up to grade 10 (DOE) - 7 years to 15 years Ensure functional and monitored schools (DOE) Ensure there is no discrimination against vulnerable children (DOE) Monitor school attendance (DOE) Provide vocational training for older

RIGHT	HOUSEHOLD	COMMUNITY	NGO	STATE
	with the child			children (DOE) <ul style="list-style-type: none"> • Provide awareness, knowledge and skills for caregivers and children on building a learning environment in the home (DOE) • Provide learning opportunities for the child who has become a caregiver and dropped out of school
<i>Participation</i>	<ul style="list-style-type: none"> • Adult caregiver to discuss care plan with child and get the child's contribution to the care plan • Apply decision making and problem solving processes that are acceptable to the culture, as long as they are within the best interest of the child 	<ul style="list-style-type: none"> • Promote and encourage community participation 	<ul style="list-style-type: none"> • Provide decision-making processes which include children's views on those decisions that affect their lives • Involve children in developing indicators for evaluating services provided to them and use participatory research methodologies • Provide awareness, knowledge and skills for caregivers on, for example, how to help children set their own goals and make choices • Provide opportunities for children's forums 	<ul style="list-style-type: none"> • Provide decision-making processes which include children's views on those decisions that affect their lives • Involve children in developing indicators for evaluating services provided to them and use participatory research methodologies
<i>Understanding, Awareness, Information</i>	<ul style="list-style-type: none"> • Adult caregiver to have an interactive and interpretative communication style with the child • Language usage to fit the background of children and families • Ensure the child understands, and has opportunities to talk about, the implications of the imminent death of parent, family member or their own death • Ensure the child understands, and has opportunities to talk about, the implications of their own health status if HIV positive • Provide training in basic survival life skills, for example how to open a can, how to manage a fire, how to collect and purify water 	<ul style="list-style-type: none"> • Provide training in basic survival life skills • Disseminate information and raise awareness on HIV/AIDS - challenge stigmatisation and discrimination 	<ul style="list-style-type: none"> • Provide life skills training for children including training in basic survival life skills • Provide accurate information on HIV/AIDS to traditional leaders, community leaders and political leaders - challenge stigmatisation and discrimination • Provide programmes which allow for the development of caregivers and children's knowledge around sex and relationships, including HIV/AIDS attitudes and implications • Provide awareness, knowledge and skill for caregivers in the child's need to understand their own health status as well as that of their family, and the child's need to understand and talk about death and dying 	<ul style="list-style-type: none"> • Provide life skills training for children (DOW, DOE) • Provide accurate information on HIV/AIDS to traditional leaders, community leaders and political leaders (DOH, DOW) • Provide programmes which allow for the development of caregivers and children's knowledge around sex and relationships, including HIV/AIDS attitudes and implications (DOE, DOH, DOW)

RIGHT	HOUSEHOLD	COMMUNITY	NGO	STATE
<i>Supportive Services/ Counselling</i>	<ul style="list-style-type: none"> • Provide a sensitive, caring and reliable adult caregiver who lives with or in close proximity to the child and can provide continuity and security • Caregivers to communicate in an open and caring manner to children and be sensitive to their needs • Caregivers to understand the psycho-social needs of different age groups, including the need for limit setting • Accept HIV positive family members 	<ul style="list-style-type: none"> • Accept HIV positive people • Provide emotional and spiritual support for caregivers 	<ul style="list-style-type: none"> • Accept HIV positive people • Provide awareness, knowledge and skills to caregivers and care supporters in responding to the social and emotional needs of children • Provide emotional and spiritual support for caregivers and care supporters • Provide a referral, reporting and networking system for children needing supportive services 	<ul style="list-style-type: none"> • Provide a referral, reporting and networking system for children needing supportive services (DOW, DOE) • Provide social workers who are available and respond timeously to referrals (DOW) • Provide social workers that are equipped to act proactively and insightfully. • Provide social workers who effectively assist the caregivers in accessing resources, within themselves and externally • Provide social workers who are able to move out of their offices and work in the community
SELF-ACTUALISATION				
Recreation/ Idleness	<ul style="list-style-type: none"> • Ensure a balance between household chores and creative, idle and recreation time for the child • Ensure the child has time to play and is able to be a child. 	<ul style="list-style-type: none"> • Monitor child's placement to ensure they are not being used for cheap labour and that the child has time to play • Teach traditional songs, stories and rhymes to children 	<ul style="list-style-type: none"> • Monitor child's placement to ensure they are not being used for cheap labour and that the child has time to play • Provide awareness for caregivers on how to encourage children to use their imagination, intelligence and playfulness 	<ul style="list-style-type: none"> • Provide awareness raising for caregivers on how to encourage children to use their imagination, intelligence and playfulness
Freedom of expression	<ul style="list-style-type: none"> • Provide space for the child to be able to question and discuss values, philosophies and morals and to express own views 		<ul style="list-style-type: none"> • Screen and monitor caregivers in terms of amenability to children's views • Provide awareness, knowledge and skills for caregivers on the need for children to express themselves and encourage children to talk about and discuss their beliefs 	
PALLIATIVE CARE				
	<ul style="list-style-type: none"> • Provide a caring presence and pain relief during the transitional phase • Provide closure when child and/or parent dies, acknowledging deaths to other children • Provide the child with emotional and spiritual pre and post bereavement support • Provide nappies 	<ul style="list-style-type: none"> • Respect and observe current customary burial rituals with the family • Provide emotional and spiritual pre and post bereavement support to the family 	<ul style="list-style-type: none"> • Provide awareness, knowledge and skills to caregivers and care supporters in palliative care, bereavement and grief counselling for adults and children • Provide a referral system between the caregiver, care supporter, clinic and hospital 	<ul style="list-style-type: none"> • Clinics to provide necessary medication and supplies • Remove, transport and store bodies in mortuaries (DOH hospitals) • Provide pauper's funerals (DOH hospitals)

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APPENDIX A: SITE SELECTION MATRIX

SITE	PROVINCE	U/R	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
INFORMAL FOSTERING/NON-STATUTORY FOSTER CARE						
Nceba Village	Eastern Cape	R		A one-man show supporting three women who are voluntarily taking care of at least 10 children each. He does home visits to support them in their informal child care arrangements, gives them information on HIV/AIDS, provides material relief when it is available and transport to clinics and collect water when the vehicle is operative;		
COMMUNITY BASED SUPPORT STRUCTURES						
Pin Project	KwaZulu-Natal	R	Community-fund/ income-generation project for grandparents caring for AIDS orphans			
HOME-BASED CARE AND SUPPORT						
Centre for Positive Care	Northern Province	R	Peer education	Home Care giving 43 orphans have been identified through the home care programme and are receiving support. Some child-headed households have been identified and are receiving support.		
Mpumalanga Project Support Association	Mpumalanga	R	Informal caregiver training	12 home based care projects. Older women from community are identified and trained as caregivers and placed in homes of orphaned children 300 orphans in community have been identified and are assisted with food, school fees, clothes and medical care	Assistance with accessing Child Support Grant	

SITE	PROVINCE	U/R	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Sinosizo	Kwa Zulu-Natal	U/R	Training of other organisations in providing home based care; Vegetable gardens	Supporting and teaching families to care for the chronically ill. Home visits to orphans and potential orphans. Food parcels are given when available.	Caregivers are identified and children are legally placed in foster care and assistance is given in accessing foster care grants. Children are also referred to child welfare agencies in the region.	
St Nicholas	Free State	U/R	Care training of family members: Care of the Child with AIDS and Home Care of People with AIDS AIDS awareness programmes Research on MTCT and guidelines of care of children with AIDS	Mobile outreach provides care and support to children in remote areas Includes: medical care, counselling Identification of orphans or potential orphans and assists with placement or referral On-going bereavement support	Assistance to access grants	In-patient palliative residential care (full/ part-time and respite) for children needing pain management, terminal and respite care
UNREGISTERED RESIDENTIAL CARE						
Nkosi's Haven	Gauteng	U	Small income generation project for women living at the home	Home visits and food parcels to families with orphans in Sebokeng and Thembisa		House for 7 HIV+/AIDS-ill destitute mothers and their 11 children. When mothers are ill or die the children stay on at the home. No statutory procedures.
Sophie Jardim's Home	Mpumalanga	U				Residential care of 14 children, 6 of whom are formally placed there in foster care. Welfare agents place all the children there.
STATUTORY ADOPTION AND FOSTER CARE						
Durban Children's Society	KwaZulu-Natal	U/R			"Community-family" foster care programme and kinship care. Independent family-type care provided for up to 6 children of all ages in their communities of origin. Welfare society owns homes and appoint community mothers Also offer professional foster care and adoption programme	William Clarke Gardens in-patient special care unit caters primarily for HIV+ and AIDS-ill babies and children.

SITE	PROVINCE	U/R	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
STATUTORY RESIDENTIAL CARE						
Nazareth House	Western Cape	U				Statutory residential care for children infected and affected by HIV/AIDS. Formal organisational structure.

APPENDIX B: SPECIAL CHALLENGES FACING CHILDREN ORPHANED BY AIDS AND OTHER VULNERABLE CHILDREN

SURVIVAL

"The conditions of children in their homes is terrible. When they come to the day care centre you can see they are hungry. Some of them are alright but most of them need food"
(Volunteer pre-primary schoolteacher at Sunflower House).

Food, in particular nutritious and balanced meals, was identified as an essential means to positive living for children infected with HIV. However in some families it was a matter of mere survival and just having enough food was all they asked for.

Most children had at least the basic *clothing*, however in some instances some children were observed to not have more than one change of clothes which was clearly insufficient. Furthermore *nappies* were identified as a necessity especially for carers of children with chronic diarrhoea and incontinence.

For those places where *basic infrastructure* was lacking, it was regarded an essential need for basic survival and without which hygiene, infection control and basic home care was not possible.

The need of children for a *functional health system*, which provided stocked and staffed clinics, was stressed. The most commonly mentioned health needs of HIV positive children were treatment for opportunistic infections, bactrum and vitamin supplements. Children also needed a reliable adult who could administer medication and supplements as prescribed.

It was mentioned by some people that children are increasingly being called upon to act as caregivers. They needed to be informed about *infection control* and equipped with the necessary skills and protection to be able to apply this information: "The grannies are taught infection control but they still tell the children to do the care" (Sinosiso Co-ordinator)

It was widely recognised that many orphaned and vulnerable children need assistance with a range of *social and emotional problems*, in particular relating to sexual abuse, and sometimes require skilled counselling from a professional, as the following case example highlights:

The researcher accompanied the Centre for Positive Care's Orphan Co-ordinator on a family visit. The family consisted of a granny and her four grandchildren. Both parents had died of AIDS about a year ago. Granny said she needed help with her 15 year old granddaughter who already had her own baby. She was going out at night and visiting with the boys and granny said she could not control her anymore. Her youngest grandchild, a 3 year old girl, had been sexually molested by her AIDS-ill father. Now, whenever she sees a man she screams uncontrollably. The Orphan Co-ordinator felt this family needed professional intervention

SECURITY

Sinosio home care workers visited a household where the mother was AIDS-ill with three children. The oldest was 9 and there was a toddler and a baby. The toddler had a severe physical disability and the baby was HIV positive and ill. The 9 year old girl was carrying the burden of maintaining the home and caring for the rest of the family. When the home care workers asked her how best they could help her, she replied "I only want to play". She was removed from her family of origin and placed in foster care. When the social worker did a follow-up visit she found the 9 year old being used for cheap domestic labour, the foster care grant was spent on the other children in the house.

As the above case highlights, children's need for *protection* against exploitation and abuse, particularly sexual abuse, was identified by people at all the sites visited. In some areas the level of sexual abuse was described as being "rife - a cultural norm almost" (social worker at Durban Children's Society). Some people attributed this to the belief that having sex with a virgin will cure AIDS.

Protection against stigmatisation was also identified as a need, especially when mothers and children are chased from their homes after having disclosed their HIV status. When this happens, children lose their homes and a stable and constant caregiver.

The need of children to have their homes and inheritance protected from unscrupulous relatives was mentioned: "If care supporters do not reach the family within 8 hours of the parent's death the chances are very high that other family members will have looted the home and the children kicked out of the home. Reaching children within 8 hours of their parents death is an essential part of orphan care" (Mpumalanga Project Support Association Co-ordinator).

Children's for love and nurturing (*affection*) was raised time and time again and for many was expressed as the priority need of children.

"The children are like broken angels needing to put their wings back together" - Sister Superior

"The children come to us to be loved" - granny

"The children need a mother - someone to love and care for them like a parent" - foster mothers

"Children need holding and cuddling - someone to give them a sense of being" - volunteer

SOCIALISATION

The researcher accompanied the Sinosizo social worker on a visit to an AIDS-ill mother who was writing an "expression of wish for the guardianship of her child. When asked what she felt was most important for the care of her child she said education and love.

Education was identified by all sites as a very important need of children. A number of people mentioned that some children were not going to school because they could not afford the school fees or uniforms. The prevalence of this problem could however not be established with any accuracy. Children at Nkosi's Haven expressed the need for someone to do homework with them in the afternoons: "that is what I miss about my mother, she used to listen to us read and help us to prepare for tests" (13 year-old orphan).

Only one site identified the need of children for *vocational training* to enable them to find employment or become self-employed when they left school. This lack of long term focus or vision for the child could be due to the HIV status of some of the children and also the immediacy and urgency of meeting basic needs from one day to the next.

It was mentioned that children needed *basic life skills* for survival: "like opening a can of beans or lighting a fire" (Co-ordinator, Mpumalanga Project Support Association). In addition, some children need building skills so, in the absence of an adult, they could repair their homes or build a new one if necessary.

The child's need to *understand the imminent death* of their parent or family member or self was raised by a number site representatives. Children are often not told about their parent's death and they are left ill-equipped both emotionally and practically to deal with the consequences. Some people felt that children who were HIV positive needed to understand what this meant: "Children who are HIV positive need to understand what this means because it is important for them to be responsible in the playground" (Director, Nkosi's Haven). However, there were others who did not feel comfortable talking to children about HIV/AIDS as they felt it would upset the child.

There were differing views on whether or not the child had a need to be spoken to in their *home language*. At one site the carer was unable to communicate with children in her care about sensitive issues such as death as she could only speak English. At another site, parents caring for HIV positive babies said they saw no need to speak to the children in anything but English.

Children's need for *birth certificates* was often raised. When orphaned and vulnerable children do not have birth certificates it creates problems in accessing child care grants: "I have buried four children already without birth certificates. I cannot receive foster care grants for children who do not have birth certificates. Birth certificates were applied for them two years ago but they have still not been issued!" (Sophie Jardim, Jardim's Home).

As the following statements highlight, children's need for *kinship care and family continuity* was emphasised by a number of carers:

"What would my daughter say from her grave if her children were taken away from me - even if the foster care grant were stopped we would keep the children" - granny

"I would not sleep at night if my daughter were not with me" - granny

"A family member must be touched first (to care for the child) before touching a stranger"
- social worker

"We teach the children the right ways - how to respect elders, how to do things, how to sit" - grannies, Pin Project

The special identity needs of Children in residential care are highlighted by this comment: "Children need to have a space to keep their own possessions. This would go a long way to making them feel more of an entity in their own right and less part of an establishment" (volunteer William Clarke Gardens/Othendweni Children's Home).

A couple of sites recognised the need to involve children in decisions which affected their lives and to discuss and involve them in any plans which were being made regarding their care (*participation*). This was not a priority need.

SELF-ACTUALISATION

Children's need to be children and have time to play was mentioned. The realisation of this need was closely related to the protection of the child against exploitation and abuse.

No sites mentioned the need of the child for freedom of expression. It is clear that for all the sites basic survival needs and security needs took precedence over all the other needs. Those needs which were perceived to be unrelated to meeting survival and security needs were not given priority. In some instances these needs, such as freedom of expression, were regarded as unnecessary luxuries. However, in other instances it was more about lack of awareness of the rights of children as well as how to practically ensure the attainment of these rights in contexts of extreme poverty and unmet basic needs.

PALLIATIVE CARE

The need of the AIDS-ill child for quality care during the transition phase was recognised. This included adequate pain relief and the presence of a caring adult until the child died "Children need to be held and be with me - they need to be in adult company right up until they die" (Sophie Jardim - Jardim's Home).

The need of the child for pre and post bereavement counselling following their parents death and in preparation for their own pending death was acknowledged. However, there were some carers who said it was either not culturally appropriate to discuss death with the child or they felt ill-equipped to discuss issues of death and dying with a child: "The children need to know about death and to be helped to understand and accept it. it's the adults ho have the difficulty in talking about it - not the children" (Sinosiso). Finally, the child's need for a dignified and culturally appropriate burial was mentioned by some carers.

APPENDIX C.1: APPROACHES TO CARING FOR OVC'S

SERVICES	TARGET NO. OF PEOPLE SERVED	FUNDING SOURCES	ORGANIZATIONAL STRUCTURE	NETWORKING
Approach: Non-statutory foster care Site: Nceba Village				
-Accommodation + food (Shelter) -Guardianship and parental care -Pre-school	Children in need of care +/- 30 children	-International and local donors	No hierarchy. Organisation takes place by word of mouth and in an unstructured, responsive way	-Church -Clinics (not functioning) -Community leaders -Schools -Hospitals -Stellenbosch University -Donors / friends
Approach: Community based support structures Site: PIN Project				
-Income-generation -Support to care-givers -Information	-Caregivers of children affected and infected by HIV/AIDS 1 group - 10 grannies +/- 40 children	-British government -Sale of pins	No hierarchy. The board and voluntary director manage the project with the help of the grandmothers who earn extra income through the project.	-Zululand Crafters association -Sunflower group -SA Council for the Aged -Zululand Chamber of Business Foundations -VSO
Approach: Home-based care and support Site: Centre for Positive Care				
-Basic nursing care in homes -Food parcel / material relief -Help with school fees / uniforms -Counseling and support -Information on hygiene / AIDS / STD's -Referrals	-Children in need of care -Adults in need of nursing care at home -Orphaned or potential orphaned How many patients per HBC supporter?	-International donors (100%)	5 layered hierarchy. Management Committee oversees the organisation. There is a Director, directly under her are an assistant director, field co-ordinator, 2 youth co-ordinators and a bookkeeper/administrator. Site co-ordinators report to the field co-ordinator. Field co-ordinators manage care supporters. .	-Hospitals (very supportive) -Clinics (often no supplies) -DOW useless - no one gets CSG -Traditional leaders (supportive) -Community Health workers - essential -Schools -FACT
Approach: Home based care and support Site: MPSA				
-Basic nursing care in home -Material relief -Information -Training -Referrals -Support	-Chronically and terminally ill adults and children -Orphaned or potential orphans Themba Lethu - 905 orphans No. of projects?-	-State (DOH) - virtually 100% to projects -Project support Zimbabwe	4 layered hierarchy. Board oversees the programme. A facilitator manages co-ordinators who in turn manage care supporters.	-Clinic's and Hospitals -Churches -Projects support each other - networking between -FACT (Zimbabwe) -Schools Funeral parlours

SERVICES	TARGET NO. OF PEOPLE SERVED	FUNDING SOURCES	ORGANIZATIONAL STRUCTURE	NETWORKING
Approach: Home based care and support Site: Sinosiso				
<ul style="list-style-type: none"> -Basic nursing care in home -Material relief -Counseling and support -Information -Referrals -Training on nutrition and HBC -Identifying orphans and arranging guardianship -Linking orphans with caregivers -Poverty alleviation projects (veg gardens) -Ensure schooling 	<ul style="list-style-type: none"> -Terminally ill children -Chronically ill and terminally ill and disabled adults -Geriatrics -Orphaned or potential orphans +/- orphans 	<ul style="list-style-type: none"> -International donors -State (2 salary) 	<p>Hierarchical - Five layers to the organization.</p> <p>A board of management makes the governing decisions.</p> <p>The director manages the project with a team of employed workers who train and supervise the volunteers.</p>	<ul style="list-style-type: none"> -DOW -DOH -Health forums -Community leaders -Churches -Schools -Undertakers -Child welfare societies -University child and family unit (NU)
Approach: Home based care and support Site: St. Nicholas				
<ul style="list-style-type: none"> -Basic nursing care in homes -Material relief -Counseling and support -Information -In-patient palliative care unit -Referrals to hospitals, places of safety -Training -Day care 	<p>Terminally ill children (and adults)</p> <p>Children with incurable disease and those vulnerable because of incurable disease</p> <p>Accommodation for +/-8 children</p> <p>20-30 patients per community field worker (+/- 80 in total)</p>	<ul style="list-style-type: none"> -State (DOH) - 41% - Local donors - 32% -State (DOW) - 7% -N.Mandela's Children's Fund - 11% 	<p>4 layers. A board oversees the organisation. An Executive Director manages a Registrar, Director of Palliative Care and Financial Manager. Professional nurses, auxillary nurses and home-care workers report to the Director Palliative Care.</p>	<ul style="list-style-type: none"> -Hospitals (very supportive) -Clinics(relevant to give supplies) -DOW - placing children in place of safety / foster care / grants -DOH-funding -NGO's -Churches -Donors -University/Technikon/Schools
Approach: Statutory residential care Site: Sophie Jardin				
<ul style="list-style-type: none"> -Full accommodation -Home for HIV+ children and others in need of care -Offers guardianship / parental care -Emotional support 	<p>Primarily HIV+ children</p> <p>Children in need of care</p> <p>13 children</p>	<ul style="list-style-type: none"> -State funded -Income-generation / home industry 	<p>No hierarchy - Sophie Jardim, the appointed caregiver is only answerable to social workers form external service organization who supervise the statutory placements.</p>	<ul style="list-style-type: none"> -Child Welfare Society -Church -Neighbours -David Patient -Schools -Extended family (own) -Donors

SERVICES	TARGET NO. OF PEOPLE SERVED	FUNDING SOURCES	ORGANIZATIONAL STRUCTURE	NETWORKING
Approach: Non-statutory residential care Site: Nkosi's Haven				
-Full accommodation for HIV+ mothers and children -Arrange schooling -Arrange medical care -Guardianship / parental care -Income generation for mothers -Food to township families	HIV+ mothers and their children (don't need to be HIV+) 7 adults 11 children = 18	-International and local donors	3 layered hierarchy. A Board oversees the organisation. The Director manages the resident manger and administrator.	-Hospitals (Helen Joseph) -Childline -Pre-school across the road -TB hospital in Hillbrow -TMI counseling -Schools -Donors
Approach: Statutory adoption and foster care Site: Durban Children's society				
-Special care unit for HIV+ children -Adoption -Foster care -Crisis care -Community-family care (DCS boys house, appoints a mother to care for children) -Accommodation /food /guardianship /parental care	All children in need of care -orphaned and vulnerable children (OVC's) 573 - knship care 63 - crisis care 324 - non related foster care 12 - community family care Special care: 16 HIV+ children (3:1)	-State subsidies (DOW) -Local donors	5 layered organisation. A Board of Governors with four standing committees oversees the organisation. The Executive Director manages the Senior Management Team which in turn manage functional and area teams. Within these teams, the team manager manages social workers and auxillary workers.	-Community structures -NGO's - referrals /CBO -Political parties -Hospitals -Creches / Schools -CPU -Residential care facilities -Children's courts -Donors
Approach: Statutory residential care Site: Nazareth House				
-Full accommodation -Pre-schooling -Nursing care -Outings -Occasional respite care -Home for HIV+ children -Training/awareness on HIV/AIDS for community -Emergency care	Primarily HIV positive children 48 children in total: 36 are HIV+ 5 "handicapped" 2 emergency placements	-State funded (subsidy) -International / local donors	Hierarchical - 6 levels Board of management makes governing decisions. Director is the sister superior. Staff recruitment, management and training is contracted out to private company.	-Govt. Dept's -Churches -Volunteers -Child Welfare Societies -Police -Hospitals -Schools -Community resources -Donors

APPENDIX C.2: APPROACHES TO CARING FOR OVC

WHO PROVIDES THE SERVICE	REMUNERATION	INCENTIVES / BENEFITS	PREVENTION OF BURNOUT	CONSTRAINTS	FACILITATING FACTORS
Approach: Non-statutory foster care Site: Nceba Village					
-8-10 children per 1 adult untrained	-If there is money they get about R250	-Occasional food and clothes -Water collection with vehicle -Connections with hospitals/ clinics	-Encouragement given by Deon -Alleviates stress by providing food relief -Fellowship	-Local clinics not supplied -Hospital labs don't do HIV testing -Inadequate infrastructure (no water, no electricity) -Unreliable schooling -Distance to local authorities - births not registered, grants not applied for -Transport expensive	-Community networking -Kinship
Approach: Community based support structures Site: PIN Project					
-1 Co-ordinator	-Grannies get some money from sale of pins - varies - (how much?) - R10 a pin - R6 goes to granny	-Caregivers have satisfaction in taking care of their own family	-No structure -Grannies support each other (fellowship) -Very linked with church, meet on weekly basis	-Lack networking with other organizations -Not registered	-Connections with VSO and Zululand Chamber of Business and Zululand Crafters association
Approach: Home-based care and support Site: Centre for Positive Care					
-67 HBC supporters - 4 projects (15 HBC supporters per project) --6 staff members in total, including 4 site co-ordinators - Care supporters identify and train a primary caregiver in the home for on-going support - Care supporters receive training in home-based care	-Care supporters R250 p/m -Staff get salaries -Co-ordinators R1000 p/m	-Uniform -Training on-going -Weekly support meetings -Certificates for training -Staff work flexible hours -Personal satisfaction -Status in community	- Care supporters work 8 hrs a day, sometimes over weekends - Staff encouraged to take leave / sick leave and - Counselling if needed --Weekly support groups for care supporters -Accompany carers to difficult cases -Positive feedback given regularly	-Poor roads -Tight kinship loyalty - assistance only to family members -Local clinics not supplied -DOW says they have no money for GSG -Births, deaths not registered	-Connection with FACT -Model to follow -Grassroots organization - status in community and willingness to volunteer

WHO PROVIDES THE SERVICE	REMUNERATION	INCENTIVES / BENEFITS	PREVENTION OF BURNOUT	CONSTRAINTS	FACILITATING FACTORS
Approach: Home based care and support Site: St.Nicholas					
<ul style="list-style-type: none"> -3 professional nurses -8 community workers - Weekly home-based care training is given as well as on-going training in specialised palliative care and counselling of children 	<ul style="list-style-type: none"> -Field community workers R1200 p/m -Hourly rate R2/hr -Volunteers - pay taxi fares if needed 	<ul style="list-style-type: none"> -Uniforms -On-going training -Hepatitis-B vaccine -Assistance if they get sick -Intensive and supportive supervision -Personal satisfaction 	<ul style="list-style-type: none"> - Care supporters work long hours also over weekends - voluntarily -Workers encouraged to take leave -Strong supervision -Staff support each other -Counselling if needed -Director very aware of burnout -Workload structure -Personnel are valued 	<ul style="list-style-type: none"> -Clinics not supplied -Transport expensive and long distances 	<ul style="list-style-type: none"> -Support from church -Part of Hospice SH -Connection with hospitals -Well known in Bloemfontein, good PR -Well resourced
Approach: Home based care and support Site: Sinosiso					
<ul style="list-style-type: none"> -89 volunteers, staff 4 = 93 staff -8 orphans per volunteer over whole year -Weekly home based care training 	<ul style="list-style-type: none"> -Staff and care workers get salary 2/3 of market value 	<ul style="list-style-type: none"> -Phone card -Uniform -Umbrella -Shoes -Sometimes food packages -Status in community -Gratitude certificates after 1 year -Christmas presents for volunteers and their children -Easter gift 	<ul style="list-style-type: none"> -Strong support with supervision leave "fun" workload management -S/W intervention for volunteers if necessary -Large case loads - overworked -Demand exceeds what they are able to give -Spiritual support -Assist care workers with difficult cases -Certificates -Personal value given to people 	<ul style="list-style-type: none"> -Roads poor -Political violence -Crime -Evolving model 	<ul style="list-style-type: none"> -Social worker paid for by DOW -Connection with University -Support from churches

WHO PROVIDES THE SERVICE	REMUNERATION	INCENTIVES / BENEFITS	PREVENTION OF BURNOUT	CONSTRAINTS	FACILITATING FACTORS
Approach: Home based care and support Site: Mpumalanga Project Support Association					
-40 care supporters - Themba lethu -+/- 23 orphans per care supporter -Weekly home based care training	-Care workers get R250 p/m -Co-ordinators R1000 p/m	-Uniform -Shoes -Training -Certificate -Weekly support meetings with spiritual support -Personal satisfaction -Status in community	-Little awareness of burnout - Care supporters work 8hrs or more a day, sometimes 7 days a week -Spiritual support -Support each other at weekly meetings -Accompanying care workers to assist with difficult cases	-MEC for Health -Clinics not supplied	-Connection with FACT -Working with DOH -Model to follow
Approach: Unregistered residential care Site: Nkosi's Haven					
-Mothers care for own children -1 resident manager -3 staff members - No training	-1 resident manager R500p/m if money is available	-Mothers get all food etc needs met -Training for resident manager -Full board and accommodation for resident manager -Personal satisfaction	-Staff supportive of each other -Daily house meetings with prayers and discussion of problems -Counseling from social worker -Fellowship	-Lack of employment opportunities for mothers -Mothers tried to apply for CSG - no luck	-Connections with donors in USA -Nkosi -Well resources
Approach: Unregistered residential care Site: Sophie Jardin					
-7 children to 1 adult (2 permanent assisted by 2 casuals) - No training	-Salary for Sophie (R1000p/m) -Foster care grants (R375 per child) for 6 children -If there is enough assistants get something - one helper gets paid R720p/m	-Assistants get food -Self-fulfillment - meets need to serve	-Fellowship - mutual support -David patient helps in crisis and on on-going basis	-Regulations about 6 children per foster mother -Relationship with welfare organizations - keep asking her to take more children, but she can legally only take 6 children	-Link with David patient -Supportive neighbours and family

WHO PROVIDES THE SERVICE	REMUNERATION	INCENTIVES / BENEFITS	PREVENTION OF BURNOUT	CONSTRAINTS	FACILITATING FACTORS
Approach: Statutory adoption and foster care Site: Durban Children's society					
-Volunteers - 35 crisis care families, basic orientation -Community family care: 1 adult - 6 children, basic child care training -Organisation - 300 staff members, 61 social workers, case load 50-60 cases p/m	-Social workers starting salary R2597p/m -Care workers R1200 p/m -Community Family mothers R600 p/m (R100 per child) + R350 foster grant per hild -Crisis Care - R12,50 per day place of safety grant -Foster mothers -R375 foster grant per child p/m	-Community family mothers get accommodation -Meets needs to serve and make a difference/altruistic -personal satisfaction for "mothers" -Optional Medial aid -Compulsory pension	-Leave system for community - family mothers (3 weeks a year)	-Poor acces in informal settlements -Amalgamation of 3 welfare societies -High turn-over of staff (social workers) - no salary increase for 3 years -Dangerous work environments -State system accessing grants difficult	-Social workers have access to state system
Approach: Statutory residential care Site: Nazareth house					
-Ratio 4 children - 1 adult -Staff trained in child care and nursing care	-Caregivers receive a salary	-Medical aid/pension -Looking at staff motivation, under review -Looking for appropriate training	-Proper leave system -Workload structure -Mutual support -Volunteers relieve care givers	-Removed from community functioning -Staff turn-over	-Part of a holding structure -Volunteers -Good PR -Well resourced

APPENDIX D.1: ASSESSMENT - NCEBA VILLAGE (INFORMAL FOSTERING/NON-STATUTORY FOSTER CARE)

ESSENTIAL ELEMENT	ASSESSMENT
SURVIVAL	
Food	<ul style="list-style-type: none"> ▪ Meals are irregular and are not balanced or nutritious - depends on availability of funds to buy food and weather for subsistence farming ▪ Food prepared and served in traditional ways appropriate to culture ▪ Food is prepared and served by informal carers and children are involved in these preparations
Clothing	<ul style="list-style-type: none"> ▪ Children have only one set of clothes each ▪ Clothes are unclean
Home environment	<ul style="list-style-type: none"> ▪ Children live in traditional-style huts with no "modern" equipment ▪ There is no water, electricity or sanitation ▪ Refuse is buried, burnt or discarded outside the household, causing considerable litter ▪ Dogs and pigs wander around picking up any remnants from people ▪ Yards are not fenced and domestic farm animals like chickens and goats wander around freely in the homes ▪ Maintenance of the home depends on inclination and capacity of the informal carer
Hygiene/infection control	<ul style="list-style-type: none"> ▪ Informal carers were ignorant about basic hygiene practices ▪ Sick and well children live together in the same dwelling
Treatment and health care	<ul style="list-style-type: none"> ▪ Immunisation cards were kept by Deon ▪ Difficult access to clinics and hospitals, which were ill-equipped and poorly supplied ▪ No awareness of illness indicators and when and how to respond ▪ HIV testing unavailable
SECURITY	
Protection	<ul style="list-style-type: none"> ▪ The children are not committed to informal caregivers care; they arrive in an unstructured and ad hoc manner ▪ Informal carers look after up to ten children each, but the number varies ▪ There is no formal supervision, however there is a community member who lives nearby and watches over and checks on the children ▪ Informal carers discipline children according in their own styles, which is not always positive and corporal punishment is applied
Affection	<ul style="list-style-type: none"> ▪ Informal carers look after up to ten children each ▪ They provide a constant and reliable presence and are affectionate in their own styles and within their own capacity ▪ Informal carers were not selected, there were the only ones available to look after abandoned and orphaned children
SOCIALISATION	
Education/schooling	<ul style="list-style-type: none"> ▪ Formal schooling is haphazard - dependent on child's health and whether or not the schools are functioning ▪ Community member offers a very basic early childhood development centre - tries to access funds and materials from different sources

ESSENTIAL ELEMENT	ASSESSMENT
Identity	<ul style="list-style-type: none"> ▪ Births are not registered ▪ Names of children are retained ▪ Children live in their communities or origin and their kinship links are retained ▪ Kinship and cultural history and folklore is passed on to children through stories ▪ Siblings generally share the same home ▪ Celebration of birthdays is not a tradition in this community
Participation	<ul style="list-style-type: none"> ▪ Children's participation varies with each informal carer - generally the adult makes the decisions and the child is not included in decision-making, which is appropriate to cultural ways ▪ Children were often required to give information - e.g. the whereabouts of a child, messages from school, messages from other members from the community. Although adults depended on children for this information, they did not allow the children to be part of the proceedings beyond being an informer ▪ Deon tries to include children in discussions
Understanding	<ul style="list-style-type: none"> ▪ Children assist with household chores, including collection of water - in this way they are exposed to basic life skills ▪ The HIV status of children was not known and HIV and other sexuality issues were not spoken about with children ▪ The role of women was also observed to be subservient - their knowledge about their own reproductive health was extremely limited
Supportive services/counselling	<ul style="list-style-type: none"> ▪ Very little awareness of children's psycho-social needs ▪ No professional assistance
SELF-ACTUALISATION	
Recreation/Idleness	<ul style="list-style-type: none"> ▪ Children provide playmates for each other ▪ Children play with friends in the community ▪ Children have time and space to play ▪ Access to TV for about 1 hour a day, in Deon's home - he has a generator operating for about 2 hours a day
Freedom of Expression	<ul style="list-style-type: none"> ▪ Mothers raise their children within their own cultural and religious norms ▪ Children were observed to have their own views and observations through the role plays they did - but, in adult company they were not free to give their views
PALLIATIVE CARE	
	<ul style="list-style-type: none"> ▪ No pain relief medication ▪ Children die at home in presence of informal carer or in hospital ▪ Children are buried in traditional way, with traditional ceremonies and in simple coffins

APPENDIX D.2: ASSESSMENT - PIN PROJECT (COMMUNITY SUPPORT STRUCTURE)

ESSENTIAL ELEMENT	ASSESSMENT
SURVIVAL	
Food	<ul style="list-style-type: none"> ▪ Meals in homes are often irregular and are not balanced or nutritious - depends on conditions in the home, availability of funds to buy food and weather for subsistence farming ▪ Grannies who benefit from the fund use the additional money for food
Clothing	<ul style="list-style-type: none"> ▪ Availability of clothes depends on conditions in the home ▪ Grannies who benefit from the fund, use extra money earned to buy school clothes for grand children
Home environment	<ul style="list-style-type: none"> ▪ Conditions of homes varies form family to family, depends on resources ▪ Township areas have water, sanitation and electricity. Rural areas do not have access to these services.
Hygiene/infection control	<ul style="list-style-type: none"> ▪ Grandmothers may have knowledge of hygiene/infection control measures, but this is not built into the PIN projects services ▪ Other organisations in the area are accessed to help grandmothers with these concerns
Treatment and health care	<ul style="list-style-type: none"> ▪ Children may or may not be immunised - depends on awareness of granny ▪ Access to clinics and hospitals is variable - clinics are often under-resourced , particularly in the rural areas ▪ No input or training is given to grannies
SECURITY	
Protection	<ul style="list-style-type: none"> ▪ Children live in the care of their grandmothers who provide a constant, reliable and caring adult presence ▪ Discipline practices vary from home to home ▪ Cases are referred to child welfare and social services for formal placements and for grant applications
Affection	<ul style="list-style-type: none"> ▪ Children live in the care of their grandmothers who provide a constant, reliable and caring adult presence
SOCIALISATION	
Education/schooling	<ul style="list-style-type: none"> ▪ Children may or may not attend school -depends on availability of resources in the home and whether schools respect their Constitutional right ▪ Grandmothers receiving benefits from the fund are obliged to send the grandchildren to school
Identity	<ul style="list-style-type: none"> ▪ Births may or may not be registered ▪ Child's name is kept ▪ Culture is retained with history and stories passed on through the grannies ▪ Children are kept in their community of origin
Participation	<ul style="list-style-type: none"> ▪ Children's views are generally not listened to in the home - as is the cultural norm
Understanding	<ul style="list-style-type: none"> ▪ Children assist with household chores, including collection of water - in this way they are exposed to basic life skills ▪ HIV/AIDS and sexuality issues are not spoken about in the homes - there is hardly an acknowledgement of the presence of AIDS in the community
Supportive services/counselling	<ul style="list-style-type: none"> ▪ No professional services are provided by PIN project, but referrals are made ▪ Grannies applying for assistance are visited and helped by the committee members who do the screening of the applicants ▪ Pin project provides informal support group for grannies

ESSENTIAL ELEMENT	ASSESSMENT
SELF-ACTUALISATION	
Recreation/Idleness	<ul style="list-style-type: none"> ▪ Children play with friends in the community, including songs, ball games, action rhymes and interpretative play ▪ Children may or may not have time to play; depends on conditions in the home
Freedom of Expression	<ul style="list-style-type: none"> ▪ Grandmothers and extended families raise their children within their own cultural and religious norms
PALLIATIVE CARE	
	<ul style="list-style-type: none"> ▪ Children die at home in the presence of their caregiver or in hospital ▪ Pin project offers a forum for mutual emotional and spiritual support in the event of a death ▪ Referrals are made to appropriate service providers in the area

APPENDIX D.3: ASSESSMENT - CENTRE FOR POSITIVE CARE (HOME BASED CARE)

ESSENTIAL ELEMENT	ASSESSMENT
SURVIVAL	
Food	<ul style="list-style-type: none"> ▪ Meals in homes are often irregular and are not balanced or nutritious - depends on conditions in the home, availability of funds to buy food and weather for subsistence farming ▪ CPC provides relief food parcels when there is a need (depend largely on donations for food parcels)
Clothing	<ul style="list-style-type: none"> ▪ Availability of clothes depends on conditions in the home ▪ CPC provides clothes when there is a need (depend on donations)
Home environment	<ul style="list-style-type: none"> ▪ Conditions of homes varies from family to family, depends on resources ▪ Some areas have water, sanitation and electricity , others don't
Hygiene/infection control	<ul style="list-style-type: none"> ▪ CPC care supporters offer basic training, guidance and awareness raising for family members in hygiene and infection control ▪ Care supporters are supplied with gloves, family caregivers are encouraged to use some form of protection when needed ▪ Sick and well children live together in families
Treatment and health care	<ul style="list-style-type: none"> ▪ Children may or may not be immunised - depends on awareness of family - however care supporter encourages this basic health practice ▪ CPC facilitates access by families to clinics and hospitals - clinics can often be out of stock and CPC will then purchase essential medications and dressings ▪ CPC care supporters are aware of indicators of illness and appropriate ways to respond (including home remedies) - they advise and educate family members
SECURITY	
Protection	<ul style="list-style-type: none"> ▪ Orphaned children live with extended families, mostly single and elderly grannies ▪ Child-headed households are not committed to the care of CPC ▪ Care supporters document identifying information about each child and their immediate family on a referral form - this form also contains information about the whereabouts of extended family members ▪ If care supporters identify abuse they refer to the social workers - however there is often no response or it takes a long time for a response ▪ Care supporters refer disputes over property to traditional leaders and advocate for the child to remain in their parent's home ▪ Care supporters try to encourage adults to make arrangements for alternative care for their children before they die -if a parent dies without these arrangements they try to find extended family members to assist ▪ There is no formal supervision - care supporters visit homes with orphans (orphan headed households as well as those living with extended families) as part of their duties - this could be once a month depending on the need ▪ Family members discipline children according in their own styles, which is not always positive and corporal punishment is applied
Affection	<ul style="list-style-type: none"> ▪ Extended families - grannies in particular - provide a constant and reliable presence and are affectionate in their own styles and within their own capacity ▪ Care supporters are selected for their caring qualities

ESSENTIAL ELEMENT	ASSESSMENT
SOCIALISATION	
Education/schooling	<ul style="list-style-type: none"> ▪ CPC arranges for donations of school uniforms which they distribute at Christmas time - without which some children are not able to attend school ▪ They also sell donated clothes and toys to raise funds for school fees - again in some cases without which some children are not able to attend school ▪ There were no pre-schools or early childhood education facilities in the areas visited by the researcher
Identity	<ul style="list-style-type: none"> ▪ Births may or may not be registered - one of the duties of a care supporter is to assist families to obtain these documents ▪ Children live with their families in their communities of origin and their kinship links are retained ▪ Kinship and cultural history and folklore is passed on to children through stories ▪ Siblings share the same home ▪ Celebration of birthdays is not a tradition in this community - mostly due to lack of resources
Participation	<ul style="list-style-type: none"> ▪ Care supporters are encouraged to talk to children individually, not in the presence of an adult when they visit the home to find out their needs ▪ Children's views are generally not listened to in the home
Understanding	<ul style="list-style-type: none"> ▪ Children assist with household chores, including collection of water - in this way they are exposed to basic life skills ▪ The HIV status of children (or adults) is not spoken about and HIV and other sexuality issues are also not commonly spoken about with children ▪ CPC arranged for two orphans to attend an orphan workshop where they had an opportunity to talk about what it meant to be an orphan and learn some coping skills
Supportive services/counselling	<ul style="list-style-type: none"> ▪ Very little awareness of children's psycho-social needs ▪ No professional assistance
SELF-ACTUALISATION	
Recreation/Idleness	<ul style="list-style-type: none"> ▪ Children provide playmates for each other and play with friends in the community ▪ Little adult engagement ▪ Children may or may not have time to play; depends on conditions in the home - there was limited awareness on the part of care supporters of this need of the child
Freedom of Expression	<ul style="list-style-type: none"> ▪ Extended families raise their children within their own cultural and religious norms ▪ Care supporters promote Christian values
PALLIATIVE CARE	
	<ul style="list-style-type: none"> ▪ Children die mostly at home in the presence of their family and often the care supporter ▪ Basic pain relief medication is provided ▪ Care supporters assist with arrangements for transport of body to mortuary ▪ Care supporter provides family members with emotional and spiritual support during pre and post bereavement stages - however care supporters are reluctant to talk to children about death

APPENDIX D.4: ASSESSMENT - MPUMALANGA PROJECT SUPPORT ASSOCIATION (HOME BASED CARE)

ESSENTIAL ELEMENT	ASSESSMENT
SURVIVAL	
Food	<ul style="list-style-type: none"> ▪ Availability and quality of food varies - mostly irregular and inadequate ▪ MPSA provides relief food parcels when there is a need - depends on donations
Clothing	<ul style="list-style-type: none"> ▪ Availability and quality of clothes varies - mostly inadequate ▪ MPSA provides clothes when there is a need - depends on donations
Home environment	<ul style="list-style-type: none"> ▪ Conditions of homes vary - generally rudimentary structures with limited access to basic amenities
Hygiene/infection control	<ul style="list-style-type: none"> ▪ Care supporters offer basic training, guidance and awareness raising for family members in hygiene and infection control ▪ Care supporters are supplied with gloves, family caregivers are encouraged to use some form of protection when needed
Treatment and health care	<ul style="list-style-type: none"> ▪ Children may or may not be immunised - depends on awareness of family - however community workers encourage this basic health practice ▪ Care supporters facilitate access to clinics and hospitals - clinics can often be out of stock and care supporters provide basic home remedies and over the counter medication ▪ Care supporters are aware of indicators of illness and appropriate ways to respond (including home remedies) - they advise and educate family members
SECURITY	
Protection	<ul style="list-style-type: none"> ▪ Care supporters record identifying information about each child and their immediate family on a referral form - this form also contains information about the whereabouts of extended family members ▪ Community workers encourage adults to make arrangements for alternative care for their children before they die ▪ If care supporters identify a child in need of care they try to find an extended family member or neighbour or refer to the social workers who rarely respond ▪ Orphan headed households are not committed to the care of MPSA
Affection	<ul style="list-style-type: none"> ▪ Care supporters are selected for their caring qualities
SOCIALISATION	
Education/schooling	<ul style="list-style-type: none"> ▪ MPSA advocates on behalf of the child to attend school when access is refused because school fees can't be paid or there is no uniform
Identity	<ul style="list-style-type: none"> ▪ Births may or may not be registered - care supporters assist families to obtain these documents
Participation	<ul style="list-style-type: none"> ▪ Care supporters are encouraged to find out about the needs of children individually, not in the presence of an adult, when they visit the home
Understanding	<ul style="list-style-type: none"> ▪ Most children assist with household chores - in this way they are exposed to basic life skills, however for those children who don't have this, care supporters assist children with basic life skills training including making a fire for cooking. Older children receive training in building so they can maintain their own homes ▪ The HIV status of children (or adults) is not spoken about and HIV and other sexuality issues are also not commonly spoken about with children
SELF-ACTUALISATION	
Supportive services/counselling	<ul style="list-style-type: none"> ▪ No professional assistance is available ▪ Care supporters have basic training in listening and counselling skills

ESSENTIAL ELEMENT	ASSESSMENT
Recreation/Idleness	<ul style="list-style-type: none"> ▪ Children provide playmates for each other and play with friends in the community ▪ Little adult engagement ▪ Children may or may not have time to play; depends on conditions in the home - there was limited awareness on the part of care supporters of this need of the child
Freedom of Expression	<ul style="list-style-type: none"> ▪ Extended families raise their children within their own cultural and religious norms ▪ Care supporters promotes Christian values
PALLIATIVE CARE	
Palliative care	<ul style="list-style-type: none"> ▪ Children generally die at home in the presence of their family and often the care supporter ▪ Basic pain relief medication is provided when it is available - often it is not ▪ Care supporters assist family with arrangements for transport of body to mortuary ▪ Care supporters offer family members emotional and spiritual support during pre and post bereavement stages ▪ Care supporters often funerals of their patients

APPENDIX D.5: ASSESSMENT - SINOSIZO (HOME BASED CARE)

ESSENTIAL ELEMENT	ASSESSMENT
SURVIVAL	
Food	<ul style="list-style-type: none"> ▪ Meals in homes are often irregular and are not balanced or nutritious - depends on conditions in the home, availability of funds to buy food and weather for subsistence farming ▪ Some areas have food gardens co-ordinated by Sinosizo ▪ Soup kitchens provide food and milk formula is given to infant orphans
Clothing	<ul style="list-style-type: none"> ▪ Availability of clothes depends on conditions in the home ▪ Sinosizo distributes clothes when there is a need (depends on donations to the organisation)
Home environment	<ul style="list-style-type: none"> ▪ Conditions of homes varies form family to family, depends on resources - urban areas better resourced that peri-urban and rural areas ▪ Some areas have water, sanitation and electricity, others don't - urban areas comparatively better off
Hygiene/infection control	<ul style="list-style-type: none"> ▪ Home care workers offer basic training, guidance and awareness raising for family members in hygiene and infection control ▪ Home care workers are supplied with infection control materials
Treatment and health care	<ul style="list-style-type: none"> ▪ Home care workers monitor the Road to Health cards ▪ Sinosizo facilitates access by families to clinics and hospitals ▪ Home based care workers are aware of indicators of illness and appropriate ways to respond (including home remedies) - they advise and educate family members - for difficult cases they can call on the professional nurses employed by Sinosizo
SECURITY	
Protection	<ul style="list-style-type: none"> ▪ Home care workers encourage adults to make arrangements for alternative care for their children before they die ▪ Home care workers identify children in need of care and refer to the social worker employed by Sinosizo ▪ Sinosizo has s social worker who identifies children in need of care and arranges suitable substitute forms of care (either statutory or non-statutory) ▪ Identifying information about each child is kept by the organisation and family caregiver ▪ Home care workers are trained to identify signs of abuse ▪ All children in need of care are accepted by their service providers regardless of creed, culture or race
Affection	<ul style="list-style-type: none"> ▪ Voluntary workers are often instinctively caring people ▪ Home care workers are trained in child's need for affection
SOCIALISATION	
Education/schooling	<ul style="list-style-type: none"> ▪ Sinosizo advocates for children who cannot afford school fees - it is still a problem for some children who are refused entry because of no uniform
Identity	<ul style="list-style-type: none"> ▪ Family caregivers are encouraged to keep memory boxes ▪ Births may or may not be registered - home care workers assist families to obtain these documents

ESSENTIAL ELEMENT	ASSESSMENT
Participation	<ul style="list-style-type: none"> ▪ Children's views are generally not listened to in the home ▪ Care supporters are trained to listen to children's views
Understanding	<ul style="list-style-type: none"> ▪ Children assist with household chores, including collection of water - in this way they are exposed to basic life skills ▪ The HIV status of children (or adults) is not spoken about and HIV and other sexuality issues are also not commonly spoken about with children in the home ▪ Home care workers are trained in the need of the child for understanding
Supportive services/counselling	<ul style="list-style-type: none"> ▪ Social worker is available for professional counselling
SELF - ACTUALIISATION	
Recreation/Idleness	<ul style="list-style-type: none"> ▪ Children play with friends in the community, including songs, ball games, action rhymes and interpretative play ▪ Children may or may not have time to play; depends on conditions in the home - Sinosizo staff are aware of the child's need to play
Freedom of Expression	<ul style="list-style-type: none"> ▪ Extended families raise their children within their own cultural and religious norms ▪ Sinosizo promotes Christian (Catholic) values
PALLIATIVE CARE	
	<ul style="list-style-type: none"> ▪ Children die at home in the presence of their family and the home care worker who provides an active and constant presence ▪ Basic pain relief medication is provided - many patients are "drug naive" and do not require anything stronger than a first level analgesic (aspirin) ▪ Home care workers have been trained in bereavement counselling

APPENDIX D.6: ASSESSMENT - ST NICHOLAS HOSPICE (HOME BASED CARE)

ESSENTIAL ELEMENTS	ASSESSMENT
SURVIVAL	
Food	<ul style="list-style-type: none"> ▪ Meals in homes are often irregular and are not balanced or nutritious - depends on conditions in the home, availability of funds to buy food and weather for subsistence farming ▪ St Nicholas provides relief food parcels when there is a need (depend largely on donations for food parcels) ▪ Day care centre three days a week provides children with nutritious and balanced meals ▪ In-patient hospice provides regular, routined, nutritious and balanced meals
Clothing	<ul style="list-style-type: none"> ▪ Availability of clothes depends on conditions in the home ▪ St Nicholas provides clothes when there is a need (depend on donations)
Home environment	<ul style="list-style-type: none"> ▪ Conditions of homes varies form family to family, depends on resources ▪ Some areas have water, sanitation and electricity , others don't ▪ There is no water, electricity or sanitation ▪ In-patient hospice facility is fully equipped, comfortable and homely
Hygiene/infection control	<ul style="list-style-type: none"> ▪ Community workers offer basic training, guidance and awareness raising for family members in hygiene and infection control ▪ Community workers are supplied with gloves, family caregivers are encouraged to use some form of protection when needed ▪ In-patient hospice facility adheres to strict standards set by national hospice association - they are rigorous
Treatment and health care	<ul style="list-style-type: none"> ▪ Children may or may not be immunised - depends on awareness of family - however community workers encourage this basic health practice ▪ St Nicholas facilitates access by families to clinics and hospitals (although hospitals will not admit an AIDS-ill child) - clinics can often be out of stock and St Nicholas will then purchase essential medications and dressings ▪ St Nicholas care supporters are aware of indicators of illness and appropriate ways to respond (including home remedies) - they advise and educate family members. For difficult cases, they can call on the support from a professional nurse who is on call 24 hours a day 7 days a week ▪ The in-patient facility provides 24hour palliative nursing care for children in their last stages with all the necessary pain relief medication and equipment - it also offers respite care for families
SECURITY	
Protection	<ul style="list-style-type: none"> ▪ St Nicholas has appointed an OVC co-ordinator to identify and attend to the needs of children whose parents have died or who are ill ▪ Community workers document identifying information about each child and their immediate family on a referral form - this form also contains information about the whereabouts of extended family members ▪ If community workers identify a child in need of care they refer to the social workers who respond and find alternative care arrangements ▪ Community workers encourage adults to make arrangements for alternative care for their children before they die -if a parent dies without these arrangements they refer to social workers ▪ Strict screening criteria are applied before selecting suitable staff and volunteers for both home care and in-patient care work ▪ There is a supportive network amongst staff and volunteers at St Nicholas - with weekly group supervision

ESSENTIAL ELEMENTS	ASSESSMENT
Affection	<ul style="list-style-type: none"> ▪ Care supporters are selected for their caring qualities ▪ Staff are aware of the child's need for affection and put effort into building individual relationships with children
SOCIALISATION	
Education/schooling	<ul style="list-style-type: none"> ▪ St Nicholas arranges for donations of school uniforms which they distribute at Christmas time - without which some children are not able to attend school ▪ They also advocate for children to attend school where families cannot afford to pay fees ▪ St Nicholas offers a day-care programme three times a week for ill children and has a structured ECD programme in the morning run voluntarily by a trained pre-primary school teacher.
Identity	<ul style="list-style-type: none"> ▪ Births may or may not be registered - community workers assist families to obtain these documents ▪ Community workers make a point of celebrating the birthdays of the children in their care ▪ Ill children are assisted to realise their dreams through organisations such as Reach for a Dream
Participation	<ul style="list-style-type: none"> ▪ Care supporters are encouraged to talk to children individually, not in the presence of an adult when they visit the home to find out their needs
Understanding	<ul style="list-style-type: none"> ▪ Children assist with household chores, including collection of water - in this way they are exposed to basic life skills ▪ The HIV status of children (or adults) is not spoken about and HIV and other sexuality issues are also not commonly spoken about with children ▪ CPC arranged for two orphans to attend an orphan workshop where they had an opportunity to talk about what it meant to be an orphan and learn some coping skills
Supportive services/counselling	<ul style="list-style-type: none"> ▪ Community workers and staff are trained in counselling of children ▪ Play therapy is available ▪ Social worker at the hospital is available
SELF-ACTUALISATION	
Recreation/Idleness	<ul style="list-style-type: none"> ▪ Children provide playmates for each other and play with friends in the community ▪ Little adult engagement ▪ Children may or may not have time to play; depends on conditions in the home - there was limited awareness on the part of care supporters of this need of the child
Freedom of Expression	<ul style="list-style-type: none"> ▪ Extended families raise their children within their own cultural and religious norms ▪ St Nicholas promotes Christian values
PALLIATIVE CARE	
	<ul style="list-style-type: none"> ▪ Children die at home in the presence of their family and often the community worker or at the in-patient facility which offers 24 hour nursing care and the services of a volunteer doctor ▪ Pain relief medication is provided ▪ Community workers assist family with arrangements for transport of body to mortuary for home death ▪ Community workers and professional palliative care nursing staff provide family members with emotional and spiritual support during pre and post bereavement stages - play therapy is used to children about death ▪ Memorial services are held for children

APPENDIX D.7: ASSESSMENT - JARDIM'S HOME (UNREGISTERED RESIDENTIAL CARE)

ESSENTIAL ELEMENT	ASSESSMENT
SURVIVAL	
Food	<ul style="list-style-type: none"> ▪ Nutritious meals - within budget constraints ▪ Meals are usually varied - dependent on funds ▪ Meals are served in a fairly regular pattern (other urgent activities may delay meal times) and individual food needs are responded to as they arise ▪ Children eat together with adults ▪ Food is prepared by Sophie, sometimes with children helping - children make their own snacks and are required to clean up after themselves
Clothing	<ul style="list-style-type: none"> ▪ Children are adequately clothed for all seasons ▪ Clothing is individualised, however some sharing does take place
Home environment	<ul style="list-style-type: none"> ▪ The house is over-crowded and in need of repair ▪ All basic amenities with in-house water, sanitation, electricity ▪ Grounds are child-friendly ▪ Children share bedrooms but sleep in their own beds ▪ Children have their own storage spaces
Hygiene/infection control	<ul style="list-style-type: none"> ▪ Some awareness of universal precaution guidelines, however gloves are not used ▪ Tooth-brushes and face-cloths are shared ▪ Sick and well children live together in the home, infections spread as they would in any home
Treatment and health care	<ul style="list-style-type: none"> ▪ Immunisation cards are kept ▪ Easy access to clinics and hospitals ▪ Awareness of indicators of illness and when and how to respond ▪ Sophie prefers homeopathic remedies to "chemicals" ▪ Doctors in private practice provide free medical attention and if possible provide medication (e.g. samples) ▪ Medications bought at reduced rates from pharmacies
SECURITY	
Protection	<ul style="list-style-type: none"> ▪ All children are committed to the home by court order ▪ A couple of the children are being adopted by Sophie ▪ Social workers are required to prepare bi-annual reports on the children for the courts ▪ There is one primary carer (house mother) who lives in the home with the children and is a constant presence - she has employed three people to assist her with maintenance and caring ▪ Children are disciplined and limits are set ▪ All children are accepted regardless of HIV status, creed, culture, gender or race

ESSENTIAL ELEMENT	ASSESSMENT
Affection	<ul style="list-style-type: none"> ▪ The house mother who lives in the home with the children is a constant and reliable presence ▪ The home has a supportive network of family and friends of the house mother ▪ Children are responded to in a genuinely warm and caring manner by the house mother, home helpers and members of her supportive network
SOCIALISATION	
Education/schooling	<ul style="list-style-type: none"> ▪ Children 7 years and older attend school outside the home (fees, uniforms, books are paid for) ▪ No formal pre-school or early childhood education is provided, but activities are done with pre-schoolers, sometimes with a visiting teacher
Identity	<ul style="list-style-type: none"> ▪ Children are not retained in community of origin - sometimes to protect them from abusive relationships ▪ Attempts are made to register all births ▪ Name of children are sometimes changed when they are placed in the home ▪ Identifying records of the child are kept ▪ If the origin of the child's family is known, then attempts are made to retain contact - however, experience of this has been traumatic for Sophie and the children ▪ Memories of the child are retained, spoken about and photos of the children are taken and kept ▪ Each child's birthday is celebrated - if the date of birth is unknown then the date of entry of the home is celebrated ▪ Individuality of child is acknowledged - their characteristics and gifts are spoken about and encouraged by Sophie and her helpers, because they get to know the children very well
Participation	<ul style="list-style-type: none"> ▪ The older children's views are considered when discussing care plans, but generally the children have little option, but to accept the social workers views
Understanding	<ul style="list-style-type: none"> ▪ Primary carer can only communicate with children in English which impedes communication especially on sensitive issues ▪ Child welfare social worker spends time with children about once a week and she speaks to the children in their own language ▪ Children are informed about their health and HIV status in a supportive manner ▪ Children assist with chores in the home and all that is involved in running a home - are exposed to basic life skills in this way
Supportive services/counselling	<ul style="list-style-type: none"> ▪ Professional services are provided by the social workers from CMR - to Sophie and the children. However, Sophie feels this is still not enough "we are still very heartsore"
SELF-ACTUALISATION	
Recreation/Idleness	<ul style="list-style-type: none"> ▪ TV is viewed in restricted times Limited toys ▪ Children provide playmates for each other ▪ Limited adult engagement, apart from craft work which Sophie gets the children to help her with
Freedom of Expression	<ul style="list-style-type: none"> ▪ Humanitarian and justice values underlie the principles in the home
PALLIATIVE CARE	
	<ul style="list-style-type: none"> ▪ Children die at home, preferably especially since Sophie had a negative experience in hospital - Sophie stays with the children until they die ▪ Attentive funerals are arranged, with supportive people in the community ▪ Grieving children are supported ▪ Aware of need to discuss death with children but there is a language barrier

APPENDIX D.8: ASSESSMENT - NKOSI'S HAVEN (UNREGISTERED RESIDENTIAL CARE)

ESSENTIAL ELEMENT	ASSESSMENT	SCORE
SURVIVAL		
Food	<ul style="list-style-type: none"> ▪ Nutritious, balanced and varied meals ▪ Meals are served regularly and individual food needs are responded to as they arise ▪ Children eat together and with mothers ▪ Food is prepared and served by mothers and children are involved in these preparations 	
Clothing	<ul style="list-style-type: none"> ▪ Children are fully clothed for all seasons ▪ Clothing is individualised, however some sharing does take place 	
Home environment	<ul style="list-style-type: none"> ▪ The house is comfortable and well-maintained, although it is over-crowded ▪ The house is fully-equipped with all the basic amenities with in-house water, sanitation, electricity ▪ Grounds are child-friendly ▪ Children share bedrooms and sleep in their own beds - older boys are separated from girls 	
Hygiene/infection control	<ul style="list-style-type: none"> ▪ There are very clear guidelines in the home on personal hygiene practices for both mothers and children - residents are required to strictly adhere to these ▪ Universal precaution guidelines are applied when necessary ▪ Sick and well children live together in the home 	
Treatment and health care	<ul style="list-style-type: none"> ▪ Immunisation cards are kept ▪ Easy access to clinics and hospitals ▪ Awareness of indicators of illness and when and how to respond ▪ Mothers educated in administering medications and supplements for both themselves and their children ▪ Sponsorship of a new immune-building supplement from America has been arranged for the mothers and children 	
SECURITY		
Protection	<ul style="list-style-type: none"> ▪ None of the children are committed to the home by the court, they arrive with their mothers ▪ Some mothers nominate the Director of Nkosi's Haven as the legal guardian of their children in the event of their death ▪ Children live in the home together with their mothers until the mothers become ill and are hospitalised or die ▪ For orphans, the resident manager becomes the primary caregiver supported by the other mothers ▪ Before mothers die they are encouraged and assisted to identify caregivers for their children and formalise these arrangements in their will ▪ Staff are aware of the need for healthy discipline practices ▪ Mothers discipline children according in their own styles, not always positive and corporal punishment can be applied - they have had talks on positive discipline from the social worker ▪ Where mothers are ill or stressed, the other mothers form a protective and supportive network around the child ▪ Access to the home by non-residents is controlled ▪ All children are accepted regardless of HIV status, creed, culture, gender or race 	

ESSENTIAL ELEMENT	ASSESSMENT	SCORE
Affection	<ul style="list-style-type: none"> ▪ Children live with their mothers in the home who provide constant, reliable care and “mothers love” ▪ Where mothers are ill or stressed, the other mothers form a protective and supportive network around the child ▪ For children who are orphaned, the resident manager provides the constant and reliable presence and the other mothers are required to assist with parenting duties ▪ Children are responded to in a warm and caring manner by all the staff 	
SOCIALISATION		
Education/schooling	<ul style="list-style-type: none"> ▪ Children 7 years and older attend school outside the home (fees, uniforms, books are paid for) ▪ Children under 7 years attend a pre-school (fees are paid for) 	
Identity	<ul style="list-style-type: none"> ▪ All births are registered ▪ Names of children are retained ▪ Identifying records of the child are kept ▪ Mothers live in the home together with their children until they are hospitalised or die ▪ Siblings share the same home ▪ Children don't live in their communities of origin ▪ If the child is orphaned and the origin of their family is known contact is encouraged ▪ Memories of the child are kept through photo books and some mothers write their children letters and stories ▪ Each child's birthday is celebrated 	
Participation	<ul style="list-style-type: none"> ▪ Children's views regarding future care plans in the event of their mother's death are considered ▪ Children's views regarding day-to-day arrangements are considered <p>Children are included with the adults in discussions on the running of the home and other issues (family meetings)</p>	
Understanding	<ul style="list-style-type: none"> ▪ Children assist with household chores and caring for younger siblings - in this way they are exposed to basic life skills ▪ If a child is HIV positive the implications of this is explained to them at an early age ▪ Resident manager discusses sexuality and HIV/AIDS issues with the children - she is guided by their questions ▪ Mothers remain primary caregivers and discuss issues with their children within their own cultural and personal comfort zones ▪ Open communication in the home is encouraged by the Director 	
Supportive services/counselling	<ul style="list-style-type: none"> ▪ Professional social work service is available when there is a need ▪ Staff are aware of psycho-social needs and refer to professional help if necessary <p>Mothers and staff provide children with informal psycho-social support</p>	
SELF-ACTUALISATION		
Recreation/Idleness	<ul style="list-style-type: none"> ▪ Toys, books and art materials are available ▪ Outdoor play equipment ▪ Children provide playmates for each other ▪ Limited adult engagement ▪ TV watching allowed - although mothers have more access than children 	

ESSENTIAL ELEMENT	ASSESSMENT	SCORE
Freedom of Expression	<ul style="list-style-type: none"> ▪ Mothers and their children are free to belong to different cultures and religions but the expression of these difference is not encouraged in the home ▪ Mothers raise their children within their own cultural and religious value systems 	
Palliative care	<ul style="list-style-type: none"> ▪ Children die in the hospital ▪ Personalised funerals are arranged ▪ Grieving mothers and children are supported ▪ Death is discussed with the mothers and children when there is a need 	

APPENDIX D.9: ASSESSMENT - DURBAN CHILDREN'S SOCIETY (COMMUNITY-FAMILY FOSTER CARE MODEL)

ESSENTIAL ELEMENT	ASSESSMENT
SURVIVAL	
Food	<ul style="list-style-type: none"> ▪ Regular meals are served but not necessarily nutritious or balanced - depends on awareness of caregiver and funds ▪ Individual food needs and tastes are accommodated within budgetary constraints ▪ Children eat with their foster parents ▪ Food is prepared and served by foster mothers and children can be involved in these preparations
Clothing	<ul style="list-style-type: none"> ▪ Children are adequately clothed for all seasons ▪ Clothing is individualised, however some sharing does take place
Home environment	<ul style="list-style-type: none"> ▪ Homes have all the basic amenities and are equipped with stove, fridge and furniture ▪ Yards are fenced ▪ Children share bedrooms and sleep in their own beds
Hygiene/infection control	<ul style="list-style-type: none"> ▪ Foster mothers are aware of personal hygiene practices ▪ Universal precaution guidelines are not applied as none of the children are HIV+
Treatment and health care	<ul style="list-style-type: none"> ▪ Immunisation cards are kept ▪ Relatively easy access to clinics and hospitals which were ill-equipped ▪ Some awareness of illness indicators and when and how to respond
SECURITY	
Protection	<ul style="list-style-type: none"> ▪ All the children are committed to foster care by the court - this provides legal protection up to the age of 18 years ▪ With this model, the home of the children is protected as it is owned by DCS - if the foster mother withdraws, the children don't have to be moved from their home, schools and community ▪ Foster mothers can only look after a maximum of six children ▪ Social workers are required to prepare reports on foster children for the court every 2 years ▪ Social workers at DCS are required to visit the children every six months which does not always happen - they are also not always available in a crisis ▪ Mothers discipline children according to their own styles, which is not always positive, and corporal punishment can be over-applied ▪ Community-family foster mothers were not prepared to care for HIV+ children and preferred girls
Affection	<ul style="list-style-type: none"> ▪ Foster mothers can only look after a maximum of six children ▪ Foster mothers provide constant, reliable care and "mothers love" ▪ Foster mothers were selected on the basis of their suitability as caregivers of children which included their love for children and their ability to be available to them
SOCIALISATION	
Education/schooling	<ul style="list-style-type: none"> ▪ Children 7 years and older attend school outside the home ▪ Children under 7 years attend pre-school

ESSENTIAL ELEMENT	ASSESSMENT
Identity	<ul style="list-style-type: none"> ▪ Names of children are retained ▪ Identifying records of children are kept by DCS ▪ Foster mothers have limited knowledge of children's histories, backgrounds and whereabouts of other family members - their past is not referred to ▪ Children are housed as far as possible in their communities of origin ▪ Siblings share the same home ▪ Each child's birthday is celebrated
Participation	<ul style="list-style-type: none"> ▪ Extent of child's participation varies with each foster mother, generally the adults make the decisions and the child is not included in this decision-making
Understanding	<ul style="list-style-type: none"> ▪ Children assist with household chores - in this way they are exposed to basic life skills ▪ Foster mothers felt uncomfortable with discussing issues of sexuality and HIV/AIDS with the older children
Supportive services/counselling	<ul style="list-style-type: none"> ▪ Social workers at DCS were not available to foster families in a crisis situation ▪ Children who need specialised psycho-social care receive it ▪ Foster mothers are aware of psycho-social needs and try to access external support when needed
SELF-ACTUALISATION	
Recreation/Idleness	<ul style="list-style-type: none"> ▪ Children provide playmates for each other ▪ Children play with friends in the community ▪ Children have time to play
Freedom of Expression	<ul style="list-style-type: none"> ▪ Foster mothers raise their children within their own cultural and religious norms
PALLIATIVE CARE	
	<ul style="list-style-type: none"> ▪ None of the children in community-family care are HIV+ and it is therefore not an issue for the foster mothers ▪ In other foster care arrangements, notably crisis care, when HIV+ children get ill they go to the DCS special care unit

APPENDIX D.10: ASSESSMENT - NAZARATH HOUSE (STATUTORY RESIDENTIAL CARE)

ESSENTIAL ELEMENT	ASSESSMENT
SURVIVAL	
Food	<ul style="list-style-type: none"> ▪ Nutritious, balanced and varied diet ▪ Meals are regular and scheduled ▪ Children are fed in groups ▪ Food is prepared by home's kitchens, children are not exposed to or included in these preparations
Clothing	<ul style="list-style-type: none"> ▪ Children are fully clothed for all seasons ▪ Clothing is individualised and of good quality
Home environment	<ul style="list-style-type: none"> ▪ Fully equipped and spacious home ▪ Well-maintained ▪ All basic amenities with in-house water, sanitation, electricity ▪ Well-ventilated ▪ Grounds and buildings are child-friendly ▪ Children sleep in dormitories in their own beds
Hygiene/infection control	<ul style="list-style-type: none"> ▪ Universal precaution guidelines are applied - gloves and masks are used as and when required ▪ Sick children are put in the nursery with the babies which could lead to spread of infection ▪ A number of children have obvious warts ▪ Supervised toilet routine ▪ Each child has their own tooth-brush, face-cloth and potty
Treatment and health care	<ul style="list-style-type: none"> ▪ Immunisation records kept ▪ Daily health record kept of each child ▪ Regular doctor's visits ▪ 24hour nursing care ▪ Easy access to clinics, hospitals and dental facilities
SECURITY	
Protection	<ul style="list-style-type: none"> ▪ Child is committed to home by the court ▪ Staff to child ratio is 1:4 and staff work shifts and take leave; there is a constant adult presence but it is not always the same adult ▪ There is a strict screening system for staff and volunteers ▪ Staff are closely monitored and supervised and there is a supportive network between staff and volunteers in the home ▪ Staff are trained in healthy discipline practices ▪ A discipline record is kept - corporal punishment is not allowed as a discipline measure ▪ All children are accepted regardless of HIV status, creed, culture, gender or race

ESSENTIAL ELEMENT	ASSESSMENT
Affection	<ul style="list-style-type: none"> ▪ Staff to child ration is 1:4 and staff work shifts and take leave; there is a constant adult presence but it is not always the same adult ▪ Child care workers are trained in how to communicate positively with children and are generally caring ▪ Each child is allocated a dedicated volunteer, who maintains a concerned relationship with child ▪ Children tend to be clingy and attention seeking
SOCIALISATION	
Education/schooling	<ul style="list-style-type: none"> ▪ Children 7 years and older attend school outside the home ▪ Special provision is made for those children with physical or learning disabilities ▪ Pre-school is provided by the home
Identity	<ul style="list-style-type: none"> ▪ All births are registered ▪ Name is retained if identified by family (some children are abandoned) ▪ Identifying records of the child are kept ▪ If the origin of the child's family is known, then attempts are made to retain contact ▪ Memories of the child are retained how with photos, scrap books and individual files ▪ Children are taught traditional songs ▪ Each child's birthday is celebrated ▪ Child's individual volunteer ensures they do not get lost in the "system"
Participation	<ul style="list-style-type: none"> ▪ Most of the children are under 6 years old - participatory discussions are not age appropriate ▪ Children's views are taken into account when making decisions about weekend/holiday outings
Understanding	<ul style="list-style-type: none"> ▪ Caregivers receive training in positive communication practices ▪ Children are informed about their health and HIV status in a supportive manner ▪ Children are all under age 6 years, sexuality and relationship discussions not age appropriate
Supportive services/counselling	<ul style="list-style-type: none"> ▪ Full-time social worker at the home ▪ Part time psychologist services provided in the home ▪ The child's individual volunteer, the social workers, the nuns and other caregivers provide psycho-social guidance and support ▪ Staff are aware of the children's psycho-social needs
SELF-ACTUALISATION	
Recreation/Idleness	<ul style="list-style-type: none"> ▪ Time for recreation is structured and adults engage children in recreational activities ▪ Recreational facilities are available and children have time to play ▪ Quality educational playing equipment is provided ▪ Two TVs provide supervised entertainment ▪ Volunteers spend time with e children in groups, supervising recreational and stimulatory activities
Freedom of Expression	<ul style="list-style-type: none"> ▪ Children are raised in the Catholic faith - but discussion of other religions is not discouraged

ESSENTIAL ELEMENT	ASSESSMENT
PALLIATIVE CARE	<ul style="list-style-type: none"> ▪ In-patient hospice care unit at the home ▪ Respite care is offered to children living in the community ▪ Pain relief, medication and equipment available 24hours ▪ No child ever dies on their own, there is 24 hour nursing care ▪ Talk of death is minimised, however other children are always informed and supported when a child dies ▪ Nuns offer spiritual support ▪ Memorial services are held for children in place of funeral