REPORT ON THE ASSESSMENT OF NEIGHBOURHOOD CARE POINTS

SWAZILAND - 2006

For every child
Health, Education, Equality, Protection
ADVANCE HUMANITY
HIV infection in Swaziland has shown a rapid increase since the early 1990's bringing the country's prevalence rate to one of the highest in the world. HIV prevalence among pregnant women attending antenatal clinics was 3.9% in 1992, 26.0% in 1996, 34.2% in 2000 and 42.6 % in 2004. Annual AIDS-related deaths are estimated to be 17,000 within a population of slightly over one million, and the number of orphans in the country has increased from an estimated 12,000 in 1999 to 69,000 in 2004, which is still on the increase. The traditional extended family and other support systems are overwhelmed by the situation. To provide care and support to Orphans and Vulnerable Children (OVC) at the community level in the face of social breakdown, Neighborhood Care Point (NCP) started as a community-driven initiative and has rapidly expanded across the country in the past few years.

As the NCP has been fully incorporated into the National Plan of Action for OVC (2006-2010), there was a need to review the past experiences and to identify effective and efficient ways for further up-scaling. The NCP Assessment 2006 was designed to obtain an overall view of the situation in the communities and with the OVC, evidence-based data on the level of functionality and sustainability of the UNICEF-supported NCPs, and an analysis of the impacts made on children by the NCPs. The assessment commenced in April and completed in September involving extensive community work in the most remote areas of the country.

We wish to acknowledge ECHO and DFID for providing the necessary financial resources for the assessment. UNICEF would especially like to commend Dr. Solomon S. Dlamini, the chief consultant, for his commitment and hard work in producing this report. His team members included Ms. Buyile Mavimbela, Mr. Njabulo Nhlanhla, Mr. Ziphozonke Dlamini, Ms. Bethusile Khumalo. Our thanks are also extended to Ms. Lindiwe Sithole and Ms. Hazel Zungu (Guidance and Counseling Officers) for facilitating a consultative workshop with OVC.

Lastly and most importantly, we would like to thank the communities and households from which data was collected for their cooperation and patience, caregivers and children for sharing their experiences, and our implementing partners for contributing to the concept formulation of the assessment and for supporting the assessment process throughout by making arrangements with the communities.

The report provides us with six concrete recommendations. We are looking forward to continue working together with our implementing partners both in the governmental and non-governmental sectors towards realizing these recommendations.

October 2006

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EXECUTIVE SUMMARY

This report presents the findings of an assessment of Neighbourhood Care Points (NCPs) in Swaziland that was conducted from May to July 2006. The assessment sought to, among other things, determine the different levels of functionality of three different cohorts of NCPs established with emergency funding received from the European Community Humanitarian Organization (ECHO) in 2003-2005 and identify the specific results arising from the NCPs in terms of the health, nutrition, access to education and psychological well-being of orphaned and vulnerable children (OVC) they served.

The assessment was carried out in two phases by a task team consisting of a chief consultant, assistant consultant, and two research assistants. The first phase assessment consisted of national survey of 62 NCPs out of a target population of 438. A survey questionnaire was administered and in-depth interviews conducted, with NCP caregivers and OVC at the NCPs as the respondents. The second phase assessment consisted of key informant interviews, community meetings (“focus group discussions”), and a household survey of 70 households with OVC. The households were also drawn from communities where there were non-UNICEF/ECHO supported NCPs and those without NCPs for comparative purposes.

The results of the assessment indicated that the majority of the NCPs were functioning well and were playing a critical role in the care and support of OVC in the communities where they have been established. Constraints faced by NCPs were identified, as well as factors that contribute to their success in the various communities. The key factors in these regard included community support, NCP management and monitoring structures, and regular supply of food. Recommendations were made on how to improve the functionality of NCPs and make the NCP initiative sustainable.

ACRONYMS AND ABBREVIATIONS

AIDS  Acquired Immune Deficiency Syndrome
AMICAAL  Alliance of Mayor’s Initiative for Community Actions on Aids
ECHO  European Community Humanitarian Organization
DFID  UK Department for International Development
HIV  Human Immuno-deficiency Virus
NCP  Neighbourhood Care Point
ORS  Oral Rehydration Salts
OVC  Orphans and Vulnerable Children
RHMs  Rural Health Motivators
UNICEF  United Nations Children Fund
WFP  World Food Programme
1.0 INTRODUCTION

1.1 Background and Rationale for Assessment

Swaziland is in a vicious cycle, where the impact of HIV and AIDS, exacerbating poverty and food insecurity and increasing vulnerability of already marginalized children and women to sexual abuse and exploitation, is resulting in additional HIV infections and AIDS cases. Children are bearing the greatest brunt of the HIV and AIDS pandemic, destitute and forced to fend for themselves, with their parents and guardians absent because of AIDS. At present there are approximately 69,000 orphans, and 130,000 orphans and vulnerable children (OVC) in Swaziland, but by 2010 the projected numbers of orphans and vulnerable children will be 189,000 in a population of a little over one million.

The 2001-2005 Government of Swaziland/UNICEF Programme of Cooperation recognized that all development efforts would come to naught, unless HIV rates decrease and the impacts on children are mitigated. The Neighbourhood Care Points (NCPs) were established by a few communities in 2001 in an effort to provide care and support for orphans and vulnerable children. Using a Human Rights Based Approach to programming, UNICEF began sensitising communities to the unmet rights of OVC in their communities. Communities began to realise their obligations to support OVC, and recognised that NCPs could play an important role to fulfil these rights.

In the period 2003 to 2005 UNICEF received emergency funding of approximately 3.1 million US dollars from ECHO for the care and protection of orphans and vulnerable in Swaziland. This funding was directed towards the establishment and strengthening of community-driven NCPs, which provide food and nutrition, basic health care, non formal education and recreation opportunities, and psycho-social support to orphans and vulnerable children. UNICEF support to communities to establish NCPs had started in 2001 using other resources, but large-scale ECHO funding enabled UNICEF to rapidly expand the number of NCPs and improve quality service provision. In total, between 2001 and 2005, UNICEF spent over 8 million US dollars on the NCP initiative, out of which ECHO funding constituted 32.06%.

Between 2001 and 2005 NCPs became core community service-delivery entry points, making isolated OVC, living in scattered homesteads, visible to communities. At the time of this assessment, there were 438 NCPs benefiting approximately 33,000 OVC. These were established in three phases with ECHO funding enabling a rapid scaling up:

1. 220 new NCPs in the drought affected areas of Lubombo and Shiselweni were established between 2003-2004;
2. 125 new NCPs were established in Manzini and Hhohho in 2004-2005; and
3. 90 new NCPs were established in Shiselweni, Manzini and Hhohho in 2005-2006.

At any given time these NCPs have varying levels of functionality depending on the commitment of communities, availability of supplies, and regularity of food provision. Some NCPs have done better than others, providing regular quality care, protection and support to OVC, whilst others have been barely functional or are not at all functional.

With communities, national and international partners increasingly recognising NCPs as a core impact mitigation intervention for OVC, this assessment was initiated to identify the functionality status of NCPs, and
reasons, in order to document lessons learned and to apply the “learn as you go” approach.

NCPs are incorporated in the 2006-2010 National Plan of Action for OVC, which targets to scale up NCPs to every community in Swaziland by 2010. This assessment, therefore, seeks to review past experiences, and develop improved strategies for sustaining and expanding NCPs in Swaziland. It examines the achievements and shortfalls of the NCPs as an emergency intervention strategy and investigates its performance as channels for provision of basic services to OVC. Community views and experiences are explored in qualitative interviews to understand how NCPs may be strengthened, complemented, reinforced, or replaced using different or improved approaches.

1.2 Objectives of the Assessment

The objectives of this assessment were to:

- Assess the level of functionality of three different cohorts of NCPs established during the ECHO implementation period;
- Identify the key factors that determined the different levels of functionality of the NCPs;
- Identify the specific results arising from the NCPs in terms of the health, nutrition, access to education, and psycho-social well-being of OVC they served;
- Identify feasible strategies and specific action points for strengthening of NCP capacities and improving sustainability;
- Identify how communities with non-UNICEF supported NCPs both in rural and urban areas, as well as communities with no NCPs, have been coping with challenges of realizing the rights of OVC, and lessons learned from their experiences; and
- Assess the positive and negative aspects of use of emergency funds for expansion of the NCPs, as a strategy for reaching the un-reached children affected by the HIV/AIDS epidemic.

More specifically, the assessment seeks to determine the following:

- Percentage of functional NCPs among the three different cohorts;
- Understand which services are regularly provided and/or sustained at NCPs, including food, health care, non-formal education, and psychosocial support;
- Factors which hinder functionality and sustainability of NCPs;
- Extent of networks and linkages with other service providers or local institutions;
- Extent to which various trainings for caregivers have made an impact on the level and quality of service delivery at NCPs;
- Reasons for caregiver attrition, if it has occurred;
- Type of support required to sustain caregivers in their care giving roles;
- Factors that are encouraging the children to attend NCPs;
- Difficulties some NCP-registered children face in regularly attending NCPs;
- Impact, if any, the existence of NCPs has had on OVC access to formal educational opportunities;
- Differences observed between the OVC enrolled in NCPs and the OVC who are living in the same community and not attending an NCP;
- Differences observed between the OVC enrolled in NCPs and those living in other un-reached communities without NCPs;
Strategies employed by non-UNICEF supported NCPs and what lessons can be learnt from their experiences; and
How the OVC needs are addressed in communities with no NCPs.

2.0 METHODOLOGY

2.1 Assessment Design
The assessment consisted of two different phases. The first phase assessed the status and functionality of NCPs from three different cohorts representing different phases of ECHO funding (438 in total) and analysed success stories and reviewed lessons learned. The three cohorts are as follows:

- Cohort 1 – 220 NCPs in Lubombo and Shiselweni received ECHO support beginning November 2003;
- Cohort 2 – 125 NCPs in Manzini and Hhohho received ECHO support beginning July 2004; and
- Cohort 3 – 93 NCPs receiving ECHO support beginning from September 2005.

The second phase sought to draw out the differences UNICEF support to the NCPs had made in the lives of OVC and in the capacity of the communities to cope with the crisis emerging from the HIV and AIDS pandemic. To this end, comparative analysis was undertaken. Several NCP communities surveyed in the first phase were selected on the basis of equal representation of different functionality levels and different ecological zones. These selected communities were compared with those where NCPs were established and have been maintained without UNICEF support including those located in urban areas and with those communities where no NCP exists. In each of these communities, the situation of NCP-enrolled OVC was compared with the situation of NCP un-enrolled OVC through a household survey.

After completion of the data collection, a draft final report was produced, which was shared with all the NGO implementing partners for their inputs and comments. The findings and recommendations were also presented at the Child Protection Network Meeting in September and were discussed with stakeholders from government and civil society. Finally, from 28-30 September, a consultation workshop was held with 28 children and youth selected from vulnerable households. Following a presentation on assessment results, participants actively discussed challenges they face at NCPs and how to improve the NCPs. The final recommendation of the report has been reviewed based on the outcomes from the consultation workshop.

2.2 Selection of NCPs for First Phase Assessment
For the first phase assessment, random samples of NCPs were selected within each of the three cohorts of NCPs, as follows: 30 NCPs from cohort 1, 18 NCPs from the second cohort, and 14 NCPs from cohort 3. In total, 62 NCPs were included in the sample, which constitute 14% of the target population. In selecting the sample, the geographical distribution of the NCPs across the country’s four regions was also taken into account (see, Table 1).
### Table 1: Sampled NCPs by Cohort and Administrative Region

<table>
<thead>
<tr>
<th>Cohort</th>
<th>Hhohho</th>
<th>Manzini</th>
<th>Shiselweni</th>
<th>Lubombo</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>-</td>
<td>-</td>
<td>12</td>
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<td>2</td>
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<td>Total</td>
<td>13</td>
<td>9</td>
<td>15</td>
<td>25</td>
<td>62</td>
</tr>
</tbody>
</table>

2.3 **Assessment Criteria for NCP functionality**

The initial criteria for assessing the functionality of the NCPs were as follows:

- **Well functioning NCPs** – NCPs open five or more days a week and offering services in addition to food provision.
- **Functioning NCPs** – NCPs open more than three or more days a week and providing food.
- **Poor or, non-functioning NCPs** – NCPs that are not able to provide food.

During the assessment these criteria were found to be limited, especially when considering the purpose of an NCP and what an “ideal NCP” should provide and their failure to distinguish a poorly functioning NCP from a non-functional one. According to a UNICEF training module, the aim of establishing an NCP is to:

> “Create a human and physical infrastructure at the neighbourhood level to address critical needs of orphans and vulnerable children. The focus in the first instance is on providing a place of psycho-social support and care for children who have lost or been abandoned by parents, especially those living in child headed households or in households where the incapacity of overburdened caregivers and relatives leaves the children largely on their own. The NCP also aims to ensure OVC access a cooked meal once a day, participate in non-formal education and play activities, and receive basic health care and nutrition in a place where they feel safe and loved (page 2).”

The module identifies the following as the “wish list” for the “ideal NCP”:

- Basic day-time shelter from rain, wind and cold;
- Warm clothing against winter cold;
- Basic interaction, and developmental simulation activities for young children;
- Availability of first-aid treatments and basic health care;
- Teaching and story-telling activities to provide life skills and build resilience;
- Play, drama, singing and sports opportunities;
- Consciousness raising and protection from abuse and HIV infection;
- Gardening and keeping of small livestock;
- Non-formal and after-school education activities; and
- Psychosocial support and counselling for children with special needs.

In light of the foregoing, the criteria provided in the terms of reference were refined. First, a distinction was made between the non-functional NCPs from those that are poorly functioning. Second, a ranking system was developed for the well-functioning category.

In line with the ideal characteristics of an NCP, points were awarded to well-functioning NCPs as follows:

- Structure with storage facility (2 points), structure without storage facility (1 point), first-aid kit (1 point), ORS
(1 point), toilet (1 point), functioning garden (2 points), garden (1 point). The maximum points that an NCP could earn were 10 (7 points for the facilities and 3 points for meeting the basic requirements, i.e., NCP open five or more days a week and offering services in addition to food provision). Subsequently, the well-functioning NCPs that earned a total of 9-10 points were classified as excellent, those with 5-7 points as very good NCPs, and those with 3-5 points as good NCPs. The point system was also extended to the other categories as follows: not functioning – zero, poorly functioning – 1 point, and functioning- 2 points. Thus, the final classification system used in assessing functionality was as follows:

<table>
<thead>
<tr>
<th>Points</th>
<th>Classification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zero</td>
<td>Non-functioning</td>
</tr>
<tr>
<td>One</td>
<td>Poorly functioning</td>
</tr>
<tr>
<td>Two</td>
<td>Functioning</td>
</tr>
<tr>
<td>3-5</td>
<td>Well functioning/Good NCP</td>
</tr>
<tr>
<td>6-8</td>
<td>Well functioning/Very Good NCP</td>
</tr>
<tr>
<td>9-10</td>
<td>Well functioning/ Excellent NCP</td>
</tr>
</tbody>
</table>

2.4 **Fieldwork for First Phase Assessment**

Data collection in the first phase assessment consisted of both quantitative and qualitative approaches. Quantitative data were collected using a survey form on NCP functionality. The form comprised questions covering managerial and administrative issues, activities and service provision. Qualitative data were collected through questionnaire-guided in-depth interviews of caregivers and school-age children older than 6 years attending the NCPs and observation of activities.

The actual fieldwork was conducted on weekdays from the 27th April to 25th May 2006 (20 working days). An average of three NCPs were visited a day. A three-person team comprising the chief consultant, assistant consultant, and research assistant visited the NCPs. During the visits, a total of 114 caregivers and 53 children were interviewed.

Difficulties experienced during the fieldwork included locating the NCPs, the long distances between NCPs, and finding of the caregivers and children in cases where the NCPs were temporarily closed because of school holidays and the harvesting season. Consequently, in some NCPs only one caregiver was interviewed and no children were interviewed.

2.5 **Selection of Communities and Households for Second Phase Assessment**

Based on the results of the first phase assessment, a total of 17 communities were selected for the second phase assessment, as follows: 3 communities with well functioning communities; 4 communities with poorly or non-functioning NCPs; 4 communities with non-UNICEF/ECHO supported NCPs; 4 communities with no NCPs, and 2 communities from urban or peri-urban areas. An effort was made to ensure that there was a geographical balance between the drought-affected Lowveld ecological zone and the Middleveld or Highveld zone. In addition, a household survey was conducted to assess the well-being of OVC. The selection of the households was carried out as follows: From communities with well-functioning or functioning UNICEF/ECHO supported NCPs and non-UNICEF/ECHO NCPs, 3 vulnerable households with NCP-enrolled children and 3 other households with NCP un-enrolled/un-attending children were selected. From the communities where there are
poor or non-functioning or no NCPs, 3 households each were selected. A total of 70 households were surveyed.

2.6 Fieldwork for Second Phase Assessment
The fieldwork for the second phase assessment was carried out by the chief consultant, assistant consultant, and two research assistants between 12th June to 14th July. Meetings ("focus group discussions") were held in all the selected communities, with the participants mainly consisting of the traditional leadership and community-based workers and volunteers such as RHMs, NCP caregivers, child protection committees, and community police. In-depth interviews were held with head teachers of nearby schools. The household survey was carried out by the research assistants. In communities with NCPs, the caregivers helped with the selection and identification of target households. However, in communities without NCPs, RHMs played a major role in the selection and identification of households. The guiding principle in the selection of households was vulnerability and presence of orphans.

2.7 Limitations of the Assessment
The timing of the first phase assessment was such that a lot of NCPs were not open on the days they were visited, resulting in poor coverage of NCP children (only 53 children were interviewed in the 62 NCPs visited). However, while the quantitative findings with respect to children would need some caution in generalization, the issues identified may be reflective of the situation and perceptions of other NCP children. The conduct of “focus group discussions” in the second phase assessment instead of individual key informant interviews somewhat limited the amount of probing that could be done on the issues raised. Nevertheless, the assessment was able to identify key issues relating to the overall situation concerning OVC in the communities and to find out how the communities are responding. The in-depth interviews held with head teachers were especially informative on the extent of inter-linkages with NCPs and other community groups for ensuring OVC access to education.

3.0 PHASE I: SUMMARY FINDINGS

3.1 NCP Functionality
To assess the functionality of the NCPs, questions were asked relating to operational status, children enrolment, record keeping, type of activities conducted at the NCPs (in addition to food provision).

3.1.1 Operational Status of the NCPs
- Only half of the NCPs (51.6%) were open at the time of the visits. This was mostly attributed to the closure of schools and the harvesting season. Some of the closed NCPs (30%) were not operational at all, for various reasons, including community disputes, lack of food, no structures, some which were still under construction.
- The overwhelming majority of the functional NCPs (93%) are open on weekdays (Monday to Friday). Only about half of the NCPs open on Saturdays (47%), and a very small proportion (8%) is open on Sundays. Less than half of the NCPs (46%) are open during school holidays.
- Whilst, there was a great diversity in terms of the reported opening hours, it was evident that most (87%) NCPs start operating in the morning and close mid afternoon.
3.1.2 Children Enrolment and Attendance

- About 58 children, on average, are enrolled in each NCP. However, it was difficult to verify the reported enrolment figures for some of the NCPs because about a third did not keep registers.
- The overall enrolment situation with respect to the distribution of children by age and sex was not clear because of the poor record keeping by most NCPs and the absence of knowledgeable caregivers at the time of the visits. However, it was evident that most NCPs observed the policy of admitting OVC of school going age.
- Attendance at NCPs was generally poor at the time of the visits because of the closure of schools, the harvesting period, and the timing of the visits. However, the assessment team was assured by the interviewed caregivers that attendance was generally good, with most registered children regularly coming to the NCPs.

3.1.3 Record-keeping

- Record keeping at the NCPs was generally poor, with only about 68% having the Standard Register. Of these, about three-quarters (76%) had the register filled. However, only 21% of the NCPs who had the standard register kept it up-to-date.
- The caregivers who act as teachers at the NCPs usually keep the registers.

3.1.4 Activities at NCPs

3.1.4.1 Food Provision

- The serving of food to the children is the major activity at the NCPs, with all functional NCPs providing food to the children. All the functional NCPs reported that they serve at least one meal a day, with 40% providing only one meal a day, 53% providing two meals a day, and about 5% providing more than two meals a day.
- Most NCPs (93%) provide food for 5 days a week. Only about 5% reported that they provide food for only 2-3 days a week.
- The serving of food continues even during school holidays and on weekends, so long as the NCP is open.
- The type of food served at the NCPs is largely the same, consisting virtually of what they receive as donations from external agencies. Thus, maize-meal is the staple food served, with beans being the main relish. Rice and vegetables are sometimes prepared when available, but this is rare. The serving of meat is very rare, with only three NCPs reporting once a month servings. Breakfast/snack consisted mainly of Corn Soya blend, among those NCPs that served two meals a day. A concern was expressed by virtually all caregivers about the lack of variety in the types of meals served.
- The food prepared at the NCPs is mainly supplied by the World Food Programme (73%) on a monthly basis. Community donations were reported by only 19% of the NCPs.

3.1.4.2 Other Activities at NCPs

- Whilst the serving of food is the major activity at the NCPs, caregivers undertake various other
activities with the children, including playing games, story telling, teaching, drama, singing, and dancing. Most of the NCPs have other activities in addition to food provision (85%).

- The most common other activity at the NCPs is the playing of games, which is a daily occurrence. This is followed by teaching and story telling (including bible stories), conducted by about 86% of the operational NCPs. Topics and items covered in the lessons conducted include alphabets, vowels, identification of body parts, poems, dancing, writing, counting, respect and proper behaviour.
- Though conducted at some NCPs (31%), psychosocial counselling of individual children is not common. Even in those NCPs where it is conducted, it is infrequently done, with the caregivers reporting doing it once a week or whenever the need arose. This was attributed to the lack of awareness and training on psychosocial issues, especially on bereavement and grief.
- Generally, the issue of HIV prevention is not addressed at the NCPs, with only 29% reporting that they address it. Even among these NCPs, the issue is not addressed frequently. This could be attributed to, among other things, the cultural attitude that sex-related issues should not be discussed with children.
- The situation is slightly better with issues of child abuse and protection, with about 32% of the NCPs reporting that they address them. The frequency with which these issues are also addressed is also not high; they are mostly addressed either weekly or whenever the need arises. Only about 4% of the NCPs reported addressing these issues daily.

3.2 **NCP Facilities and Amenities**

3.2.1 **NCP Structures**

- The majority of NCPs visited (84%) had structures. However, the quality of the structures was generally poor, with only 17% having been constructed with permanent materials (bricks). Most of the structures were constructed out of stick and mud. The floors were mainly earth, or a mixture of sand and cow dung. Only 33% had cement floors. It is notable that, although most of the NCP structures had doors (83%), they were not lockable in about 20% of the NCPs. There were no NCP structures without roofs, except those still under construction.
- Many of the NCP structures consist of only one-room (48%) or two rooms (31%). Generally, the NCPs with one room have no storage facilities and rely on members of the community for the storing of food and other materials. This also applies to some NCPs with two-roomed structures, which, for security reasons, stored their food supplies at the homesteads of community members or in other structures. Consequently, only 32% of the NCPs stored their food in their own structures.

3.2.2 **Sources of water and sanitation**

- The majority of NCPs have no access to tap or borehole water (65%). They collect their water from other sources, such as rivers and dams, which are in most instances distant from the NCPs. In addition, many NCPs utilize rainwater stored in water tanks. However, less than half of the NCPs (44%) have 5000-litre water tanks. In general, water tanks are used for storing rain-water; only one NCP reported the supply of water by a water-tanker.
- Nearly half the NCPs (47%) reported that they their sources of water are safe. To make the water safe, most NCPs reported that they use Jik (70%), and others boil it (15%).
- The sanitary situation in most of the NCPs is poor. Refuse disposal is largely indiscriminate. Only
19% of the NCPs have toilets. In most of the NCPs with toilets, the communities constructed them, with the caregivers taking the leading role. Many of the caregivers working in the NCPs without toilets expressed a desire and/or intention to have toilets constructed. They attributed the present situation to lack of building materials or lack of community support.

3.2.3 **NCP garden and livestock**
- Generally, the NCPs do not have their own sources of food or resources to supplement the food donations. Thus, only 37% of the NCPs have gardens, which were largely not viable. About half of the gardens had no crops at the time of visit. The reasons cited for this situation include the lack of water, fencing materials, and seedlings, in that order. None of the NCPs kept any livestock.

3.2.4 **Basic health, first aid and hygiene resources and practices**
- The majority of NCPs (58%) keep oral re-hydration salts (ORS) and most of the caregivers where these were kept (74%) have received training on how to use them.
- Slightly more than a third of the NCPs (37%) have first aid kits, and only 20% of the caregivers had received training on their use. Most of the NCPs without first aid kits had never had them.
- Almost all the NCPs (95%) reported that hand washing before eating is practiced by the children. However, it was reported that the shortage of water and soap sometimes hampers the practice of hygiene at the NCPs. This was in relation to the need to sometimes have the children bathed or have their clothes washed.

3.3 **Situation and Perceptions of NCP Caregivers**

3.3.1 **Socio-demographic characteristics**
- Most of the NCP caregivers are females; only about 6% are males. Their ages range from 21-59, and more than 90% are married.
- The numbers of caregivers per NCP ranged from 3 to 10, with 5 caregivers per NCP, on average. There is at least one caregiver in each NCP who acts as teacher and record keeper, whilst the rest concentrate in cooking. Cooking is usually done in turns, with one group cooking during one week and the other during the following week.
- On average, there are two caregivers per NCP who have completed (at the minimum) standard five. The caregivers with the highest levels of educational attainment usually act as teachers.

3.3.2 **NCP Caregivers' Selection Process**
- In general, NCP caregivers are selected/elected by the community, usually at the Chief's kraal. About half reported being chosen at the *Umphakatsi* (chiefdom) level, by the Chief and his Inner Council. These had no choice, but responded to their Chief or community's call. However, most of the caregivers stated that what began as a call of duty has evolved into a commitment, for the sake of the children in their care.
- The above notwithstanding, virtually all the caregivers are volunteers; some of them were already involved in community activities in other capacities, such as being rural health motivators, home-based care providers or child protectors.
3.3.3 NCP Caregivers' Motivation and Reasons for Dropping-out

- **Compassion**: the love for the children; fulfilling the needs of the less fortunate; the Christian thing to do (“love one another”); and pity for some of the children who have no parents;
- **Incentives**: food packages for caregivers (in those areas that receive them).
- **Training**: the occasional training courses enable the caregivers to travel, receive participation fees and broaden their knowledge base.
- **Practical considerations**: with the HIV/AIDS scourge, tomorrow it might be their own children in need, so there is a need to contribute while still able, so their own children might also be taken care of in the uncertain future.
- **Progress and development**: caring for the future leaders of the country will uplift and develop the community.
- **Duty to the community**: continued service as an obligation; selected by the Chief so law is expected of them.
- **Material Gain**: in many cases the caregivers' children eat at the NCP.
- **Family support**: with a few exceptions, caregivers have the support of their families, especially those that receive monthly food packages.

- Dropping out is not a common occurrence among caregivers; the level of commitment is generally very high. However, the caregivers who dropped out did so for various reasons, with the majority dropping out because of the lack of remuneration or having secured employment elsewhere. Other reasons included additional family commitments, relocations, or death.

3.3.4 Problems/Challenges faced by NCP caregivers

Whilst the commitment of the caregivers is relatively high, they face many problems/challenges in discharging their duties. The reported problems (in order of importance) were as follows:

- **Shortage of water**: this problem was reported at most of the NCPs, with the caregivers having to struggle to obtain water without any community support. Even the NCPs with water tanks face difficulties, especially during the dry season. In most cases the caregivers have to travel long distances to fetch water to the NCP, or have to buy the water with their own resources.
- **Lack of soap or other supplies, such as matches and soap** – Caregivers reported that soap for dishwashing and hygiene (both for caregivers and children) is not supplied to the NCPs, yet they are expected to practice hygiene. In fact, soap was reported to have been distributed to NCPs only once (ECHO supplies). Also, other small, but important materials such as matches, salt, and sugar are not supplied. They have to secure these themselves, usually from their own homes.
- **Lack of community support**. Community support is minimal in the majority of NCPs. Some NCPs are still having trouble with erecting structures because all the work has to be done by the caregivers; even condiments such as salt and sugar have to come from the caregivers' own pockets, yet they have no sources of income. While many communities have established NCP committees, these were largely not effective in mobilizing community support.
- **Negative attitudes of community members**. Many caregivers reported that some members of the
community were very critical of their work; in many instances accusing them of helping themselves on the NCPs' food. Other negative comments related to the monthly food packages received by some of the caregivers.

- Lack of food variety. This was the most common problem reported by caregivers. They felt that the consumption of mealie meal and beans every day for months on end was really tough for the children. This situation was especially hard-felt by those NCPs that do not receive community contributions and were without functional gardens.
- Uncooperative guardians and parents: In many instances some children are not able to attend the NCPs regularly because they are not allowed by their parents or guardians; instead, they are sent on different errands such as herding cattle.
- Absence of monitoring visits. Many NCP caregivers expressed a sense of isolation, with no one to report their problems to. This was especially the case in situations where the NCPs had little or no community support.
- Food shortages. For some NCPs the food supply is irregular, hence they have to close down periodically. Without food, the NCP closes down.
- Destitute community members: In some NCPs the caregivers have to allow destitute members of the community, such as the elderly, disabled, mentally challenged, and chronically sick (especially those on ARVs), to partake in the food meant for the children.

3.3.5 Training Opportunities and Requirements

- The majority of NCP caregivers have received training in the form of courses attended. The courses covered various topics on child-care, including the following: child development, hygiene and sanitation, basic health care, immunization, and psychosocial support for abused children.
- NCP caregivers reported that they use the knowledge gained from the courses attended to enhance their service delivery. In describing the usefulness of the training, they used key phrases such as broadening the mind, intensifying their understanding, elevating awareness, deepening their compassion and patience for the children and others less fortunate. All this has equipped them to take better care of the children.
- NCP caregivers further reported that what they learned has also impacted on their personal lives and changed their attitudes. Most reported increased self-awareness as well as broader issues surrounding child-care. This has enabled them to care for their own children and families in a more knowledgeable manner.
- Most of the caregivers expressed the need for refresher courses and further training on child-care, especially on issues such as children's experiences of bereavement and grief.

3.3.6 Linkages with other community development structures

- NCP caregivers reported that they work closely with other community development workers such as RHMs, child protectors, community police, and head teachers on issues affecting the children.

3.3.7 Types of External Support Needed

NCP caregivers expressed the need for assistance in various areas including the following (in order of importance):
- Help with water supply, through the supply and filling of water tanks and the construction of boreholes.
- Incentives (honorarium/stipend), which they termed “soap money”. Many caregivers were happy with the monthly food packages they were receiving.
- Mobilization of the community to support the NCPs and the caregivers in their efforts.
- Supply of a variety of foods, and make sure to include rice because the children were reported to be happy when it is part of the meal served.
- Clothes for the children, especially during winter. A lot of the children do not have any warm clothes or shoes. The tracksuits that they received from UNICEF a couple of years ago are now worn-out or have become too small.
- Further training and/or refresher courses to reinforce what they have already been taught.
- Visits (especially for monitoring purposes) by UNICEF. In the absence of these visits, NCP caregivers feel abandoned, especially if they are not receiving much support from their communities.
- Soap for dishwashing and general hygiene for the children. Currently, caregivers have to provide from their own pockets.
- Gardening inputs and materials, such as seedlings and fencing, to establish, or enhance already existing gardens.
- Building materials to construct or complete/improve their NCPs structures.

3.4 **Situation and Perceptions of NCP Children**

3.4.1 **Selection Process**
- The Inner Council and community members, who select caregivers to assist in the process, mainly do the identification of children that are registered at NCPs. In other cases the children are just selected by the NCP caregivers, in consultation with other community-based workers such as RHMs, child protectors, and church officers. Efforts are made to ensure that all the children are orphans (who have lost one or both parents) and are from destitute families (OVC). However, in most cases no children are turned away.
- Children who are not enrolled at the NCPs (but are OVC) are said to be those who live with families that do not see the need for them to attend NCPs. There were, however, some cases where the caregivers had managed to persuade the reluctant families to enrol the children. Generally, it was difficult for the caregivers to give estimates of the numbers of OVC in their communities that are not enrolled at the NCPs.
- The family situations of the children enrolled at NCPs are well known to the caregivers. This is achieved through family visitations and through knowledge obtained by virtue of the caregivers being members of their respective communities.

3.4.2 **NCP Attendance**
- Most children registered at NCPs attend regularly, even during school holidays. This applies to both school children and those not attending school.
- Caregivers follow up cases of prolonged absence or irregular attendance. They
send messages through the other children, and then follow up with home visits if the responses are not satisfactory or the absence persists.

- The reasons for some children not attending the NCPs include the chores at home, running errands, and illness. Some of the very young ones usually need someone to bring them to the NCP, who might not be available at the time. The chores mentioned include work around the homestead as well as planting, weeding and harvesting in the fields.

3.4.3 Children's Reasons for Attending NCPs

- Food. NCP children (43%) revealed that their most favoured activity at the NCP was eating. For many of the children, the meal(s) received at the care point is the most nutritious they will get. For some, it is their only meal of the day. When asked how many meals they eat in the course of a day (outside of the NCP meal), the children generally responded with “2 or 3”; however, further probing did reveal that a slice of mealie-bread, or a handful of guavas or other fruit, washed down with water constituted a meal in their minds.

- Learning. Learning was the next in the list of favourite things at the NCPs. Various non-formal educational activities such as singing, dancing and drama were mentioned as the second favoured activities. Although often non-formal and basic, for some NCP children the learning experience provided by caregivers is the only one. Of those children found to be out of school at the NCPs, about half have never been to school (aged between 9 and 14 years).

- Playing. Playing with the other children and making friends was given as the next favoured activity at the NCP.

- Donated clothes. Some of the children reported that receiving clothes was what they enjoyed about the NCP. Indeed, seeing how impoverished some of them are, this would be a highlight of the NCP experience.

- Care and support. When asked what the caregivers do for them, children responded with a host of answers indicating tremendous care and support from the NCP caregivers, e.g. “talk to us”, “listen to us”, “and help us if we have problems”. The psychosocial impact of all this is rather profound in children who only live with single mothers, or grandmothers, or aunts, or even older siblings and do not get the attention needed by all children.

3.4.4 Relationship with NCP caregivers

- All the children interviewed expressed fondness for the caregivers. The reasons given were along these lines: “they cook and feed us”, “they care for us”, “they teach us many things”, “they care for us if we are sick”, “they help us if we have problems”, and “they give us clothes.”

- Caregivers are seen as different from schoolteachers because the former cook for them whilst the latter do not.

- The disciplinary measures used by caregivers to address children's misbehaviour include reprimands, advice, scolding, shouting, and in some cases corporal punishment. Good behaviour is rewarded with praise and appreciation.

3.4.5 School Enrolment

- OVC of school-going age enrolled at the NCPs that were out of school were those who had been unable to
access government and other grants, or dropped out because they did not have school uniforms. However, there were few such children at most NCPs. Many children have been able to enrol or return to school, mainly through the government programme for OVC. Head teachers were said to have been of great assistance in this regard.

- Most of the NCPs did not require children to provide their birth certificates or immunization cards. Many NCP caregivers reported that it was only recently that, after visits by health workers, they started asking for and checking the children's immunization cards. Thus, NCP caregivers generally did not have an idea on numbers of children with birth certificates or immunization cards. However, there was a high level of awareness among the caregivers about the importance of ensuring that the children had birth certificates and immunization cards. In particular, the caregivers explained that these documents helped children to access the government fund for OVC and enrol in school. They thus saw it as one of their responsibilities to help the children to obtain them.

3.4.6 Knowledge/Awareness of HIV and AIDS and Sexual abuse

- Awareness of HIV and AIDS is very low among NCP children, with only 28% reporting ever being told about them. This is disturbing, considering that many of the children are likely to have lost parents, guardians and family members to the AIDS pandemic. This may be attributed to the stigma still surrounding HIV and AIDS and the inability of people to openly talk about these issues. However, it is notable that many of the children were aware of what constitutes sexual abuse. About 48% of the children reported being made aware of sexual abuse and what constitutes a 'good touch or a bad touch'.

3.4.7 Children's appearance and health status

- Most of the children at the NCPs were visibly destitute (more than 95%). Many had not been bathed and wore dirty and torn clothing and were without shoes at the time of the visits. However, they generally did not look malnourished, although some looked unhealthy, especially with symptoms of skin diseases. These could be attributed to poor hygiene, among other things.
- The extent of actual or suspected HIV infection among NCP children could not be determined. With a few exceptions, NCP caregivers reported that they were not aware of any confirmed or suspected cases of HIV infection among the children. This could be attributed to the stigma associated with HIV and AIDS.

3.5 Conclusions

- Most (75.8%) of the NCPs visited were well functioning, i.e., open five or more days a week and offering services in addition to food provision. Out of the 62 NCPs, only 9 (15%) were either not functioning or poorly functioning.
- There is, however, considerable diversity among the well-functioning NCPs; hence the need to further classify them. The further classification was based on a system that awarded NCPs points for having some key facilities, such as a structure with storeroom, a functioning garden, oral re-hydration salts, first aid kit, and toilet. Accordingly, NCPs were classified as good, very good or excellent depending on the availability of these facilities. In terms of this classification, 53% of the well functioning NCPs were assessed to be very good, and 38% were found to be good NCPs. Out of the 47 well functioning NCPs, only 4 (9%) were classified as excellent (see Table 2).
- The NCPs that were not functioning at all include those that were closed temporarily or indefinitely, or
had not started operating. The reasons given for not functioning included no food (2 NCPs), structure still under construction (3 NCPs), no structure - only land allocated (2 NCPs), caregivers expelled by chief (1 NCP), and caregivers locked out because of community problems (1 NCP).

### Table 2: Functionality Status of Sampled NCPS

<table>
<thead>
<tr>
<th>Classification</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Functional</td>
<td>5</td>
<td>8.1</td>
</tr>
<tr>
<td>Poorly Functioning</td>
<td>4</td>
<td>6.5</td>
</tr>
<tr>
<td>Functioning</td>
<td>6</td>
<td>9.7</td>
</tr>
<tr>
<td>Well functioning/Good</td>
<td>18</td>
<td>29.0</td>
</tr>
<tr>
<td>Well functioning/Very Good</td>
<td>25</td>
<td>40.3</td>
</tr>
<tr>
<td>Well functioning/Excellent</td>
<td>4</td>
<td>6.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>62</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

- Cohort-based assessment of the functionality of the NCPs revealed that there are significant differences by cohort. More specifically, the level of functionality was highest for NCPs from the first cohort and lowest for the third cohort (see Table 3). This is to be expected since the NCPs from the first cohort have had more time to establish themselves. The importance of the cohort was evident even in the further classification of the well-functioning NCPs, with most of the very good NCPs coming from the first and second cohorts.

### Table 3: Functionality of NCPs by Cohort

<table>
<thead>
<tr>
<th>Classification</th>
<th>Cohort 1</th>
<th>Cohort 2</th>
<th>Cohort 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not functioning</td>
<td>1 (3.3%)</td>
<td>1 (5.6%)</td>
<td>3 (21.4%)</td>
</tr>
<tr>
<td>Poorly functioning</td>
<td>1 (3.3%)</td>
<td>2 (11.1%)</td>
<td>1 (7.1%)</td>
</tr>
<tr>
<td>Functioning</td>
<td>1 (3.3%)</td>
<td>3 (16.7%)</td>
<td>2 (14.3%)</td>
</tr>
<tr>
<td>Well functioning/Good</td>
<td>11 (36.7%)</td>
<td>2 (11.1%)</td>
<td>5 (35.7%)</td>
</tr>
<tr>
<td>Well functioning/Very good</td>
<td>15 (50.0%)</td>
<td>7 (38.9%)</td>
<td>3 (21.4%)</td>
</tr>
<tr>
<td>Well functioning/Excellent</td>
<td>1 (3.3%)</td>
<td>3 (16.7%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>30 (100%)</strong></td>
<td><strong>18 (100%)</strong></td>
<td><strong>14 (100%)</strong></td>
</tr>
</tbody>
</table>

- Regional comparisons revealed that NCPs in Manzini has the highest level of functionality, followed by those in Shiselweni and Lubombo (see Table 4). The reasons for these regional differences are not immediately apparent. It is, however, important note that before February 2006 WFP was only providing food in Lubombo and Shiselweni in the context of drought relief. Also, the NCPs in Manzini were not in the remote rural areas like most of the others.
Table 4: Functionality of NCPs by Administrative region

<table>
<thead>
<tr>
<th>Functionality</th>
<th>Hhohho</th>
<th>Manzini</th>
<th>Shiselweni</th>
<th>Lubombo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not functional</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>(7.7%)</td>
<td>(0.0%)</td>
<td>(6.7%)</td>
<td>(12.0%)</td>
<td></td>
</tr>
<tr>
<td>Poorly functioning</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>(15.4%)</td>
<td>(0.0%)</td>
<td>(6.7%)</td>
<td>(4.0%)</td>
<td></td>
</tr>
<tr>
<td>Functioning</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>(23.1%)</td>
<td>(0.0%)</td>
<td>(6.7%)</td>
<td>(8.0%)</td>
<td></td>
</tr>
<tr>
<td>Well funct./Good</td>
<td>4</td>
<td>0</td>
<td>1</td>
<td>13</td>
</tr>
<tr>
<td>(30.8%)</td>
<td>(0.0%)</td>
<td>(6.7%)</td>
<td>(52.0%)</td>
<td></td>
</tr>
<tr>
<td>Well funct./V. Good</td>
<td>3</td>
<td>6</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>(23.1%)</td>
<td>(66.7%)</td>
<td>(66.7%)</td>
<td>(24.0%)</td>
<td></td>
</tr>
<tr>
<td>Well funct./Excel.</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>(0.0%)</td>
<td>(33.3%)</td>
<td>(6.7%)</td>
<td>(0.0%)</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>13</td>
<td>9</td>
<td>15</td>
<td>25</td>
</tr>
<tr>
<td>(100%)</td>
<td>(100%)</td>
<td>(100%)</td>
<td>(100%)</td>
<td></td>
</tr>
</tbody>
</table>

- The role played by the NCP caregivers in ensuring that the NCPs are functioning cannot be over-emphasized. Working under difficult conditions in most cases and without pay (except for the food rations received by some of them), they strive to provide daily meals for the OVC, basic education, and other care-related services. For many of the children, the meals provided by the NCPs are their only meals.

- Community support for the NCPs is generally poor. This not only places a burden on the caregivers, but also raises the more fundamental question of the viability and sustainability of the NCP project if the current levels of support do not improve.

- Not withstanding the challenges facing the NCPs in many communities, they play a very important role in addressing the dire situation of OVC in the country.

4.0 PHASE II: SUMMARY FINDINGS

4.1 Socio-demographic Characteristics of Surveyed Households

- The 70 households visited were mainly in the rural areas (85.1%), and were spread over eight political constituencies (Tinkhundla) in three administrative regions (Hhohho, Manzini and Lubombo).

- The number of OVC in the households ranged from 1 to 8, with an average of 3.2 OVC per household. The total number of OVC in the surveyed households stood at 382. There was an almost equal distribution of the OVC by gender, with females slightly exceeding males, at 50.5%.

- A higher proportion of the children in the surveyed households reported death of father (67.6%) than that of mother (53%). About 57% were double orphans.

- About 19% of the households reported that there has been a family member who had been sick for at least three months in the past year. A corresponding proportion (20%) reported deaths of family members in the last year. Nearly all the deaths were said to be sickness-related. Tuberculosis was the most cited cause of death.

- The households were in deep poverty, with about half reporting no source of income whatsoever. Virtually all reported that they had not received any government social grant in the last three months, with only 20 percent having received the elderly grant of E240.00 paid every three months. An overwhelming majority of the households (84.3%) reported that they had also not received any non-governmental financial support in the past three months.
4.2 OVC's Access to food and nutrition

- Food security was generally a problem among the households. However, NCP attending children had better access to food than children in communities where there were no NCPs. A higher proportion reported having at least two meals a day (74% compared to 65%). In addition, there was more certainty about the next meal among children attending NCPs. The quality of the food was also an issue, with meals served in many of the households not anywhere near balanced diets.
- Most of the households (80%) reported that there is no seasonal variation in their food situation. Those households who reported seasonal variation in food availability reported that the worst times are the winter months and during the ploughing season in summer.
- About half of the households reported that they had received food support (46%). This support was from various sources, within and outside the communities. Organizations mentioned included the Disaster Task Force, Lutheran Development Federation, religious organizations, Save the Children, Indlunkhulu (Chief's field/communal field), NERCHA, and Red Cross.

4.3 OVC's Access to Medical Care

- Although OVCs' access to medical care was generally poor, OVC enrolled in NCPs had better access to medical care than those living in communities without NCPs. Caregivers often intervened to solicit medical assistance for the children enrolled at the NCPs.
- Rural Health Motivators (RHMs) were reported to the most accessible source of health care support. More than 90% of the households reported receiving medical care supplies and advice from RHMs. However, it was reported that they tend to focus on older and very sick members of the community. This, notwithstanding, there was a good working relation between NCP caregivers and RHMs in helping children to access medical care.
- The type of health services provided by the RHMs were said to be very limited, with most households reporting simple check up visits where medical advice is provided and basic medicines are provided. Other services provided by RHMs include the supply of protective gloves, disposable nappies and body lotions.

4.4 OVC's Access to Education

- School enrolment was slightly higher among children in communities where there are NCPs. Whereas 80% of OVC of school going age were enrolled in school in communities with NCPs, 73% of OVC were attending school in communities with no NCPs. Most of the children not attending school cited financial constraints for being out of school.
- NCPs were identified as important sources of pre-school education for OVC in communities where they were operational.
- Besides formal schools and NCPs, churches (“Sunday Schools”) were said to play an important role in the provision of basic education and learning to children.
- Most of the children enrolled in school in the households surveyed were benefiting from the Government educational fund for OVC (73%). Other organizations that were said to be providing educational support for OVC included World Vision, Save the Children, Tibiyo TakaNgwane, and Catholic churches.
- NCP caregivers and RHMs played a critical role in helping children to enrol in school. This was confirmed by the head teachers that were interviewed, who stressed the role played by NCP caregivers.
and RHMs in bringing children out of invisibility and ensuring that they had the required documents for school enrolment. Other important players in the enrolment of OVC in schools were the guardians/surviving parents and members of the Chief's Inner Council.

- All the households visited lamented the fact that the educational support they received was only for school fees (partial payment); no support was provided towards school uniforms and shoes. This was also the issue raised by all the head teachers visited.

### 4.5 OVC’s Access to Psychosocial Support

- There was generally a lack of emotional, spiritual, psychological support services for OVC in all the communities visited. Less than half of the households (44%) reported that they receive such services.
- The most frequently cited sources for psychosocial support were the nearby churches (55%). The other providers of psychosocial support were said to be the RHMs, NCP caregivers, home-based caregivers, and neighbours, in that order.
- None of the households reported receiving any legal/child protections services or support. However, the majority acknowledged the existence of child protection committees (*Lihlombe lekukhaletla*) in their communities, although their establishment was said to be a recent development. This seems to indicate that the said committees are not yet operational or their roles are not clearly understood in the communities visited.
- Generally, OVC were poorly provided for in terms of clothing in all communities. Less than half of the children (42%) were said to have at least two sets of clothes. Even fewer had a pair of shoes (32%). However, the majority (60%) had a blanket to sleep with (including shared use).
- OVC enrolled in NCPs appeared to be somewhat better cared for than those in communities where there were no NCPs. This could be observed in the children's physical appearance.

### 4.6 Factors affecting Functionality of NCPs

- *Involvement and support by the local leadership structures.* Involvement of the local authorities offered a number of advantages to NCPs including the mobilization of the communities to participate in NCP activities, such as construction of structures and securing of land for NCP use and the recruitment and supervision of caregivers.
- *Involvement, participation and ownership of NCP by community members.* Associated with the previous factor, the functionality of NCPs tended to be strongly associated with community involvement. This was in turn affected by the manner of introduction of the NCPs and the communities’ level of awareness about what NCPs offer and what the role of the community should be. Whilst the level of community support for NCPs was generally poor, the situation was even worse in communities where NCPs were not functioning or poorly functioning.
- *Presence of NCP management committees.* Most of the well functioning NCPs had management committees that were responsible for overseeing the activities at the NCPs. These committees monitor the activities of the caregivers and provide assistance in running the NCPs. In communities where there were no NCP management committees the caregivers were left on their own to run the NCPs, with great difficulties. Also, some of the caregivers would not discharge their responsibilities diligently, such as often being absent when it was their turn to work at the NCP.
- *Absence of chieftaincy disputes/unity of purpose in community.* Besides food problems, community
disputes are the common denominator among non-functioning NCPs. In such communities, factions in the community who want to have their chosen caregivers to run the NCPs often harass the caregivers.

- **Regular supply of food.** The provision of food to the children is the most important activity at the NCPs, without which the NCPs do not function. It is also what motivates the children to attend and the parents/guardians to send their children. The NCP caregivers and communities made it clear that the NCPs would cease to operate if there was no food; indeed most of the non-functional NCPs visited cited lack of food as the reason for their situation.

### 4.7 Observations on Non-UNICEF Supported NCPs

- The operations of non-UNICEF supported NCPs were, by and large, similar to those supported by UNICEF, in that their functionality or otherwise primarily depended on the availability of food, commitment of the caregivers and community support. NCP caregivers concerns were similar, focusing on their daily struggles to provide care for the OVC, the lack of incentives, and lack of community support.

- The main differences observed related to the quality of the NCP structures of the AMICAAL supported NCPs in the urban areas. There was simply no comparison, with the urban NCPs made of permanent materials and offering a more conducive environment for NCP activities. Also, more importantly, monitoring visits were reportedly more common among AMICAAL supported NCPs.

- The situation of non-UNICEF supported NCPs in rural areas was generally more precarious, with shortages of food and other materials not uncommon. Shortages of food were mostly reported in communities not covered by WFP.

### 4.8 Care for OVC in Communities without NCPs

- Various initiatives were used to provide care and support to OVC in communities without NCPs, including the following:
  - Allocation and ploughing of fields for OVC at the chief’s kraal;
  - Reliance on food supplies and other materials supplied by the Disaster Task Force, donor organizations and religious organizations to poverty and drought-stricken communities;
  - Although this was rare, some community members (especially women) assume guardianship of the OVC; and
  - Some religious organizations, especially from the Catholic Church, operate orphanages and schemes to provide assistance to OVC.

- Notably, these initiatives were also found in communities where there were NCPs. However, it was evident that these initiatives were not managing to reach out to OVC in the same way that NCPs do.

### 4.9 Communities’ Views on Issues of OVC and NCPs

- All the communities surveyed were unanimous in the view that the numbers of OVC were high and increasing, and that HIV/AIDS-related deaths were the major contributing factor.

- The major challenges pertaining to OVC facing the communities related to food insecurity, shortage of clothing, and poor access to medical care and education (inadequacy of the educational grant from Government).

- Physical and sexual abuse of OVC was generally not perceived as a common phenomenon. It was
difficult to determine whether this was simply due to denial or it was the reality. Most communities
surveyed did not view physical and sexual abuse of OVC as a major welfare challenge.

- Members of communities where there were NCPs were in agreement that they played a critical role in the
care of OVC, and expressed the need for the number of NCPs to be increased. The situation of OVC was
said to have improved considerably after their establishment.

- With a few exceptions, members of communities visited (especially in the rural areas) were opposed to
institutional care for OVC; such structures were viewed an alien to the Swazi way of life and likely to
have negative effects on the development of children. This attitude may be attributed to the fact that most
institutions caring for OVC are based in the urban areas.

- In communities where there were no NCPs, there was generally poor understanding of what NCPs were
and how they operated. Not only was there lack of knowledge about NCPs, in a few communities there
was opposition to the NCP project. It was claimed that NCPs were likely to make OVC lazy and
disrespectful towards their surviving parents/guardians because they were assured of meals outside the
home. However, the majority of communities without NCPs expressed the need for NCPs in their
communities.

- Poor access to water (especially in the Lowveld) and widespread poverty were regarded as the major
welfare challenges in most communities. It was said that these factors also negatively affected
community efforts to address OVC problems, including providing material support to NCPs.

4.10 Conclusions

- NCPs are playing a critical role in the care and support of OVC in the country, and there is overwhelming
support for their increase to cover all parts of the country. Despite the problems that NCPs face in the
various communities, as a relatively new strategy for addressing challenges facing OVC, they are by and
large viewed as effective in providing care and support to OVC.

- The functionality of NCPs depend on various factors including the following: regular supply of food and
other essential materials, involvement of the local leadership in NCP affairs, community support, and the
establishment of community-based management/monitoring structures.

- There is widespread lack of knowledge of the NCP concept, especially in communities where there are
no NCPs. This contributes to the generally poor support from communities, who tend to view NCPs as
entities from without (for example, as UNICEF structures); not as an integral part of their communities.

- Comparative analysis revealed that OVC in communities with NCPs tend to fare better in terms of
welfare than their counterparts in communities without NCPs. More specifically, former have better
access to food, health care, education and overall care and support.

- However, in all communities visited OVC experienced problems related to adequate clothing, poor
access to medical care, and the inadequacy of the educational grant from government to cover all the
requirements for schooling, such as uniform and shoes.

- There is generally a lack of psychosocial support for households with OVC even in communities with
NCPs. Religious organizations were reported to be the primary sources of psychosocial support, followed by RHMs.

### 5.0 RECOMMENDATIONS

- The NCP initiative should be expanded to ensure that NCPs are established in all parts of the country. At the same time there is a need to strengthen the capacities of the NCPs including additional training for the caregivers. They must not only meet physical and social needs, but must be able to meet OVC's psychological, emotional, and spiritual needs as well as development needs i.e. life skills and livelihood skills education.

- Dialogue with all stakeholders especially the community leadership should be enhanced and continued in order for awareness raising on the plight of vulnerable children and on the benefits of having NCPs as an entry point for improved service delivery. A communication strategy should be developed to address the limited awareness and ownership in the communities, to mobilize more support for NCPs and to recognise them as community structures for children.

- Community-based monitoring of the NCPs should be strengthened to ensure availability of reliable data that will inform policy and targeted interventions.

- Support mechanism for NCP caregivers such as the WFP-supported food for work programme need to be expanded to cover all NCPs. Communities should explore initiatives such as caregiver associations that promote livelihood projects that support caregivers. NCP caregivers should also be empowered to be able to voice their challenges to the leadership within their communities.

- The Nation particularly is encouraged to mobilise second-hand clothes to be distributed for the children at the NCPs so that they would be adequately clothed especially during the winter season.

- Efforts must be made to ensure NCP access to improved water sources. This would spare the NCP caregivers from spending long periods trying to secure water, would ensure sanitation and hygiene for both children and caregivers, and facilitate establishment of functional NCP gardens which would supplement the feeding programme.
ANNEXTURES
ANNEX 1: NCP STATUS ASSESSMENT FORM

Date and time of visit: day/month/year_____________________________ Time: a.m./p.m/_________

Region_____________________________________ Inkhundla:________________________________

Name of NCP:__________________________________________

Name of Respondent (Care Giver): __________________________ Age and Sex:________________

Registration
Year and Month of NCP Establishment: ____________________________ Cohort: I, II, III

Total Number of children enrolled.
Total: M: F:
Number 0-5 yrs: M: F:
Number 6-12 yrs: M: F:
Number 13-18 yrs: M: F:

Total number of caregivers volunteering at the NCP:_____________
How many of these caregivers have completed standard 5?_____________

Is the Standard Register Book Available? Yes/No
If yes, is it filled? Yes/No
If yes, is it up to date? Yes/No

NCP Functionality
Is the NCP open at the time of visit? Yes / No
Is the school open today? Yes / No
If the NCP is not open, what is its status?
i) Only closed for today/this week
   ii) Temporarily closed
      (Since __________ , planned re-opening date/month _________)
   iii) Closed with limited possibility of re-opening
   iv) Other, specify_____________________

What are the opening hours of the NCP?
On which days of the week is the NCP open? Mon. Tue. Wed. Thu. Fr. Sat. Sun.
Number of children present at the time of visit: M: _________ F:
How many children who are attending school, come to the NCP in the afternoon? _____________
How many children who are attending school, come to the NCP during weekends? _____________
How many children who are attending school, come to the NCP during holidays? _____________
How many school age children are not-in-school in this NCP?

Services:
Food:
Is food being served today? Yes/No
If no, why?
i) No food
ii) No water
iii) No caregivers to cook
iv) No wood
v) Other, specify_____________________

SWAZILAND - 2006
How many days a week is food served? One/two/three/four/five/six/seven
How often is food served per day? Once a day/twice a day/more
Is food served during school holidays at the NCP? Yes/No

Type of food prepared and number of days per week they are served:

i) Breakfast/snack
   Corn Soya Blend: 5-7 days a week/3-4 days a week/1-2 days a week/rare
   Other, specify__________: 5-7 days a week/3-4 days a week/1-2 days a week/rare

ii) Staple:
    Maize Meal: 5-7 days a week/3-4 days a week/1-2 days a week/rare

iii) Relish:
    Beans: 5-7 days a week/3-4 days a week/1-2 days a week/rare
    Vegetables: 5-7 days a week/3-4 days a week/1-2 days a week/rare
    Meat: 5-7 days a week/3-4 days a week/1-2 days a week/rare

Where does the food come from, and how regularly?

i) WFP distributions
   Food Type: Maize Meal/ Corn Soya Blend/Beans/ Sugar/Oil/Meat/Vegetable
   Regularity: daily/weekly/monthly/quarterly/yearly

ii) NERCHA donations
   Food Type: Maize Meal/ Corn Soya Blend/Beans/ Sugar/Oil/Meat/Vegetable
   Regularity: daily/weekly/monthly/quarterly/yearly

iii) Community donations/Community Gardens
   Food Type: Maize Meal/ Beans/ Sugar/Oil/Meat/Vegetable
   Regularity: daily/weekly/monthly/quarterly/yearly

iv) NCP vegetable gardens/livestock
   Food Type: Maize/Beans/Vegetable/meat/egg
   Regularity: daily/weekly/monthly/quarterly/yearly

v) Other source: ___________________
   Food Type: ___________________
   Regularity: daily/weekly/monthly/quarterly/yearly

Is there a garden at the NCP? Yes/No
If yes, how large is the size of the garden compared to a soccer pitch?
Half or more/Third/Less than a third
Are there crops on the garden on the day of visit? Yes/No
Does the NCP keep livestock? Yes/No
Does the NCP (caregivers) sell the food (vegetables/livestock)? Yes/No
Comments on quantity sold/income generated:_________________________________

Where is the food stored? _______________________
Is the food securely and safely stored? Yes/No
Is raw food stored in a hygienic manner? Yes/No

Other Services and Activities
In a typical day, what activities are undertaken at the NCP, and how frequently?

i) Play activities (soccer, netball, games etc.)
   – Yes/No Daily/weekly/monthly/quarterly
   If yes, please give examples:

ii) Drama, and singing
   – Yes/No Daily/weekly/monthly/quarterly
   If yes, please give examples:

iii) Teaching and story-telling (including bible stories)
   – Yes/No Daily/weekly/monthly/quarterly
   If yes, please give examples of topics:

iv) Psycho-social counselling for children/listening to children individually
v) Through the above activities, is HIV prevention addressed?
- Yes/No Daily/weekly/monthly/quarterly

vi) Through the above activities, is child abuse and protection issues addressed?
- Yes/No Daily/weekly/monthly/quarterly

Health
ORS: Does the NCP have ORS packets? Yes/No
If no, why? Never had any/finished all
Have any of the caregivers been trained on how to use ORS? Yes/No

First Aid Kits: Does the NCP have a First Aid Kit? Yes/No
If no, why? Never had any/finished all
Have any of the caregivers been trained on how to use it? Yes/No

Water and Sanitation:
Source of water: Tap or borehole/River or dam/Water tank (500 litre/5,000 litre)/Other: ________________
How long does it take to reach the water source from the NCP?
Is the water safe/unsafe?
If unsafe – what actions are taken to make it safe? Boiling/Use Jik/Other, specify______________/nothing
Is there a 5000-litre water tank?
If yes, does the caregiver know whom to contact to fill up the tank? Yes/No
When the water tanker brings water, is there a charge? Yes/No
If yes, how much? ________________

Hand washing before eating by children? Yes/No
Refuse disposal – indiscriminate/refuse pits/toilet/others, specify______________
If there is a toilet, was it constructed by the community? Yes/No, Other, specify______________

If there is no toilet, why wasn't the toilet constructed?
  i) Materials not delivered to NCP
  ii) Materials still in storage in community
  iii) Part of the Materials used for NCP structure
  iv) All or part of the materials used by community member for private home
  v) Other, specify______________

NCP Structures:
Is there an NCP structure? Yes/No
If no, why is there no structure?
  i) Materials have not arrived
  ii) Materials arrived but in storage
  iii) Materials gone missing, specify which______________
  iv) No community labour to build the NCP
  v) Other, specify______________
If yes, how many rooms does it have?
Was this structure built by the community? Yes/No
What is the structure made of? Clay/Wood/Brick/other, specify______________
Is there a door on the structure? Yes/No
If yes, is the door lockable? Yes/No
What type of floor does the structure have? Earth/mixture of sand & cow dung/Cement/Other, specify______________
Does the NCP have a roof? Yes/No
If yes, what type of roof? Corrugated metal/Tiles/Other, specify______________
ANNEX 2: IN-DEPTH INTERVIEW WITH NCP CAREGIVERS

Date of Interview: day/month/year__________________

Inkhundla: ___________________________

Name of NCP:________________________

Name of Respondent (Care Giver): _______________Age:_______ Sex:__________

Period served as caregiver: Since (month/year) ______________ till present
Length of service: Less than 6 months/6-12 months/1-2 years/More than 2 years

Interview

Enrolment/Attendance of children
- In this community, who identified the children as orphans and vulnerable children (OVC) to be registered at the NCP? Please explain the selection process.

- Do you think there are OVC in this community that are left out/un-enrolled in the NCP? If yes, how many additional OVC do you think need to be enrolled? What are the reasons for them not being enrolled?

- How well do you know the individual children's family situation?

- If any child is absent for a couple of days, what would you do?

- What are the reasons for some registered children not attending the NCP regularly?

- Why are some of the OVC at this NCP out of school?

- Approx. how many NCP children have returned to school since the NCP establishment? How did it become possible to return to school? Who helped them in the process to access the education grants?

- Do you have any idea how many of the children have birth registration document? How about the immunization card?

• Care givers motivation and external support
  - Why did you decide to be a caregiver? How did the community select the caregivers?

  - Why have you continued volunteering as caregiver?

  - How are your family members feeling about your being a caregiver?

  - Having been a caregiver, have the community members' attitudes towards you changed?

  - What are the difficulties you face in being a caregiver?

  - Were there any caregivers that dropped out? If yes, how many dropped out? Why was that?

  - How do the community support/manage the NCP? Is there a mechanism/institution for this e.g. NCP committee/OVC committee?
- What kind of services and support are provided by outside organizations and agencies to your NCP?

- Do you have any linkages with RHMs and Clinic outreach services, or others (specify) to improve the health and nutrition status of children? Please explain how they are helping?

- Do you know or suspect any child in this NCP having HIV? If yes, are any service provided to them? How is the stigma/discrimination from the community and from other children?

- Do you have any linkages with community child protectors/community police/school teachers/counsellors to address child abuse and other sensitive cases?

- Are there any areas that you feel more external support is required?

- Are there any areas that you feel you would need more knowledge or skills? If yes, what area is that?

- What training did you receive so far? (Ask each care giver who attended different trainings, e.g. basic health and first aid, psycho-social support, and others)
  - What did you learn from the training? (This is an open-ended question, not restricted to the topics they learned).
  (Background information:
  Topics covered by health training: Immunization / Growth monitoring / Nutrition Pneumonia/ Diarrhoea /Hygiene
  Topics covered by psycho-social support training: symptoms child may show in bereavement and grief, types of abuse and symptoms of an abused child, referral, child rights)
  - How are the knowledge and skills helping you in fulfilling your role as caregiver?
  - Were you able to help a child using the knowledge and skills from the training? How?
  - Did you refer any child to get professional services/help? What danger sign did you recognize at that time? Who did you refer the child to?
  - Did the things you learnt change your personal life and attitudes?

- Questions directed to the (ex-)caregivers or community leaders, where NCPs are temporarily closed or closed for a long time
  - What were the reasons for closing down?
  - What do you think is required to re-open the NCP?
  - Were the constraints you and the NCP were facing discussed among the community members? If yes, were any actions taken since then?
  - What happened to the children who were previously enrolled?
ANNEX 3: IN-DEPTH INTERVIEW WITH NCP-ENROLLED CHILDREN

Date of Interview: day/month/year__________________

Inkhundla:_________________________

Name of NCP:_____________________

Respondents' Age:_______ Sex:__________

* Respondent should be over six years old.

Period enrolled in NCP Since (month/year) ____________ till present

Length of enrolment: Less than 6 months/6-12 months/1-2 years/More than 2 years

• NCP experience
  - Do you like coming to the NCP?
  - Who can come to the NCP?
  - What do you do here?
  - What do you like best?
  - Before the NCP started in this community, can you remember how were you spending the day (who did you play with, where did you go during the day)?
  - When you or your brother/sister are sick, who do you ask for help?
  - When you feel very sad or very troubled, who do you ask for help?
  - Except the meal taken at this NCP, how many meals do you have a day?
  - (If there is a NCP garden/livestock) Did you learn how to grow vegetables/keep the livestock? Do you have a garden/livestock at home?

• School and NCP
  - Do you go to school?
  - (If not,) how many years have you completed at school? Why did you stop/ why you are not attending school now?
  - Is anybody helping you to find out ways for you to go to school?
  - (For school-going children), do you come to the NCP after school, or do you come to the NCP only when school is closed?
  - What do you learn at school, and what do learn at the NCP? What do you think is the difference between school and NCP?

• Relationship with caregivers
  - Do you like the caregivers? Why?
  - Are they different from school teachers?
- What do they do for you?
- When you do something wrong or misbehave, what do they say?
- When you do something good, what do they say?
- Did they tell you about the HIV?
- Did they tell you about the difference between “good touch” and “bad touch” to your body by other people? Do you know there are body parts that should not be touched by others?
ANNEX 4: GUIDING QUESTIONS FOR FOCUS GROUP DISCUSSION/ COMMUNITY MEETING

- What are the general problems/challenges in the community (including food security)?

- (approx.) How many OVC live in the community? What is the situation concerning the OVC in the community (general perception of the trend of AIDS related deaths, number of OVC, is it increasing, getting serious etc)?

- What has been done/has been discussed so far for them by the community members (including the process towards establishing the NCP, chief's garden, etc.)?

- Does the community have any institutions (committees) that are responsible for the community action?

- Who is responsible for the overall coordination, leading the process etc.?

- What role is the NCP playing? Before and after establishment of NCP, how do you think the situation of the children changed? If the NCP close down, what will happen to the OVC?

- What other solutions do you think might be possible other than the NCP to provide care and support for the OVC?

- Which external agencies/organizations are working in the community? What services do they offer? (including questions about Kagogo centres of NERCHA, if exists)

- Did any of the community members receive training from external agencies/government, e.g. NERCHA, DPM, UNICEF, MOHSW? What was the training, how many people trained, and duration of training?

- What kind of support does the NCP need to be sustainable for long term?

- (If the NCP is not functioning well), what were the constraints faced.
SECTION I: DEMOGRAPHIC INFORMATION

The following questions are directed to the household head.

1-1 Since when did you become the household head? (Q. for Head)
1-2 Before that time mentioned in 1-1, who was the household head?
1-3 Has any family member been sick for at least three months during the past one year (chronically ill)?
1-4 Please list all family members who died during the last year (relationship to the head, age). What were their main causes of death?
   (This is a very sensitive question, especially if the head is a child. If the RHM or other community members know well about the household, the question can be avoided.)

SECTION II: HOUSEHOLD INCOME/FOOD SECURITY

2-1 How much income did the household receive in the last 3 months (in Emalangeni:__________ )?
2-2 Did the household receive any social grants in the last 3 months? (Elderly, Education, etc.)
2-3 Did the household receive any other financial support (for example, support from relatives in town) in the last 3 months?
2-4 How much did the household spend in the last 3 months (in Emalangeni:__________ )?
2-5 Does the number of meals/amount of food vary seasonally? Which are the months of the year with the lowest and highest amount of food in your household?
   Lowest:
   Highest:
2-5 Did the household receive any food support in the last 3 months?
   If yes, from which organization/whom?

SECTION III: HEALTH

3-1 If the household has chronically ill persons (1-3) or had deceased members (1-4), who was the main person in the household who provided care?
3-2 Did/does the household receive any medical care/home-based care services?
   If yes, please explain who visited and what types of services were provided.
3-3 Did/does the household receive any medical supplies or medicines? If yes, please explain from whom/which organization and what.
3-4 Did/does the household receive any emotional, spiritual, psychological support services?
3-5 Did/does the household receive any legal/child protection services or support e.g. about succession planning, appointing guardians for children
SECTION IV: EDUCATION

Please fill in the table (sheet 2) in the beginning.
The following questions are directed to the household head.

2-1. If any of the children are receiving any other educational support except for the MOE Education Grant, please explain which organization is providing what kind of support (School uniform, ad hoc financial aid, etc.)

2-2. If any of the household children are receiving MOE education grant, who played the major role in the application process? Please specify.

2-3. Besides schools and NCPs, what other educational opportunities do the children in the household have? (e.g., Church Sunday schools, Sebenta, foot ball/sporting teams)

2-4. Ask the children the following questions:

- When you or your brother/sister are sick, who do you ask for help?
- When you feel very sad or very troubled, who do you ask for help?
HOUSEHOLD SURVEY OF CHILD-HEADED HOUSEHOLDS/VULNERABLE OVC HOUSEHOLDS

SECTION I: DEMOGRAPHIC DATA

<table>
<thead>
<tr>
<th>NAME</th>
<th>1-1. RELATIONSHIP to HEAD (01-Head, 02-Wife/Husband, 03-Son/Daughter, 04-Grandson/Granddaughter, 05-Brother/Sister, 06-Other relative/Adopted, 07-Not related, 08-Other)</th>
<th>1-2. Age</th>
<th>1-3. Gender (01-Male, 02-Female)</th>
<th>1-4. Natural Father’s Status* (01-Alive + whereabouts known, 02-Alive + whereabouts unknown, 03-Dead)</th>
<th>1-5. Natural Mother’s Status* (01-Alive + whereabouts known, 02-Alive + whereabouts unknown, 03-Dead)</th>
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* I-4, I-5: Ask this question only to the household head who is under 18 years old.
## SECTION II: HOUSEHOLD INCOME/FOOD SECURITY

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<tr>
<th>S/N</th>
<th>II-1. How many meals per day did each household member have last month?</th>
<th>II-2. For each child member, does he/she have a blanket to sleep (including shared use)?</th>
<th>II-3. For each child member, does he/she have a pair of shoes?</th>
<th>II-4. For each child member, does he/she have two sets of clothes?</th>
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### SECTION III: EDUCATION DATA

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<th>S/N</th>
<th>III-1. School enrollment (Please answer for children 6-18 years old: 01-In-school, 02-Out-of-school)</th>
<th>III-2. School Name</th>
<th>III-3. Grade/Form</th>
<th>III-4. Is the child receiving MOE school grant? 01-YES 02-NO</th>
<th>For all members: III-4. Highest level completed 01: not at all, 02: lower primary (G1-2), 03: upper primary (G3-7) 04: Secondary (F1-3, 05 High School (F4-5), 06: A level (F6), 07: Higher</th>
<th>III-5. Period being out-of-school (ex. How many years or months?)</th>
<th>If 02 for QIII-1: III-6. Reason for being out-of-school (01-financial, 02-house work/labour, 03-unwilling/uninterested, 04-health reasons, 05-others. Please specify)</th>
<th>III-7. NCP (01-attending, 02-not attending)</th>
<th>III-8. Reason for not attending (01-financial, 02-house work/labour, 03-unwilling/uninterested, 04-health reasons, 05-others. Please specify)</th>
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ANNEXURE 6

REPORT ON

THE NCP ASSESSMENT
CHILDREN AND YOUTH
CONSULTATION WORKSHOP

HAWANE RESORT

28 - 30 SEPTEMBER 2006
Introduction

The workshop was aimed at bringing together children and youth who are orphans and/or vulnerable so as to get their views on what goes on in the Neighbourhood Care Points (NCP). This was conducted as part of the Assessment of NCP that was carried out by UNICEF and the workshop was to enable the children to discuss further on the recommendation of the study.

The participants were orphans and vulnerable children aged between 12 to 18 drawn from fifteen communities in the Hhohho, Manzini and Lubombo Regions. There were a total of 27 children comprising of 13 boys and 14 girls. Some of the participants were from communities that have NCPs and were attending NCPs, while others were not attending because either the NCP was too far or there was no NCP at all in their communities.

Objectives of the meeting:
1. To present findings of the Assessment of Neighbourhood Care Points.
2. To discuss further the recommendations of the study and find out from the children what kind of support should an ideal NCP offer.
3. To find out if everything in the NCP was running smoothly or what sort of problems they encounter in the NCPs.

Day One 28 September 2006 – Thursday

Participants were registered 17:00 onwards and had dinner before the official opening of the workshop.

Orientation

The workshop started with a word of prayer and welcome remarks. The objectives of the workshop were discussed as shown above.

Getting to know each other:

Different games and energizers were used to introduce participants to each other. However even after several energizers and games the children were still closed and not free to talk to each other.

The participants then formulated their ground rules as follows:
1. Respect one another
2. do not look down upon others
3. Love each other
4. Do not steal
5. Do not gossip about others
6. No fighting
7. do not temper with facilities around
8. do not make noise
9. should have prefects

Day Two 28 September 2006 – Friday

Recap and Prayer

After a song and prayer, the participants were asked to say what went well the previous day and what did not work well for them in the workshop.
Life Skills Empowerment through Experiential Learning

This was necessitated by the fact that the participants seemed tense and closed. Those who were from the same communities were clinging to each other and they were not mixing well with others. Facilitators felt there was need for more of the outdoor activities. Indeed the power of play was observed as the children started to talk to each other as they worked as groups to accomplish the given tasks in each of the different games:

The games done:
- The trust fall
- Circle of confidence
- Follow the leader
- Surfing the web
- Rabbits and houses and earthquake

These activities were done in order to raise the participants’ self-esteem, to build trust among them and to create cohesion in the group.

The game, surfing the web also helps in developing self-awareness, critical thinking and decision making.

Presentation of the Report on the Study: Assessment of NCPs.

The participants were taken through the key findings of the first phase and second phase assessment, however, the recommendations were not discussed to avoid preempting the participants on the exercise they were to do as discussed in the objectives of the workshop.

After the presentation, there was an energizer to promote concentration: Go and buy OMO. This energizer seemed very interesting for the children and there was quite a lot of laughter and interaction among them.

Challenges Faced by the children as OVC.

The facilitators asked the pupils to share some of the challenges they face due to the fact that they had lost their parents. It was emphasized that they should also think of other children they know who are in the same situation, as they think of these challenges in the same situation they know, and say the challenges they face.

These are the challenges that came out from the plenary session: The talking ball was used and each child would throw the ball to another one when they had shared with the group, so that they could also share.

- Lack of food in their homesteads.
- Lack of medical care when sick due to financial constraints. The children also do not know the RHMs in their community; so they do not go to them and sometimes the RHMs do not have adequate medication.
- No clothing
- No money for bus fare to school, which causes them to walk long distances (about 3-4 km). This results in them arriving at school late and tired. They are beaten by teachers when late if this late coming persist they are expelled from school.
- No money for school fees.
- Dropping out of school due to lack of funds.
They leave home very early while it is dark for school and only get home from school late in the evening when it is dark again. This exposes them to danger and they are usually very afraid.

- No school uniform.
- Lack stationary and books, which results in teachers beating them.
- The illness of their parents, as a result the children have to take responsibilities of caring for their siblings.
- Lack of safe drinking water.
- Sometimes there is no soap for washing and bathing.
- Some have very poor housing structures.
- When the NCP is closed on weekends or during the holidays, some children have no food at all to eat.
- Neighbours now complain when the children keep on asking for food.
- Irresponsible relatives who dump their young children in the Child-Headed homestead to continue with their promiscuous ways.
- Heading families with no adult supervision and support – very frustrating.
- Government grant has been reduced and the school head teachers demand the balance from the OVC and have told them that they will not allow them to school in October if the balance is not settled.
- Children from child-headed homestead have no one to guide, protect and even discipline them.
- Relatives take away the properties left by the parents of the orphans.

Group work
In preparation for the group work, a game to encourage teamwork and cohesion was done: Holding hands (standing in a circle) and not allowing any person to break the chain by holding tightly to each other.

Participants then formed three groups randomly, using the game: there is a fire on the mountain.

Through group work, they were supposed to discuss the following:
1. What are some of the challenges they face at the NCPs.
2. What Improvements could be made to enable NCP to effectively meet the needs of children

Issues raised by the groups:
Challenges faced at the NCPs:
- Caregivers distribute some of the food packages amongst themselves and their families and friends, especially the 'nice' food such as rice, chips, juice and meat.
- Children of the caregivers get second helping of the food.
- Treatment by caregivers is not fair. Their children get special attention and favour, especially when there are conflicts amongst the children.
- There is no safe drinking water and they sometimes run out of water.
- No variety on the menu.
- Caregivers do not show interest when the children tell them their concerns/problems.
- Some caregivers revenge by ill-treating the child if they had conflicts with their parents or guardians.
- NCPs do not effectively follow-up the issue of registering the children to get government grant at school (formal).

Improvements that could be made to enable NCP to effectively meet the needs of children
- NCPs should cater for all the basic needs of the children e.g. enough food, clothes, medication when sick and lodging facilities for those who have no homes.
Caregivers should show unconditional love and acceptance of the children, as if they were the children's parents.

There should be a variety in the menu including vegetables and meat instead of the beans and corn Soya everyday.

There should be recreation facilities for games such as soccer, netball, tennis, volleyball and some swings.

Caregivers should listen with empathy when the children tell them their problems and make means to help them.

Children would appreciate to have three meals per day when it is not a school day.

Caregivers should educate and empower the children with behaviour and livelihood skills. They could form partnerships with other caregivers in the community such as the LLs and the RHMs and start up income generating projects that will support the children.

Caregivers can make gardens or rear chicken for food and also selling. The children (OVC) should be actively be involved and take turns in working in the projects.

Caregivers should be faithful and not take the OVC food for themselves.

Community leadership should monitor the running of the NCP so that the food is used for the benefit of the OVC.

NCPs should be open everyday.

Caregivers should be given financial incentives so that they are motivated in their work and they are not tempted to steal the food. They are usually needy themselves.

NCPs should provide OVC with soap rations.

There should be playing toys.

Caregivers should be trained on personal hygiene and clean food handling. They should be clean at all times, so that children can find it easy to eat the food they cook.

As time goes on, if funds are available, community children’s villages should be built in order to house those children whose homes have fallen and they have no parents.

There should be safe drinking water at the NCPs.

More RHMs should be available at the NCPs because there are many sick children there.

Those areas without NCPs also need to have them.

NCPs should be kept clean, so soap should be provided for this purpose.

Caregivers should keep confidentiality when children have disclosed certain issues to them.

Caregivers should report children’s problems to the chiefs, may be the chiefs could make means to meet the needs of the children. E.g. sell cows to cater for the needs of the children.

Caregivers should also be lay counselors and provide support and refer issues beyond their scope to relevant stakeholders in the communities such as the LLs.

Day Three 28 September 2006 - Saturday

Prayer and Recap

After song and prayer, the children were asked to evaluate the previous day activities.

Debriefing Session

Some time was spent assuring the children that what they had discussed during the workshop would be kept in confidence. They were also assured that this was not going to be shared with the caregivers. However the aim of the meeting was to inform the stakeholders, specifically UNICEF on improvements that need to be made, to ensure that NCPs provide adequate support for the children. This was necessary, as some of the children may have left the meeting worried about what might happen to them when the caregivers got to know the things they shared in the meeting. Actually, one participant expressed that fear after the plenary session on Friday.

Observations and comments by Facilitators:
At first, when the children came they were closed up and withdrawn. The programme had to be delayed in order to make them open up. Experiential games were done and the power of play was observed to be effective as the children started to interact and talk freely.

As the children related the problems they face, it became apparent that these children are really vulnerable and living under difficult conditions, especially those that head homesteads. However, they showed that they have hope for the future. They have not given up.

From the discussions, it transpired that these children need adult guidance and they expressed their need to be empowered with life skills, both behavioural and livelihood in order to survive and protect themselves. A workshop for life skills education is necessary for these children.

Those children who are not in school, expressed a strong desire to go back to school.

The children are willing to take responsibility for their welfare, e.g. involvement in income generating projects.

There is need to train caregivers/cooks with basic Counselling skills, so that they are able to listen effectively to children’s concerns.
Unite for Children
Unite Against AIDS