

PHASE 2 REPORT

PROTECTING THE RIGHTS OF ORPHANS AND VULNERABLE CHILDREN AGED 0 – 6 YEARS

A South African Case Study

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Acknowledgements

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Background Reports

This report draws on the following reports on the three study sites:

- Protecting the Rights of Orphans and Vulnerable Children Aged 0 – 6 Years: the Masiphumelele Case Study, August 2005
- Protecting the Rights of Orphans and Vulnerable Children Aged 0 – 6 Years: the Nkandla Case Study, August 2005
- Building a safety-net to support child well-being in Hammanskraal and Temba, August 2005

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ACRONYMS

AFSA	AIDS Foundation of South Africa
AI	Appreciative Inquiry
ART/ARV	Antiretroviral Therapy/Antiretroviral
CBO	Community-Based Organisation
CCCC	Community Child Care Committee
CHW	Community Health Worker
CRC	Convention on the Rights of the Child
CSA	Centre for the Study of AIDS
DOTS	Directly Observed Therapy Short-course
ECD	Early Childhood Development
ECDNA	Early Childhood Development Network for Africa
ELRU	Early Learning Resource Unit
EPWP	Expanded Public Works Programme
ESAR	Eastern and Southern Africa Region
FBO	Faith-based Organisation
FCG	Foster Care Grant
FCM	Family and Community Motivator
FF	Family Facilitator
HBC	Home-based Carer
HCBC	Home and Community-based Care
HRAP	Human Rights Approach to Programming
IECDI	Integrated Early Childhood Development Initiative
IMCI	Integrated Management of Childhood Illnesses
LPA	Local Programme of Action for Children
MDF	Masiphumelele Development Forum
MSF	Multi-sectoral Stakeholders Forum
NIP	National Integrated Programme
NGO	Non-Governmental Organisation
NPO	Non-Profit Organisation
ORC	Office of the Rights of the Child
OVC	Orphans and Vulnerable Children
PMTCT	Prevention of Mother to Child Transmission
PSS	Psychosocial Support
SAPS	South African Police Services
SAQA	South African Qualifications Authority
SCFUK	Save the Children Fund United Kingdom
SETA	Sector Education and Training Authority
SMME	Small, Medium and Micro-Enterprise
RTO	Research and Training Organisation
TREE	Training and Resources in Early Education
VCT	Voluntary Counselling and Testing
VDP	Valley Development Trust

GLOSSARY

Child Care Forum	A forum consisting of a locally based, organised group that is committed to caring for children within their community
ECD Training and Resource Organisation	An organisation providing training and other services such as materials, outreach and community programmes aimed at young children and those who educate and care for them.
Family Fieldworker/Family and Community Motivator	A volunteer trained to capacitate and support primary caregivers to provide care and stimulation for their young children and to link to and access public and other resources to assist with this.
Home-based Care	The provision of comprehensive services by formal and informal caregivers in the home in order to promote, restore and maintain a person's maximum level of comfort, function and health, including care towards a dignified death.
Orphan	A child who has no surviving parent caring for him or her.
Primary Caregiver	A person who has the parental responsibility or right to care for the child and who exercises that responsibility and right.
Safety Net	Supports and service delivery that ensure that all rights of children are protected.
Vulnerable Child	A child whose survival, care, protection or development may be compromised due to a particular condition, situation or circumstance and which prevents the fulfilment of his or her rights.

EXECUTIVE SUMMARY

Overview

This relatively small action research project investigated safety nets with a focus on young children in three sites in different parts of South Africa. The urgent need for action in terms of the impact of the Aids pandemic on children across Africa, together with the understanding that there is still little or no attention being given to the youngest, most developmentally vulnerable children, motivated the study. This report, documenting the main study of the South African action research project conducted during 2005 and investigating effective safety nets for young children in the context of the HIV/AIDS pandemic, should be read in conjunction with the first phase report (Biersteker and Rudolph 2003).

In South Africa, like other parts of Africa, the initial thrust of policy and government intervention has been on HIV awareness and prevention, particularly targeting youth. The importance of care and treatment is increasingly being recognised as the overwhelming impact of the pandemic is felt. The growing awareness of the plight of orphans has in recent years expanded to include a wider category of vulnerable children. Vulnerability is being defined as “A child whose survival, care, protection or development may be compromised due to a particular condition, situation or circumstance and which prevents the fulfilment of his or her rights” (Department of Social Development 2005).

While there has been a significant shift in South Africa at conceptual and policy level, towards the acknowledgement that any effective response must include partnerships between all duty-bearers, including government, families and communities, government is to a large extent still working in isolated silos and there is little experience in forging effective partnership across different spheres and sectors within government. Relevant policy and programme developments discussed, include: The Children’s Bill; National Department of Social Development strategic Plan; Five Year HIV/AIDS Strategic Plan for Social Development 2003-2008; Policy Framework for Orphans and Other Children Made Vulnerable by HIV/AIDS; An Integrated Plan for ECD in South Africa 2005-2010 and the Expanded Public Works Programme.

Methodology

A participatory action research methodology was used for this study. This approach was seen as having value for mobilising the stakeholders and involving them in finding immediate and longer term solutions, which was important for continuity in the sites after the fairly short term of the research project itself. It was also aimed at exploring “insider perspectives” of vulnerability and well-being, and reflecting on factors that contribute to the necessary integration and cohesion for a safety net.

The action research process was adapted to the needs and circumstances of the three sites, drawing in contributions of a wide range of stakeholders but followed the same broad format drawing on Appreciative Inquiry and a rights-based approach.

Description of the three sites

The research partners were Valley Development Project in Masiphumelele, TREE in Nkandla and Centre for the Study of Aids at the University of Pretoria in Hammanskraal. The three sites differed considerably, not only in terms of general context but also the extent to which a safety net and focus on young children had been established before the start of the project. In Nkandla local government had teamed up with an ECD Training and Resource organisation (RTO), TREE with support from UNICEF to initiate a safety net with a specific focus on young children. Although roles and responsibilities had not been established, training had taken place and there was strong political will and some funding to build the partnership and capacity needed for co-ordinated action. In Masiphumelele, the Valley Development Project another ECD RTO has been working extensively in responding to the needs of young vulnerable children through a wide variety of strategies along side several other local organisations. While there was already a strong focus on young children at the start of the action research, there was not yet any explicit strategy to co-ordinate a safety net. In Hammanskraal there was no strong ECD organisation operating, no focus on young children and no co-ordinated safety net strategy. However the research partner had previously raised awareness through conducting research into the impact of HIV and AIDS on rights in the area and there are several organisations responding to the needs of orphans and vulnerable children, though most of them work with children of school-going age.

The action research process in the three sites

Information from the sites was gathered from stakeholder workshops. These were jointly facilitated by the lead and co-researchers, supplemented by site-specific focus groups conducted by the co-researchers and participant generated cases and organisation descriptions. Co-researchers introduced the lead researchers to the site and to existing local data sources to inform the study. Co-researchers were responsible for all logistics, documenting the focus groups and translation in the general workshops which were conducted in the local languages.

Findings

In Part Five, the key themes generated by the participatory process are discussed in the light of current literature and debate under four main headings: targeting and programme focus, accessing resources, partnership and learning, accountability and advocacy.

Understanding and effectively using the complex notion of vulnerability to target children that need help is at the heart of any successful safety net. Different role-players in different contexts expressed different perspectives. As explained above, while there was a strong

focus on young children in two of the sites, this was not true of the third, which is probably more representative of the majority of areas in South Africa. The importance of psychosocial support is discussed in relation to selection of programme options. Generally the urgent and overwhelming survival needs are crowding out attention to psychosocial needs in all three sites.

The need for resources and support for families and community-based organisations was a strong focus in all three sites. Most of the burden of caring for vulnerable children is falling to families and community based organisations that are generally straining and extremely vulnerable themselves. In particular, volunteers are carrying a major burden with little or no remuneration and limited co-operation or support from the government departments they are assisting.

The experience in all three sites illustrates that technical support and long term consistent funding is essential for strengthening of safety nets that can include a strong focus on young children. The support needed by community-based organisations to access and manage funds as well as advocacy to ensure that funding is made available for the organisations to function and to strengthen family coping capacity is illustrated and discussed.

The quality of partnership is a key factor in integrated delivery and is consequently integrally related to the effectiveness of a safety net for young children. The report explores the role players and their relationships in each of the research sites and then discusses the potential of Child Care Forums as promoted in the recent policy framework of the Department of Social Services.

Strategies are needed to assist families and community-based organisations to access funds, including improving the flow of information as well as adapting funding strategies to accommodate small community-based organisations that need small amounts of funding provided regularly over the long term. The Child Care Forums being promoted through Department of Social Development policy hold great potential as safety nets. However, young children will need to be fore-grounded and brought into strong focus. Funding and technical support will be needed to ensure that these forums are effective and do not place yet another burden on those already struggling to care for and support vulnerable children.

Another important strategy for strengthening safety net initiatives is through monitoring and evaluation. Three broad areas need to be assessed: targeting, responses and resources. Monitoring and evaluation is important for tracking government and donor spending in relation to effective targeting and to ensure that organisations operating on the ground are learning and accountable. Sound monitoring systems should track the nature and scale of impact of the pandemic on children's lives, and the effectiveness of various responses to the resulting conditions. This presents a complex range of issues to be considered, in terms of strategies

for identifying and prioritising need, both in relation to children and responses, and then assessing the effectiveness of the selected targeting and programme strategies. Evidence of effective and responsible responses, is in turn essential for advocacy. The many layers of complexity in the South African social environment require data disaggregated at different levels. However, evidence from the sites is that while efforts are being made to identify and prioritise needs, effectiveness of the programme and targeting strategies has not yet been systematically monitored. Child Care Forums and other safety net initiatives have an important role to play in terms of monitoring, evaluation and advocacy.

Summary of findings in relation to international principles

The UNGASS goals and UNAIDS principles and other best practice principles for programming are used as a lens to summarise the components of the safety nets supporting the well-being of vulnerable children in three sites.

The experience in the three study sites generally supports current “best practice” principles. The rights based approach, supported by a participatory appreciative approach, proved valuable because of the holistic focus and because concepts of rights holders and duty bearers were helpful for community level understanding and for advocacy. Building on strengths generated motivation for positive change.

UNAIDS principles that were found to be most utilised in the operation of the safety nets in the sites include strengthening the care and protection of young OVC within their extended families and communities, use of a wider definition of vulnerability than just orphans; the development of partnerships at all levels and creation of a forum for information sharing and accelerating learning. Challenges are to enhance economic coping of affected families and community-based responses, adequate provision of psychosocial support both to children and their caregivers, links with HCBC services, and utilising ECD centres for the protection and development of children whose caregivers might be unable to care for them fully.

The most severe challenge to implementation of the UNGASS goals is the lack of sufficient public and donor funding affecting the capacity of state and civil society responses in support of young vulnerable children

Concluding reflections and call to action

Lead researcher reflections are added to distil and consolidate the learnings and recommendations in terms of methodology, programming implications and advocacy issues.

Learnings include

- Confirmation of the value of the formative action research approach for immediate improvements and application in the research sites.
- Insight into models of partnership and strategies for generating common understandings of holistic care and support.
- Recognition that programming challenges persist in terms of appropriate and sustained resourcing, monitoring and evaluation and psychosocial support.
- The important role of ECD focused service providers in ensuring a developmentally appropriate programme focus for very young vulnerable children.
- The need for multi-sectoral, multiskilled teams and to reduce the gap between professionals and volunteers through capacity building and remuneration.
- The critical importance of broad community awareness raising about the needs of very young children to bring about the required focus and strong advocacy for public funding.

Hopefully this study will be of value not only to the three partner sites, but also as a catalyst for urgent action to address the impact of the AIDS pandemic on young children and their families across Africa. In addition to the findings and the lessons learned, the participatory appreciative action research strategy itself is offered as an example of a potential approach to forging the partnership and co-ordinated action, not only to respond at a local level, but to mobilise resources and support at the scale needed to ensure a bright future for Africa.

PART ONE: OVERVIEW

1.1 Background

There is a growing awareness of the urgent need for action in terms of the impact of the AIDS pandemic on children across Africa. However, there is still little or no attention being given to the youngest children, who are most developmentally vulnerable to deprivation of consistent, responsive care, adequate nutrition and interpersonal and environmental stimulation. While there has been a significant shift in South Africa at conceptual and policy level, towards the acknowledgement that any effective response must include partnerships between all duty-bearers, including government, families and communities, government is to a large extent still working in isolated silos and there is little experience in forging effective partnership across different spheres and sectors within government. Despite increased funding commitment in response to the AIDS pandemic, both nationally and globally, services for vulnerable children are under-funded and insufficient funding is reaching the families and local non-government organisations that are carrying the heaviest load.

In South Africa, like other parts of Africa, the initial thrust of policy and government intervention has been on HIV awareness and prevention, particularly targeting youth. The importance of care and treatment is increasingly being recognised as the overwhelming impact of the pandemic is felt. The growing awareness of the plight of orphans has in recent years expanded to include a wider category of vulnerable children. It is acknowledged that long before being orphaned, many children suffer the long-term decline in health of their parents or guardians, reduced family income, and the psychological and material consequences of both. Stigma and deepening poverty is pushing programmes setting out to respond to the needs of AIDS orphans, to broaden their focus to include all vulnerable children. Vulnerability is being defined as “A child whose survival, care, protection or development may be compromised due to a particular condition, situation or circumstance and which prevents the fulfilment of his or her rights” (Department of Social Development 2005).

The Department of Social Development Draft Policy Framework (2005) notes that,

While HIV/AIDS dramatically increases the population of orphans and vulnerable children, it also reduces the pool of traditional caregivers and the number of breadwinners. The realisation of the rights of orphans and other children made vulnerable by HIV/AIDS and the vigorous advancement of the social development agenda to restore their dignity and well-being requires collective effort from government, business sector, civil society and the strengthening of community responses. (2005: 4)

This report documenting the main study of the South African action research project investigating effective safety nets for young children in the context of the HIV/AIDS pandemic

should be read in conjunction with the first phase report (Biersteker and Rudolph 2003)¹. The study was conceptualised and undertaken in three phases as part of a five-country study initiated by the Early Childhood Development Network for Africa (ECDNA).

The purpose of the study is

- To identify safety net initiatives supporting orphans and vulnerable children aged 0 – 9 years;
- To understand the factors that contribute towards effective safety nets for young orphans and vulnerable children in different contexts (differentiating the needs of children aged 0-3 years and those 4 – 9 years);
- To build capacity in research sites to strengthen existing safety nets;
- To draw lessons and examples of good practice for transfer and policy implementation;
- To act as a catalyst for urgent action for vulnerable children including resource mobilisation.

In the first phase, funded by the UNICEF, Pretoria office, an initial literature review and desk scan of existing initiatives targeting the youngest children (from birth to at least 9) and working in an integrated way, or with the potential to move swiftly in this direction, was undertaken. The investigation found that although there are increasing numbers of projects and some research programmes in South Africa concerned with vulnerable children, a particular focus on children in their earliest and most vulnerable years is often missing. Similarly, although partnership and integrated service delivery is critical for an effective response, there are few examples of such co-ordinated responses. This report on phase two, funded by Rockefeller Brothers Fund describes the action research project, in response to the urgent need for comprehensive information sharing, facilitation and support for collaboration identified in the first phase of the study. In phase three conclusions from the study will be disseminated to advocacy groups, service and training NGOs, government, donors and the private sector to inform policy and programme implementation.

1.2 Introducing the study

In this phase, the factors and role players that contribute towards effective safety nets for young children were investigated in three sites, with different demographic circumstances and degrees of safety net development.

Nkandla in KwaZulu Natal was selected as a research site because it is rural, very poor and lacking in infrastructure, in an area with high HIV prevalence. The area is unusual because of the Municipality's commitment to "Making Nkandla a Municipality Fit for Children". A local programme of action for children (LPA) was developed in 2004 following training in a Human Rights Approach to Programming (HRAP). TREE and UNICEF are working on this project with a specific focus on the youngest children.

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Valley Development Project's (VDP) Early Learning Support Project in Masiphumelele was approached to join the study as a co-research partner in the Western Cape. Peri-urban Masiphumelele was selected as one of the three research sites because community indicators predispose children to vulnerability and because there is a strong service emphasis on young children in the area. It is very poor, with higher than average provincial HIV and TB rates. Masiphumelele is a relatively new settlement with many informal dwellings. Most residents are economic migrants from the Eastern Cape within the last decade, an indication that tends to be associated with social isolation (Dawes and Donald 2000). Valley Development Project supports early childhood development services in the area and has a particular focus on vulnerable children. Through the training of family and community motivators in that area, a rights-based approach has been introduced and a safety net initiated with a strong focus on young children.

The third site, which for the purposes of the study is referred to as Hammanskraal, stretches across Hammanskraal and Temba and straddles the border of Gauteng and North West Province. It is peri-urban with informal settlements. Hammanskraal differs from the other two sites in this study, in that there is no strong ECD organisation operating in the area and no safety net response specifically initiated before the start of this investigation. Given the scarcity of existing safety net initiatives with a focus on young children, evident in the first phase of the project and preliminary search for sites for this study, it was acknowledged that it could be helpful to explore the extent to which these factors might exist outside of a purposeful safety net intervention. The impact of the pandemic on rights in this area, hard hit by HIV and poverty, had been investigated by the research partner, the Centre for the Study of Aids (CSA) at the University of Pretoria. They found that there was already a strong presence of organisations responding to children affected by HIV/AIDS. It was understood that if the action research study found that partnerships had not been established with a focus on young children, the intervention could initiate and document the process of capacity development towards a safety net that could be taken forward by CSA.

The notion of safety nets in the context of this study assumes building partnerships between all critical role players in the life of the child, including all spheres of government, non-government agencies, community-based organisations and families. Between, the first and main phase of the study, the Department of Social Development introduced a policy framework for Child Care Committees, which supports a very similar strategy to this notion of a safety net. The introduction states that

The Policy Framework reflects the collective commitment of government, faith-based organisations, community-based organisations, civil society and the business sector [to OVCs] and serves as a guiding tool to all people involved in HIV/AIDS and the children's sector. It seeks to reinforce the existing commitments and efforts to create a supportive and enabling environment for our children (2005:4).

Although the policy framework, described in more detail below, emerges from concern about the impact of the AIDS pandemic, it acknowledges the compounding factors of poverty and seeks to protect the rights of all children whose care is compromised. However, no special focus is given to the youngest children.

As explained above, the study sought to identify, in different contexts, what might constitute a safety net, why and how and for whom it "works". The notion of safety nets that assumes building partnership between all critical role-players in the life of the child including all spheres of government, non-government agencies, community-based organisations and families provided one lens for investigation. In addition to investigating and learning from how participants in the three sites understand and are responding to vulnerability in young children, the action research design promoted community action and capacity building in terms of the needs in each site. While it is acknowledged that this study itself can only have minimal impact in terms of the scale of the problem, it is intended primarily to serve as a catalyst for urgent action in response to the challenge of galvanising systematic and sustained attention to vulnerable children, specifically the youngest (those from birth to nine) infected and affected by HIV/AIDS. The intention is to facilitate a process of transfer of lessons and expertise across the pilot sites and beyond.

A variety of networks and list serves will be used to disseminate the research report, which consists of the following parts: Part One gives the background to the research project and introduces the main phase and provides an update on the current research context; Part Two describes the methodology; Part Three provides a summary description of the three research sites; Part Four a brief description of the research process in these sites. The findings are discussed in Part Five and then summarised in relation to international principles and goals in Part Six. In Part Seven, the lead researchers reflect briefly on the key issues, giving direction for the way forward and call for urgent action.

The next section of the report sets the scene in terms of current research and policy. It starts with an introduction, provides an update on the statistics and trends and then briefly introduces the following policies and programmes: The Children's Bill, National Department of Social Development Strategic Plan (including the HIV/AIDS strategic plan and policy framework for orphans and other children made vulnerable by HIV/AIDS South Africa), the Integrated Plan for ECD in South Africa 2005 – 2010, and the Expanded Public Works Programme.

1.3 The research context

Most studies and programmes for HIV/AIDS affected children cover the whole 0 – 15 or 18 year age range and little is known about the state of care of young children. Undifferentiated services do not indicate what should be provided for children under 8 years, creating a major obstacle in providing appropriate support for young children (UNESCO 2003). The first phase

report (Biersteker and Rudolph 2003) confirms that at that time in South Africa too, there was very little local programming directed to the younger age range of children made vulnerable by HIV/AIDS, except for initiatives focused on Prevention of Mother-to-Child Transmission (PMTCT).

Several recent reviews have however, begun to focus attention on the younger age groups. Richter et al (2004:13) discuss the different risks depending on the age of the child pointing out that

Infants and toddlers are especially vulnerable to health risks and to the negative effects of group care. Preschool children are especially vulnerable to nutritional deficiencies, abuse and neglect and to loss of stimulation and opportunities for schooling.

According to Dunn (2005:13) “the fact that the children under eight as a target group have distinct experiences of HIV/AIDS pandemic has so far largely been ignored”. The main activities have been around prevention and treatment, or the wider impact on the education system.

UNICEF also argues that children under three years of age, because they are entirely dependent on primary caregivers, need a different response from those between 4 and 8 years. However, this special response needs to be integrated within programmes with a broad framework, developed with and for families and communities, and must respect cultural values and build local capacity. There should be equal access for all children and programmes should be flexible and reflect diversity (UNICEF 2001).

Dunn (2005) supports this view and draws attention to the need for this special focus on young children, especially for those who are already vulnerable because they are living under conditions of poverty or dependent on ill and tired caregivers. Girls are particularly vulnerable to sexual abuse and rape even under 6 years of age. Maternal depression and lack of social support has a negative effect on mother and infant bonding and parenting functions, which impacts on the growth and psychological and cognitive development of the child. Most children born to HIV positive parents are at least 5 before their parents die and rarely receive the proper attention and care-giving required during a critical stage of their development. They frequently witness their parents' traumatic illness and death. Dunn draws attention to the important role of households and communities as immediate carers and supporters of young children and the need for support to care for young children in a very holistic way.

1.3.1 The current situation

HIV/AIDS are a dire threat to the survival and well-being of very large and growing numbers of young children in South Africa. As shown in Table 1 below, 28% of pregnant women tested at public facilities in 2003 were HIV positive (Makabulo et al 2004), with serious implications for the future of their babies.

About one third of infants born to HIV positive mothers are infected with HIV. The National Household HIV Prevalence and Risk Survey of South African Children (Brooks, Shisana and Richter 2004) found HIV prevalence among children 2 – 18 years of 5.4% without significant age variation. In addition to vertical transmission, the study identified poverty and inadequate care and protection at home and school as risk factors making children vulnerable to infection by putting them at risk for sexual abuse and possible HIV transmission. This study proposes that interventions should focus on increasing care and protection at home and school and making communities safer. A further small investigation of HIV risk exposure of young children, 2 – 9 years, in the Free State Province² indicates that breast feeding of babies by a non-biological carer with HIV is the single most important factor associated HIV infection. Health facility related infections from poor control of expressed breast milk and contamination of instruments with blood also pose a risk. Effects of the pandemic show in reversals in the improvements in infant and child mortality rates. Between 1998 and 2002 estimates are that the infant mortality rate is estimated to have increased from 45 to 59 per 1000 almost exclusively because of mother-to-child transmission of HIV. The under-5 mortality rate almost doubled to 100 per 1000.

Far greater numbers of children have their survival and well-being compromised through growing up in households where breadwinners and caregivers are infected or have died. According to Brooks et al (2004), a tenth of children have lost a parent or caregiver by the age of 9 years, not only from AIDS related causes. African children, children in poor households and those living in informal settlements are most affected. Orphanhood has not substantially increased since 1995, suggesting that South Africa has not yet felt the full impact of HIV/AIDS on orphanhood and the emergence of child headed households.

Table 1 HIV Prevalence by province among antenatal clinic attendees, South Africa (2003)

Province	HIV Prevalence (Confidence Interval 95%) 2003
KwaZulu-Natal	37.5 (35.2 - 39.8)
Mpumalanga	32.6 (28.5 - 36.6)
Free State	30.1 (26.9 - 33.3)
North West	29.9 (26.8 – 33.1)
Gauteng	29.6 (27.8 – 31.5)
Eastern Cape	27.1 (24.6 - 29.7)
Limpopo	17.5 (14.9 – 20.0)
Northern Cape	16.7 (11.9 – 21.5)
Western Cape	31.1 (8.5 – 17.7)
South Africa	27.9 (26.8 – 28.9)

Source: Makubalo, Netshidzivhani, Mahlasela and Du Plessis 2004

1.3.2 Relevant policy and programme developments

² Results of a Research Report into HIV risk Exposure of young children 2 – 9 to HIV in Free State Province [http:// www.hsrc.ac.za/media/2005/4/20050405_1.html](http://www.hsrc.ac.za/media/2005/4/20050405_1.html).

Major policies relating to HIV and children are described in our Phase 1 report (Biersteker and Rudolph 2003). In this section we outline new developments and trends.

A rapid appraisal of priorities, policies and practices for children affected by HIV/AIDS in South Africa notes the following emerging trends in responses to OVC

- The prevention focus now being supplemented by recognition of the importance of treatment, care and support
- Less emphasis on services for AIDS orphans – understanding that there is little or no benefit in targeting services based on cause of orphanhood or vulnerability
- A better balance between programmes for HIV infected children and those for OVC (Smart 2003a).

Another apparent trend is the strengthening, at least at the conceptual level of policy and strategy, of intersectoral and integrated initiatives involving all social cluster partners. Smart's appraisal (2003a) raises the importance of keeping infected mothers alive, as maternal survival is a strong protector of child survival. A public programme for the Prevention of Mother-to-Child Transmission of HIV (PMTCT) started in 2001 and now operates at a number of public hospitals and community health centres throughout the country. Providing treatment and support to children's mothers and other caregivers, so they can provide good care for as long as possible, is critically important.

The Department of Health approved the national roll out plan in November 2003 for the "Comprehensive Care and Treatment for HIV/AIDS". Part of this plan makes provision for antiretroviral therapy (ART) within the public sector to persons with HIV-infection who meet certain qualification criteria. In April 2004, a national ART treatment programme started. However, it has faced numerous challenges especially in the poorer provinces and is not rolling out rapidly enough to meet the demand for treatment. Midway through the first year only 8 000 of a target of 53 000 people were receiving treatment in the public sector (http://www.tac.org.za/newsletter/2004/ns13_09_2004.htm).

In particular, major challenges remain in terms of treatment for children. A recent discussion paper (Shung-King and Zampoli 2004) describes the gaps and challenges, including

- inadequate consideration of counselling needs of children
- complexities with regard to HIV testing in young babies and children, particularly HIV-diagnosis in instances where children have no adult caregivers or are in residential care
- specific difficulties of diagnosing HIV and associated illnesses like TB in children
- special considerations in terms of procurement, storage and adherence.

The discussion paper points out that "Current implementation statistics suggest that, aside from the overall roll out plan being way behind schedule, the sites currently providing ART for children are in the minority" (Shung-King and Zampoli 2004:8) and concludes that, "despite the strong rights-based framework in which South Africa operates, children's health rights and in particular the rights of children with HIV have not yet been met" (Shung-King and Zampoli 2004:10). There is clearly an important role for safety nets in terms of supporting the

implementation of treatment and ensuring that policy-makers take into account the special needs of children.

There are several other key government policies and programmes that are relevant to safety nets for young children. These are introduced briefly here and some are discussed further in relation to the findings in Part Five of the report.

The Children's Bill

Important aspects of a safety net for all children affected by HIV include improving access to grants of different kinds and adoptions. In particular accessing Foster Care Grants (FCG) by caregivers for children, who are not their own by birth, is a slow statutory process requiring fast tracking. The Children's Bill is an avenue for ensuring adequate legislative provisions for vulnerable children. When the Draft Bill was handed over to the Department of Social Development by the South African Law Commission in December 2002, it included a comprehensive social security scheme for children including a range of grants, benefits and services which could form an important part of a safety net for vulnerable children. Those made vulnerable by HIV/AIDS include children living with HIV and other chronic health conditions, children experiencing orphanhood (defined as a child who has no surviving parent caring for him or her) and a number of considerations related to social grants (Giese 2003). However, many of the provisions relating to a package of services have been removed from the Bill. The Bill was split³ and is still going through parliament. So far the main gain is that it recognises a category of informal kinship care. This would entitle kin to a grant without the monitoring required by the foster grant system.

National Department of Social Development Strategic Plan

This Strategic Plan (for 2002/2003 and from 2004/2005 to 2009/2010) is aimed at building a caring society and a better life for all and especially for children. It includes among other provisions, a commitment to improved social grants administration, a strong focus on mitigating the impact of HIV/AIDS on poor communities, the Expanded Public Works Programme (EPWP) which has provisions for ECD and home/community-based care and support (see below) and a new policy of financial support to NGOs and other civil society organisations serving the needy and vulnerable. All of these are relevant to a safety net for vulnerable children.

Five year HIV/AIDS Strategic Plan for Social Development 2003- 2008

In 2003 the National Department of Social Development developed this plan with guidelines

³ The Bill has been split into a Section 75 and a Section 76 Bill. A 75 Bill is deemed to be an ordinary Bill that does not affect the provinces. The content of the Bill does not fall under provincial management, planning, budgeting or implementation by the provincial departments. The content is considered to be of National competence only. A 76 Bill is a Bill as described at Section 76 of the Constitution, it is considered to be a Bill that affects the Provinces and requires provincial management, planning, budgeting and implementation. The Bill will not be implemented until both the section 75 and section 76 Bills are passed and the entire Act is published in the gazette (Jamieson and Proudlock 2005).

and goals for the short, medium and long term, which recognises its role in leading a strong intersectoral approach for dealing with vulnerable groups. It acknowledges the role of all government departments at national, provincial, district and local level, civil society and the private sector as well as international partners.

Policy Framework for Orphans and Other Children made Vulnerable by HIV/AIDS (South Africa)

Smart (2003a) draws attention to the need to establish networks that can function to protect OVC. During 2003, the Department of Social Development put out guidelines for establishing Child Care Forums (Department of Social Development 2003), which are community structures focusing on the needs of orphaned and vulnerable children in the community and meeting of their needs. Core roles include assessing the situation within the community, mobilising the community and strengthening the care-giving and coping capacities of families. The Child Care Forums proposed in this policy could play an important role as a safety net for vulnerable children. Although the policy suggests appropriate strategies for children of different ages there is no specific mention of the special vulnerability of the youngest ages. The most recent version (2005) is currently being costed⁴. Training manuals have been developed.

An Integrated Plan for ECD in South Africa 2005 – 2010 (Tshwaragano Le Bana)

The social sector cluster (social development, health and education) was mandated to develop an integrated plan for ECD by a Cabinet lekgotla in May 2004. This has been presented to Cabinet for consideration⁵. The plan aims at greater integration for ECD through a comprehensive approach to policies and programmes, networking to improve the use of resources and intersectoral collaboration across government, NGOs and communities. The initial planning period from 2005 - 2010 includes

- Integrated management of childhood illnesses
- Immunisation
- Nutrition
- Referral services for health and social security grants
- Early learning stimulation and
- Psychosocial programmes.

Two thousand community development workers will target poor and vulnerable children from birth to four years in all provinces. Sites will include homes, ECD centres, prisons and orphanages. This will be piloted in a selection of rural nodes and one informal settlement after which it will be progressively implemented until the target of 4 million children is reached. Combating HIV/AIDS is a focus of the plan including identification and service provision for OVC both through supporting families and training for those working in ECD centres, schools and CBOs.

⁴ Presented by a Department of Social Services official at the Casnet meeting, 2 September 2005.

⁵ Although it is not yet in the public domain, the information here is based on a presentation by Department of Education Director for ECD, Marie Louise Samuels at the Nelson Mandela Children's Fund Seminar in Johannesburg, November 29, 2004.

Expanded Public Works Programme (Social Cluster)

The Public Works Programme (EPWP) for 2004/5 – 2008/9 provides a substantial opportunity to link ECD and poverty alleviation. It targets women in the areas of ECD and Home and Community-based Care (HCBC) for AIDS sufferers. SETA budgets will be used and integrated for capacity building in these areas. There is potential for synergies between an ECD provincial plan and HCBC because young children in AIDS affected households may be rendered very vulnerable if their primary caregivers are affected.

The provision of comprehensive services including health and social services by formal and informal caregivers in the home, as well as patient care includes several aspects that would be very significant for young children in those households

- Early identification of families in need, orphans and vulnerable children
- Addressing the needs of child headed households
- Linking families and caregivers with poverty alleviation programmes and services in the community.
- Family support
- Income generation.

ECD will focus on birth to 6 years and includes components that involve children in ECD provision and those in the care of their parents. For children in ECD provision, it targets untrained or under-trained personnel in facilities in poor areas, and in facilities unregistered by the Department of Social Development as well as those, which have been registered. The programme will include learnerships at Levels 1 and 4 and skills programmes. Grade R practitioners have been targeted for Department of Education learnerships at Level 5. There are also opportunities for training of support staff (gardeners, cooks and administrators) in existing ECD centres. In the Parents Informing Parents (PIP) programme (not yet finalised) NGOs, CBOs and local authorities will be supported to provide unemployed persons with training in nutrition, health care and cognitive development to boost care of poor children outside ECD services. Secondly parents would be trained in playgroup work to educate other parents or facilitate stimulation playgroups for children whose families cannot afford ECD services. This will involve employment opportunities for three months for unemployed parents through existing schools and local authorities.

Unfortunately roll out of the EPWP has been extremely slow so far, highlighting some of the difficulties of operationalising an intersectoral approach and there are tensions between the goal of creating new jobs and capacity building for those already in the ECD sector.

However, this could provide valuable opportunities for strengthening support services to young and vulnerable children. The potential and the disadvantages are discussed further in the findings in Part Five. Part Two describes the research methodology.

PART TWO: METHODOLOGY

2.1 The method

The literature reviewed for this study, informed the project methodology. In particular, one of the gaps identified in the 2002 Save the Children Pathways to Action Study on HIV/AIDS Prevention: Children and Young People in South Africa was that

Qualitative methodologies and formative evaluation models, which emphasise programme development and development indicators will assist us in understanding “community level dynamics relating to such concepts as social capital and social cohesion” (Kelly et al 2002:18).

Appreciative Inquiry and an action oriented rights-based strategy guided the action research approach. However the method was interpreted and implemented somewhat differently in each site. In this section of the report the methodology will be described broadly, followed in Part Three by descriptions of the three sites and in Part Four by an overview of the process in each site.

Action research is conventionally defined as “a small-scale intervention in the functioning of the real world and a close examination of the effects of such intervention”, although “usage of the term varies with time, place and setting” (Cohen and Manion 1994:186).

In the first briefing meeting with the Hammanskraal co-researchers, there was strong agreement about the notion of action research. The following agreements summed up the discussion: possible definitions, “It is a small scale intervention in the real world and a close examination of the effects of such intervention” or “identify strategies of planned action which are implemented and then systematically submitted to observation, reflection and change“. Four features of action research include that it is situational, collaborative, participatory and self-evaluative. The role of the researcher is very different in action research compared to traditional research. All participants are co-researchers, rather than subjects of the investigation. Ongoing critical reflection is an important part of action research.

In both Masiphumelele and Nkandla the co-researchers were familiar with participatory action research approaches, which they had found useful in the past, and were enthusiastic about the possibilities for the development of their programmes that this approach facilitates.

In action research it is not a matter of researchers just being “eager to know”, but rather involving the participants or “subjects” in the process of knowing and learning. Stakeholders are mobilised and involved in finding solutions. This was particularly important for ethical concerns of continuity in the sites after the fairly short term of the research project itself.

Communication for Social Change requires three shifts, namely, from message to dialogue, from problem solving to appreciation and from expert solution to community solution. In this project, the participants were invited to build on their strengths and plan and implement action in the community to support the well-being of children. Social justice is a prerequisite for child well-being and consequently the strategies used must address major issues, such as power relations. The notion of “Communication for Social Change” assumes a basket of different strategies that can be used to engage communities in working together for a better future. Appreciative Inquiry is one of these strategies used in the project.

Appreciative Inquiry (AI) is based on the belief that individuals change most easily when they move towards a positive image of a desired future state. AI creates a positive image by identifying and expanding successes and peak moments that have already occurred. It gives people the emotional and creative energy they need to change their existing practice. AI can be applied within communities in the following way

- The community discovers the strengths and good childcare practices that already exist within it, using any of the range of available participatory techniques
- Community members collectively visualise (or dream) the best possible future state for their children based on expanding and improving current strengths and best practices
- They design a strategy to achieve their vision
- They deliver (or implement) the strategy.

The vision that community members create for their future is not utopian, based on unlimited outside support and resources. Rather, it is practical in nature, based on the expansion of practices and achievements that already exist inside a community. This development pathway produces action plans that are truly owned by community members, leading to changes that can be sustained after development programmes end (Rudolph 2002). To facilitate this a more detailed report was prepared for each site in addition to this combined report for broader advocacy.

Richter et al (2004) express a similar view in describing the value of participatory techniques to conduct local needs assessments to reach agreement on programmes to support young children.

Community mobilisation and capacity building are catalytic processes through which an outside agency can help a community to identify what concerns them most, what to do about it and assist them to take action. (Richter et al 2004:43)

Richter et al (2004:43) quote Lorey and Sussman (2001) who emphasise the value of participatory technique in the context of the AIDS pandemic as it

Aims to make as many people as possible in a community aware of the impact of HIV/AIDS and encourage participation in and ownership of efforts to assist vulnerable children through forming community care coalitions.

The difference between some traditional participatory approaches and Appreciative Inquiry is that the latter builds on strengths, rather than starting with concerns. Problem solving remains

an important component of Appreciative Inquiry. In order to create a shared vision of the community's future, participants must overcome conflict, dissatisfaction and disagreement that arise from differences in their power, perception and knowledge. The effectiveness of the engagement process is seen in the extent to which these disagreements are resolved, leading to consensual and collective action. Problems must also be solved when a community, in partnership with government departments and development agencies, implements an action plan to achieve a community-owned vision. However, it must be noted that problems are best addressed after a vision has been created and shared.

Another important theoretical framework that informed the project is the **Human Rights Approach** set out in a document distributed by the Southern and Eastern African region of UNICEF (UNICEF 2001). The distinction between rights and needs is helpful, since the notion of rights leads to the notion of duties. It is generally accepted that a critical feature of safety nets is helping all role players understand children's rights. Families and communities need to identify responsible duty-bearers and articulate their demands. Family members, who are generally the first level of duty-bearers, frequently do not realise that the reason they are not able to protect some of their children's rights might be because one or more of their own rights might be infringed. Through facilitating this dialogue in the partnership, the community is able to articulate their own rights, understand the underlying barriers, identify the secondary duty bearer responsible and claim their rights.

2.2 Scope and limitations

Action research is time-consuming and requires a certain level of engagement, motivation, and commitment from all members of a developing partnership. In this study, this proved to be both an advantage and a barrier. Potentially the primary advantage is ownership of the questions, findings and outcomes of the investigation, particularly in terms of taking forward the process. However, negotiating time and involvement of the co-researchers alongside of their already busy programmes caused delays, particularly in terms of their checking early versions of the report.

It was clear at the time of conception, that the scale and scope of this investigation was relatively small and would need research partners who could take the process forward. The long term role of research partners differs across sites and it is hoped that all the research partners will be able to take the process forward.

The guidelines to programming for vulnerable children that express current understandings of best practice will be used as a lens to examine the safety net strategies in the three sites. The value of this study was the opportunity to explore with the stakeholders in the different sites "insider perspectives" of vulnerability and well-being, to carefully consider assumptions

regarding risk resilience and recovery in different contexts and begin to reflect on what factors contribute to the necessary integration and cohesion for a safety net.

As explained above, these frameworks were interpreted differently in terms of the specific needs and circumstances in each of the three sites. However, close communication between the two lead facilitators ensured that the primary framework of the study was implemented as uniformly as possible. The three participating sites are described in the next section.

PART THREE: DESCRIPTION OF THE THREE SITES

The three sites and the state of the existing safety net for young vulnerable children is described in this section. Reasons for selection of the sites are given in Part 1.2. Detailed cases with site descriptions, research process, findings and recommendations prepared for each of the sites are available on request⁶.



Location of the research sites

3.1 Demographic information for the three sites

3.1.1 Masiphumelele

Of the three sites, Masiphumelele was the most compact with the smallest population. Masiphumelele is a township about 40km south of Cape Town, close to Fish Hoek and Kommetjie in the southern peninsula. It was established in 1992 after a struggle for land rights. In 2002 the largely Xhosa-speaking population was approximately 12 000 (Middlekoop 2002) but unofficial estimates are double this number (Dawes et al 2004). The population is a predominantly young one with 55% between the ages of 20 and 39 years, 10% are children up to four years and 16% between 5 and 15 years. Unemployment is very high (about 90%) and the HIV/AIDS is having a debilitating effect on the population.

⁶ Nkandla from tree@worldonline.co.za; Masiphumelele from lynne.vdp@netactive.co.za; and Hammanskraal from csa@up.ac.za or author Norma Rudolph at normar@netactive.co.za.

There are three areas in the community including a formal serviced area (electricity, toilets, running water), the “old school site” with informal dwellings (3 communal taps, 6 communal toilets and no electricity) and the unserviced “wetlands”. Overcrowding is a problem especially in the wetlands where there is an average of 4.5 people per shack.

In 2001 Valley Development Project conducted a survey of 107 households with children aged under 7 years in Masiphumelele (Dlangamandla and Erlank 2001). Most of the families in this area were young, 81% of adults are in the age range 21 – 40 years. Seven out of 10 adults had Grade 8 and above with nearly 40% having either Grade 10, 11 or 12; 28% were in full time employment and 39% had part time/casual employment (mostly domestic work). The majority of children (64%) lived with both parents. Most people lived in shacks and 84% of these had access to electricity (some of this illegally taken straight from the electric poles); 83% of shacks had water on site and 11% from a communal tap. About 16% of children attended preschool/school and a third of children’s births were not registered. Most children in this age group were immunised (93%) but few families have accessed the Child Support Grant (about 20%). 84% of parents and caregivers were concerned about the safety of their children from rape, sexual abuse, accidents and neglect. Malnutrition and TB (a problem in the area) and chest problems were the most common children’s illnesses.

Feedback from stakeholders in the area in 2005 is that child support grants were much more widely accessed and birth registration was better established. Malnutrition remained a problem and rapes of children were high but often unreported. In the wetland illegally drawing electricity “from the pole” was still a problem and unprotected cables lie across the ground.

According to local authority health statistics the Infant Mortality Rate has risen from 11.9 per 1000 in 2000 to 44.8 in 2003. In 2003 a third of these deaths were caused by HIV/AIDS and other infectious diseases. TB remains a serious problem with 70 new positive cases in 2004. 109 of 419 persons tested for HIV at Masiphumelele clinic in the first half of 2005, were confirmed positive. Antiretroviral therapy is accessible to many people in Masiphumelele being offered both by the government and the Desmond Tutu Foundation.

The clinic operates from 7.30 to 14.30 on weekdays. There is no community health committee in Masiphumelele. The nearest day hospital for Masiphumelele is Ocean View and Masiphumelele residents may go there between 7h30 and 16h00. Except for emergencies, an appointment needs to be made to go to False Bay Hospital. This may mean waiting for an appointment as long as three weeks because there is only one doctor there. A problem highlighted by fieldworkers is that the Masiphumelele clinic will not issue cards to people who already have cards in the Eastern Cape resulting in children not getting their immunisation.

3.1.2 Nkandla

Nkandla is a widespread, rural, hilly area, within the Uthungulu District Municipality in KwaZulu Natal. Nkandla town can be referred to as peri-urban and the rest falls with the Ngonyama Trust Board. Planning for the area therefore involves both the traditional leadership of the amakhosi and izinduna and the municipality. It is very poor in infrastructure with few accessible roads and characterised by high levels of poverty. More than 90% of the workforce is unemployed and the majority of households are headed by women. According to Census 2001, nearly 50% of households had no annual income. Informal trading or hawking is an important employment opportunity, others are employed in agriculture and forestry but numbers are not significant. Nkandla is divided into 18 small villages and the approximate population is about 136 000 people (SA Health Review 2004). 60% of the population consists of children under 18 years and 14% under 5 years, placing a high dependency burden on a relatively small group of adult earners.

Ten clinics service the area including mobile services and there are two hospitals. The Nkandla hospital has only one filled post of 6, the other 5 relying on sessional doctors. Pulmonary TB, pneumonia, gastro-enteritis, diabetes, cryptococcal meningitis, herbal enema intoxication and malnutrition are the most common diseases. HIV prevalence in the area is estimated at one in four.

A community-based, household survey of the health of children aged 0 – 23 months was undertaken in February and March of 2005 (Gibson and Kerry 2005). This will act as a baseline for an intervention to strengthen the community component of Integrated Management of Childhood Illnesses (IMCI). Mothers who were primary carers for 86% of children and other caregivers were the respondents. The findings provide useful insights into the status of young children in the district. Among others these indicated:

- A low 24% of registered births for children under two though 97% of children had Road to Health cards
- High knowledge of the child support grant but less for foster grants and the care dependency grant
- Only 57% of children were fully immunised by their first birthday
- Not all children were growth monitored as often as they should be, exclusive breastfeeding rates were low and micronutrient rich foods were lacking in the diets of children between 6 and 23 months
- Awareness by caregivers of some danger signs of illness but prevention of diarrhoeal disease through safe handwashing was hampered by lack of water and soap.
- A need to strengthen the community health worker programme
- Many mothers were offered Voluntary Counselling and Testing (VCT) and Prevention of Mother to Child Transmission (PMTCT) during pregnancy but new information about prevention of vertical transmission was not widely known
- Information about preparations HIV positive parents can make for their children and care for HIV positive children is starting to be known.

Social service delivery is generally poor with only 8685 child support grant beneficiaries, 200 foster grants and 239 care dependency grantees. There has been a huge increase in

reported cases of child sexual abuse from 148 cases in 2000 to 1711 in 2003 (Eyethu Development Consultants 2004).

48% of the population has no formal education, 33% primary education only. Approximately 85% of children attend school but at least 15% of eligible children are not at school because of inability to pay fees, buy uniforms and stationery and/or because of illness or death of parents. Only two of five circuits in the area have feeding schemes and absenteeism and dropout rates are high (Masahela 2005).

There are 51 community ECD schools and 122 Grade R classes attached to primary schools. Only a very small number of the community-based crèches are registered with the Department of Social Welfare and Population Development and only 22 Grade R classes receive a subsidy. Most are under-resourced lacking materials and trained teachers. There is no uniform standard of facility. The vast majority of young children are not enrolled in ECD programmes. There is a well-equipped library in Nkandla town with an excellent children's section in English and isiZulu, reference and fiction for adults, but it is very under-utilised. Preschools could use the library service but distances and lack of transport are a challenge.

3.1.3 Hammanskraal

As explained above, the site referred to in this study as Hammanskraal also includes Temba. The geographic area identified for this site is a complex mix of rural and peri-urban communities that falls within the Municipal boundaries of the City of Tshwane, previously known as Pretoria. Under the new demarcation it is cross provincial, falling within both the Gauteng and North West Provinces creating a situation of overlap in the area for various services, including health and education. Thus, the Tshwane Municipality, the Moretele Local Municipality and the Bojanala District Municipality are all involved in service delivery in the area⁷ (Zuberi 2004: 11).

Hammanskraal falls mainly within Ward 49 and Temba in Wards 8, 73, 74, 75 and 76. Generally, the area is semi-urban. The population is predominantly African, and the local language is Setswana.

Hammanskraal is made up of 2376 households with a total population of 9664 consisting of 1002 children under 4 years and 2212 between the ages of 5 and 14. The 19523 households in Temba constitute a total population of 70909, of which 7446 are under 4 years and 14949 between 5 and 14. In both areas about 5000 people over the age of 20 have had no schooling and 7000 have only had some primary schooling. Less than one third of the population is employed, and unemployment is slightly higher in Temba than in Hammanskraal. The largest single employment category in both areas is "community, social

⁷ The situation analysis is primarily drawn from the Tswelopele Report (Zuberi 2004) and updated from www.demarcation.org.za

and personal services". Only about 7000 of the total population of about 80000 earn more than R1600 per month.

Most people live in formal housing although there are informal settlements as well. While the majority of households in Hammanskraal have electricity, the majority in Temba use candles for lighting and paraffin for cooking. There are 1537 households with no sanitation.

There are about 240 ECD services and 26 primary health clinics and two mobile health clinics. The major hospital in the area, Jubilee Hospital, offers voluntary counselling and testing (VCT) and prevention of mother-to-child transmission (PMTCT) services, but has not been selected for the ARV roll out in North West Province. Two clinics, the Getaway Clinic and the Mankapastad Clinic, are also providing Nevirapine as part of the government PMTCT programme. 16 clinics offer VCT services. According to the Department of Health, Hammanskraal District Office, of the 9408 people tested in the year April 2004 to March 2005, 3175 tested positive. At the time of the inquiry, none of the clinics in the area are offering ARVs to patients, but the recently accredited ARV clinic had started seeing patients and was waiting for drugs to start the roll out in September 2005.

There are a number of traditional healers in the area. They are fairly well known and the population relies on them for health services. Together with the elected local council, tribal authorities are still prominent in the areas. Most traditional leaders are involved in the administration of justice, and deal with issues such as domestic problems. They generally do not deal with HIV issues. There is one court at Moretele in Temba and two police stations in the area.

According to Zuberi, (2004:12)

Despite the number of services available, and the fact that there are two provinces involved in service delivery, effective service delivery is limited. In general, services are clustered in Temba and there is a need for greater spread of services. In addition, although there have been HIV/ AIDS initiatives within the community and other sectors, there is little or no coordination of these activities.

Approximately 25 organisations providing a range of HIV/AIDS services, participated in the ECD study including 15 non-governmental organisations, representatives from the Departments of Home Affairs, Health, Education, SAPS, the Community Policing Forum and Social Services as well as two Day Care Centres and a community Radio Station.

3.2 Existing safety nets and role-players for each of the sites

3.2.1 Masiphumelele

In Masiphumelele a range of CBOs and NGOs offer services for children (Bosman and Rinksma 2005). The Valley Development Trust administers a number of projects, these include the *Open Door* and *Eye on the Child* volunteers who look after and offer protection to children who are abused and neglected; *Nceda Nani* volunteers visit homes with a focus on support for the HIV positive (providing food to 35 homes and referring abused, neglected or

“left alone” they are taken to the social worker). *Hokisa* provides residential care and medical services for young children infected or affected by HIV whose parents cannot look after them. *The Living Hope Centre* provides prevention programmes, care and treatment of HIV/AIDS. Services include a hospice, health clinic, women’s health clinic, youth programmes, and home-based care (in partnership with the Health Department).

Valley Development Project’s *Early Learning Support Project* manages preschools and *Khanya Kwezi*, a community-based programme for young children who are unable to attend preschools. Volunteer family and community motivators (FCMs) visit households to teach parents and caregivers to support early learning at home and to link them with community support services such as the clinic, home affairs and social services. The programme includes monthly workshops on topics such as child safety, nutrition and stimulation. FCMs receive a monthly stipend. They visit each of their families twice a month for an hour and a half to two hours, run a cluster workshop once a month and attend a food distribution session. In addition they write up reports and attend training and weekly feedback sessions for about two hours.

A number of initiatives provide nutritional support. *Siphosethu* supports adequate nutrition through provision of food parcels to children in the FCM programme, food to preschools as well as a direct feeding service to neglected children. *WARMTH* has a community kitchen, which sells inexpensive daily meals.

To support grant applications, Home Affairs comes to the area once a month for birth registrations. The City of Cape Town community development services support capacity building with a particular focus on women and children. There is a local primary school with high school classes on the same site, both of which are overcrowded. There are 11 preschools in the area, who are members of the ECD Forum which assists in accessing information from departments of education and social services and provides ongoing professional development. These are mostly home-based and informal and only 3 centres receive a welfare subsidy. There is no Grade R class at the local primary school but the Western Cape Education Department has registered two of the preschools. The library in Masiphumelele is a place where children can do their homework and there is a lap programme to encourage reading for young children one morning a week using volunteers. In addition to books, there are puzzles and games. At the Baptist Church there is an afternoon recreational programme for children aged 2 – 6 years.

As part of a separate partnership initiative between the Early Learning Resource Unit and VDP to develop a better service response for vulnerable young children in Masiphumelele, Ocean View and Red Hill, stakeholders engaged in mapping resources and identifying the gaps for young children in each of these areas in February 2005. This was done within a Human Rights Framework and included introducing stakeholders to the Human Rights

Approach to Programming. Gaps identified in Masiphumelele included basic infrastructure such as a fire station, police station, day hospital and park/playground, as well as concern for food security, safety concerns e.g. fires and risks from electricity, need for regular access to social workers, home care for children and aftercare. The issues stakeholders prioritised for immediate action for the support of young children in the area were

- Clinic, health services (accessibility, responsiveness for young children)
- ECD centres including subsidies and training
- Additional training in HIV
- Support for caregivers
- Food support through gardening
- Library services – involving parents
- After care and special care.

This wide range of services, many of them NGOs with community volunteer support make up the existing safety net for vulnerable children. A generally strong focus on young children in these services, the role of FCMs and good networking with others such as social workers and even to some extent, Home and Community-based Carers, for finding and referring vulnerable young children are particular strengths. Good links between ECD practitioners through a regular forum also have potential for strengthening the safety net for young children. Community participation on a broader basis however needs to be developed as linkages between the different stakeholders and particularly provincial services need strengthening.

3.2.2 Nkandla

To address the challenges to the well-being of young children in Nkandla the Municipality has initiated an integrated programme in collaboration with TREE, UNICEF and the provincial departments of health and welfare. This is part of their broader commitment to making Nkandla a “Municipality fit for Children”.

In 2002 the Department of Social Development requested UNICEF to fund a situation analysis of children in the Nkandla and Mhlathuze Local Municipalities. UNICEF initiated contact with TREE to jointly address issues of ECD and Community IMCI. All these processes utilised a human rights approach to programming (HRAP). To integrate all the processes and strengthen partnership, HRAP training took place for government departments, councillors, local municipality, and CBOs from Nkandla in August 2004. Local partners agreed that a Local Programme of Action for Children (LPA) in Nkandla should be developed and this was later integrated into the Municipality’s Integrated Development Plan.

The Local Programme of Action for Children (LPA)

The LPA noted the need for formation of partnerships and integration of services to enhance the development of children and for promotion and protection of their rights. Existing structures such as Thuthukani, an ECD Association, would not only work with the Department

of Social Development but also the Departments of Health, Agriculture, Education and traditional and local government.

Components of the LPA Strategic Programme of Action with the most relevance for young children include the following:

- Recognition of the tremendous need for complementary and alternative forms of child care and early education because of the high number of children not in ECD centres coupled with weakened family and public social sector support for child development in Nkandla.
- Strengthening of home-based interventions – where services are provided to children within the child's home through intensive work with the child's parents and the family as the primary focal point for growth and development of the child.

Planned interventions for developing an integrated ECD programme relate both to ECD centres and to wider community initiatives to support young children. Plans for ECD sites (community centres and Grade R classes at schools) include training and support for teachers in sound ECD methods and how to support children with disabilities, HIV/AIDS, orphans and those who are abused; providing educational resources, timely payment of subsidies and lobbying for feeding for pre-Grade R children. More general interventions include parent education and information, registering all child births and helping with grant processing, community IMCI and welfare support for hungry children. Volunteers will be trained and community members assist in the drop in centres.

During 2004 the Nkandla municipality took the following measures, which prioritised children's issues within their activities:

- Forming a multisectoral forum (MSF) to improve delivery of services to children
- Collaborating with the Department of Health to develop a home-based care programme (HBC) and working closely with the Department of Social Development and CBOs to identify AIDS orphans in Nkandla.

The Integrated ECD Initiative (IECDI)

The IECD Initiative in the process of development by TREE, the Municipality and other stakeholders with support from UNICEF is piloting in Wards 4, 9 and small parts of 8 and 10. In February 2005, when this research project began, the project had been going for 6 months and much of it had involved the establishment of networks and structures. There are distinct resource differences in the two main pilot IECDI areas of Ekukhanyeni, which is closer to town and has more resources, and Ngono. The initiative has a focus on young children in ECD sites and in households. Ten Community Child Care Committees (CCCCs) have been formed, two per zone and each village nominated a volunteer with previous experience in voluntary community work to be a Family Facilitator (FF). The ability to read and write was a recommended criterion.

These facilitators will work with vulnerable children and families. Their first task has been involvement in an assessment of households, which the CCCCs identified as poor, 341 in Ngono ward and 320 in Ekukhanyeni ward (Valley Trust 2005). This involved geographic

mapping of the household and developing a family profile including the number of children, adults, ages, food security and health questions including whether anyone in the house had been bedridden in the last two weeks. The survey was seen as a starting point and useful for developing an understanding of well-being and vulnerability of children in Nkandla. From this experience the FFs identified priorities for intervention. In order of priority these were health, birth registration, social security e.g. grants and foster care, food security, education (children out of school, dysfunctional ECD centres), energy, water and income generation.

However the development of volunteer activities had been slow. This has partly been due to lack of funding (in the first six month period, there was only sufficient for a once off payment as appreciation for collecting the household information) but also as the TREE Project Manager explains because “the experience of accessing one’s rights and that of others has been outside of the mindset of family facilitators since these services have not been readily available for the marginalised majority. Assistance has tended to be on a neighbourly basis.”

The role of the FFs will be to visit homes to support caregivers, OVCs and children. This will include play and ECD stimulation, information to improve parenting practices (including the 16 key messages from IMCI) and assistance with accessing grants and documents. Each FF will work 5 days per month with 10 families and the ECD site nearest them over a 12 month period. Then after review, they will cascade to others over a 3 year period. Provision has been made to pay them a stipend from September 2005. It is planned that other existing volunteers and Community Health Workers (CHWs) will be used to increase and extend the programmes. 21 FFs started the programme but two have left, one to take up employment and the other because she found the work too stressful.

Capacity building for the ECD sites, FFs and CCCCs is the responsibility of TREE. The FFs have attended the following training and development sessions:

- TREE Parenting and Toy making
- The role of FFs as duty bearers in relation to child headed households
- Roles and responsibilities of FFs in IECDI
- Self Help Groups and SMME
- How to participate in the Child Health Survey
- Meeting with the Departments of Home Affairs and Social Welfare and Development to help them understand what information is needed to apply for documents and grants.

The Children’s Desk (Project) Coordinator, in the Municipal Offices supervises the FFs meeting with them once a month, and is in turn mentored and supported by TREE and UNICEF. He reports on a monthly basis to TREE but is also accountable to the municipality to whom he reports on the project and on child related issues in the area. He previously coordinated the HIV/AIDS network and is very motivated about the importance of safety nets.

The CCCCs are ongoing and have had a similar training to the FFs. They are part of Social Services' National Integrated Plan on vulnerability and linked to the Child Protection Forum in Nkandla. As a result they have an increased awareness on matters of child health and child care and have participated in campaigns to extend foster care and birth registration in Nkandla.

Structures in support of the IECDI

The Nkanda IECDI Stakeholders Group and Children's Desk are located within the Nkandla Municipality. The Local Programme of Action for Children is the desired structure within the Municipality to co-ordinate the delivery of all services that respond the needs and rights of the children. An IECDI Advisory Group has been established including TREE, UNICEF, consultants and district and government officials and other NGOs and CBOs from the area and beyond. This links with the Multi-sectoral Stakeholders Forum (MSF) in the LPA. Once the MSF is formalised, representatives from the Community Child Care Committees and the FF coordinator from each area (5 zones as delineated by the Management Committee of Nkandla) will attend.

In Nkandla there has been a concerted effort to structure stakeholders at all levels to provide a safety net for vulnerable children. Like Masiphumelele it is based on a human rights approach. While Masiphumelele has more access to the resources provided by service organisations, and to provincial services, Nkandla has moved to formalise the safety net and has strong community and local leadership support. Like Masiphumelele the safety net has a strong ECD focus largely due to the involvement of TREE, an NGO which specialises in the well-being and development of young children.

3.2.3 Hammanskraal

No co-ordinated safety net response had been initiated in this area at the start of this study. There was no special focus on young children and no strong ECD organisation. However there were several organisations responding to children, mostly of school going age or to children as part of services to households affected by HIV and AIDS. The participating organisations are described in more detail in the separate case and in the findings in Part Five of this report. Since there was very little documented information available at the start of the project, data on the participating organisations was generated through the workshop process.

The eleven non-government organisations that participated in the research process provide a range of services including training of ECD practitioners, training for income generation, peer education, support groups, HIV/AIDS awareness and empowerment, aromatherapy and care for the terminally ill. Most organisations offered a combination of home-based care, advice and assistance in getting documents and grants, food parcels and assistance with food gardens, income generation and programmes for orphans or vulnerable children. These

organisations provide an important service but generally lack access to funds and the necessary skills and capacity. There is a mix of some more well-established or well-resourced organisations like *Sunrise Hospice* and those like *Tsepong*, which is non-profit faith-based organisation that depends on donations and is staffed entirely by 10 volunteers. However, most of the NGOs are staffed by volunteers who do not earn and in relation to the population only reach a small number of those needing services.

Keletsong Community Training and Resources Centre is the only organisation in the area that focuses specifically on young children as it trains ECD practitioners, offering a basic Level 1 training and the Level 4 national certificate. They offer maths, science and literacy training for ECD practitioners and other caregivers, and HIV training. In the 3 years they have been operating in Hammanskraal they have trained about 200 practitioners. However because trainees cannot afford the costs of training Keletsong can only train when they receive donor or public funding. As a result of funding constraints at the time of the research, they were not offering any training in Hammanskraal or Temba. *Kanana Development Centre* provides education and training in health related issues skills development for job creation.

A Re Direng Care Givers, who have worked with vulnerable children since 1998, explain that the aim is to help vulnerable children to develop psychological skills to cope better in situations of stress and trauma. They have realised that this requires rigorous intensive training of care-givers, the involvement of the community and the joint effort of all stakeholders. Consequently, “the planned programme is not operating smoothly as expected due to lack of adequate funds and well-trained skilled staff”. This is one of the NGOs in the area specifically responding to vulnerable children aged 3 to 13 as they recognise the youngest need the most help. Its mission is to continue with caring, loving and supporting orphans and vulnerable children and those who are affected and infected by HIV/AIDS through home-based care. Orphan programme activities include assisting with school work, support and counselling, providing children with nutritious meals daily, assisting with grant applications and food parcels. They have 130 orphans registered.

Other NGOs with a specific focus on the chronic and terminally ill and orphans include *Perseverance Rural Development Centre (PRUDEC)*, *Moretele Sunrise Hospice*, *Tswaraganang Community Project* and *Maubane Health Information Centre*. PRUDEC services rural areas in the Moretele district where HIV/AIDS facilities are scarce. They assist orphans and run a children’s programme for 465 children including life skills, dance, indigenous games and assisting children with grants and attending school. Food parcels are provided for up to three months while the families are waiting for foster grants. *Moretele Sunrise Hospice* similarly assists OVC with psychosocial support, food until they receive grants, and school uniforms. They also provide training for starting of food gardens. *Tsepong*, a faith based organisation, provides support for HIV positive people and orphans

including food parcels while people are waiting for grants and skills development for income generation.

Eight volunteers provide all the services offered by *Tiisanang*, which means “strengthening”. The empowerment centre offers home-base care and a support group for People Living with AIDS (PLWA) holding socials every Friday, visiting orphans in their homes and offering peer education and focusing on teenage pregnancy.

Most of these services were initiated by the community in response to the deepening HIV crisis and rely heavily on volunteer support and donations. It is clear that these organisations are providing an important service. However as will be discussed in Part Five, most of them complain of difficulties accessing funds and the necessary skills and capacity.

PART FOUR: THE ACTION RESEARCH PROCESS IN THE THREE SITES

In this section we describe the action research process for the sites. While there was broad consistency across the three sites, the degree to which the stakeholders in each site were familiar with the human rights approach to programming, appropriate programming for young children and how developed the safety net was, determined what capacity building and facilitation was required. Since the process in Masiphumelele and Nkandla was similar, the descriptions have been integrated. The process in Hammanskraal is reported in the following section, as the circumstances required a somewhat different approach.

Information from the sites was gathered from stakeholder workshops, jointly facilitated by the lead and co-researchers, supplemented by site-specific focus groups conducted by the co-researchers and participant generated cases and organisation descriptions. Co-researchers introduced the lead researchers to the site and to existing local data sources to inform the study. Co-researchers were responsible for all logistics, documented the focus groups and provided translation in the general workshops, which were conducted in the local languages: isiXhosa in Masiphumelele, isiZulu in Nkandla and Setswana in Hammanskraal.

4.1 The research process in Masiphumelele and Nkandla

4.1.1 Initial contacts

Once the research partnerships had been established, initial contact was made with the co-researchers and some of the local stakeholders in both sites. In Masiphumelele this involved the Early Learning Support Project coordinator, Lynne Lamb, the family and community motivators (FCMs) and the principal of Masakhane Educare, Zanele Bontshi who plays a key role in the local ECD Forum. In Nkandla, there were meetings with the TREE Project Manager, Vicky Sikhakane, Councillor B.V. Khanyile, who holds the portfolio for child and disability issues and a group of ECD practitioners. Subsequently Mzothini Mkhize, Nkandla Project Coordinator, and Chris Gibson, TREE, participated as the main co-researchers. Preliminary planning included identifying local words for vulnerable (*abasengciphekweni*, which literally means “those standing on the edge/at risk of falling”, in isiXhosa and *olimazeka kalula*, “those who are easily hurt”, in isiZulu).

4.1.2 General workshops

The first workshop followed the same format in all three sites and was for a broad group of stakeholders involved with services affecting young children in the area as well as political and community leadership. Service providers invited included provincial departments, volunteers, NGOs, CBOs and ECD practitioners. The researchers involved in each site had discussed the format and felt it to be appropriate for their sites.

The aim was to explain the purpose of the study, to find out the ways young vulnerable children were being helped in the research site and to make a short term plan for addressing gaps in the safety net.

After introductions in which each participant was explained their name, institution and what they felt good about in relation to helping young children, there was discussion in groups about

- What is a vulnerable child?
- Who identifies vulnerable children? and,
- What do you do to help vulnerable children in Masiphumelele/Nkandla?

Participants were then asked to visualise/dream about what they wanted for vulnerable children in their community. Their dreams were expressed in simple sentences in the present tense (e.g. Children are not hungry) then categorised and finally grouped into those that could be done immediately without outside resources and those that could be done later. The immediate activities were prioritised by voting and turned into a short term programme of action for the next six weeks.

Although they had been invited, unfortunately not all the targeted stakeholders attended. In Masiphumelele 21 participants from 10 different services/structures attended. These included 10 Family and Community Motivators, two volunteers and two staff members from HIV support programmes, three from feeding and support programmes for vulnerable children, two ECD practitioners, a volunteer from Eye on the Children and the Early Learning Support Project Coordinator.



Stakeholders in discussion at the Initial General Stakeholder workshop in Masiphumelele

In Nkandla representation of traditional and local authority leadership was encouraging. The workshop was attended by 20 people, including two councillors, an induna, an ECD practitioner and 16 family facilitators.

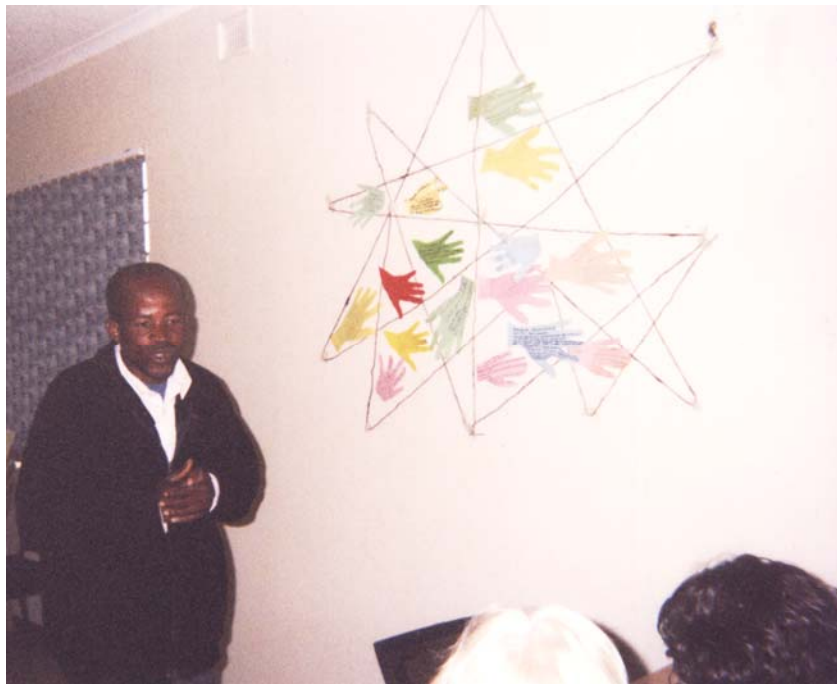
Evaluating this process participants in Masiphumelele commented particularly on what they had learned about other community services and with whom they could network. In Nkandla the process of turning dreams into actions required a useful mind shift in the group and there was some vigorous problem solving around ways of operationalising goals for the prioritised areas. The group commented that this had been very useful in helping them know what to do from now on. The reason that this had not yet been done was partly concern about whether continuity of funding from UNICEF was possible and also because the project was in the early stages. The TREE Project Manager commented that "The methodology was engaging people making them internalise the simulations and helped them to think about their own reality."

The second general workshop took place as the final research project activity and after the different discussions and groups facilitated by the co-researchers and described below. A particular effort was made to draw in representatives from provincial health, social services and education departments, other home-based initiatives such as community health workers or HCBC and in Masiphumelele political leadership.

The aim of this workshop was to

- Remind stakeholders of the aim of the initiative i.e. to help young children grow well, and help those at risk
- Review what had been done since the initial stakeholder workshop
- Get input from new stakeholders
- Clarify different roles when vulnerable young children are identified – are there barriers (*imiqobo/izingqinamba*)?
- Discuss what help is needed from other role-players, and
- Consider the way forward.

An introductory exercise provided an effective practical illustration of the idea of a safety net. A ball of string was thrown from person to person with each holding his/her strand. This formed a woven platform onto which we placed a cloth 'child'. Participants observed how the net supported the child and then how, as different participants were asked to drop the strand they were holding, the net sagged and the child became more and more insecure, finally falling through the strands. Participants then reflected on the importance of each role-player playing his or her role, in order to protect the rights of vulnerable children. The importance of networking was reinforced in another introductory exercise in which a similar string safety net was prepared on the wall and each stakeholder present, wrote on a cut out paper hand what they were doing, and then after describing this, stuck it onto the net. With aid of a local case study, the help different role players can offer was discussed, as well as the barriers they experienced and what assistance they needed from other role players to strengthen the safety net.



Mr Mazwendoda Ngubane, Induna of Skwane at Ngono, who also serves as a CCC member, introduces himself and how he contributes to the safety net. His role written on the cut out hand will be added to the net on the wall.



Mzothini Mkhize, NPC coordinator and Child Care Committee members discussing how they help vulnerable children

Turn out was disappointing in Masiphumelele despite promises of attendance, though this workshop did bring in some stakeholders who had not previously been there. It was attended by 10 people including City of Cape Town library and community development services, ECD practitioners, FCM representatives, Eye on the Child, Parents and volunteers from Nceda Nani.

In Nkandla, despite a crippling taxi strike, which caused the workshop to start very late, the 26 participants represented a wider range of stakeholders than previously. They included 10 Community Child Care Committee participants (who included an induna, community health workers, ECD practitioners and community members), 4 ECD practitioners and 13 Family Facilitators. Again the absence of provincial department staff who had been invited was disappointing.

In Masiphumelele when the way forward was discussed and the fact that there is no coordinating mechanism or forum to bring together the many support initiatives for vulnerable children was noted as the challenge to be addressed. The need to share and cooperate was affirmed.

In Nkandla where there is an existing coordinating mechanism, the emphasis for the future was on specific areas of follow up, especially access to documents and grants and resources for ECD centres. However in his evaluation the coordinator notes that he will be working to draw more stakeholders in to the net,

I think we need to involve churches, councillors, all the departments and the NGOs and take it to a larger audience. Collaboration between ECD practitioners and the circuit office needs to be strengthened.

4.1.3 Site-specific focus groups and consultations

Masiphumelele parent/caregiver cluster workshop

In Masiphumelele there was the opportunity to use a regular monthly workshop for caregivers/parents involved in the FCM programme, to establish how they viewed vulnerability and who they saw as important resources for a safety net. The FCMs ran this after an introductory workshop the previous week, to establish their experiences of vulnerable young children in Masiphumelele and take them through the format for the parent workshop.

Although it was rainy 101 parents attended and were divided into groups each facilitated by an FCM. Questions related to the signs of vulnerability, which children in the area were most vulnerable and why, opinions about the relative vulnerability of children under 3 and 3 – 6 years, what could help vulnerable young children and which of these resources were available in Masiphumelele.



Nompumelelo Mbunjelwa, family and community motivator, facilitates discussion at the parent/caregiver cluster workshop

ECD Forum focus groups in Masiphumelele and Nkandla

There had been many references to ECD centres as part of a safety net but very few practitioners had attended the introductory stakeholder workshop in either Masiphumelele or Nkandla. ECD centres, on the whole, appeared to be playing a rather limited role in addressing the needs of the most vulnerable young children. For these reasons, it was decided to convene ECD practitioner focus groups. This was seen as an opportunity to

- explore what ECD practitioners were doing for vulnerable children who attended their centres and,
- get practitioners thinking more deeply about vulnerable children at their centres, their specific needs and the services required.

In Masiphumelele the regular monthly ECD Forum Meeting was used for the focus group and was attended by 10 preschool principals from the area. In Nkandla the Children's Desk Coordinator also has a regular meeting with ECD practitioners and 18 ECD practitioners attended.

Masiphumelele focus group with VDP social workers and other staff

Social workers were identified in all the workshops and meetings as a key resource in assisting vulnerable young children in Masiphumelele but had themselves not been able to attend the stakeholder meetings. FCMs and parents had indicated difficulties in accessing social workers quickly if a vulnerable child had been identified. For these reasons the co-researchers felt it would be valuable to involve all the Valley Development Project staff, in particular the social workers, in a focus group. The meeting aimed to

- update the social workers and other VDP staff about the research pilot, what had been done so far and what the feedback on the local safety net had been
- get their perspective on vulnerability in relation to young children, how they feel the safety net is working and how it could be strengthened.

It was attended by 4 social workers, a manager of their feeding programme, the youth project manager, a social work student and the administrator. Issues discussed related to common referrals for young children, the extent the services reached children who needed them, which cases were given priority, possible back ups, barriers and enabling factors to performing their roles.

Nkandla Family Facilitator training

In Nkandla a training session for the family facilitators, provided a number of indications of which children were perceived as vulnerable and which vulnerable groups were not considered. Problems FFs were encountering when attempting to assist vulnerable households were raised and the roles and responsibilities of FFs in the Nkandla IECDI project were discussed.

Case histories

In addition the sites were asked to provide examples of specific cases in which a vulnerable child was identified which would indicate the ways in which the safety net for young children in the area was working or not. For Masiphumelele cases were extracted from the Family and Community Motivators' notes. For Nkandla there were cases from the Children's Desk Coordinator and one provided by an ECD practitioner.

4.2 The research process in Hammanskraal

The action research in Hammanskraal was undertaken primarily through a series of three workshops between April and June 2005, working closely with the main co-researchers Solomon Shirinda and Ben Koma from the Centre for the Study of Aids (CSA) at Pretoria University. The first and second were each one day and the final workshop was held over two days. More than 25 representatives from a wide range of different government and non-

government stakeholders participated. Unfortunately some of the government officials did not attend on all the workshop days. There was strong commitment from all participants to take the process forward and engage more of the government role-players. A steering committee was established to take the process forward with the support of the CSA. The plan was to seek support from the Department of Social Services to establish a Child Care Forum in terms of the policy guidelines, which participants regarded as helpful.

4.2.1 Initial negotiations and preparation

Partnership with several potential sites in Gauteng was investigated, before a meeting with Pierre Brouard and Farhana Zuberi led to an agreement with CSA. In the first meeting with co-researchers clarification was negotiated about the purpose of the study, geographical scope, the role players, mapping strategies, and research questions and methodology. The four interlinked methodological strategies have been discussed in Part Two:

- Action research
- Communication for social change
- Appreciative Inquiry
- Action-oriented rights based approach

Co-researchers expressed their appreciation for the participatory approach that involved all of them actively. They felt empowered by the new vocabulary and “conceptualisation gained”. They liked the acknowledgment “that each and every one of us within our community has a role to play in child development”. One co-researcher noted that it was interesting to take part in planning the project and stated, “I believe we have already made the first move”.

4.2.2 The series of three workshops

The purpose of the study and workshop was introduced in the first workshop and the notion of action research explained. Using an appreciative approach for the introductions, each participant was asked to say their name, their organisation and one thing that makes them good at what they do. This exercise was designed to motivate and energise the group by building on the positive, rather than starting with problems. During the reflection on the introductions, participants noted how difficult it is for them to talk about their strengths, as this is often seen as “boasting” and in poor taste. However, everyone agreed that it is important to talk about our strengths and successes as well as our difficulties. In using an appreciative approach, the first question is said to be “fateful” as it can determine the tone of the entire process.

In the first “Discovery” phase, participants worked in groups to answer three questions about their strategies to identify and support vulnerable children. Their responses are discussed in Part Five together with their dreams of how they would like things to be for vulnerable children. They were asked to write these dreams in the form of specific statements in the present tense about the future. They were then asked to organise the dreams into three

categories: those that could be implemented without additional resources and help from outside the community; those that would need some help and resources; and those that would need a lot of additional resources.

Groups were then asked to select about five of their dreams from the first group (those that could be implemented without additional resources) and turn them into a plan of action. The most important outcome of this process was that participants realised that unlike most other workshops that they attended, this project expected them to engage in real action. They explained that normally when they went to workshops, the discussions were theoretical as they were merely receiving “training”. Most participants liked the workshop and felt they had learned a lot.

Participants were asked to think about how they could work together to ensure the well-being of all children in the community. They were asked to look for opportunities that exist in the communities and in their work.

The second workshop was facilitated and documented by the co-researchers. 24 participants from the 15 NGOs, 2 day care centres, Department of Education and South African Police Services attended.

The aim of the second workshop was to

- report back on the progress since the last workshop
- improve understanding of what makes young children vulnerable and to start to tackle the more difficult dreams for helping them
- plan tasks to do in our organisations and communities before the next workshop
- set a date for the next workshop
- promote interaction between participants.

Following the introduction, participants met in the same groups as the previous workshop to reflect on and report on progress on the plans they had made. The aim of the next session was to deepen the understanding of how young children grow and learn. From the first workshop, it was apparent that organisations were not making the link between poverty and vulnerability and were also not focussing on young children as the most vulnerable sub-sector. Consequently group discussions were facilitated to help participants make the link with poverty and recognise the special needs of the youngest children.

Participants were given two homework tasks. Firstly, they were all asked to describe their organisation and the work it does. Secondly, they were given a choice to either hold a small focus group with one of the stakeholder groups or tell a story of how they tried to help a young child.

The evaluation of the workshop by participants was extremely positive. They enjoyed the workshop and were particularly impressed by process, the participation and facilitation, and that it was in the local language. One participant noted, “Information gathered opened my

eyes and heart". Participants learned a range of things about supporting vulnerable children and networking. They also learned about their own self worth, for example, "From today I know that I am the backbone to my community being a caregiver as I am; I can access every institution to help with every help the community need" and "That my involvement in the community is vital especially for orphaned children".

Many participants noted that they had learned a lot about responding to the needs of vulnerable children. Some mentioned their psychosocial needs, "I learnt that many of the children that are vulnerable need most love and care".

Many responses referred to learning the value of networking and getting helpful information from others, especially about referral. Here are a few examples,

- I have learnt that as a group of NGOs, Department of Health, Department of Education working together hand in hand, we can all help each other to help children in our community.
- Working together and networking is the best
- More about networking, it works
- Together we can beat anything.

Participants were particularly pleased about participation of Department of Education officials and found the information they provided very helpful

Twenty-two participants attended the third two-day workshop. As in the other sites the participants also started with the string safety net activity. As participants had arrived, each participant received a hand cut out of coloured paper and asked to write their name, their organisation and how he or she had helped a young child since the previous workshop. Each now placed his or her hand on the net prepared on the wall, introduced him or herself, talked about their organisation and described how they had helped a young child. After each presentation, participants had an opportunity to ask questions of clarification, but were asked to wait until the next session for discussion of the issues.

During these presentations, issues for discussion were identified and listed on newsprint. This took a large part of the first day, but was well worth the time spent as it helped participants understand the work of other organisations and the connections. It also generated the issues for discussion on the following day. At the end of the session, participants were asked to prioritise the five issues that they would most like to discuss the following day. In this way the participants were able to analyse the data themselves. These discussions are presented in Part Five of the report.

An action oriented rights based approach was introduced, using an activity that highlights the relationship between economic status and rights, followed by an introductory brainstorm and discussion that clarified the difference between a need and a right

- All rights are needs based
- Needs are turned into rights through laws
- There is one or more duty-bearer responsible for protecting all rights.

As an introduction to the discussion of the issues prioritised the previous day the importance of understanding underlying causes was emphasised. It is important to understand why all the rights of young children are not being protected and why their needs are not being met. This must include physical, emotional, social and spiritual needs.

Since the challenge is to mobilise communities to protect child rights, there was a brief discussion about how communities can monitor child well-being and protect child rights. An early draft of the guidelines for Child Care Forums being promoted by the Department of Social Services was introduced and discussed briefly and a copy of the guidelines was provided for the co-researchers.

Participants then discussed the way forward, elected a Steering Committee and identified tasks for them. They completed evaluation forms before leaving and the responses were once again extremely positive, with a clearer understanding of the notion of safety nets emerging and commitment to take the process forward.

4.2.3 Homework tasks and focus groups

Participants were also asked to provide a written description of their organisation and their stories of having helped a young child to be included in the research report. The verbal and written reports were synthesised and presented together in the Hammanskraal case as part of the findings and site descriptions. Most chose to provide stories. Co-researchers also held focus groups with ECD practitioners, home based care-givers and primary care-givers.

Of the five caregivers interviewed, two of them take care of their biological children, two are caring for orphans and one is looking after her grandchild. While they all recognise the value of ECD centres, some cannot access this services as they cannot afford the R60 fees. The child support grant is generally covering the fees of those attending an ECD centre. While they all access the child support grant, it is not sufficient for some and so they report they want a Foster Care Grant.

Five home-based caregivers were interviewed. They offer care, support and counselling to orphans, sick adults and their families. They list the following challenges:

- Lack of trust between them and the patients
- Sick people belong to the family and some families don't want their assistance because of stigma
- Children that stay with grand parents do not go to school due to negligence and not seeing importance of education
- Child headed households.

These caregivers said unemployment played a huge role in the negligence of children, as family members cannot help orphans. They said that only orphans that had relatives who are employed could go to school. As an organisation working with orphans, one of their responsibilities is to find children who do not go to school and send them to school. They said

they could talk to school principals to provide school-fee exemption for children that cannot pay fees. The problem is that they find some children in the middle of the year, when they cannot be accepted into schools.

A third focus group with ECD practitioners from the same centre that charges R80 per child per month. They said sometimes they struggle to get the fees, as some parents do not work, but said that most get a government grant and they use that money to pay. They also said they get a subsidy from the government which is R4-50 per child per day. But they said they get this money late in the year (this year they haven't received it yet) but they do get it.

Challenges they have are:

- Not having enough food
- Not enough classrooms
- Not able pay teachers.

It is clear that despite the eagerness of non-government role players, without strong technical and financial support, co-ordination and partnership with government, they will not be able to carry the increasing burden of protecting the rights of children in the context of the AIDS pandemic as is evident from the workshop discussion. The three themes prioritised by participants for discussion in the final workshop, and described in more detail in the findings below, related primarily to the urgent need to bring resources into the community through grants and income generation, funding for NGOs and support for volunteers. All of these will require much stronger government involvement and co-ordination.

PART FIVE: FINDINGS

Although it was not possible for participants to engage directly with the findings from other sites, reflection across sites was facilitated in an ongoing way through the lead researchers. In this part of the report the findings from all three sites are compared and contrasted in the light of current policy, programmes and thinking on each issue. The findings are discussed under four main headings: targeting and programme focus, accessing resources, partnership and learning, accountability and advocacy.

5.1 Targeting and programme focus

In order to prioritise and select strategies that mitigate the impact on young children of the AIDS pandemic and related risk factors, a range of decisions have to be taken. While sound development approaches should be holistic and integrated, it is necessary in certain circumstances to target particular categories of children as well as categories of support. Three issues to be considered in determining responses have been identified for discussion in the next part of the report. We start with a general discussion of the way in which vulnerability is understood, look at the importance of targeting the youngest age cohort and at the need to ensure there is a specific focus on psychosocial support alongside of survival issues.

5.1.1. Understanding vulnerability and identifying children that need help

The way in which the well-being and vulnerability is understood affects what service 'strands' a local safety net might include. Consequently this was at the heart of our investigation.

The literature

The literature on programmes supporting vulnerable children frequently alerts programmers to the importance of a shared concept of vulnerability. Smart (2003b) notes the complexity of defining vulnerability, with policy definitions across different African countries differing substantially. Commonly used national proxies for vulnerability such as orphanhood or household income may not hold in individual cases and may exclude other vulnerable groups of children, while local community definitions often include categories other than orphans such as the destitute and disabled.

South African policy generally identifies as vulnerable, a child who is orphaned, neglected, destitute or abandoned, has a terminally ill parent or guardian, is born of single mother or teenager, is living with a parent or adult who lacks income generating opportunities, is abused or ill-treated by a step parent or relatives, or is disabled. The recent draft Department of Social Development's policy framework for orphans and other children made vulnerable by HIV/AIDS (2005) defines a vulnerable child much more broadly as "a child whose survival,

care, protection or development may be compromised due to a particular condition, situation or circumstance and which prevents the fulfilment of his or her rights.” Since the majority of South African children classified according to economic and health indicators might be considered to be vulnerable, a finer system of classification is needed to identify those children who face the greatest threats to their well-being.

Grainger, Webb and Elliot (2001) raise the concern that the “mismatch between notions of vulnerability and the imposition of external definitions tends to result in a top-down approach that is unlikely to encourage community ‘ownership’ of programme activities.” For this and targeting reasons, determining community understanding of well-being and vulnerability is a necessary step for any intervention.

A recommendation of the rapid appraisal of priorities, policies and practices for Children Affected by HIV/AIDS in South Africa (Smart 2003a: 69) was to “develop agreed understandings – at policy and community level – of vulnerability”. Smart (2003a: 69) points out that orphanhood is not necessarily synonymous with vulnerability and that there should be agreement on processes to define criteria of vulnerability in different local contexts. A participatory appraisal of children’s needs has been shown to be a useful way of reaching a common understanding (Harrison, Edstrom and Chan 2003).

The concepts of risk and protective factors are often used in relation to determining the vulnerability of children. Clacherty (2001) notes that securing the right of access to health care services, sufficient food and water, social security if necessary and education are protective factors, which reduce vulnerability. Added to this are the protective factors related to the child’s personal characteristics (self esteem, ability to communicate, internal locus of control), a family which provides support and care and social support networks for children and their families (Donald, Lazarus and Lolwane 1997). Clearly these assumptions about protective factors should be carefully examined in different cultures and contexts, though there is evidence that they hold in some form across a number of different groups (e.g. Grotberg 1995). In Clacherty’s study she looked at how stigma and discrimination reduce protective factors and access to rights.

Examining vulnerability in the research sites

Reflecting on the notion of vulnerability was a central focus in the study in both the stakeholder workshops and many of the focus groups. Participants in all sites were asked

- Which children are vulnerable?
- What are the signs of vulnerability?

Tables 2 and 3 below give rankings of these responses, from small group discussions in the workshops at each site. There was no limit to the number of responses each small group could give but the number of times a particular category of response was elicited is regarded

as an indication of how stakeholders understood the issue. A ranking of 1 indicates that it was most often mentioned.

In considering which children were vulnerable (see Table 2 below) in Nkandla, where effects of the HIV pandemic are most pronounced, participants mention children whose family members are ill or have died. Orphans were specifically referred to by caregivers in Masiphumelele but only twice (of a total of 38 responses), and not mentioned at all in Hammanskraal, despite the fact that several organisations focus their work primarily on the support of orphans and many of the stories that participants told about helping a vulnerable child, were specifically about orphans. The term OVC was readily used in Hammanskraal as an umbrella term. As identified in the literature, orphans per se are not necessarily vulnerable. However in Nkandla and Hammanskraal children who are not cared for are seen as very vulnerable. This appears to reflect children without obvious caregivers as compared with situations where inadequate care is identified. In Masiphumelele parents who drink or take drugs were seen as putting children highly at risk (and this is reflected in several cases reported in the area). One group in the Nkandla workshop also mentioned this category of risk. Concern that children are vulnerable because of rape is very high in Masiphumelele but this may be part of the more general category of abuse, which is also reflected in the other two sites. In Nkandla there is a particular concern about children with disabilities as a vulnerable group. This may be because of vigorous campaigning by a local councillor to provide better services for the disabled. However, it is significant that they were not mentioned in the other sites even though the issue of children with developmental delays or disabilities comes up in the Masiphumelele case histories.

As with orphanhood, HIV is infrequently mentioned in any of the sites, bearing out the importance of taking a broad approach to vulnerability. Although HIV is not mentioned specifically in the discussion about vulnerability in Hammanskraal, it was specifically mentioned in many of the cases. Many of the organisations were started in response to the impact of AIDS. The lack of focus may relate to stigma but also reflects that there are many other risks facing young children (some of which may be exacerbated by HIV) and these may well be more obvious and appear more pressing. One response in Nkandla, "A child who is not accepted in the home or in the community" appears to relate to stigma. A number of vulnerability factors raised especially in the context of young children include environmental dangers and injuries, to which "children with careless parents" or "neglected by the whole family" or "not at school" might be exposed.

Table 2 Understandings of vulnerability (categorised and ranked by site)

	Masiphumelele	Nkandla	Hammanskraal
Family members ill or have died		1	
Poverty, hunger		1	
No one to care for		1	1
Disability		4	
Abuse	3		2
Substance abuse by parents	1		
Rape	2		
Neglect			2

Any early identification of children likely to be at risk requires the ability of those who make up the safety net to be alert for signs of vulnerability. Stakeholders in the three sites were asked “How do you identify children or households that are vulnerable?” Table 3 ranks the most frequently mentioned indicator categories.

Table 3 Indicators of Vulnerability (categorised and ranked by site)

	Masiphumelele	Nkandla	Hammanskraal
Behavioural problems / stealing / aggressive/ problem at school	3	1	2
Lonely / isolated	1	3	1
Withdrawn / unresponsive			2
Frightened	2	3	
Signs of disability		2	
Not hygienic / dirty / unwashed	3	2	

Everybody answered this in relation to the child rather than the household which may explain why so many services focused on one person in the household (e.g. HCBC and DOTS) fail to pick up on other household members who may be at risk.

Community members, fieldworkers and ECD practitioners in the three research sites were able to identify a range of signs of distress and vulnerability including some psychosocial indicators. These seem to be quite generally understood, though with different emphases across sites. Some of these are however severe manifestations of distress and awareness raising to develop an early advance warning system may be useful. The ECD practitioners in Masiphumelele and participants in Hammanskraal commented on early warning signs such as “changed behaviour in the child”, “cannot settle or attend” or “does not take part in activities”.

Many of the signs of vulnerability identified by different stakeholders in the three sites, accord with some of those identified by Richman (1996) in the context of children in the north living with violence. These include

- No friends, isolated, withdrawn

- Apathetic does not play or study
- Worries, fears and panics, nightmares
- Aggressive, disobedient
- Restless, poor concentration
- Marked change in behaviour or capacity to learn.

A key component for understanding vulnerability is how it is understood in terms of different age groups. This is explored in the next section.

5.1.2 Vulnerability in relation to age

The question of whether younger children are more or less vulnerable than older children was specifically asked of ECD practitioners in Nkandla and of FCMs and parents in Masiphumelele. They all agreed that younger children were the most vulnerable. In Masiphumelele the respondents were asked why this was the case. Infants were perceived to be very dependent on carers, but children from 3 – 6 years were seen to be more vulnerable. This was firstly because they are less likely to be closely supervised by parents and caregivers and secondly are seen to be more vulnerable to abuse. Other comments such as “those wandering around out of school” (preschool and Grade R) relate to this. Brooks et al (2004) identify issues of unsafe environments as a key aspect in child vulnerability to HIV infection.

An ECD practitioner in Hammanskraal comments in similar terms – “children under 3 years or between 3 and 6 years are more vulnerable than older children because they cannot take care of themselves and they don’t know safety at all. They can even kill themselves trying to do something to help themselves”.

Respondents in Masiphumelele felt that older children are more likely to recognise and be affected by the illness and death of their parents. This suggests that the effects on very young children of living in circumstances where care-giving is compromised is perhaps an area for further discussion with parents and fieldworkers in all three sites, as it is a key concern raised in the developmental literature from a survival perspective.

5.1.3 Focus on the youngest children

The starting point for this study was the recognition that vulnerabilities differ at different ages. Early childhood is recognised as a sensitive period for survival, growth and psychosocial development. As was noted above (in 1.3), there are distinct vulnerabilities at different ages during the early years. Richter et al (2004) point out that infants and toddlers are especially vulnerable to health risks and to the negative effects of group care. They are also highly dependent. Preschool children are especially vulnerable to nutritional deficiencies, abuse and neglect and to loss of stimulation and opportunities for schooling. At the same time their

increasing independence exposes them to a range of safety risks. A programming framework needs to be responsive to these different needs. One of the major obstacles to providing appropriate services for young children affected and infected with HIV/AIDS identified at the UNESCO/ECDNA workshop was that undifferentiated programmes for OVC under 15 years of age did not indicate what should be provided to children 0 – 8 years of age. Another obstacle was the lack of knowledge of factors that affect the developmental aspects of the young child (UNESCO 2003:22).

Where young children are poor they are vulnerable but where their caregivers are sick, elderly, young or dealing with high numbers of dependents their vulnerability is even greater. In the Phase 1 report of this study (Biersteker and Rudolph 2003) we refer to several aspects of vulnerability highlighted by Lusk and O’Gara (2002).

In Masiphumelele and Nkandla the presence of an NGO, which promotes the interests of young children quite broadly through a home and community-based approach as well as through the ECD centres, was key in ensuring that attention is given to young children. The role of fieldworkers or foot soldier volunteers with a broad integrated perspective was significant in bringing forward young children and in providing support to primary caregivers. In Masiphumelele linkages by the NGO with broader groups such as HCBC, feeding support and orphan support groups as a referral conduit, was particularly successful. What is less evident and will be picked up in the next section of this report was a focus on the psychosocial needs.

In Hammanskraal, where there was no co-ordinating ECD organisation or co-ordinated safety net strategy and most of the participating organisations worked primarily with children of school going age, it proved very difficult to hold the focus on young children. Despite questions specifically focusing on young children, participants repeatedly returned to their experience with older children. One of the responses to the workshop evaluation questionnaire was that the participant had “learned a lot, especially about a child from 0 – 9 years”. Many of the stories of how participants had helped a child included younger children and attempts to meet their needs for grants, food, clothing or care but there seemed to be little understanding of the special needs of the younger age group. Even though A Re Direng Care Givers explains that their target group of children is 3 to 13 years because they recognise the youngest need the most help to make sure they grow well and thrive, it would seem that the children’s programme targets children of school going age.

5.1.4 Survival priorities leave little time and energy for psychosocial support

The focus in many programmes for children made vulnerable by HIV has tended to be on material needs (e.g. Grainger et al 2001). Richter et al (2004:17) observe that

Psychosocial support continues to be one of the most neglected areas of support for vulnerable children. The long term consequences for children who experience profound loss, grief, hopelessness, fear and anxiety, without assistance can include psychosomatic disorders, chronic depression, low self esteem, low levels of life skills, learning disabilities, and disturbed social behaviour.

In the Rapid Appraisal, Smart (2003a) includes a recommendation to “strengthen certain aspects of programmes including emphasising importance of psychosocial support for affected children”.

Psychosocial support (PSS) has tended to be seen as the opportunity for emotional and social support. The Regional Psychosocial Support Initiative for Children Affected by HIV/AIDS (REPSSI) defined PSS as “provision of the possibility of individual disclosure of feelings and emotions and expression of personality (psycho) combined with influencing the social environment to reintegrate affected children into normality and encourage broader understanding of their specific situation (social)” (www.repssi.org). This links strongly with children’s participation rights. REPSSI also includes meeting of physical, emotional, social, mental and spiritual needs of children in this.

The focus for PSS is often on children but a significant aspect of providing for young children’s psychosocial needs is through supporting their caregivers. UNICEF (2002) defines psychosocial as an interconnected relationship between the psychological and social effects of an event. When this is disrupted through extreme stresses and hardships some form of external support may be needed to restore the relationship between the individual and environment. The support elements that are built into the intervention programmes providing psychosocial support focus on enhancing the natural resilience of the children involved in the programme and strengthening family and community support skills (Nott et al 2004). The importance of holistic development is seen in the dreams for a better future for vulnerable children expressed by stakeholders in the three sites. Survival and protection issues included many development and even participation issues. Table 4 below categorises these dreams.

Table 4 Categorisation of Dreams for Vulnerable Children for the Three Research Sites

Dreams Categorised	Nkandla	Masiphumelele	Hammanskraal
Survival food, clothing, support grants, health, shelter, food gardens	11	12	4
Protection Love and care, Caregivers, Child care centre, freedom from abuse	6	8	2
Development Education, places to learn, things to play with, crèche, recreation	6	6	7
Participation Know where to get help, Know rights, Get their rights	3	2	
Capacitated Caregivers Trained, know how to deal with problems, trained ECD practitioners, parents educated about child development	3	3	1
Information / monitoring Community knows who caregivers are, who they work with/who to refer to, community takes responsibility, backup and emergency procedures for young vulnerable children	2	5	1
Networking with / access to government departments			2
Funding for service projects			2

Despite this vision, the strong focus on material needs was evident in the research sites. In Masiphumelele, despite a strong programme encouraging caregivers to interact with their children in ways that promoted participation and learning, the case studies focus on assisting immediate survival issues, with access to health services and grants being the most obvious. The Early Learning Support Project co-ordinator comments that the reports of their Family and Community Motivators (FCMs) reflect on survival and safety issues despite training and despite the fact that most of the interactions with the mothers are around educational issues. Some of the cases reflect these FCMs as being friends to the mothers, keeping in touch with them etc. One case history described a mother who had disclosed her HIV positive status and that of their baby. The child's father "threw the mother out" and threatened to kill the child. The mother was forced to live in a damp shelter made of plastic bags and the child had developed a chest infection and had to be hospitalised. The FCM reported that she "has given her a telephone number to call if she needs support and plans to visit the mom at hospital to discuss the child and to support the family".

In another case the fieldworker had discovered a child with a disability who was rejected by the father. He said "'There are no disabilities in my family' and would tell the mom to take the child out of the room so no one could see the child". The fieldworker helped the mother visit the social worker and the child has been placed in a special school where the mother visits regularly. A more overt focus on psychosocial support has recently been readdressed in training in Masiphumelele and will be strengthened. In particular the need for training in

counselling skills has been identified. The Early Learning Project Coordinator has talked about the Family and Community Motivators “skidding over the top – touching the tip – we are constantly having to talk about empathy at the feedback sessions”. This is attributed to the fact that the FCM volunteers themselves experience the difficult living conditions of the caregivers they are called upon to support.

In Nkandla the family workers had not yet started to interact with families except in the context of the household vulnerability survey but clearly see their role as including stimulation of children, which would provide some support and provide an example. They intend to “Stimulate children to play and encourage their parents to play with them, which will help to identify children who need special attention”. There is no explicit focus on psychosocial support for parents or caregivers at present or in the plans for the next 18 months though it is likely that the initiatives such as teaching them to play with their children, developing food gardens etc. will provide a great deal of such support.

Several of the Hammanskraal organisations, which do not necessarily focus on young children, do however provide psychosocial support. A Re Direng Care Givers for example includes as one of its objectives, “To continue to increase the level of confidence to people living with HIV/AIDS, orphans and vulnerable children”. One of the members explains that the aim is to help vulnerable children develop psychological skills to cope better in situations of stress and trauma. They have realised that this requires rigorous intensive training of caregivers, the involvement of the community and the joint effort of all stakeholders. Consequently, “the planned programme is not operating smoothly as expected due to lack of adequate funds and well-trained skilled staff”.

PRUDEC offers children’s programmes on Mondays to Fridays, “like, life skills, cultural dance, dramas and homework, story-teller motivation and music”. Tsepong offers support groups for people who are HIV positive. Tshwaraganang community project provides home-based care and includes in their objectives “developing personality”. Maubane Health Information Centre offers life skills and ongoing counselling. However, most of these services tend to be for school going children and adults.

Hammanskraal participants specifically mentioned “destigmatising” children in schools and institutions. As in the other sites, the stories or cases told are predominantly about assisting with basic needs, but many stories included elements of mental illness, particularly on the part of adults and in some cases the child. For example one 18 month-old child of a mentally disturbed mother was found abandoned in the bush. Apparently the mother had stopped taking her medication. A mentally disturbed 4 year old was found wandering alone in the street, because the mother had gone off for the night with a boy-friend.

Given the deep poverty and pressure to respond to material needs, it is understandable that few of the stories address psychosocial aspects of care. Participants agreed that this kind of help requires advanced skills not necessarily available in their organisations. At the same time, they all acknowledge the positive impact of interest, care and concern as is evident in the following example.

One NGO representative reported on the major improvement in a 10 year-old HIV positive boy, whose mother died of AIDS. The school referred the child and the special care he has been given twice a week has led to a major improvement.

ECD practitioners in all three sites did not strongly present the psychosocial support aspect of their roles. For example in Masiphumelele at a focus group of ECD practitioners the co-researcher, herself principal of an ECD facility explains, "We discussed vulnerable children in our community and how, without realising their needs, these children are often ignored because caregivers/educators often do not know or do not want to make the effort of finding out or referring".

In Nkandla, ECD practitioners explained their role largely as a teaching one, for example,

- I am mediator, allowing learner centred (learning)
- I teach small children about hygiene and food that builds their bodies and their bones
- I teach them about child rights and about dangerous areas
- We teach them to run and play. They know how to wash themselves and how to dress themselves.

Nevertheless two of these teachers talk about problems too "When the children come to school we can talk about all their problems and we can solve them".

A practitioner interviewed in Hammanskraal talks mostly of young children's survival and protection needs. "They deserve security and a good healthy environment; they must be fed properly and clothed warmly with love and care. They have a right to education..."

Apart from the urgency of dealing with survival needs, which predisposes efforts of volunteers and other services in this direction, it does seem that the lack of knowledge and training of what to look for or how to provide support is a barrier.

Suggestions in the literature are that training for parents, guardians and other adults should be introduced or strengthened: first to be alert for the signs of distress and then to better understand how to care and support; second that teachers should be trained to recognise and respond supportively to withdrawn or disruptive behaviour, to a drop in academic performance or even school attendance (Richter et al 2004, Dunn 2005).

Understanding what appropriate interventions might be for carers and young children in different contexts needs to be further explored. Liddell (2002) for example warns that western

assumptions regarding risk resilience and recovery need to be considered very carefully when examining risk in non-western cultures.

It is often suggested that children need opportunities to express anxieties and fears. Parents need support to disclose their HIV status to their children and to plan for the future (wills, care arrangements, memory boxes etc.). The support of being in a group and continuity of care are other programming elements.

The Aids Foundation South Africa (AFSA) has piloted a psychosocial support programme for “gogos” (grandmothers) caring for their orphaned grandchildren. Children from five to nine years were a focus for this pilot.⁸ This was a response to concerns that some traditional cultural norms might have a negative impact on coping processes, such as disallowing talking with an older person about sex, death and fears of the disease. However the intervention design took account of the important cultural element of collectiveness by providing for a collective approach, working in a supportive group, which was felt to be especially important with normal community support systems overburdened due to AIDS.

Gogos were selected because although many kinship caregivers are elderly grandmothers there has been little focus on their needs. The stresses of dealing with this burden of care with little support can result in helplessness and withdrawal from both gogos and the children in their care, increasing isolation and decreasing the likelihood of reaching out for support and care that may be available. The form of support piloted was filial play therapy (Nott et al 2004), because it provides dual support for caregiver and child. In filial therapy, the caregiver is trained to use basic play therapy skills as a way of changing behaviour in the child. This fun and developmentally appropriate activity has been shown to bridge communication gaps between caregivers and children, increasing warmth, trust and self esteem and giving carers an insight into the emotional world of the children. The play techniques were taught in a group, which provided a supportive environment for the gogos. Jewitt and Rozenthal-Thresher (2004) describe the intervention as

..... a programme that is aimed at helping Gogos follow play guidelines/processes to help the children in their care express their feelings, become self-aware, be secure in safe boundaries, and receive positive feedback. In order to do this the Gogo will need to practice certain key skills to apply to the play situation namely listening, reflecting the child's feelings, giving the child positive (constructive) feedback, and limit setting. The support group for Gogos, based on filial therapy principles, is aimed at supporting the Gogos practically and emotionally through this learning process (2004: 23-4)

Since completion of the pilot project, AFSA has been training its partner organisations in this method. It is currently being implemented in three districts of KwaZulu Natal, in Nelspruit and in Viljoenskroon.

⁸ Telephone interview with Nozuko Majola, AIDS Foundation 20 September, 2005

In the research sites play opportunities are considered an important avenue for children to express their feelings and fears (an interesting comment from a practitioner is that a sign of vulnerability is that the “child acts sick even if she is not sick”). TREE training encourages play for young children in their ECD curriculum and is a planned intervention for the Nkandla area. In Hammanskraal organisations report the effectiveness of using play and drama and the value of one-on-one contact, mostly for older children.

Support to adult carers does not seem to have been prioritised in any of the three sites, though it is clear from examples that many of the carers are in desperate need of support. In the Hammanskraal cases, there were many references to caregiver’s emotional and mental health and in Nkandla there was reference to the last surviving carer in a household who was threatening to kill the children in her care. AIDS dementia was not referred to explicitly, but some of the cases suggest that this may be a growing factor and will have major impact on children generally but particularly on the youngest. This is not to say that there is no support to caregivers, clearly the FFs in Nkandla and FCMs in Masiphumelele play a crucial support role, and in Hammanskraal the many CBOs support families as well as children. However there seems to be a need for more conscious and skilled PSS interventions for caregivers.

In addition to the psychosocial needs, basic survival needs must also be addressed and across all sites, where deepening poverty was a key issue. The next section of the report addresses the important issue of resources for families and community-based support organisations. It compares the funding situation in different sites, draws attention to the heavy burden on volunteers, flags the coping capacity of families and the need for other resources and then makes some recommendation for addressing these barriers.

5.2 Accessing resources

A recent Save the Children Fund UK publication “Bottlenecks and Drip-feeds: Channelling resources to communities responding to orphans and vulnerable children in Southern Africa” provides a compelling argument (Foster 2005). As illustrated in the findings of the action research, Foster points out that despite increased funding for HIV/AIDS in Africa, “Expanded resource allocation has rarely translated into enhanced funding at community level” and argues that “CBOs need long term funding that is ‘drip-fed – continuous, steady, small amounts of resources to ensure that communities can sustain their responses and improve quality of life for African children” (Foster 2005:1).

Out-of-pocket spending by households, most of whom are poor, is the largest single component of overall HIV/AIDS expenditure in African countries, a stark reminder that the economic burden is borne by those least able to cope. Households are increasingly vulnerable as they are impacted by sickness and death, and the extended families and community members are assuming care and support of affected children. These structures are straining under the weight. It is clearly a case of the very poor helping the destitute. It is imperative that new ways are found to reduce the share of total AIDS spending by the poor. The priority question for governments, international agencies and

others is how to ensure that available and new resources for orphans and vulnerable children (OVC) and HIV/AIDS initiatives can best be disbursed in order to build the capacity of affected communities and households and directly benefit vulnerable children (Foster 2005:1).

Relevant key findings of the study indicate that current mechanisms do not allow for resource flows that reach community-based organisations. There is lack of clarity about numbers of children reached and quality of interventions. Donors and governments are not held accountable for spending to support community initiatives (Foster 2005:2)

Similarly a recent analysis of interventions for the care of OVC in Botswana, South Africa and Zimbabwe identifies the greatest weakness in that all of the projects visited experience problems with funding – inadequate funding or resources and stoppage of funding pose a real threat to their future. Projects are limited in their impact through over-stretching of resources, including staff (Dlamini 2004: 18).

The SCFUK report, acknowledges the important role that government must play, but

focuses on identifying how adequate resources can reach community-based groups and thereby improve the flow of resources to communities providing support to children affected by HIV/AIDS. Despite growing national commitments from governments in southern Africa and elsewhere, and an increasing commitment of resources through HIV funding, the majority of children are still cared for within their own communities with meagre resources.

When considering community responses to vulnerable children, there is a tendency to idealise the notion of 'community' or use the term as a metaphor for an imaginary safety net of supportive social networks. This places unrealistic expectations on the community and also fails to recognise the limitations of communities. Communities are stepping forward, but can only deliver the needed services to children if they are supported to do so, both financially and technically, in terms of programme design and evaluation (Foster 2005:3).

This understanding is strongly supported through the findings of our study. In Masiphumelele, NGOs have been relatively successful in raising funds for key aspects of the safety net. Nkandla has been hampered by start-stop funding and Hammanskraal provides an excellent example of local organisations struggling without adequate funding.

5.2.1 Reliance on donor funding in Masiphumelele

One of the key indicators for effective safety nets is clearly access to funding not only for co-ordination but also for the functioning of the participating local organisations. The functioning of the Masiphumelele safety net is due to the effective fundraising efforts of the Valley Trust and several other NGOs serving children in the area. Masiphumelele falls within the relatively well-resourced Cape Town Metropolitan district.

With the exception of social grants, health care, statutory social services, the Nceda Nani fieldworkers and provincial subsidisation of two of the 11 crèches in Masiphumelele all other

safety net services in the area are donor funded or rely on volunteers. The Family and Community Motivators and Siphosethu (a food support project) volunteers receive stipends raised from donor funding, though several of the 10 FCMs work at other part time jobs to help make ends meet and this consequently compromises their availability to the programme. The food parcels they provide (R150 per family per month) are also donor funded on a year-by-year basis. They have applied to the Provincial Administration of the Western Cape for funding with no success to date.

5.2.2 Lack of funding hampers progress in Nkandla

The intervention of TREE and UNICEF in Nkandla has also managed to lever some funds for the safety net. However, the irregular funding flow has hampered the intervention. The development of Family Facilitator (FF) volunteer activities had been slow, mainly due to lack of funding. In the first six-month period, there was only sufficient for a once off payment as appreciation for undertaking the household survey. In future the role of the FFs will be to visit homes to support caregivers, OVCs and children. This service will include play and ECD stimulation, information to improve parenting practice, training in the 6 key Integrated Management of Childhood Illness (IMCI) messages. They will assist qualifying families to access grants and the necessary documents. The first three-year plan proposes that each FF will work with 10 families and the ECD site nearest them for 5 days per month for the initial 12-month period. After one year progress will be reviewed with the intention to cascade to other families. Provision has been made to pay them a stipend from September 2005. Of 21 FFs who started two have left, one to take up employment and the other because she found the work too stressful. The plan is for Community Health Workers (CHWs) and others already volunteering to increase and extend the programmes.

Ongoing access to funding support will be key to sustaining the Nkandla safety net. With the exception of social grants, health care, statutory social services, key strands of the safety net depend on volunteers or donor funding for stipends, training costs and transportation.

The TREE Project Manager comments

When TREE initiated Siyafundisana (the Parent / Child programme), we were concerned about the sustainability of the payment. Not remunerating the volunteers created a strained relationship. We felt the fact that we wanted certain information and work done by the volunteers who themselves had nothing was morally wrong. It also hindered the truth of the findings as we soon discovered that some wrote reports without making the effort to verify the information. We then opted to have an open discussion about the issue of remuneration and came to agree on a simple Memorandum of Understanding, which they readily signed. It stated that remuneration is dependent on availability of funds and the life span of the project. This is still a challenge and we realise that we are walking on thin ice when it comes to this issue.

She adds, "it makes it quite a challenge to talk about a three year programme, yet one has to stop and start activities."

The TREE staff member providing mentoring and capacity building to the Family Facilitators and Programme Coordinator reports that in the case of the IECDI

The break in (project) funding has certainly made it difficult to maintain momentum in the project resulting in lack of continuity. Worse than that the relationships that have been built up with the Municipality and the communities based on mutual trust and respect are being called into question because there is no action.

The valuable role that experienced ECD organisations could play in strengthening the safety net through training and support would also require funding.

5.2.3 Call for funding in Hammanskraal

Hammanskraal, which has no overarching safety net or funding strategy, probably provides a more representative picture of the current funding situation for small NGOs and CBOs struggling to respond to the enormous demands created in the wake of the main wave of the pandemic.

Although there was strong representation from non-government organisations (NGOs) in the action research project, many are themselves vulnerable as they do not have access to sufficient funding and they complain that “funds are not forthcoming”. Despite a strong reliance on NGOs, CBOs and FBOs, most of them are in need of funds.

Participants in Hammanskraal research explain that additional funding could be used for a variety of community development programmes such as skills development, awareness campaigns and training workshops, food parcels, home-based care programmes and programmes for children, including psychosocial support. They need buildings from which to operate. There is a call by some for orphanages and foster homes, old-age homes and hospices.

The scope of the research did not allow for a full investigation of the needs described above or the possible causes of the lack of funding. The group identified the following possible causes for the lack of funds: organisations are not registered or unable to meet requirements such as the preparation of business plans; lack of information about funders; lack of expertise in proposal writing; a history of bad financial statements and record keeping; or inadequate accountability structures, for example NGOs which operate like small family businesses.

Accountability and fragmentation are major linked problems. Often, an individual family starts an organisation as a strategy for income generation. While the service they are providing can benefit the community, this can also lead to the abuse of public funding. There is limited understanding of appropriate accountability structures and organisations seem to operate in isolation.

There is a strong call for training and support groups for similar organisations. There is a suggestion that they form clusters to work together on fund-raising. They are asking for help in “identifying relevant funders or donors”. A specific proposal is to establish a “District task team to help NGOs”. This could include developing an “appropriate career path for NGO employees”. There was much discussion about the need to use the South African Qualifications Authority (SAQA) to ensure that payment of volunteers is linked to appropriate recognition for their expertise as they get more training and take on more responsibility. They suggest that a task team could also engage with the “European Union and Department of Health to recognise and fund home-based care givers”. This is taken up in the next section as the lack of funding emerges most poignantly through the stories of the volunteers in Hammansraal.

5.2.4 Heavy burden on volunteers

One of the issues of great concern in the Hammanskraal site is that of volunteerism⁹, particularly since several of the participants are home-based caregivers. They are not earning or earning very little despite the important and difficult service they are providing. For example, the founder of Vukani Community Development Organisation explains that it is not easy to keep people in the organisation, especially because they are volunteering, “so most of the members dropped out. Some found jobs and some just stayed at home. There was lack of support from community leaders, especially ward councillors”.

The explanations of participants in the last workshop for why they volunteer with little hope of getting paid, fell into two broad categories, on the one hand they see themselves providing a service and on the other, there is the hope that eventually they will be paid e.g. “they are also hoping to be hired permanently one day” and recognise that they are gaining skills. They suggested that they are looking for a better happy, healthy living for people (sustainability); they want to help others to know their rights and meet their needs; they want to overcome stigma and give the love to help people. Since they are unemployed they explain that they volunteer to “keep ourselves busy”.

Volunteers face many problems in their own families and within the communities in which they live and work. The first and probably greatest is money. They tell many stories of being faced by the grinding poverty in the households they serve, and having to use the little they have to help. Volunteers are not protected by law. The examples they give are “indemnity and workmen’s compensation”. Without the necessary apparatus, such as “home-based care kits” they are themselves at risk of infection.

The following quotation supports the research findings

⁹ Issues regarding the viability and sustainability of using volunteers surfaced in Masiphumelele and Nkandla as well, but was raised as a major concern in Hammanskraal

Home-based care workers report sometimes facing hostility from community members, they are often nervous about their personal safety in walking the streets on their home visits, they have to be secretive in visiting some homes as a visit may be tantamount to disclosure to the neighbourhood that a person has AIDS, and they are continually faced with complex family and psychological problems which they often do not have the means to resolve. Training, mentoring and support for their work is in short supply (Kelly and Mzizi, 2005:61)

Government is relying increasingly heavily on volunteers, as there are “not enough government workers to do the job”. Unfortunately there is a major polarity, with relatively highly paid civil servants, such as social workers on the one end and volunteers who are either unpaid or receiving a small stipend on the other. There is very little co-operation between these two groups.

The strongest plea of the volunteers is “To work together with the government, for example, the Departments of Home Affairs, Social Development, Education and Health; local government; and police”. They want better channels of communication. For example, they want to be recognised by clinic staff when they bring in their patients. They feel they should be allowed to take their patients to the front of the queue instead of having to wait with them for hours, thus preventing them from reaching all the households they serve. They also want to be treated more respectfully by health personnel and be recognised for the important service they provide. They need transport to get their patients to the hospital. They need to be protected by law. Most importantly they “need recognition of partnership”.

The major polarity between employed workers and volunteers was identified as a major issue. There was a long and heated debate, in which some participants stated that, “volunteering is not working”. This turned out to be a semantic problem that was clarified as volunteers not being “workers”, meaning “employees”. It was agreed that government distinguishes between “employees” and “volunteers” and consequently volunteers have no rights.

The discussion continued focusing on whether some of these problems, e.g. volunteering is not working, identified by volunteers, lay in the policies or the “tendency” of officials. It was agreed that solutions to some of these problems are possible, through the kind of partnership being promoted by the action research study. Through dialogue, for example, government health-workers could see how they are being helped by the home-based caregivers and in turn give them the support they need. It is also difficult for volunteers, who might start out with little training and experience, to be acknowledged and get appropriate remuneration as their experience and expertise increases.

The Expanded Public Works Programme (EPWP) referred to in Part One of the report, offers some promise in this regard despite the extremely slow roll-out thus far. The quotation below from the recent IDASA publication (Streak 2005) throws important light on this development.

Social programme spending has been identified as one of four types of spending for job-creation and training through the EPWP. This includes spending on volunteers who are trained as child and youth care workers and community care workers to deliver early childhood development services, and auxiliary and community workers to deliver other services to children.

The accredited learnership materials for community development workers and child youth care workers is being finalised and provinces are coming up with implementation plans. Apparently stipends are already being paid to workers delivering services to children in some provinces and training (using provincially developed materials) has begun. The plan is to pay workers – formally volunteers – with Level 1 and 2 training R500 per month, with Level 3 training R750 per month and with Level 4 R1000 per month. Fast tracking implementation and taking the project to a decent scale is now critically dependent on the finalisation of the relevant training materials at a national level, as well as provinces finding and allocating more resources (Streak 2005: 34).

As explained above, it is important to note that the EPWP is designed to provide temporary income and involves a number of measures, such as employers setting wage rates locally that do not attract workers away from permanent employment and workers can only be employed for a maximum of 24 months in a five-year cycle (Streak 2005:33). Other shortcomings include insufficient emphasis on income generation measures, the weak financing policy to support service delivery for vulnerable children, the absence of an umbrella policy framework and the problem of many policy documents and programmes that do not talk to each other (Streak 2005:35). The scope of this study does not allow for a more detailed discussion. It is clear that safety nets will need to understand these weaknesses and advocate for improvement if they are to achieve the aim of strengthening community economic safety nets, in addition to providing much needed public goods and services.

5.2.5 Economic coping capacity of families

In South Africa, the social grant system provides the first line of support to the economic coping capacity of vulnerable families. However, it is generally those in deepest poverty and difficult circumstances, who have greatest difficulty in accessing the grants to which they are entitled. This is generally because they do not have the information, required documentation or resources necessary to access the grants. The legal process to access Foster Care Grants is very slow.

In rural areas, such as Nkandla the participants identified the following barriers in accessing grants; no identity documents; no photocopier to make copies of documents; and little access to department officials. The FFs explained that they make a date with Home Affairs officials to come to their community and then the officials do not arrive or come on another day when they not are expected. It is interesting to note the difference between the two areas in Nkandla, where one is more rural than the other. Participants from the more poorly resourced Ngono did not identify social grants in their responses to the question about other role players

with whom they work. On the other hand, the Ekhukanyeni group identified documents as an issue for which they needed the help of the Induna, Councillors and Traditional Leadership. They take the child to the Traditional Leader to write a letter confirming residence of parents and to police to write an affidavit.

The ECD practitioners however, noted their frustration

We do make the community, Amakhosi, councillors aware of the challenges. We sometimes refer the family to the welfare. When you reach there they ask which place you are coming from and take you to a social worker responsible for your ward or area to help you with the issue... only to find when you make a follow-up they didn't receive a proper or suitable service since the day you requested help.

In Hammanskraal there is agreement that not everyone who qualifies for a grant is getting it. Barriers identified in the structured discussion on access to grants in the final workshop are shown in the box below.

Reasons identified for some people who qualify for a grant not being able to get it include: Not having necessary documents (such as birth certificates, identity documents or death certificates); Lack of information, being ignorant; Not taking responsibility; and Fear of unknown.

One of the reasons making it especially difficult for some grannies to get grants for children in their care is conflict between families. For example, "Perhaps the daughter is married and she and the husband pass away. If someone is deceased then children usually go to the mother's family, but if the children are using father's surname then the maternal grandmother cannot get the grant".

Literacy can also be a barrier. "If the granny does not know how to write or read, she cannot fill in documents, so she lands up not doing anything with it".

Poverty is a major barrier to accessing grants. The applicant needs money to access documents or get to the offices. "Often the mother leaves the child with the granny who does not even have a cent and the mother is somewhere else using the money". This problem is particularly common as the mother is able to have the child care grant paid into her bank account and there is no way of checking that the child continues to be in her care.

However, this is an area in which the participating organisations are already making substantial progress in helping people to get the documents they need to get grants by referring them to the Department of Home Affairs, clinics, social workers, churches and tribal authorities. Having two Department of Home Affairs officials participate in all the workshops was a definite advantage. They explained the special procedures and forms in cases of people who do not have any documents. Children of immigrants were identified as a category of particular concern in the discussion. Officials from the Department of Home Affairs indicated that they should also be referred to them, as there is a special section in their office to assist them.

"Working together as a team" was identified as the best way to make sure that everyone who has a right to a grant gets it. This should include NGOs, FBOs, government departments and

through Imbizos. Home-based care workers have an important role to play as they visit homes regularly, “so they can help to collect information and advise them where to go”.

Some participants explained that they call officials from the Department of Home Affairs to come to their project to process applications. Telkom has donated a photostat machine to make copies of documents. The Department of Home Affairs also works with schools to undertake campaigns for learners to apply for identity documents. Some schools help to develop a data-base of children qualifying for grants. Churches help with baptismal certificates. Officials from the Department of Home Affairs explain that they organise “mobile offices” to go into communities every week and even on Sundays. The Office of the Speaker at Tswane Metro is working with the NGOs and clinics to help with the process of accessing grants.

In Masiphumelele, a problem experienced is that children who have cards issued in the Eastern Cape do not get others from the local clinic. These are required for birth certificates (and grants) as well as enrolment into school thus hindering these processes for many children. Access to the identity documents and grant application procedures has been greatly facilitated by government departments regularly visiting the area on request from NGOs, who also alert community members to the dates that officials will visit the area.

Initiatives to promote income generation in the sites were rare. In Masiphumelele, the City Council social development officer for the area offers courses in income generating skills but no information was available on the extent or beneficiaries of these. In Hammanskraal the Kanana Development centre is trying to meet the needs of the community and to find ways to support the poor and the needy people, helping people to sustain their lives and also to start their own business. It is

a multi-skills non-government organisation that is providing education and training skills to the disadvantaged community of Kanana village. KDC provides skills on health related issues like HIV/AIDS and human rights, ancillary health care, early child development and also assist the community with labour skills in construction related field, like electricity, plumbing and brick laying for job creation purposes. KDC is aiming to alleviate poverty, crime, unemployment and HIV/AIDS pandemic.

However, they explain that

They experience major problems to find other solutions as quality skills are in demand for the management and staff. The resources and finances are a delay to our success. KDC needs financial assistance in as far as meeting its mission and objectives. There are lots of activities to be achieved but without sufficient resources the NGO fails.

5.2.6 Access to other resources

Providing families who are waiting for grants with food parcels is a key strategy in the Masiphumelele and Hammanskraal areas. In Masiphumelele, the main provider of food support for young children is Siphosethu, which supplies food parcels to poor families, feeds

very neglected children and provides crèches in the area with supplementary groceries. Living Hope plays a role in providing support through food parcels, gardening projects and financial assistance to enable adults or children to attend hospitals. Nceda Nani also has gardening projects and provides food assistance, school books, uniforms and payment of school fees.

Several organisations in Hammanskraal are providing food parcels, and have identified that this can only be a temporary measure, so they also provide training for food gardens and income generating projects. However, clear success in these strategies was not evident. Many of them offer other types of assistance such as psychosocial support and support groups, clothing, blankets, cooked meals, school uniforms and fees and some recreational activities. Tshwaraganang community project which provides home based care identifies needy children by asking teachers at the school. They describe how they solicit donations of vegetables and blankets and “when we have not got money we ‘pop’ from our pockets”.

The Masiphumelele FCMs may also have to make payments from their own pocket as illustrated in the following typical example of one FCM who gave a mother R20 to take her child to hospital, because she had noticed that the child was “looking funny and breathing funny” and the mother had no bus fare. She reported that the child was taken to False Bay Hospital and found to be suffering from Kwashiorkor and at that time was still there.

In Nkandla, volunteers are assisting with feeding through the Department of Social Services National Integrated Programme for OVC (NIP) at drop in centres but the key role of the safety net has been in providing information, training and referrals to government services. While priorities identified for the LPA include programmes to support OVCs and children in child-headed households, and the establishment of community drop in centres, it is not clear how these are progressing or how resources can or will be accessed. Similarly food security is identified as one of the priority interventions for FFs, and one of the strategies to address this is through promoting food gardens.

During the focus group with ECD practitioners in training, they were asked about how they helped vulnerable young children. Their strategies seemed to be mostly restricted to the ECD context. For example, children who bring lunch are asked to share with hungry children but there is no attempt to help hungry households find food support. They explain they need basic resources to help, as they have for example to pay “out of our pockets for transport”.

The induna and councillor and other members of the CCCC described their roles:

- (I help) little children who don't have parents or are distressed, I help link them to get a grant
- I help to make sure they are well – small children – that they are clean, that they are healthy, to make sure they get food, to make sure that if they are emotionally disturbed, to help them.
- I try to give them shoes and clothes to make sure they go to school
- I look at health in community and look at toilets so we prevent disease. I help the volunteer to register the children who are born and have died. I help children in distress so they can get grants. (This member is also a CHW).

It is not clear where the resources are accessed, for example for shoes and clothes for children to go to school or for the building of toilets.

The ECD group said they want to “provide children with resources like teaching aids, provision of food, clothes and health awareness information”. The barriers they identified are:

- Insufficient money to buy teaching aids
- Not having enough knowledge to improvise
- Not having addresses to apply for donations
- No money to buy food, clothes and medicine.

When general workshop participants were asked to describe what Nkandla should be like for vulnerable children, meeting survival rights (food, clothes, immunisation, support grants) was given the highest priority. When ECD practitioners were asked what would help them to provide better support to young vulnerable children, their responses included food once a week, half-way houses and drop in centres. However, it would seem that in terms of accessing these resources the safety net relies primarily on informal strategies, which are unlikely to be adequate as the AIDS pandemic continues to deepen poverty.

With 8 unpaid volunteer staff members, the main objective of *Tshwaraganang community project* in Hammanskraal is “to alleviate poverty, develop personality, upgrade the living environment and give care to HIV/AIDS affected children”. With donations for food and clothes and some help from *Moretele Hospice*, they are helping 120 orphans from birth to 21 or 22 and 105 needy families. They report that

Some shops know us like the vegetable shops. They phone us and tell us to come and fetch when they have. We also have to “pop” from our pockets every now and then.

They are waiting for funding from Department of Health.

None of the organisations in any of the sites is specifically supporting ARV treatment for children or PMTCT, but as indicated above, this will become increasingly important as the roll-out is implemented. Support around PMTCT is included as an objective for the Nkandla FFs.

5.3 Partnership

The quality of partnership is a key factor in integrated delivery and is consequently integrally related to the effectiveness of a safety net for young children. The following section of the report explores the role players and their relationships in each of the research sites and then discusses the potential of Child Care Forums as promoted in the recent policy framework of the Department of Social Services.

5.3.1 Participating safety net role players

The Nkandla safety net incorporates many stakeholders, including members of the Community Child Care committees (CCCCs), Family Facilitators, Community Health Workers (CHWs) and some ECD practitioners and has particular strength in its strong support by local authorities and traditional leaders. However, provincial stakeholders (education, health, home affairs, social development) who were invited did not participate in the process. Weaknesses identified by participants were all in the remit of these absent government departments. For example, access to identity documents and birth certificates to facilitate getting of grants, lack of subsidisation and support of ECD facilities from either the Departments of Social Services or Education. Nkandla has reported that since the final research meeting, a break through has occurred with the Department of Home Affairs soon to locate a mobile unit at the Municipal offices.

Participants at the first workshop in Nkandla, who included councillors, an induna, an ECD practitioner and 16 family facilitators, listed a range of role-players, who identify vulnerable children: Community Health Workers, volunteers, relatives, community, caregivers, teachers, social services, social worker, inkosi, izinduna, councillors and pastors, with amakosi, izinduna and councillors being mentioned most frequently.

In response to the related question “What people/resources/services are helpful to you when you identify a child that has difficulties?” all the groups at the stakeholder workshop participants identified, “Community Health Workers and volunteers”, which is probably, because they identified this as one of their own roles. Strikingly there was no mention at all of the Community Child Care Committees (CCCCs) and when the researcher queried this, it seemed that their role was still unclear, though members of these CCCCs include a number of the role players identified by the group. CCCC members at the final workshop described their roles as helping with documents and checking on clinic cards. Indunas were identified as helping with grants and trying to get children to crèches. The role of traditional and elected leadership as a resource is strong. This is partly due to the role they play in community life in this rural area but the focus on children clearly relates to the vision for “Nkandla fit for children” and perhaps to the fact that these leaders had been involved in HRAP workshops in the start-up stages of the IECDI.

In a training workshop for family facilitators (FFs), they developed this list of their roles indicating that they see their roles quite broadly. Health, play and stimulation feature prominently including development and identification of children who need special attention. Promotion of sustainability is also mentioned.

- Check immunisations for children from the Road to Health Chart (RtHC)
- Encourage the community to establish food gardens and teach them about good nutrition for children 0-5 years
- Encourage people to go for VCT and to know their HIV status

- Inform parents where they can refer abused children
- Assist children to exercise their rights to clothing, food and education
- Encourage care of orphans and sick care givers
- Stimulate children to play and encourage their parents to play with them, which will help to identify children who need special attention
- Facilitate the formation of Self Help Groups to the poor and backward community members
- Be involved in issues of child protection.

From the workshop notes it is clear that this was what they thought their role should be, as IECDI had not specified roles. In the report the TREE facilitator notes the influence of the child health and parenting training on FF perceptions of their roles. She raises a concern that no one mentioned identifying the households with orphans and vulnerable children except to try to find clothes for orphans or checking documents at the household level to ensure that if grants were needed the correct documents were in place. This was, however, mentioned by volunteers as they described their roles at the final workshop

- I make a note of all the children who are orphans;
- refer problems to Induna and get affidavits;
- I go into the community and I look for the children who have problems – if they do not have parents or are sick then I take them to the councillor or the Induna to see if I can help them.

Their personal involvement and care for the children by the Induna and councillor comes through the descriptions of their roles in helping little children who don't have parents or are distressed, "I help link them to get a grant; I help to make sure they are well – small children – that they are clean, that they are healthy, to make sure they get food, to make sure that if they are emotionally disturbed, to help them".

However given the potential of CCCCs, the izinduna and councillors to be a focal point for the safety net at a very local level (izigodi or sub-ward), the development and capacitating of the structures to take on coordinating and monitoring functions for the safety net is a gap to be addressed as the initiative progresses.

Participants in the workshops and focus groups in Masiphumelele identified a range of role players and strategies to support young vulnerable children. Social workers were most frequently mentioned, and this could be explained in terms of their understandings of vulnerability being closely linked to rape and abuse as well as parents who are substance abusers. Police and the safe house were also identified as key to helping young children. The role of parents is also recognised as important but there is not much emphasis on neighbours and other community structures as supports. This is perhaps related to a reluctance to get involved, mentioned by stakeholders in the final stakeholder workshop and is a challenge in strengthening early identification systems.

The safe house most often mentioned as a resource in the area appears in fact to be under-utilised because of its association with HIV/AIDS and lack of community understanding about the service. FCMs are an important resource for those families they visit. There is much less focus on crèches and the school as offering support for vulnerable children. As very vulnerable children seldom access crèches and schools it is not surprising that this is not mentioned very often. The ECD practitioners themselves commented that the poorest children do not attend preschools because their families don't have money and that parents who drink or neglect children do not send them either. However expanding the role of ECD facilities in the local safety net is an area the research project attempted to open up for discussion.

Health services were identified as the largest service gap in Masiphumelele. Many of the FCM case studies described assisting parents to access health services, often by providing bus fare for parents to take their children there. The police were also viewed as inaccessible and the Valley Development Project (VDP) social workers reported on the lack of trust that the community has for the police services. The delays in gaining access to a social worker were reflected but also a concerning perception that they "don't care". ECD practitioners suggested that social workers visit the centres perhaps once a week to check on problems. In the focus group, the social workers comment on the "bad mouthing" of their services because of the slowness of statutory procedures. Subsequent to the research intervention, social workers have visited a number of FBOs and other organisations in the area to explain their role and alert community members to other sources of support, for example, suggesting that in cases of domestic violence they should go directly to SAPS.

In their meeting, the ECD practitioners reflected on their need for training and workshops to assist them to deal with the problems facing vulnerable children and on their need to share information with parents. The focus group held with the ECD Forum as part of this research process was the first opportunity to do this and information on the health services was shared. This forum meets monthly but it was the first time they had discussed the way they could assist vulnerable children and shared experiences.

In Hammanskraal workshop participants most often mentioned schools and educators as those who identify vulnerable children, with community members and caregivers as another significant group. Churches and children's friends ('other kids'), the Child Protection Forum, CBOs and NGOs were also resources for identifying vulnerable children. The range of services offered by NGOs and CBOs who participated in the study has been described above. The use of schools as a major point of contact with vulnerable children has resulted in a focus by most of the services on the school going age group.

When asked what they did to help vulnerable children, very specific answers illustrate the strategies used by the role-players.

- You interview the child to find relevant information or a member of the family and then you refer them to the relevant organisation
- An identified child should be reported to the social worker, child protection unit, clinic, or community councillor.
- Do follow ups after reporting
- Provide the child with food parcel, refer to children's home
- Be accommodative e.g. provide counselling and create friendship.

Workshop participants described many of the challenges they face in helping children access resources and in offering support with limited or no funding. It is clear that these organisations are providing an important service. However, as explained above, most of them complain of difficulties in accessing funds and the necessary skills and capacity. Some of the services, such as providing psychosocial support or income generating require advanced competency not available in the organisation.

A positive aspect of the workshop process was that in addition to the participating NGOs, two Department of Home Affairs' officials made an important contribution by attending all of the workshops, as did the Ward councillor. Officials from the Department of Health and Education as well as members of the South African Police and policing forum attended some but not all of the workshops.

5.3.2 Child Care Forums and safety nets for young children

The challenge in all three sites lies in bringing NGOs, CBOs and government into the same conversation so that all have a shared understanding of child rights and their own roles as duty-bearers and rights claimants. It is through this dialogue between rights claimants and duty-bearers that the barriers to child well-being and programme implementation can be identified and removed. However, shared understanding needs to be linked to capacity in the form of skills and financial resources. The Nkandla forum is an excellent example of a structure still developing an understanding of its roles and having difficulty in accessing resources. Where barriers are created by the lack of resources, there will need to be advocacy by those engaged in the dialogue.

The Child Care Forums referred to in Part One of the report, currently provide an excellent vehicle for establishing and maintaining sustainable safety nets. The objective of the policy framework is to

- ensure coordinated action at national, provincial, district and local level to realise the rights of orphans and other children made vulnerable by HIV/AIDS, their caregivers, families and communities
- ensure that legal, policy and institutional frameworks for the protection and promotion of the rights of affected children are implemented at all levels
- provide an overarching framework to support stakeholders in the development of comprehensive, age appropriate, integrated and quality responses to orphans and other children made vulnerable by HIV/AIDS (Department of Social Development 2005:15).

The framework acknowledges the need for collaborative action and describes objectives of the coordinating structure at provincial, district and local level which are

- to promote coordination between all stakeholders at all levels - government, non-governmental, civil society, private sector and labour – to effect action to realise the rights of OVC.
- to share information with regard to issues and programmes for orphans and affected children.
- to promote collaboration between stakeholders to improve services and programmes for orphans and children made vulnerable by HIV/AIDS.
- to ensure ethical research is conducted into relevant issues and that the findings of research inform action to improve the circumstances of orphans and other children made vulnerable by HIV/AIDS.
- to advocate, together with relevant stakeholders, to ensure that action to secure the rights of OVC remains a priority.
- to mobilise and disburse resources for the implementation of the Policy Framework for Orphans and other children made vulnerable by HIV/AIDS (Department of Social Development 2005:15).

The final bullet point is particularly relevant in terms of the findings of our study described above, as access to resources is critical for the sustainability of the organisations that are playing a key role in providing safety net strategies. The Child Care Forums can play several key roles in assisting with access to resources. Through the Forum, research can be undertaken and information collected in order to quantify the scale of the need and lever the necessary funding. Technical expertise can be channelled to help access funding and ensure effective financial and project management. Most importantly, co-ordination can ensure that services are spread across the area targeting those children in greatest need as well as avoiding duplication.

Foster (2005: 26) argues that, “Greater investment is needed at different levels of the funding system to ensure resources reach communities and respond rapidly to the needs of children, taking risks where necessary”. Donors should try out quicker systems for disbursement, making use of existing networks, including religious co-ordinating bodies, and supporting intermediary bodies to be able to make small grants (2005:25). These forums could include or constitute the “intermediary organisations” needed to

Help build the capacity of local organisations; strengthen CBOs’ financial capabilities and systems; ensure that information on resources is made available to CBOs using appropriate media and facilitating information exchange; simplify financial reporting systems to ensure that small amounts of funding move quickly; support CBO beneficiaries to ensure that simple monitoring of resources is carried out and reported upward (Foster 2005:25)

In Nkandla, Community Child Care Committees (CCCCs) had been established based on the draft guidelines before our study began. The action research process, helped to clarify roles and make suggestions for strengthening this new initiative. In Masiphumelele the research process indicated that while there are many services focused on vulnerable young children in the area a coordinating body such as a Community Child Care Forum should be established

to develop and sustain the synergies and networking strengthened in this research process. This should also fall under a broader community development banner such as the Masiphumelele Development Forum. In Hammanskraal, the key outcome of the research process, is that the Department of Social Development has been approached and started to do training for the establishment of a Child Care Forum.

Unfortunately, the initial Social Development framework, although it refers to “age-appropriate strategies”, does not identify the youngest as the most vulnerable, but hopefully, this research can flag this omission. In addition, it is important to note that the establishment of a forum, as in the case of Nkandla, does not automatically lead to improvements in the circumstances of children. The forum requires an effective strategy, the necessary resources and appropriate monitoring and evaluation to ensure that it is working and accountable.

5.3.3 Strengthening community responses through safety nets

The experience in all three sites illustrates that technical support and long term consistent funding is essential for strengthening of safety nets that can include a strong focus on young children. This section of the report discusses the findings in terms of support needed by community-based organisations to access and manage funds as well as advocacy to ensure that funding is made available for the organisations to function and to strengthen family coping capacity.

The most important source of funding is from the government. However, public funding policy does not take account of the kind of circumstances found in all three sites. Except for child social assistance programmes, public budgets are not based on estimated costs of service delivery. The budgets do not clarify the extent to which these critical services for vulnerable children are currently underfunded, and “data presented in the 2005 provincial budget statements predict that this situation will remain a problem into the medium term” (Streak 2005:52). IDASA suggestions include the following policy priorities to address the shortcomings they identify

- Development of more extensive and effective measures to raise income capacity of poor families and communities caring for children affected by HIV/AIDS, as well as changes to the social grants policy
- Clarification of norms and standards in relation to the full basket of integrated social assistance and welfare services required by vulnerable children
- Establishment of more effective monitoring systems in relation to care being provided to children
- The development of a policy document to govern social service delivery to all vulnerable children. (Streak 2005:54)

Child Care forums and other co-ordinated safety net initiatives can play an important role in supporting advocacy for improved public funding policy and access to funding by channelling information in both directions between communities and government.

Even when funding is available, civil society organisations experience barriers in obtaining funding such as identification of funders, funding requirements, making and checking progress of applications.

Community-based organisations could access the necessary information and skills through the safety net initiative and also advocate for improved systems. In particular, they could provide 'mini-umbrellas' through which small 'risk' grants can be channelled and monitored as illustrated by the Firelight Foundation. This supports vulnerable children in 12 African countries through one-year 'risk' grants of \$5000 or less to small NGOs and CBOs with little or no experience of external donor funding.

After one year, three-quarters of grants were considered successful and grantees received re-grants. Risk grants led to organizational growth, with strengthening of NGO leadership, strategic development and increased community participation. Some organisations succeeded in acquiring extensive new funding from other sources. Around one-quarter of risk grants were not renewed, mostly because of concerns about programme orientation rather than organizational capacity (Foster 2005:14).

FLF is now seeking to establish a new approach (mini-umbrella grants) to get even smaller grants to small community groups through intermediary organisations

While international frameworks recognise communities as the front line of support for children, this is not translating into adequate resourcing for care and support of the most vulnerable. More work is needed to test the merits of different funding systems and types of funding organisation, and to identify which schemes work best in different contexts. Funding mechanisms that promote local ownership and long-term perspectives, and which provide the technical support for small groups to improve their capacity to support children, appear to strengthen community responses (Foster 2005).

One strategy suggested is government-NGO partnerships. However, skills and support are needed to ensure that these partnerships are effective. For example in Masiphumelele government funded social workers have been deployed in an NGO. However, there is a need for a closer working together of the social workers with the other community outreach services and volunteers. In Nkandla the local Municipality has partnered with an NGO, TREE to implement the safety net.

Another important strategy for strengthening safety net initiatives is through monitoring and evaluation, which is dealt with in the next section.

5.4 Learning, accountability and advocacy

Three broad areas need to be assessed: targeting, responses and resources. Monitoring and evaluation is important for tracking government and donor spending in relation to effective targeting and to ensure that organisations operating on the ground are learning and accountable. Bray and Dawes (forthcoming) consider that one of the objectives of a sound

monitoring system should be to, "Track the nature and scale of impact of major epidemics such as HIV/AIDS on children's lives, and the effectiveness of various responses to conditions brought about by AIDS". This presents a complex range of issues to be considered, in terms of strategies for identifying and prioritising need, both in relation to children and responses, and then assessing the effectiveness of the selected targeting and programme strategies. Evidence of effective and responsible responses, is in turn essential for advocacy.

This section of the report will start by looking at where and how and what sort of data is collected in terms of targeting and monitoring responses. It suggests that new monitoring and evaluation strategies are needed and it then goes on to link this to the important role of safety nets or Child Care Forums, particularly in terms of tracking funding.

5.4.1 The kind of data needed

Given the complex mix of cultural, socio-economic, and physical (rural and urban) environments in South Africa, Bray and Dawes (forthcoming) argue that "data must be gathered at provincial, district and on occasion, even local neighbourhood levels" to take account of variations and because policy implementation primarily takes place at the provincial and local level. Smaller spatial levels are particularly important for programme outcomes monitoring. This accords with Kelly et al (2002) in the Save the Children Pathways to Action study who, noting that little is known in the case of younger children about HIV prevalence or the numbers affected indirectly, propose that

it would be worthwhile to aggressively pursue fast-track systems of monitoring that can be applied at local level, and that can be used to frame planning and evaluation of grassroots activities and support. (2002:13)

Effective targeting requires disaggregated data, which is a feature of rights based monitoring,

A rights-based approach to monitoring is consistent with developmental theory because it prioritises a disaggregated approach to data collection and analysis that enables links to be established between children's situation, developmental outcomes and the fulfilment of their rights. Such an approach is particularly valuable when we consider that the most vulnerable children are those who are exposed to multiple disadvantages (either simultaneously or successively), and that a primary goal of monitoring is to identify where and why children are under acute or chronic stress (Bray and Dawes forthcoming).

With regard to monitoring responses Richter et al (2004) stress the need for systematic evaluation especially of multi-sectoral initiatives with several aims.

They suggest that the HIV and AIDS field "has not drawn on conceptual and measurement tools available in child development for assessing outcomes for families and children". In addition, "goals are often poorly defined" and it is difficult to differentiate the "impact of HIV and poverty in resource poor settings".

Effective monitoring and evaluation strategies help “to prioritise actions, allocate resources and improve services”, including developing and disseminating good practice guidelines to those working with children affected by HIV/AIDS and may encourage buy in from communities and further support from external agencies (Richter et al 2004:55).

5.4.2 Monitoring and evaluation in the research sites

Despite the important purposes of monitoring and evaluation, the experience in the research sites is limited. In Masiphumelele, the FCM programme began in 2001 with a baseline survey of households with young children in the area. This informed its programme and decision about whom to target for services. Young children selected for the FCM programme must meet certain criteria, such as: “the parents are unemployed, children do not attend an ECD centre or are referred by another service in the area”. Through the FCM and other VDP programmes, there is regular monitoring of very vulnerable children participating in the programme and if household circumstances change families are asked to withdraw to “create space for others”. There is a good network of following up on referrals via the FCMs, who are in regular contact with their target families. When children are identified as vulnerable through other routes (such as social workers, Eye on the Child, the clinic or HCBC services), the Early Learning Support Programme follows up.

These are not coordinated efforts. Many organisations monitor and evaluate their interventions for young children against their own goals. A broader participatory analysis of the situation for young vulnerable children was recently undertaken in the context of a related project in the area and raised extremely valuable issues such as the role of health services, social workers and ECD centres in supporting young vulnerable children.

However, more detailed information is needed about who the most vulnerable young children in the area are and how many need services. There is need for systematic and comprehensive assessment of the impact of the range of safety net activities on child well-being. ECD centres need to be encouraged to participate in such monitoring. Once the safety net is formalised, ways of collecting this information need to be strategised.

In Nkandla, there is a stronger emphasis on monitoring and evaluation. The situation analysis for UNICEF, the LPA and the Integrated Development Plan provide general baseline data. The Health Survey provided specific data to support training about IMCI. The household assessment undertaken by Family Facilitators was undertaken to provide the information needed to target the poorest. It was not random, relying on pre-selection by community leadership. Specific indicators and targets for family and ECD centre intervention have been set for the next period by UNICEF and TREE. There are also goals relating to the capacity of the Nkandla Multi-sectoral Stakeholders' Forum, the CCCCs and other networks in support of young children. One of the indicators of capacity will be the availability of key child data sets for monitoring.

Targeted house-to-house assessments are an important starting point. A subsequent step to broaden the data base could be a more participatory exercise, engaging community members in developing and managing indicators to track child well-being, prioritise action and then track progress of their selected responses. As yet, this kind of participatory approach has not been undertaken, although there is great potential to build this into the participatory rights-based approach introduced previously through HRAP training.

While vulnerable young children may be identified, concerns were raised by ECD practitioners that families are often not able to get access the services to which their children have been referred and consequently nothing happens. However, since the position was created, cases reported to Nkandla Project Coordinator are followed up and the CCCCs should take on this role too.

In Hammanskraal, there was no evidence of any systematic evaluation. Although some organisations mentioned having criteria for identifying vulnerable children, these were not made explicit. There was also no mention of organisational monitoring and assessment. Training and support in effective strategies for targeting and tracking progress is potentially a very important component for the safety net currently being developed.

5.4.3 New approaches to learning and accountability

While the important function of monitoring and evaluation is not in question, it poses several challenges, particularly at the local level. Firstly there is the tension between registering orphans and vulnerable children and avoiding stigmatisation. Secondly, the popular approaches to monitoring and evaluation are not effective for tracking long-term complex strategies and are more suited to short-term measurable impact, though participatory and iterative needs analysis is an extremely useful and manageable tool at community level. Attention should be given to assisting communities to systematically document their findings.

While it is generally agreed that local community members are best placed to identify vulnerable children, stigma and opportunism have the potential to distort the findings. On the one hand, some families are ashamed or afraid to be identified as needing help and on the other, some families take the opportunity of accessing material support although they might not be in the greatest need. As discussed above, although the notion of vulnerability and the abbreviation "OVC" is commonly used, understanding the concept and utilising it effectively for targeting assistance is less common. While confidentiality is essential in the context of the continued stigmatisation of people living with HIV/AIDS, this obstructs effective responses and their assessment.

Despite the important value of household and base line surveys, needs analysis and logical frameworks, limitations emerge in tracking complex developmental strategies that must of

necessity be flexible. The scope of this project does not allow for a comprehensive exploration of alternatives. However, we flag the need to explore appropriate strategies for small local organisations to document and reflect on their work in a way that is systematic and can be verified. There is an urgent need to shift emphasis from external evaluation to internal strategies for learning accountability.

As mentioned above, effective evaluation is the foundation for advocacy. Without information about the scale of need and the relative value of different responses, it is extremely difficult to mobilise the necessary resources.

5.4.4 Tracking funding

Foster (2005: 26) points out that little data is currently available to track government spending and that good OVC programming requires information to determine where gaps occur and to prioritise spending. In South Africa

the budget classification system for social development undermines comprehensive tracking of all the public monies allocated to and spent on social development interventions for children made vulnerable by HIV/AIDS. Only HCBCS and coordinated action budgets are clear, social assistance and social welfare services cannot be tracked because they are insufficiently disaggregated (Streak 2005: 44).

More importantly Foster (2005: 26) argues that

HIV/AIDS funding must be tracked to determine how much reaches communities to benefit children. Donors and national decision-making bodies must: prioritise the tracking of HIV/AIDS expenditure on orphans and vulnerable children, particularly below national level, to identify where additional resources are required; ensure information is available on the amount of HIV/AIDS funding actually reaching community level, as well as the operational costs within each sub-granting organization; build in-country capacity of independent public expenditure monitors to track spending of Resources; include CBOs in developing tracking systems.

Effective safety nets can play a critical role in tracking government spending by including CBOs in developing these tracking systems.

In Part Six of the report, the findings are summarised using the UNGASS goals and UNAIDS principles.

PART SIX: SUMMARY OF FINDINGS IN RELATION TO INTERNATIONAL PRINCIPLES

An aim of this study was to attempt to identify why safety nets work in some circumstances and not in others and the mechanisms that communities employ in attempting to make the safety net work for them. We were interested in how holistic the approach to assisting children to realise their rights – survival, protection, development and participation - is. The study also aimed to provide information about the effectiveness of implementation of the UNGASS goals in the different sites.

In this section the UNGASS goals and UNAIDS principles¹⁰ and other best practice principles for programming are used as a lens to discuss the components of the safety nets supporting the well-being of vulnerable children in three sites. Richter et al (2004) have noted a dearth of systematic evaluations of programmes for HIV/AIDS affected children and that what predominates is “anecdotal accounts which draw their legitimacy from their alignment with agreed good practice in the field of social development”(2004:55). This short term action research study cannot hope to evaluate impact however we are able to examine the way that alignment or non alignment with international goals and practices appears to have strengthened or compromised the safety nets for young children in these three sites.

We start by summarising the widely used good practice principles and then discuss the application of these principles in the South African case study sites.

6.1 Statements of commitment, principles and guidelines

6.1.1 Convention on the Rights of the Child

The Convention on the Rights of the Child (CRC) provides the basis for evaluating whether policies and interventions provide holistically for the realisation of children’s rights. In arguing for an age specific focus in addressing the situation of vulnerable young children, Dunn (2005) points out that the CRC applies to all children under 18, including babies, infants and children up to 8 years. It is obvious in looking at the four areas of rights (survival, development, protection and participation) that states need to respect and ensure that there are specific issues to be taken care of in respect of very young children because of their rapid rate of development and extreme dependency on their caregivers.

¹⁰ These are a guide to Programming for Orphans and other Children Affected by HIV/AIDS as adapted to give particular consideration to ECD at a UNESCO hosted meeting of the ECDNA in Paris in May 2002

In September 2004, the UN Committee on the Rights of the Child held a “Day of general discussion on implementing child rights in early childhood”. The most important issues included

- Rights to survival and development, health nutrition and education, leisure, play rest and recreation.
- State parties must give appropriate assistance to parents and legal guardians, young children must be seen as full actors of their own development – what are best practices and those to be avoided to involve young babies and young children in their own development?
- Child participation in family, school settings and community – in all matters affecting him or her. It is strongly process oriented, based on social interaction skills: a learning process for adults and children.
- State parties must ensure that there are child sensitive and centred programmes and services offering a sound environment for the development of participatory rights – in day cares, EC Programmes, preschool, pre-primary and the first years of primary education. In all, the child should be promoted as a rights holder. (Dunn 2005:17) ¹¹

6.1.2 UNAIDS principles

The twelve principles to assist vulnerable children were endorsed by the UNAIDS Committee of Co-sponsoring Organisations (November 2001) were adapted with a specific focus on understanding their application for very young children at the UNESCO/ECDNA workshop in Paris 2002. These were

- Strengthen the protection and care of young orphans and other vulnerable children within their extended families and communities.
- Strengthen the economic coping capacities of families and communities with young children.
- Enhance the capacity of families and communities to respond to the psychosocial needs of young orphans, vulnerable children, and their caregivers.
- Link HIV/AIDS prevention activities, care and support for people living with HIV/AIDS and efforts to support young orphans and other vulnerable children.
- Focus on the most vulnerable young children and communities, not only those orphaned by AIDS.
- Give particular attention to the roles of young boys and girls, men and women, and address gender discrimination.
- Ensure the full involvement of young children as part of the solution.
- Strengthen early childhood services and ensure access to learning and education
- Reduce stigma and discrimination.
- Accelerate learning and information exchange.
- Strengthen partners and partnerships at all levels and build coalitions among key stakeholders.
- Ensure that external support strengthens and does not undermine community initiative and motivation.

¹¹ UNHCR Day of General Discussion on Implementing Child Rights in Early Childhood 17 September 2004 www.unhcr.ch/html/menu2/6/crc

6.1.3 UNGASS goals

The so-called UNGASS goals were the other lens through which the safety nets have been evaluated. A Declaration of Commitment relating specifically to children orphaned and made vulnerable by AIDS was formulated at the United Nations General Assembly Special Session in June 2001. It states

Article 65: By 2003 develop and by 2005 implement national policies and strategies to build and strengthen governmental, family and community capacities to provide a supportive environment for orphans and boys and girls infected and affected by HIV/AIDS including by providing appropriate counselling and psychosocial support; ensuring their enrolment in school and access to shelter, good nutrition, health and social services on an equal basis with other children; to protect orphans and vulnerable children from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance.

Article 66: Ensure non-discrimination and full and equal enjoyment of all human rights through the promotion of an active and visible policy of de-stigmatisation of children orphaned and made vulnerable by HIV/AIDS.

In 2003 an Eastern and Southern Africa Regional workshop on children affected by HIV/AIDS in Windhoek picked up on key themes in relation to implementing the UNGASS goals in the region. These included access to education, access to health services and nutrition, provision of psychosocial support to OVC, access to social services and getting resources to community level, protection of children's rights and combating stigma. South African commitments given at this conference are given in the box below.

South African Commitments at the ESAR Workshop, Namibia 2003, were to

- expand their integrated plan to all critical government departments including the social cluster, home affairs, justice, agriculture.
- provide psychosocial support to OVC, teachers, caregivers – through departments, NGOs, CBOs FBOs teachers, lay people, community care givers, private sector. Capacity building for this would take place by 2005.
- improve access of OVCs to education and life skills - and have a data base of OVCs. Communities would be mobilised to identify OVCs, support would be provided at school level by 2005.
- promote children's rights – monitoring in communities by March 2005.
- improve and increase access of OVC, caregivers and mothers to health nutrition, through extension of the PSNP to all learners in primary schools, provision of food parcels to poor families and opportunities for food production and income generation.
- access to health including removal barriers e.g. fees, roll out of PMTCT, rapid scaling up of CHB and treatment of opportunistic infections by 2005.

6.2 How the principles apply in the study sites

6.2.1 The CRC in relation to the safety nets in the three sites

A general concern in programming for vulnerable children is that immediate and pressing survival and protection rights tend to predominate over development and participation rights, which are of great importance both to children's immediate well-being and to their long term capacities for productive engagement in society. In Part Five (5.1.3) the need for greater emphasis on psychosocial support for children and on survival and protection issues was noted. This may partly relate to the need for more intensive training but is also an indication of the amount of time and energy needed by stakeholders in any safety net to assist vulnerable children and households to access basic assistance for their survival, mostly in the form of grants and food support. However, when visualising a community, which is supportive of vulnerable children, stakeholders emphasised all four rights pillars (see Table 4: 54).

While a rights based approach is considered to be established best practice, Smart (2003a) has noted in her Rapid Appraisal that projects did not operate from rights perspectives or have strategies for child participation. The use of a Human Rights Approach to Programming (HRAP) in the development of the Nkandla safety net, had had the effect of sensitising diverse stakeholders to children's rights and to their responsibilities to the realisation of these. In Masiphumelele, the approach was considered to be useful in that it highlighted the roles of the different service providers as duty bearers. The Hammanskraal site was selected to build on the earlier Tswelopele study that looked at HIV/AIDS stigmatisation and concomitant discrimination in relation to rights violations, identifying organisations and institutions that were playing a role in the promotion of human rights at local level. However, there was no evidence of a strong and systematic action-oriented rights approach being used by the organisations participating in our study.

6.2.2 UNGASS Goals in relation to the three sites

While government policies reflect UNGASS priorities, the three sites in this case study suggest that this is not effectively reaching local level. In our study sites the greatest barriers to implementation are efficient access to public entitlements and services especially social security and funding for safety net activities. In Nkandla, while the safety net incorporates many stakeholders and has particular strength in its strong support by local authorities and traditional leaders, weaknesses in the safety net were all in the remit of these provincial departments especially home affairs (where getting identity documents and birth certificates was a particular difficulty)¹², health support (the community survey indicates a poor delivery

¹² Though as mentioned in this report progress has since been made.

record), education (very little support for ECD sites which could play a key role in the safety net) and access to grants. In peri-urban Masiphumelele there was much greater access to provincial services and NGOs in the area had facilitated this in partnership with the province. For example, home affairs and social services come to the area on particular days each month to facilitate the acquisition of documents and grants. However there was little participation in the safety net workshops by provincial education, social and health services.¹³ The local authority social development coordinator did participate, but the local councillor did not respond to invitations. These aspects of the safety net need strengthening. In Hammanskraal there is little evidence that the national policies and strategies to build and strengthen governmental, family and community capacities to provide a supportive environment for children infected and affected by HIV/AIDS are being implemented systematically and effectively in the area. The response to the growing need is being carried primarily by small and fragile community initiatives with very little support from and collaboration with government.

The role of funding support for sustaining the safety net is a key one. It is significant that with the exception of social grants, health care, statutory social services, key strands of the safety net depend on volunteers or donor funding including stipends, training costs and transportation. Breaks in the donor funding cycle have delayed and compromised training and other activities.

With regard to stigma, there was little mention of HIV when community stakeholders in Nkandla discussed young child vulnerability, despite the fact that there is a well-established HIV network in the area, reflecting the stigma that still surrounds this disease. Less direct expressions of vulnerability such as a "child who is not accepted" may well refer to stigma. HIV is not openly discussed in Masiphumelele despite efforts to destigmatise it, and concerns and stigma are evident in a case history in which the mother had to leave home to protect her HIV positive child from the father and in the relatively poor utilisation of a residential facility for HIV infected and affected children in the area. In Hammanskraal it continues to be a major obstacle for the provision of support.

6.2.3 UNAIDS Guidelines (special ECD considerations) in the three sites

Strengthen the protection and care of young orphans and other vulnerable children within their extended families and communities

Many aspects of the safety net in Nkandla and Masiphumelele are focused on strengthening care and protection within the family and community. For example in Nkandla there are CHWs and HCB carers though it is only the IECDI, which has a focus on young child care and

¹³ In a related initiative, indabas were organised with health services and caregivers/CBOs and other stakeholders, and with provincial departments of Education and local health (Occupational Therapy services) as a focus on Inclusive Education. This enabled the building of some partnerships and sharing of information around services.

information as well as linking them to relief services, social security and nutritional support if this is needed. A number of the initiatives in the Masiphumelele safety net are related to supporting the family with skills and information for the care of young children as well as linking them to relief services, social security and nutritional support if this is needed. The FCM programme is particularly sensitive to building on indigenous child care models.

It is heartening that in Hammanskraal, attention has shifted from HIV/AIDS prevention activities, to include care and support for people living with HIV/AIDS and efforts to support young orphans and other vulnerable children. There are a number of organisations offering this kind of support, though on a small scale due to funding constraints. Most of the programmes for children do strengthen the protection and care of young orphans and other vulnerable children within their extended families and communities. There were some calls for orphanages or institutional care, particularly for children who had some severe form of disability (usually of a mental nature), since there are no such services available, but all of the work is directed to strengthening and supporting families. However, it is clear that in some cases where children are being passed from one adult to another after the death of their parents, there is serious danger of neglect or abuse. There does not seem to be adequate capacity to fully investigate or act in these cases.

Few of the ECD facilities in any of the sites are geared to sustained extra support for the needs of vulnerable young children, though some practitioners refer to efforts made to assist such children.

Institutional care is generally considered to be the option of last resort on grounds of cost, further stigmatising children and often offering poor quality care, but these may be necessary. The home in Masiphumelele, which provides care for young children whose families are unable to care for them due to HIV/AIDS, avoids many of the pitfalls of institutional care and children participate in local ECD centres and schools. The Early Learning Support Coordinator says "it is a warm house-like place for only few children. All staff are involved, including the men working at the centre who you will often find feeding a baby."

Strengthen the economic coping capacities of families and communities with young children

So far strengthening the economic coping capacities of families is not the strongest programme element in any of the sites and probably needs the most urgent attention. There are some initiatives in all three areas regarding food gardening, access to the identity documents and grant application procedures as well as interim supports through food parcels.

More proactive attention needs to be given to advocating for all families (not only those directly affected by AIDS) to plan for the future, ensuring that all documents are kept in a safe place, wills are written and plans made in case of the death of a primary caregiver. This is

going to be increasingly important as the older relatively uninfected generation passes on. In addition to accessing grants, other strategies to strengthen economic coping capacity are urgently needed. It would be valuable to understand the difficulties of those organisations that are attempting with apparently very little success, to introduce income-generating activities, so that the barriers can be removed.

Enhance the capacity of families and communities to respond to the psychosocial needs of young orphans, vulnerable children, and their caregivers

This is also not a particularly strong area in any of the three sites. In Nkandla, there have been some initial attempts to enhance the capacity of families and communities to respond to the psychosocial needs of young vulnerable children through the Family Facilitators and more training is planned. In Masiphumelele, while there are attempts particularly through the counselling provided by Living Hope and the Family and Community Motivator programme to enhance the capacity of families and communities to respond to the psychosocial needs of young vulnerable children and their caregivers, this area seems to be largely undeveloped. This relates both to the pressure to deal with day-to-day survival needs and also it is not an easy area for intervention. There are clear indications that some mothers are depressed in the Masiphumelele case studies and the responses in the parent and volunteer focus groups that the 0 – 3 year olds are not as affected by the death and illness of primary caregivers indicates the need for further discussion and possible training. In Hammanskraal at present there is very little capacity to respond to psychosocial needs. Those organisations that have had some training, point out that it is not adequate to deal with the major trauma and stress they are finding. It seems critical that the safety net access appropriate training that includes mentoring and follow up.

ECD practitioners are also likely to need more support in this area and the training planned for them is likely to include this. Training in dealing with HIV in the classroom has been offered in Masiphumelele and apparently to some practitioners in Hammanskraal, but more training is probably needed. The ECD Forums in Nkandla and Masiphumelele could play a valuable role in allowing practitioners to share ideas and experiences and to debrief. Some work done in Masiphumelele with preschool and Foundation Phase teachers about stigma and human rights making use of persona dolls¹⁴ has been very helpful and could be usefully employed in all the sites.

Link HIV/AIDS prevention activities, care and support for people living with HIV/AIDS and efforts to support young orphans and other vulnerable children

One of the potentially most promising opportunities for early identification and subsequent monitoring of young vulnerable children is through home and community-based carers. This is

¹⁴ Persona dolls are designed to look like young girls and boys of different cultures and backgrounds. They are used with children to unlearn prejudices and encourage empathy and acceptance of diversity.

a frequent programming recommendation (e.g. Dunn, 2005; Smart, 2003a) but has been difficult to implement. The Early Learning Coordinator in Masiphumelele comments that “this does already happen. However due to their huge client base these resources are not always available to attend (coordinating) sessions”. In Hammanskraal there is also scope to help organisations, many of which had a strong focus on HIV/AIDS prevention and support activities, which are only indirectly concerned with children to bring children into stronger focus in their work. Here too the home-based caregivers are in an excellent position to identify and help vulnerable children, however this is only possible if the enormous burden they already carry can be lightened. The FFs at Nkandla are involved in supporting the NIP initiative of providing food to orphans at drop in centres.

Focus on the most vulnerable young children and communities, not only those orphaned by AIDS

With regard to the guideline that there should be a focus on the most vulnerable young children, not only those orphaned by AIDS, the Nkandla safety net works broadly for vulnerable children and through the IECDI, young vulnerable children. In Masiphumelele safety net is very broad, though there are some HIV/AIDS specific programmes. Interestingly a focus on young children with disabilities as being vulnerable is beginning to emerge in Masiphumelele as a result of this and a related integrated ECD community programme.

In Hammanskraal as noted above, even those organisations that are providing services specifically for children generally do not include the youngest subsector. This is of critical importance, as the youngest children are least visible and consequently in greatest danger of not having their basic needs met. Here too, although participating organisations, readily used the term OVC, it would seem that the primary criteria for participation in their children’s programme is orphanhood rather than other forms of vulnerability. There was no discussion of strategies such as memory work or succession planning or help for children taking care of sick caregivers.

Give particular attention to the roles of young boys and girls, men and women, and address gender discrimination

There are indications in two of the sites of how the roles of men and women strengthen or weaken supports for vulnerable young children. Participation in the Nkandla safety net of men in leadership positions - the councillors and the izinduna - and their support for the initiative seems to have been crucial to the widespread community perception of it as an important process.

Gender discrimination remains a challenge in Masiphumelele. The Early Learning Coordinator comments “Men are not carers in Masiphumelele and households operate with little or no input from fathers, as this is seen as the mothers’ responsibility. Boy children are generally

excluded from household chores or caring for younger siblings. Men are however leaders in community structures such as the business people committee and the Masiphumelele Development Forum (MDF)". The case studies in the area included two examples of men rejecting vulnerable children and leaving their mothers to deal with them. Concerns for the sexual abuse of young girls in the area were frequently expressed. Only two men attended the stakeholder workshops, one being from the MDF. Nevertheless there are examples through the FCM training of men becoming involved in play and stimulation of their young children.

In Hammanskraal gender issues were raised explicitly during the research process, however increased vulnerability was noted in the case of the death of a mother and a child being left with a man who is not the father. Most "volunteers" are also female and it is clear that women are carrying the heaviest burden.

Ensure the full involvement of young children as part of the solution

Interpreting the principle relating to child participation for very young children in the context of the research sites is not easy because of their extreme dependency and cultural constructions of the child. The Committee on the Rights of the Child guideline (UNHCR, 2004) indicates that for young children participation should involve a process orientation based on social interaction skills and child sensitive and centred programmes and services, which will help develop participatory rights and promotion of the child as a rights holder. Following this interpretation there are indications that the Nkandla safety net includes some of these aspects. There seems to be a developed understanding among the stakeholders of children's survival, development and protection rights. In Masiphumelele there are plans to run workshops for parents on child rights. There are also ongoing efforts to improve the quality of ECD programmes so that they are more responsive to children's rights and needs. In their stories the Hammanskraal participants gave many indications of making opportunities for child participation. For example a worker at one NGO said, "We see the importance of counselling and talking and listening to children. We use drama". However this is easier to do with the older age groups who are the recipients of their services.

Strengthen early childhood services and ensure access to learning and education

In all of the sites it was clear that the most vulnerable children do not access ECD centres, the majority of which receive no state subsidisation and are struggling to sustain themselves on irregular fee payments and fundraising. In Masiphumelele parents and FCMs specifically commented that some children cannot access services because their parents are not working. In Hammanskraal there are several struggling ECD centres, which are not accessed by the poorest and most vulnerable children. Local training for ECD centre staff is not currently available and there is a need to strengthen this form of service.

Attention to the role of ECD services in supporting young children and on the role of primary carers and family members in the learning and education of their young children is being addressed through training and awareness raising in both Nkandla and Masiphumelele. This needs to be ongoing and the quality of provision improved. Hammanskraal has no such family-based approaches and it would be important to develop these.

In the medium term the ECD services in these sites which are unsubsidised should be assisted to be registered and subsidised as unless they are, they will not be able to take in children whose home circumstances are such that they would benefit from enrolment in a daycare programme. There should also be an active strategy to assist such children to access ECD services. A particular training need is to encourage caregivers to listen to young children and observe them carefully and give caregivers the knowledge and skills to respond appropriately.

Reduce stigma and discrimination

As discussed in 6.2.2, stigma and discrimination appear to remain a problem in all three sites. In Hammanskraal perhaps due to the earlier Tswelopele research, reducing stigma was identified as one of the 'dreams'. An action plan was discussed, but no progress was reported. In the other two sites, there does not appear to have been an overt focus on addressing stigma and discrimination.

Accelerate learning and information exchange

In Nkandla the support and reporting structures created for the IECDI including links from community level committees and FFs through the project coordinator in the municipality to the LPA provide for information exchange. This should strengthen as the programme becomes fully operational. The sharing that took place during the research was seen to be valuable, indicating that certain of the stakeholders had not previously been in the sharing process. In Masiphumelele, the action research highlighted the lack of this exchange even between different services offered by the same institutions and has already led to some useful links between services. Here accelerating learning and information exchange and strengthening partners and partnerships at all levels and building coalitions among key stakeholders would also be facilitated by the creating of a forum.

The emerging safety net in Hammanskraal has great potential for accelerating learning and information exchange. Careful attention will be needed to find the best ways to realise this potential.

Strengthen partners and partnerships at all levels and build coalitions among key stakeholders

The action research process appears to have helped build a shared understanding of the value of partnerships in all three sites, even in Nkandla there has been excellent and painstaking work building partnerships at local, district and provincial level. There are plans to draw in additional partners to the existing forums.

In Masiphumelele although Valley Development Project's Early Learning Support Project was very well networked with partners in the area and able to call them to meetings, there was the realisation of the benefits of a forum where all partners could explain their main purposes and think about how better to collaborate and draw in new partners. Plans to locate the forum in the Masiphumelele Development Forum could add the political and business leadership, which would enhance the safety net, if they are willing to oversee the process.

In Hammanskraal the Tswelopele research and previous work done by the Centre for the Study of Aids (CSA) in the area provides a strong foundation to strengthen partners and partnerships at all levels and to build coalitions among key stakeholders. In particular, the CSA co-researchers have deepened their understanding of the potential of partnership.

Ensure that external support strengthens and does not undermine community initiative and motivation

The final principle warns against external support undermining community initiative and motivation rather than strengthening it. Comparing Nkandla with the situation in the urban Masiphumelele site that formed part of this study, the community ownership of the safety net is strikingly strong. While this reflects the way that many rural communities operate, the careful process that has gone into developing the Nkandla LPA for Children, the political and traditional leadership's commitment to children and development of Community Child Care Committees is likely to have been a contributory factor. The role of outside resources such as TREE in supporting the process has clearly been seminal and the need for turning these structures into capacitated and sustainable bodies will require further support. A challenge is to bring in the critically needed resources without compromising existing strengths and ownership. The TREE project manager, comments

We are attempting to ensure that critical responsibility is held by the local community members with the inclusion of Councillors, both from the tribal authority and from civil society. Manpower and rotation of staff often hinders progress if the communities rely on the social workers.

The tension between the need for demonstrating impact when the start up processes need time, has been felt in the Nkandla project. The need for time to understand roles, what might best be done, was evident when at the first workshop for this research project, it emerged that

stakeholders were not certain what to do next, and that operationalising the plan was seen as valuable.

I find that some people want quick fix results and I believe that communities need ownership of both negative and positive results and at this early stage they are inconclusive. It is not possible to have sustainable impact in the first six months.
(TREE project manager)

In Masiphumelele the Early Learning Coordinator commented on an over-reliance on social workers and professional support, which is a reflection of the lack of social interconnectedness in this recently settled area.

Yes there is an over reliance particularly on social workers. Neighbours would suggest that people go to them. Some support is offered by neighbours depending on the relationship they have with them.

She is not certain how neighbourliness could be strengthened and comments that few people support infected people. Workshop feedback indicates that fear of external agencies can also be a problem e.g. police are not called in, fear of a child being removed etc., which leads to no support being available at all.

In the Hammanskraal area, there has been limited external support as most of the initiatives are community responses. While external support is urgently needed, it is important that this is provided with sensitivity to what already exists in order to strengthen rather than undermine community initiative and motivation. Following this principle, the action research process itself used an appreciative rather than problem solving approach in order to build on existing strengths.

PART SEVEN: CONCLUDING REFLECTIONS AND CALL TO ACTION

In conclusion the lead researchers have distilled lessons framed in the light of the key literature introduced earlier in the report, in terms of the methodology, programming implications and advocacy issues. The framework for this reflection is the initial project motivation and questions raised in the Phase One report of February 2003.

7.1 Methodology used

The qualitative participatory action research methodology confirmed the value of “formative evaluation models with an emphasis on programme development rather than outcome evaluation” (Kelly et al 2004: 18) as sites benefited from the research intervention itself rather than having to wait for research findings to be implemented at some later stage.

At the end of the action research process the co-researchers in the sites gave feedback on the action research process and future plans including whether the process had assisted in strengthening the safety net in any way.

The process was seen as strengthening the safety net in that

It got service providers talking together. This enabled services providers to understand the roles and limitations of services rendered, realise the gaps and look at ways of building safety nets to ensure that all children are protected (Masiphumelele).

Before the research the safety net was there, because we were having ECD sites, CBOs, clinics, CCCC, CHWs, FFs and the members of the community including Indunas (but) all working separately without knowing each others' role and without the knowledge and picture of working together in their minds.

The involvement in the last ELRU workshop has deepened their understanding of safety nets. (Nkandla)

7.2 Implications for programming

Smart's Rapid Appraisal on Children affected by HIV/AIDS in South Africa (2003a) recommends the need to strengthen specific aspects of programmes, specifically to learn more about how to

Develop models of partnership to benefit OVC; Generate common understandings about holistic care and support; Emphasise the importance of PSS for affected children; Provide appropriate and sustained support for the caregivers and service providers; and Develop and test indicators to be used to monitor and evaluate programmes (2003a:72)

The study offers insight into models of partnership and strategies for generating common understandings of holistic care and support and illustrates that challenges persist in terms of appropriate and sustained support, monitoring and evaluation and psychosocial support.

The Pathways to Action study recommends the need to localise interventions and for models for community based responses to HIV/AIDS expressing the concern that “Fragmented and insubstantial local projects need to be reoriented towards standardised models of intervention and co-ordinated in a centralised way” (Kelly et al 2002:67 –8).

The study findings support the value of coordination particularly at local level. Locating the initiative within local government as in Nkandla is particularly promising. The IDP contains programmes to broadly address a number of the factors contributing to vulnerability as well as making specific provision for children affected by HIV. It has potential for accessing budget resources and for facilitating linkages to provincial duty bearers responsible for vulnerable children. A recent road show of the Office of the Rights of the Child (ORC) in the President’s office announced a new policy to locate such ORCs in each local municipality.

The Masiphumelele safety net provides a good illustration of the need for central coordination even in a relatively small area, which has access to a number of services and resources for vulnerable children. The ECD stakeholders have recognised the need for locating the coordination in an overarching and politically connected structure, which would be able to bring in a wider network of partners and lever resources.

Hammanskraal identified the need for co-ordination and building partnership and have taken action to seek assistance from the Department of Social Development to establish a Child Care Forum.

The Nkandla model demonstrates a multi-sector, multi-stakeholder approach with strong community input through volunteer family workers and Child Care Committees, coordinated within local government and supported by TREE, a specialist ECD NGO and UNICEF. Cognisance needs to be taken of the investment of time required to build the political will and community ownership and understanding of children’s rights in order to grow the programme and develop the coordinating structure. If the time-consuming process of developing community buy-in and ownership is not recognised and valued, tensions may arise from expectations of rapid service delivery and impact by external donors as well as public partners.

The study demonstrated the catalytic role of outside agencies in developing the partnership, in terms of TREE in Nkandla, and the action research process in Masiphumelele and Hammanskraal. Challenges for developing a coordinated partnership in support of OVC are both cost and capacity. Coordination takes time and may also require partners to travel considerable distances, necessary training and capacity building must also be considered. Streak (2005:45) notes that “the budget for facilitating coordinated action for more effective service delivery for children made vulnerable by HIV/AIDS is tiny – only .0003% of the total

allocated for national department spending". It is not clear how much is needed but in our study funding had to be made available for bringing the stakeholders to meetings. Securing commitment from public role players who are overstretched and often under-capacitated is also difficult.

As discussed, partnerships can only be effective when the partners are capacitated and have access to funding to deliver their services. However, in all three sites lack of funding and other resources constitutes a major constraint.

The study assumes that holistic care and support requires age specific programme elements. The role of ECD focussed NGOs or CBOs in developing an appropriate targeted focus on young children emerged as a clear learning. It is difficult to introduce an ECD focus where participating organisations focus on adults, older children or more general care and community development as in Hammanskraal. On the other hand ECD specialists may not be focused on broader household factors that support children such as economic support strategies. Except for accessing social security, this was a weak area in the sites in this study.

Stakeholder discussions clearly indicated the need to develop the role of ECD centres as part of a safety net and the potential of support to ECD Forums to facilitate this. The role of family and home-based workers with a strong ECD focus was a significant element in providing holistic care and support, including psychosocial support (PSS). For young children PSS cannot be achieved without support for their caregivers, a programme element which is less crucial and not emphasised for older children. As noted in the report it was generally underdeveloped for a variety of reasons including focus on survival and protection issues, but particularly lack of understanding and appropriate training for volunteers, parents and ECD practitioners. The fact that difficult circumstances are usually the experience of carers as well as for those who are receiving support seems to 'normalise' them and makes empathy difficult to achieve.

It is recommended that safety nets explore the establishment of multi-skilled multi-sectoral teams, where less experienced community workers, such as home-based caregivers, can work under the supervision of more experienced or qualified team-members, such as social workers or child care workers. The gap between professional workers and volunteers must be bridged by ensuring that all team members are on a career path with increasing experience and training being matched with increased remuneration. It is recommended that schools are included more actively in the safety net and opportunities for collaboration between NGOs and schools is further explored not only in terms of psychosocial needs but generally in identifying and responding to children who need help. However, it is important that educators are not expected to carry the additional burden and that schools are viewed as the sites of service provision, rather than service providers.

The lack of appropriate monitoring and evaluation in support of vulnerable children, either for identification and targeting or for assessing impact is another gap, and has been discussed in the findings in Part Five.

7.3 Advocacy issues

The urgent need to develop an action plan for young children affected by HIV/AIDS in Africa that prompted this study is echoed in the view that

There is a need to promote dialogue and partnership among researchers, ECD professionals, policy and decision makers and planners. Evaluating current 'safety nets' and assessing information and communication strategies is also useful. (Dunn 2005:41)

Smart (2003a) identified a number of areas for advocacy on behalf of OVC in South Africa including scaling up and rolling out appropriate responses/models of care and support.

This study endorses the view that broad community awareness raising about the needs of very young children is critical to bring about the required focus and that stakeholders should advocate strongly for public funding to support the volunteers and support programmes in their area in order to enable the expansion of the safety net and to sustain it. Framing this awareness raising and advocacy within a human rights approach is useful in a number of ways including understanding of the holistic nature of rights and identifying duty bearers.

7.4 Conclusions

In conclusion the distilled lessons are flagged and framed through the international programming goals and principles considered in Part Six, followed by a call for action and invitation for further conversation.

The experience in the three study sites generally supports current "best practice" principles. The rights based approach, supported by a participatory appreciative approach, proved valuable in all the sites, because of the holistic focus and because concepts of rights holders and duty bearers were helpful for community level understanding and for advocacy. Building on strengths generated motivation for positive change.

Some of the UNAIDS principles that appear to be particularly useful in the operation of the safety nets in the sites include strengthening the care and protection of young OVC within their extended families and communities, particularly through the use of family workers who have a particular training and focus on young children; use of a wider definition of vulnerability than just orphans; the development of partnerships at all levels and creation of a forum for

information sharing and accelerating learning. Challenges are to enhance economic coping of affected families and community-based responses, adequate provision of psychosocial support both to children and their caregivers, links with HCBC services, and utilising ECD centres for the protection and development of children whose caregivers might be unable to care for them fully. ECD training in community development is essential. There is some tension between the need to bring in outside resources while remaining sensitive to local context and strengths. Principles such as child participation are less central in the context of safety nets for young children and somewhat foreign to local constructions of childhood. However, encouraging caregivers and family members to listen to young children and provide opportunities for them to learn to make choices is important. The presence of a strong ECD NGO in the safety net is clearly a critical factor in keeping an appropriate age related developmental focus on young children.

The most severe challenge to implementation of the UNGASS goals is the lack of sufficient public and donor funding affecting the capacity of state and civil society responses in support of young vulnerable children. This affects human capacity, as public and NGO staff tend to be extremely overstretched, and there is clearly a need for more specific training to meet the needs of very young children. Stigma and discrimination appears to still be a significant problem in all areas.

Hopefully this study will be of value not only to the three partner sites, but serve also as a catalyst for urgent action to address the impact of the AIDS pandemic on very young children and their families across Africa. In addition to the findings and the lessons learned, the participatory appreciative action research strategy itself is offered as an example of a potential approach to forging the partnership and co-ordinated action, not only to respond at a local level, but also to mobilise resources and support at the scale needed to ensure a bright future for Africa.

We encourage readers to take this conversation forward in many locations and at all levels. We would appreciate feedback, not only on the report itself, but also on other safety net initiatives either preceding the study or generated by it.

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