Provision of psychosocial care and protection services by home and community based care and support organisations.

By

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i. DECLARATION

I, Zamanguni Genevieve Gumede declare that

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(ii) This dissertation has not been submitted for any degree or examination at any other university.

(iii) This dissertation does not contain other persons' data, pictures, graphs or other information, unless specifically acknowledged as being sourced from other persons.

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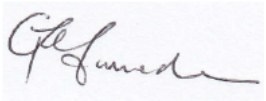
Signature:  Date: 22 September 2020

ii. ABSTRACT

Providing adequate care and support for OVC continues to be a significant challenge in South Africa. For the province of KwaZulu-Natal, the situation is even worse, with this province remaining the highest in HIV prevalence and incidence. Several initiatives have been undertaken to provide psychosocial support to orphaned and vulnerable children, including education, food, shelter, and counselling.

This research study aimed to document what psychosocial care and support services are being provided to orphaned and vulnerable children (OVC) by home and community-based care and support organisations in the EThekwini Metro. The intention was to generate practical information that could be used to improve delivery of these services to OVC. Underpinned by a qualitative approach and descriptive design, the study utilised semi-structured, in-depth interviews to obtain data from a sample of two HCBC organisations in both urban and semi-rural settings. The two HCBC centres covered in this research have one common goal, and that is to provide care and support to OVC.

Generally, caregivers in both HCBC organisations understood necessary PSS requirements, although low skills levels negated this. In respect of the psychosocial care and support programmes delivered, both organisations use innovative, low-cost methods, such as partnerships and resource sharing to deliver PSS services to OVC. Key challenges hindering the delivery of these services include a shortage of skills, financial constraints, and lack of cooperation from participating Departments. The critical needs of OVC were, among others, primary child care, protection against abuse, documentation, support, and nutrition.

Overall, provision of psychosocial care and protection services to OVC in the participating HCBC organisations was relatively stable despite the lack of resources. The study makes some recommendations for practice, policy, and further research.

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iv. DEDICATION

This work is dedicated to individuals, groups, practitioners, and organisations that provide care and support for OVC.

v. ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
CCG	Community caregiver
CBOs	Faith-based organisations
CDWs	Community development workers
CYCW	Child and youth care worker
DHA	Department of Home Affairs
DSD	Department of social development
DoH	Department of health
ECD	Early childhood development
HCBC	Home/community-based care and support organisations
HIV	Human Immunodeficiency Virus
NACCW	National Association of Child and Youth Care Workers
NGOs	Non-governmental organisations
NPOs	Non-profit organisations
OVC	Orphaned and vulnerable children
PSS	Psychosocial support

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CHAPTER ONE:
ORIENTATION TO THE STUDY

1.1 INTRODUCTION

For far too long, South Africa's HIV scourge was allowed to thrive in the midst of denial, misinformation and poor policy (UNAIDS, 2016:1). The epidemic has profoundly impacted children in South Africa. According to Neudorf, Mokgatle-Nthabu, Taylor, and Thurman (2012), illness and death of parents and caregivers cause enormous stress for children which results in an unstable home life and poor mental health.

Community based organisations (CBOs) have remained an essential resource for locally-based services to orphaned and vulnerable children (OVC) and their families. Yakuborich, Sherr, Cluver, Skeen, Hensels, Macedo and Tomlison (2016) acknowledge the potential of these CBOs to provide high-quality services for OVC in resource-limited settings. The home and community-based care and support organisations under study fall into this category as they are localised and react to challenges concomitant with HIV and AIDS. Such organisations have a primary focus on child and family service provision.

The Department of Social Development (DSD) (2012) notes that in South Africa, HIV and AIDS, TB and other chronic conditions are significant challenges facing the Govenment. Resulting changes and challenges in children's well-being are cumulative, multi-faceted and interlinked. These challenges include higher chances of school drop-outs, increased risks of poor performance, elevated risks of HIV infection, STIs, reduced access to medical care as well as other services linked with poverty (Zagheni, 2011).

Against this background, Chapter 1 highlights the justification of this study, including its aims and objectives, and the underpinning theoretical framework. This study will focus on psychosocial support (PSS) interventions for OVC while providing data which can be utilised to enhance PSS service delivery. Also, the study will assist in policy-making, planning and improved programming for interventions targeted at providing

PSS.

1.2 DESCRIPTION OF THE PROBLEM AND RATIONALE

HIV and AIDS have left many orphaned children without the care, love, protection, and nurturance of their biological parents. Many live in conditions that prevent them from attaining their full potential. Sub-Saharan Africa remains hardest hit by HIV, with over 20 million infected and some 70 million children facing the consequences of living with sick people (Cluver, 2011).

Cluver and Gardner (2006) highlight that most services and programmes supporting orphans target meeting their basic needs for food, clean water, medical care and shelter. Cluver (2011) advocates for the necessity of evidence-based PSS interventions for children infected and affected by HIV and AIDS or living with sick adults. In addition, it is argued that the challenges children experience start long before parental death (Cluver, 2011).

Interventions have been introduced to bring relief to OVC. These include broad-based community interventions as well as other components such as planning for children's future alternative care, fighting against land grabbing through proper estate planning, providing PSS, measures aimed at addressing poverty or fostering HIV prevention behaviour (Schenk, 2009). In practice, however, children need various types of support, including accessing health care, education and provision of PSS. Apart from psychosocial pain "resulting from the death of one or both parents, orphaned children become vulnerable to poverty and abuse" (DSD, 2010). Schenk (2009) points out that most OVC support initiatives and strategies generally aim to improve children's well-being; which resonates with the Millennium Development Goal of improved child health and education.

PSS is concerned with a spectrum of activities which aim to safeguard the psychological welfare of individuals and communities (DSD, 2010). Schenk (2009) asserts that advancing and supporting children's psychological well-being is a vital intervention which requires the attention of skilled CCGs. Berry (2012) defines psychosocial programmes as those programmes that promote children's mental and emotional health. The focus of this study looks at what psychosocial services are

provided to OVC to help them become well adjusted, self-aware, caring and trusting individuals.

Home / Community-Based care and support (hereafter HCBC) organisations have been the key service providers in the area of HIV and AIDS by civil society groups since 1999 (DSD, 2010). The provision of psychosocial assistance has been one of the essential services expected from HCBC organisations. It is necessary to review this support periodically to determine whether it is still relevant and whether or not it responds to society's needs. During a National Conference on OVC held in Durban on 27-30 May 2013, one of the resolutions included the need to support evidence-based prevention programmes that strengthen family and community-based responses in building resilience amongst the OVC and youth. Resilience links to PSS. As characterised by DSD in a Conceptual Framework for PSS services for OVC made vulnerable by HIV and AIDS, resilience is about an ability to remain positive and strong and face the adversities that life brings. As large numbers of children were left in great need of care because of the HIV/AIDS pandemic, a gap was identified in the provision of quality psychosocial support services. HCBC organisations would beneft from empowerment with knowledge in mitigating possible negative mental health outcomes amongst ovc. This study aims to address this research gap.

1.3 AIM OF THE STUDY

This research aims to document the psychosocial care and support services being provided to OVC by two Home/Community-Based care and support organisations (HCBC) in the eThekwini Metro. After having worked with various HCBC organisations for sometime, the researcher identified these gaps during monitoring, reporting and evaluation tasks. This study used qualitative research methods to enable a comprehensive understanding of PSS services in two OVC Centres in EThekwini Metro. These were Phinduvuye and Vusisizwe Community Care Centres.

1.4 RESEARCH OBJECTIVES

The objectives of this research study are:

1.4.1 To determine the psychosocial care and support services that are provided to OVC by HCBC organisations.

1.4.2 To identify needs and challenges experienced by HCBC organisations in delivering PSS services to OVC.

1.4.3 To document the critical needs of OVC that are still not being met, from the HCBC organisations.

1.5 KEY QUESTIONS

The fundamental questions were as follows:

1.5.1 What psychosocial care and support programmes are delivered to OVC by HCBC organisations?

1.5.2 What are the needs and challenges faced by HCBC organisations in providing PSS interventions?

1.5.3 What are the critical needs of OVC which are not met and why?

1.6 SIGNIFICANCE OF THE STUDY

The findings of this study will improve understanding of psychosocial services that are provided to OVC. It will also determine the gaps and challenges that exist in providing these services. These findings could assist policy makers and implementers to provide better PSS services. The findings will also be relevant to the HCBC in this study as the challenges and gaps identified will assist in identifying potential areas of improvement.

It is relevant to notice that PSS services cut across many fields and disciplines; for example, psychology, social work, health, education, probation work, gender-based violence and child protection. Consequently, a range of service providers will be sensitised about the importance of these services to OVC which will enable them to incorporate PSS in their programming. Such providers include CYCWs, State Departments, NGOs / CBOs / FBOs, Boards of Management, Donors and other social service professionals.

Findings also provide invaluable information to HCBC providers at different levels. PSS services is a responsibility shared by communities, NGOs, and government departments at all levels. It also focuses on things such as strengthening resilience, coping, well-being and mental health. Marici (2015) claims that resilience goes

beyond the current stressors, as it involves also coping with past stressors (loss and trauma), as well as with anticipated adverisities (relational and financial difficulties). As many people face various adversities in life, resilience interventions, which include the provision of psychosocial support are necessary.

This study provides national and provincial departments with information to improve existing and proposed policies and guidelines, thus improving service provision. The study will contribute to the delivery of quality services and serve to inform policy decisions in the field of PSS. It must however be noted that there may be a need for further studies in the area due to the limited participants undertaken in this study.

Provision of PSS is seen as a cutting thread across services and programmes that target the most significant and effective psychological diemsions in preventing negative outcomes in children, youth and adults as well. This study is significant and will benefit many sectors. Below is a discussion of the benefits of this study to the various sectors.

The Department of Education's concept of schools as nodes of care and support for example can benefit from the findings. The inclusion of psychosocial support in the Life Orientation curriculum, will enable children and young people to develop life and social skills. Additionally, the Department of Sports and Recreation can also incorporate and identify avenues for social support and PSS inclusion in their buddy programmes and peer support programmes. In the same way, the Department of Social Development can benefit across all social service programmes delivered. The role and importance of PSS in support groups, where both children and young people express themselves more freely with other people in similar circmustances, will be highlighted.

NGOs like Family and Marriage Society of South Africa, the South African Depression and anxiety group, Child Welfare, South African National Council for Alcohol and substance abuse, Cancer Care Association, Hospice Care Association and others will be enable to identify and connect specific children's needs with PSS provisions. As PSS is about humanity shown to other people, it assists people facing adversities to contend with familial, economic and social difficulties. Another important sector is the

Faith Based sector (FBOs), which also plays an important role in PSS provision. This FBO sector can intensify their role as conveyors of morality to society as they provide both spiritual and moral guidance.

Another added value lies with the contribution to various Sector Education and Training Authorities (SETAs) providing skills programmes and qualifications on mental health. Amongst these are the Health and Welfare SETA, the Education, Training and Development Practises (ETDP) SETA and the Services SETA. This study may highlight the need to consider socio-economic conditions and their impact on mental health and the need for PSS provision, to be incorporated in learning and development programmes.

Additionally, providers of Employee Wellbeing programmes (EWP) will also benefit from this study and incorporate some elements in their psychosocial counselling support services. Considerations on trauma counselling services for example, for both children and adults can be beneficial. The psychosocial ramifications of COVID-19 have also posed significant challenges for many households hence the need to strengthen the provision of PSS. Many children and families are faced with living in adverse circumstances following losses experienced.

This study reviews the worlds of children and young people throught the PSS lens, looking at what constitutes their worlds as they grapple with not only parental illness or loss but sometimes with prospects of impending deaths. It thus offers some insights into the lives of children and youth that have become orphaned and vulnerable.

From a research standpoint, the broad themes may offer a useful framework for future research on this subject, particularly in connecting PSS and resilence theory. It is hoped that the findings will contribute to the body of knowledge by also highlighting key challenges faced in the provision of PSS services.

1.7 THEORETICAL FRAMEWORK GUIDING THE STUDY

The ecosystems approach adopts as a theoretical framework for this study. Berk (1998) draws from the writings of Urie Brofenbrenner, who is regarded as the innovator behind the ecological systems theory, stating that this approach sees a

human being as growing within complicated systems of relationships. Such relationships are microsystem, mesosystem, exosystem, and macrosystem. Such an approach provided an understanding of the relationships that exist between HCBC organisations and their environments. The ecosystems approach is significant in demonstrating the interconnections between different contexts in which children live (Khanare, 2009). This approach emphasises viewing every aspect of life in a holistic manner, as well as interventions that should concentrate on understanding the varying levels of the ecosystem. The emphasis on the interconnectedness and interdependence of relationships in all systems (micro to macro) is in Bronfenbrenner's ecological systems theory (Mthiyane, 2013). As HCBC organisations are in constant interaction with the environment, and the role players in the environment impact the welfare of OVC, this approach is considered a suitable base for this study.

Khanare (2009) adds that this approach reflects social relations, i.e. individuals need each other for survival and social functioning and also influence each other reciprocally. Children, the family, the school, the community and broader society are the most crucial variables in their environment (Mthiyane, 2013). These affect their overall growth and development and how they cope with undesired experiences and challenges of life (Mthiyane, 2013). HCBC organisations also build relations and connections with other organisations, professionals and other service providers in their environments. These resources include schools, the community, the media, religious and cultural organisations.

Wilder (2009) asserts that the systems perspective assumes that people interact consistently with their surroundings and develop within networks that are capable of affecting them either positively or negatively.

An ecosystems approach provides a model that focuses simultaneously on multiple levels of phenomena and helps in understanding how the various levels of HCBC organisational functioning affect and are affected by individuals, families, the community as well as the range of stakeholders. If these varied levels are not conducive and functional, it will be difficult for the HCBC organisation to do its job. HCBC organisations are well positioned to be an entry point to other family and community services as they already have developed relationships with these systems.

Such organisations serve a range of client systems that include individuals, families, groups, communities and other organisations. They need to ensure that all systems interact effectively to maintain order, and to provide high-quality services. Regarding PSS services, it is necessary to observe, monitor and manage changes that occur in their environments, as they affect how such children cope with their lives. Such observation will help care providers identify interventions needed.

Berk (1998) identifies the micro system level as the lowest level and states that it pertains to activities and interaction patterns in a person's immediate surroundings. In this study, the micro system relates to the HCBC organisations themselves as a unit of analysis. Relations, interactions, and the locations of such organisations form essential aspects of this system. HCBC organisations need to continually engage in the process of review of the work they do and the services they provide to beneficiaries. If any changes occur in a child's circumstances for example illness, death – the interventions should focus on responding to these to benefit the children client-systems, building their resilience and helping them cope with those adversities.

Berk (2010) refers to the mezzo system as connections among microsystems that foster development. These microsystems include families, schools and community organisations. Families that are serviced by HCBC organisations are the mezzo system. The family thus continues to be regarded as an essential institution in society, playing a role of socialising, nurturing and caring for its members. HCBC organisations' work is promoted by effective involvement with the families around them. The role of the family is thus critical. The school community and the faith-based sector are also part of important systems for HCBC organisations. Services provided may not be beneficial to the preservation of family life, yet the institution of the family is important for children's upbringing. CCGs support families through identification, screening and referring those in need. They educate family members on a range of care and support options for their members. The researcher believes that increased educational efforts for families, practitioners and community members could help sensitise them about their roles and responsibilities in promoting the well-being of OVC.

It is ideal for PSS to come from an individual's family. Current services rendered by HCBC organisations may not be holistically addressing the needs of the families who need them. In particular, appropriate strategies aimed at enhancing the children's well-being are needed. Awareness and advocacy campaigns are also undertaken by HCBC organisations to teach communities about daily challenges faced by OVC and also to effect changes in policy and decisions about such children. Also, children may not be receiving much-needed support from their communities. It is in such situations that support structures like Child Care Forums become essential for promoting children's rights, needs and their general wellbeing, including their right to psychosocial care and support.

According to Berk (1998: 24), "the exosystem refers to social settings that do not contain the developing person, but that affect experiences in immediate settings". In this regard, the community, society, other HCBC organisations, government departments, donor bodies and culture reflect elements of the exosystem. These are also sometimes known as social factors contributing to the well-being and development of OVC. They do not have a direct effect on the children serviced by HCBC organisations but have a bearing on the success of programmes offered. Interventions that focus on stigma and discrimination mitigation, for example, are needed on an ongoing basis as part of broader social supports to OVC.

The macro system refers to the broader environment consisting of varying systemic levels indirectly interacting with the family unit, but holding significant influence on the family (Naidoo, 2004; Kasiram 1995). Berk (1998) asserts that the macro system refers to the values, laws, customs, and resources of a particular culture which includes, for example, social cohesion, prevailing ideologies, policies and funding patterns. Funders play a prominent role in influencing decision making on programme development and service delivery by HCBC organisations. Many creative OVC programmes do not seem to work well because of the lack of or limited funding available to HCBC organisations.

Existing HIV and AIDS guidelines, policies and legislation form part of the HCBC organisations' macro systems. The Children's Act 38 of 2005, in section 50 calls for the protection of all children by the State. Living circumstances of children may differ

and include abandonment, orphanhood, being with no means of support and all forms of street life. Understanding the needs and circumstances of OVC would allow for appropriate interventions in policy making and OVC care and support programme formulation.

1.8 DEFINITION OF KEY CONCEPTS

- **Child – "**any person under the age of 18 years" (Chapter 1, section 1 of the Children's Act No 38 of 2005).
- **OVC –** A vulnerable child is defined as "one whose mere survival is under threat due to any circumstance which prevents the fulfilment of his or her rights" (DSD, 2005). An **orphan**, defined in Chapter 1 of the Children's Act (No 38 of 2005), is "a child with no surviving parent caring for him or her".
- **Psychosocial support –** As defined by Thyre-Murray (2009) psycho-social support (PSS) is "professional assistance intended to assist beneficiaries in realising self-reliance in dealing with psychological and social challenges associated with shock or trauma". It manifests itself through relationships which display empathy and acceptance (Morgan, 2010).
- **Home / community-based care and support programme (HCBC) –** This programme seeks to provide comprehensive and quality health and social services "to promote, restore and maintain a person's optimum level of comfort, social functioning and health" (DSD, 2012)
- **Community caregiver –** A person who gives care and protection to someone in the community (can be a child, an older person or a sick person (Children's Act Guide, DSD: 2011).
- **Community care centre –** refers to "a community-based facility that provides a comprehensive basket of essential services to meet needs of vulnerable groups" (Department of Health and Social Development, 2010).
- **Resilience –** refers to "patterns of positive adaptation in the context of significant risk or adversity" (Masten and Powell, 2003 in Ungar, 2008).
- **Well-being –** A child's well-being is achieved when the child realises their developmental potential in a caring and supportive environment (DSD, 2010).

- **Continuum of care -** This is when a child receives care over time and in a range of ways (Berry, Jamieson, and James: 2011).
- **Mental health –** A state of wellbeing in which every individual realises his ir her potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (WHO, 2016).
- **Childcare forum –** A group responsible for managing support to vulnerable children (DSD, 2010). The Human Sciences Research Council (HSRC) define such forums as "locally based groups caring for vulnerable children within their communities. They are places where children can be linked to essential services".
- **Child-headed household –** A household in which no adult family member cares for the children, or where a child is forced to assume the role of primary caregiver (DSD, 2010). Roux-Kemp (2013) defines child-headed households as "households where the older child/children assume most of the parental responsibilities due to the death, illness or incapacitation of that child/children's parent(s) or other adult caregiver".

1.9 RESEARCH METHODOLOGY

This study adopts a qualitative methodological approach. Qualitative approaches, according to Nieuwenhuis (2010), are preferable where the goal is to understand something in context. This is congruent with the researcher's goal which requires an understanding of the provision of PSS interventions delivered to OVC by HCBC organisations.

The sample used 14 participants (7 per HCBC organisation) for this study. The choice of participants from two different contexts, namely semi-urban and rural, was deliberate in the sense that it provided a comparable experience of service provision for OVC.

The study gathers information through interviews, written records, and observations. The usage of semi-structured interviews allows for participants to think deeply and analytically; to examine their knowledge, feelings and experiences regarding the provision of PSS. Consequently, for validity, triangulation is used, which involves the use of multiple data collection instruments. Triangulation assisted in increasing an

understanding of daily experiences and emotions as far as PSS services to OVC are concerned.

1.10STRUCTURE OF DISSERTATION

The next section is a brief overview of what will be covered by subsequent chapters of the dissertation. The dissertation comprises of five chapters; each described briefly in the sections below.

Chapter 1: Orientation of the study

Chapter 1 encompassed the background and context of this study, including a description of the research problem, rationale, aims and objectives, research questions, as well as the significance of the study.

Chapter 2: Literature review

Chapter 2 examines the literature on HIV/ AIDS in South Africa. It delves into the situation in KwaZulu-Natal; the social impact of HIV and AIDS on children; the legislative and policy mandates underpinning provision of psychosocial programmes to children and their families; effect of HIV and AIDS on children and the support services provided by HCBC organisations to OVC.

Chapter 3: Research methodology

The third Chapter deals with the methodology employed in generating data required to address the research questions. It uses a qualitative research design which enabled a comprehensive analysis of the nature of PSS services rendered by HCBC organisations. The further discussion relates to the methods and tools of data collection utilised.

Chapter 4: Presentation and analysis of findings

Chapter 4 is the presentation and analysis of research results. A thematic analysis is used, guided by relevant literature and the theoretical framework. Study limitations as well as ethical issues are also covered.

Chapter 5: Conclusions and recommendations

Chapter 5 summarises the results in terms of the study's objectives. It contains recommendations to help mitigate the challenges impacting provision of psycho-social services to OVC.

1.11CONCLUSION

Chapter 1 explained the background, aims and objectives regarding the provision of psychosocial care and protection services by HCBC organisations. The following chapter addresses the literature review.

CHAPTER 2
LITERATURE REVIEW

2.1 INTRODUCTION

In an attempt to understand the services provided by PSS interventions, this chapter scans the literature on HIV and AIDS within South Africa. Various treaties are also reviewed to learn about children's rights and the provision of psychosocial services to OVC. The first part of this chapter will begin with an overview of domestic legislation regarding children's rights, with specific reference to PSS. The second part deals with OVC care and support programme elements as well as available models of child care and protection services.

2.2 HIV AND AIDS: A SOUTH AFRICAN PERSPECTIVE

Provision of PSS is vital in building the coping capacity of young children dealing with difficulties in their learning and development. Due to that fact that PSS represents an essential component in children's rights, it should be incorporated into all services offered by HCBC organisations.

HCBC is a community-led response to a range of social ills. These include HIV/AIDS, teenage pregnancy, substance abuse and many others. Although many government departments recognise the importance of protecting the rights of children with HIV/ AIDS, many caregivers and HCBCs are not sufficiently prepared to provide PSS services to OVC. As a result, people and in particular children living with HIV suffer due to inadequate care. HCBC organisations are well positioned to assist families and community service providers as they already have developed and established relationships with these systems (www.avert.org).

Several institutions have widely researched the HIV and AIDS pandemic in South Africa. A UNAIDS (2013) report indicated that "South Africa has the most significant burden of HIV in the world – 18% of all HIV positive people live in South Africa, which translates to a total number of approximately 6 million people". Also, the said UNAIDS 2013 report indicated that 16% of all new infections are occurring in South Africa even

though the country recorded the most substantial decline in the number of new infections since 2010 (www.avert.org).

2.2.1 STATISTICS RELATING TO THE POSITION OF CHILDREN

Statistics South Africa (2013) indicates that KwaZulu-Natal, Gauteng, Eastern Cape and Limpopo account for over two-thirds of the child population. KwaZulu-Natal, in particular, is regarded as one of the most child-poor provinces in the country, accounting for 24,5% of all poverty-stricken children in the country. The Statistics South Africa report (2013) cites a Living Conditions Survey (LCS) 2008/2009 report which found that "approximately one in five children were orphans in the country. A total of 12,0% of children had lost a father, 3,8% had lost a mother, and 4,2% had lost both of their parents; meaning that an estimated 3,8 million children were found to be orphans during the survey year" (Statistics South Africa, 2013). The General Household Survey (2015) indicates that "South Africa's population increased from 45,8 million in 2002 to 54,4 million in 2015. Gauteng led with more than 13 million, followed by KwaZulu-Natal and Eastern Cape with 10,6 million and 6,6 million respectively". Approximately 45% of all HIV positive children under the age of 15 years are currently on ART (DoH: 2014). Without proper treatment for HIV, 80% of children living with HIV could die before the age of 5 years with the peak in mortality occurring at 2-3 months of age (www.aids2014.org). According to Hall and Wright (2013), many children grow up in areas with poor infrastructure, inadequate municipal services and without easy access to schools and clinics.

Statistics South Africa (2013) recorded that black children, in particular, bear the brunt of poverty. Almost 25% of children are without either parent living with them. Some of these children are orphans, but eight out of ten have at least one living parent who stays elsewhere. According to Mokgatle-Nthabu et al. (2011), approximately two million orphans reside in child-headed households. Meintjes, Hall, Marera, and Boulee (2013), argue that whereas the number of orphans is increasing, the number and proportion of child-headed households is decreasing.

It is essential that all sectors remain concerned about the special needs of children residing in child-headed households. Safety nets are still required for children living in child-headed households. Additionally, policy responses have to take cognisance of

the situation of children living in households headed by children (siblings). Statistics South Africa (hereafter StasSA), (2006) asserts that children should receive the necessary support and protection from the State, more so as their rights are enshrined in the South African Constitution. This support and protection should include access to health care, education as well as facilitated access to any other social assistance programme available in the country. Holistic services to children and their families are thus encouraged. Another critical issue raised by Meintjes et al. (2013) is that children in child-headed households are mostly teenagers. Active programmes are required to target teenagers, especially young girls.

Community-based care is among the best options for children as they benefit from being cared for in their local and familiar environments. There is an overstretched capacity to care for people and provide for those with deceased loved ones in impoverished communities (UNICEF,2009). Skovdal and Campbell (2010) supported this view and asserted that "the quality of care available to children affected by AIDS becomes compromised". The kind of support that is needed includes mental health and PSS to children to address their vulnerabilities.

2.2.2 KWAZULU-NATAL HIV AND AIDS SITUATION

KwaZulu-Natal has excessive exposure to HIV and AIDS, partly due to its geography. KwaZulu-Natal is predominantly poor and rural, resulting a higher dependance on the government (KZN Provincial economic cluster, 2006). Defined in several data as the "populous province" (StatsSA, 2013; KZN Office of the Premier, 2012), KwaZulu-Natal has topped most provinces on a range of social phenomena/ills. These include having the largest orphan population at 23,8% (StatsSA, 2002 - 2013) and being home to a fifth (20,9%) of all poor households in the country (StatsSA, 2013). Also, a significant proportion of poor women in the country are living in KZN (StatsSA, 2013). KZN has two-thirds of the country's child population (StatsSA 2013).

Furthermore, Berry et al. (2013) state that 27% of children in KwaZulu-Natal have lost either parent. Statistics South Africa (2013) reports that KwaZulu-Natal has the most significant share of poverty nationally, with many of the country's poor adults living in this province. Well-planned action to intervene early is required to address the needs of these children. Slemming & Saloojee (2013) contend that when sectors address

problems early, many risks are likely to be reduced. If sectors pull together in a multi-disciplinary approach, intervening early enough; they can achieve the holistic and optimal development of all children. Such development encompasses children's well-being and increased resilience.

An understanding of South Africa's context is essential for informing programming with regards to services required by OVCs in particular. Collaboration amongst the key stakeholders, for example, NGOs, government departments, donors and business organisations is key to improving the provision of PSS services to OVCs.

2.3 THE SOCIAL IMPACTS OF HIV AND AIDS ON CHILDREN

HIV has left many families and children economically vulnerable and often socially stigmatised. Smart (2003) in Ebersohn & Elloff(2006) identify certain groups of children as being vulnerable – these include "children with disabilities; children with chronic illnesses; children infected and affected by HIV/AIDS; children without caregivers; children at work and children living on the streets". As a result of the vulnerabilities, such children lack the necessary resources, and this impacts their lives negatively.

DSD developed a conceptual framework for PSS in 2011. It records that children orphaned by AIDS tend to be "more impoverished than others; less likely to attend school; more likely to be living in a family without access to social assistance; have caregivers who are unwell and spend more time on household chores". Other emotional and "psychological challenges they face are anxiety, depression, anger, sleep problems and nightmares, suicidal thoughts, poor peer relationship, post-traumatic stress, delinquency and conduct problems" (DSD, 2011). This view is supported by Ruiz-Casares (2009:370), who maintains that "there is growing evidence that orphaned children experience poorer psychological outcomes than non-orphans, including elevated levels of depressive symptoms and suicidality". These symptoms are suggestive of depression and anxiety.

Bachmann and Booysen (2003) maintained that OVC experience higher levels of poverty as well as extremely high levels of stigma and bullying. Qiao, Li, Zhao, and Stanton (2014) state that the children orphaned by HIV/AIDS may be forced to deal

with more psychosocial challenges; these include stigma, discrimination, and social isolation. Qiao et al. (2014:370) add that “these challenges are assiciated with persistently unresolved grief and prolonged psychological problems”.

Thurman and Kidman (2011) maintained that OVC are at higher risk of abuse and child maltreatment than other children, suggesting a strong need for economic support, preventative parenting programmes, and family support. In an Early Childhood Development (ECD) context, Slemming and Salojee (2013) allude to increased risks experienced by children infected and affected by HIV and AIDS. These are said to be at the economic, social and food security domains.

Cluver et al. (2012) and Operario et al. (2011) stated that OVC had increased sexual risk behaviour, including transactional sex. This behaviour links to depression, abuse, and extreme poverty. Girl children, in particular, are more likely to become infected with HIV. Hardee et al. (2014) are of the opinion that the critical challenges of evidence-based programming to decrease the risks to HIV of adolescent girls include “a lack of evaluated interventions from developing countries that focus on adolescent girls as many programmes do not adequately address gender dynamics”.

The psychosocial well-being of OVC is a significant focus of this study; such integration gets explored as a micro level intervention in the HCBC programme. It becomes critical that at a macro level, legislation and policy responses address these challenges faced by young children. Such children could be in ECD facilities, HCBC programmes and other child protection contexts. On a micro level, support organisations are also encouraged to gauge the extent to which the psychological distress experienced by young children gets incorporated into their programmes and services.

2.4 CHILDREN’S RIGHTS FRAMEWORK

This section concentrates on the guiding framework for children’s rights in addressing their various needs, from an international, regional and domestic levels. As there exists a high prevalence of vulnerabilities for South Africa’s children, legislative and policy provisions serve as essential guides in developing strategies for child care and protection. The children’s rights framework is incorporated as a lens for the research.

2.4.1 UNITED NATIONS CONVENTION ON CHILDREN'S RIGHTS (1989)

Delany, Jehoma and Lake (2016: 18) remind that South Africa ratified both the United Nations Convention on the Rights of the Child (from now on UNCRC) and the African Charter on the Rights of the child (ACRWC), which are regarded as key international child rights instruments. The UNCRC assigns State parties certain obligations regarding the protection of children. These include the protection of children against all forms of physical and mental violence (Article 19); non-discrimination (Article 2); protection against torture and cruel, inhuman and degrading treatment or punishment (Article 37) and the right to enjoy the highest possible standard of healthcare (Article 24(1)). It is argued that PSS forms part of Article 24 specifically (as health includes mental health) as well as Article 6 (right to life, survival, and development). The children's need for PSS is a human rights provision formed across a range of international treaties and domestic legislation.

Rohrs, Berry, Lake and Shung-King (2016) add the responsibility of member countries to report on their progress every 5 years. A specific committee namely the United Nations Committee on the Rights of the child (UNCRoC) is dedicated to receive and assess country reports on the extent to which they have realised children's rights. Such country reports serve as important accountability mechanisms by different member States. Progress (or lack thereof) in promoting children's rights is measured (Rorhs et al, 2016).

At a regional level, the African Charter on the Rights and Welfare of the child (from now on referred to as the Charter) becomes an important premise and reference point.

2.4.2 AFRICAN CHARTER ON THE RIGHTS AND WELFARE OF CHILDREN (1990)

The Charter of 1990 (hereunder ACRWC) is one of the Treaties designed as a protective measure for children at a regional level. South Africa is a signatory to the Charter, meaning that the country has a responsibility to ensure its implementation. Because of children's particular vulnerabilities, they have particular rights that recognise their unique needs for protection. The Charter is thus one of the instruments, linking and relating specifically to children on the African continent.

The Charter is “the second global and first regional binding instrument that identifies the child as a possessor of different rights and makes it possible for the child to assert those rights in domestic, judicial or administrative proceedings” (Chirwa, 2002). Chirwa (2002) further mentions that the principle of non-discrimination lies at the centre of the Charter. More often, OVC are discriminated against, necessitating that support programmes encompass stigma and discrimination activities as part of a holistic package. Article 11 of the Charter provides for the children’s right to education and Article 14 the right to health stated as “the enjoyment of the best attainable state of physical, mental and spiritual health”. Mental health is an essential aspect of PSS and State parties have a responsibility to ensure that this Article, alongside others, is honoured.

Similarly as in the UNCRC obligation to report, Governments need to submit a progress report every three years to the Committee of Experts on the Rights and Welfare of the child. Rohrs et al (2016: 18) hold that community service organisations (CSOs) can also participate in the monitoring process by submitting so-called “shadow” or “alternate” reports presenting their own data and/or challenging information provided in the Government reports.

2.4.3 DOMESTIC LEGISLATION

South Africa has enacted legislation, drawing from and aligned to international and regional conventions.This study looks at the legislation applicable to OVCs.

2.4.3.1 THE SOUTH AFRICAN CONSTITUTION

The legislative framework of South Africa is stipulated in the Constitution (No 108 of 1996) and affords all South Africans certain “fundamental socio-economic rights such as the right to access health care, housing and sufficient food and water” (Stats SA, 2013). With regards to children, the basic premise of a children’s rights framework seeks to ensure that all children’s rights under Section 28 of the Constitution (as well as other Acts of Parliament) are guaranteed.

2.4.3.2 SECTION 28 RIGHTS OF THE CONSTITUTION OF SOUTH AFRICA

The Bill of Rights provides all citizens with numerous rights and freedom including children. OVC as a special category of children are also entitled to the rights and protection under the Constitution. The Constitution describes a range of equality and socio-economic rights. Socio-economic rights include the right to adequate housing (Section 26(1)); the right to have access to health care, sufficient food, water and social security (Section 27) as well as the right to education (Section 29). Other rights include basic nutrition, shelter, basic health care services and social services as well as the right to protection from abuse and neglect.

Section 28 which relates specifically to the rights and protection of children highlights the best interests of the child principle as of paramount importance in all matters concerning children. By specifying these rights, the Constitution recognises that children require extra protection because they are dependant on others for their safety and well-being (Rohrs et al, 2016: 25). The concept of the best interests of the child is also described in the UNCRC. Under this Convention, Article 3 refers to the "best interests of the child as a primary consideration in matters concerning children". Whereas Article 4 (1) of the African Charter refers to th best of the child as 'the primary consideration'. PSS falls within the bounds of social services referred to under this specific right.

2.4.3.3 CHILDREN'S ACT NO 38 OF 2005 AS AMENDED

In South Africa, the Children's Act 38 of 2005 was passed in 2005 but it came into effect on 01 April 2010. It provided for a "comprehensive range of social services for children and their families and introduced a new developmental approach to South Africa's child care and protection system" (Jamieson, Proudlock & Chakarisa, 2012). The aims of the Children's Act 38 of 2005 are to "give effect to the particular rights of children as contained in the Constitution and to set principles relating to the care and protection of children" (Matthias & Zaal, 2009).

The Children's Act gives effect to individual rights of children as contained in the Constitution. PSS is an integral component of the care and protection element afforded to children by the said Act. It includes the promotion of the overall well-being, particularly for children who face trauma and any form of distress. The important

considerations underpinning PSS and which improve the psychosocial well-being of children fall within the perspective of children's rights and include “protection from harm; the best interests of the child; child participation; family-based care; *Ubuntu;* social and community integration; social development; prevention as opposed to reaction; gender sensitivity and age and developmental appropriateness” (DSD, 2011).

Chapter 7 of the Children’s Act relates to child protection. Section 150 (1) of the Children’s Act deals with children in need of care and protection. A child will be in need of care protection if such child:

“(a) has been abandoned or orphaned and is without any visible means of support;
(b) displays behaviour which cannot be controlled by the parent or care-giver;
(c) lives or works on the streets or begs for a living;
(d) is addicted to a dependence-producing substance and is without any support to obtain treatment for such dependency;
(e) has been exploited or lives in circumstances that expose the child to exploitation;
(f)lives in or is exposed to circumstances which may seriously harm that child’s physical, mental or social well-being;
(d may be at risk if returned to the custody of the parent, guardian or care-giver 30 of the child as there is reason to believe that he or she will live in or be exposed to circumstances which may seriously harm the physical, mental or social well-being of the child;
(h) is in a state of physical or mental neglect; or
(i) is being maltreated, abused, deliberately neglected or degraded by a parent, a care-giver, a person who has parental responsibilities and rights or a family member of the child or by a person under whose control the child is.”

Of particular importance and relevance to OVC is section 150 (1) (a) and (f). There is a duty on social workers who find children in need of care and protection to take measures to assist the child, including counselling, mediation, prevention and early intervention services, family reconstruction and rehabilitation, behaviour modification, problem solving and referral to another suitably qualified person or organisation (Section 150 (3) of the Children’s Act).

Chapter 8 of the Children's Amendment Act 41 of 2007, allows for the establishment of prevention and early intervention programmes. Section 144 (1) of the Amendment Act sets out that these inventions must focus on improving the life of a child. With OVCs section 144 (1) (e) is important as requires the provision of psychological, rehabilitation and therapeutic programmes for children. In addition protection services for children who have been abused, abandoned and neglected as well as provision of alternative care (including foster care and adoption) are specified (Section 144 (1)(f) of the Children's Amendment Act 41 of 2007). The provision of PSS falls within these realms in that HCBC services and programmes seek to prevent children from falling victims of stressful and traumatic experiences through, for example, loss. When conducting home visits, CCGs identify children in need of care and protection. CCGs offer a range of care, counselling and services that support the child and his/her family. Where death occurs, CCGs render ongoing PSS services to the affected children. At the DSD and the National Action Committee for Children (NACCA) partners workshop held in Durban on 02-03 June 2011, participants agreed that programming and research are a collective process, with a shared goal of "improving the well-being of children infected and affected by HIV and AIDS".

2.4.3.4 THE SOCIAL ASSISTANCE ACT NO 13 OF 2004

The Social Assistance Act (2004) is highlighted in this study as it is considered crucial to the longer-term poverty reduction for OVCs, whilst upholding their human rights to dignity. The Constitution, provides that everyone has the right to have access to social security, included are people who are unable to support themselves and their dependants (Section 27 (1) (c) of the Constitution 108 of 1996). The state is required to take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these right (Section 27 (2) of the Constitution 108 of 1996). This Act also applies and makes provision for the financial support children including vulnerable children. OVCs are not specifically mentioned in the Act however it can argued that in terms of section 6 a primary cargiver of an OVC may be eligible to apply for a child support grant (Section 6 of the Social Assistance Act 13 of 2004).

The Social Assistance Act provides a national legislative framework for the provision of social grants (Rohrs et al, 2016). Whilst the national Department of Social Development of Social Development is responsible for policy, legislation and funding of social assistance, the South African Social Security Agency (SASSA) is responsible for the administration and delivery of social grants (Rohrs et al, 2016). Social grants contribute significantly to poverty alleviation interventions. Rohrs et al (2016: 31) argue that lifting children out of poverty also requires improvements in the availability and quality of schooling; health and social services; policies that address the structural causes of poverty and inequality as well as increased work opportunities for children to access when they are older. The plight and the situation of children, particularly OVCcan be greatly improved if such conditions are taken seriously. The government has made efforts at alleviate poverty through various policies and programmesfor example in introducing feeding schemes and no-fee paying schools in poorer communities. In addition, the country's National Development Plan (NDP) also highlights the important role that social assistance plays in tackling poverty and inequality in South Africa.

Hall, Sambu, Almeleh, Mabaso, Giese and Proudlock (2019) refers to an essential package of services of Early Childhood Development (ECD) services and programmes. The said authors purport that the essential package is a necessary precondition to realise children's constitutional rights and includes birth registration, access to social grants, responsive child protection services and provision of psychosocial support. It is in this light that this study seeks to highlight the range of OVC needs as well as services and programmes they can benefit from, in efforts to ensure that they achieve positive outcomes in various areas of their lives.

2.5 AN OVERVIEW OF POLICIES AND PROGRAMME INITIATIVES IN SOUTH AFRICA

The government of South Africa has made great strides in the initiation of several policies and programmes in efforts to mitigate the economic, health and social impacts of HIV/ AIDS. HIV support programmes have scaled up significantly.

The DSD guides services to persons infected and affected by HIV/ AIDS by a number of legislative mandates, policies, guidelines as well as norms and standards.

Legislation such as Section 28 rights in the South African Constitution, Children's Act No 38 of 2005 and the White Paper for Social Welfare (1997) relate. The National Action Plan 2016-2020; the Framework for Home and Community Based Care (HCBC) and support programme (2012); and Conceptual Framework for PSS for orphans, and other children made vulnerable by HIV and AIDS (2011) also relate. Guidelines on PSS for Adults living with HIV and AIDS and other chronic conditions (2010); the Policy Framework for CCGs (2009); and the National Integrated Plan for children, youth and families infected and affected by HIV/AIDS (2000) conclude this expansive list. The study discusses some of these policy directives in the sections that follow.

On a macro level, Shisana (2012) states that it is critical that policymakers and researchers unite to understand and combat HIV, TB, and STIs – this can be done by researchers preparing policy briefs for submission, and policymakers staying in dialogue with researchers to ensure the accuracy of their information.

2.5.1 THE 1997 WHITE PAPER FOR SOCIAL WELFARE

The White Paper (1997) introduced the "developmental approach" to service delivery, shifting from a "remedial service delivery model" (White Paper, 1997) of the past. It seeks to protect all categories of vulnerable groups, whether these are children, people with disabilities or older persons. The document provides an essential mandate in the arena of social welfare service provision. Also, the White Paper (1997) has one of its strategies as the "mobilisation and improvement of community-based care, support, and protection of orphans and other children made vulnerable by HIV/ AIDS".

In view of the changing socio-economic conditions in the country and globally, it became necessary to review the White Paper. A comprehensive report on the Review of the White Paper for Social Welfare, 1997 (dated 28 September 2016) informs that a ministerial committee was appointed by then Minister of Social Development, Ms Bathabile Dlamini in 2015, to engage in a process of review of the implementation of the said White Paper. Its mission was to assess the extent to which services and interventions provided by the Department were responsive to the needs of the recipients of services. Furthermore, provision of an implementation framework

for social protection and developmental welfare services was an important objective. Social welfare services across all vulnerable groups and clientele were reviewed. These included older persons, people with disabilities, children and persons infected and affected by HIV and AIDS.

According to the White Paper Review report (2016), the Ministerial committee finalised and released its report during 2016, with certain recommendations. In respect of the HCBC programme, the report highlights challenges faced by community caregivers overtime, with limited support (financial and otherwise). Currently such caregivers receive a stipend. A discussion with a DSD official during August 2020 revealed that CCG's full absorption (as they are still considered as contract workers, with no beneftis) on the Expanded Public Works programme (EPWP), clarification of conditions of work, being placed on Government payroll are all issues that are yet to be finalised which impacts on job security and service delivery.

Although this study is not focussed primarily on policy implementation, the researcher did view the 5C Protocol advocated by Brynard and De Coning (2006) in their study of policy implementation in South Africa. The five C's include the content or the policy, context in which policy is implemented, commitment from those implementing the policy, the role of clients and coalitions and the capacity of those tasked with implementing the policy (Brynard et al, 2006). There are however other C's involving communication, coordination and change management – which all have an impact on policy implementation (Brynard et al, 2006). Much changes however were observed since development of the White Paper for example, the launching of the "Integrated Service Delivery Model" (ISDM) in 2005 whose aim is to render comprehensive services to all clients. This was on par with the need to integrate and coordinate services, as purported by the White Paper. Another development was the identification of three main programmes, with a goal of ensuring sustainable development and addressing past imbalances. These were social security, social welfare and community development (Rohrs et al 2016). Social security subsequently became an autonomous agency with its own budget.

The White Paper is commended for incorporating several interrelated Acts of Parliament. In addition, international Treaties for example UNCRC are incorporated.

DSD however still has an important task in communicating the revised policy, ensuring coordination of services and managing changes brought about the ever changing socio-economic environment.

2.5.2 THE NATIONAL STRATEGIC PLAN FOR HIV, STIs AND TB 2017-2022

South Africa's response to the fight against HIV, STIs and TB is guided by the National Strategic Plan (NSP). The NSP thus acts as an important roadmap in the journey towards a TB and HIV free generation. Under the current NSP of 2017-2022, the aim is to reduce new HIV infections by 63%, from 270 000 in 2016 to less than 100 000 by 2022 (www.sanac.co.za). The NSP seeks to ensure that 90% of all people living with HIV know their HIV status, 90% diagnosed with HIV infection to get their ART and 90% of them to have the virus suppressed. This is in line with the 90-90-90 targets set out by UNAIDS. There are grave concerns in the country around new infections among adolescent girls and young women in particular. In attempts to address this challenge, the NSP adopted a "focus for impact" approach, which will see an intensified focus on districts and locations with high burdens of HIV, STIs and TB, on adolescent girls and young women and on tailoring interventions for the key and vulnerable populations (www.sanac.co.za). Key features of the current NSP include the prioritisation of HIV prevention, accelerating implementation of universal test-and-treat, an intensified focus on location as well as a strengthened multi-sectoral response.

The NSP 2017-2022 further identifies five critical enablers to maximise the reach and impact of South Africa's response to the HIV, TB and STI public health concerns. Enabler 2 has a stronger relevance for this PSS study as it provides for building of strong social systems of care and support. Such systems include families and communities and their role in supporting key vulnerable populations, OVC in particular. Within a context of a multi-sectoral response, a core package of multi-sectoral services will need to be provided. Different sectors are thus forced to implement together rather than in silos.

2.5.3 POLICY FRAMEWORK FOR ORPHANS AND OTHER CHILDREN MADE VULNERABLE BY HIV AND AIDS IN SOUTH AFRICA (2005)

In 2005, the DSD developed the National Policy Framework for orphans and other children made vulnerable by HIV and AIDS in South Africa. The purpose of developing the Framework is a common agenda for mounting an adequate response (DSD, 2004). The policy aimed to reinforce an enabling family-centred environment for OVC. The need to restore the families drives the National Policy Framework of 2005, and the subsequent NAPs (2006-2008, 2009-2012 and 2012-2016) which have been destabilised by the twin epidemics of HIV and TB and weakened by urbanisation and poverty (NAP for OVC 2012-2016: 21).

2.5.4 THE 2012 FRAMEWORK FOR THE HCBC PROGRAMME

The revised National Framework for the HCBC programme, developed by the DSD (2012) defines HCBC as "the provision of comprehensive and quality health and social services in the home and community to promote, restore and maintain a person's optimum level of comfort, social functioning, and health". As indicated earlier, social support is essential for all children in distress. Community-based support structures for example faith or cultural groups can also serve as critical supportive mechanisms and protective factors. An exploratory study of psychosocial well-being and PSS programmes undertaken in Zimbabwe (2006) recommended that "it is necessary to find creative ways of sensitising parents and caregivers to children's need to talk to someone about their feelings, relationships and healthy life decisions". This view supports the idea that community support for OVC should be encouraged and developed. Such support needs to be provided consistently as well, allowing for OVC to feel loved and cared for. Furthermore, these support ought to be provided to both OVC and their caretakers.

Qiao, Li, Zhao & Stanton (2014:370) define social support as "the existence and availability of interpersonal relationships through which an individual feels cared for, valued and loved". The said authors further add that "social support can buffer stressful life events to reduce the likelihood of depression among adults and children" which signals that there is value in providing and receiving social support. Studies highlight the role of PSS in reducing symptoms of post-traumatic stress disorder (PTSD) among orphaned children (Cluver et al. (2012), Qiao et al. (2014).

Khanare (2009) asserts that schools provide a protective role in HIV and AIDS-related issues – this is recognised by both national and international policies that set the framework to respond to issues of OVC. An example mentioned by Khanare (2009) is the South African Schools Act No 84 of 1996. This Act entrenches State support in the form of exemption from payment of school fees and providing of feeding schemes (Department of Education, 1996 in Khanare, 2009), under certain conditions. OVC would ordinarily benefit from this support as some of their primary caregivers, who hold primary responsibility for their education have died. The Act ensures that children are kept in school while enjoying the needed social supports. Schools thus represent part of the HCBC organisations' social context that must be considered in efforts to respond to challenges facing OVC. At a mezzo system level, therefore, it is imperative that HCBC organisations engage with local schools for protection, caring and addressing the varied needs of OVC. Such engagements can, for example, be through the Department of Education's Integrated School Health Programme (ISHP) which rests on the concept of "care and support for teaching and learning" (CSTL). According to the Department of Education (2013), ISHP aims to improve both the education performance and well-being of children by addressing their health and social challenges.

2.6 OVC CARE AND SUPPORT PROGRAMME ELEMENTS WITHIN HCBC

The HIV and AIDS pandemic has brought along many challenges in society. It has compounded other socio-economic challenges as they relate to poverty, unemployment and meeting other basic needs of communities, a challenge which the State cannot address alone. The section below reviews the background of OVC care and support programmes. It shows how they have evolved. Also, it looks at the care and support elements. The assets-based strengths approach in supporting OVC will also be looked at in brief. The final part examines the psychosocial domains as well as outcomes as identified through a Zimbabwean exploratory study.

2.6.1 BACKGROUND AND CURRENT TRENDS IN THE DELIVERY OF OVC CARE AND SUPPORT PROGRAMME

The HCBC programme remains as a key HIV and AIDS intervention strategy by civil society groups since 1999, when the DSD and DOH were mandated to oversee its

implementation through the National Integrated Plan (NIP) for children, youth and families affected by HIV and AIDS. The NIP is still considered the South African Government's commitment to the fight against the spread of HIV infections and the promotion of care and support where infection had occurred. Also, the NIP aims to reduce the societal effects of HIV/ AIDS. It was implemented in phases in various provinces, scaled up exponentially over the subsequent financial years.

The KwaZulu-Natal province initiated the first strategy during the 2001/02 financial year with Community Care Centres. The concept was seen as an "integrated social care model", which needed to be "replicated in every ward, supplementing and complementing clinics, health centres, schools and DSD service points". In the NIP, the Home / Community-Based care and support programme was highlighted for the delivery of prevention, care and support to vulnerable groups. Such care and support, in particular, included the provision of PSS. For DOH, prevention, palliative and other forms of ongoing primary supportive care were provided outside the formal health care facilities, i.e. at the patients' home. Another key department in NIP implementation is the Department of Education, which is charged with the responsibility to provide life skills education in schools. The Audit report by DSD (2010), found that HCBC forms an essential part of a continuum of prevention, care, treatment and support services.

Karim and Karim (2010) contend that AIDS has placed a significant burden on an already strained health care system in South Africa. An Audit by DSD (2010) further reveals that services rendered by HCBC organisations focused on home visiting, making referrals, distributing material support, providing PSS, offering prevention programmes and running support groups. These services are provided by CCGs, who serve as the first line of support for communities.

In KwaZulu-Natal, CCGs funded by DOH and DSD were absorbed into the said Departments' persal (payroll) systems. This move was part of an effort to create a single cadre of workers, easily identifiable and with common working conditions. It was part of the implementation of Operation SukumaSakhe (OSS), a brainchild of the former Premier Dr Zweli Mkhize, which seeks to ensure service integration at the local level (KZN Office of the Premier, 2011). The OSS approach seeks to create a single model for the delivery of "integrated community-based services".

Skovdal and Campbell (2010) argue that society needs to acknowledge the “resilience of children affected by AIDS as opposed to seeing them as passive victims”. Furthermore, the authors state that through taking account of traditional means of coping and the dynamics between children and foster families, programmes stand a chance of empowering communities to better promote resilience and pscyhosocial well-being of children infected and affected by HIV and AIDS.

DSD (2011) contends that “the emergence of resilience theory has been associated with a move away from emphasising people’s weaknesses to a focus on triumphs in the face of adversity”. It is assumed that children and families have the strength which allows them to resolve their challenges. An assets-based strengths approach shares similar sentiments in that it focusses on positive outcomes.

The assets-based strengths approach is proposed by Ebersohn and Eloff (2006) as an approach that can support vulnerable children in education. Also, the authors suggest that “knowledge of asset-based good practices could be shared with families in school-based sessions, thereby developing schools, families and communities’ capacities to support vulnerable children”. Kretzmann& McKnight in Khanare (2003) indicate that an assets-based approach focusses on the “belief that people who feel connected through supportive relationships more readily develop and become people with resources who can solve problems in partnership with professionals”. OVC in particular, need this connectedness for their growth and development. Consequently, their health, educational and social outcomes may be improved.

Furthermore, an exploratory study of psychological well-being and PSS programmes by Gilborn, Apicella, Brakarsh, Dube, Jemison, Kluckow, Smith and Snider in Zimbabwe (2006) identified critical psychosocial domains and outcomes as follows:

Table 2.1: Psychosocial domains and outcomes

Psychosocial well-being	Psychosocial distress	Lingering grief
● Self-confidence ● Hopefulness	● Sadness ● Crying	● Sadness about deaths ● Anger about deaths

● Self-efficacy ● Ability to cope	● Feeling overwhelmed ● Hopelessness ● Disinterest in life	● Fear about deaths

Source: Gilborn et al (2006)

2.6.2 CHILD CARE AND PROTECTION PROGRAMMES AND ACTIVITIES

There are a range of models (documented and undocumented) whose aim is to offer optimal support to OVC (and their families). Communities utilise limited resources to reinforce children's resilience and coping in ways unimaginable. Some of the models that are generally known include Isibindi Model, Operation SukumaSakhe in KwaZulu-Natal, Bana Pele in Gauteng, echo-therapy trails, peer support programmes (e.g. Kids' Clubs / Soul Buddies), memory box project, holiday camps, Goelama programme, schools as nodes of care and support and many others.

The HCBC model provides, among other things, care, counselling and supportive services as well as the establishment and facilitation of support groups. The norms and standards for HCBC (DSD, 2010) emphasises the provision of essential services, which include establishing and managing support groups. More often than not, in the researcher's work experience, the support groups formed are for adults living with HIV and AIDS – few exist as groups specifically for children. The Guidelines on PSS highlight four key areas as PSS services – these are counselling, disclosure, supporting the affected children and succession planning (DSD, 2010).

Isibindi is a support programme for OVC, developed by the National Association of Child Care Workers (NACCW) and has been implemented nationally. Isibindi meaning courage is a holistic model striving to "give children the best start in life as well as continued support" (NACCW, 2010). It associates with a system of packaging together a range of services for children. Designed by NACCW, it is a model that has been researched and evaluated. It aims to create safe and caring communities through partnerships with local stakeholders.

Critical services provided through Isibindi include emotional support for OVC and their families, improving psychological well-being and strengthening resilience. Model

activities include the creation of Safe Parks for children in their local communities, linking OVC with available social services, ECD and the memory box project. This model was recognised by the National Department of Social Development (NDSD) as "a best practice in meeting the needs of children orphaned and made vulnerable by HIV and AIDS in South Africa" (DSD, 2011). It has been scaled up nationally by NACCW, with the support of NDSD since the financial year 2012/13 to date. The Model will utilise 10 000 CYCWs through 400 Isibindi project sites countrywide. This scaled-up service was envisaged to assist approximately 1.4 million children in need of care and protection (DSD, 2011).

Importantly, Ebersohn & Eloff (2006) highlight the shared characteristics of programmes implemented to accommodate vulnerable children. These include "community-based participation; programmes that build and strengthen internal capacities; community resource mobilisation; networking; advocacy; use of embedded (indigenous) knowledge and practice as well as information sharing" (Ebersohn & Eloff, 2006).

Whereas benefits of OVC through HCBC services have been highlighted in literature, Yakubovich, Sherr, Cluver, Skeen, Hensels, Macedo and Tomlison (2016: 62) contend that no evidence was found on improvements on more severe psychological outcomes such as child trauma and suicidal ideation. This is one of the challenges in HCBC work as some NGOs and CBOs may not have specialised training or skills in this regard. It thus signals a need for further training of their staff or alternatively strengthening referrals for appropriate psychotherapeutic interventions for OVC. In addition, inadequacy of funding of HCBC services has been another key challenge identified in various research reports (White Paper Review report, 2016 and Berry et.al, 2013). This requires that alternate mechanisms for supplementing funding for HCBC work are necessary. Cash generating programmes for example those involving horticulture, where communities produce vegetables for sale and direct proceeds towards assistance of orphans were found in a Zimbabwean study as useful (Chitiyo, 2017). Although this may appear as a small scale support, greater involvement of various Government Departments and civil society is critical for achieving maximum impact.

The Expanded Public Works Programme (EPWP brought with it a skills development component, which sector Departments have to comply with. This can be seen as means to addressing the skills gap and ensuring provision of quality services to OVC. Additionally, inadequate referral systems and insufficient public sector psychologists, physiotherapists and occupational therapists pose a challenge when HCBC organisations want to follow up with heatlh care facilities (Berry et.al., 2013). Berry and Dawes (2013) also add systemic barriers to effective ECD service delivery in South Africa. Such barriers include policy and planning issues (limited integration across policies; no shared vision nor goals), good governance challenges (poor instituitional arrangements for example) and inadequacy of resources (human, financial and service infrastructure). There is a need to clarify roles and responsibilities amongst different role-players in multi-disciplinary service provision; address infrastructural challenges; coordinate better and ensure effective monitoring and evaluation of programmes to ensure quality service delivery.

2.7 CONCLUSION

This chapter has looked at the South African context of the HIV and AIDS pandemic, highlighting the demography of the country's children as well as the impact HIV and AIDS has on children. The children's rights framework and vital instruments – legislative and policy directives about OVC were discussed. The review has shown that crucial mandates premise all services and programmes to OVC. Some of these, however, may need to be reviewed to be in line with current realities facing children. Programme elements, as well as available models, have also been highlighted in the latter parts in hopes that these will guide both policy makers and implementers.

Finally, it is clear that young people represent a major focal point of policymakers primarily due to their potential to be a significant resource for national development (StatsSA 2002 – 2012). The field of child protection is broad, whether one looks at it with ECD lens, statutory protections as well as Home / Community-based care and support. Across all these, PSS remains a pivotal programme in contributing to the well-being of children and their families. All children should benefit from supportive services that are continuous, functional and reliable. In the next chapter, attention is focused on research methodology, giving an account of how the study was designed and implemented.

CHAPTER THREE
RESEARCH METHODOLOGY

3.1 INTRODUCTION

The main aim of this chapter is to outline the research procedures followed in selecting and implementing the research design. This study adopted a qualitative research paradigm, which was viewed as congruent with the researcher's aim as she sought tounderstand the psychosocial support aspects in HCBC prgrammes. The method relating to the selection of the HCBC organisations and the research participants will be discussed. Further discussion will include the methods for data collection, data analysis techniques and ethical considerations. The last part of this chapter indicates the limitations of the study.

3.2 RESEARCH PARADIGM

A qualitative approach was used in this study. Qualitative research is defined by Fossey, Harvey, McDermott, & Davidson, (2002:717) as "a broad umbrella term for research methodologies that explore, describe and explain the participants' experiences, behaviours, interactions and social contexts without the use of statistical procedures or quantification". A qualitative research paradigm was therefore chosen as a method to realize the objectives of this research study. Such an approach provided the researcher with an opportunity to explore an in depth understanding of the topic from the perspective of the HCBC personnel and Board members. It was found to be necessary in describing PSS interventions being implemented by non-Governmental organisations (NGOs) through the Home / Community-Based care and support programme in the ethekwini District.

This study used face-to-face semi-structured interviews, enabling an understanding of the HCBC staff's experiences while providing PSS services to OVC. This study was descriptive. According to Babbie (2014), "descriptive research is used to obtain information concerning the current status of the phenomena to describe what exists concerning variables or conditions in a situation". It attempts to describe the "characteristics of a population or phenomenon" (Shields, Patricia, and Rangarjan,

2013 and Babbie, 2014), for example, this study sought to understand what psychosocial services are offered to children and in what form.

3.3 SELECTION OF HCBC ORGANISATIONS

Two HCBC organisations in ethekwini Metro namely Vusisizwe Home / Community Based Care Centre and Phinduvuye Community Care Centre were selected for the purposes of this research. One is located in a semi-urban area while the other is more rural based. The aim was to understand more about the PSS services provided to OVC in different social settings and/or contexts, hence this choice was deliberate. The HCBC organisations were purposively selected by the researcher based on her knowledge and experience of the HCBC programme, after being a provincial coordinator of this programme within the DSD. Guided by Holloway & Wheeler (2009) and Fossey et.al (2002) a sample of informants was chosen purposively based on their capability to provide rich and appropriate data. Polkinghorne (2009) describes purposive sampling as "a process which allows researchers to choose people or artefacts from which they can learn". DSD as well as the HCBC organisations' Boards governing such organisations and management granted permission to conduct the study. The criteria used for this study's sample was as follows:

- HCBC organisations must have an NPO registration number. This meant that they complied with the requirements of the NPO Act (Act No 71 of 1997) (as amended) as this piece of legislation governs the operation of NPOs in communities.
- Selected organisations must have delivered the HCBC programme for a minimum of 5 years and
- Such organisations must have a functional Board of management.

3.4 PARTICIPANTS IN THE STUDY

Table 3.1 below provides a summary of participants that were involved in the study. Sixteen participants were interviewed – seven in each organisation, plus two CYCWs in Centre A.

Table 3.1: Participants in the study

HCBC organisation	Number of participants	Selection criteria
Centre A	1 Board member	Must have served on the Board for a minimum of two years.
	1 Project Manager	Must have been in this position for at least two years.
	2 CCGs	Must have worked in the HCBC programme for a minimum of one year.
	1 CCG supervisor	Must have been in the supervision position for a minimum of two years.
	2 Childminders	Must have worked in the HCBC organisation in this position for a minimum of two years.
	2 CYCWs	*Recently employed.
Centre B	1 Board member	Must have served on the Board for at least two years.
	1 Site facilitator	Must have been in the position for at least two years.
	1 Project Manager	Must have been in the position for at least two years.
	1 CCG	Must have worked in this role for at least one year.
	1 CCG supervisor	Must have worked in this position for at least two years.
	2 Childminders	Must have worked in the HCBC organisation in this role for a minimum of two years.
TOTAL	**16**	

In this study, only Centre A was an implementing agent for the Isibindi Model. It is to be noted that at this time, CYCWs were not identified as potential participants as this Model had not taken off ground prior to the field research being undertaken. The researcher was unaware of the implementation of this Model at this organisation, it

was three months old at the time of conducting the interviews. Twenty-five CYCWs had been engaged during the initiation of the Model, but five dropped out. Two were included in the sample and interviewed as their programme is a crucial part of PSS provision to OVC, chosen through availability sampling. Chapter 4 provides more details on each category of participant.

3.5 DATA COLLECTION

Cohen, Manion and Morrison (2001: 112) assert that "exclusive reliance on one data collection method may bias or distort the researcher's picture of the particular slice of reality being investigated". Data collection methods "include interviews, observations, documentation, discussions, visuals, and a set of rules for gathering information" (Creswell, 2003). This study used semi-structured interviews to gain a detailed picture of the participants' accounts of PSS services provided to OVC. This also aided a fuller description of the PSS phenomenon. Fossey et.al (2002) contend that the use of interviews is most common in qualitative research. Predetermined open-ended questions are contained in an interview schedule (see Appendix 1) as they are used to "guide an interview rather than be dictated by it" (Greeff, 2011).

3.5.1 SEMI-STRUCTURED ONE-TO-ONE INTERVIEWS

Semi-structured interviews allow for the gathering of information on the participants' experiences (DiCicco-Bloom & Crabtree, 2006). According to Fossey et.al.(2002: 727), "semi-structured interviews are used to facilitate more focussed exploration of a specific topic, using an interview guide". An interview guide consists of "generalised questions which allow participants to discuss experiences extensively" (Haley, 2001). An interview guide was developed by the researcher as a means chosen to record the deliberations and discussions with participants. In the process, the interactive participation allowed participants to think deeply and reflect on their responses about PSS provision in their respective organisations. Consequently, in the researcher's opinion, the process promoted a possible review and examination of future actions that may need to be taken by the organisations in as far as PSS provision is concerned.

In this study, participants were allowed to communicate in isiZulu and English. Each interview session lasted for approximately forty-five minutes to allow for sufficient data

collection. Rich information obtained through participants' sharing their views in their local language and one which they are comfortable with, informed the thematic focus of these discussions.

All interviews were recorded via audio with permission from the participants. Smit et al., (as cited in Greef, 2002:304) state that a "tape recorder allows a much fuller record than notes taken during the interview". Patton (as cited in Rubin and Babbie, 2005: 457) suggests that this technique should be backed up by "notes" taken by interviewers during the interview. The researcher used both the audio recording and note taking simultaneously. Consequently, transcripts were also produced using both these methods (audio recording and notes).

3.5.2 WRITTEN RECORDS

The researcher also examined written records. HCBC organisations have a role in keeping records of all OVC assisted and services provided. These included children's enrolment registers and data from community-based information system (CBIMS) utilised by both HCBC organisations and kept on site. CBIMS seeks to standardise monitoring and evaluation tools for measurement of all services provided, including PSS services. These forms contain information that are captured on the system and includes the following:

a) N03 a – basic HCBC Information form.
b) N03 b – HCBC Personnel Registration form indicating all staff within an HCBC organisation.
c) N04 – is about training and workshops attended. A project manager or site facilitator completes this form detailing training activities attended by staff.
d) C03 – contains the child's information. They detail the background information; the challenge presented, interventions, as well as care plans.
e) C01 – Household Registration Form. It is a form of an intake form, completed during the first visit and reflects a full profile of each household reached.
f) CO5 – HCBC Support Group Form. This form consists of the details of available Support groups. Should the HCBC have a children's Support

group, information derived here will help complement the observation also made (as another data collection method).

g) S01 b – Beneficiary Master Register – Children.
h) S03 – Monthly Supervisor report. This form contains data collected and recorded by a CCG supervisor.
i) So4 – Household Master Register. It records details of all households reached in a particular month.
j) S05 – Beneficiary referral form. This form is about referrals made, highlighting reason(s) for such referral and name of the organisation referred.

Although the intent was to examine all registers kept by the HCBC organisations as well as the implementation of CBIMS, the researcher learned that some registers kept are not standardised for example Centre A keeps enrolment registers, a feeding scheme register, register of child-headed households, youth-headed households as well as support group register. Centre B, on the other hand, keeps a food parcel beneficiaries register, loss register, staff register, feeding scheme and a visitors book. A common denominator for both organisations in the implementation of CBIMS was the C0 forms, i.e. C01, C02, and C03. When inquired about the other forms, both Centres informed that they need a refresher workshop on the implementation of the other forms as they felt ill-equipped to utilise them.

3.6 TRUSTWORTHINESS OF DATA

Validity and reliability are about ensuring the “integrity and credibility of research findings and conclusions” (Berg, 2005 and Babbie, 2014). Shenton (2004) identifies four dimensions of trustworthiness met in this study. The first dimension concerns credibility (in preference to internal validity). Data collection techniques were varied, for example, a combination of semi-structured interviews, observation, and document reviews were used to collect sufficient and varied information on psycho-social support services provided to children in the two Centres under study. Data sources came from different stakeholders such as board members, CCGs, site facilitators and childminders.

The second dimension is transferability (in preference to external validity/generalizability). Merriam (2001) explains that “external validity means the degree to which the research findings are applicable to other situations”. To improve prospects of transferability, the researcher applied the principle suggested by Guba and Lincoln (2011) that “the investigator should provide sufficient contextual information about the phenomenon under study”. Consequently, detailed information on the participating HCBC organisations was provided, thus making it possible for the reader to make the transfer.

The third dimension of trustworthiness satisfied by this study is dependability. In keeping with this principle, the researcher employed interviews which enabled direct interactions between the researcher and participants; thus helping to improve rapport and mutual trust between the interviewer and interviewee (Babbie, 2014). Dependability was catered through comparison of answers across the participating organisations, i.e. Centre A and Centre B in order to identify similarities, differences, and deviations. The fourth method involved reading and double-checking the data to check for possible distortion and misrepresentation of data on the psychosocial services offered to children in these two participating HBC organisations.

The last dimension of trustworthiness linked to qualitative research is conformability. Strategies that were employed to ensure objectivity in this research include highlighting the methodological limitations of the study; “documenting field notes in the context of what was being observed to allow fellow researchers to form valid judgements about the research findings” (Brink, 1993) and, finally, explaining the theoretical framework that informed and guided the research project (Neuman, 2012).

3.7 DATA ANALYSIS

De Vos (2002) states that data analysis is a “process that brings order, structure, and meaning to a mass of collected data”. Responses from the interviews were transcribed together with observational data as well as data from written records. The data were analysed using “thematic analysis” (themes that emerged from the data) and “content analysis” (coded by categories) (Dawson, 2002).

According to Creswell (2003) and Macmillan and Schmacher (2001), data analysis is "mostly a process of sorting data by category to identify relationships between categories". The interviews were recorded and immediately transcribed. Six main themes and twenty-six sub-themes emerged from this analysis. Chapter Four presents a detailed description of these findings.

Data analysis was accomplished using the thematic approach. According to Braun and Clarke (2006: 82), thematic analysis is "a qualitative analytic method for identifying, analysing and reporting patterns (themes) within data. A theme captures something important about the data in relation to the research question and represents some level of patterned response of meaning within the data set".

Braun and Clarke (2006) suggest six steps to be followed when conducting thematic analysis; these include: "becoming familiar with the data, generating initial codes, searching for themes, reviewing themes and defining and naming themes and producing the report". Based on these guidelines, the researcher identified themes, categorised them into sub-themes and created codes that were representative of the data at hand. Interpretation of data was facilitated by the use of the ecosystems theoretical framework. This theoretical framework served as a basis to show connections between micro-level events and the broader social forces and to explore more precise questions that future research can answer.

3.8 LIMITATIONS OF THE STUDY

Limitations included the limited number of HCBC organisations sampled. The intention of the study, however, was to provide in-depth data rather than to generalise the findings. Also, some participants preferred to express themselves, for the most part in their first language – which is IsiZulu. This preference was respected and granted. The translation may have resulted to some degree, in loss of essential meaning.

3.8.1 ETHICAL CONSIDERATIONS

Ethical clearance and permission from the HCBC organisations was obtained. Written correspondence was sent to the HCBC organisations requesting their participation. It

contained details of the objectives of the study, consent issues, and logistics. Both organisations provided approval for the study.

The researcher had to ensure that the participants participated voluntarily and were informed of the purpose, benefits of participation, and the ease with which they could terminate their participation. Participants were informed that the consent form (see Appendix 4) served as evidence that they were participating voluntarily. Additionally, explanations were provided, where required, with an opportunity to ask questions availed. The consent form was read aloud together with each participant, before the commencement of the interview. Such forms were provided to participants in both English and IsiZulu lanaguages. Participants' right to refuse or to withdraw from participation without a negative sanction of any sort was highlighted. It was also explained that DSD was supportive of this venture and had provided permission for the study.

Berg (1998: 48) asserts that in most qualitative research, the researchers know the subjects and "anonymity is virtually non-existent". It is essential to provide subjects with a high degree of confidentiality. The participants were required to complete a consent form, which emphasised confidentiality. This reassured participants that the information gathered would be kept strictly confidential and their identity would not be divulged.

There is little likelihood that personal harm of a physical or emotional type would have resulted in a study of this nature. In addition to the adherence of the above ethical principles, the researcher is a trained social worker who is registered with the South African Council for Social Service Professions as well as the South African Association of Social Workers in Private Practise; with vast experience in child care services.

3.9 CONCLUSION

Chapter three has explained the research methodology adopted to document what psychosocial care and support services were being provided to OVC by two Home / Community-Based care and support organisations (HCBC) in eThekwini Metro.

This study utilised a qualitative research paradigm. The sample comprised two Board members, site facilitator, project managers, caregivers and their supervisors. Since only two HCBC organisations were part of this study, the generalizability of the findings is limited. Ethical issues for the research study were carefully considered to ensure ethical practice. Chapter Four covers the data presentation and analysis.

CHAPTER FOUR
DATA ANALYSIS AND DISCUSSION OF FINDINGS

4.1 INTRODUCTION

This chapter presents the data analysis on the provision of PSS by HCBC organisations. Rich data collected will be described, discussed and analysed. This qualitative study utilised semi-structured interviews, written records as well as observations to collect data. In keeping with the qualitative paradigm, 'thick' descriptions are used to substantiate the findings. Data were analysed thematically. Results were categorised into six (6) broad themes namely; PSS conceptual understanding, PSS programmes offered, processes involved in rendering PSS services, gaps in the provision of PSS, governance and challenges encountered by HCBC organisations.

The structure of this chapter starts by providing background and organisational settings. Themes and sub-themes are used to analyse the participant responses. The findings reflect the perspectives and experiences of participants from the two participating HCBC organisations, viz. Phinduvuye Community Care Centre and Vusisizwe Home / Community Based Care Centre.

4.2 BACKGROUND AND ORGANISATIONAL CONTEXT

4.2.1 Phinduvuye Community Care Centre

Entablished during the 2007/08 financial year, Phinduvuye Community Care Centre (hereafter referred to as Centre A) is located in a semi-urban area and provides services to OVC, youth, families, and people with disabilities. The Centre's main aim is primarily to render services in the field of HIV and AIDS. The nearest town used by the local community is Pinetown. Their clientele is mostly OVC and their families in one specific ward. Good road infrastructure with tarred road and pavements was observed. Centre A receives funding predominantly from DSD. The project manager indicated that other sources are the Department of Education (for the 2 ECD practitioners) as well as the Rotary Club (supporting library services). Other in-kind supports are received from members of the War Room. War Rooms are forums of multi-stakeholders that meet on a monthly basis to identify community concerns and

engage in measures to address these. Meetings held are chaired by a local ward councillor.

During the financial year 2014/15, the organisation introduced a new programme delivering Isibindi Model, with its components of Safe Park. The staff structure consists of a Project Manager, two cooks, two multi-skilled workers, 2 ECD practitioners, two childminders, one administration support, two CCGs and one CCGs' supervisor. The existing Management Board is responsible for oversight and governance of the organisation's services and programmes. The Board consists of seven members who provide guidance, leadership, act as a link between the organisation, DSD and the community as well as ensuring organisational policy development and enforcement, amongst other roles.

The Centre also boasts infrastructure which consists mostly of park homes, custom made for the organisation's activities and programmes. Park homes are portable, customizable buildings ideal for on-site offices, ablutions, clinics, classrooms and other portable buildings. These park homes are assembled on an engineered steel chassis and then transported to site. They have pre-installed power and plumbing connections and can be easily connected. The park homes, however, do not have ablution facilities as these were built as standalone structures.

4.2.2 Vusisizwe Home / Community Based Care Centre

Vusisizwe Home / Community Based Care Centre (hereafter referred to as Centre B) was established during the financial year 2004/05 and is located in a semi-rural neighbourhood, providing services to the local community, in partnership with a local hospital's community outreach project. Similar to Centre A, the aim is HIV and AIDS prevention, care and support. Residents reportedly use Pinetown as their nearest town (other than travelling to Durban CBD). The Centre supports one ward. Road infrastructure in the area is mostly gravel. The Centre is close to the community it serves. The guidelines for services to persons affected by HIV/AIDS developed by the DoH and Social Development (2010) affirm that the HCBC programme enables individuals, families, and communities to have access to services at or near their homes.

Human resources at Centre B consist of a Project Manager, a site facilitator, two multi-skilled workers and two childminders (who also serve as cooks). The Management Committee / Board, consisting of seven members, provides good governance and leadership.

Service beneficiaries at Centre B include OVC, youth, older persons, and families. The importance placed on education by staff was noted. Both the project manager and the site facilitator were pursuing a social work degree. Both were enthusiastic about their studies and reported promoting education as both a protective factor for children and as a pathway to the betterment of lives.

Whereas Centre A appeared to have better space/infrastructure, Centre B was observed to be lacking sufficient formal space from which to operate. In Centre B, one building is used for all services rendered, including limited office space.

The researcher observed that there are standard features between the two HCBC organisations as there are also some differences. Standard features include the following:

- Main clientele serviced are OVC and their families;
- Both deploy CCGs to conduct home visits and submit reports on their findings;
- The staff structure is more or less the same, except for Centre A having CYCWs responsible for the Isibindi programme;
- Both have a rich history and a wealth of knowledge on development work with children and their families.

The differences are few and relate primarily to additional supports received, for example, Centre A benefits from support from a Rotary Club while Centre B has the support of a local hospital (amongst others).

4.2.3 PROFILE OF PARTICIPANTS

The biographical data obtained during the semi-structured interviews identified information regarding the participants' gender, age, educational background and length of service in the HCBC organisation as well as their respective roles. Table 4.1 presents the biographic data of participants:

Table 4.1: Biographical data of participants

No.	Centre	Educational background	Age	Gender	Length of service in the HCBC organisation	Role in the HCBC organisation
1.	A	Matric, ECD Level 4 qualification	26	F	Six years	Childminder
2.	A	Matric, HIV/AIDS counselling certificate	30	F	Six years	CCG
3.	A	Matric	27	F	Four years	CCG supervisor
4.	A	Matric	31	F	Two years	Child & youth care worker
5.	A	Grade 10 and an orientation course on storytelling	29	F	Four years	Childminder
6.	A	Matric and a Nursing certificate	48	F	Six years	Project Manager
7.	B	Matric, Social Auxiliary worker and currently studying towards a BA (SW) degree – in her 2nd year	26	F	Two years	Site facilitator
8.	B	Standard 6 (Grade 8), Certificates in counselling, Home Based care and nutrition	41	F	Four years	CCG
9.	B	Matric, certificates in Home Based care and ECD	35	F	Five years	Childminder
10.	B	Grade 11, studied	36	F	Twelve	CCG

		Matric but did not pass it, Certificates in Home Based care & counselling. Attended a course on men having sex with other men (MSM)			years	
11.	B	Matric, certificates in palliative care, Home Based care, child care, TB, OVC counselling and also attended Thogomelo programme (care of the caregiver programme)	35	F	Eleven years	CCG supervisor
12.	B	Grade 11, certificate in Home Based care	38	F	Two and a half years	Board member
13.	A	Grade 12	48	M	Nine years	Board member
14.	B	Grade 12	29	F	Four years	CCG
15.	A	Grade 12	30	F	Five months	Child and youth care worker
16.	A	Grade 12	32	F	Five months	Child and youth care worker

The table above indicates a total of sixteen participants, nine from Centre A as this Centre has Child and Youth care workers employed to implement Isibindi programme. Seven participants were interviewed at Centre B. Participants ages ranged between twenty-six and forty-eight years, with an average age of thirty-two years. Regarding work experience, the longest-serving participant has been in HCBC work for 12 years.

All participants, except one, were females which confirms the generally held view that females often deliver care work. In the section below, the categories of participants interviewed are discussed:

(a) Board members

A Board governs each HCBC organisation. The Board has amongst its responsibilities, development of organisational policy, organisational governance matters, providing leadership and resource mobilisation. Two Board members from both Centres, one in each was interviewed.

(b) Site Facilitator

According to DSD plans and programme design, each organisation is supposed to employ a dedicated site facilitator. It was learned that in Centre A, when the site facilitator left the position, it was not re-advertised and this left the centre without a site facilitator. The project manager reportedly assumes both the roles of site facilitator and project manager. Centre B, on the other hand, hired both a site facilitator and a project manager. The former was hired to facilitate OVC programme implementation and reporting thereon. The site facilitator's responsibilities include among other things overseeing OVC care and support programmes rendered in the organisation, facilitating OVC support group(s), compiling reports on OVC activities and programmes at the end of each month and quarter. These include non-financial data (NFD) as key data utilised by national treasury when deciding on future programme allocations of funds.

(c) Project Manager

Both Centres are managed by project managers whose primary responsibility is the overall management of the HCBC organisation's activities. The project manager is accountable to the Board, the community, funders and other stakeholders. She is also responsible for the management of the organisation's budget, human resources, and other assets.

The researcher learned that both Centre A and Centre B utilise a system known as Community Based integrated monitoring and evaluation system (CBIMS) developed by DSD. The vision of this system is "to contribute to the realisation of the outcomes

of the HCBC programme through the production of credible, reliable and value-adding data by ensuring that all HCBC programme implementers implement the integrated monitoring and evaluation" (DSD: 2010). DSD developed a system guide targeted at caregivers, supervisors and project managers. The guide outlines what each category is expected to achieve daily, planning checklist, service delivery checklist as well as an administration checklist. These checklists ensure that daily activities get conducted according to system requirements.

(d) Childminders

In any given staff structure of HCBC organisations funded by the DSD, DSD employs two people as childminders. Their primary responsibilities include providing stimulation to children, assisting school-going children with homework (homework support) and providing care and support to children who benefit from meals at the sites, i.e. the HCBC organisations. Two childminders in each organisation were interviewed, totalling four persons.

(e) Community caregivers

Community caregivers (CCGs) are also known as the first line of support for children and their families; these are the foot soldiers that visit people's homes, identifying children and families in distress. Each CCG carries a caseload of 60 households within a particular catchment area. These households are visited, reported on, referrals dealt with and follow-ups made. CCGs were also interviewed in each organisation. CCGs report to a CCG supervisor.

(f) Community caregiver supervisor

The CCG supervisor is responsible for the supervision of caregivers allocated to him/her. On average, each supervisor is responsible for ten caregivers. Supervisors meet weekly with their supervisees, collecting data and debriefing. He/she collates data and prepares consolidated reports to submit to the HCBC organisation's site facilitator or project manager. Such reports get compiled on a monthly and quarterly basis. One supervisor per HCBC organisation was interviewed, totalling two persons.

(g) Child and Youth care workers

CYCWs are a dedicated cadre of workers who undergo accredited training on child and youth care (NQF Level 4 qualification). They are deployed by NACCW in communities, linked and working closely with HCBC organisations' staff on Isibindi Model delivery. Since the Isibindi Model has one of its aims as child protection, it was considered relevant for this study.

4.3 THEMES AND SUB-THEMES IDENTIFIED

Murray (2009) describes psychological support as "a professional service designed to help people achieve long-term self-sufficiency in addressing psychological and social challenges that result from trauma". A thematic analysis of interviews revealed six (6) emergent key themes. Direct narratives from participants appear as quotes and are Italicized and indented. Below are the six themes and sub-themes:

Table 4.2: Themes and sub-themes

THEME	SUB-THEME
Theme 1: PSS	● Understanding of PSS ● Needs of OVC
Theme 2: PSS programmes offered	● Isibindi Model ● Support groups ● ECD ● Bereavement support ● Life skills and peer education ● Dialogues and debates ● Awareness programmes ● Camps / outings / excursions
Theme 3: Processes involved in rendering PSS services	● Intake process ● Home visits ● On-site services ● Dealing with referrals
Theme 4: Gaps in PSS provision	● Extension of the feeding scheme ● More opportunities for OVC to talk about their pain

	● Children with disabilities ● Supporting children on antiretroviral drugs (ART)
Theme 5: Governance	● Networking and intersectoral collaboration ● HCBC income generation ● Sustainability of services and programmes
Theme 6: Challenges encountered by HCBC organisations	● Skills development for staff ● Funding and resource mobilisation ● Accessing civil registration documents ● Lack of cooperation from Government Departments

Source: Field data

Discussed below is the separate themes and sub-themes:

4.3.1 THEME 1: PSYCHOSOCIAL SUPPORT

The two sub-themes highlight the participants' conceptual understanding of PSS.

4.3.1.1 SUB- THEME: UNDERSTANDING OF PSYCHOSOCIAL SUPPORT

(a) Presentation of data:

Participants were requested to explain the meaning of PSS from their own experiences and knowledge. The responses were varied as noted in the extracts below. The ***site facilitator in Centre B*** articulated her understanding as:

> *"My understanding of psychosocial care and protection services is that it is about all elements of helping a child. These can be through counselling services; it may happen that the person needs to be registered to a feeding scheme, join a support group, assisting with documentation, ensuring access to social grants and linking with the children's families, supporting them".*

The ***Project Manager in Centre A*** expressed her understanding as:

"It is about psychological support, dealing with challenges that children face. The key elements include dealing with peer pressure and support groups. The support groups play an important role in providing emotional support and ample opportunities to "let off steam".

The ***Board member in Centre B*** shared her views as follows:

"…it is the right job – for childminders to care for children, giving them love, especially those that did not get it from their homes. Also, if family circumstances are not right at home, children are assisted here because they do not only eat here, sometimes we take them on outings, we do parties – all the things that make them happy take place here. I think that a child ends up forgetting about his background".

A ***childminder in Centre B*** shared her understanding as follows:

"My view is that it is about assisting children to develop, protection from things that harm them cognitively".

The ***childminder in Centre A*** expressed the following:

"I think it is about playing puzzles, storytelling, free play and dealing with referrals. In free play, we can identify the needs of children".

A ***CCG in Centre A*** expressed her views as follows:

"I understand it to be about the protection of children without parents and others who do have them but are not taking good care of the children. It also involves the provision of food support…it is also about a support group for children, where children talk about the challenges they experience…it is also about dealing with referrals."

A somewhat different and expanded view of a conceptual understanding of PSS services was received from a ***supervisor of CCGs in Centre A***. Her response was:

"My understanding is that we provide support, holistically – without looking particularly at whether the challenge is physical, social or emotional. Looking after the child in all ways, so that the child achieves his psychosocial well-being."

She added that

"In psychosocial support is where we divide according to four aspects. We provide physically, emotionally, socially and spiritually. When I talk about psychosocial, it is whereby all these things are provided to a person so that he enjoys good well-being, looking after the welfare of a person."

A ***CYCW in Centre A*** articulated the observation of rights in her conceptual understanding of PSS and reported thus:

"We are looking at the rights of people, physically, emotionally and spiritually.

She substantiated further by adding that:

"Physically, according to the well-being at home, you may perhaps find that a child does not have parents, staying with other children and their parents. These adults may be failing to treat all the children equally…now we want a situation that all children in the home be treated the same".

The Project Manager of Centre B asserted that:

"…all work that we do in our organisation is rights-based in approach. This is emphasised whenever we meet with other NPOs in the network with our local Hospital".

A ***childminder in Centre A*** expressed her understanding as follows:

"…we can talk with him for example if a child has been abused at home, we talk with the child – even with the way the child is playing with dolls, being rough, there we take notice and give that child more love than the others. Even in the paintings, if you see the colours the child uses…Even the drawings will be different from those of other children. You notice that whereas at the beginning of the year, the child used to draw bright things, now over time the child's drawings change and uses darker colours. Maybe, the child used to draw pictures with Mom and Dad, later Dad's drawings are removed or Mom. We ask why Dad is not in this one?"

(b) Analysis of data:

The responses of the supervisor of CCGs in Centre A participant demonstrated a distinct understanding of PSS principles by mentioning that her centre provides holistic assistance to ensure that children have a balanced life and consequently achieve psychosocial well-being. It was impressive to note this response from a supervisor as

she is entrusted with the responsibility to guide caregivers, providing them with the direction in the delivery of services to OVC and their families. These responses established some understanding of the various domains of PSS, in its totality. Notably, the absence of the legal domain of PSS was observed. This domain concerns access to legal protection for example, in cases of property grabbing after the death of parents, as well as all forms of abuse.

Embedded in the Constitution is the rights-based approach. The UNCRC also guarantees children's rights. As South Africa supports the Convention, it is essential that children's rights to identity, survival, development, and protection from abuse and neglect are ensured. Children also have the right to be heard and have their best interests held paramountly.

A CCG supervisor in Centre A mentioned that she cares for children who do not have parents, giving support, including those who do not have food at home. She added that she also facilitates a support group every Friday and if there is a problem beyond her control, she refers it to social workers. For this participant, PSS also involves following up to ensure that children are registered to receive grants, more so for children in the care of grandparents and other relatives, or those whose parents are deceased. The childminder in Centre A extensively elaborated on ECD due to her involvement. It is evident that it is necessary to mainstream PSS across all interventions and programmes in the social sector.

All participants interviewed emphasised love, care, and protection as integral aspects of PSS. Organisations such as REPSSI (2009) assert that PSS addresses children's needs for love, care and protection. Moreover, the Children's Act (No 38 of 2005) promotes childrens development, protection and well-being and obliges South Africans through the constitutional dictates to assert that children's rights are indeed human rights. Jamieson and Berry (2012: 12) contend that "the aim of the Children's Act is to support families to promote their children's wellbeing, prevent abuse and neglect and to ensure appropriate care for children in need of care and protection".

It was evident that critical concepts that underpin psycho-social support (PSS) were alluded to, though not holistically. DSD (2012) identifies these key concepts like well-

being, resilience, social connectedness as well as risk and vulnerability. Resilience, according to Marici (2015) “represents a human capacity manifested when individuals face different situations and mean the skills, abilities, knowledge, and insight that accumulates over time as people struggle to surmount adversity and meet challenges”. This explanation is supported by DSD (2012) which defines resilience as “the capacity to face, overcome and even be strengthened by extreme circumstances”. Additionally, DSD (2012) identifies five domains of PSS well-being. These are the social, spiritual, physical, cognitive and emotional. This view is supported by the International Federation of Red Cross and Red Crescent Societies (2010), which claims that only PSS can meet a person’s emotional, social, mental and spiritual needs. The social domain represents the children’s social world – their relationships with friends, family and broader community. The spiritual realm is about belief in a higher power, while the physical concerns proper nutrition, being healthy and having warm clothes as well as a safe place to live. On a cognitive realm, DSD refers to being able to think and learn, including life skills to cope well with life’s challenges and opportunities (DSD: 2012). Emotional wellness signifies a child’s ability to process and express feelings. UNICEF (2009) documented that although “all households with OVC need support, some OVC are more in need of external support than others”. HCBC organisations aim to provide much needed external social supports and can be considered useful and necessary for the care and protection of all children.

The table below illustrates the participants’ broad conceptual understanding of PSS.

Table 4.3: Conceptual understanding of PSS

HCBC organisation	Conceptual understanding of PSS
Centre A	● “It is about the psychosocial well-being of children.” ● “Includes physical, emotional, social and spiritual support.” ● “Protection of children.” ● “PSS for abused children.” ● “Assisting children to develop.”
Centre B	● “Put the child’s best interests first.” ● “Involves food support.”

	● "Rights-based approach in PSS provision." ● "It is about giving love, protection, and care." ● Dealing with stigma and discrimination of OVC

Source: Field data

Consideration of the best interest principle in programming is vital as HCBC staff is cognisant when making decisions about any service, care, or another form of support provided to children and their families. Generally, a good understanding of PSS amongst participants was observed. REPSSI's (2009) definition of psycho-social support services highlights "the restoration of normal functioning" in people by enhancing their mental, social, spiritual and emotional well-being. In this light, it is evident that PSS ensures that OVC engage positively in relationships, in a way that other children in their communities do. From the above it is evident that the participants have a clear and concise understanding of the provision of PSS at their centres.

The second sub-theme on the needs of OVC is discussed hereunder.

4.3.1.2 SUB-THEME: THE NEEDS OF OVC

(a) Presentation of data:

When articulating their understanding of PSS, participants alluded to and emphasised the needs of OVC, some of which are being addressed by their organisations. The majority of participants agree that the OVC's priority needs are for food, clothing, and shelter, which represent the basic needs for all persons. Participants also mentioned areas of OVC protection and care, encouragement, and observation of their rights. These rights are discussed below.

One ***caregiver in Centre B*** commented as follows:

> *"Children need clothes. Sometimes even though the grant is received, but we still find children not adequately dressed for the weather".* This caregiver added that *"the critical needs of OVC that are still not being met by our organisations are food, clothing, and shelter. The organisation does not have enough money to ensure provision for these needs at all times".* Additional comments by this caregiver were *"Even those who receive a grant; they also need food. I do not know, something that*

happens, you find that people receive a grant but no food has been bought, especially people who are young like us…they do their own things. You find that maybe we have a trip and we tell children to wear better clothing. Some children come with tatty clothing such that we give them something better from donations".

The ***CCG participant from Centre A*** shared almost similar sentiments as her colleague when she stated that:

"Children need clothes. Sometimes even if the grant is received, but we still find children that are not adequately dressed for the weather. Children need toys to play".

The site facilitator in Centre B added other needs for cash, varied programmes, spiritual support as well as validation of being loved to develop resilience. She stated thus:

"We, as an organisation, do not provide housing and the process of allocating houses by the municipality is slow...but they identify those in greatest need. Now we see that it is quiet on that issue. Now…he lacks funds, to go, maybe to a social worker when there are things that he must submit – cash is a challenge".

The site facilitator of Centre B articulated the OVC need for protection as follows:

"OVC also have a need to be protected. Through the on-site services that we provide; home visits and follow up, we strive to ensure that children are protected".

A caregiver in Centre A highlighted the following:

"OVC need support as orphaned children. Society must not discriminate them. These children also need guidance on responsibilities; they need support to deal with anger…OVC have emotional needs as well. Children also need to be involved when deciding about their future so that their voices will be heard".

A caregiver in Centre B informed that:

"Parents need to check if the child is all right and okay. Other parents neglect children and are not even keeping homes clean".

This caregiver added the practice of "ukuthwala" in their community once challenged them. "Ukuthwala" is where much older men abduct girl children and force them into early marriages. She added that:

"*Of great concern, for us as community caregivers, is the realisation that the parents gave away their children to older men in return for cows".*

She indicated that this practice has however stopped, since the intervention of local leadership. HCBC organisations thus serve as an important protective factor for all children facing and exposed to abusive situations.

A site facilitator in Centre B alluded to the importance of social and community support as follows:

"In the communities we serve, children are somewhat protected by members of the community. Neighbours would, for example, be concerned about families who do not have enough to eat and would organise themselves to go and assist in delivering groceries. Sometimes this happens through church groups in the area, who identify needy members and assist them and their families. As an organisation, we are grateful for these gestures as they reflect that there are people who care".

Encouragement, accompanied by love and affection were identified as other OVC needs. As a ***caregiver in Centre A*** put it:

"All children need love to grow and develop".

Other caregiver statements were:

"Children need love and affection".

"There is a lack of a spirit of caring in most households that we work with."

"…they are experiencing pain for the loss experienced", hence the need for love and assurance."

This ***caregiver from Centre B*** alluded to the pain experienced as leading to stress and anger in children, necessitating measures to engage them in life skills programmes where they can learn to deal with anger for instance.

A ***childminder in Centre A*** articulated her response as follows:

"…our facilities are not sized according to the needs. Others get bored of jungle gyms; maybe it will be better when the library starts so that children have facilities that they look forward to after school, for example, netball and soccer."

A ***Board member in Centre B*** reported thus:

> "*When you look at PSS, it is about reducing children's worries and increasing their hope."*

(b) Analysis of data:

In Centre B, food insecurity was reported as high in the communities serviced. OVC's need for food as a critical need was highlighted, hence meal provision as well as the distribution of food parcels to identified needy households as key and essential services were provided. This service is also rendered in Centre A. The site facilitator in Centre B was referring to a case of a youth-headed household that was in dire need.

Also, both Centres' staff indicated that they assist households in distress with access to social relief, which provides temporary assistance while applicants await permanent grants. The challenge reported, however, is that it is available only for three months. This period is considered by HCBC staff as rather short as often the supporting documents are sometimes still not received from the Department of Home Affairs (DHA). Extensions were reported highly unlikely, despite clients providing proof of application. CCGs reported that they understand the families' dire circumstances and this adds to their frustrations when households', particularly children's needs are not met. A UNICEF (2009) study documented that OVC are less likely to have their basic material needs met than others.

Earlier, care and protection were identified as another vital need for OVC. Protection includes protection from all forms of abuse, neglect, discrimination, exploitation, and trafficking. Similarly, it can also be viewed as protecting the rights of children as these are constitutionally guaranteed. Jamieson and Berry (2012) as well as Berry, Dawes, and Biersteker (2013) assert that social services are vital to support families and children. Social services must include protection from abuse and neglect, adoption, early childhood development programmes, home based care, foster care and cluster foster care. Berry et.al. (2013) further contend that "many children in South Africa experience violence, abuse, neglect and loss of caregivers and PSS services may be needed to help children cope with grief, loss, and trauma". The same is the case in

the OVC serviced by the two HCBC organisations under study, as they strive to offer protection and care to all children in need.

As can be noted, “it takes a village to raise a child” is increasingly becoming important in OVC care work. Communities represent the HCBC organisations’ mezzo system and hence an important consideration in HCBC service delivery. The Save the Children Alliance (2008) stresses that “community involvement in child protection is vital, even when adequate protection services and structures exist and are operating effectively”.

Some communities initiated child protection groups like Child Care Forums, which aim to protect and care for vulnerable children in their communities. The DSD developed guidelines for initiation of such forums, and these were reportedly widely shared amongst funded NPOs in particular. Guidance to NPOs in implementing these guidelines remains a key challenge, it appears, for departmental officials. These guidelines highlight the important role of PSS in programming principles. The Save the Children Alliance (2008) also adds that “active involvement of children in protecting themselves from abuse, neglect, exploitation, and violence, and in demanding accountability from adult duty-bearers for the fulfilment of children’s rights to protection” is an important component of a country’s child protection system. It is worth noting that child protection services are guaranteed by the Children’s Act 38 of 2005 and thus an important aspect of children’s rights.

The theme pronounces the need for social connectedness amongst OVC and their caregivers, families, friends, religious organisations and other social groups. These would assist OVC to develop a sense of belonging, be encouraged, feel accepted and get some sense of security. Moreover, this can be interpreted as a preventive mechanism to foster PSS. Through these developed relationships, children are enabled to communicate their needs and make decisions on issues affecting them. There is seemingly an inextricable link between social supports and measures of well-being in that people with close personal relationships cope better with various stressors. OVC face a range of stresses and anxieties which include illness, bereavement, their future care and risks of abuse and rape.

The next section presents the second theme, that of PSS programmes offered by HCBC organisations.

4.3.2 THEME 2: PSYCHOSOCIAL SUPPORT PROGRAMMES OFFERED

The question posed to participants on what PSS programmes their HCBC organisations deliver sought to reveal the extent to which such programmes promote positive outcomes for children in their social, spiritual, emotional and psychological realms. These programmes are also indicative of efforts to develop and improve OVC's resilience and coping capacity.

Several responses emphasised specific services while others enumerate programmatic interventions, all aimed at provision of PSS. Sub-themes are discussed hereunder and they include: Skills development (Isibindi Model); Early child development initiatives and Support initiatives (Life skills and peer education**,** support groups, bereavement support, dialogues and debates, awareness programmes and camps / outings / excursions).

4.3.2.1 SUB-THEME: SKILLS DEVELOPMENT

(a) Presentation of data:

The Isibindi Model of care is a national programme developed to work with children orphaned by HIV and AIDS.

When asked about programmes implemented by the Centre, the ***project manager of Centre A*** responded thus:

> *"We have the following programmes – a support group for children; dialogues – parents/guardians and children together; Isibindi Model, which includes the Safe Park – it provides opportunities for learning through play. Children also receive stimulation through the ECD programme; camps/outings; life skills programmes for the youth and library services."*

A ***CCG supervisor of Center*** A reported thus:

> *"The Safe Park started this year…though we did not have a Safe Park, we were using the space we have to play games with the children. Since there is now Isibindi Model, we play below."* She added that *"…we are in cooperation with Child and Youth care*

workers in the Safe Park. Sometimes they do activities like storytelling, with younger children, of say five years."

A ***CYCW from Centre A*** has reported as follows:

"We, as Child and Youth Care Workers, visit those families if a child is abused, we hold family meetings, trying to solve the problem that the child is facing at the time. At times, let's say a child who is sexually abused by someone staying in the home, this child will not be able to grow well, because the abuser is always there with the child at all times and when you look at the child, he/she has anger. We as child care workers link up with social workers so that the child may be removed from that home or the person who is abusing the child to be away from the child, so that the child may feel all right.

(b) Analysis of data:

The critical ingredient for the success of the model is the nurturing and presence of CYCWs (NACCW, 2010). NACCW also regards Isibindi Model as a "social franchising model" in that it pools a range of resources through partnerships formed both within Government, FBO and NGO sectors. In this way, quality child protection services are ensured – as the Model thus becomes an effective tool for expansion of quality services. NACCW maintains that the Safe Park Model offers the possibility of fun in the context of desperation – an essential ingredient for overcoming hardship. Also, the Safe Park is where the community embraces its members, countering the stigma plaguing children and families affected by HIV/AIDS. The Safe Park is a beautiful place of healing, support, and belonging (NACCW, 2010). The safe park can also be likened to a community sports ground and an important recreational facility. Also, it offers security for children, as they play after school and during school holidays. These elements are essential for the provision of PSS in children. The UNCRC in Article 31 recognises the children's "right to rest and leisure; engage in play and recreational activities appropriate to the age of the child". Playing is vital for the healthy development of children, many being currently unable to enjoy such activities given the changed family structures – as children become parents to younger siblings. Moreover, Kanel (2012) encourages the benefits of age-appropriate play for those young preverbal children who do not often respond verbally.

Both the Project Manager and the CCG supervisor of Centre A regarded the Isibindi Model as beneficial to the organisation, supplementing the work undertaken by CCG. The supervisor informed that there are two CCG under her supervision, the addition of child care workers has assisted in easing and sharing the workload, which helps them to respond more effectively to identified children's needs.

This CYCW at Centre A added that CYCWs take turns having discussions with children and they prepare each time. Workers arrive at the Safe Park at 13h30 so that when children arrive at 14h00, they are ready to receive them and start their planned activities. There were reportedly 40 children attending, although the numbers tended to vary.

Although the Isibindi Model was a new implementation at Centre A, interest displayed by the project manager and staff in its implementation was visible. They all talked about it with enthusiasm and eagerness to see it meet its aim.

4.3.2.2 SUB-THEME: EARLY CHILDHOOD DEVELOPMENT

(a) Presentation of data:

It was learned through the collection of data that only Centre A has a structured and DOE subsidised ECD programme. The Project Manager mentioned its availability as one of the programmes with which the Centre prides itself. The concern, however, was that DSD does not provide a subsidy and several negotiations have been entered into in this regard, to no avail. The Centre Manager was however hopeful that their wish to receive DSD subsidy will be approved in the future. The ***project manager*** reported thus:

> *"We pride ourselves on the ECD programme, and we are thankful to DOE for the support they provide to Grade R practitioners. One of our highlights this year was ECD training of childminders by ABI. A graduation was held recently, and it was in the newspapers. We are still faced with the challenge that DSD is not subsidising our ECD, despite repeated requests and discussions…however, we are however hopeful that DSD will come on board and subsidise this programme."*

A ***childminder, who is a Grade R educator in Centre A***, reported on the ECD programme:

> *"We in the Grade R class, which is the 5 to 6-year-olds, teach them cognitive skills, for example being able to hold a pen, that they can socialise and taking them outside helping them to develop large muscles, i.e. through exercising. Also, the fantasy play where we build up the imagination of children language and Maths as well as Life skills".* This childminder also spoke of psychosocial support: "*…even psychosocial support they do get it here because some you can see that they stay too much with adults during the day. When they are here, they start becoming children. You hear about the way they are talking. That this one was staying a lot with adults and not with other children".* When asked further about what form their PSS takes, her response was: *"…we can talk with a child if he/she has been abused at home – even with the way the child is playing with dolls, being rough, there we take notice and give that child more love than the others. Even in the paintings, if you see the colours the child uses..red and black..even the drawings will be different from those of other children. You notice that whereas at the beginning of the year the child used to draw bright things, now over time the child's drawings change and uses darker colours. Maybe the child used to draw pictures of Mom and Dad, later Dad's drawings are reduced or Mom. We ask why Dad is not in this one?"*

A ***CCG from Centre A*** highlighted their involvement in ECD as follows:

> "*If CCGs, during their home visits, find a young child, not in an ECD facility, they refer to the site."*

A ***childminder in Centre A*** reported their involvement in the Grade RR programme, which deals with 4-year-olds. She reported their activities as follows:

> "*What we do are creative activities for example drawings and paintings; storytelling; names and respect; talking about home circumstances and fantasy play. The highlights for me have been the education that childminders offer to children. Children pass well in Grade R. Growth and development in children is also noticeable. We also have built good relationships with the children, they know us and can come to us anytime to talk about anything."*

In this study, only Centre A provides a structured ECD programme, despite not receiving financial support from DSD yet. The Department of Education, however,

subsidises two posts of Grade R practitioners. A ***childminder in Centre A*** expressed the importance of ECD as follows:

> *"Education is critical to developing a child's future…all children must get education… ECD work is important. It contributes to growth, education, and development of children. There needs to be ongoing community awareness about ECD so that the community supports the work done".*

Another Grade R ***childminder from Centre A*** shared her experiences as follows:

> "*We in the Grade R class teach them cognitive skills, for example being able to hold a pen; that they can socialise and taking them outside helping them to develop large muscles, i.e. exercising. Also, the fantasy play where we build up the imagination of children and also language and maths as well as life skills."*

This childminder commented further on the added benefits of socialisation:

> "…*they do get it here because some you can see that they stay too much with adults during the day. When they are here, they start becoming children. Children, you hear about the way they are talking that this one was staying a lot with adults and not with other children".*

(b) Analysis of data:

One of the child care and protection programmes providing PSS to OVC was the ECD programmes. Sambu, Almeleh, Mabaso, Giese and Proudlock (2019) assert that the provision of a package of interrelated and integrated services covering the period from conception to six years of age contributes to children's long-term development. In this regard, maternal, child health, nutritional support, support for primary caregivers, social services and protection and quality learning programmes are key. Collaborative partnerships are thus key in improving the lives of children as no sector can deliver the essential package alone.

Undoubtedly investments in pre-school years cannot be overemphasised. According to Richter and Rama (2006), investments in early years entails: "(i) supporting children's nutrition and growth and minimizing childhood illnesses; (ii) promoting strong caregiver-child relationships to ensure children's nurture and protection; (iii) increasing access to ECD programmes for safety, stimulation and preparation for

school and (v) promoting educational access, retention and achievement". As HCBC organisations also strive to promote these goals, CCGs and ECD practitioners are a vital component as they provide stability as well as care and support to OVC. Stability increases children's psychosocial well-being, including support during times of bereavement.

The response of the childminder in Centre A highlights the importance of building positive relationships between children and their caregivers/staff at HCBC organisations. This relationship benefits children as they would know about social supports available to them during times of distress. A Board member of Centre A also alluded to the availability of ECD programme in their Centre and being grateful for DOE supports.

Berry et.al. (2013) define ECD services as "a broad range of services to promote or support the development of young children and respond to their needs across interdependent development areas: physical, social, emotional, language and cognitive". These authors further stress the importance of having various role-players with different skills and expertise to deliver a range of services to young children and to ensure "all-round development". Other sources of literature refer to 'providing building blocks for access to quality early stimulation, education and care' (Berry et.al, 2013) and 'laying foundations for physical, cognitive and emotional development of children' as well as 'ECD as the basis for future growth and development of children'. All these point to the importance of children's early stimulation giving big gains to children's later life. The Minister of Basic Education held in her Child Gauge (2013) report that earlier educational interventions can be expected to have greater returns than later remedial interventions.

4.3.2.3 SUB-THEME: SUPPORT INITIATIVES

4.3.2.3.1 SUPPORT GROUPS

(a) Presentation of data:

A ***CCG supervisor in Centre A*** reported thus:

> *"We also have a support group where we meet on Mondays and Fridays…we do it in the afternoons and also assist children with homework".*

She added that the intent is to discuss common issues facing the children.

A ***childminder respondent in Centre A*** also noted support groups for children that the Centre facilitates. Such groups aim to build OVC coping capacities, promote peer support and foster hope. This participant reported thus:

> *"We have support groups, where we teach them [children] about things that will protect them for example, we tell them that they must not walk alone on the road at night. For the younger ones, we do fantasy play – things that develop them like storytelling and many others."*

Another recent initiative in Centre A was a library facility on site. This facility is funded and supported by the Rotary Club. The ***project manager*** reported:

> *"As an organisation, we were concerned about the location of a community library in town is far from the local people. Many children had difficulty accessing it as many parents could not afford taxi fares. It was for this and for other reasons that the organisation saw the need to bring this service closer to the local people".*

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A ***site facilitator in Centre B*** also mentioned support groups as one of the OVC care and support programmes. She mentioned thus:

> *"…we have support groups, facilitated by childminders and we also have a homework club. We check homework that children have…"* Regarding topics discussed in the support groups, the site facilitator informed that: *"We talk about topics like teenage pregnancy, drugs etc. At other times we ask them what they want to discuss. We do not always talk, but we also have games and other things we do with them, that they participate in".* When asked whether she thought that support groups are a critical need for OVC, her response was "*Yes because it gives children an opportunity to talk."*

The ***childminder in Centre B also*** added to the existence of support groups in her Centre as follows:

> *"We have programmes that aim at increasing open communication with children. We have a Support group that meets on Tuesdays and Thursdays at 14h30 for about 20 minutes. This group was initiated towards the end of last year. The childminders facilitate it, sometimes the site facilitator does. The topics we talk about include abuse and neglect, stressing the importance of telling someone if abuse happens."*

(b) Analysis of data:

It was evident that both Centres recognised the value of support groups and had initiated support groups for children. The gap, however, was that persons responsible for facilitation of such groups had not received training thereon. The creation of support groups for children was a positive development. Whereas in most instances support groups have concentrated on adults living with HIV and AIDS, this organisation decided to conduct groups specifically for children. These measures are essential for improving the organisational provision of PSS initiatives for OVC. Engagement of children on a social level was found by the researcher to enrich the OVC support programme further. Furthermore, support groups assist in stigma reduction as OVC experience stigma and discrimination in many areas of their lives. Strydom and Strydom (2011) affirm that support groups assist in overcoming feelings of alienation, stigmatisation, and isolation and normalises experiences. DSD Psychosocial support Guidelines (2010) also acknowledge the advantages of support groups as "creating a space for vocal ventilation (talking about stressful situations), while also developing a sense of belonging". Incorporation of culture within the programme was also observed at the two organisations.

Support groups for children are essential as they may benefit children to feel less alone, make friends with other children and youth facing similar challenges, learn different ways of coping, share feelings, provide practical help to each other and develop a sense of belonging (DSD psychosocial support guidelines: 2010). It is important to also note that caregivers also need own psychosocial support groups, being enabled to look after their own wellbeing as well.

It was evident that Centre A does strive to provide holistic services for the development of children. Responses revealed the often undervalued and overlooked children's need for PSS on all aspects of children's programming principles. Virtually all services for children should be delivered being cognizant of their psychosocial well-being. Furthermore, the main aim of PSS programming should be the reduction of risk factors and preventing children from being further exposed to harmful circumstances.

4.3.2.3.2 BEREAVEMENT SUPPORT

a. Presentation of data:

Bereavement support is another counselling services provided by PSS services. A ***CCG supervisor from Centre A*** reported thus on the aspect of bereavement support:

> "*We sometimes intervene by lobbying for social relief for the bereaved; we go to DSD – you find that families do not have anything to prepare for the funeral or to bury their loved ones".* This supervisor also added that through participation in support groups, bereaved children and others needing emotional support benefit psychosocially."

A ***Board member from Centre A*** also shared the sentiments of the CCG supervisor about the link with DSD in providing short-term relief during times of bereavement. He spoke of the spiritual counselling they provide to OVC and their families:

> "*Yes, bereavement support is one of the key services we provide. Counselling is provided to support the OVC and their families. Often a local Pastor is also involved in providing spiritual care and support. Our organisation ensures that we work with the FBO sector in these matters of the heart".* By 'matters of the heart' he substantiated that it is the emotionally laden work and services that the Centre provides, where the staff put faces and voices of children in distress."

The ***site facilitator from Centre B*** added that the Centre provides food parcels at funerals. She mentioned a case of a family where a mother died, leaving minor children without visible means of support, in a tin house. The children did not have full information about their relatives. The Centre had to intervene and assist with their mother's burial and provided food as well as emotional support to the bereaved children. She added this in her response:

> "*Efforts that bring hope to the lives of children become important spiritual and emotional needs of growing children because we are encouraging them to grow and get educated and make better lives for themselves."*

A ***childminder from Centre B*** also added to this dimension by specifying bereavement support as one of the needs of OVC. She reported thus:

> *"OVC need love, encouragement and care. They also need to have someone to talk to, especially during times of bereavement. They need clothing, including shoes and school uniforms."*

A ***CCG in Centre B*** referred to a boy child who had lost his mother and was refusing to communicate with others:

"There's one who is my client, whose mother passed on. He is now in Grade one; he was around three years when I first met him. He just used to cry; he is the child that, when seeing people, he cries. Maybe you call the child and say "boy come", but he will not come, he will not want anything. When you talk with the grandmother, she tells you that he does not want people, when seeing them he cries a lot and then goes and sits elsewhere."

This child's mother had recently passed on and was still reportedly highly traumatised by the loss. He was reported to be on ARVs, collected by his older cousin on his behalf. She reported having a few children on ARVs but felt ill-equipped to properly support them, as HIV treatment literacy is a challenge.

This CCG also referred another case of a family where a mother died, leaving behind four children. The children's mother had died of cancer of the cervix. The family received a voucher of R1 300,00 as part of bereavement support. This family presented with added challenges of a lack of food, no birth documentation for children and no proper housing. According to this CCG, a local social worker from DSD discussed the matter with the family.

A ***CCG supervisor in Centre B*** commented on the emotional support provided to OVC as follows:

"Emotionally, is where we sit with them {OVC} to do memory work. We sit…sometimes you can see when a child has things that he does not want to talk about, you can see that there is a challenge."

A ***CCG from Centre A*** highlighted a need for memory work is as far as the funding challenge is concerned:

"We need more resources, especially funding so that we can take the children on more outings, for example, the "healing of the past" programme, if it can be done on a monthly basis, allowing children to ventilate and deal with everyday hurts and joys".

This programme is seen as a facet of supporting bereaved children cope with the loss experienced. Interestingly, a ***CCG supervisor from Centre A*** indicated that memory work is not undertaken only with bereaved children. She reported thus:

"We mix them because we do not want those with parents to feel isolated and discriminated against".

b. Analysis of data:

Memory work is viewed as an essential aspect as it serves to build memories through deliberately planned activities with the child and family members (DSD, 2010). Memory boxes or books assist to remember and describe a person's life and may focus on specific events and periods within a person's life. Partab (2006) validates the advantages of memory boxes as developing a memory pool as the deceased becomes part of the endeavour, shaping what memories should be left behind. These family experiences are documented through diaries, albums, videos or a quilt (DSD, 2010). We can deduce that memory boxes promote emotional well-being, coupled with counselling. Corr and Corr (2013) also concede that such activities provide nurturing and continuity in the lives of the children. The making of memory boxes provides children with group therapy. In these boxes, children are able to store photos of their parents, cards and toys. It is believed that these boxes keep happy memories and assist them in overcoming their grief. The HCBC funding challenge was highlighted as caregivers hoped for service expansion in the area of memory work. Insufficiency of funding does seem to indeed compromise good programmes. This view was supported by a UNISA study on child-headed households (2008) which asserted that even delays in payments to NPOs and irregular fund transfers compromised programmes.

It was noted that Centre B participants had a lot more to share on the bereavement aspects of the provision of PSS. Evidently, the work of CCGs is quite emotionally challenging, especially if it involves children losing parents at a young age. PSS remains critical during such periods and is the knowledge that all CCG need to possess.

4.3.2.3.3 LIFE SKILLS AND PEER EDUCATION

(a) Presentation of data

A programme facilitated by an organisation called World Changers Academy was mentioned by ***a CCG of Centre A*** as follows:

"World Changers Academy – a programme that involves teaching children and youth about life skills. Children aged 14 to 15 years participate in this programme. We also involve children up to Matric level. It was started four years ago".

The ***Project Manager of Centre A*** articulated the programmes mentioned earlier:

"Life skills programme for the youth – the organisation is supported by World Changers Academy in this. Their focus is on the youth, including youth-headed households. They also deal with youth at post-Matric level. Through the support of the Rotary Club, Pinetown, our youth are also exposed to work opportunities, for example, some got jobs at Mr Price. We are planning to support our youth with computer literacy as well".

The World Changers Academy programme is conducted during school holidays and targets the youth aged between 18 and 35. The programme provides life skills training. A site facilitator of Centre B reported that it is linked to the schools as the Academy facilitators also deliver it at local schools. Also, a ***CCG supervisor in Centre A*** added that:

"When we close, in December, we have Christmas parties. We give them presents around that time".

A ***CCG supervisor in Centre A*** illustrated the peer support programme with an example of a boy who was assisted by the organisation as follows:

"The programme has indeed benefitted many OVC. There is a boy, Philani who was assisted by the organisation at a young age. His mother was very ill and could not take good care of him. With the intervention by the organisation, his life changed. He too cooperated well in all programmes and advice provided. Philani is currently in Matric and is doing well. He sometimes comes to motivate other children. We have managed to build relationships with the children, even when they leave the Centre, they can still come, and we embrace them / the errors they made. Such children end up being motivators for the other children".

Other related comments on peer education support from a ***CCG at Centre A*** were:

"In this one for peer education support, I think we managed to help children to open up and talk because there is a child that you can give food. The child eats and goes, without even talking. When we sit with them, you can see them opening up and talking so that when one is experiencing a challenge, you can see. Even amongst the

children themselves, they do identify challenges and come to us to report that so and so is doing this and that. It assists to open communication with the children".

Peer support is reflective of the social domain of PSS in that it promotes OVC's positive relationships with their friends. Additionally, a sense of belonging is also strengthened within this environment which includes friends, "supportive teachers, religious leaders and sports coaches who provide encouragement" which ultimately helps to foster resilience (DSD, 2012).

A ***CCG supervisor in Centre A*** highlighted programmes as follows:

"…there are discussions between children and parents – talking about the things that parents do not like, things that children do. The children as well talk about the things that they do not like, that parents do. We open like a debate, encouraging children to be open in the presence of their parents."

This supervisor also added an element of spiritual support, where she mentioned that a Pastor is invited to talk to the children. She mentioned cultural activities as follows:

"…we include things that children can do for example singing and Zulu dance talents. There is a group that does Zulu dance. Sometimes it is boring to sit down and talk all the time. We teach them other things that make them active. Older children sometimes participate in the choir and do drama". She added that: *"…for the older ones, sometimes we ask them to do drama and act. This group gets lazy to do Zulu dance…the older ones have certain fears; sometimes they get involved in a choir – things that are kind of formal in a way…"*

A ***Board member in Centre A*** provided a more comprehensive view of the life skills programme when he reported:

"Actually when you look at the life skills programmes, it provides OVC skills and knowledge that helps them cope with life challenges…they are even protected from contracting HIV and AIDS, becoming pregnant at a young age or getting married early."

The Board member's response was viewed as significant when examining the role of life skills programmes in promoting PSS. It can also be regarded as a prevention and

early intervention programme, promoting positive outcomes for OVC on many fronts such as socially, educationally and morally.

(b)Analysis

In Centre A and Centre B, caregivers confirmed that children had been exposed to life skills and peer education, as exemplified by wide-ranging discussions on issues like peer education support and debates, which enabled children to talk openly about things that they were experiencing in their homes and communities. Peer education "can communicate positive messages to children in a way that parents cannot, and can serve as a role model for change" (UNICEF, 2012).

It is commendable to note the inclusion of peer education in programmes for OVC. As they grow into adolescents , children are more likely to listen to and openly discuss sensitive issues like sexual matters, grief and death with their peers than with adults (Department of Basic Education Guidelines for implementation of peer education programmes, 2011). The care and support for teaching and learning programme (CSTL) delivered by DBE also promotes care and support, ensuring that all children are afforded equal opportunities enabling them to reach their full potential. It is evident that the schooling system also seeks to mainstream care and support for all learners. Furthermore, young children are exposed to different vulnerabilities, not only when they become orphaned. The UNISA study (2008) contends that all children in need of care and support can be considered as vulnerable, for example street children, children living in poverty, children caring for sick adults, children in child and youth care centres (CYCCs) as well as children in foster care. It can also be argued that through peer education, OVC are enabled to broaden their networks for social support, which benefit them as they grow into adulthood, increasing their resilience as well.

4.3.2.3.4 DIALOGUE AND DEBATES

(a) Presentation of data

Participants also mentioned dialogues and debates as part of programmes delivered. A ***CCG supervisor in Centre A*** provided the following information:

"…there are discussions between children and parents – talk about the things that parents do not like, things that children do. The children as well talk about the things that they do not like, that parents do. We open like, a debate, encouraging children to be open in the presence of parents – parents as well to be open about their feelings, honest as well".

This participant reported that 12 to 17 year olds participate in these debates. Amongst examples of topics discussed during debates and dialogues are issues of human trafficking, as alluded to by the ***CCG supervisor from Centre A***:

"Other examples are human trafficking…what parents and children understand about it, also what can be done to prevent it- things like that. Sometimes you find that it happens because of carelessness on the parents' part at home".

The space fostered and encouraged healthy communication styles. Centre B, however, did not report such debates.

(b) Analysis of data:

Dialogues and debates are considered essential in both promoting care / the spirit of Ubuntu and having an educational function. They create avenues for discussions on measures about the care of OVC, hence also promoting social support. It is important that community structures are also targeted during these debates and dialogues for example, in rural areas, Amakhosi and Izinduna (traditional leadership) should be invited to be part so that they commit to solutions on the plight of OVC. The same will hold true for ward councillors in semi-urban and urban areas. The social ills are too many in communities and it takes the entire community to step up and take responsibility for protecting all its children.

According to DSD PSS Guidelines (2010: 31), community dialogues or conversations are a helpful way of discussing PSS and raising awareness. Issues of importance in a particular community, involving as many community members as possible are discussed. It is thus evident that community dialogues reflect another form of HCBC service delivery channel, serving as an important prevention, care and protective factor for all children.

4.3.2.3.5 AWARENESS PROGRAMMES

(a) Presentation of data:

Awareness programmes are identified as one of the essential programmes in HCBC organisations' work. As alluded to earlier, a partnership with the World Changers Academy also assists the two Centres in conducting awareness programmes in schools. These sessions include child protection concerns and life skills.

A ***childminder in Centre A*** was of the opinion that the community does not seem to possess a distinct understanding of the crucial roles played by CCGs and she articulated as follows:

> *"Community needs to be made aware of what a CCG is – more awareness needs to be created."*

Another ***CCG participant from Centre B*** supported this view and held that:

> "*There is no recognition for CCG work."*

Both the CCGs confirmed that as much as the objectives of awareness programmes concentrate on improving awareness about the needs of OVC and spreading the message, Government alone would be unable to provide for those needs. Hence communities are expected to recognise their work and their worth.

Awareness programmes tend to be combined with motivational talks and the faith-based sector. As a ***CCG supervisor in Centre A*** stated:

> *"We invite a Pastor that we know to talk to children, but we ask him to talk with the children at school and not here at the Centre. Most of the children that come to the Centre attend local schools. Other children do not go to Church, so they do not get these talks that motivate them; they thus get them in schools because we work well with the local schools".*

This partnership with the FBO sector and local schools are essential for all HCBC organisations as it reflects their mezzo level supports and interventions in addressing the OVC's holistic needs. Spiritual support also serve to attend to the spiritual domain of OVC.

The ***CCG supervisor in Centre A*** highlighted community awareness when dealing with abuse and articulated it thus:

> *"Many people are not aware that they are abusing children, thinking that abuse is only about rape. They are not aware that other things they do to children also amount to abuse. We do notice that they become interested, they ask questions. We often involve people from Childline, Child Welfare to come and explain, telling them about other discipline options. It becomes very eye-opening for the community and us as well".*

It is apparent that awareness raising interventions are also part of prevention and early intervention programmes. Perhaps awareness programmes would better be seen as far more than just raising awareness but as interventions aimed at reducing risk amongst OVC, while also strengthening protective factors. PSS aims to also assist in the prevention, early intervention, and continuing care levels.

(b) Analysis of data:

As can be noted by the CCG statement above, CCGs sometime feel that their work is not recognised. These workers would sometimes travel long distances, on foot, in hot weather and sometimes in areas where terrain is difficult. Funding sectors and other partners Should seriously consider additional social support services targeted for caregivers / home based carers, besides the stipend provided. The UNISA study (2008) identifies the options of certificates of appreciation, capacity building in child counselling skills and end of year functions in appreciation of performance during the year. As community members would be part of these events, a greater understanding of the work and roles of CCGs would be promoted, so will recognition for the hard work CCGs do.

Hall et al (2019) highlights the need for increased efforts to strengthen the child protection system and ensure that various duty-bearers such as DOH, DSD and the criminal justice system can collaborate better in improving efficiency of responsive services and referral systems. The continuing challenges of abuse of women and children, child trafficking and others that people continuet to hear about in both print and electronic media are ordinarily part of discussion areas where much concerted efforts must be made to strengthen. This means that awareness campaigns about

HIV/AIDS, drug abuse, teen pregnancy, gender based violence and child protection need to be staged more frequently in communities. Part of the CCG's scope of work involves raising awareness on care and protection of OVC as well as assistance in conducting awareness campaigns on issues affecting individuals, families and communities and mapping services offered in the community (DSD PSS Guidelines, 2010).

4.3.2.3.6 CAMPS / OUTINGS / EXCURSIONS

(a) Presentation of data:

The significance of camps, outings and excursions were noted by participants in both Centres as part of PSS programmes that serve to improve the children's overall well-being. *A **childminder in Centre A*** stated as follows:

> *"…outings of children is a good practice. Because a child gets an opportunity to come out of normal and usual home circumstance…those two days or a weekend so that the child can be happy with other children".*

A ***CCG in Centre A*** shared similar sentiments when she reported:

> *"…this allows children to destress as they visit different areas. This is important for the children as some parents cannot afford even to take them to the beach".*

(b) Analysis of data:

The above discussion indicates that programmes undertaken by HCBC organisations are extensive. The children's need to play and engage in recreational activities outside of the family setting is addressed through excursions. OVC's social and psychological aspects inform these programmes. Children's access to recreational facilities was found by UNISA study (2008) to be assisting in counteracting idling by OVC and hence should be increased. Another cadre of the social service workforce, defined by the Chidlren's Act as "social service professionals" are the social auxiliary workers. Berry et al. (2013) contend that growth of the social service profession has been observed overtime, with an aim of creating a multidisciplinary workforce to implement the Chidlren's Act effectively. Social auxillairy workers act as a supportive service to social workers, practising under their guidance. This support includes attending to children's recreational needs and care and support during emotional

trauma. They thus can be engaged when planning and undertaking outings and excursions for OVC.

Working collaboratively with families, other stakeholders and the community reflects the HCBC's work at a micro and mezzo levels. These systems became evident in this study as it noted the multifaceted levels at which HCBC organisations engage in delivering these services and programmes. Such intersectoral collaboration in resource-limited environments ultimately benefit the children and families. They deliver aspects of care such as healthcare, "economic and food security, legal aid, psychosocial, spiritual and educational assistance, and other services" (Richter and Rama: 2006). Richter and Rama (2006) contend that "individual approaches fail to respond to the needs of vulnerable children and frequently duplicate the conditions existing in health services, schools, and developmental programmes". This stresses the need for multisectoral partnerships in the delivery of quality social protection services.

The next section focuses on the third theme, on processes involved in rendering PSS services.

4.3.3THEME 3: PROCESSES INVOLVED IN RENDERING PSS SERVICES

Another dominant theme identified was the processes involved in rendering PSS services. Both Centres followed more or less similar process, which commences at the intake level.

4.3.3.1 SUB-THEME: CLIENT INTAKE PROCESS

(a) Presentation of data:

When questioned on the identification of the families, a ***CCG in Centre A*** reported:

> *"When we identify people, we complete an intake form, recording personal information as well as information on people he stays with at home, family income, breadwinner etc."*

A ***childminder from Centre*** A also clearly communicated her understanding of the process, even though she did not necessarily conduct home visits herself. She reported:

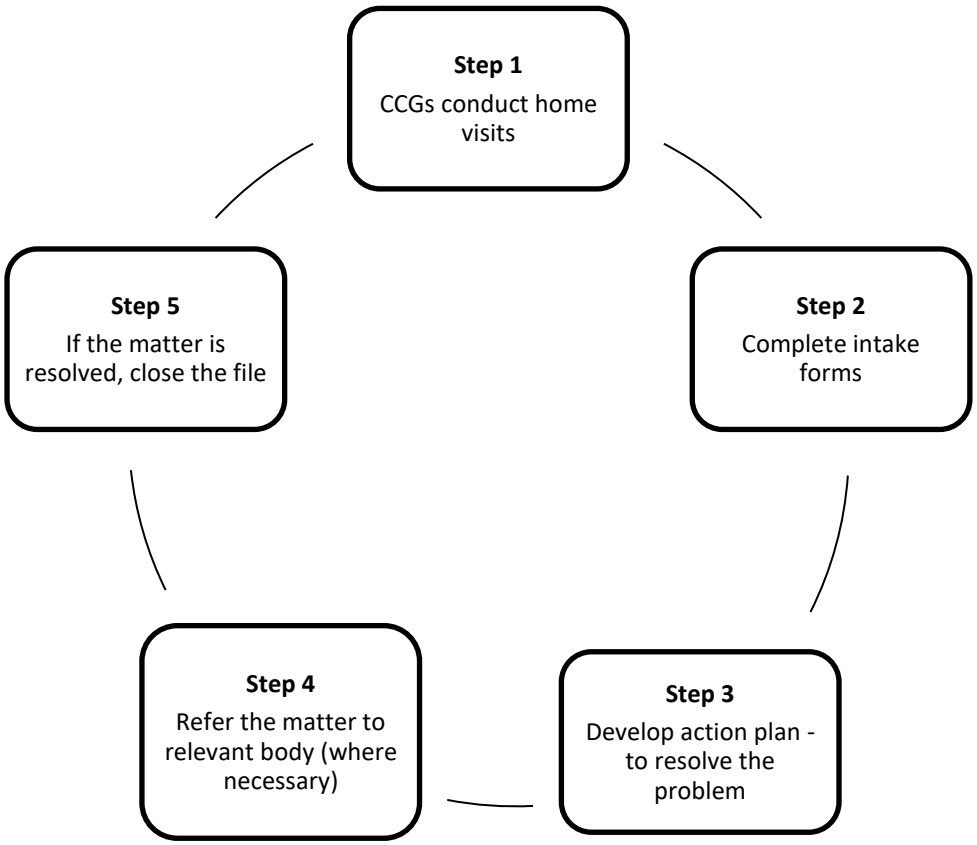
"CCGs either identify children in the community, or the parents bring them to register them on site. We complete registration forms and ask for the necessary documents, for example, the birth certificate, immunization card and consent form. We ask parents if the child (ren) has any allergies. Other issues we ask about are: who will collect the child at the facility and the person's contact details. We create a file for each child. The child's details are also then entered on the register".

A ***CCG supervisor from Centre A*** shared similar information as the CCG but articulated the intake process as follows:

"Through door-to-door visits –that is where we introduce ourselves, explaining that we provide these and other services in that way. After that, if it is a challenge that we can address as an NGO, for example, food support, we tell the person or child to come and eat while we continue with the referral to where assistance will be received. We write a referral letter and give the client, or if the client is not helped, I go as a supervisor to hear why the client is not getting help. We also continue with a form called process report, that on a specific day I conducted a visit and found a specific challenge. If the client eventually gets the help needed, we close the file and record that the client has been helped in this way".

Based on the views and inputs of the participants from both participating organisations, the steps followed to deliver PSS services to OVC can be illustrated as follows:

Figure 4.1 Process for accessing psycho-social support services



Source: Field data

Figure 4.1 depicts five steps that are followed to deliver PSS services to OVC in the case study organisations. The first step entails conducting what one respondent described as the door-to-door visits or home visits in order to identify the needs of childrens. Once the affected child is identified, they complete the paperwork (i.e. Intake Form) and submit it to the project manager's office (Step two). Step three entails developing a plan of action, in attempts to resolve the problem which, depending on the situation, may involve accepting/accommodating the child in the care centre temporarily so that he/she can receive PSS, or referring him or her to the right department of NGO for help. The referral (Step 4) is made if the problem is beyond the control of the HCBC organisation. We should note though that they need some form of verification through documentation such as birth certificates, guardian or parents contact details. Home visits by caregivers are undertaken during the process, by a CCG supervisor or a site facilitator in the course of the process for example, in finalising a plan of action. It is evident that some needs assessment is conducted by CCGs, which involves screening of the socioeconomic conditions of each family and ascertaining each child's needs. These may be nutritional, educational, emotional and

financial. These needs then inform the range of services to be provided to that OVC as well as their household.

(b)Analysis of data:

The nature of HCBC work consists of home visits. Children and families in need are identified by CCGs and other community members through such visits. Berry et.al. (2013) identify home visits as a vehicle or mechanism through which ECD and HCBC services are delivered. Others include play groups, working with school based support teams and visits to health facilities.

Cases identified by CCGs, CYCWs and SAWs are managed using a case management approach. DSD PSS Guidelines (2010: 23) define case management as a method of providing services whereby a service provider assesses the needs of the child and the child's family, when appropriate, arranges, coordinates, monitors, evaluates and advocates for a package of multiple services to meet the specific child's complex needs. Case management also involves development of care plans for each of the HCBC beneficiaries.

Both Centres were found to implement a system of HCBC monitoring and evaluation, developed jointly by the DSD and the DoH. This system is known as the community based information management system (CBIMS) and has a set of tools utilised by caregivers, caregiver supervisors and project managers when reporting beneficiary data. The vision of this monitoring and evaluation (M and E) system is to contribute to the realisation of the outcomes of the HCBC programme through the production of credible, reliable and value-adding data by ensuring that all HCBC programme implementers implement the Integrated M and E system (DSD &DOH, 2013). It is however recommended that an electronic system be considered as it allows for electronic data management at different levels, and reduces the likelihood of organisational files going missing.

CCG supervisors have responsibilities that include among other things to train and assist caregivers to competently fill the C0 forms and to follow up on referrals and queries. They use of S0-forms, for example, the S03 comprises a supervisor monthly report (developed from the consolidation of CCG supervisees' C04 and C06 forms).

The S05 is a referral form handed to the supervisor by the caregiver, which is discussed by the two of them together and an agreement reached on where to refer the beneficiary. The Centre Managers have their own set of tools, known as the N0-forms. Some of these are N03a, which is the HCBC information form, the N03b – personnel registration forms, the N01 monthly stipend form and N04 which records training workshop or seminar reports. It was noted that at both Centres, these forms are not religiously used for data capturing. Staff are informed that they would benefit from refresher training on the utilisation of the S and N forms. These tools are currently available on the paper-based system, although Centre Managers indicated that there is a plan to move to an electronic data capture system shortly.

It is apparent that DSD and DOH have made attempts at ensuring uniformity and standardisation in reporting, by developing a common M and E system. Ultimately for the beneficiaries, it does not matter whether DOH or DSD fund a CCG, but rather that their needs get addressed by the appropriate services (DSD and DOH, 2013).

4.3.3.2 SUB-THEME: HOME AND ONSITE VISITS

(a) Presentation of data:

CCGs conduct home visits to identify beneficiaries early and also to provide follow up support to families which enables them to access care and support and provides a linking mechanism. A ***CCG supervisor from Centre A*** highlighted the following when CCGs conduct home visits:

> *"We visit families to talk about parenting skills to parents, educating them, telling them that it is important that when their children do good things, they must praise them and encourage them. Sometimes we face challenges here, especially things that show love is hidden from the children. We do tell them that when the child has something good, hug them and show some love and that they did well…because children do not know that, they fright / get scared when we praise them for doing well".*

This supervisor also added an element of spiritual support provided to families during home visits as follows:

> *"We do [provide spiritual support] when we conduct home visits we do. There are challenges people face that you see if you leave the person, you'll come back and find that the person has hanged himself, yes we do".*

Micro-level interventions by HCBC organisations include counselling, provision of meals, homework support, ECD, library (Centre A) and support groups. Marici (2015) asserts that the individual is influenced at the micro systems level by the family, school, peer group or workplace as a result of direct interaction. Consequently, services and programmes delivered to OVCs ought to take into cognisance this microsystem level of interaction.

The ***site facilitator of Centre B*** indicated that they commenced with a homework club. Also, she added that it is necessary to undertake holiday programmes on site. A CCG from Centre A reported about the library service:

> *"Another need that we realised, especially for those in High School, is a library. Libraries are far, need to get transport to reach the town, and you find that others do not have taxi fare. That is what we were trying here, but it is not yet ready, I think it will be next year. You find that children need information, but we are unable to assist, need a book obtainable at the library. We do now have a few books, but we need more".*

(b) Analysis of data:

As indicated above, home visits reflect one of the HCBC delivery platform. On-site services include support groups for example treatment literacy groups, parenting support groups and groups for OVC themselves. By meeting on-site, beneficiaries share information and are supported in efforts to lead improved psychosocial wellbeing (DSD PSS Guidelines, 2010).

Availability of libraries within HCBC organisations can serve as an important educational function and a protective factor. The DBE's care and support for teaching and learning (CSTL) programme identifies its indicator for success as the extent to which all children enjoy equal opportunities to education (DBE Handbook for the provision of an integrated package of care and support for learners in SA schools, 2016). Although developed as a policy for the school community, from a human rights lens as well as a multidisciplinary partnership approach, this document is also useful at community level where the HCBC organisations are based. Schools are an important mezzo level partners for HCBC organisations. The concept of school-based support teams where issues of bullying, teen pregnancy, HIV and AIDS amongst

others are discussed. Such teams comprise learners and community based cadres for example CYCWs and CCGs. DSD PSS Guildeines (2010) highlight that school-based support teams mainstream and integrate PSS into schools, reaching all schoolgoing children.

4.3.3.3 SUB-THEME: LACK OF DOCUMENTS

(a) Presentation of data

This sub-theme was one of those expected from the participants as assistance in acquiring important documentation and ensuring access to social grants is one of the critical services delivered by HCBC organisations. CCGs mentioned that civil registrations through birth registrations are still a challenge. In other instances, they stated that death certificates are a challenge. These challenges included unavailability of necessary documentation, sometimes through loss, impacts negatively on the child's ability to access financial means to survive.

Although there reportedly is broad eligibility for the child grants (child support and foster care grants), participants in both organisations indicated that many children still do not access these for various reasons.

(b) Analysis of data:

Sambu et al (2019) contend that early registration of births is important because a birth certificate is a gateway to other services and benefits, including the child support grant. As such, many households survive through social grants and hence hope for a better life stops when a grant payment stops. Richter and Rama (2006) refer to grants as a statutory social support scheme available in South Africa. They add that governments need to be encouraged to increase and improve the formal safety nets available to the citizenry. Informal safety nets, on the other hand, are made up of "donations of exchanges of cash, food, clothing, and voluntary associations and solidarity groups who provide essential support to vulnerable households" (Richter and Rama: 2006).

Taylor, Kidman, and Thurman (2011) support this idea as they hold that "despite the wide availability of the child grants, and their proven potential to benefit the recipients, not all eligible OVC households are accessing these critical resources". The said

authors add that the lack of supporting documentation could be a barrier to social grants access. Thus they recommend that OVC programmes can increase access to social grants if households were informed with correct information. In practice, however, the CCGs were found to provide this form of education and would go all out to assist the households. The Guidelines for Social Services (DSD, 2005) also mention this as one of the fundamental responsibility areas of CCGs.

4.3.3.4 SUB-THEME: DEALING WITH REFERRALS

(a) Presentation of data

HCBC staff refer matters to government departments and other stakeholders when necessary. Reportable incidents involving children, for example, child abuse and neglect matters are referred to additional and specialised services as child abuse protocols require. ***A childminder from Centre A*** expressed this as indicated below:

> *"Children's experiences at their homes, for example, abused children tend to become slow in class. We refer these matters to the area social worker who comes to the site every Monday".*

A ***CYCW from Centre A*** also mentioned the referral to a social worker that visits their Centre:

> *"We do have a social worker that counsels them because even if you have gone to a family and seen that they have a challenge, you can come back and report and ask that the social worker sees them. I had a case of a child who was abandoned by the mother, then I came here to ask for support, and I also went to Child Welfare. The social worker at Child Welfare and I found that the mother was unable to give the child love, sometimes leaving the child alone at home".*

The above section demonstrates the process followed when interventions are necessary. These are general processes, usually followed by most HCBC organisations. Referrals were also made to various medical professionals who formed part of interdisciplinary teams attending to clients' care and treatment. These were both in the NGO and Government sectors. As providers of care and support services, HCBC organisations work closely with other likeminded providers of these services. There has been an acknowledgement that follow-ups on referrals have been missing and could be built into referral systems utilised. It is critical that referral systems be

functional and continuous to be useful as it again asserts that systems operationalise themselves for the benefit of those vulnerable. In the section below theme four is discussed.

(b) Analysis of data:

Although working closely with the social sector Departments of Social Development, Health and Education, referrals are made by HCBC organisations to other Government Departments who support their initiatives. Close relationships are forged with local SAPS, SASSA and Home Affairs for example. Dealing with referrals is often built in on HCBC plans each financial year, in the same way monitoring, reporting and evaluation are. This comes from a recognition that there will be aspects of care and/or case management that staff are ill-equipped to deal with or falls outside of their scope of practise. Such aspects include referrals for specialised services and therapeutic interventions e.g. play therapy for children. Rohrs et. al (2019) contend that early detection and therapeutic interventions minimise long-term risks and help break intergenerational cycle. Conversely, a poor response can lead to secondary trauma and increased risks.

4.3.4 THEME 4: GAPS IN PSS PROVISION

Several gaps were identified in PSS provision of services by the participants.

4.3.4.1 SUB-THEME: EXPANSION OF THE FEEDING SCHEME

(a) Presentation of data

As the feeding scheme provides food to OVC who drop by on their way to school, caregivers expressed concerns over the other children in households, who, for various reasons are unable to go to Centre A. More often these were reportedly younger children and children with disabilities, kept at home. The CCGs reported having raised this concern with DSD that the feeding scheme is 'expanded' to cater for siblings that remain at home. Limited funding (provisions) was reported by DSD, according to caregivers, as a critical challenge. A ***Board member of Centre B*** raised this issue when she gave a suggestion for improvement and stated as follows:

> "*That children get food and also come to carry home for siblings that remain behind. If it can happen that after meals are dished, children be allowed to carry some [more food] in containers."*

(b) Analysis of data:

It was evident that OVC serviced within HCBC organisations seek assistance not only for themselves but for other household members. Family unit survival is key at all times. The extension of a feeding scheme can go a long way in supporting other beneficiaries of HCBC services and programmes, for example children and adults on ART. Leatt and Berry (2005) maintain that malnutrition in HIV infected children can speed up progression to AIDS, hence effective interventions must include food and nutrition.

4.3.4.2 SUB-THEME: INCREASE PLATFORMS FOR DISCUSSION

(a) Presentation of data

A ***CCG in Centre A*** reported thus in this sub-theme:

> *"As CCG, we wish that there could get more funding so that more programmes can be offered to OVC to talk about their worries, their pain, and their concerns."*

(b) Analysis of data

From the above it is illustrated that there is a need for further platrforms to allow OVCs to talk about their issues and concerns. The lack of funding however is a problem which makes the realisation of this service difficult. According to Richter and Rama (2006), "children need opportunities to ask questions and have them answered sensitively and honestly in ways that a child can understand". The said authors affirm that "involving children in efforts to help, assigning them with appropriate tasks and responsibilities, also enable children to manage their distress better". The support group for children intervention/services, will provide opportunities to normalise the children's situations, experiences, and environments. Friendship groups are also formed during such peer meetings, hence promoting resilience building in children

4.3.4.3 SUB-THEME: SUPPORT TO CHILDREN WITH DISABILITIES

(a) Presentation of data

Challenges experienced by children with disabilities was also noted by the caregivers, who highlighted that such children need assistive devices as well as assistance in enrolling in specialised schools. A ***caregiver supervisor in centre A*** expressed this need as follows:

"We need wheelchairs and crutches for children. The local hospital gets these through donations."

The ***Board member in Centre A*** added that:

"*In our organisation, we wish that we could provide visible and practical supports to OVC. Yes, we do provide love and care to children living with disabilities, but we can do more through programmes that target such children. We hope though that through the Isibindi model, we can improve our services."*

Centre B also alluded to the same sentiments of their counterparts in Centre A, as can be seen in a comment from a site facilitator:

"*I know that the Children's Act provides for care and protection of all children, including children living with disabilities. In our organisation, however, we are challenged by limited knowledge and skills in dealing with OVC living with disabilities. Perhaps if DSD can provide the capacity building in this regard, the situation would be better. Such capacity building should involve staff at all levels so that everyone is enabled to have an increased understanding in supporting children with disabilities and providing them with psychosocial support".*

(b) Analysis of data

Generally, knowledge on how to manage children (and adults) with disabilities appeared to be limited in both Centres as can be deduced from the above statements. Participants seemed to agree that information on dealing with children with disabilities is lacking and capacity building in this regard is needed. Servicing children with disabilities requires specialised care and skills gained through dedicated training. Children with disabilities are one of the categories of vulnerable groups targeted by interventions rendered by DSD.

It is to be noted that Section 28 (1) (c) of the Bill of Rights in the South African Constitution guarantees every child the right to social services. All children, including children in difficult circumstances for example, children with disabilities are covered and guaranteed by these rights. On the other hand, the Children's Act also aims to give effect to the rights of children to "family care or appropriate alternative care" and the right to protection from maltreatment, neglect, abuse or degradation (Dutschke and Jo Manson, 2008). These rights apply in the same way to children living with

disabilities and services provided to them therefore should take regard of this. As identified by the participants, support for families with children who have disabilities form part of services and programmes they provide. In addition, when conducting information campaigns about disability to their local communities, the rights of children with disabilities ought to be factored in. However, HCBC workers reported not feeling sufficiently empowered with information in this regards and it is an area that the relevant supporting Departments need to take a closer look at. As OVC with disabilities grow up, they will require vocational training as well. The current situation will make their lives even more difficult, if not addressed whilst they are younger.

4.3.4.4 SUB-THEME: SUPPORT FOR CHILDREN ON ANTIRETROVIRAL DRUGS (ART)

(a) Presentation of data

Caregivers and their supervisors in both Centres alluded to experiencing a service gap in supporting children on ART:

> *"Some of the children we work with are on ART. Even though some of us received short courses on HIV and AIDS, they did not empower us with skills and knowledge in supporting these children. We think that there is a gap there. We need a full course specifically on treatment literacy, particularly for supporting children".*

A ***CCG in Centre A*** highlighted this gap from a previous course she attended:

> *"I did the HIV and AIDS Counselling Course – it covered PMTCT, disclosure as well. It was a one month accredited programme and offered by the KZN Experimental College. I think it was during 2007 or 2008 when I did this Course. The gap I discovered was the area of dealing with children living with HIV and who are on ART – specific knowledge and skills in this area was not covered (ART in children)".*

(b) Analysis of data

It appears that caregivers felt ill-equipped to deal with children who are on ART and require further training. These caregivers are in need of training in order to be able to assist OVCs. The lack of training makes caregivers feel inadequate and ill equipped to provide the necessary support. Supporting children to adhere to treatment reflects another vital domain of PSS service provision. Berry, Dawes & Biersteker (2013) highlight that there still are many children living with HIV and AIDS, on ART in South

Africa. These authors contend that despite a "decline in child mortality rates in South Africa due to significant take up in HIV prevention and treatment programmes, a large number of children are living with HIV" (Berry et al, 2013). The HCBC caregivers also reiterated the need for supporting children on ART. In addition, supporting children on ART forms part of a range of children's socio-economic rights for basic nutrition, basic health care, shelter and social services. Shung-King and Roux (2005: 24) highlight that where children do contract HIV, it is important to understand what responses are required to address their health needs best. Such needs include nutrition (interventions to include food and nutrition based programmes); medication (preventive and treatment medicines); education (adherence support promoted through caregiver education) and Home Based care. The value of psychosocial support for HIV infected children also forms an important aspect of their care plans. Such children have specific emotional, psychological and social needs, which include help with pre-test counselling, disclosure of the diagnosis to the child, disclosure to others and adherence support (Shung-King and Roux, 2005).

4.3.5 THEME 5: GOVERNANCE

Effective governance is central to the daily functioning and sustainability of any organisation, including HCBC. What follows is a discussion of the governance issues that impacted on the provision of PSS in the two HCBC organisations.

4.3.5.1 SUB-THEME: NETWORKING AND INTERSECTORAL COLLABORATION

(a) Presentation of data:

Participants expressed the necessity for continuous networking. We can regard such networks as care networks and influences that surround children and include families, schools, neighbourhoods and the media (Richter and Rama, 2006). NPOs networking with one another promote joint learning, as they engage in exchange programmes, share information, attend workshops/seminars together. Through collaboration, NPOs can share knowledge and expertise on how best to support OVCs in their care. As a ***project manager of Centre B*** mentioned:

> *"We have a Forum of NPOs in the area…all NPOs are working with OVC and their families. It helps to network as we can share our limited resources. The local hospital's outreach programme has been instrumental in the initiation and continued existence of this Forum".*

Hall et.al (2019) contend that the Children's Act is based on a cooperative implementation model, explicitly requiring the State to adopt a comprehensive inter-sectoral strategy aimed at securing a properly resourced and coordinated national child protection system. Reported lack of proper collaboration and networking at local level makes it difficult for NPOs in particular to render effective and quality services. Hall et.al. (2019) add that Section 110 of the Children's Act obliges social workers and police officers to cross-refer cases. The extent to which this provision is implemented in reality however seems still challenging, if understanding statements from HCBC staff and Board members.

A ***CCG from Centre A*** emphasised the importance of functional networks and involvement with DSD, the Centre's main funder as follows:

> *"There is not very good cooperation by DSD. Sometimes DSD plans events on their own, without involving us and we are just asked to bring children to those events. We wish that we could be involved more".*

The same CCG shared her feelings about the non-recognition of CCG work thus:

> *"There is a need for the public to take CCGs (and CCG work) seriously. Various government departments need to realise that we are also community workers and part of them. They thus must give CCGs specific training programmes, for example, SASSA, DSD. CCGs are also often not recognised when they come to their offices, if this situation could change, it will help encourage CCGs in their work".*

The participant above raised another pertinent issue of shared training skills, which will further skills development.

A ***Board member in Centre A*** also commented thus on this theme:

> *"We are trying our best as a management committee in ensuring good governance in our organisation. We can hold quarterly meetings and keep records thereon. When the service office coordinator of DSD comes to visit at the Centre, she also checks on minutes amongst other things. I must say however that the committee also needs training in understanding their roles and responsibilities well. We need to be trained in understanding the importance of networking, for example, leadership skills also….not to mention all the laws that govern our work."*

The above Board member is quite experienced in HCBC work, and the researcher could establish this in his responses.

(b) Analysis of data:

The data presented above is indicative of the value of networking, working together with like-minded organisations allows for information sharing, team effort, and joint development at both personal and organisational levels. Furthermore, the needs of beneficiaries are ultimately better met. Networking also encourages resource sharing. With the dwindling funding of NPOs, limited resources can be shared amongst a consortium of like-minded NPOs for example, those working in the child care and protection field. NPOs also need to create links and partnerships with the private sector to increase their awareness and responses to the spread and impact of HIV and AIDS, especially with children. Richter and Rama (2006) assert that "civil society organisations, in their role as watchdogs, should advocate and lobby government to allocate resources and ensure the development and implementation of policies, plans and interventions explicitly addressing children's issues, including children living in communities affected by HIV/AIDS". This means that NPOs must be assisted to work together to maximise their efforts ans share skills. The DSD and UNISA study (2008) highlights that collaborations strengthen performance, guarantee continued existence and reassure funders and donors.

There is value in networking and intersectoral collaboration as HCBC organisations are enabled to learn from each other, share resources and respond more effectively to the needs of OVC and their families.

4.3.5.2 SUB-THEME: HCBC INCOME GENERATION

(a) Presentation of data

Engaging in income generation activities was identified as one of the means of ensuring HCBC organisational sustainability. Coupled with this, is the issue of skills – teaching caregivers skills that can generate income. The site facilitator in Centre B indicated that staff attended a baking course, which empowered them with baking skills. Consequently, the Centre purchased a stove which they intended using to bake as the Centre's income generation project, also a measure to increase sustainability.

A Board member of Centre A expressed his concerns about the viability of income generation activities used at his Centre. He informed thus:

> *"How can I forget….implementation of income-generating activities. Over the years, we have tried many things such as beadwork, sewing etc. These have not been viable. The budget that DSD provides to us towards these activities is also small. We need to sit as a Board and look at ways to network more innovatively and maximise our resources."*

It is evident that small income generation activities do not always raise adequate funds to support the efforts of HCBC organisations. Income generating activities ought to be carefully implemented and monitored. HCBC organisations require innovative networking to maximise resources. Networking with the corporate sector, for instance, may assist in supplementing organisational income and improving sustainability.

4.3.5.3 SUB-THEME: SUSTAINABILITY OF SERVICES AND PROGRAMMES

(a) Presentation and analysis of data

Participants generally held that additional assistance from external agencies and the State is essential for the sustainability of HCBC services and programmes. This view is supported by Richter and Rama (2006) who claim that "ensuring that resources reach community-based groups, to enable them to continue assisting vulnerable children and their families is a critical requirement of governments, assisted by local and international aid agencies". DSD (2010) National Guidelines define sustainability as the ability of a programme or project to continue being active, over the medium-to-long-term basis. HCBC appear to be viable social care models and would benefit from increased and ongoing support, this will enable them to sustain their services and programmes.

The last theme addresses the challenges identified by HCBC organisations.

4.3.6 THEME 6: CHALLENGES FACED BY HCBC ORGANISATIONS

These two organisations noted several challenges under study.

4.3.6.1 SUB-THEME: SKILLS DEVELOPMENT FOR STAFF

(a) Presentation of data

The concern of training was reiterated by the caregivers as one of the challenges experienced. They believe that exposure to ongoing training and education opportunities would contribute to quality HCBC service delivery, helping staff to also keep abreast with developments in the child care and protection field. A ***caregiver in Centre B*** expressed her concerns as follows:

> *"…part of my responsibilities as a childminder includes facilitating support groups. This interferes with my duties as a cook as well. As childminders, we did not receive any training on facilitating support groups for children and wish that this can be provided. What we do is to talk about general issues with the children merely. Sometimes we engage children in games".*

The above statement clearly expresses the childminders' wish to have training on facilitating support groups. In the researcher's view, this would enable them to do their allocated work more confidently, effectively and efficiently.

A ***caregiver in Centre A*** shared these sentiments about the need for ongoing training and skills development:

> *"…exposure to ongoing training and education opportunities will contribute to us providing quality services. It will help us as staff to keep in touch with developments in the child care and protection field".*

A ***childminder in Centre A*** briefly stated that:

> *"Training to all staff, especially on how to deal with children in distress is needed".*

This worker highlighted this as an essential suggestion and need of HCBC organisations. She explained that working with children in difficult circumstances is challenging and sometimes they find themselves ill-equipped to deal with these.

A ***caregiver supervisor from Centre B*** provided additional training areas for CCGs and supervisors as follows:

> *"While I recognise the need for first aid training, there are other training areas that we need to be developed. I am talking about bereavement care, counselling children, art, and music therapy…all these are important aspects of our work."*

(b) Analysis of data

Also, as has been indicated earlier, there are HCBC staff members who are registered with tertiary institutions on a part-time basis. They reported finding their studies very beneficial to the work they do at HCBC organisations. DSD National Norms and Minimum Standards for HCBC (2007) highlight the need for training of all CCGs in efforts to ensure the provision of quality services. The training acquired by some of the participants include first aid, basic counselling skills, baking skills, social auxiliary work and home based care. The training still reportedly needed is ART support for children and their caregivers, nutrition, first aid (to those not yet exposed) as well as resource mobilisation.

This study revealed that CCGs require good knowledge and skills base to draw from when confronted with care and support needs of OVC. Ongoing training is vital to reinforce existing and to develop new skills. Training on a broader understanding of PSS was however not identified as a training need by any of the caregivers interviewed in this study. One staff member at Centre A highlighted that training in first aid was needed.

A Board member in organisation B highlighted that training activities assist staff to face current realities (as situations change). She also emphasised that training activities need to be offered to both caregivers and childminders. Notably, a Board member did not mention governance and leadership training as a training need.

Ongoing staff skills development is a vital aspect for HCBC organisations, who have repeatedly declared it as a challenge. Beyond developing themselves, it logically impacts on the quality of their services. Artwork and music therapy, for example, can assist improve emotional well-being outcomes for OVC. Partab (2010) also advocates that music therapy which furthers emotional, cognitive, physical and social integration. The section below addresses the challenge of funding and resource mobilisation.

4.3.6.2 SUB-THEME: FUNDING AND RESOURCE MOBILISATION

Although this paper have identified some positive impacts in the HCBC programme, significant challenges have been identified. The existence of these challenges supports the theory that social programmes, in general, are never problem-free but

always have to co-exist with significant problems which often have the potential to close down such projects (Mouton, 2001).

A ***childminder from Centre A*** expressed the funding challenges which are also related to training and further skills development as follows:

> *"I would like to see the growth of the organisation; perhaps if we had more funding, we could achieve more. As staff; we also need ongoing exposure to new learning, so if staff can undergo further relevant training it will be appreciated. This will allow us to try out new and creative ways of doing things".*

The ***site facilitator*** alluded to the funding challenge as follows:

> *"CCG reports indicate the need for health services. They also need gloves and home based caring kits. In the absence of this, they are unable to bed bath patients who need such. We are currently lobbying for these necessities through the local clinic. We have no funding for health services".*

She also added the following:

> *"…we asked for funding as we do not have specific funding for it. Funds that we have are for World AIDS Day. We ask sponsors for help so that there are things that children can take home".* In this instance, she was referring for funding of holiday programmes undertaken on site. She further added "*…maybe it happens that funding that we have, as we have DSD…funding is never enough. I can say that funding is not enough. However, we do apply in several other places, as it is we await responses where we applied."*

A childminder from Centre B reported thus:

> "*The need for food is far greater than we thought. Not all children can come to the site to eat. We are unable to reach more because we do not have satellites to operate from, so only the nearby children can come. Funding is a big challenge for us to expand our reach to more children".*

The situation of funds was reported to have a significant impact on foodservice provision as was alluded by a ***childminder from Centre B***, also supported by a ***Board member from the same Centre:***

"Sometimes we do not have breakfast, depending on the situation of funds. Bread, in particular, is a problem as we cannot make the children sandwiches if we do not have bread. This becomes problematic as the expectation was created on the children's part".

A ***Board member of Centre B*** provided her version of the situation of funding as follows:

"…because of financial difficulties we can only afford to give one child (a uniform) *in each family. The others wait their turn for the next years, by that time, their uniforms are old and worn out – but we are unable to give all of them at the same time".*

She responded to a question about the supply of uniforms to only one child in a family of three or more children. She appeared disheartened about this situation, which the Centre has little control of, unless if additional funds are received elsewhere. When asked a question on the needs and challenges faced by HCBC organisations, one ***childminder from Centre A*** reported:

"1.Insufficient community / social supports -The community does not cooperate fully with us in the programmes we deliver. Even when we call for parents' meetings for our ECD children, most parents just don't come. Other parents also pay fees late. We are planning graduation at the end of the year and have requested parents to contribute financially towards this, very few have paid, and others have been asking why it is necessary?

2. Insufficiency of food - We are unable to ensure a balanced diet at all times because sometimes we run short of food on site.

3. Insufficient funding - The funds we receive are not enough for our needs, we wish we could do more for our children, but funding is a big challenge.

4. Other stakeholders and business sector support - Support are unreliable and not frequent, we cannot guarantee a specific date of receiving whatever form of support. This makes it difficult for us to plan our work activities and programmes."

External social support is critical to the provision of services by these two centres. Households need support from their extended families as well as the community at large. UNICEF (2009) quotes in their 2005 report stipulating that "the foundation of an effective response is to reinforce the capacity of families and communities to provide protection and care for vulnerable children".

A ***childminder from Centre A*** highlighted this point when she said that:

> *"I think it is just that the community is made aware that when a child is being abused, and you are aware of it, you are responsible, that children must be protected in our communities".*

Approximately 90% of participants identified the funding challenge. This situation appears to be an ongoing challenge as funding for HIV and AIDS programmes is becoming progressively scarcer. Some NPOs who were funded in the KZN province by Global Funding, PEPFAR, and other Donors had indicated (through informal discussions) that funding is drying out and this affects the efficiency with which they can deliver their programmes. At worst, many NPOs may be forced to close their doors as they find it increasingly challenging to render services without sufficient budgets. The need to target resources efficiently remains a priority for many NPOs.

The ***site facilitator*** explicitly stated thus:

> *"…funding is never enough. We do apply in several other places, as it is we await responses where we applied."*

A ***CCG*** highlighted the following challenges they encounter in the delivery of services:

> *"1. There are members of the community who are still afraid to report sexual abuse of children, especially if it happens at home…often people in power are feared and no reports laid against them.*
>
> *2. Training activities. We wish that DSD could give CCGs training that would empower them to better their services and the quality of services provided.*
>
> *3. Lack of home based care kits is also a pressing challenge, even the DoH CCGs do not have these.*
>
> *4. Lack of recognition of CCG work. We were once approached by a Union, PSCA, who told us that they would fight for better working conditions, including payments. We contributed for some years until later the Union told us that it was a mistake that they took our money, they should not have. Then they promised to pay our funds back…when the funds returned, only a small portion was paid back, approximately R418,00 – other funds have not been received to date."*

Other challenges reported by the CCGs were families living in dire poverty – food insecurity is some households. A Board member highlighted the challenge of high bank charges, which affects service delivery on site. She added that the banks charge high amounts and she wished that this situation change. At one point, the bank charged the organisation an amount of R1 000, 00 which they can ill afford within their restricted resource situation. She concurred with other staff who alluded to limited funding received from DSD. She indicated that they have written to several donors and funding development agencies unfruitfully. The Board member also highlighted the lack of transport. She indicated that sometimes a gas cylinder finishes and they struggle to get transport to go fill it up. This situation sometimes results in the organisation being unable to prepare meals for the children.

(b) Analysis of data:

Berry et al (2013) identify inadequacy of funding and inappropriate funding models as one of the challenges facing the ECD sector. It can be argued, as also indicated by statements from particpants above, that the same holds true for HCBC work. Funding could assist HCBC organisations in expanding their human resources, addressing staff training and development needs, expand services (whilst ensuring quality as well) and improving on good governance.

It is evident that HCBC staff operate in the context of challenges. These include:

a. Insufficient funding from DSD;
b. Delayed transfer of funds to organisations' accounts by their primary funder, DSD;
c. The rather high expectations from the community who do not realise that the organisations do not have sufficient funding to address all their needs. Such expectations include people asking for houses;
d. Community members who try to abuse the system, pleading poverty when they have viable incomes. There was, however, an indication that there is gross poverty in the area although some community members are better off than others;
e. Delayed receipt of necessary registration documentation from the DHA. UNICEF (2009) highlights the critical nature of birth registrations for children and state that "orphans without proof of birth lack the essential protection that

stems from this legal form of identity". Also, birth registration documents are essential for correct data on births;

f. Lack of home based care kits. A caregiver from Centre B expressed a concern that unavailability of such kits affect their work, in that they are unable to bath patients confined to the bed. She informed thus:

"We experience the challenge of not having home based care kits. DSD does not provide the kits, yet the other 12 CCGs from COC do place orders for things like vaseline, soap, nappies, and they do get them. COC CCGs place new orders so that they can give others. DSD still does not give us anything. Sometimes you find that a person you are visiting is hungry and you are empty-handed, not even porridge, but at least this side they can assist". She was referring to a partner organisation, which seems to be more resourced than they are and this in itself frustrates them as care workers.

g. The reluctance to report child abuse matters by the community members resulting in unreported cases and continued abuse of young children;

h. Families are refusing to provide ID copies, for fear of possible criminal activities; articulated by the ***caregiver from Centre B*** as follows:

"A person will tell you that there is someone who has a challenge at home, and then you tell them that you need an ID to register them for support. That is where the problem is, a person would refuse with it, claiming that they are afraid we will use them for fraudulent activities like getting into unknown debts. When this happens, we are unable to continue with our interventions."

i. The caregivers stated that despite sending requests for training to DSD, this has not been forthcoming. They believed that service quality would be significantly enhanced if staff was exposed to ongoing training and development. Another caregiver reported that sometimes the children talk about challenges that they do not know what to do about them. In such instances, referrals are made to DSD. She added that it hurts them as caregivers when children tell shocking and traumatic stories. This same caregiver added that sometimes they are unable to give children breakfast, especially when DSD has not given them approval requisitions on time.

j. At Centre B, a staff member indicated the challenge presented by the practice of "ukuthwala" where much older men abducted girl children and forced into early marriages. She added that of great concern was the realisation that the

parents “gave away” their children to older men in return for cows. She indicated that this has however stopped, since the intervention of the local leadership.

It is evident from the above the two Centres under study have faced significant challenges which impact on the servive delivery to OVC. The most significant being the lack or delay of funding, poor community engagement and assistance, delays in obtaining necessary documententation as well as inadequate training of it’s staff. Such challenges need to be addressed to ensure between service delivery to OVC. OVC already face prejudice and discrimination and should therefore be provided with care and protection. As a result of the challenges listed and discussed above this is not always the case.Funding and resources are a serious challenge. The problem however is that this study has been limited to two centres therefore the reliability of the findings is uncertain. It would be interesting to determine whether other centres have experienced similar challenges. Some of the identified challenges are in keeping with the HCBC Audit findings from a study commissioned by DSD and DOH in 2010, which also found challenges including inadequate stipends, slow processing of tranches, lack of HBC kits and lack of knowledge on fund-raising.

As alluded to previously, NPOs are regularly required to engage in resource mobilisation activities to ensure sustainability.

4.3.6.3 Accessing civil registration documents

(a) Presentation of data

A ***CCG in Centre A*** expressed the documentation challenge as follows:

> *“…documentation for Grade R children. Children are not accepted in Grade R if they do not have the necessary documents. When we try to source these from the Home Affairs Department, we also experience challenges there. Sometimes gogos are asked to make affidavits about the unknown whereabouts of their sons/daughters. Gogos sometimes lack cash to be travelling to and from”.*

A ***CCG supervisor from Centre A*** highlighted the documentation challenge indicated above as follows:

"Another challenge is that in the community, the ignorance and not taking issues up…the child is not getting assistance because the people the child stays with are too laid back, and the child ends up not being assisted. For example with documents, the child must have a birth certificate, but you find that the parent is not cooperative and not pushing, the parent does not have an ID. They also complain about not having money, for example, the transport fee to go to Home Affairs or a letter from the school. Our greatest challenge is about people who are not from here in South Africa, maybe coming from Umtata, Matatiele, Lesotho and do not have passports, things like that. This ends up abusing children; you find that a child is not attending school because the school wants a birth certificate".

The documentation challenge was highlighted by a ***CYCW in Centre A*** when she reported thus:

"What is more important are certificates. You see, until they get the certificates, they are unable to access government support. Others end up not going to school because the parent is unable to buy the child's school uniform, what will they buy with? Because if it is a child living with the grandparent, grandparent not receiving a grant, it ends up a big problem".

A ***caregiver from Centre B*** cited that sometimes it is the adults themselves who do not have the necessary documentation:

"Even adults who do not have IDs, maybe if you ask them, they tell you that I am lazy ---my child is not even getting any grant. You ask about a certificate, advising on what they need to do. You find that a person remains with a child that does not access grant support, so they do get help – the person applies for own ID as well as the child's birth certificate, afterwards goes to SASSA to register for a grant".

(b) Analysis of data

In both centres under study, participants reported households with low per capita income, with most of them depending on grants for survival. A serious issue and obstacle raised by the participants above is the lack of documentation required to apply for grants. It was reported that the delays arise from government departments as well as parents or caregivers. These parents or caregivers indicate lack of knowledge and funds to access the documents. This impacts on the lives of children. This is problematic and a serious challenge. The child support grants are needed to

ensure the child receives adequate care. The delays in accessing and lack of documentation impacts on the OVC right to adequate care, to attend school, food, clothes and so on. Staff at the two centres are therefore unable to provide the OVC with their needs due to the above challenges. In this regard, Taylor, Kidman, and Thurman (2011) note that organisations who work with OVC attempt to increase access to grants to their recipients. These efforts can be strengthened through provision of information on how to overcome access barriers. Berry et.al (2013: 32) also support this view as they contend that timely birth registration enables access to other services such as social grants, free health care and education.

Centre B informed the researcher of refugees, who experience difficulties when applying for South African citizenship. Although Regulation 11 of the Social Assistance Amendment Act (Act No 5 of 2010) does provide for grant application without an abridged birth certificate, there seems to be reluctance among some SASSA officials to pursue this. Also, we observed that children with a refugee status could access the foster care grant, but they too experience challenges with such applications which frustrates both the organisation and the clients.

4.3.6.4 SUB-THEME: LACK OF COOPERATION FROM GOVERNMENT DEPARTMENTS

(a) Presentation of data

A concern was expressed by participants about a slow response rate from government departments. As ***a caregiver participant from Centre A*** aptly put it:

> "*It hurts us as workers when you make a follow up with a government official and find that nothing was ever done about the matter you referred, more so if it was a reportable incident like child neglect or abuse…this situation is frustrating".*

She added her frustrations thus:

> "*Delays by social workers to respond, other NGOs as well for example Child Welfare Society. Sometimes Government officials give us challenges when they do not respond to emergency cases referred to them*".

(b) Analysis of data:

Evidently, a series of challenges face HCBC organisations in delivering their services to communities in general and OVC in particular. From an ecosystemic perspective, the state as the highest organ in the country should continue through legislation and policies reflect a commitment to improve the lives of children in South Africa. This would reflect macrosystem level support for HCBC organisations. Marici (2015) contends that broader macrosystem effects have an influence on any child's life and they include the economy, cultural values and other most remote elements in society. Relationships need to be nurtured with the broader "players" in the social sector, continuous referral systems strengthened, and communities (meso-level) are encouraged to play their roles in support of all children (Marici, 2015). The exosystem factors, also regarded as social factors that impact the wellbeing of OVC can be regarded as having a bearing on the success of programmes offered by HCBC organisations (Marici, 2015). An ecosystem approach reasserts the collaborative ethos that will produce high-quality services to those most vulnerable. Berry et al (2013) contend that to realise the country's National Development Plan (NDP)'s vision, "access to sound programmes that nurture children's basic health and nutrition, improve their living environments, support caregivers, offer stimulation for early learning and provide referrals to appropriate health care and social services are essential".

4.4 CONCLUSION

This chapter has presented and thematically discussed the findings of the study. It has noted challenges needing to be addressed to ensure the long-term success of the HCBC programme in providing PSS. Programmes that assist OVC educationally, materially, emotionally and legally are essential. From an Ecosystems perspective, it is highlighted that interactions at the microsystem, where a child is influenced by the family, school and peer group for example are taken into consideration in programming. HCBC organisations benefit from cooperation of families in the delivery of all types of services. Good relationships with parents / children's cargivers inter alia are key for successful mezzo system delivery. Recognition is made of macrosystem issues impacting on delivery of services by HCBC organisations. These include relevant social policies, enabling legislative environment as well as cultural and societal factors.

The next chapter will provide a summary of the main findings, recommendations and future research areas.

CHAPTER FIVE
CONCLUSION AND RECOMMENDATIONS

5.1 INTRODUCTION

In this final chapter, the objectives of the study will be revisited to demonstrate the coherence with the conclusions and recommendations for future PSS service provisioning. The chapter concludes with future research considerations.

This study sought to document psychosocial care and support services provided to OVC by HCBC organisations. The specific objectives of the study were:

i. To describe the psychosocial care and support services that are provided to OVC by HCBC organisations.
ii. To identify the needs and challenges experienced by HCBC organisations in the provision of PSS services to OVC and
iii. To document the critical needs of OVC.

5.2 DISCUSSION OF MAIN FINDINGS

Psychosocial support describes a wide range of care, support and protection activities that aim at ensuring the social, spiritual, emotional and psychological wellbeing of individuals, their families and communities (DSD PSS Guidelines, 2010). This study however focused primarily on PSS as provided to orphaned and vulnerable children (OVC). In line with the objectives listed above, the following pertinent themes were identified in addressing the study objectives.

5.2.1 Psychosocial services provided by HCBC organisations

The majority of the participants from the two HCBC organisations, despite their relatively low skills levels, demonstrated a conventional understanding of PSS. They were able to articulate some of the fundamental principles of PSS; such as placing the children's best interests first, counselling to assist children to cope with grief, observing and protecting children's rights; involving children in decision making, and providing love and care among other things. Efforts by HCBC organisations are commended for prevention of negative mental health outcomes, which get worse if not properly attended to. It is thus important that OVC receive psychosocial support.

UNAIDS Fact Sheet (2016) highlights the need for a combination of efforts in preventing new HIV infections as well as improving the diagnosis and treatment [and care] of children. It is noted that the growth of the Social Service Profession had led to creation of a multidisciplinary workforce responsible for implementation of the Chidren's Act. This workforce includes probation officers, youth workers, CYCWs, social auxiliary workers, development workers (Berry et. al, 2013). These are cadres all have a role in supporting PSS interventions for all orphaned and vulnerable children. In addition, collaborative networks with other sectors also contribute to the realisation of the rights of children.

Participants in both HCBC organisations identified and reiterated that the critical needs of children had not been fulfilled. Examples include food, clothing, shelter, protection against abuse and support for children with special needs. Seemingly, while concerted efforts have been made to deliver PSS to OVC, such efforts were hampered by capacity constraints and lack of funds. Berry et.al (2013: 28) contend that a child rights lens demands a focus beyond children's potential contribution to the adult workforce, and the recognition, promoting and nurturing of their instrinsic value and abilities as young citizens.

With regards to PSS programmes delivered to OVC, the findings suggest that while prescribed programmes for OVC care dominate the list, innovative initiatives are also being undertaken to improve the provision of psychosocial care and support services to OVC. The former includes programmes such as life skills programmes, holiday programmes, and support groups. The importance of early childhood education is also highlighted in this study. It is unfortunate however that process in registration and subsidisation of such programmes takes time, frustrating effforts of HCBC organisations to provide holistic care. Berry et. Al (2013) assert that ECD does make a real lasting difference in children's lives and benefits derived there from persist at least several years into schooling.

5.2.2 Needs and challenges experienced by HCBC organisations

Numerous challenges confronting HCBC organisations emerged. Essentially, the funding and the concomitant financially constraining environment invariably impacted on the organisation's commitment to deliver services efficiently. The scarcity of funds

not only impacts on the recipients of the services but the entire organisation, especially for staff growth and development. NPOs in general continue to deliver the bulk of social services to vunerable groups. Variuos studies have identified the funding challenge for NPOs and the need to expand and strengthen service delivery through provision of reliable funding (DSD and UNISA Study, 2008).

Staff from both HCBC organisations reiterated their need for on-going training and skills development and noted the ramifications on operational costs for the functionality of their organisations. To enable HCBC organisations to continue providing the valuable services they provide, adequate guidance, support, funding and skills development is necessary (DSD and UNISA Study, 2008).

Another pertinent challenge identified was non-recognition of the work undertaken by CCGs and CYCWs in communities served by various partners, especially in Government. Whereas there exists a general understanding of HCBC caregivers being an 'extended arm of Government', this 'arm' may not perform duties due to lack of resources. Social support service for caregivers is also highlighted in the study. It is important that they are appreciated and recognised for the work that they do. Care of the carer programmes for example are suggested and they include debrieifing sessions and some incentives (DSD and UNISA study, 2008). CCGs play an important role in the OVCs lives, who sometimes identify with them and depend on them for moral education and socialisation, in the absence of their biological parents. A collaborative relationship amongst various stakeholders contributes towards meeting the mandated needs of the communities they serve. It is evident that communities and other resources need to be mobilised and utilised to assist OVC in a manner that will improve their quality of life, promoting their optimal development.

Accessing civil registration documents was reported as a salient challenge encountered by participants, particularly in accessing available social grants. This study has acknowledged that one of the HCBC role and function is to facilitate access to essential documents and grants, and apparently, this function is central to achieving other outcomes for OVC and other vulnerable members of the community.

5.2.3 Critical needs of OVC still not being met

The identified gaps in PSS service provision included support to children on ART; insufficiency of food for the feeding scheme; insufficient opportunities for OVC to discuss their pain and care for children living with disabilities. Shung-King and Roux (2013) identify specific health needs for children on ART that need to be addressed. Measures to counter malnutrition for example through an intervention that includes food and nutrition would assist with preventive and treatment medicines.

PSS focuses on strengthening resilience. Measures to promote resilience can go a long way in providing opportunities for OVC to discuss their pain and make them feel more hopeful. Ray and Patterson, in Marici (2015) define resilience with reference to children as "the capacity of those who are exposed to identifiable risk factors to overcome those risks and avoid negative outcomes such as delinquency and behavioural problems, psychological maladjustment, academic difficulties and physical complications". Other terms that overlap with this definition are hardness, coping, mental toughness, positive judgement, resourcefulness and competence (Marici, 2015). These are aspects that PSS interventions seek to address.

On a governance level, this study emphasised the necessity for continued and consistent networking, good governance and intersectoral collaboration. Berry et.al (2013) assert that addressing a range of systemic challenges in efforts to quality service provision is key. These include enabling policies, population-based planning and adequate resourcing. Although a number of laws, policies and programmes have been put in place by the State, a research review found that current services are not sufficient to prevent many of the risks faced by children or to promote their optimal development (Berry et.al, 2013). The mobilisation of resources as a measure to ensure sustainability was considered. Capacity building of management committees on a range of governance issues as a critical need was also identified.

5.3 CONCLUSION

From the objectives of the study mentioned above, the following conclusions can be drawn, framed by the different systemic levels of the microsystem, mesosystem, exosystem, and macrosystem.

5.3.1 Microsystem

Generally, both HCBC organisations have attempted to ensure the provision of on-site services consistently. Their primary challenge, as mentioned above, however, has been funding constraints that seem to hamper their efforts. Despite this, there have been good relationships forged between OVC and their CCGs and CYCWs. As OVC visit these Centres daily, they look forward to receiving the support, love, and care from their 'external' caregivers. The quality of these positive relationships continues to strengthen.

5.3.2 Mesosystem

As indicated in Chapter One, the families serviced by HCBC organisations reflect the mesosystem. Programmes that support children, invariably support their families. Family preservation, including the provision of cultural and religiously appropriate interventions, are critical components of services rendered by HCBC organisations. The findings suggest positive relationships between the HCBC organisations and families, although occasionally parents are not cooperative. CCGs from both HCBC organisations reported working closely with OVC' primary caregivers, their parents.

School was another component of the mesosystem. According to CCGs interviewed, they enjoy positive and supportive relationships with local schools. Collaborative, successful awareness programmes conducted jointly with religious organisations reach out to many children in their local schools. The findings suggest the necessity to continue strengthening and sustaining these relationships within these systems.

5.3.3 Exosystem

Bronfenbrenner, as cited in Berk (2001) refers to the exosystem as social settings that do not contain the children but have the potential to affect their experiences in the settings (like the home and the school). The HCBC exosystem includes religious organisations, child protection forums, community forums and other significant stakeholders. Such stakeholders include government departments from whom HCBC organisations are largely dependent. It is evident in this study that there are tensions between the HCBC organisations and some government departments, for example, DSD and DHA. These result in frustrations arising from an inability of HCBC organisations to perform their roles and functions successfully. Perceived lack of support and recognition from government departments was evident. CCGs expect recognition of their roles, their work and their worth from government departments.

The importance of community supports / social supports to all children cannot be overemphasised. The promotion of a spirit of *Ubuntu* and a nation that invests in its children has constitutional imperatives. Continuing community awareness programmes need to be strengthened, which will promote the observation of children's rights and positive outcomes on the educational, psychosocial, spiritual and other realms.

5.3.4 Macrosystem

Chapter 2 encompassed a discussion of legislation and policies that guide psychosocial service provision to OVC. South Africa's commitment to various international and regional treaties also forms a central component of the macro level and national efforts to support all children. Various Guidelines were developed in particular by DSD, to support OVC with PSS. It seems however that the implementation of these is a challenge. Although this was not necessarily a focus of this study, it can be deduced from participants' responses when they mention, for example, a need for training and retraining to deliver an improved standard of work. There is an identified need to mainstream the provision of PSS in all aspects of policies and programmes, particularly in the social sector. Mainstreaming ensures addressing of PSS aspects for different service beneficiaries, not only OVC. Commitments of the South African Government at the macrosystemic level would reflect better when mainstreaming is ensured.

5.4 RECOMMENDATIONS

Given the above summary and conclusions of this study, the researcher offers recommendations for practice, theory, and further research.

5.4.1 Recommendations for practise

5.4.1.1 Provide sustainable supports to HCBC organisations

A crucial challenge of funding emerged in this study as both HCBC organisations noted with concern how their efforts are frustrated by an inability to reach their beneficiaries as they would expect. Funding would also serve to reinforce HCBC organisations' capacity to provide care, protection, and support to all children. The ECD programme is viewed as an important protective factor for younger children and will also benefit from subsidisation. There is a need for DSD and other participating departments to scale up the provision of financial and material resources to assist in improving the provision of PSS to OVC. Notwithstanding this, HCBC organisations themselves also need to engage in resource mobilisation drives to supplement governmental support actively. Seeking support from the corporate sector may also aid to improve their resource situation.

5.4.1.2 On-going training to HCBC organisations is critical

Whereas CCGs did allude to the need for training on various aspects of caregiving, this needs adequate planning and a budget for the funders. The quality of service provision is strengthened through the provision of opportunities keeping staff abreast of developments in their respective fields. Moreover, proper induction and training ensure that the needs of beneficiaries are not compromised, due to lack of knowledge and appropriate skills on the caregivers' part. It is necessary even to diversify CCG training programmes, to ensure that they meet the unique needs of OVC. From the analysis, it was evident that there were concerns that CCGs are not given sufficient training on child care, as most training received tended to focus on HIV /AIDS and general life skills. Training on creative programmes for example on art and music was highlighted. The role of a CCG in child care and protection is so important that they need to remain adequately staffed to ensure beneficiaries receive the expected quality of services. Without proper training and capacity building, CCGs will be left in tiresome and overwhelming situations.

Training targeted at HCBC management and Boards is als crucial. These could be financial management and corporate governance for NPOs for example. Offering these training activities can prevent situations where organisations loosing the very limited funding they seek.

5.4.1.3 DSD to guide managers and site facilitators on how to plan and schedule PSS

There is a requirement for the provision of assistance and guidance to project managers and site facilitators of HCBC organisations when planning and scheduling services to ensure that OVC receive adequate supports. Government officials may sometimes not be fully conversant with relevant and applicable guidelines, legislation as well as national and international frameworks guiding OVC work. Policy promotion sessions would thus be beneficial and greatly assist officials to effectively support HCBC organisations. Also, it is essential to acknowledge the impact CCGs have on the children's well-being. CCGs provide a stabilising factor for many children experiencing loss or any form of distress. Southgate and REPSSI (2006) maintain that the goals of psychosocial care and support interventions include maintaining a sense that children are connected to their communities socially, building a sense of self-worth and value; self-esteem and positive well-being as well as building hopefulness or optimism about the future.

5.4.1.4 Strengthen coordination mechanisms at all levels to ensure effective collaboration between HCBC organisations and relevant Government Departments

The value of intersectoral collaboration and communication. Effective implementation of OVC interventions requires close collaboration between all parties involved. Cooperation between the various sectors needs to be strengthened, especially between HCBC organisations and DSD, DOH, DHA, and SASSA. Exisiting partnerships between other government departments and NPOs should not be neglected as these will require on-going strengthening as well. All sectors to ensure that quality relationships in efforts for cooperation and coordination are maintained. The Traditional Leadership sector, along the FBO sector must also be involved. Many believe that close partnerships improve the care provided to beneficiaries.

5.4.1.5 As part of quality management, monitor and evaluate programme activities to ensure that PSS services meet the minimum required norms and standards

DSD as the primary funder needs to engage in active monitoring and evaluation of funded programmes. Monitoring and evaluation will serve an essential function of demonstrating such programmes' usefulness to Treasury, consequently securing future additional funding. We should capacitate HCBC organisations on M and E in its varied aspects. CBIMS as a monitoring system for community-based organisations serves as a useful tool. However, this too must be monitored. Staff at HCBC organisations will benefit from refresher training on the implementation of CBIMS.

5.4.1.6 Educate communities about their roles and responsibilities in the provision of PSS to OVC

In both HCBC organisations, participants reported that some parents are not cooperating with the organisational staff, highlighting a need to educate them about their duties in the provision of PSS to OVC.

5.4.1.7 Sensitise community members on how to identify and report cases of child abuse to law enforcement agencies and the HCBC organisations

Participants in the two HCBC organisations indicated that child abuse was one of the significant challenges experienced by children in their care. Ongoing community education is key, especially with a children's rights lens. One of the key findings from the document review is that adequate provision of PSS to OVC depends on the involvement of all key stakeholders, including local communities.

5.4.1.8 Encourage community participation through food security projects to combat poverty amongst OVC

The Department of Agriculture could play a significant role in assisting to raise awareness and encouraging participation in food security projects, in line with its constitutional mandate to ensure the realisation of a child's right to food. In addition, the FBO sector can be greatly involved in these intiatives as well.

5.4.2 Recommendations for theory

5.4.2.1 Promotion of Multisectoral roles in PSS provision

As is evident in this study, provision of PSS is a responsibility of multisectors, who ought to mainstream it on programming principles. This starts from a recognition that children's emotional and social well-being affects every aspect of their lives for example their ability to learn, to play and to relate well with other people as they grow. It is thus essential that shared responsibility for PSS provision be highlighted in various aspects of theory.

5.4.3 Recommendations for further research

This study only focused on the provision of psychosocial care and support services in two HCBC organisations in the Durban Metropolitan municipality in KwaZulu-Natal. Replicating a similar study in other provinces would be worthy.

5.4.3.1 Conduct an evaluative study

This study recommends that conduct an evaluation of the quality of PSS services rendered to OVC.

5.4.3.2 Mobilisation of communities for optimal development of OVC

Although the need for greater community involvement and mobilisation for OVC work has been identified, perhaps it is necessary that the 'how' of this aspect be researched further. Often individuals and communities may want to assist children to improve their future prospects and achieve development, but how this can be done may be lacking.

5.5 CONCLUDING COMMENTS

Chapter five summarises findings, conclusions and recommendations based on the previous data analysis chapter. It is evident that PSS interventions are multidimensional and complex. Evidence highlighted that there is excellent potential for HCBC interventions to improve the provision of PSS to OVC. This study can contribute to changes in the level of service provision/practice.

Occupational challenges such as inadequate and generalised training of all categories of staff, as well as to governing structures also emerged as threats to the HCBC organisations' attempts to deliver effective and efficient provision of PSS to OVC.

HCBC staff remain proactive in their implementation of strategies for collaborating with other organisations that could aid their rate of efficiency.

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6 APPENDICES

6.1 APPENDIX 1: INTERVIEW SCHEDULE

6.2 APPENDIX 2: SAMPLE LETTER TO NPOs

6.3 APPENDIX 3: PARTICIPANT CONSENT FORM

6.4 APPENDIX 4: PARTICIPANT CONSENT FORM

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

20 May 2014

Ms Zamanguni G Gumede (941350504)
School of Law
Howard College Campus

Protocol reference number: HSS/1083/013M
Project title: Provision of psychosocial care and protection services by Home and Community-based Care and Support organizations

Dear Ms Gumede,

Full Approval – Expedited Application

With regards to your response to our letter dated 21 October 2013, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol have been granted **FULL APPROVAL.**

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

.....
Dr Shenuka Singh (Chair)

/ms

cc Supervisor: Professor Carmel Mathhias
cc Academic Leader Research: Dr Shannon Bosch
cc School Administrator: Mr Pradeep Ramsewak