



# FROM THE CHILDREN'S MOUTHS

IMPROVEMENTS IN THE LIVES OF  
SOUTH AFRICAN ORPHANS AND  
VULNERABLE CHILDREN

*"Without the drop-in centre, I wouldn't be here. I would have long ago left school or maybe I could have long ago died of hunger and poverty and diseases."*

*—A teenaged orphan*

IPHC

INTEGRATED PRIMARY HEALTH CARE PROJECT

## ACKNOWLEDGMENTS

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MSH endeavours to continue strengthening South African community-based organisations to meet the objective of helping OVC to live normal and productive lives.



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COVER PHOTO AND PHOTO BELOW BY MSH STAFF



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# BACKGROUND & METHODS

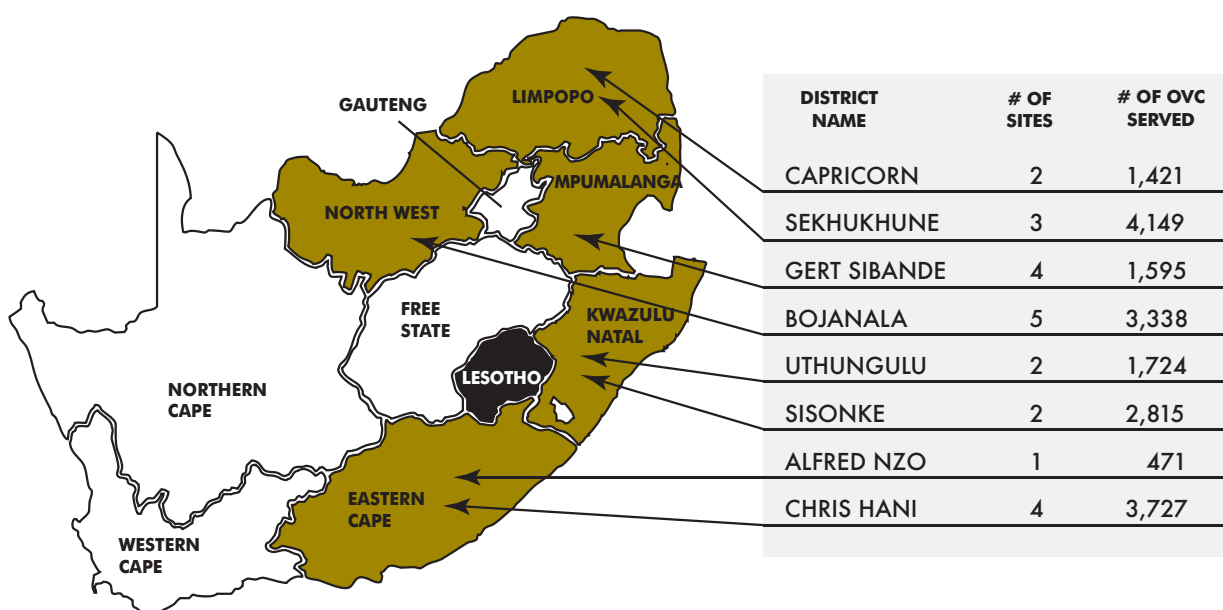
## The IPHC Project: Helping Orphans and Vulnerable Children

In March 2006, with generous support from USAID and PEPFAR, MSH initiated performance-based funding<sup>1</sup> for an Orphans and Vulnerable Children (OVC) Project through the Integrated Primary Health Care (IPHC) Project. The OVC project started with six home-based care (HBC) organisations based in four provinces of South Africa. By December 2006, the number of organisations had increased to 23, and coverage included five provinces and eight districts. (The appendix lists these 23 organisations and their locations.) The organisations have drop-in centres for children to come to after school and, in some cases, operate early learning or day care centres for the younger children.

Since 2006 MSH has assisted more than 19,000 OVC, using more than 9 million South African rand in grant funding to the 23 organisations. The services rendered to these children include the following:

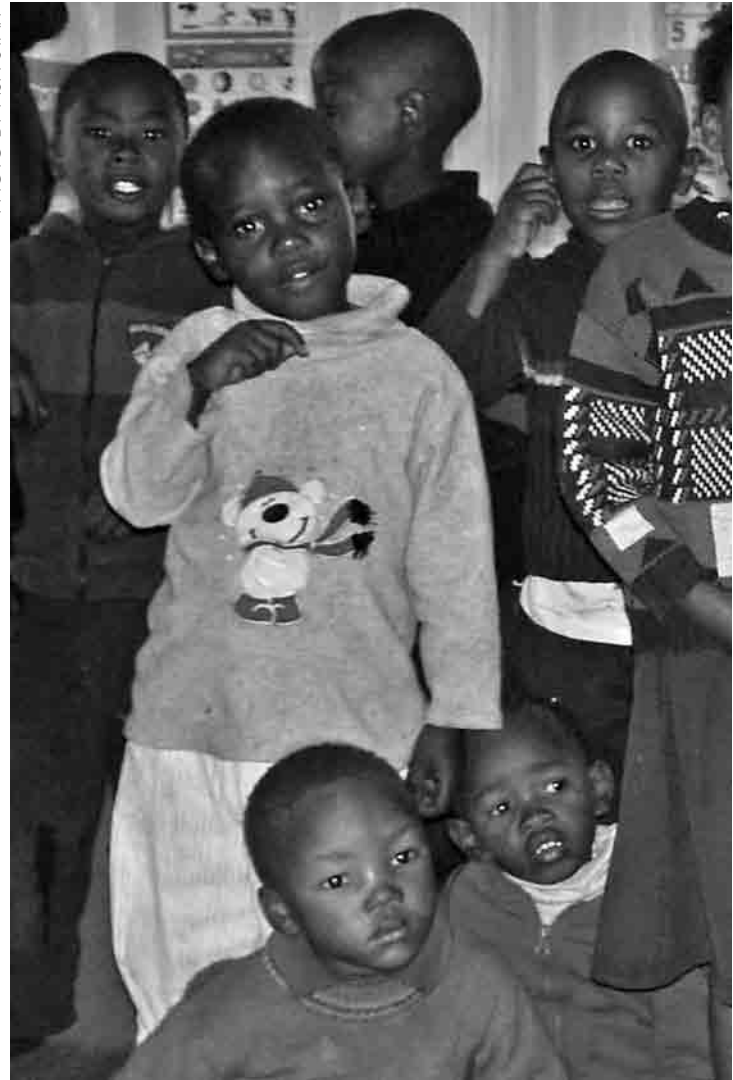
- **CLINICAL NUTRITION** interventions that cover medical aspects of nutrition typically associated with food insecurity (such as malnourishment)
- **FOOD PROVISION**, mostly from soup kitchens, to children participating in activities at drop-in centres
- **SHELTER** interventions that include identifying potential caregivers or reintegrating children who are currently in institutional care through family tracing and foster care
- **CHILD PROTECTION** interventions that aim to minimise stigma and social neglect faced by OVC, as well as abuse and exploitation

### IPHC-SUPPORTED SITES OFFERING OVC SERVICES IN SOUTH AFRICA September 2008



**Five Provinces, Eight Districts,  
23 Locations, and 19,240 OVC Served**

<sup>1</sup> To maximize the impact of funding on the people it should serve, MSH uses performance-based grants to link a CBO's financing with its achievement of set targets.



- **GENERAL HEALTH CARE** services such as referrals and linkages to child health care, immunization, growth monitoring, malaria prevention, and, when appropriate, HIV testing
- **HEALTH CARE SUPPORT**, specifically for antiretroviral therapy (ART). This service includes prevention of mother-to-child transmission (PMTCT) or specialized paediatric ART. Skin conditions, weight, and vital signs are also monitored. Periodic CD4 and HIV testing for all children and youth and paediatric ART and ART-adherence interventions for HIV-positive OVC are also provided.
- **HIV PREVENTION EDUCATION** for behaviour change using HIV prevention messages
- **PSYCHOSOCIAL CARE** to provide both children and their caregivers with emotional support
- **GENERAL EDUCATION** to ensure that OVC stay in school over the short term. Direct assistance is provided to subsidize school-related costs such as fees, books, and uniforms.
- **VOCATIONAL TRAINING** that encourages access for OVC to learn a trade, such as carpentry, welding, sewing, or agriculture
- **ECONOMIC OPPORTUNITY** or economic strengthening that includes access to social grants, livelihood opportunities (e.g., income-generating activities, links with the private sector), small-business development, and activities to create entrepreneurs from among older HIV & AIDS OVC and caregivers

In addition to funding, MSH has provided these 23 organisations with both formal and informal technical

By eliciting first-hand experiences of these children, we can help assess the impact of services provided to OVC.

support. Through workshops and on-site coaching and mentoring during field visits, MSH has offered training in project monitoring and management. MSH has designed data collection and reporting tools and has set up a reporting and documentation system that is used by the organisations.

This report focuses on the impact of work done in three of the OVC projects supported by MSH: Inkwanca Home-Based Care (HBC) in Chris Hani District, and Khanyiselani Development Trust (KDT) and Masakhane Women's Organisation in Sisonke District. More information about each project can be found beginning on page 14.

## Interviewing Children

### WHY COLLECT CHILDREN'S VOICES?

MSH commissioned Glynis Clacherty and Associates for their expertise in participatory work with children. Glynis Clacherty and Associates talked to young people who are benefiting from three of the OVC programmes supported by USAID and PEPFAR through MSH's IPHC Project. Reports often focus on the quantitative aspects of programmes, but quantitative analysis is not the whole story. Guided conversations with the beneficiaries of the OVC programmes help to demonstrate qualitatively the programmes' positive impact.

By eliciting the firsthand experiences of these children and their caregivers, we can help assess the impact of services provided to OVC and identify successful approaches to share with other stakeholders and partners, including community-based organisations (CBOs) that work with children.

### METHODS USED BY GLYNIS CLACHERTY AND ASSOCIATES

Glynis Clacherty and Associates used a combination of activity-based focus group discussions and interviews to gather information. This flexibility worked well because it accommodated different contexts in different communities.

- At the Masakhane Women's Organisation, the consultants conducted two focus groups of eight children, each for two different age groups (6- to 8-year-olds and 9- to 12-year-olds).
- At KDT, the consultants interviewed seven children in the 6–10 age group in the junior primary school, four children in the 11–12 age group in the senior primary, and a 15-year-old girl and 16-year-old boy together from a local high school. (The girl started crèche at KDT, and the boy is a head of a household.)
- At Inkwanca HBC in the Eastern Cape, the consultants conducted two focus groups of nine children in the 6- to 8-year-old group and eight children in the 9- to 12-year-old group.

In all, 46 children (16 at Masakhane Women's Organisation, 13 at KDT, and 17 at Inkwanca HBC) participated in this exercise.

Glynis Clacherty and Associates designed activities to be simple and friendly and to allow even the youngest children to participate. The instrument can be used either outdoors or indoors—underneath a tree or in any available space. In two cases, the consultants spoke with children in an outdoor space. The consultants also used "icebreaker" games at the beginning of the exercise and at intervals to create a relaxed environment.

The instrument is open-ended and allowed children to come up with their own opinions. Picture codes, relevant scenarios, and third-person methods were used to help the interviewers introduce sensitive issues in a nonconfrontational manner. Interviewers created a safe space for children to participate openly and talk about their experiences without necessarily revealing their identity. Children needed to be relaxed and comfortable when they talked about these issues.

### ETHICAL CONSIDERATIONS

- Explaining clearly the purpose of the discussion and how the information was going to be used
- Reinforcing to the children that it was okay for them not to talk when they felt uncomfortable or when they did not want to share something and that declining to talk was not going to be used against them at any stage
- Explaining to children that the discussion was confidential and that their identity would not be used
- Asking permission from the children to use the tape recorder



The interviewer asked the children to respond using art: “Draw all the things that the centre helps you with.”

### THE ACTIVITIES USED TO ELICIT THE CHILDREN’S OPINIONS

The children enjoyed the many icebreakers used to help them relax.

#### Activity 1

Silhouette figures helped to create a safe space for children to talk about their situations without feeling that they were giving away too much information about themselves.

When the interviewer brought out a silhouette figure, he or she would say,

*This boy/girl comes to the centre.*

The interviewer would then ask the children,

*Who does he/she stay with at home?*

*What are his/her problems at home?*

*What does he/she need?*

#### Activity 2

The interviewer sought to learn about the practical help that the children get from the centre by asking the children, “How does the centre help you?” The interviewer asked the children to respond using art:

*Draw all the things that the centre helps you with.*

The interviewer then delved into the activities by requesting that the children:

*Draw the different things that you do at the centre here.*

Next the interviewer elicited discussion about the two drawings:

*Let’s talk about them.*

#### Activity 3

The interviewer wanted to find out what children felt were the positive and negative aspects of their experience at the centre, so he or she gave them the following instructions:

*Divide your paper into two parts.*

*On the left-hand side of the paper, draw all the things that you like about the centre.*

*On the right-hand side of the paper, draw the things you do not like about the centre.*

#### Activity 4

In talking with the first two groups, the interviewer noted that the children frequently referred to their lives before coming to the centre. To capture this information, the interviewer added this activity while speaking with children in the last group only.

The interviewer told the children to draw two pictures entitled:

*Me—before I started coming to the centre*

*Me—after I came to the centre*

The interviewer then asked:

*How is your life different from what it was before you came to the centre?*

# THE CHILDREN SPEAK



PHOTO BY MSH STAFF

The consultants taped and transcribed the discussions with the children, and then sorted the quotes into themes (e.g., "I get help with my education"). Voices of children from the three projects are combined here. To preserve the children's words, we edited the quotations for punctuation and spelling only; each child's gender and age range follow the quote in parentheses.

## Hardships I Faced Before Finding the Centre

Some children were comfortable discussing their own struggles; others talked about likely situations faced by silhouette figures representing children like them.

*She gets to school late and they laugh at her. There is no electricity at her home and she has to wash with cold water. (Boy, 9–12)*

*I don't like it when other children play rough. I don't like smoking. I don't like being a street kid. (Boy, 9–12)*

*Maybe she stays with her grandfather, and her grandfather does not take care of her and he hits her with a stick when she comes home late. (Boy, 9–12)*

*I don't like being hit with claps at home. (Boy, 9–12)*

*I felt sorry for myself and thought it would have been nice if I had parents. (Girl, 6–10)*

*There is no food at home.... They do not buy food; they spend money on alcohol.... They treat her badly at home.... No one cares for her.... They hit her.... They do not want her to go to school.... They do not want to give her food. (Boys and girls, 6–8)*

## I Get Help with My Education

Children talked about how the drop-in centres helped them access schooling by helping them with uniforms and school supplies.

*At Khanyiselani, we are given uniform when we do not have. Food we are given and books when we don't have. (Boy, teenager)*

*When you come here and lay your problem before them—tell them that you do not have clothes, you do not have school uniform, you do not have shoes, you do not have a trouser—they give you. It can be a pen, pritt [glue stick], anything that you need for school you get here. (Boy, 9–12)*

*It helped me with school uniform and with food every day after school. (Girl, 6–8)*

*They buy you the uniform. They also pay for your school fees. (Girl, 9–12)*



## I Get Help with My Homework

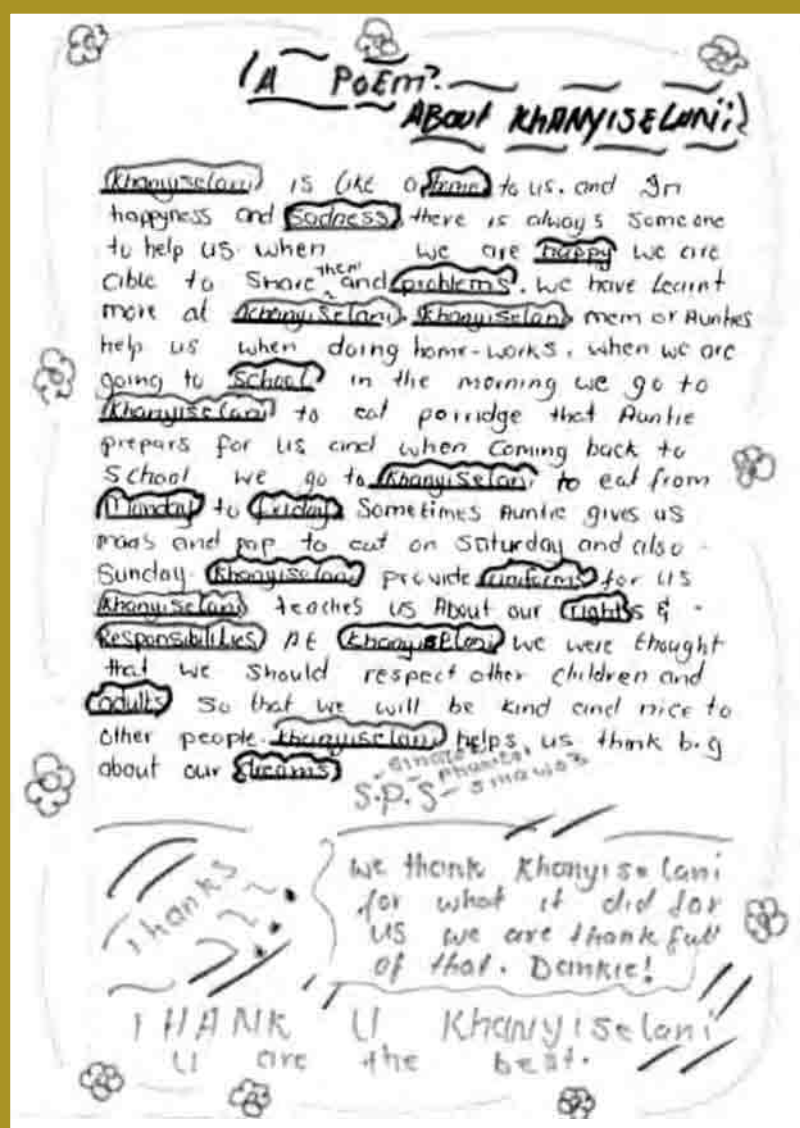
Children mentioned homework as one great support that they received from the centres. Homework included other projects, such as baking, that they were expected to do at school. In one group, children talked about basic literacy as something that they really appreciated. Homework is an important factor because one principal was sceptical about the help the centre was giving children; he mentioned that teachers themselves often struggled with the curriculum.

*Some days we do homework, but if you have a problem with your work regardless of the day you can bring it and someone will help you with it. We mostly do homework when Love Life people are around.* (Girl, 9–12)

*I like the fact that what they give us is valuable [izinto ezine nqondo], things like helping you with your homework.* (Boy, 6–8)

*What I like about Pink Huis [drop-in centre] is that when you struggle at school with your work—when you fail and always get things wrong at school and you do not have all your school things—they help you. They help you with your homework, they explain things, and they give you things that you need for the school. You become clever at school, and you pass.* (Boy, 9–12)

*The other day, we had a project at school. Sis suggested that we should bake for the project. They bought us the ingredients here at the centre, and Sis baked with us. She taught us to make a banana bread. We used the stove in the kitchen. Our choice of the project was the best,*



*“They help you with your homework, they explain things, and they give you things that you need for the school.”* (Boy, 9–12)

*and we felt proud. Other children liked the banana bread, too.* (Girl, 9–12)

The experience of working with children has shown that school is the most important part of the lives of vulnerable children. For most children, when the researchers asked about their needs, school uniforms, school fees, and books took top priority above everything else, including food. This significance is not surprising because the children spend most of their time at school, and school is probably the only place where the OVC feel the same as other children.

## The Food Is Good Here

Food has always been a challenge for children to accept as an intervention both in public and at school because of the stigma attached to it. Why stigma is attached to food remains unclear, but nevertheless, the children feel differently about accepting the food from the drop-in centres.

Judging from what the children say, the food that they get from the centres is of good quality, well balanced, and nutritious, and it is prepared carefully and very nicely. They are given the food with dignity, the preparation is good, and children feel valued. In some cases, it was also mentioned that children who go to these centres do not eat in the feeding schemes in schools; they wait until lunch at the centre, especially the children who get breakfast as well at the centre.

*I like fruit. I like the food. I like the fact that we laugh a lot when we are here. I like playing with the bicycle, and I like it when we sing.* (Boy, 9–12)

*What I like here is the way they cook the food. The food is nice.* (Boy, 9–12)

*In the morning I wake up, make the fire, warm the water, wash and put on uniform, and go to*

*school. I come here to eat porridge. I go to school. During break time, I play, and after school, I come here and eat and go home.* (Boy, 6–8)

*I like the food here. They cook it nicely. I like my friends. I like listening to music. I like netball.* (Girl, 9–12)

*When we get to Khanyiselani we eat, we get full. We have a snack or juice.* (A teenager)

In isolated cases, children who were not part of the centre would sneak in for the food. Although this practice was, of course, not encouraged because food is prepared according to the numbers registered at the centre, the centres did their best to care for these other vulnerable children. The fact that it happens shows how the centres have managed to feed the children with dignity.

“I like the fact that we laugh a lot when we are here.” (Boy, 9–12)

PHOTO BY MSH STAFF



## I Go on Outings and Picnics

Children mentioned food during outings and picnics as one of the things that they enjoyed:

*I enjoyed food and swimming when we went to East London. (Boy, 9–12)*

*Food was very nice. We had a braai [barbeque] at the beach. (Boy, 6–12)*

*Some days we just play and play at the centre. On some special days we are taken out, and we eat out at Nando's in town. (Girl, 6–10)*

*We went to a dam, we played games, we danced, they braaied for us and we had fun. (Girl, 11–12)*

It is not hard to see how the centres have tried to create a homey atmosphere around the outings. They have gone out of their way to make the picnics family outings, and the children have loved it. In some centres, children are taken out to restaurants.

## I Take Trips

Many children in poor environments do not travel far from their homes. In actual fact they have never been beyond their hometowns. They lack exposure. This does not happen just to vulnerable children; it happens to most people in these communities.

*We travel to places for games and trials. We are taken out to faraway places like Port Edward. It is like a treat being taken out to natural settings to think and talk about our troubles. We come back light, hopeful about our future and looking forward to living our lives. You cry when you want to cry; you pray when you want to pray. (Girl, 11–12)*

*In East London, we went to the Mhlobo Wenene [a radio station], to the museum, to the zoo, and to the beach. It was so much fun. We enjoyed it [besi onwabile—“with smiles on our faces”]. (Boy, 9–12)*

*We have outings. We braai. We dance. We have Christmas parties, and they buy us presents. (Girl, 6–10)*

*We feel free and happy at these outings. (Girl, 6–8)*

*Most of us went to East London for the first time and now we are going to Ebhayi [Port Elizabeth]. (Boy, 9–12)*

## I Enjoy Different, Fun Activities

Activities varied from sports activities to cultural activities. The centres seem to have filled a gap of organised activities in their communities. This component is quite important and has been found to be lacking nationally in all the municipalities and leads to many of the social problems experienced by youth and children in the communities. Children have neither play spaces nor well-maintained sports facilities in these communities.

*We do marjorettes here at school and at the centre. We have a beautiful uniform here at the centre; we perform in some of the dos in the township as a centre. I love it. (Girl, 11–12)*

*There are cultural activities, art activities, and all sorts of activities that start at four. Everyone is welcome. Many children love coming. (Boy, 11–12)*

*We have a park with swings, with abojingo... We play where it is safe. (Girl, 11–12)*

*Some days we eat, do hand work like sewing and crocheting. Only older children like us do these. I can put on back a seam on my uniform dress when it's undone. [says it proudly] (Girl, 11–12)*

## I Learn Important Life Skills

Some of the life skills topics that the children mentioned help to instil in them the values of Ubuntu, a philosophy that focuses on people's allegiances to and relationships with one another—values that some South Africans feel are disappearing with the disintegration of society. The centres seem to be central in restoring and reinforcing the role that



PHOTO COURTESY OF WINTERVELDT HIV/AIDS PROJECT

**“It is like in the centre we have our mothers even though we are orphans.”**  
 (Girl, 9–12)

the functional society and its institutions such as the church and units such as families should play in raising the children.

*We come here after school. We eat. We play. We are taught about HIV. Sometimes they wash our uniform on Saturdays. (Girl, 9–12)*

*They teach you things that you do not know. (Girl, 9–12)*

*There are older children who are taught to sew. They work with their hands, and they are taught many things. (Girl, 9–12)*

*I like the care centre because it teaches you about the things that you didn't know. They teach us that we should not sleep with boys before it is your time, and that those who are doing it should use a condom. (Girl, 9–12)*

*I like the care centre. They found most of us smoking on the streets. They took us in and took care of us. They taught us about drugs in our groups, and they sent us back to school. Now we eat here after school. It is like home. (Boy, 9–12)*

*At the centre, we are taught how we should behave, that we should obey adults when they talk to us. (Boy, 9–12)*

*I like it when they teach us about different drugs. I used to smoke glue and they taught us how it harms us. They showed us pictures of what different substances did to our different body parts. (Boy, 9–12)*

Loving one another was a life skill that children had said they had learned.

*We are taught that we should be peaceful with other children when we play. We should not fight with them, and we should not swear at them.*

*(Boy, 6–10)*

*We are taught to take care of the younger children who also come to Khanyiselani; for example, we should help them to cross the road safely when we go home. (Girl, 11–12)*

*We are also responsible for walking home with our younger siblings who are at the crèche after eating. (Girl, 6–10)*

## I Found a Place to Call Home

Many children who go to the centres feel as though they are home. For some children, the centres are the homes they never had and for some they are the homes that they once had and lost. It is clear from some children's comments that the centres provide for them much more than they could hope for in a home, and they appreciate that.

*Pink Huis [drop-in centre] is like your mother or father. They do for you all the things they do not do for you at home—they give you food and school things that you do not have, and you can come and talk to someone when you have a problem, and they help you. (Girl, 9–12)*

*I know what I go to Khanyiselani for. It is a home.... [T]here are people we can talk to about our problems. It is just an amazing place. I feel that when I grow up I want to contribute to an environment like that. I wasn't this big when I first came here. They brought me up. (A teenager)*

“There is always someone to talk to us at the centre. They listen to you, and they help.” (Girl, 9–12)

*It is like home because they give us stationery, they give us food, and they help us; now I am well. They first took care of me when my mother died.* (Girl, 9–12)

*It is like in the centre we have our mothers even though we are orphans. There is that love that we get from our caregivers, when we have problems we can talk to our caregivers.* (Girl, 9–12)

*It has been 8 years since I started eating at Khanyiselani, and I am still eating there now, because Khanyiselani is a place that I can call my home.* (Girl, 15)

*When I walk into the centre after school, I feel like I am walking into my home which is well built and beautiful.* (Girl, 11–12)

## I Have Someone to Talk to

Many children in general find it difficult to talk to an adult about their problems. Children in the centres felt protected and listened to. This feeling gives the children the message that they are valued and that they are important.

*There is always someone to talk to at the centre. They listen to you, and they help.* (Girl, 9–12)

*When you do not feel right—when there is something bothering you at home, when they do not treat you well—you come and talk to a social worker about it here at the centre.* (Girl, 11–12)

*When you have a problem at home, they solve it for you, they talk to the person who bothers you at home.* (Boy, 6–10)

*When you have a problem of children who bother you here at school, you can tell them at Khanyiselani, and someone will come to talk about your problem here at school.* (Girl, 11–12)

## I Have the Company of Other Children from My Community

Children have formed their own network of support with other children. At the centres, they feel like other children, and they can relax and laugh about things.

*I like being with other children.* (Boy, 6–8)

*When we are here at Inkwanca, we are like apples—like other children—because they make me laugh. [I like] playing soccer with other teams, riding a bicycle, and [going to] school.* (Boy, 6–8)

## My Health Is Important Here

Most centres have clinic records of their children. They also follow up on children's health, send them for screening, and keep their medical histories. They make sure that children have access to medical treatment when they need it. This attention makes children feel special and cared for. The centres are more organised than some parents in this regard.

*Before we came to the centre, we sometimes (most of the time) did not eat in the morning before we came to school. After school you would find that you eat only pap, and at school, we would eat starch only with gravy. Now that we are in the centre, we eat nutritious, balanced food, and we no longer get sick.* (Girl, 6–10)

*I used to have stomach aches. I was thin.* (Girl, 11–12)

*We used to have sores on our body. Now they are gone.* (Boy, 6–10)

*Sometimes I used to sleep in class. I don't anymore. It was hunger. (Girl, 11-12)*

*I also want to thank Khanyiselani because I am always well since I started in Khanyiselani. I used to be sickly. (Girl, 11-12)*

*Since I joined the centre, I am well. At first I used to be sickly, and I slept in hospital a lot. When I was in hospital, they made sure I had nutritious food with nutrients like proteins and vitamins, and they brought me fresh food. (Girl, 11-12)*

When we are sick—

*When you are sick, your parent or guardian has to report here at Khanyiselani that you are in hospital or so that they take you to hospital. Then people here at Khanyiselani go and see you in the hospital and they bring you healthy food that you should eat—food that is safe; food that builds your body. (Boy, 6-10)*

*I was once in hospital after I had an accident and my grandmother came to report here at the centre. I slept there for a day, but they came on the first day to see me, and they brought me food and snacks (peanuts and raisins). (Girl, 11-12)*

## Everyone Who Is Vulnerable Is Welcome at the Centre

The fact that not only children and people who are sick and vulnerable are helped has probably helped to prevent the centres from being labelled negatively. Everyone seemed to benefit from the centres in some way or the other:

*What I like about this place is that they do not only take care of children who do not have parents, they also help children who are needy, who stay on their own. (Girl, 9-12)*

*There are children who are not taken care of at home and who live here at the centre. For some they do not have parents and some have parents but they do not care for them. (Boy 9-12)*

“There are children who are not taken care of at home and who live here at the centre. For some they do not have parents and some have parents but they do not care for them.” (Boy, 9-12)

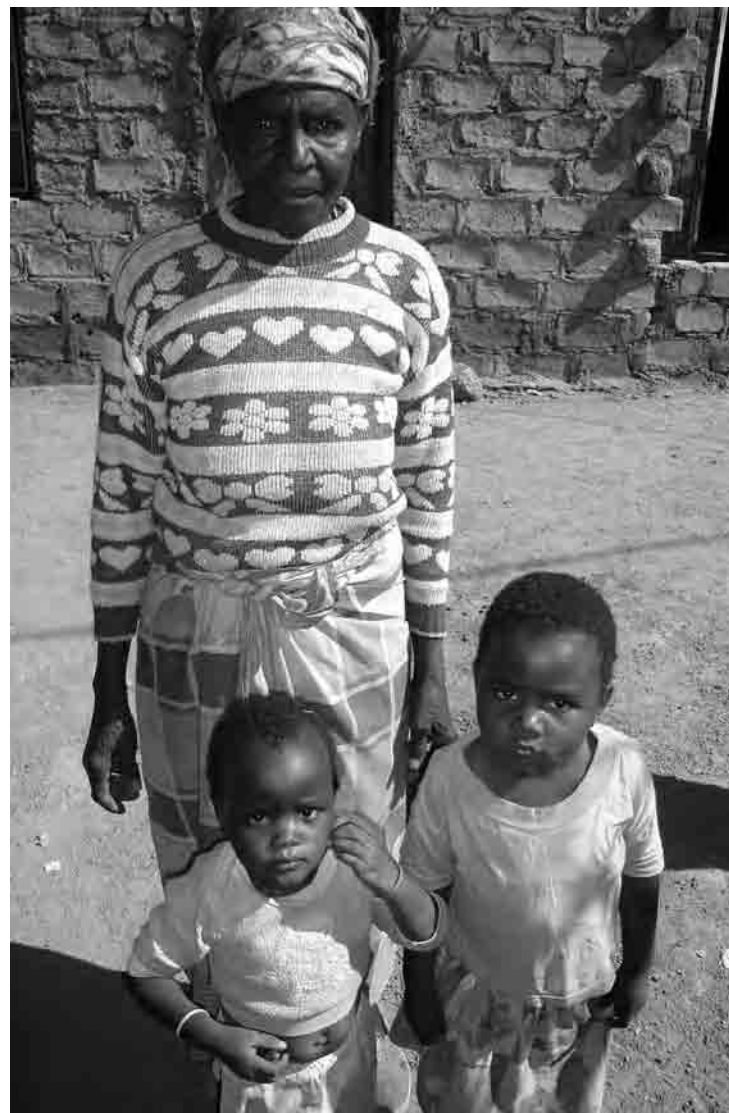


PHOTO BY MSH STAFF

Some people who are poor and some who are sick get groceries here. (Boy, 6–8)

If she [a girl represented by the silhouette figure] comes to the Care Centre, she will be cared for by the women at the Care Centre. They will talk to her, and they will protect her from being a street kid. (Boy, 9–12)

## I Am Cared For and Protected

Centres provide a haven for children who may have no other refuge.

I feel like there is someone who knows you and cares. When you come to the centre, they want to know everything about you—they want to know who you are staying with and what are your problems so that they can help you. They can talk on your behalf. (Girl, 11–12)

It has kept us safe [Isilondolozile]. It has protected us by taking care of us at our homes and at school. (Boy, 6–10)

She [a girl represented by the silhouette figure] will feel better and she will get help [from the centre] and will realize she is not alone. (Girl, 9–12)

I used to worry about myself. Now I don't—boAuntie [aunties] at Khanyiselani help us when we have a problem. They help by listening, and if you need something they make sure that they get it for you. (Girl, 6–10)

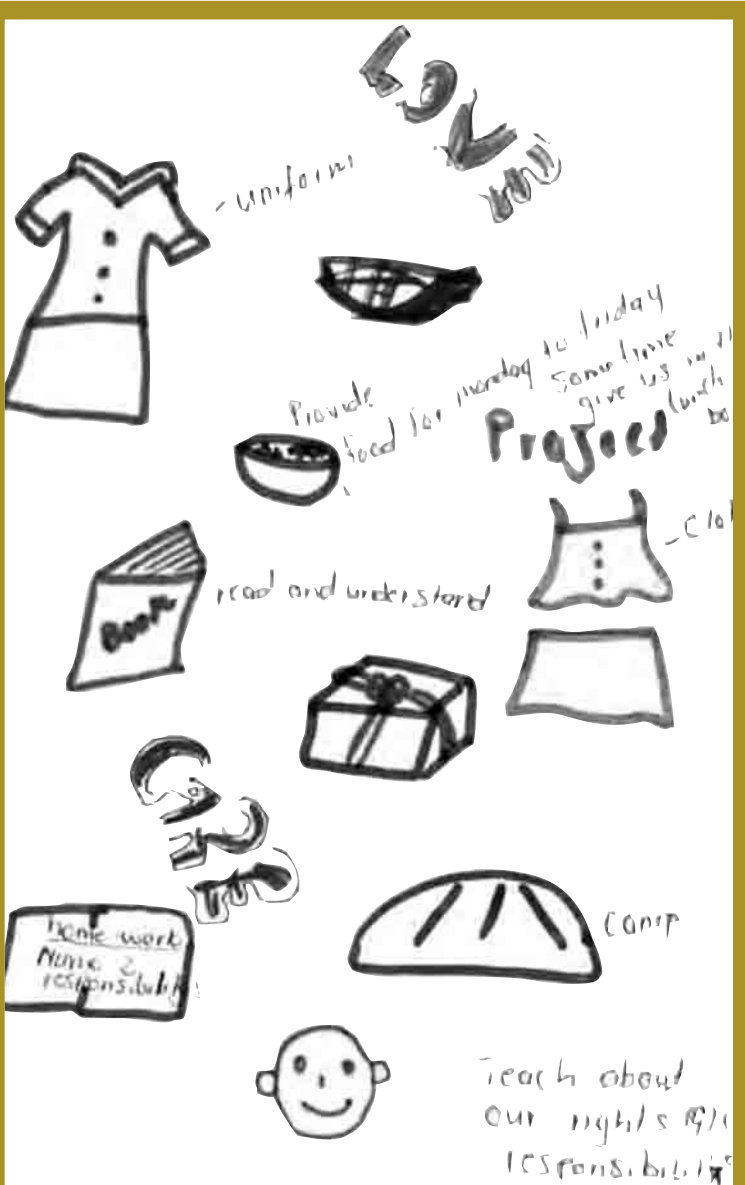
## I Feel Good about Myself

The centres affirm the children. They boost their confidence.

I feel good about myself because of what the centre helps me with. I feel like other children. I used to feel bad about my situation at home. (Boy, 6–10)

Since I have been at Khanyiselani, I feel free. I feel much better. (Girl, 6–10)

I am right now. I used to feel worried and I got help. (Boy, 6–10)



“I feel like there is someone who knows you and cares.” (Girl, 11–12)

# THE ORGANISATIONS & THE CENTRES

## Masakhane Women's Organisation

Masakhane Women's Organisation (MWO), a community-based initiative that was established in 2003, is located in Hlokozi village, a rural area situated in High Flats, in the Sisonke District of KwaZulu Natal Province. The project is under the Ubuhlebezwe local municipality in the subdistrict of Ixopo. The municipality has a total population of 122,860 people and a high unemployment rate: 82 percent. The major economic activity is sugar cane farming and forestry, but estimates indicate that 83 percent of the households have no monthly income. Projected estimates show that 20 percent of the population is HIV positive.

Masakhane Women's Organisation has a staff of 25 consisting of a project manager, a project administrator, 18 caregivers, and 3 professional nurses. In addition to the funding from IPHC, the Masakhane Women's Organisation also receives funding from the South African Department of Health.

The organisation supports 367 OVC, the majority of whom (53 percent) are male (Table 1). These are some of the activities being undertaken by Masakhane Women's Organisation to support OVC:

- Supporting an early learning centre for 28 OVC
- Facilitating access to health care through a mobile clinic once a month
- Assisting OVC to obtain identity documents and birth certificates
- Providing counselling services and protection to abused and neglected OVC

**Table 1. A Summary of Services Provided to OVC by MWO**

MASAKHANE WOMEN'S ORGANISATION	MALE	FEMALE	TOTAL
Clinical nutrition interventions	5	5	10
Food and/or food parcels	190	170	360
Shelter interventions	2	0	2
Child protection interventions	192	167	359
General health care services	59	50	109
Health care support specifically for antiretrovirals (ARVs)	61	50	111
HIV prevention education or interventions	59	52	111
Psychosocial care	0	1	1
General education	60	51	111
Vocational training	1	0	1
Economic opportunity or economic strengthening	1	1	2
<b>Total number of OVC supported at MWO</b>	<b>195</b>	<b>172</b>	<b>367</b>

**Note:** Each orphan or vulnerable child may receive several services. **Source:** IPHC Semi-Annual Report (2008)



**Table 2. A Summary of Services Provided to OVC by HBC**

<b>INKWANCA HOME-BASED CARE (HBC)</b>	<b>MALE</b>	<b>FEMALE</b>	<b>TOTAL</b>
Clinical nutrition interventions	133	107	240
Food and/or food parcels	25	36	61
Shelter interventions	17	23	40
Child protection interventions	113	85	198
General health care services	254	123	377
Health care support specifically for antiretrovirals (ARVs)	13	15	28
HIV prevention education or interventions	105	127	232
Psychosocial care	295	186	481
General education	272	169	441
Vocational training	104	71	175
Economic opportunity or economic strengthening	56	39	95
<b>Total number of OVC supported at HBC</b>	<b>290</b>	<b>187</b>	<b>477</b>

**Note:** Each orphan or vulnerable child may receive several services. **Source:** *IPHC Semi-Annual Report (2008)*

- Providing care and support for HIV-positive OVC at the drop-in centre
- Networking with government departments in addressing the needs of OVC
- Conducting awareness campaigns to advocate for child protection needs
- Identifying clinically malnourished OVC and referring them to clinics or hospitals for treatment
- Leveraging access to food support from other donors to provide food parcels to the OVC and their families and meals to OVC at the drop-in centre
- Supporting OVC to obtain temporary shelter in cases of abuse
- Providing adolescent OVC with life skills and prevention messages in partnership with Love Life
- Leveraging of cost-avoidance programmes for OVC school fees and facilitating access to school uniforms for OVC
- Facilitating access to social grants for OVC caregivers
- Conducting awareness campaigns to advocate for child protection and needs

## Inkwanca Home-Based Care

Established in 2001, Inkwanca HBC operates in Chris Hani District of Eastern Cape Province. Inkwanca local municipality has a small population of 14,000 people, of whom 5,000 are children. The aim of the Inkwanca HBC is to provide holistic, community-based care to vulnerable children, their families, and the larger community in the town of Molteno. Inkwanca HBC also hopes to establish a second community centre in the nearby town of Sterkstroom.

Currently, Inkwanca HBC supports 477 OVC, the majority of whom (61 percent) are male (Table 2). The activities undertaken by Inkwanca HBC in supporting the OVC include:

The project has 12 caregivers, including the project manager and coordinator, to look after the children.

MS. SOPHIE MANXALA

## The Inkwanca Director Speaks

While I was working at the hospital I realized that everybody was sent to the hospital for different problems—even for the ones where the hospital couldn't help. I felt that some people suffered just because of social problems, and they did not need hospitalization but just counselling. Some of the problems were because of communicable diseases like diarrhoea and many other diseases that could be prevented. Hunger [malnutrition] was the main issue for children.

We started as a soup kitchen—cooking soup from a small room, and I went around the community asking for spoons, plates, and whatever people could give me to feed the vulnerable children and also the orphans. Fortunately, the community of Molteno responded, giving us clothes as well. A group of ladies from different churches started taking interest, and they ended up giving us food every Friday to cook for the children. I could then afford to feed continuously.

We realized that a lot of street children were eating from the dustbins. I then initiated this as a multipurpose centre, to address other social problems like alcoholism and HIV & AIDS, and to help everyone who was needy in Molteno. I recruited the volunteers to visit the people and find out more about what was wrong within this community.

### IN-HOUSE SERVICES

Now we are fortunate to get funding from different donors like the Department of Health, Social Development, the European Union, and MSH-USAID that have enabled us to render our services more efficiently.

### THE DAY CARE CENTRE

This centre started after we went door-to-door and found that some of the orphans were left with sick old ladies and so were not growing up in a normal healthy environment—and the old ladies were struggling with them. Some of the children were left with alcoholic foster parents. So we thought the day care centre would be the best way to protect the children and to take care of them. We took the children in, observed them, and referred them to different institutions for different assessments. We now have children from ages 2 to 5 years. They come in the morning until 13:00. Some are HIV positive and on treatment. Because of this, the diet is very healthy and takes into consideration their specific needs. We have a well-equipped playground for them and experienced early-childhood development practitioners.

### LUNCH AND TRANSPORT ARE FREE

The parents do not pay anything toward the centre. Children get all their meals here, and they have free transport that fetches them from home to school and back again.

### ACTIVITIES FOR SCHOOL-AGE CHILDREN AND AN ONGOING LIFE SKILLS PROGRAMME

Schoolgoing children come to the centre every day after school for their lunch. They have activities in the afternoons, and there are life skills programmes that are offered on an ongoing basis.

### HOMEWORK

Children get support with their homework and projects here at the centre.



PHOTO COURTESY OF WINTERVELDT HIV/AIDS PROJECT

## OUTREACH PROGRAMMES

We went from strength to strength, and we reached out to the community by providing the following additional services.

### MEALS ON WHEELS

In this project, we take meals to the community. We cook for them, and a group of volunteers offered their cars to deliver the meals in the homes of vulnerable people on Mondays, Wednesdays, and Fridays.

### EDUCATION FOR CAREGIVERS OF CHILDREN AND SICK PEOPLE

We go out to the community to train caregivers on how to take care of people who are sick and vulnerable. We also recruited volunteers and taught them the same skills and further skills on how to identify people and children who are needy in the community up until they accepted and owned the project.

### LIFE SKILLS PROGRAMME

This programme has been extended to local schools. So we do not only reach children who come to the centre, we also reach other children as well.

### RELATIONSHIP WITH MSH

MSH started supporting us in 2006 regarding the OVC. They fund us [through USAID], and they started with R300,000, and in 2007 they increased it to R350,000 because of the other branch at Sterkstroom where we have extended our services. They give us this money in tranches; we first give them a quarterly report, and they give us the tranche. We use the money and write them a report. One of the reasons that we have been chosen for the MSH funding is that we do care and provide support for the OVC. ♦



KDT is currently providing support to 1,594 orphans and vulnerable children.

## Khanyiselani Development Trust

Established in 2001, the Khanyiselani Development Trust (KDT) operates in the Sisonke District of KwaZulu Natal Province. Its aim is to provide holistic, community-based care to vulnerable children, their families, and their communities in the greater Kokstad local municipality. Kokstad has a population of more than 46,000 people, and approximately 9,000 are children.

In 2002, the National Peace Accord Trust (NPAT) established a formal partnership with KDT to build the capacity of the organisation and help it to expand into surrounding areas. NPAT has experience in trauma counselling, so the partnership has enabled KDT to offer counselling services to OVC traumatized by abuse or bereavement.

Since 2002, the main activities of NPAT have related to capacity-building of KDT and provision of support services. The executive director of NPAT,

who is based in the organisation's Gauteng headquarters, visits KDT approximately once a month. NPAT has satellite offices in Margate and Kokstad in KwaZulu Natal—hence the easy access to Khanyiselani. NPAT has also helped Khanyiselani to develop into a National Integrated Programme. The support of NPAT to KDT includes provision of salaries to six KDT staff members.

KDT is currently providing support to 1,594 OVC, the majority of whom (59 percent) are female (Table 3). These are some of the activities undertaken by KDT:

- Helping OVC obtain ART
- Leveraging access to food support to provide meals to OVC at drop-in centres
- Supporting OVC through vocational training in beadwork, sewing, and painting
- Providing OVC with psychosocial care through performance arts, including dance, poetry, and music

The partnership with NPAT has enhanced the performance of KDT in management of its financial resources. NPAT provides financial oversight of all KDT expenditures for its OVC activities, including a monthly review of all expenditures and accounting through receipts.

e urani siyadla ekuseni nantqmbama  
 siqashelwe izimbo siyodlak  
 eya bhalala sihlakule  
 Sinikwa umfanekiso wesikole  
 Shikwa ukwala okwemaphakethei  
 Sibona umehluko omkhulu  
 Siyasina siqashelwe izimbo  
 sihamba  
 Sinikwa izimbo zokudlala  
 Akufani nasokhaya  
 Sibona umehluko omkhulu  
 uyasi biza kakhulu sesingco  
 kunalokhu kakhulu

“We have seen children who were shy, who were not confident, and who couldn’t open up being transformed... they are now confident, and they talk more.”

**Table 3. A Summary of Services Provided to OVC by KDT**

<b>KHANYISELANI DEVELOPMENT TRUST</b>	<b>MALE</b>	<b>FEMALE</b>	<b>TOTAL</b>
Clinical nutrition interventions	32	33	65
Food and/or food parcels	290	357	647
Shelter interventions	0	0	0
Child protection interventions	308	340	648
General health care services	263	238	501
Health care support specifically for antiretrovirals (ARVs)	107	139	246
HIV prevention education or interventions	307	341	648
Psychosocial care	215	231	446
General education	264	275	539
Vocational training	200	228	428
Economic opportunity or economic strengthening	0	0	0
<b>Total number of OVC supported at KDT</b>	<b>647</b>	<b>947</b>	<b>1,594</b>

Note: Each orphan or vulnerable child may receive several services. Source: IPHC Semi-Annual Report (2008)

MS. THEODORA NONDUMISO  
MAKALIMA

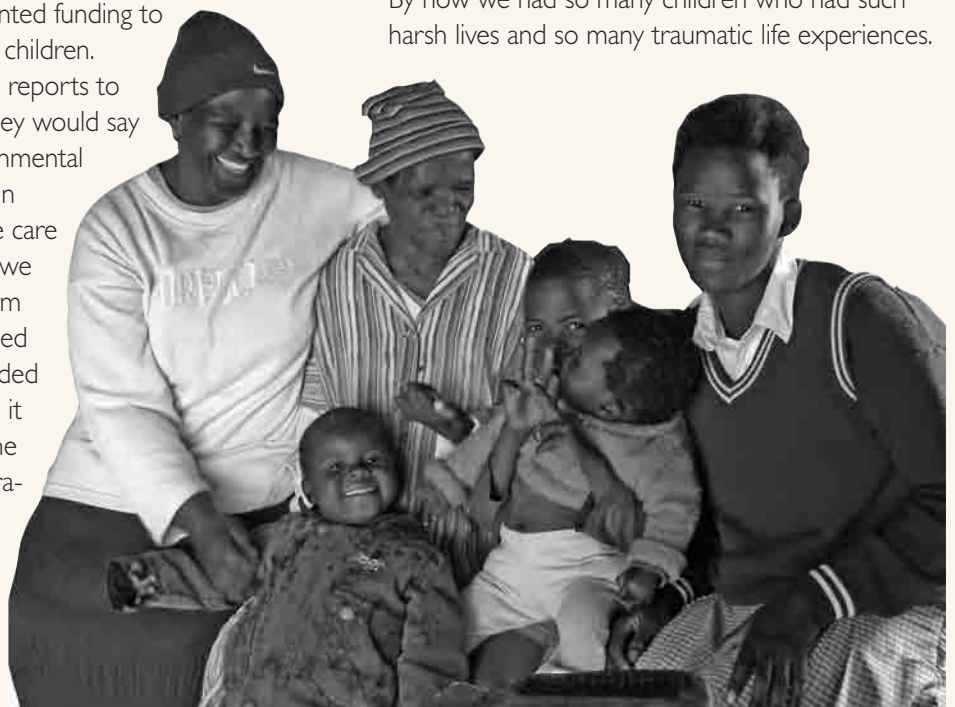
## The Director Describes the KDT Project

We started as a small project in church. We gathered children who were eating from the dumpsite and gave them food. We asked members of the church to donate food for cooking and second hand clothing for the children. We invited the children to church on Sundays, and they would be beautiful and clean. We went to town and asked for food donations, and some would donate things such as soup, and we cooked for the children.

Then came 2000, I decided to take early retirement because I started having a passion to work with these children. I was working at the district office, and all of a sudden I was inundated with calls from people who wanted funding to work with vulnerable children.

When we took these reports to the provincial level, they would say if we had a nongovernmental organisation (NGO) in Kokstad, it would take care of such things. When we advised people to form NGOs, they abandoned their ideas until I decided to leave work and do it myself. We collated the statistics of the vulnerable children.

After some time, I saw an advertisement in the newspaper about the government's National Integrated Programme for vulnerable children, for which they were inviting NGOs to apply. I applied, and we were selected as a pilot site for the project. We had nowhere to work from. As you know, the government does not fund churches. We had to look for a place as a result, but then in the meantime, we were allowed to utilize the church as our site, as it had space. But we had to be clear that we were not a church organisation. We applied to the municipality to give us a space. The Department of Health offered us a park home that had offices and a kitchen, and that is the one that is right there and works as a crèche now. Then we found this house, and the municipality renovated it for us. There was now growth and development in the organisation. By now we had so many children who had such harsh lives and so many traumatic life experiences.



We partnered with a number of groups:

### NATIONAL PEACE ACCORD TRUST

Through this partnership, we were now able to have a holistic intervention. We initially had the health, welfare, and education interventions, but the component of psychosocial support was lacking, and the partnership with NPAT helped in that regard. Its main mission is around trauma intervention strategies; therefore, it gave a huge boost to emotional wellness as part of our intervention.

Our caregivers were exposed to trauma management, which enabled them to deal with their own traumas before they could deal with the children's traumas. They were also exposed to skills in ecotherapy, which is a trauma intervention strategy. We now have ecotherapy facilitators who have been trained by the NPAT. It is a very powerful tool in addressing the traumas of the participants. It is such an eye opener, and it is unbelievable to listen to small children—10- and 11-year-olds—sharing their experiences about the ecotherapy and their lives.

### DEPARTMENT OF WELFARE

The Department of Social Welfare and Development identified us as a site that could benefit from an Association for National Youth and Caregivers. Our field workers could be trained and accredited for child and youth work. This training would enable them to deal with issues that emanate from dealing with OVC.

### ART TEACHERS, WHO USE ART AS A FORM OF THERAPY

Two art teachers from the local schools offered to volunteer their services to us after school. Art has really taken shape, and it has really helped our children. It has always been our dream to have art at the centre, but we did not know where to start. The impact on the children has been unbelievable.

We have seen children who were shy, who were not confident, and who couldn't open up being transformed when they perform—they are now confident, and they talk more. They are assertive. It has boosted their morale. Both the performance arts (drama, music, poetry, and dance) and the visual arts (sewing, drawing) are used. They have been exposed to workshops in art, and now we have networked with people at the provincial level on arts.

### NFSAS

In 2005 I saw an NFSAS [National Education Financial Scheme for South African Students] advertisement in a newspaper inviting NGOs to a meeting in Durban. They said when they made their survey on the beneficiaries of their services, they found that it was vulnerable children from the cities who benefited more from them and not children from the outskirts like us. They were looking at ways of working closer with people from the small and marginalized communities. This presented us with a real opportunity, so we applied as Khanyiselani to partner with them. They accepted us. Because of this partnership, we are now able to refer students who are vulnerable to the nearest tertiary institutions. We have seven of our beneficiaries in tertiary at different levels—three at third year, two at second year, and two at first year. We have since realized (now that we can interact with government departments) that they have bursaries, so this year we have two children who are doing degrees in agriculture, and they are now sponsored by the Department of Agriculture in KwaZulu Natal.

One of our success stories is a girl who graduated on April 21, 2008, with a social sciences degree. We sent her for her first-year studies with a donation that we received from Standard Bank; that was before we had NFSAS. She is now doing her honours. ♦

## Centre Staff Discuss MSH Support

Researchers also talked to the staff about their experiences of working with OVC. For many, the experience of watching children transform as a result of their intervention was a key factor in why they are committed to the work they do.

*The work gives pleasure because you can actually see the children you have identified getting help. Some get food here in the mornings, some get food parcels to cook at home, and some get uniforms from the centre. Through helping them, you feel you are making a difference. You see them become children again.*

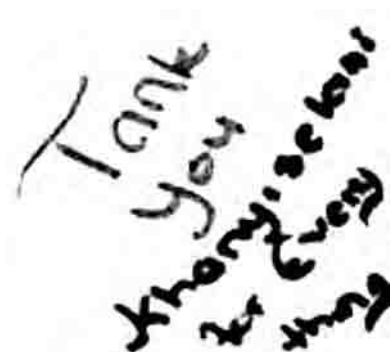
*As volunteers, we are paid by PEPFAR. The stipend that we get makes a big difference in my life. I am being paid to help my community, and I am also being taught by attending workshops. I am grateful.*

*MSH bought the children soccer jerseys.... Everyone in the villages cannot close their mouths about it. They look like professional players when they go to play. They are the envy of the village. (Note: This reduces stigma and enhances the children's self-esteem.)*

*When it comes to children's things, PEPFAR does not laugh. They support us, they make sure that the children are catered to. Look at the playground things for the preschool children. We are not found wanting in that division. They provide.*

*PEPFAR helps us a lot in providing for the children. It helps us a lot on travel (petrol and logistics), stationery for the children... general education, play equipment for the early-childhood development centre.*

*HIV education and issues of child protection are important—like if a child has been raped, we can start by reporting to the Induna [traditional leader], then the police. They pay stipends for 10 HBC people, training.*



“Through helping them, you feel you are making a difference. You see them become children again.”

*Their funding is not for food, but when they came, they saw that we had a day care centre and that we did not have food for the centre; they said we can buy meat. So because of the day care centre, we do buy food because some of the children are infected.*

*The big thing is that they are one of the funding organisations that you can access food as well, which the other funding organisations do not allow—they do it only with specific occasions. With MSH, you can access the groceries and that sort of thing to feed the children. It is purely used to feed the children. It is for the day care and the after care. That has helped a lot.*

*I found people from MSH who have been here a great help. Talking to them puts into perspective what your actual job is. Speaking to project staff when they came down here almost told me what my job was. That was great support. I think they are fantastic. They keep systems—you are able to keep track. It helps—you know administration offices are not usually the best, but because of their intervention I can find you anything, anytime, I promise you.*



# CONCLUSION

**M**uch recent thinking around the best approach to helping vulnerable children has focused on the theory of resilience. The work of Julia Bala (1996) is an example of this theory. Bala identifies four levels at which resilience can be built in children:

## REDUCING STRESSORS

- Reducing the impact of present stressors
- Unloading accumulated problems
- Assisting in making peace with the past
- Minimizing anticipated stress that could interfere with daily life

## STRENGTHENING AND SUPPORTING THE USE OF EXISTING PROTECTIVE FACTORS

- Within the child
- Within the family
- Within the wider social environment (e.g., friends and neighbours)

## BROADENING COPING ALTERNATIVES

- Facilitating the use of existing coping strategies
- Providing assistance in seeking new coping skills (including, for example, training, life skills, and beliefs)

## STRENGTHENING AND OPENING FUTURE PERSPECTIVES

- Supporting the search for future possibilities and visions

A complete impact study developed around specific indicators would be required to measure the extent to which these factors are present in the lives of the children who attend the MSH-supported centres. It is possible, however, to look at the quotations collected from the children in this report and see how the centres are building resilience in children.

It is clear that the drop-in centres play an important role in the children's lives. They obviously provide help at a physical level—children receive food and help with school needs. What stands out from what the children say, however, is the extent to which this meeting of physical needs has an impact on their psychosocial well-being. Clearly reflected in their comments is the fact that meeting their physical needs reduces their emotional stress (present stressors) and minimizes anticipated stress. Furthermore, this provision of physical needs also works to build protective factors within the individual child. Having everyday needs met creates a sense of self-worth and locus of control—both important components of resilience.

Additionally, the centres also make a big contribution to children's psychosocial well-being through the social interaction that the staff at the centres have with children—the outings, the help with homework—and the contact with other children in similar circumstances. Children feel loved when they go to the centres. This feeling of acceptance reduces emotional stress and helps children deal with grief to some extent too (i.e., to unload accumulated problems). Additionally, the comments indicate that the centre staff and other children, in some cases, become an alternative family, providing the protective role that family would play for children. The children also talk about how they have learned new skills and problem-solving strategies (e.g., learning about rights) through the life skills education they receive.

Again, a more comprehensive study would be needed to confirm this assertion, but this preliminary work suggests that the drop-in centre model is an effective way of reaching vulnerable children. ♦



**Bala, J. 1996.** Strengthening the Protective Umbrella: The Refugee Child and the Family. *Proceedings of the Congress on Children, War and Persecution – Rebuilding Hope*. Maputo 1–4 Dec.

**Integrated Primary Health Care Project, 2008.** *Semi-Annual Report to USAID*. Pretoria, South Africa.

**Khulisa Management Services. 2008.** *Case Studies of PEPFAR Funded OVC Program in South Africa*.

☺ Many foster  
☺ happy

## Organisations Supported by the IPHC Project

PROVINCE	DISTRICT	NAME OF HBC ORGANISATION	LOCAL PROJECT AREA
<b>Eastern Cape</b>	Chris Hani	Inkwanca HBC Ikhwezi Lomso Child and Family Welfare House of Hope Hospice Ncedisizwe HBC	Molteno Ngcobo Indwe Whittlesea
	Alfred Nzo	Bonukahnyo Youth Organisation	Mount Ayliff
<b>KwaZulu Natal</b>	uThungulu	Sibambisene Organisation Inkosingathi HIV/AIDS Project	Emgangezi Empangezi
	Sisonke	Masakhane Women's Organisation Khanyiselani Development Trust	High Flats Kokstad
<b>Limpopo</b>	Capricorn	Makotse Women's Club Direlang Project	Lebowakgomo Lenting Village
	Sekhukhune	Makhuduthamaga HBC Lafata HBC Mohlarekoma HBC	Jane Furse Boleu Nebo
<b>Mpumalanga</b>	Gert Sibande	Zimeleni HBC Thuthukani HBC Sizanani HBC Luncedo Lwesizwe HBC	Sheepmoor Leandra Wesselton Ferne
<b>North West</b>	Bojanala	Thibela Bolwetse Project Botho Jwa Rona HBC Pholo Modi Wa Sechaba HBC Winterveldt HIV/AIDS Project Progressive AIDS Project	Hebron Mabeskraal Mogwase Winterveldt Mabopane

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NATIONAL DEPARTMENT OF  
HEALTH OF SOUTH AFRICA



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FROM THE AMERICAN PEOPLE



SOUTH AFRICANS AND AMERICANS  
IN PARTNERSHIP TO FIGHT HIV/AIDS

**MSH** MANAGEMENT SCIENCES *for* HEALTH

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