A situational analysis of orphans and vulnerable children in four districts of South Africa

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Edited by Donald Skinner & Alicia Davids

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ACRONYMS AND ABBREVIATIONS

AIDS	acquired immunodeficiency syndrome
BPDM	Bojananla Platinum District
CBO	community based organisation
CBD	central business district
DA	Democratic Alliance
DoA	Department of Agriculture
DoE	Department of Education
DoH	Department of Health
DSD	Department of Social Development
DOTS	directly observed treatment; short course
ECD	early childhood development
FBO	faith based organisation
GGP	gross geographical product
HIV	human immunodeficiency virus
IDP	integrated development plan
IEC	information, education and communication
KOSH	District of Klerksdorp, Orkney, Stilfontein and Hartebeesfontein
NAPWHA	National Association of People Living with HIV/AIDS
NGO	non-governmental organisation
NGK	Dutch Reform Church
NMCF	Nelson Mandela Children's Fund
NPO	not-for-profit organisation
OVC	orphaned and vulnerable children
OVV	Oranje Vroue Vereeniging
PLWHA	people living with HIV/AIDS
PMTCT	prevention of mother-to-child transmission
PSNP	primary school nutrition programme
RDP	reconstruction and development plan
RLM	Rustenburg Local Municipality
SADC	Southern African Development Community
SAPS	South African Police Services
STI	sexually transmitted infections
TLC	transitional local council
VCT	voluntary counselling and testing

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EXECUTIVE SUMMARY

In 2002 the Human Sciences Research Council (HSRC) received funds from the Kellogg Foundation to undertake interventions and research on orphaned and vulnerable children (OVC) in three countries in southern Africa; South Africa, Botswana and Zimbabwe. The project aims to contribute towards improvement of the conditions of orphaned and vulnerable children (OVC) in these countries.

In South Africa, the HSRC partnered with the Nelson Mandela Children's Fund (NMCF) to undertake the project. We are currently working in two provinces identified as having a great need for such interventions. The project has several stages. This report is limited to the first stage and is a situation analysis.

The situation analysis was conducted in the Free State province in the Matjhabeng Municipality under the Lejweleputswa District and in the Kopanong Municipality under the Xhariep District. In the North West province it was undertaken in the City Council of Klerksdorp under the Southern District and in the Rustenberg Municipality under the Bokome-Bothlaba District. The situation analysis was conducted in these districts to gain information about services offered to OVC by government and non-government organisations (NGOs) and the situation of OVC in general, to identify strengths and weaknesses of these services and to suggest possible ways of improving them.

The objectives of the study are to improve the social conditions, health, development, and quality of life of vulnerable children and orphans; to support families and households coping with an increased burden of care for affected and vulnerable children; to strengthen community-based support systems as an indirect means of assisting vulnerable children and lastly, to build capacity in community-based systems for sustaining care and support to vulnerable children and households over the long term.

The methodology combined various qualitative approaches, such as, in-depth interviews, informal conversations and observations. Information for the situation analysis was collected from government departments, NGOs/community-based organisations (CBOs), and community leaders. All interviews were tape-recorded and later transcribed and analysed using a thematic analysis.

The following information provides a brief description of the towns in which the situation analysis was conducted and which will later be elaborated on in this report.

Welkom and Virginia in the Matjhabeng Municipality, Lejweleputswa District in the Free State

Both Welkom and Virginia are part of the Matjhabeng Local Municipality, which in turn forms part of the Lejweleputswa District. Virginia is about 25 kilometres from Welkom. The road between the two towns is well constructed, so it is easy to move between them. The dominant culture and language is seSesotho, which is spoken by almost 70% of the population, followed by Afrikaans and isiXhosa. Many people who speak isiXhosa are believed to be migrant mine workers from the Eastern Cape, which shares a border with the Free State.

Kopanong municipality, Free State

The Kopanong Municipality, where this study took place, falls under Xhariep District Municipality in the Free State province. There are 17 towns in Xhariep, nine under

Kopanong, five under Letsemeng and three under Mohokare. Kopanong is the largest of the three municipalities, covering an area of 15 190.54 km^2, with 41% of the district population residing there. Although it covers the largest area (34 131.55 km^2), Xhariep district has the smallest population in Free State (approximately 135 000), which makes it the most sparsely populated district in the province (Reviewed IDP 2003). The other two local municipalities that fall under Xhariep are Letsemeng and Mohokare. There are 17 towns in Xhariep, nine under Kopanong, five under Letsemeng and three under Mohokare. Kopanong is the largest of the three municipalities, covering an area of 15 190.54 km^2, with 41% of the district population residing there.

Kanana and Umuzimuhle townships in Orkney, North West province

The City Council of Klerksdorp is located in the North West Province. The City Council of Klerksdorp is part of the Southern District Municipality. The district municipality is situated on the south-eastern border of the North West province. One of the biggest industries in the City Council of Klerksdorp is mining. The municipality includes all 11 language groups in South Africa. The Setswana (36%) and seSotho-speaking people (21%) constitute the biggest language groups, with Afrikaans (19%) and isiXhosa (17%) following (Statistics South Africa, 2001).

Rustenburg local municipality (RLM)

The RLM is one of five local municipalities that form the Bojanala Platinum District Municipality (BPDM) in the North West province. The Bojanala District Municipality is a District Council in the northern part of North West province. Including the RLM, BPDM comprises of five local municipalities and one district Management Area:

- Meretele Local Municipality
- Madibeng Local Municipality
- Kgetleng River Local Municipality
- Moses Kotane Local Municipality
- Pilanesberg District Management Area.

There are approximately 300 towns and villages in BPDM and the largest towns are Brits and Rustenburg, which serve as the primary activity nodes (centres of job opportunities, economic activity and services). Although mining activities have been increasing in the district, its economy has become diversified, while at the same time declining.

The results revealed many gaps in the services for OVC in these municipalities. Common issues and problems extracted from each municipality emphasised that there is a desperate need for the provision for food, shelter, clothing, educational attire and consistent care, not only from guardians with whom OVC are placed, but from the entire community as well. Therefore it was stressed that there is a need for a culture of care within these communities to address stigmatisation and discrimination of OVC, as well as bereavement counselling for OVC who have lost one or both parents.

A main concern expressed by guardians of OVC in the various municipalities was the lack of access to grants, as it was said that even when applying for these grants it would be a tedious process often with few results.

For NGOs/CBOs/faith based organisations (FBOs), even though they do provide essential services and interventions to communities in need, the increase in OVC has created a

huge demand on service delivery. The problems NGOs/CBOs/FBOs experienced were expressed as:

- Shortage of staff and the lack of skilled staff members.
- Coordination and communication between various NGOs in some communities are non-existent, which results in the duplication of services, which in itself poses more problems.
- Transportation, especially when having to travel vast distances, becomes another serious obstacle, as many of the NGOs are not equipped with vehicles and because of the poor road infrastructure, maintaining vehicles becomes costly.
- NGOs need community participation in order to deliver services effectively. Although in some communities this does occur, in most of the communities the responsibility is shifted to the NGOs with little community participation in interventions.

As for government departments such as the Department of Health (DoH), Department of Education (DoE) and Department of Social Development (DSD), which all provide critical services needed by communities, they expressed the following problems and concerns:

- Lack of staffing affects the quality of services provided. For example, social workers are unable to give attention to emotional aspects of their clients and could only provide material support.
- Recipients of government finance are not properly trained in matters related to management of businesses and as a result are unable to sustain themselves.

As a result of the problems and concerns experienced by OVC, carers, NGOs/CBOs/FBOs and government departments, it is recommended that these agencies need to take on a more active role in addressing the issues affecting OVC. A holistic approach needs to be included when addressing the health, nutrition, psychological, educational and economic needs of children and families who care for them. Communication between all NGOs/CBOs/FBOs and government departments needs to be developed and secured, so as to eliminate issues of overlapping services delivered within these communities. Lastly, the community needs to be involved and provided with the relevant knowledge and skills to assist these agencies in delivering effective services to OVC and families that are in desperate need.

The Matjhabeng, Kopanong and Rustenburg municipalities, as well as the Kanana and Umuzimuhle townships in Orkney, are areas identified for services envisaged by the project, since such services are urgently needed here and infrastructure for the envisaged services does exist. The HSRC and NMCF will have to work together with the local NGOs and provide them with necessary skills to effectively deliver services for the OVC. There is a need to increase collaboration of all service providers, including the involvement of community members, to make sure that services are effectively delivered.

CHAPTER 1

Introduction

Donald Skinner and Alicia Davids

HIV/AIDS information

One of the major challenges facing the southern African region as a result of the HIV/AIDS epidemic is the increase in the number of orphans and other vulnerable children (OVC). UNICEF estimates that by 2010, 25 million children under the age of 15 are likely to be orphans, most of whom will be in sub-Saharan Africa (UNICEF, 2005).

An estimate of the numbers of orphans and future projections of orphans in any country depends on the criteria being used to determine orphan status and also on the model being used at that particular time. Johnson and Dorrington, using the ASSA 2000 model, estimated that 'by 2015, without significant changes in sexual behaviour or interventions, roughly 15% of all children under the age of 15 are expected to be orphaned'. By 2015 '18% of all children under the age of 18 will have lost their mother, 28% will have lost their father and 12% will have lost both parents. Roughly 33% of all children under the age of 18 will have lost one or both parents if no change in sexual behaviour patterns occurs or if no significant health interventions are introduced, (Johnson & Dorrington, 2001, p. 14).

Death from HIV/AIDS is by far the largest contributor to the problem of OVC in southern Africa. Children whose parents have died of HIV/AIDS are often left to be cared for by their relatives, including grandparents (Bray, 2003). Other care structures include foster homes, group homes, orphanages and child-headed households. In the latter case, where there is nobody else taking care of them, the children often take care of themselves, with older ones acting as household head.

The importance of considering the situation of children orphaned by AIDS has been made clear – both by the projections of the number of orphans expected, and the lack of adequate caring mechanisms and service structures to support them. However, looking at the situation of these orphans does not address the full scale of the problem, since the epidemic and surrounding poverty are generating a context in which large numbers of children are becoming vulnerable (Baylies, 2000). The term 'orphaned and vulnerable children' or OVC was introduced due to the limited usefulness of the construct of orphanhood in the scenario of HIV/AIDS (Smart, 2003; World Vision, 2002).

Early on in the project a community based definition for OVC was established across the countries of Botswana, South Africa and Zimbabwe. At core, the definition of OVC defines children as being under 18 years of age, and an orphan, as a child who has lost either one or both parents to death or desertion. The definition, furthermore, recognises that children can be vulnerable if compromised in terms of material, emotional or social problems (Skinner, Tsheko, Mtero-Munyati, et al., 2004).

Background to the project

In 2002, the Human Sciences Research Council (HSRC) received funding from the Kellogg Foundation to develop and implement a five-year intervention project on the care of OVC as well as families and households coping with the care of affected children in Botswana, South Africa and Zimbabwe.

The goals of the project are to:

- Improve the social conditions, health, development and quality of life of vulnerable children and orphans.
- Support families and households coping with an increased burden of care for affected and vulnerable children.
- Strengthen community-based support systems as an indirect means of assisting vulnerable children.
- Build capacity in community-based systems for sustaining care and support to vulnerable children and households over the long term.

The main aims of the project are to develop, implement and evaluate some existing and/or new OVC intervention programmes that address the following issues:

- home-based child-centred health, development, education and support
- family and household support
- strengthening community-support systems
- building HIV/AIDS awareness, advocacy and policy to benefit OVC.

There are two major components, namely intervention and research, that form part of this project. In each country there is a research partner and an intervention partner. In South Africa, the partners are the HSRC and the Nelson Mandela Children's Fund (NMCF). In Botswana the partners are the University of Botswana and the Masiela Children's Fund and in Zimbabwe it is the Biomedical Research and Training Institute and the Family AIDS Caring Trust.

In each country there are two sites where the best practice interventions are to be evaluated and the baseline research to be done. There are also intervention sites where interventions with children are implemented on all the levels stated above. The implementing partners either run interventions themselves or fund various CBOs and FBOs in the intervention areas to deliver necessary services to those who need them. The project will, in addition, work in partnership with all levels of government in each country, as well as with the local communities at the various sites, to ensure that the intervention programmes continue after the project officially ends in December 2006.

The research component included a number of components. Firstly, the situation analyses were directed at identifying the general context of OVC in the site, identifying services already available in these study areas, examining their strengths and weaknesses and making recommendations for improving the situation of OVC. Secondly, the baseline research involved qualitative interviews, a census survey and a directed psycho-social survey with OVC at the two intervention sites. At one site a behaviour and sero-prevalence study was also done. This information will inform intervention plans developed to assist OVC and indicators for monitoring the interventions. This report is concerned with the situation analysis component.

Work in South Africa

The HSRC, together with the NMCF are collaborating to conduct research and interventions on OVC in two provinces in South Africa, namely the North West and the Free State. The main aims of the collaboration are to improve the lives of OVC and to support the caregivers and households who care for them, as well as their communities. In South Africa, the NMCF was chosen to work with the HSRC as an implementing partner.

In the Free State, the study is taking place in the Matjhabeng Municipality under the Lejweleputswa District, and in the Kopanong Municipality under the Xhariep District. In the North West province it is being undertaken in the City Council of Klerksdorp under the Southern District and in the Rustenberg Municipality under the Bokome-Bothlaba District. Further baseline research was done in Kopanong and Kanana, which are focus sites for interventions.

In undertaking this intervention-based research, the NMCF and HSRC aim to partner with local NGOs to deliver services to those in need. The time frame for the study is five years. As a first step towards making an entry into the field, the HSRC and NMCF met with key individuals and organisations and conducted a situation analysis of Welkom and Virginia in the Matjhabeng Municipality

Definition of orphaned and vulnerable children

One of the first research tasks was to establish a definition for orphaned and vulnerable children. As stated above, the impact of HIV/AIDS goes beyond the children orphaned as a result of their parents dying in the epidemic and has multiple effects.

OVC definition studies were conducted in South Africa, Botswana and Zimbabwe as part of the situation analysis and the qualitative research component. These definition studies are based on focus group discussions with members of NGOs, officials from government departments and carers and OVC, as well as community members in the three countries. In South Africa this included participation of stakeholders of the City Council of Klerksdorp and the Municipality of Matjhabeng in the Free State.

Based on the discussions in the three countries, there appeared to be a consensus that the age limit for the definition of a child should be 18 years. The overall response, with regard to orphanhood, appeared to support the construct that the loss of either one or both parents would indicate a situation of likely vulnerability. The remainder of the definition needs to centre around three core areas of dependence (Skinner, Tsheko, Mtero-Munyati, Segwabe, Chibatamoto, Mfecane, Chandiwana, Nkomo & Tlou, 2004):

- Material problems, including access to money, food, clothing, shelter, health care and education.
- Emotional problems, including experience of caring, love, support, space to grieve and containment of emotions.
- Social problems, including lack of a supportive peer group, of role models to follow, or of guidance in difficult situations, and risks in the immediate environment.

Aims of the situation analysis

This is the only baseline research task that was conducted in all the sites where interventions are being done. The situation analysis had two aims. The first aim was to collect information on conditions of OVC in the Kopanong Municipality and on general living circumstances of people, together with information about government services and NGOs based in the towns that provide assistance to the OVC. This information would then be used to inform the OVC survey and development of interventions. Secondly, this process also served as an entry into the field. It was hoped that while in the field researchers would establish contacts with community leaders and relevant stakeholders in all the towns so as to create a context conducive to the survey and subsequent interventions.

CHAPTER 2

Methodology for the situation analysis

The role of the situation analysis in intervention research is to provide a background on the community, for making decisions about interventions, introducing the community to other stakeholders who are observing the interventions, including evaluators, funders and policy makers, and to provide background information for the generation of additional research in the communities. The methodology described below is directed to these ends and is specific in its intent. Many of the methods will overlap regarding the results produced, which enhances the validity of the interpretation. This document provides a general outline of the methods that will need to be adapted for the context in each site.

Methodology

A standard combination of research methods was used. Where necessary these were adapted to the needs of the local context. A general outline of the approaches is provided below.

Semi-structured interviews

Semi-structured interviews were conducted with OVC, their carers, and representatives of state and NGO services, community leadership and other stakeholders. All interviews were transcribed. The research process used the interviews done for the qualitative research, but only some of the interviews were used. About ten interviews are necessary with the final sample size depending on the context. The interview schedules attached provide a good outline for the interview structure, but may need to be adapted for the local context (Appendices 1 and 2). Informed consent was obtained for all interviews.

Focus group discussions

One or two focus groups were conducted in each site with community members and service providers. The interview schedule was similar to that used for the individual interviews. These groups were not recorded and the analysis was done from notes. Informed consent was obtained for these interviews

Observation

Observations noted during visits to the community were recorded. These included observations made and points noted during conversations with members of the community. Care was taken that this material, particularly the notes from conversations could be used in this report. Notebooks were used to record this information. When first entering a community, the researchers were taken on a tour by one of the community members.

Proceedings of workshops

During the establishment of the intervention it was useful to draw all the stakeholders, and especially the service providers, together into a single workshop. While the focus of this was more on the introduction of the new interventions into the community, it did provide a useful place from which to generate information for the situation analysis.

Secondary data and documentation

Secondary data and documentation was used. This included census reports and data, reports from other research done in the community on related or overlapping issues, reports from organisations working with OVC or generally working in this community and

national reports that incorporate this community. These were collected and the relevant information extracted. Care was taken that the material used were public documents so that confidentiality and other legal issues were not compromised. Any information taken from these reports was carefully referenced. Consent was obtained to use and publish information from any material that may not be in the public domain.

Ethics, consent and confidentiality

This type of research has fewer ethical issues than most, as there are no body tissue samples taken and most of the information is available in the public domain. The interviews were one area where it was important to obtain formal consent. Letters of consent were signed by respondents. Care was also taken to ensure that consent was obtained for the use of reports in workshops and points obtained from personal conversations.

Analysis

A mixture of analytic approaches was used. Dominantly, a content analysis method drawing on a qualitative approach was used for the analysis of the information from the interviews, observations and narrative-based secondary documents.

Writing up of situation analyses

Based on the initial aims and role of the situation analysis, a format for the write up of the reports has been established.

CHAPTER 3

Situation analysis of services provided to orphans and vulnerable children in Welkom and Virginia in the Matjhabeng Municipality, Lejweleputswa District in the Free State

Dr Donald Skinner, Sakhumzi Mfecane, Nkululeko Nkomo, Shai Makgoba, Tshepo Mdwaba, Charles Mandivenyi and Ntjantja Ned

Description of Virginia and Welkom, Matjhabeng

The total population of Matjhabeng is 408 169, and there are a total of 120 289 households in the municipality (Statistics South Africa, 2001). The majority of residents are black (356 098; 87.24%), followed by whites (42 693; 10.46%), coloureds (8 906; 2.18%) and Indians (468; 0.11%). The percentage of women is slightly higher than that of men (51.4% vs 48.6%, 1996 Census). The age distribution is presented in Table 1.

Table 1: Age distribution of population of Matjhabeng

Age breakdown	Matjhabeng	%
0–4	36 728	9.0
5–19	120 285	29.5
20–29	70 656	17.3
30–39	72 834	17.8
40–49	56 955	14.0
50–59	27 482	6.7
60 and older	23 229	5.7
Total available information	408 169	100

The population of Matjhabeng is relatively young, with 73% of the population being less than 40 years of age. Adults aged over 60 years formed the smallest group.

According to the Matjhabeng Integrated Development Plan Review (2003), Welkom is situated central to the Goldfields metropolitan area consisting of Ventersburg, Henneman, Virginia, Odendalsrus and Allanridge. Welkom is a young town, having been the centre of the Goldfields since 1947. The town gained prominence when gold was discovered on a farm called St Helena. Virginia was established at the peak of the gold rush on the banks

of the Sand River. It was named after American surveyors who carved their name into a stone at Merriespruit in 1890. Both Welkom and Virginia are part of the Matjhabeng Local Municipality, which in turn forms part of the Lejweleputswa District.[1]

Virginia is about 25 km from Welkom. The road between the two towns is well constructed, so it is easy to move between them. The Virginia central business district (CBD) is relatively small (compared to Welkom) and does not look well developed. This can be attributed to the decline in economic growth in the area over the last few years because of massive job losses in all sectors of the economy, particularly mining and agriculture. While Welkom is bigger, it has experienced economic decline over the last few years as well. There are a number of stores, including the major shopping chains and fast food franchises. Meloding, a township in Virginia, is exclusively black and accounts for about 70% of the population of Virginia. Like any other black township in South Africa, Meloding is lagging in terms of infrastructure and development.

The dominant culture and language is seSotho, which is spoken by almost 70% of the population,followed by Afrikaans and isiXhosa. Many people who speak isiXhosa are believed to be migrant mine workers from the Eastern Cape, which shares a border with the Free State. There is also a presence of migrant workers from neighbouring Lesotho. The main mode of transport in the towns of Welkom and Virginia is taxis, but these are not available to all. In the informal settlements in Meloding township taxis are scarce. People here who work on the mines use the transport that is organised by employers to get to work, and payment is deducted from their salaries. In Thabong taxis run from 03h00 to 24h00 to accommodate mine workers.

Thabong and Meloding are both different and similar in many ways, given that they are sited near to each other. The easily visible difference is in housing structures, especially the mix of formal houses, informal houses, hostels and RDP houses. Formal houses are properly numbered while informal houses are not. In order to access a house in an informal settlement, markers are used. For example, a container where cell phones can be used indicates where one stays. The quality of houses differs. Thabong has modern houses built with modern materials such as face-bricks. The houses in Meloding, on the other hand, are older brick and plaster houses. Housing structures are a good marker of economic status so Thabong can be said to be economically better off than Meloding.

The numbers of households in Matjhabeng with a flush toilet connected to a sewerage system or a septic tank is 72 269 (60.1%) and 898 (0.7%) respectively, and there are 29 943 (24.9%) households with piped water inside their dwelling and 53 872 (44.8%) with piped water on their property (Census, 2001). The most impoverished area in Thabong is Hani Park an informal settlement situated next to the main road to Virginia. Hani Park does not have access to sanitation – they use pit latrines. As for water, there are communal taps that appear to be easily accessible.

There are no playgrounds or health facilities. In order to access facilities people have to go to Bronville, a formerly coloured area situated opposite Hani Park (the road separates them). In Meloding the most impoverished area is called Zone 14. As in Hani Park, Zone 14 does not have access to sanitation, but it does have a clinic. The main roads in both areas are tarred, but small streets are not. This makes driving inside the townships difficultand slow. Public phones, both cellular and land-line, are available in both townships.

1 The Constitution of South Africa provides for three categories of municipalities: Category A (6 metropolitan), Category B (231 local municipalities) and Category C (47 district municipalities). District municipalities are mainly responsible for capacity building and helping local municipalities develop to their fullest capability.

Poverty and unemployment (47% in Matjhabeng) are very high, which, according to a number of interviewees, compromises the culture of caring in the community. They felt that they cannot afford to provide additional caring to other children as they can barely afford to cover the needs of their own children. However, there are examples of caring and interviewees gave many examples of individuals and groups making great efforts and some people making significant contributions from quite a meagre base. A number of the organisations providing care rely on public contributions for their survival.

Economic conditions

The area is supported by a declining gold production industry. In 1995/1996 the contribution of Welkom to the gross geographical product (GGP) of the Free State was approximately 19%, with the gold industry in Welkom alone responsible for 51% of the total mining industry contribution in the Free State. The larger Goldfields area contributes 88% of the total mining income in the Free State. These figures emphasise Welkom's economic status in the Free State and the strong dependence of the local economy on the gold industry.

The Lejweleputswa District has the highest contribution to the GGP in the Free State (Matjhabeng IDP Review Committee, 2003). However, over the last decade the entire Free State economy has shown a decline in economic activities, mainly due to problems in the agricultural and mining sectors. Many mines have closed down, resulting in high numbers of unemployed people.

Problems

Welkom and Virginia have high unemployment rates. Unemployment in the district of Lejweleputswa stands at 45%, and in Matjhabeng specifically it is 47%. This was reported by informants to lead to a number of social problems, including substance abuse, poverty, teenage pregnancy and the mushrooming of informal settlements. Notwithstanding the declining economic conditions and increasing unemployment, it is clear that many retrenched mine workers are not leaving the area, since the population is continually increasing. Those migrants who do return to their original homes often leave another family behind in Matjhabeng.

The overall rate of HIV/AIDS infection for the district is estimated at 30%. The government's antenatal survey figures put prevalence levels at 28.8% for antenatal clinic attendees for 2002, down slightly from 30.1% the previous year. This ranks the Free State as having the third highest prevalence in the country (Department of Health, 2003). In the national sero-prevalence study conducted by the HSRC in 2002, the Free State recorded a prevalence level of 14.9% across the whole population – the highest in the country for any province (Shisana and Simbayi, 2002).

In the Virginia township of Meloding there are some HIV-related activities and structures, for example, Hospice Home-Based Care and the Virginia Community Project, Youth against AIDS. There is a loveLife billboard, but there are no offices, although there is a loveLife office in the Welkom township of Thabong. Mobile clinics operate in the rural areas, but these are not sufficient. Clinics and hospitals in urban areas are overcrowded. Emergency services are not readily available and their response times to emergency calls are slow.

Availability of medicines at clinics is a further problem, caused by lack of control and poor distribution systems. The chief environmental factors impacting on the demand for primary health care in the district are poor sanitation, health risks from waste dumps,

pollution and lack of safe water. Generally the level of advocacy and education around HIV is poor and often reliant on national campaigns or isolated local work not necessarily attached to any specific organisation.

Conditions of OVC in Virginia and Welkom

There is no certainty about the actual number of orphans in the area. Research conducted by the DoE estimated the number of orphans at schools to be 2 831. However, the DoE does not have statistics on orphans who do not go to school. The South African 2001 Census found that 286 (2.4%) children under the age of 15 in Meloding and 813 (3.1%) in Thabong had lost both of their parents (Census, 2001).

Table 2 gives the number of children in Matjhabeng within each age group who have lost either their father or their mother.

Table 2: Children in Matjhabeng who have lost one of their parents, by age group

	Lost mother		Lost father	
	No.	%	No.	%
0–6	1208	2.3	4070	7.9
0–14	8095	7	13 958	12.1
0–18	10 061	6.8	20 940	14.1

Source: (Census, 2001)

Most of the orphans are of African origin. One informant from the DSD stated that 98% of them are black or coloured and about 2% of them are white. Most orphans live with their families, extended families or foster families. There are some orphans who are heads of households, but child-headed households are a minority.

Generally poverty is a major – if not the major – contributor to vulnerability in children. The high number of OVC in Matjhabeng was mainly attributed to the high rate of unemployment. Many people who worked on the mines were migrants, who after they lost their jobs went back to their home towns, leaving their children behind. Many migrants have families at their home base, but were also involved in relationships with local women while working on the mines.

A small number of children have problems with shelter. Many interviewees felt strongly that OVC should be provided with safe places of abode. Although they acknowledged that this might stigmatise the children, they felt that shelter is a basic need for children. Some were against foster placement because there was no guarantee that a child will receive all the necessary care. They felt that if children are provided with proper shelters, they would be better monitored and cared for.

The safety of OVC in the community raised further concerns. The informal settlements were described as unsafe for children because of crime, violence and abuse. In all cases OVC are cared for in daycare centres where they receive proper food and care, but when they get back to their homes there is less guarantee of care and protection. Morning Star, an NGO based in Welkom, is considering opening a place where children can be cared for day and night so that their safety can be guaranteed.

In addition to the concerns raised above, poverty generally affected the majority of children. Poverty leads to a lack of food and so hunger among OVC. Many OVC and other children line up at the offices of social development for support in the form of food. Given the high levels of poverty and lack of food, the nutritional status of children is poor. The only form of guaranteed nutritious food for children living in impoverished households is that provided by NGOs and at crèches (for example, Morning Star). In most of these institutions children receive food at least three times a day and that food is meant to provide them with nutritious supplements necessary for good health. As one staff member of a crèche in Virginia commented, 'At least they receive three meals a day'. OVC who are not part of these programmes may be facing nutritional deficiencies.

In addition to affecting the nutritional status of children, poverty has consequences that further increase vulnerability of OVC. For example, a representative from the DoE raised the problem that some OVC have become involved in criminal activities to get money. Male OVC may commit crime in order to support their siblings. In the process they are arrested, and eventually end up living on the streets. One participant from Correctional Services was concerned that the department is not making enough efforts to help OVC who end up in jail. Some girls were said to be involved in sex work in order to support siblings and pay their school fees. They are at risk of, among other things, infection from HIV and other sexually transmitted infections (STI).

In addition to problems caused by structural conditions, OVC are also exposed to certain vulnerabilities within households. In one focus group discussion participants said some families abuse and take advantage of OVC. They claimed that certain people adopt orphans only for their own financial gain. They do not have the orphans' interests at heart and use the foster grants to support themselves instead. Others provide only material support, but no emotional support. A case was mentioned of an uncle who provided all the support to orphans he adopted, but he sexually abused them.

A number of OVC were reported by social workers to be experiencing psychological problems, particularly depression. It is likely that a number of them are also experiencing problems with mourning, have experienced high levels of trauma and have to cope with multiple changes in their life style, routines and immediate context over a short period of time. All of these can contribute to anxiety, damage their personality structure and undermine their coping strategies. In the long term there is an increased chance of social problems and more long-term psychological problems.

Stigma and discrimination against OVC and people living with AIDS (PLWHA)

Stigma can refer to that which is either internalised or enacted. The internalised stigma is that felt by the ill – a feeling that others will stigmatise him/her due to his/her condition. Enacted stigma, on the other hand, refers to the negative behaviour aimed at someone because he/she suffers from a certain unacceptable illness. Although the situation analysis did not deal directly with these aspects of stigma and discrimination, our impression was that OVC are not a stigmatised category. This was evidenced by the willingness of people to assist those who are in need. There was a general feeling among participants that many people are willing to care for OVC but, due to financial difficulties, their capacity to provide assistance is reduced.

A participant from Morning Star felt strongly that the only way to deal with stigma was to talk openly about HIV/AIDS and OVC issues. His organisation openly collects children infected by HIV/ from the community every day. The name of the organisation is written

on the car. When probed as to whether this may lead to stigma and discrimination, he commented that rather than resulting in stigma, their openness has actually resulted in an increased demand for their services and currently they do not have enough space to accommodate all the affected children. This points to the role that openness can play. Another positive impact of openness about HIV in this organisation was that PLWHA publicly participated in income-generation activities.

Plans to assist OVC and PLWA: integrated development plans and OVC

Every municipality is obliged by law to compile and approve a strategic five-year integrated development plan (IDP). The process requires a municipality to be a strategic planner by establishing a developmental plan for the short, medium and long term, based on an assessment of the current social, economic and environmental reality in its area of jurisdiction.

The function of an IDP is to provide a framework for mobilising and prioritising the use of development resources and aligning internal capacity systems with strategic development objectives. It also enables meaningful engagement with stakeholder groups around concrete development priorities (Lejweleputswa Integrated Development Plan, 2003).

The IDP of both Matjhabeng and Lejweleputswa (IDP Steering Committee, 2003) outlines the plan of both the municipality and the district when it comes to HIV/AIDS. The key aims are to reduce the HIV infection rate by establishing a home-based care system and training volunteers in HIV/AIDS awareness, so that they can inform community members; encouraging voluntary, confidential counselling and testing for HIV; and ensuring provision of effective primary health care to both rural and urban communities.

With regard to children, the IDP states the following goals:

- To protect children, legally and socially, against all forms of abuse.
- To establish children's committees at local and district levels.
- To work in partnership with others active in the field of children's rights.
- To establish a database for street children and attempt to link them with their families.
- To design and implement child care programmes in the district, as part of the Child First programme.
- To hold regular seminars/workshops on children's rights.
- To encourage participation of children in socio-economic issues.
- To report all forms of abuse of children.

While these plans are clearly explained in the IDP, no significant financial allocation has been made for monitoring and evaluation work to measure impact and performance.

Government departments and their services

Government departments play a crucial role in delivering services to OVC. The major departments involved include the DSD, DoH, DoE and Department of Home Affairs (DHA). We briefly describe their services and the challenges they face in delivering services.

Department of Social Development

Formerly known as the Department of Social Welfare, the DSD is the custodian of child support and poverty alleviation in South Africa. It offers services such as foster care placements and counselling, as well as the provision of children's grants, for example, Foster Care, Child Support and Care Dependency Grants. These services are carried out by social workers. There are 33 social workers employed in the office in Welkom and there are no volunteers. In addition to office work, the staff also do outreach work, which involves monthly awareness and information campaigns. There is a communication officer who is responsible for co-operation with other government departments.

The DSD works closely with NGOs who deliver services to communities. Most but not all of the NGOs get their funding from the DSD. Only those credible enough receive financial support. Others may be given other forms of support, such as food parcels. The relationship with NGOs is based on a two-way referral system whereby NGOs refer cases to them and vice versa. Even though the DSD is responsible for the whole Lejweleputswa District, there are certain areas handled by NGOs: 'Because of empowerment, we are trying to empower the NGOs, we try not to allow them to die'. The DSD assists with the statutory work. NGOs could also handle statutory work if they had social workers who were registered with the Council of Social Workers.

There are no specific criteria for the selection of NGOs to receive support, except that the organisation must be a registered non-profit organisation, provide services directly linked to the DSD, and have professional persons such as social workers on the staff or working for them. The approval of NGOs is done at provincial level, although the district does make recommendations based on their knowledge of the NGO.

A brief description of children's support grants follows.

Foster Care Grants

Foster Care Grants are given to families who care for orphans. Requirements for getting a Foster Grant are that the child must be legally fostered, a parent should have an identity document and the child must be under the age of 18. If there is proof that a child is older than 18 but still at school, the grant can continue up to the age of 21. The application process is facilitated by social workers after following some legal procedures, which involve processing of the grant by a magistrate. Ideally the process of application should take a maximum of three months, but due to delays it may take as long as two years in Matjhabeng (DSD personnel). The DSD allocates a relief grant in the form of food for a period of three months while applicants are waiting for approval of the application.

The requirements for foster grants generate a number of problems. Firstly, many children who have lost their parents stay with their relatives, who foster them in an 'African way'. In the African way, if a parent dies a grandmother/father or a relative simply takes the child under his/her control. This is regarded as culturally appropriate. The child is, however, not legally fostered and in order to get foster grants a legal processes should be followed. Secondly, some parents do not have identity documents, making it difficult to legally foster a child. This delays the process of applying for the grant. Thirdly, the legal process takes a very long time because the magistrate can only process four applications a day and the DSD is overloaded and understaffed, making it difficult for them to facilitate the process (DSD representative). There were 3 667 beneficiaries in the district by the end of April 2004.

Child Support Grants
The Child Support Grant of R170 is meant to support poor children under the age of nine years whose parents earn less than R850 a month (for those living in informal settlements the income level is increased to R1 000 a month). This grant is easier to access but is open to abuse by people who earn more than the limit. According to one of the focus group participants representing NGOs/CBOs: 'There are people who earn R20 000 when salaries are combined, yet they also receive this grant'. There were allegations that some teachers also access the grant and that some family members whose children died still continue to access it. The interviewee on this issue also maintained that there is no networking between the DHA and the DSD, which makes it difficult for them to track down cases of duplication and corruption. Both parents and children need to have an identity document or at least a birth certificate for the child. There were 36 994 beneficiaries in Lejweleputswa by the end of July 2004.

Food parcels
These are offered both by NGOs and the DSD to those in need. DSD finances the NGOs to purchase and distribute food and to cover their administrative costs. NGOs also get support from local businesses to help them with food. Criteria for receiving a food parcel are based on need. In most cases social workers first assess the situation of OVC before they decide to provide them with food parcels. Of the NGOs interviewed, Matjhabeng Christian Leaders' Forum, Child Welfare and CANSA offer these services. NGOs make use of volunteers to deliver food parcels.

The DSD did not provide information on how often and how many OVC received food parcels. Food is delivered to the recipients by NGOs. The DSD provides food support if a person does not have food at home and is unable to work. The DSD first needs a certificate/letter from a doctor saying that a person cannot work. With no medical certificate, the social worker has to use his/her own discretion by visiting the home and deciding whether the person should receive support or not.

Social relief
This is temporary assistance in the form of food given by DSD to families who have applied for permanent assistance. The food given costs R380 per month and is meant to assist up to six family members. In cases where family members exceed six, two food parcels are given. Food parcels are distributed for a period of three months. The policy for accessing this grant is that there must be proof that the recipient is still waiting for permanent assistance. Since some people do not have identity documents, it becomes difficult to fulfil the requirements of this policy.

Department of Health

The Department of Health (DoH) is the second department of importance in the care of OVC. Here the focus will be on health issues relating to HIV/AIDS and OVC, particularly home-based care. This is one of four sections; others include HIV/AIDS, health promotion and primary health care. Currently there is only one person employed to coordinate home-based care. He works under the supervision of the District Manager and also works closely with the coordinating NGO, CANSA.

Description of services
The home-based care programme works closely with NGOs to offer care and support to those who are incapacitated and unable to take care of themselves due to sickness. Volunteers from NGOs that focus on home-based care undertake the actual process of

service delivery. These caregivers are paid R500 a month by DoH to deliver the services. The volunteers are co-coordinated by CANSA, an NGO based in Thabong. Community members, nurses and the caregivers identify sick people eligible for home-based care. OVC are also identified through their sick parents. The main health problems presented by OVC were said to be HIV/AIDS, tuberculosis, chronic illnesses and respiratory tract infections such as pneumonia (Home-based care coordinator, DoH).

In addition to home-based care, other services include free treatment for children up to the age of five years. Education campaigns are run in the schools and communities, including Condom Week around Valentine's Day. Prevention of mother-to-child transmission (PMTCT) services and, in- and outpatient treatment and support are provided for people living with HIV and AIDS. Home-based care is also being offered. This service happens in conjunction with the clinics.

Access to health facilities can be said to be reasonable, since residents have access to at least one clinic. In total there are five clinics in Virginia and nine in Welkom, three of which are primary health care clinics (Appendix 3 lists the clinics in the two towns). The five clinics in Virginia are pilot sites for PMTCT in the Matjhabeng Municipality and they also offer voluntary counselling and testing (VCT). The nine clinics in Welkom only offer VCT. Five of the clinics are situated in Bronville, Bophelong, Kgotsong, Riebeekstad and Thabong, townships attached to or close to Welkom. Antiretroviral medication is not yet provided through the health services in Matjhabeng.

Cooperation with other government departments

The DoH cooperates with a number of other government sectors in delivering services. They cooperate with the DSD on referrals of patients for food parcels and other needs, and a partnership will be developed with the Department of Agriculture to help with training people to carry out income-generating activities. The Department of Labour helps with income-generating programmes and with labour-related issues, and the DoE identifies orphans at schools. All departments felt that the quality of the collaboration should be improved and deepened.

Department of Education

Education policy in South Africa states that no child should be excluded from school on the basis of non-payment of school fees and that full school uniforms are not required. While this is the legislation, many schools have tried to exclude children on the basis that they are short of money and resources and that their schools are already overcrowded. Uniforms also create a barrier to access, since very poor children, including OVC, will stand out as different if they do not have the required clothes. This generates a form of discrimination and separation, causing students to prefer not to attend school. It is difficult to get precise figures and input on both these factors, since they are hidden practices. They are, however, likely to impact on communities in Matjhabeng. If a school is employing exclusionary practices, it is possible to report the situation to the provincial education department for action, and the child's right to access will be enforced.

In Matjhabeng the DoE helps with identification of orphans at schools. An initial study estimated the number of orphans in Matjhabeng to be around 2 861. After identification of orphans, the DoE also assists with Foster Care Grants. They designed a form to be filled in by a teacher and carer, which indicates whether the child is receiving grants or not. The work is done in cooperation with the DHA and the DSD. There are 27 schools in Welkom and 13 in Virginia. Appendix 3 provides a list of public and farm schools in Welkom and Virginia.

About 167 teachers have attended courses on HIV counselling to help children in need at schools. Lifeline has also trained teachers. However, at present there is no specific teacher who does counselling at schools. Teachers who are trained in counselling have to squeeze this service into their already overburdened schedule. Regarding specific plans for the future, the DoE wants to partner with NGOs to get food and clothes for orphans, and to obtain assistance by fundraising (DoE personnel).

School feeding schemes

These take place at primary and secondary schools. At present there are 12 schools in Welkom and 11 in Virginia with a feeding scheme programme (see Appendix 4 for a list of schools with a feeding scheme in the two towns). School feeding schemes were criticised by some participants as not being sufficient. For example, representatives of DoE maintained that children are only fed biscuits and said that these services need to be improved. Others alleged that some people take food to their own homes rather than providing it to the school children. There were also allegations that a lot of money that was meant to be used for school feeding schemes had been squandered (Community meeting, Virginia). These reports require substantiation.

Department of Home Affairs

The Department of Home Affairs carries out registration of death, births and marriages and provision of identity documents. The 17 people who staff the section are expected to visit at least ten formal offices a month. In addition to these sites, they also visit others away from the formal offices to find hard-to-reach groups. Due to the lack of infrastructure at these community sites they have to collect information, process it and distribute it during the visit. The main limitation to their work is lack of resources (especially computers), which makes it extremely difficult to deliver services in time. Their work is said to be so demanding that some of them have to work unpaid weekend overtime to cope.

One of the problems encountered was that a lot of people do not have formal identity documents. This includes South Africans who have not been registered and non-South Africans who are illegal residents and who do not want to access services so as to avoid being caught, fearing deportation. In cases where vulnerable children are encountered, they are referred to the relevant departments for help.

Challenges faced by government departments

A number of specific challenges which are outlined below, face government departments:

- The numbers of OVC are increasing due to HIV/AIDS. This puts pressure on an already overburdened system, which has to tackle other major issues such as poverty, unemployment and the general economic downturn. Communities have come under considerable pressure as a result, and have now shifted the responsibility of care to the government.
- Staff shortages, especially in relation to growing problems, increase the difficulty of providing an efficient and effective response. One DoH representative said, 'I'm the only one working under the district. I deal with 335 carers in the home-based care. I have 12 towns to train now, but we don't have manuals'. Lack of staffing affects the quality of services provided. For example, social workers are unable to give attention to emotional aspects of their clients and can provide only material support.
- The existing employees have an increased workload. This results in overtime work that is not paid for. Lack of infrastructure, such as computers further increases workload. At the DHA the staff share very few computers, which results in delays in the processing of applications.

- Placement of orphans is becoming increasingly difficult, with many orphans ending up on the street because they are not cared for. Concern was expressed that there may be a 'commercialisation' of orphans, with some people taking orphans in for the sake of money and not providing adequate care for them. Proper procedures need to be followed to ensure that grant money is spent for the benefit of the child. Staff shortages have made the monitoring of children and follow-up of cases very difficult.
- Stigmatisation of HIV/AIDS in communities creates enormous problems, since it leads to people hiding their illness. For orphans it means that there is often inadequate planning for the future, both at an emotional and material level.
- There is sometimes a lack of cooperation between government departments, which impedes overall provision of services. Some described their relationship as competitive, since each department wants to come out at the end of the year and describe its successes. This was also said to result in duplication of services. However, there is a good interdepartmental referral system, and cooperation is starting to improve. Government departments need to work closely together to make sure that resources are not wasted, that services are not duplicated and to achieve levels of synergy.
- Community involvement needs to be developed, with people becoming involved in the programmes. Communities need to be educated about the proper documents required to access certain services and need to be involved in helping OVC by acting as agents for the state services. Importantly, volunteers and community members can assist in the monitoring and follow-up of cases since social workers are not always able to.

Considerable effort is being made by state services to address problems of OVC. Current challenges such as low levels of staffing, non-integration of services and problems of access need to be addressed if these efforts are to be successful. There is great demand for these services from communities, but insufficient infrastructure to facilitate the work.

NGO and CBO services

There are a range of NGOs and CBOs offering services to OVC, from large well-funded, often national structures with professional staff, to locally based, smaller structures that are less well off. They differ regarding services offered and target populations. The major organisations working in Matjhabeng are described below.

Matjhabeng HIV/AIDS Consortium

Matjhabeng HIV/AIDS Consortium is the coordinating body for NGOs providing services in Matjhabeng. The consortium started in 2000 as an initiative by the DSD, assisted by the DoH. Its main aim is to coordinate NGOs in the Matjhabeng Municipality. Currently there are about 20 organisations registered with the consortium. They operate in different areas in Matjhabeng, with a few working as far away as Kroonstad.

Most of the organisations that are registered with the consortium started in communities with community leadership and then applied for assistance. The organisations mainly use volunteers. The consortium appoints professionals, such as a nurse or social worker to co-ordinate work in the different focus areas. The organisational coordinators are members of the committee of the Matjhabeng HIV/AIDS Consortium.

The main motive for establishment of the consortium was to address issues pertaining to PLWHA in Matjhabeng. The core philosophy of the consortium is to ensure that PLWHA

get assistance to improve their lives and well-being. The consortium coordinates funds to be distributed to different NGOs. In turn, the NGOs claim stipends for services from the consortium, as well as for their administrative work. The consortium also ensures that there is adequate networking of services. The consortium offers support to the organisations that comprise it, including financial and management support, establishing of systems and so on.

Structure of the consortium

The criterion for admission is that NGOs are registered non-profit organisations (NPOs). The structure of the consortium consists of a coordinating committee and service clusters. The coordinating committee is the administration arm of the consortium and the service clusters are the operational components. The service clusters are grouped into four areas of service.

Home-based care. This provides home care to the ill. Organisations under this focus area include Morning Star, Goldfields Hospice, CANSA, and Katlheho-Mmoho. There are seven CBOs listed under Katlheho-Mmoho. Future plans include roll-out of planned programmes. They also want to apply for a toll-free line to provide information on anti-retrovirals.

Care and support. This identifies OVC, provides support for the care and placement of vulnerable children in caring households and assists children to access grants. There are three organisations that do work in this focus area: Child Welfare, Ondersteunings Raad, and the Oranje Vroue Vereeniging (OVV).

Information and awareness. There remains a need to disseminate information so as to reduce the spread of HIV. This arm conducts workshops and seminars and sets up events. Organisations include OVV and the National Association of People Living with AIDS (NAPWA).

Counselling. Two organisations provide counselling in this area. Lifeline Free State and FAMSA. They offer direct counselling to individuals and families affected by HIV/AIDS.

The groups in the care and support and counselling focus areas cater directly for OVC, but all four sectors impact on children and youth. The care and support service cluster has organisations that offer assistance in facilitating grant access for OVC and providing food parcels.

Challenges faced by the consortium

The following were identified as challenges faced by the consortium:

- There was a feeling that government departments do not commit themselves entirely to the consortium.
- One serious threat is a lack of financial support from government departments.
- A further challenge discussed was lack of coordination between leadership in the consortium and the DSD and DoH.
- In the care and support and counselling focus areas the consortium does not have sufficient professionals involved.
- The organisations also lack resources such as office furniture, computers and so on. They rely on the individual resources of the coordinators within each group and the limited resources of the consortium.
- The consortium is limited by funding when it comes to rolling out intended programmes to specific areas in Matjhabeng.

Matjhabeng Christian Leaders Forum

The Matjhabeng Christian Leaders Forum is an NGO of approximately 140 interdenominational churches representing all demographic groups and creeds. The organisation was established on 22 May 2001, is based in Welkom and operates from Kopanong Hospital (former Provincial Hospital). It is a religious body that sees its community work around HIV as an extension of its religious activity. The forum has a manager and seven volunteers who are involved in the provision of home-based care to the needy.

To date the organisation has been successful in providing home-based care to people infected and affected by HIV/AIDS, including orphans, providing awareness and prevention services, providing food parcels to the destitute, establishing a community garden and helping in identifying people in need of official documents such as identity documents and death certificates.

The organisation has also been very successful in a number of other initiatives, including securing a deal with the local bakery to supply 200 loaves of bread to various organisations. The organisation has also managed to sign an agreement with the Free State Provincial Department of Social Development to cooperate on matters of mutual interest. The organisation provides 60 food parcels every month to a number of individuals and over 800 food parcels have been distributed since December 2002. Each food parcel is worth R60 and consists of maize meal, samp, kidney beans, soya mince, salt, milk powder and peanut butter. The food parcels are intended for the most needy and people affected by HIV/AIDS.

Church leaders and other volunteers are asked to identify those in need in the community and to apply to the forum for food parcels on their behalf. Both the church leaders and volunteers fill in an application form for parcels for five recipients. The details of the recipients are recorded in a central computer database. For all the food parcels allocated, an allocation or acknowledgement form has to be signed by the recipients. Through the database and tracking, all food parcels can be traced and a second food parcel is not allocated until the recipients' needs have been evaluated.

The organisation has started a gardening project, which aims to become a job creation project supplying food. Approximately two hectares of spinach have been planted and there are also plans to supply the spinach to the local vegetable shop once a quarter.

Challenges and needs

The organisations major challenges are the loss of volunteers and limited funding.

Morning Star

Morning Star was established as a day-care facility for HIV/AIDS-infected children. The centre was opened in January 2000 and admitted eight children. At present there are 62 children being cared for at the centre. The staff includes the founder, a manager, an administrator, driver, garden manager, professional nurse and five regular volunteers. The criterion for admission is that children should be HIV-positive. Children are admitted from a few months of age as there is care for babies as well. Those babies who are subsequently found to be HIV-negative leave the centre. In addition to caring for children, the centre also has income-generating projects for women.

The vision

The vision of Morning Star is to care for orphans who are HIV-positive. In doing so the centre is committed to restoring hope to the women and children of the Goldfields region by making a meaningful change to as many families as possible. The mission and objective of Morning Star Orphanage involve striving toward giving all HIV-positive orphans optimum care and supervision in the form of nutritious meals, appropriate medication, plenty of mental stimulation and lots of love. This is achieved by providing community care to children from disadvantaged backgrounds in the Matjhabeng area who are infected by HIV. A preschool programme continues each morning for the older children while the babies are being bathed and fed. The centre provides these children with a safe environment in which to achieve the maximum quality of life in their shortened life spans.

The centre has also broadened its services to address the immense poverty that exists and affects many families in the Matjhabeng area. Besides its own vegetable garden project and regular food parcels to impoverished families, the centre has been able to initiate an income-generating project called Tshedisanang, a seSotho word meaning to comfort and console. The help of major companies and outside facilitators has enabled the centre to train HIV -infected and -affected women to know and understand more about the disease. Every day the women in question meet to learn and do papermaking and embroidery. The centre also provides unemployed and impoverished women with sewing machines and other craft skills so that they can make clothes and sell them to the community.

The organisation draws its inspiration from a statement made by Nelson Mandela:

> The Vision which fuelled our struggle for freedom; the development of energies and resources; the unity and commitment of common goals – all these are needed if we are to bring AIDS under control. Future generations will judge us on the adequacy of our response.

Funding

Funding comes from a range of sources, including large national and international funders, mining and commercial businesses, the State, some small local organisations and members of the community. Morning Star endeavours to provide services of the highest standards and quality to all orphans under its care. The centre received an Award for Excellence from the African Heritage Trust for its significant contribution to countering HIV/AIDS in the Goldfields region. This placed the centre among the top centres in the country providing care to HIV-positive orphans.

The challenges

The challenges that face Morning Star include the need to operate on business principles, the need to attract more funders, and, most importantly, the need to expand the centre to provide 24-hour care for all the children it looks after. Already a building has been allocated to the centre so that it can expand, but without the necessary funding this will not be possible. High costs of operation also increase the financial burden.

Child Welfare

Child Welfare is a national NGO with offices in Welkom. The core philosophy and guiding principles of the organisation are care and support, statutory assistance with, for example, foster care placements and medical protection and safeguarding of children. Child Welfare's main focus is families and children. In the case of OVC their chief concern is to make sure that the children are cared for within families.

Child Welfare emphasises family care and they do not support orphanages because they separate children from their families. They also emphasise that children themselves need to be involved in decision-making regarding where they would like to be placed. Regarding staffing, the organisation has a staff complement of eight people: social workers, a bookkeeper, auxiliary community workers and a secretary. It is well resourced with furniture, computers and other equipment necessary for running an office.

Child Welfare's work is largely based on The Child Act. They work mainly with children up to the age of 18 and with the homeless. The organisation also does foster care placements, recruitment and supervision, prevention work, lifeskills education and training and statutory assistance.

It has a needlework project for a group of women from Thabong, Bronville and Hani Park. Some women in this group are assisting child-headed households. Child Welfare also assists them in getting 'piece jobs'. Most of this work focuses on black communities, especially informal settlements that seem to lack most resources. In Virginia the major work done by Child Welfare so far has covered the placement of children and the provision of grants.

Funding comes from a variety of sources, including the DSD, donations from the public, local businesses and farmers and fund-raising.

In the future, Child Welfare would like to expand their services, especially recruitment of foster parents and they also want to start job creation projects and vegetable gardens for people who are struggling. One of the major problems is work overload and backlog.

FAMSA

FAMSA is a national affiliated NGO committed to family preservation. They deliver services in Welkom, and their offices are situated in the Round Table Community Centre building in Welkom. FAMSA has service units in Bronville, Meloding, Thabong and Kutlwanong.

Their vision is to see healthy and functional families. They view this as a national priority. The mission of the organisation is to empower people to build, reconstruct and maintain sound relationships in the family, in marriages and in communities, by rendering quality preventative and therapeutic services. They also fulfil an advocacy role to influence social policy, the development of programmes and the mobilisation of resources in the context of development social services.

The main focus of their work is families. In the case of OVC, the aim is to equip parents and substitute parents with parenting skills. A primary preventative focus is life skills programmes for children and the youth in Meloding schools. As part of the family unit therapeutic interventions and pre-statutory involvement is a priority.

Funding comes from a variety of sources, for example, DSD, donations and grants. Donations, such as mealie-meal and clothes form the main resource of the material assistance programme to the children and families infected with HIV and affected by HIV/AIDS.

Activities

In addition to a holistic comprehensive service to families and children, FAMSA is involved in poverty alleviation projects, self-help work, capacity building, training and

extensive lifeskills programmes in the Goldfields, as well as victim empowerment services for survivors of violence. Furthermore, FAMSA is a partner in the HIV/AIDS Consortium. Its services in the consortium are pre- and post-test counselling and preventative and awareness work, as well as training of volunteers.

Challenges and needs

A major challenge is the increase in the demand for services and lack of manpower and financial back-up. Another vital challenge is logistical problems. For example, they have only one car for six social workers. In the future FAMSA wants to expand its services, especially in Meloding and to find financial support.

Seratuwa-Thembi

Seratuwa-Thembi is a Christian NGO based in Meloding, Virginia, under the leadership of Reverend Okpon. The mission of the NGO is to pay school fees and give food and clothes to anyone who is an orphan.

Seratuwa also offers computer training to Grade 12 and Technikon students. It runs income-generating projects, such as poultry farming and gardening for women who are unemployed. They also sell chickens to the communities for profit but at a fee lower than the usual rate.

They have a crèche/daycare centre that provides for orphans and other children from the community. Currently it looks after 64 children. The children in the crèche are provided with food and clothing and the church also pays for their school fees and assists with acquiring birth certificates. The admission criterion for children is that they have to be between nine months and five years old, but there is flexibility. They also assist children to register for and obtain grants. In future they want to work with government departments and coordinate their services with those of other NGOs.

The staff includes a matron, two well-trained teachers, two volunteers, a chairlady and her assistant and a cook. Volunteers receive financial incentives. The organisation receives its funding from the church and DSD and aims to apply for more funding from other government departments such as the DoH.

CANSA

CANSA is an NGO tasked by the DoH to coordinate home-based care programmes in the Matjhabeng Municipality. One person with two assistants is responsible for this work. The organisation works in cooperation with the DoH and other home-based care NGOs, so the methods and operations are similar to those of these organisations. As with the other structures they provide direct care to ill members of the community in their households under the auspices of the DoH. Their work is not specifically centred on HIV/AIDS, but they do offer services to households containing PLWHA.

Virginia Women's Training Network

This is a cluster of women's projects that was established in 1998 to foster cooperation, sharing of ideas, monitoring and support between the projects. The women involved with these projects are single women caring for and supporting dependents. Some of the projects and programmes are outlined below.

Albany Sewing trains women and youth in garment making. It was established in 1996 and in 2000 they received funding from the DSD. At present there are 15 beneficiaries, all of whom are women.

Philang Bakery started in 2000 and has applied for funding from the DoA (nothing has yet been forthcoming). There are five beneficiaries (women).

The Khanyiso Vegetable Farmers Project was established in 2000. The group consists of youth, women and a few men. There are 14 beneficiaries (women). They received funding from the DSD for 2002/3. The group also received fencing equipment from the DoA and they are expecting equipment for building a storeroom on their land. Currently they have 22 hectares of land, which they lease from Matjhabeng Local Municipality.

Self-Help Association for the Disabled comprises youth and women. There are 12 beneficiaries, including women and children. The youth group is functioning well with its recycling project, but the women's group is struggling, especially with accommodation.

Challenges

Poverty puts these projects under pressure. When they do not receive enough support from government departments or other funding sources, some members become disillusioned and leave to work as street vendors. Even among those who are working, some are losing hope. Youth involvement is also not sustainable because they do not receive an income for their work. Many of these youth have children and some are household heads. Members of the projects need training and support to maintain sustainability and minimise conflict.

Young Women's Christian Association (YWCA) Crèches

A group of concerned women came together to form YWCA in Virginia in 1960. They organised youth clubs to keep children off the streets. The youth clubs organised events such as beauty contests and discussion clubs. A further critical need arose when the mines in the area opened employment to women, since old ladies were then left to care for grandchildren. This was reported as resulting in increased bus accidents, paraffin poisoning, diarrhoea and vomiting among children. This spurred the YWCA to find a place of care for the toddlers. After a long struggle, Meloding Day Centre was opened in 1979. It accommodates 73 children. This started off with playgroups and has over time converted them into crèches. They receive funding from local mining companies and socially concerned organisations in the towns. Presently, there are seven orphans in Meloding Day Care Centre and two in Umzamo Crèche.

Challenges

Among the immediate challenges are the need for skills training, particularly computer literacy and funding for equipment and structural costs. They need a photocopying machine to use for fund-raising. Umzamo Crèche has fertile and spacious land that they would like to use for a vegetable garden. They also need funding to install a borehole for the vegetable garden.

Tikwe Consortium

Tikwe Consortium, established in March 2003, has two programmes with affiliated structures or organisations. The first programme, on Education, Awareness and Support, consists of the Virginia Community Project Youth Against HIV/AIDS, Saaiplaas Anti-AIDS

Youth Group, and KMD Trauma Centre. The second programme covers home-based care, and comprises Kgauhelo Care Givers, Ipolokeng Care Givers and the Virginia DOTS Programme.

The aim of the consortium is to channel or coordinate all the organisations and structures in Meloding and Virginia, to ensure commitment from organisations and co-operation among CBOs, NGOs, FBOs, and the DSD and the DoH. Ultimately the goal is to foster progress in the communities and to consolidate efforts geared towards fighting the pandemic and other health-related issues. This is to be accomplished through education, and training of affiliated structures or organisations.

Nedelandse Gereformerde Kerk (NGK) Social Services

Nedelandse Gereformerde Kerk (NGK) Social Services has a long history of caring for OVC. They are currently busy with decentralising their large orphanage campuses into smaller home units that accommodate around 12 children. In total, they care for approximately 700 children in the Free State province. These smaller youth care centres can now also become a community. Through their outreach programmes the NG Social Services strive to deliver an acceptable service to as many children as possible from the surrounding communities. In total, their outreach benefits a further 2 400 children from the community.

NG Social Services' Division of Youth Care Centres has a management structure comprising volunteers involved in different projects throughout the province. They have a director and each region, such as the Goldfields, has a principal social worker. Each Youth Care Centre has its own management committee comprising local volunteers from the community. The staff component of each individual project is a social worker, a full-time childcare worker, a part-time relieving childcare worker and a full-time general assistant.

Main focus and operations

NG Social Services focuses on providing a programme catering for the physical, emotional, social and intellectual needs of OVC. They cater for all the basic needs of the children in their programme and specialise in safeguarding children at risk and in handling traumatised children.

In Virginia they have a youth care centre called Maan Blom YCC. They would like to start a youth care centre in Saaiplaas with a strong community and outreach focus catering for the specific needs of OVC there.

Resources

They rely on public and community donations so do not seek or receive any assistance from funders for their outreach programmes. However, as they extend their services they will need additional funding. Outreach projects are handled by their existing staff component together with the help of volunteers from the local community.

Virginia Multipurpose: Matjhabeng Community Project

Virginia Multipurpose: Matjhabeng Community Project deals with different community needs. It identifies children's needs in the community and the project collaborates with other organisations in Virginia that work with children. Virginia Multipurpose also assists homeless children by helping them to find a place to stay and, if children need counselling, they are referred to other organisations that are in a position to help, for

example, Child Welfare. They offer assistance to abused children, life skills education at schools, and they collect clothes for children in need. The organisation is in need of resources to extend its services. For example, they do not have a specific place to provide counselling on a daily basis.

Virginia Community Project: Youth against HIV/AIDS

Virginia Community Project: Youth against HIV/AIDS was established in 1999. The organisation conducts dramas, speeches, and a door-to-door campaign to disseminate information about HIV and AIDS in general, and specifically among the youth. They are particularly concerned with children who are being abused. They also support people living with and affected by HIV and AIDS. It has established support groups that operate from a high school in Meloding for group walks inside and outside the high school. They have partnerships with loveLife and Harmony Mines.

KMD trauma centre

KMD started in the Goldfields in 1953, when the local branch of the Dutch Reformed Church was struck by the poverty of local people and started the organisation out of its own funds. A few years later the Volksblad Christmas Fund was established through the *Volksblad* newspaper, and more money was generated. Money from this fund is divided between different children's organisations and old-age homes.

The management of KMD consists of people from Virginia, Meloding and nearby Henneman and Phomolong, with offices in Virginia and Henneman. They have an agreement with the government to render services in the areas where they work. However, they do not receive funding from government. KMD has two social workers.

Activities
The main focus of their services is to act in the best interests of the child. They facilitate foster care placements and access to Foster Care Grants for orphans. The organisation strives to facilitate placements for at least 30 children a month. It is not possible to process more than 30 because the courts also have to accommodate other organisations that work with children.

They have a foster child group that focuses on empowering the child, where information is given in a child-friendly manner. KMD targets all age groups, as well as youth aged between 0-18 and 19-34 years who were neglected in the past and have a need to learn life skills and develop self-confidence. Areas served by the organisation are Senzela, Meloding, White City, Sloja, Merriespruit, Kittie, V2 Mine and the main area in Virginia.

The organisation informs children in general about child molestation and abuse by staging puppet shows at crèches and in the library. KMD has started a trauma centre in Meloding for children who are victims of abuse, molestation and rape. At the trauma centre the children receive counselling and support from a volunteer through the whole process of going to the police and hospital and other ordeals.

KMD teaches life skills at schools and this offers the organisation an opportunity to empower children to face life courageously. The organisation is at present also assisting street children, and they have successfully returned a few of them to their homes. A few of the children have also been included in a school programme. In addition KMD tries to instil in the children they work with a motivation to better their circumstances.

Resources
KMD's funding comes from the Dutch Reformed Church and from fund-raising. The workload is increasing, which means that it is becoming more and more expensive to pay for administrative costs and there is reduced time for fund-raising projects. This puts pressure on both existing and future projects. The plan is for some of the projects to become independent of KMD to allow other areas of work to develop.

Dunamis Christian School Educational Trust

Dunamis Christian School Education Trust is a Christian NPO based in Welkom under the leadership of Pastors Gerry and Doreen Cloete. The Trust concentrates on the Hani Park informal settlement that has around 65 000 residents who are mostly unemployed. The Trust uses a church building as a preschool during the week, with 100 children attending, who receive the full school readiness curriculum. The children are served breakfast, a mid-morning snack and lunch on a daily basis. Medical care, clothing and basic hygiene needs such as toothpaste and soap are provided for the children. They also provide counselling and transport to the hospital for the children.

A mission primary school was established in Third Street in Welkom where 30 children from Hani Park informal settlement are currently receiving free private education.

The organisation has sent seven unemployed mothers to obtain an Early Childhood Diploma (ECD) at Tosa College (the beneficiaries were due to complete these in 2004). They are all currently employed at preschools in Thabong, Hani Park and Welkom. An adult literacy programme was due to be started in March 2004 for mothers of children attending school.

The trust distributes 350 kilograms of maize meal to needy/unemployed congregation members every Sunday. It works in conjunction with the DoH to carry out community programmes and informative workshops in their buildings. The trust also provides home-based care to six families at present, along with food parcels, clothing hampers, seeds for home gardens, vitamins and medical treatment in emergencies.

The trust focuses on OVC who are identified by teachers, church members and social workers. The organisation also assists OVC and their families to obtain child grants or to get children placed into foster care. In addition, assistance is given in writing out wills and obtaining identity documents.

The organisation expanded its services in 2004 to assist the NGOs and DoE in Virginia by providing a counselling service at Virginia schools, assisting with food parcels, school clothes, etc.

Challenges
An ever-increasing need for educare and health services and the rise in HIV/AIDS-related illnesses causes a financial drain on resources. To date, no government assistance has been received, so that the organisation depends on community donations and funding. There are a lot of volunteers available to increase home-based care, but the funding is not available to expand the service to meet the needs effectively.

SA Congress for ECD Virginia Local Structure

SA Congress for ECD Virginia Local Structure was launched in 1995 with 50 affiliated members. It is an organisation that represents the voice of the children to national and

local government. The organisation operates from national offices at provincial, regional and local level. The congress advocates for the rights of children.

The main focus of the organisation is to ensure adequate nutrition, good health and full development of children from 0-6 years. The congress represents 14 crèches in Meloding, two in Saaiplaas and one in Merriespruit. These crèches are responsible for children from 0-6 years of age. Some of the crèches receive a subsidy from the DSD. Others do not because they are not registered as NPOs.

The congress would like to address the issue of AIDS orphans and vulnerable children. They also want to create innovative ECD programmes that link children and caregivers, as well as creating an environment that enables all children to enjoy their constitutional rights.

Challenges faced by NGOs providing services

The NGOs face a number of common challenges in their work. These often require solutions that are beyond their capacity, or relate to the specific role that these NGOs play. A number of the challenges are summarised below.

Staff turnover

A lot of people only join NGOs to gain experience. Once they have this on-the-job training they leave for other posts (including those in government and business), which affects services and delivery. There are also high levels of burn-out among staff, which pushes people out of the structures after a few years. Most NGOs feel compelled to help as many as they can, and therefore often overextend their resources and their staff. This also contributes to burn-out and staff turnover, since the levels of insecurity and high workload are difficult to live with.

Insufficient and insecure funding

All NGOs interviewed complained that they need financial support to extend their services, and many were uncertain of receiving sufficient funding to continue to maintain their current services. Some also complained that the DSD is not providing enough support to them. This impacts on the extent and security of their services, stifling the NGOs' delivery of services. For example, Morning Star mentioned that they still have a long list of children waiting to be admitted into the home, but because of limited space and funding they cannot admit all of them. In other cases a lack of resources, such as a car or a borehole inhibits the extension of much-needed services.

Lack of skills

It was mentioned that a lot of NGOs and CBOs do not have financial, administrative and other skills needed to successfully run an organisation. One interviewee emphasised that if the NMCF is to fund the CBOs, they first need to train them in these skills, otherwise money will be wrongly used and no one will be accountable.

Training was said to be the key. It was suggested that before funds are allocated, the capacity of NGOs to spend them effectively should be properly assessed. Training opportunities would also attract more volunteers into the organisations.

There were complaints that the DSD does not monitor funds given to NGOs and CBOs. As a result there is no accountability and there is the risk that NGOs will misspend the money.

Lack of coordination of services offered by NGOs
It was felt that a lot of NGOs offer similar services which results in duplication. This also puts increased pressure on access to resources, particularly scarce funding. The municipality also shared this sentiment. One interviewee felt that there are too many NGOs in some areas and they lacked even a register of the organisations.

Other challenges
Poverty presents a huge challenge, one that is determined by factors far beyond the reach of these NGOs, or even the communities as a whole. The lack of profitability in the mines has led to high unemployment and increasing poverty. This is the backdrop to almost all of the other needs that are presented by the NGOs.

There is insufficient involvement of members of local communities in the running and services of the NGOs. Many see very little personal return and there is a general level of despondency about the future in communities. Some volunteers have come forward, but there is insufficient community involvement and general input. Some NGOs maintained that their services are not known in the communities. A lot of marketing needs to be carried out.

Conclusion

Two major threads evident in the above are the size of the task and the difficulty of ensuring care for all OVC, as well as the level of commitment by key service providers in the district. Throughout the interviews and consultations there remained a sense of desperation and increasing apathy that could make the situation even more difficult in future.

The size of the task is evidenced by the sheer magnitude of the problems that these communities face regarding poverty and unemployment, HIV, gender and child violence and a general level of despair among the residents. The levels of poverty are evident and probably the most damaging to children and with the general economic downturn in the region this is unlikely to change. Both the mining and agricultural industries are becoming less able to support these communities.

The Free State province has the highest levels of HIV in South Africa, according to the 2002 HSRC survey (Shisana and Simbayi, 2002) and this is going to impact directly on the numbers of orphans in the future.

Attempts at care come from a range of sources and organisations. Government agencies provide the bulk of the services, whether directly or by funding other organisations to provide them, but are still very restricted. Major restrictions are around money, staffing and legislation.

Large national NGOs such as Child Welfare and FAMSA play very important roles. They are able to draw on their own experience from work in other areas and sectors, which facilitates local operations. They are also more able to draw on stable sources of income since they have a wider net of contacts. Finally, they are able to facilitate communication between the state services and smaller local CBOs and FBOs who provide services.

A number of CBOs have developed, mostly on a very small scale. These provide a localised service, but struggle to obtain funding or other support and as a result have low sustainability. There is also often a lot of overlap between the organisations, which

increases confusion. The energy within these CBOs is important since it arises directly out of the need of people to help one another.

FBOs provide similar services to the CBOs, but operate from a church. A number of these structures are large, such as the Matjhabeng Christian Leaders Forum and those services attached to the Dutch Reformed Church and these are able to offer more significant and sustainable services. The churches generally play a crucial role in serving the poorest sections of these communities.

Across all the groupings there was a heightened sense of caring and a desire to do all that was possible to assist children affected by HIV/AIDS. This commitment to serve included some significant compromises in people's own lives. However, there was concern over despair and breakdown, both in communities generally and among the helpers. Support and resources are needed to maintain these structures and the communities themselves.

Priorities for action

From the information above, a number of clear priorities for interventions emerge. These could change or become better understood as more research is done and we obtain wider experience in the district. We suggest that the following areas be prioritised for action at three levels: government, NGOs/CBOs and community/OVC.

Government

It is evident that the key challenges faced by government departments are shortages of staff and resources. This makes it extremely difficult to provide quality services that will meet the needs of communities. DSD is unable to process grants fast enough, let alone monitor their use; DoH battles to provide full efficient services; and the DHA is also unable to provide all people with necessary documents.

The coordination of services, particularly for OVC, has to be prioritised among government departments. They need to be encouraged to work together towards achieving the same goal, rather than competing to provide the same services. It is hoped that the OVC Task Team, which is comprised of personnel from different government departments and NGOs, will address this limitation.

Monitoring of funds is another important issue that needs to be addressed with regard to government departments.

NGOs

A key challenge mentioned by NGOs/CBOs/FBOs was insufficient funds. This limits their potential to reach as many OVC as possible. The majority of NGOs lack the basic requirements to enable them to provide support for OVC, such as computers, space, human resources and others. This needs serious attention.

Staff of these community-based structures also need additional training. They need this to provide the services they are offering better and more efficiently and to be able to tackle the administrative tasks of running an organisation, such as bookkeeping, record-keeping and management of people.

A key intervention required for NGOs is coordination of services. From the comments of participants it was evident that several NGO services are duplicated. This is most obvious

in home-based care, where health providers all seem to be focusing on HIV-related home-based care. Much greater collaboration and cooperation is needed between NGOs, since there is currently too much competition over resources and services. For example, NGOs need to develop a referral system whereby if one NGO cannot provide certain services, the person can be referred to another relevant organisation. This can only be achieved if NGOs/CBOs are encouraged to work together for the good of OVC rather than as competitors. It would also limit financial costs.

Community/OVC

A key intervention required for OVC is provision of shelter, whether an orphanage or foster home. It is unacceptable for children to live on the streets – especially when there are means of assisting them. More rapid allocation of children to family homes is also required. Part of this is the urgent need for houses to be built for all the people currently living in informal settlements.

The grant system also needs to be improved to increase the numbers of beneficiaries. Present obstacles – provision of identity documents, staff shortages, etc. – need to be addressed. Intergovernmental collaboration is required to attend to this problem, since it emanates from limitations in various government departments. In addition, carers need monitoring to ensure that they use children's grants for the benefit of the children rather than for themselves.

A culture of care within the community needs to be revived/encouraged. Community members need to be sensitised about the importance of caring for other needy children, even if not related to them by blood. There is a tendency for the community to leave all responsibilities to government officials. In addition, it is not enough to provide only material assistance – the children also need to be given emotional assistance to cope with the stress of losing their parent/s.

Moreover, community-based interventions need to intensify education about HIV and other related services. For example, VCT, antiretrovirals and PMTCT. However, this should focus on contextual factors specific to Matjhabeng that increase the risk of HIV/AIDS, such as mining, immigration, etc.

Improvement to the infrastructure in communities, for example, roads and community facilities, is also needed since these will allow for the ongoing development of these communities.

CHAPTER 4

A situation analysis of OVC services in the Kopanong Municipality, Free State

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Description of Xhariep/Kopanong

The Kopanong Municipality, where this study took place, falls under Xhariep District Municipality in the Free State province. In total there are five district municipalities in the Free State. We will first briefly describe Xhariep before offering a description of Kopanong and then of the towns and their conditions.

Although it covers the largest area (34 131.55 km2), Xhariep district has the smallest population in Free State (approximately 135 000), which makes it the most sparsely populated district in the province (Reviewed IDP, 2003). The other two local municipalities that fall under Xhariep are Letsemeng and Mohokare. There are 17 towns in Xhariep, nine under Kopanong, five under Letsemeng and three under Mohokare. Kopanong is the largest of the three municipalities, covering an area of 15 190.54 km2, with 41% of the district's population residing there.

Table 3: Population distribution per local municipal area, 2001

Area	Total population	Percentage of district population	Density (km²)
Kopanong	55 942	41.37%	3.68
Letsemeng	42 979	31.78%	4.22
Mohokare	36 316	26.85%	4.15
Total / average	135 237	100.00%	3.96

Note: Density refers to the number of people per km, Source: Stats SA (Census 2001).

Below we provide a description of all towns under the Kopanong Municipality, including a brief description of their conditions and how to access them (see Appendix 5 for names of other towns in other municipalities, and distances).

Trompsburg/Madikgetla

Trompsburg serves as the central town in both Kopanong and Xhariep Municipality with all local district offices situated there. It has a total population of 3 860 people who speak mainly seSotho and isiXhosa. Trompsburg is easily accessible by the N1 route from Colesburg to Bloemfontein and by the R707 from Edenburg to Philippolis. Although it

is a central town of the municipality, Trompsburg is among the least developed towns in Kopanong. Efforts are being made to upgrade it, including the construction of new municipal offices. This construction has resulted in job creation in the local community.

Edenburg/Ha-Rasebei

Edenburg is situated about 39 km north of Trompsburg and about 30 km from Reddersburg. It has a total population of 7 411. The main languages spoken are seSotho and Afrikaans; very few people speak isiXhosa/isiZulu.

Reddersburg/Matoropong

Reddersburg is the nearest town to Bloemfontein (37 km), which is the capital of Free State province and is about 65 km north-east of Trompsburg. Reddersburg is accessible via the R717 from Edenburg to Dewetsdorp; this route also connects to Bloemfontein. The total population size is 6 430. The main language spoken is seSotho, although isiZulu is also spoken by a few.

Bethulie/Lephoi

Bethulie is the largest town under Kopanong Municipality with a total population of 12 374. It is accessed by the N701 from Gariep Dam to Smithfield or by using a gravel road from Springfontein.

Jagersfontein

Jagersfontein is situated 35 km north of Trompsburg and has a total population of 6 913. Access is gained by a gravel road, the R704 between Trompsburg and Fauresmith. It is a mining area, so has many migrant workers. The main languages spoken are seSotho and Afrikaans; very few people speak isiXhosa. Compared to other towns in the area, Jagersfontein is better developed; it has more shops and is bigger. There is also a suburban area situated closer to the township, which accommodates people of all races. Together with Fauresmith, Jagersfontein has mining as its economic base.

Fauresmith

Fauresmith, situated 10 km from Jagersfontein and 47 km north of Trompsburg, also looks better developed. It has a total population of 6 822 who reside mainly in the nearest township. Access is gained by using the R704 between Koffiefontein and Jagersfontein. As one drives into different areas of Fauresmith social inequalities are evident. One part is developed with access to water and sanitation and clearly marked streets, while nearby there are old squatter houses that do not have access to water and sanitation. Unlike other towns, both blacks and coloureds occupied squatter areas in Fauresmith. Afrikaans is the dominant language, with seSotho and isiXhosa being secondary languages.

Philippolis

Philippolis is the third biggest town and comprised 6979 people. It is 55 km southwest of Trompsburg and accessible via the R717 from Edenburg and R48 between Koffiefontein and De Aar. The main languages are seSotho and Afrikaans. Philippolis is a tourist attraction because of its historic value. It claims to be the oldest town in the Free State and has a number of stately old buildings. It was also the birthplace of Sir Lourens van der Post and was the centre of the Adam Kok Griqua community.

Gariep Dam

With a total population of 1 179, Gariep Dam is the smallest town under the Kopanong Municipality, yet the most developed because it is the main tourist attraction. It is situated approximately 62 km from Trompsburg and is accessible by using the N1 from Colesburg to Bloemfontein (about 5 km from the freeway) and R701 route to Smithfield. The main language spoken is Afrikaans, although a minority speak isiXhosa and seSotho.

Springfontein

Springfontein is the closest town to Trompsburg (28 km) and about 3 km away from the N1 route to Bloemfontein. Access from other towns, Bethulie, Philippolis and Trompsburg, is gained by using a gravel road. It has a total population of 5 289. The main languages spoken are isiXhosa and Sesotho. Due to being close to the N1, levels of prostitution are said to very high.

Description of conditions

Africans form the majority of residents in the Xhariep district, followed by coloureds, whites and a few Indians. The latest review of Xhariep indicates a decrease in the white community and an increase in the coloured population. Table 4 below presents the demographic composition of the area.

Table 4: Demographic composition in 2001 compared with the average for the district in 1996

Area	African	Coloured	Indian	White
Kopanong	72.52%	17.83%	0.04%	9.62%
Letsemeng	64.99%	25.26%	0.04%	9.71%
Mohokare	89.33%	2.92%	0.02%	7.73%
Xhariep 2001	74.64%	16.19%	0.03%	9.14%
Xhariep 1996	72.92%	11.17%	0.07%	12.19%

Source: Stats SA (Census 1996 & 2001).

Population distribution

The majority of people are young (33.96% are children (<18 years) and 34.35% are youth (18–39), followed by middle-aged, 27% (40-64) and then elderly 6.71% (>64). Although old-aged people form the minority, many children who have lost their parents rely on them for support.

Roads and transportation

Xhariep district is located near three main national roads: NI – Johannesburg to Cape Town, N6 – Eastern Cape to Bloemfontein, and N8 – Bloemfontein to Kimberley. However, within the district there are many gravel roads linking one town to another.

The main modes of public transportation are 16-seater taxis. There are no public buses. Transport is very scarce and expensive. There are no direct taxis between the different towns within the district. The only taxis available travel to Bloemfontein. If someone takes a taxi he/she must pay the same amount as someone who is going to Bloemfontein. Another option is hiring a private car, which costs up to R80.

Water, housing and sanitation

Clean water is available to 91% of residents of Xhariep district (IDP Xhariep, 2003), but many residents complained that the quality is poor. Water shortages are experienced in summer due to lack of rainfall (IDP Xhariep, 2003). The main sources of water in townships are communal taps and a tap inside their property but outside the house. The communal taps are easily accessible since they are less than 500 m from households.

Housing arrangements exhibit the national trend, whereby whites predominantly occupy towns while blacks and coloureds mainly dominate townships. Coloured residential areas are also separated from the blacks', though the distance between them is not far. Among township dwellers some reside in formal houses and some in shacks, while others stay in the newly built RDP (Reconstruction and Development Programme) houses. There are no flush toilets in the shacks and many people use pit latrines and basket bucket systems for waste disposal.

Economic conditions

Kopanong Municipality makes the largest contribution to the total gross geographic product (GGP) of the district (42.41%), followed by Letsemeng (29.84%) and Mohokare (27.75%) Municipalities. The economy of the district is dependent primarily on agriculture, which contributes 35.91% to the GGP of the district, followed by government (16.17%). Mining contributes to the GGP by 6.35%. The dependence on agriculture means that the economy of the district is at risk due to the decline of the agricultural sector in the past few years. As mentioned above, droughts are also common. Unlike other towns in South Africa, informal trade, whether in the form of food, clothes, etc., does not exist within these towns, except during grant payment and other activities, when such products are sold.

In all towns there are very few commercial activities taking place, except for a few supermarkets that sell basic household goods. Big supermarkets such as Shoprite, Pick 'n Pay and Spar do not exist in the study area. This has major cost implications since residents have to pay lots of money for transport to access these shops.

Education

The illiteracy rate for the district is 22.74% according to Census 2001 (Stats SA, 2003). This has shown an increase of 1.33% since 1996. Table 5 below provides a breakdown of education levels per municipality for 2001.

Table 5: Education levels for persons 20 years and older, 2001

Area	No schooling	Some primary	Complete primary	Some secondary	Grade 12	Higher qualification
Kopanong	20.94%	25.12%	8.52%	27.74%	13.02%	4.66%
Letsemeng	25.25%	26.16%	7.85%	24.32%	12.40%	4.02%
Mohokare	22.61%	30.40%	8.64%	22.54%	11.13%	4.67%
Xhariep	22.74%	26.86%	8.34%	25.28%	12.32%	4.46%

Source: Stats SA (Census 2001).

Social problems

The key social problem mentioned by all participants was the high consumption of alcohol. The main contributors to this problem were cited as the high levels of unemployment – 40% in Kopanong and 62.8% in the district – and lack of recreational facilities for the youth.

HIV/AIDS situation

All participants who took part in the situation analysis acknowledged that the prevalence of HIV/AIDS is very high in the municipality. This was attributed mainly to the living conditions, such as poverty, unemployment, substance abuse (especially alcohol) and lack of knowledge about HIV and AIDS. The Xhariep Reviewed IDP (2003) concluded: 'Xhariep has high rates of infection, but it is not higher than the average rates of HIV/AIDS infections in South Africa'.

The circumstances contributing to HIV/AIDS differ among the towns in the area. For example, in Jagersfontein and Fouresmith, HIV/AIDS was said to result from migrant work, whereby men who work in mines were said to use their money to attract women who are unemployed and drink. Many of these men come from outside Jagersfontein and do not have partners or wives in the area.

In Springfontein, HIV/AIDS was attributed mainly to commercial sex work that was said to take place between truck drivers and women who are unemployed. Springfontein is situated 3 km from the N1 freeway where there is a resting garage for truck drivers. Among youth, HIV/AIDS was said to be due to a lifestyle of drinking in shebeens and then not using condoms in sexual encounters. Other young participants said men who work in Bloemfontein or Johannesburg use their money to attract young girls in shebeens: 'Like for example if you can come and drive around here with your car, I'm sure you can get a girl; I promise you' (youth, Bethulie).

Also related to the above issues contributing to HIV/AIDS was the issue of stigma. There was widespread agreement that HIV/AIDS still carries a stigma, hence, many people do not want to disclose their status. Almost all participants said they do not know of anyone who has openly disclosed their status. HIV/AIDS was said to affect mainly young people: 'if you look at the Xhariep district, you will only find children and elders; there are no young people … they have died of AIDS' (education department personnel).

Conditions of OVC

> Let me think about these four children: it's a small house; the mother is not working, the father is not working. The father of the mother is not working but is not at that age to get an old age grant… [They don't have food] I just sometimes give them food from my own children and most of the time we give them food parcels (NGO participant, 2004)

Conditions in the community and households

Levels of poverty are very high in the Kopanong Municipality, which is likely to leave considerable numbers of children and households vulnerable. Poverty, even more than HIV, has the major impact on children's lives. Many children, and probably even more orphans, are supported by carers who are themselves unemployed and depend on foster grants. Very

few orphans live in well-off families. Since some interviews took place inside houses where OVC stayed, researchers made observations about conditions inside households where the children lived. The three-roomed RDP houses that dominate in these communities often ended up being overcrowded while having access to very limited resources.

Given variations across the nine towns, it is difficult to make any fixed generalisations about the situation of children and especially those who are vulnerable. However many of the respondents in the qualitative interviews described the conditions of some OVC as 'unacceptable'. They said many OVC lack many of the basic requirements for the healthy growth of a child. These include shelter, clothes and food.

> I wish you were there last week when we went to look at their conditions … I wish we had taken photos so people could see how they looked like before they were taken to a place of safety … there's no beds, there's nothing, only blankets, dirty blankets. It's dark in the house, you don't even see the pot, you don't even see what they are using for cooking or what they cook. (NGO participant, Trompsburg)

This situation is not unusual – other participants also shared similar views about the situation of OVC in their own towns. It was said to be commonplace among children living in impoverished households with little or no income.

> Others are not even able to go to school, that don't have school clothes, you see, others can also go to school without having a meal. That is the situation of some of the orphans living under here locally. (Youth participant, Reddersburg).

An NGO representative based in Edenberg added:

> The conditions where they live … let me think about these poor children … because I'm also concerned about these poor children. It is a small house. It's a four-roomed home. I say it's small. The mother and father are unemployed, but they are not at the age to qualify for an old-age grant, you see.

These descriptions are likely to emphasise the more negative spaces in which children find themselves. However, the levels of poverty will impact on the children's access to food, clothing, adequate shelter and all other services. The impact of the poverty will be accentuated by them living in small towns, which increases the cost of living and reduces access to services and employment.

When asked why OVC live in such circumstances, participants offered various reasons. Some placed the blame on parents, saying that they engaged in unhealthy lifestyles such as drinking, neglect and violence.

> The problem is that our people are drinking. Others are dead because of this AIDS, and children are living with their grandmother. (Kopanong counsellor).

Others pointed fingers at the entire community for not intervening in the lives of the OVC. One participant commented that a culture of caring for children, even if they are not biologically related to you, has been eroded in the community. She urged people to adopt children who are in need. Others, however, felt that it was unfair to place the blame on the community given that families are already struggling to maintain their own children. Key across all the household situations and communities is the problem of poverty and the costs of keeping and maintaining additional children.

Specifically in relation to orphans, there were 480 children (2.1%) 18 years and younger who had lost both parents, 1 344 (6%) who had lost their mothers and 2 762 (12.3%) who had lost their fathers. Applying this to the age grouping under 6, 37 (0.6%) had lost both parents, 136 (2.1%) had lost only their mothers and 375 (5.9%) had lost their fathers. These children have a high potential vulnerability as, in addition to the pervasive conditions of poverty that they face, they do not have the direct protection of a parent. Many of the children find spaces in other households, especially of their extended family, but these placements are becoming more difficult to obtain and the conditions in these new houses are not always conducive to the children's development.

Main needs/problems of OVC

The main needs of OVC mentioned were as follows:

- school uniforms
- payment of school fees
- warm winter clothes
- food
- shelter.

The main health problem mentioned was malnutrition. Several participants felt strongly that there is a need to place all OVC in a shelter where they can be provided with all their needs under the supervision of trained carers.

Child abuse was reported to be a minimal problem faced by the OVC. Participants felt it was difficult to determine the extent of the problem since it is not talked about in the community. It is still treated as a family issue so that people tend not to intervene. This makes an accurate assessment very difficult. Others, however, acknowledged that some children do experience abuse by their parents or carers, especially when they are drunk.

Support services for OVC mainly come from the Department of Social Development (DSD) through provision of grants. The DSD has social workers active in all 17 towns (although some towns do not have social workers based there) who attend to the needs of OVC and the general community. Other than this, very little is available for OVC except for one victim support centre in Trompsburg. There are no shelters available for OVC who do not have a place to stay. The DSD prefers placing OVC under the care of someone within the community rather than building separate shelters for them.

Access of OVC to health services can be said to be reasonable since clinics are within their reach in all the towns. According to health personnel, all clinics are accessible within a 5 km distance. However, it is not known whether community members are aware of all the services offered at the clinic, e.g. nutritional supplements.

Stigma towards OVC: from comments of participants it seemed stigma was not a major problem for the OVC. They felt that the general community is sympathetic to the situation of OVC: 'What I can say is this they feel for them, to be honest…' (Ward Councillor, Kopanong). However, many people did not want to talk about the status of children under their care, indicating a possible level of internalised stigma. Efforts need to be made to encourage people to talk openly about problems encountered in their households.

Culture of care in the community: the culture of care for children is still existent in the communities observed. This was evidenced by a low number of street kids and willingness to care for children in need. It was felt unacceptable to neglect a child who

didn't have food: 'They give them food and then ask them to go back home' (OVC carer, Springfontein). However, some participants were concerned about people who adopted children merely to get their own hands on the grants, rather than for the well-being of the children. Others suggested that there should be better monitoring of the grant to make sure that it is used for the benefit of children rather than of the carers.

Services of government departments

Various government departments are involved in the delivery of services for OVC and their families. They are the DSD, of health, of agriculture, and of education. Below we briefly describe services provided by each government department.

Department of Social Development

The DSD is a custodian of poverty alleviation in South Africa. OVC-related services provided by DSD are child grants (Child Grant and Foster Grant), food parcels and allocation of children to foster homes. Families who have legally adopted/fostered a child receive a Foster Grant of R700 per month that is meant to meet the requirements of a child, such as school uniform, clothes, food, etc., although in some households it tends to be used as a support system for the entire family. The process of fostering is facilitated by social workers who first assess the household environment before deciding whether it would be appropriate to place a child under the carer. The Foster Grant takes longer to come through than others due to legal requirements and procedures involved. It is further complicated by the high workload of the social workers who process these grants.

We learned that in Kopanong very few people have access to grants, including the Child Grant and Disability Grant, and this was due to many factors, one of them being the unavailability of identity documents (birth certificate and ID) required to access them. The DHA is based in Bloemfontein and only makes one visit a month. Given the size of the Xhariep district, more visits are required from the department so that more people could be provided with the relevant documents.

In addition to grants, the DSD also provides support through provision of food parcels, which are given to the families while they are still awaiting the grants. Ideally this process should take only three months, but due to the delays mentioned above, may take up to 12 months.

The DSD also provides funding to youth organisations in the district. However, this service was not well used among the community. It was felt that 'the community associates the department with food parcels; they know little about other services that we offer'. Currently the DSD also funds two consortiums, Lekomo and Bokomoso, whose role is to coordinate services of NGOs that are assisting OVC. The consortiums also distribute food parcels. The Philani Victim Support Centre, discussed below, also receives its financial support from the DSD.

The DSD's mission is to assist children within families rather than building or providing a separate shelter for them; hence no OVC centres exist in the area. However, this position seemed to differ from that of community members and community leaders, who felt strongly that there is a need to provide OVC with shelters where they can be cared for by people who have their own interests at heart. Currently there are no programmes for street kids, even though certain children are found on the streets during the day.

Department of Health

Access to health services is easier for the majority of residents since there is a clinic in every town and virtually all residents of the towns are within 5 km of a facility. All clinics are on a 24-hour call service, meaning that although they close at 16h00, if someone needs a nurse after working hours someone will be available to help. There are also plans to improve the present health services, including the upgrading of Jagersfontein Hospital and building a new clinic in Bethulie (IDP Xhariep, 2003). Out of 17 towns (or clinics), nine have established VCT for HIV, but VCT services are available in all clinics. Nevirapine for PMTCT is available in the district hospital at Jagersfontein, but because of the vastness of the district, access is likely to be restricted.

The home-based care service is a key intervention of DoH aimed at increasing access to health services. DoH contracts several volunteers from local NGOs and CBOs to deliver services to people, including provision of medicine, assisting with domestic chores, washing and dressing the patients and health education. In return for services they receive stipends of R500 per month. Through the home-based care programme, the DoH also identifies OVC in the community. Once they have identified them they hand the OVC to the DSD to provide necessary assistance for them. However, the DoH attends to any health needs, such as malnutrition.

In addition to home-based carers, the DoH employs counsellors to work in clinics and provide HIV-related information to their clients, such as PMTCT, VCT and safe sex practices. The main challenge expressed by the counsellors was the unwillingness of clients to test for HIV/AIDS after receiving counselling. 'You can provide them with counselling and all that but when it comes to testing and receiving results, they run away'. This was disputed by the health personnel interviewed, who said that more than 60% of people who attended HIV information sessions get tested for HIV/AIDS.

Department of Education

A key intervention of the DoE is the school-feeding programme, intended to benefit poor children at primary schools. According to the educational personnel this service contributes greatly towards improvement of school attendance.

> Since the introduction of school feeding schemes the numbers have increased … at least they know they will have something at school. That does encourage them. (Education specialist, Bloemfontein).

In addition to school feeding schemes, DoE also encouraged children to carry lunch boxes to schools. This latter intervention was not successful, since children who come from poor families had no food at home. This marked them out as being poor (DoE personnel).

The DoE is also involved in the identification of OVC at schools in an attempt to assist them to acquire grants. The DoE also contributes towards education of learners by exempting learners who come from impoverished families from paying school fees. However, an educator felt that many families did not know about this programme and that those who knew were uncomfortable accessing it since it exposed their impoverishment.

> The only problem is that students do not tell their parents, that is why they do not make use of these services. (Educator, Trompsburg).

HIV-related activities

According to the policy of the DoE, each school is supposed to have a policy on HIV/AIDS. However, the implementation of this policy 'is still said to be a problem'. The DoE has also made attempts to train staff and students regarding HIV/AIDS-related matters. In Xhariep district the DoE works together with loveLife to organise events whereby students debate many issues affecting them, including HIV/AIDS.

Department of Agriculture

Compared to other government departments, the DoA is minimally involved in OVC services due to financial constraints. A key intervention aimed at children is a Youth Programme for Grade 3-10 children. The main aim of this programme is to encourage children to develop an interest in agriculture through the formation of youth clubs. Currently there are two clubs in Petrusburg, two in Koffiefontein and one in Springfontein. Due to financial constraints this programme cannot be extended to all towns. In addition, there is no budget for the programme so it is difficult to maintain.

Another intervention of DoA is through a food security programme. Conducted in collaboration with DSD, the aim of this programme is to assist poor people to develop their gardens in their own backyards. The DoA provides seeds to people to facilitate this. DSD, on the other hand, assists with the provision of food parcels and identification of eligible recipients. The main challenge to this programme is extra costs incurred during the watering of plants. Currently there are plans to negotiate with the municipality to allow the recipients of this programme to use more water than is now allowed and to pay less for it.

Kopanong local municipality

The Kopanong local municipality has no services particularly targeting the OVC and their focus is mainly on poverty alleviation. The municipality contributes towards this by funding small local income-generating projects, such as poultry farming, a bakery, etc. The participants from the municipality expressed concern about their inability to sustain the project. The main barrier to sustainability was lack of management skills of recipients.

> I will not agree with a situation whereby you are given R500 000 to run a project. And then they pay themselves huge salaries; and for that matter, production has not even started …why not remunerate yourself in terms of the profit that you make. (Government representative).

Another challenge mentioned was reliance on government to sustain projects. There was a feeling that community members expect the government to keep providing them with money, which they do not use effectively: 'People think that the government should keep pumping money into their projects to be able to pay their salaries' as stated by a government representative.

Challenges of government departments

The following were challenges faced by government departments based in the Xhariep district:

- **High levels of need for services**: The key challenge faced by all government departments was high levels of need in the community, which put considerable pressure on the under-resourced services. This was exacerbated by staff shortages, especially in DSD and DoE. Doctors are particularly scarce. Although attempts are being made to recruit more personnel, including doctors, potential employees are reluctant to work in the rural areas.

- **Lack of commitment/participation from the community**: Government representatives were particularly concerned about lack of community involvement in poverty alleviation initiatives. They felt that the community relies too heavily on government interventions to provide services for them, while they are not doing anything to uplift themselves from poverty.
- **Sustainability**: As mentioned above, many projects fail because of misuse of money and lack of the skills required to sustain them. Recipients of government finance are not properly trained in matters related to management of businesses and as a result are unable to sustain them.
- **Duplication of services**: This took place between government departments and within the DSD. This occurred particularly regarding the identification of OVC, in which all government departments seem to be involved in various ways. For example, DoE identifies OVC at schools; DoH identifies them through home-based programmes; and DoA through primary school programmes. The personnel from DSD said that even within the DSD duplication of services happens – that it is not uncommon for one family to receive three food parcels a month from different sectors within the department.
- **Transportation**: A lack of public transportation was also cited as a limitation to reaching all people in need. For example, school children are unable to attend certain activities because of unavailability of transport. Service providers, on the other hand, complained about the vastness of the district, which was said to result in slowness in the delivery of services, since they have to drive long distances to provide them. This was exacerbated by having to travel on gravel roads.
- **Infrastructure**: Lack of facilities in the district to attend to problems, for example, child abuse cases are dealt with only in Bloemfontein – there are no facilities in the district to attend to them.
- **Drought**: Since the economic base of the district is mainly agriculture, drought results in a decrease in production and subsequent economic decline. A challenge specific to the DoA was that agriculture was not popular in the community, so more efforts are required to increase its popularity.

Services of Non-Governmental Organisations (NGOs)

Very few NGOs exist in Kopanong. Even where there are some, they tend to lack many resources and are often not well supported financially. Below is a profile of NGOs and CBOs operating in Kopanong.

Support groups

Voluntary support groups exist in all towns under Xhariep Municipality and their main services are home-based care, HIV/AIDS/PMTCT/VCT education, supporting HIV-positive people, identification of OVC through home-based care, DOTS (directly observed tuberculosis treatment; short course) and distribution of food parcels. Many members of the support groups are contracted by DoH and are reimbursed a stipend of R500 a month. They tend to be based in clinics in the towns.

The support groups also work closely with DSD in delivering services to the people. For example, they assist with the identification of OVC through home-based care and the distribution of food parcels. One interviewee mentioned the potential conflict between the government departments created by the involvement of volunteers from the support groups with a number of government departments.

> The thing is, you do not want to bite a hand that feeds you. (Government representative).

Lekomo HIV/AIDS Consortium

The Lekomo HIV/AIDS Consortium is an umbrella body of clusters of NGOs based in the Xhariep district. Initially the consortium was composed of NGOs in all towns under the Xhariep district, but due to the vastness of the district it was broken down into two consortiums. The new consortium is called Bokomoso. Currently eight towns are eligible to register with the consortium: Springfontein, Smithfield, Gariep Dam, Bethuelle, Zastron, Edenburg, Reddersburg and Rouxeville. The formation of the consortium was facilitated by the DSD in recognition of a need to (i) co-ordinate the activities of the NGOs in the Xhariep district; (ii) avoid duplication of services and (iii) ensure quicker delivery of services. Ideally each NGO is required to register with the consortium. However, not all NGOs are registered.

The consortium has four focus areas, namely:

- home-based care
- information, education and communication (IEC) on HIV/AIDS
- distribution of food parcels
- identification of OVC.

NGOs that are registered with the consortium offer these services, for which they receive stipends. The activities of the consortium include support for the terminally ill; support for HIV/AIDS orphans; promotion of VCT in the community; educating the community about HIV/AIDS; education of persons living with AIDS about their constitutional rights; encouraging disclosure; facilitating the identification of orphans and child-headed households and encouraging those living with HIV to remain within their communities. The consortium contracts the NGOs available in an identified area to conduct these activities.

In terms of staffing, the consortium has an executive that is composed of a member from each town. Not all of them have expertise in running an organisation or training in financial management. Courses and other assistance are planned to help them overcome this limitation.

Bokomoso HIV/AIDS Consortium

This consortium drew its name from the Lekomo HIV/AIDS Consortium. Initially members of the Bokomoso Consortium belonged to the Lekomo Consortium, but due to the vastness of the district it was decided to split it into two for better delivery of services and improved communication. The Bokomoso Consortium is composed of representatives from the following towns: Jagersfontein, Philippolis, Fauresmith, Kofffiefontein, Petrusburg, Oppermansgronde, Luckhoff, Jacobsdal and Trompsburg. They offer similar services to those of Lekomo Consortium and have the same structure.

Philani Victim Support Centre

This is an NGO, formed in 2000, whose initial mission was to address problems of woman and child abuse in the community of Trompsburg. The age group currently served is between 10 months and 15 years of age. Its small four-roomed office is situated at the old Mamelo Clinic in Madikgetla Township, Trompsburg. The NGO operated for a number of years without funding until they finally received funding from DSD.

Initially the organisation was formed to address mainly the abuse of women and children, but in the past few years it has seen a large increase in abused, neglected and vulnerable children within the community.

Activities currently taking place include the provision of emotional support and counselling to abused women and children; paralegal advice and referrals; temporary accommodation for vulnerable children and victims of rape; identification of safe homes in the community for placement of children who are victims of abuse and provision of temporary relief to children who are neglected. Most of their work involves liaising with various stakeholders such as other NGOs, South African Police Service (SAPS), DSD and DoH.

The organisation is poor in resources. There is no proper office. Inside the house, used as such, there is a waiting room, a kitchen, bathroom, and a room where all their activities are conducted. There is insufficient furniture, the organisation having only two or three chairs in the waiting room. The staff is composed of nine women and two men who have just received training on domestic violence. They all offer their services on a voluntary basis. The founder received training in domestic violence, child abuse and counselling and provision of emotional support.

Major challenges include the inability to provide permanent shelter to the women and children they assist in instances where they need to be removed from an abusive environment. Other challenges are lack of resources such as furniture and limited funding.

Oranje Vroue Vereeniging (OVV)

The OVV is a national NGO, but is named differently in each province. In Cape Town it is called the African Christian Women's Organisation. In Johannesburg it works under the name South African Women's Federation. It was established in 1904 after the Anglo-Boer war to help the poor white community, but has extended its services to black and coloured communities in the past eight to nine years. The NGO is one of a few in the district that focuses solely on children. In the past they used to provide support in the form of food to adults as well, but have since learned that the adults abuse such assistance, 'If we help them, if we for instance provide food, then they sell it and they buy alcohol with it'.

The organisation has a nursery that has about 54 children from black and coloured communities. The tuition fee is R20 and children are provided with porridge, which is sometimes donated for free by certain community members, and fruit and vegetables. The nursery is composed of unqualified teachers who work on a voluntary basis, together with two helpers who always make themselves available when their services are required. In addition to teachers there are staff who do community outreach work such as provision of food parcels and assistance with procurement of grants.

The organisation does not have an office. The staff of 16 women meets weekly at the house of a manager in Trompsburg. The majority of children who attend the nursery school come from very poor households and their parents are not working. This creates additional pressure on the organisation to provide more services for them. For example, in winter the NGO buys tracksuits for some children, but not all of them benefit from this intervention.

Currently there is no stable funding for the organisation. It survives on donations from caring community members and fund-raising activities. This limits their potential to reach more children in need, 'We really want to do more, but we don't have the funds'.

Attempts have been made to apply for funding, for example, from the national lottery, but in vain. The national lottery fund did not give them money because the organisation does not have an auditor. Another limitation is a lack of space for staff and lack of a proper infrastructure for the children. The organisation currently operates from a house in Trompsburg and the nursery school is situated in a side hall of the community centre. Due to lack of space and unavailability of cell phones, it is difficult for the staff to communicate regularly.

Challenges of NGOs/CBOs

The following were challenges highlighted by the NGO/CBO service providers:

- **Financial**. The main challenge expressed was lack of funds. DSD is the principal funder of most community-based initiatives, but the money is not enough to meet all requirements for a successful intervention.
- **Resources**. All NGOs and support groups operate without resources such as computers, photocopy machines, fax machines, etc. This limits their communication and results in poor delivery of services and inability to properly track food parcels and other interventions.
- **Transport**. Lack of public transport means that many CBOs have to hire a car in order to travel to another town. The Lekomo HIV/AIDS Consortium revealed that most of its budget for 2003 was spent on travel expenses, since they had to pay for hired cars for all members every time they met.
- **Duplication of services**. One government representative expressed concern that too many CBOs are focusing on home-based care, particularly HIV counselling, while other areas of need are not being addressed.
- **Co-ordination of services**. A challenge to both consortia is the lack of co-operation between the two government departments, DoH and DSD. The interviewee felt that the DoH did not fully approve of their involvement with the DSD, 'If we do services of social development we receive bad words from the Department of Health, saying that 'can't you concentrate on your work?' Unfortunately we don't have a programme within the health department whereby we would go out to the community and search for orphans.'

Other community structures

A number of other community structures exist, which are described below.

Youth activities

In general the youth are inactive; there are almost no activities for them. DSD personnel said that part of the problem is that the youth are not making use of their services, 'they associate DSD with child grants'. Among the services referred to here is funding for youth activities offered by the DSD, for example, HIV awareness activities. A DSD member further said that the youth are not informed about opportunities to study further after matric many of them are not enrolled at tertiary institutions.

The following are identified in the IDP as 'core issues of the youth' in Kopanong (Revised Xhariep IDP, 2003):

- High unemployment.
- High drop-out rates at schools.
- Lack of lifeskills and technical skills.
- Alcohol and substance abuse.
- Increasing rates of HIV infection.

Political structures
The African National Congress is the dominant political organisation in Xhariep district, as in many parts of South Africa. In every town in the Kopanong Municipality there is an ANC office. The Democratic Alliance (DA) has an office in Bethulie. All the town councillors are members of the ANC. The ANC officials play major roles in facilitating delivery of services to the community members. For example, they intervene to assist people if they are struggling to acquire certain grants.

De Beers Consolidated Mines
De Beers Consolidated Mines, whose offices are in Koffiefontein, play a significant role in HIV/AIDS-related matters. Recently an HIV officer was been appointed to facilitate HIV-related activities, such as peer education, family counselling and general education about HIV/AIDS. She is collaborating with local NGOs and government departments to achieve this.

Discussion and suggestions

Kopanong provides a suitable venue for the kinds of interventions envisaged for the OVC programme. It fits the profile of a community in need, that is, it is a poorly resourced semi-rural area with high levels of need. Although there are efforts to create jobs, they are not enough to cater for all residents of the area. HIV/AIDS is already presenting a problem in the community. Secondly, there are many activities currently taking place, stemming both from the government and NGOs/CBOs. NMCF/HSRC will therefore not start a completely new intervention but will work together with the government and NGOs/CBOs to strengthen already existing interventions.

The enthusiasm of the general community and key stakeholders, expressed during fieldwork, will also facilitate successful co-operation with NMCF/HSRC.

The main challenge to interventions will be the vastness of the area. Almost all participants expressed frustration over the long distances to be travelled in delivering services to various communities. Long periods of driving result in exhaustion and subsequent poor delivery of services, waste of resources through travel costs and inability to consistently monitor services. Problems with cars were reported several times by researchers during fieldwork. Smaller towns have smaller resource bases so sustainability may also be more difficult.

Conclusion

The situation analysis provided a basis for understanding services provided to OVC in the Kopanong Municipality and the challenges faced by service providers and the community. Xhariep district covers the largest area in the Free State province, yet has the smallest population size. The conditions of OVC are characterised by lack of basic services required for the well-being of a child, such as clothes, food, etc.

From the results of the situation analysis it is evident that the implementation of OVC services will be a challenging task. The size of the area makes it difficult to deliver services quickly and effectively, which also affects monitoring and evaluation. Other challenges relate to a lack of collaboration among various stakeholders, lack of community participation, duplication of services and high levels of need within the communities. These issues can be tackled if the parties involved can develop a culture of

working together. The expected willingness of the community and the service providers to cooperate with HSRC/NMCF will be a key strength in the success of the programme.

Priorities for action

During interviews we asked participants to suggest better ways of delivering services in the area and addressing the problems of HIV and orphans. The following suggestions were provided:

Door-to-door visits for HIV information dissemination
Participants, especially those from the support groups, felt that it would be helpful if attempts were made to visit each and every house in towns and to teach people about HIV/AIDS and also leave pamphlets. Given the small size of the towns and residential areas, it was felt that this task is achievable.

Involvement of the community
Some participants felt strongly that the general community needs to be involved in activities. There was a general feeling that community members are relying too much on the support of the government and are doing little to influence change within their environment. However, others felt that the entire community is poor, hence their inability to help.

Employment of more staff
A shortage of social workers was also mentioned as a barrier to quicker delivery of services. Suggestions were made that more social workers be employed; at least one in each town.

Shelters for OVC
The majority of participants felt strongly that there is a need to build shelters for OVC. Although this is contrary to DSD interventions, which encourage bringing up children within a family environment, the community members saw it as a solution to the problems experienced by OVC in homes. This also runs counter to international and other local recommendations. However, it may become essential for emergency or temporary shelter.

Integration of services
One of the main limitations observed was the duplication of services for OVC. In order to effectively deliver services for OVC this needs to be addressed. Integration of services needs to take place, at both NGOs and government departments. Currently there seems to be no proper collaboration between government departments. Instead there seems to be competition and conflict. This is especially evident on the issue of home-based carers who work for both the DoH and DSD. There were concerns that this creates conflict regarding prioritisation of their work.

Another area where duplication of services is evident is in the identification of OVC. Lots of people (NGOs, social workers, community, home-based carers, educators) are currently involved in the identification of OVC. We feel that if this process is not properly co-ordinated it could result in unnecessary duplication of services and failure to attend to all those in need.

CHAPTER 5

Situation analysis of services targeting orphans and vulnerable children in Kanana and Umuzimuhle townships in Orkney, North West Province

Nkululeko Nkomo, Donald Skinner, Tshepo Mdwaba, Charles Mandivenyi and Ntjantja Ned

City Council of Klerksdorp

The City Council of Klerksdorp is located in the North West Province. It consists of greater Klerksdorp, Orkney, Stilfontein and Haartebeesfontein (KOSH). Figure 1 shows the distribution of the four areas in the City Council of Klerksdorp, which is a part of the Southern District Municipality. The district municipality is situated on the southeastern border of the North West province. The total population of the City Council of Klerksdorp was about 359 202 in 2001 (Statistics South Africa, 2001). There are 93 339 households in the City Council of Klerksdorp (Statistics South Africa, 2001). Table 6 shows the population groups in the Klerksdorp area.

Figure 1: Boundaries of the City Council of Klerksdorp

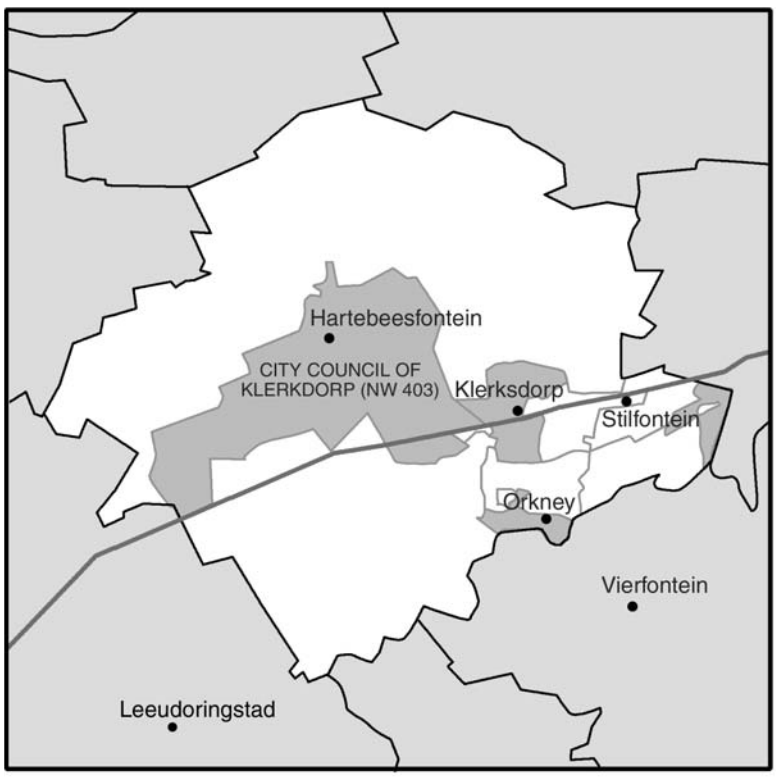


Table 6: Population groups within the Klerksdorp area, 2001

Population group	Number	%
African	283 848	79.02
Coloured	10 005	2.78
Indian	1332	0.37
White	64 017	17.82
Total population	359 202	100

Source: Statistics South Africa, Census 2001.

One of the biggest industries in the City Council of Klerksdorp is mining. In 2001 it had about 30 340 persons in its employ, down from a previous figure of 48 285 (Statistics South Africa, 2001). The gold mining industry is generally in decline following the falling gold price and increase in value of the rand. Consequently, the number of people employed is decreasing. Table 7 shows the distribution of the labour force in the City Council of Klerksdorp. These figures account only for the economically active sections of the population.

Table 7: Labour force in the Klerksdorp area, 2001

Status	No.	%
Employed	95 871	60%
Unemployed	64 027	40%
Total labour force	159 898	100%

Source: Statistics South Africa, Census 2001.

Compared to 1996 when 113 499 people were employed, in 2001 the number was down to 95 871 (Statistics South Africa, 2001).

The municipality has populations of all 11 language groups in South Africa. The Setswana (36%) and seSotho-speaking people (21%) constitute the biggest language groups, with Afrikaans (19%) and isiXhosa (17%) following (Statistics South Africa, 2001).

Orkney

Orkney was proclaimed on 20 March 1940 on the farm Witkoppen, where the Orkney Gold Mining Company under directors T S Leask and A M Campbell had dug for gold (City Council of Klerksdorp, 2002/2003). Thomas Leask was one of the many Scottish fortune-seekers who came to South Africa from the Orkney Islands in 1862, from which the South African town's name is derived. This town achieved broad name recognition in South Africa after being the centre of a humorous TV series called *Orkney Snork Nie* (Orkney does not snore) in the early 1980s.

Orkney is one of four towns in the City Council of Klerksdorp. It is still considered to be a mining town. The black and white population groups in Orkney stood at 142 200 and 12 000 respectively between 2002–2003 (City Council of Klerksdorp, 2002/2003). There

are two townships in Orkney, namely Kanana and Umuzimuhle, which are geographically distinct. Umuzimuhle is situated in a mining town called Vaal Reefs, and Kanana is close to the central business district in Orkney. The following information on these townships was collected through observation and consultation with key stakeholders and ordinary community members. Where applicable, information from the 2002/03 Annual Reports of the City Council of Klerksdorp was included.

Kanana

Kanana Township has six wards, 22, 26, 27, 28, 29 and 30, each with its own councillor. Sections within the six wards are designated into what local people call 'extensions'.

Housing, road and general infrastructure

There are a variety of housing structures in Kanana. Right at the entrance of Kanana there is an old hostel, the only one in the area. The hostel was built to accommodate migrant municipal workers from former homelands like the Transkei and Ciskei. As mining and other industries developed, other people moved into the hostel. Over the years it has transformed into dwelling units for families.

The township has formal houses, each with four rooms, and these are located in what community members call the 'old township'. Other types of formal houses include the new houses which have more rooms and are occupied by the relatively affluent and professionals.

There are a lot of informal settlements in Kanana, some with communal taps and bucket toilets, while others have homes with taps and flush toilets. Most of the homes are made of a mixture of iron and wooden boards. Informal settlements make up a significant part of Kanana. In these settlements roads are generally lacking and the population density as well as overcrowding are high. Also located within informal settlements are RDP houses. RDP houses are the Reconstruction and Development Programme housing structures that the current government is developing around the country. They differ in size, but most have four or five rooms and they are for people with either little or no income. Unlike the old, pre-1994 four-roomed houses, RDP houses have indoor toilets and bathrooms.

Generally the road infrastracture in Kanana is underdeveloped. There are areas in the township that do not have tarred streets, particularly in the informal settlements. Land line public telephones are found on all the corners of Kanana and in some areas there are cellphone containers for public use.

Schools and clinics

Kanana has nine primary schools, one intermediate school and four secondary schools (see Appendix 6 for a list of schools in Kanana). The schools are distributed throughout the township. There are two clinics in Kanana (see Appendix 7 for a list of the clinics). Shops, liquor stores and funeral parlours are found throughout the township. The James Mpheqeka Sports Stadium is the dominant recreational facility in the township, with a soccer and a cricket field. Other than this facility, there are informal soccer fields found in the various 'extensions' of the township.

Kanana has a library (T A Mafohla) and opposite this is the Kanana Municipal Building. As in most townships in South Africa, there are taxis in Kanana that transport residents within the township or to town. Local taxis include private cars (community members refer to them as 'tambaais') and mini bus taxis travelling to or from town (Orkney central

business district). Taxis to town are minibus vehicles. It costs community members R3 to use a taxi within the township or to town for a single trip. However, there is an extension that is further into the township and to travel from this area to town it costs R3.30.

Unemployment and poverty
The unemployment rate in Klerksdorp stood at 40.1% in 2002/2003 (City Council of Klerksdorp, 2002/2003). The major industries there include mining, trade, medical, transport and government. A significant number of people in the Orkney township of Kanana are at home during the day on weekdays, which speaks of joblessness. The level of poverty is also very high. Some people interviewed reported that there are members of the community who on a daily basis collect food and other things from a rubbish dump near Kanana. Some of these people include small children. Community members describe the levels of crime as very high, with robbery as the most common crime. The level of alcohol use was also reported to be very high. Tarvens and other drinking places abound throughout the township.

Umuzimuhle

Umuzimuhle is situated in Vaal Reefs, a mining area, which is a seventh ward under Kanana and as such is a lot smaller than Kanana. Mining and living sections are designated into 'mining shafts'. These shafts range from numbers one to 11 and are dispersed. Umuzimuhle only covers shaft three. Another part of Vaal Reefs falls under Greater Stilfontein. Mineworkers in the area come from all nine provinces of South Africa, as well as Southern African Development Community (SADC) countries like Swaziland, Mozambique, Lesotho and Malawi.

Housing, road and general infrastructure
No person owns property in Vaal Reefs. AngloGold Mining and Harmony Mining are the two mining companies in the area. Any property or mining shaft is under the control of one of the two companies, although the Klerksdorp City Council is involved in the governing of the area. The housing structures in Umuzimuhle are vastly different from those in Kanana. There are men's hostels and residential houses built either for mineworkers only (single quarters) or for families (family quarters). The houses are well developed and there are no informal settlements in the township. With the exception of single quarters and flats, most houses have six rooms. Toilets and bathrooms are situated inside. Roads and streets are tarred and there are public land line phones on almost every street corner. Umuzimuhle has one shopping centre and a petrol station.

Recreational facilities
There is a community hall for public use. In some areas there are informal soccer fields. The famous Oppenheimer Stadium is situated close to Umuzimuhle. This stadium has been mooted as a potential host for the 2010 Soccer World Cup.

Schools, clinics and transport
Umuzimuhle has one secondary school and two primary schools (see Appendix 6 for a list of schools). There is also a clinic that is under the management of AngloGold, called Umuzimuhle Health Clinic. There is one taxi rank. In the township there are taxis to other shafts, as well as to Orkney and Klerksdorp. To Orkney and other shafts it costs around R3, and to Klerksdorp R4.50 for a single trip.

Before we look at the situation regarding services for OVC, the next section will look at a definition of OVC gathered through the project in South Africa, Botswana and Zimbabwe.

Conditions of OVC in Kanana and Umuzimuhle

One of the effects of HIV/AIDS in the area is an increase in the number of OVC. Said one official from the DSD in Klerksdorp, 'HIV/AIDS has made the matter worse. Klerksdorp is predominantly a mine area and HIV/AIDS is a problem. Children affected and infected are in larger numbers.'

In one project run by an NGO, called the Guidance, Education and Youth Project, about 83 orphans were identified in Kanana. However, as the respondent from the project pointed out in the interview, this perhaps does not even capture the real situation – it only scratches the surface. Tables 8 and 9 provide numbers/percentages of children with mother alive/not alive and father alive/not alive in Kanana and Vaal Reefs. Umuzimuhle is situated in Vaal Reefs and Vaal Reefs itself falls under both Greater Orkney and Stilfontein.

Table 8: Individuals with mother alive/not alive in Kanana and Vaal Reefs

Kanana	Yes	No	% with mother dead	Total
0–17	23 043	1 304	5.4	24 347
18+	27 751	14 840	34.8	42 591
Total	50 794	16 144	24.1	66 938
Vaal Reefs	**Yes**	**No**	**% with mother dead**	**Total**
0–17	2 657	46	1.7	2 703
18+	6 031	2 606	30.2	8 637
Total	8 688	2 652	23.4	11 341

Source: Statistics South Africa, Census 2001

As can be seen from Table 8 there are more people who have lost a mother in Kanana than in Vaal Reefs (5.4% for the 0-17 year olds and 34.8% for the 18+ in Kanana vs 1.7% for the 0–17 year olds and 30.2% for the 18+ in Vaal Reefs). This applies to both people between 0–17 and those that are 18+. Vaal Reefs, where Umuzimuhle is located, is a smaller community. It was pointed out in a number of interviews that OVC are more difficult to identify in Vaal Reefs than Kanana. When a mineworker dies his family goes back home, which is either in another province or country. It was not clear during the interviews whether this is official mine policy or not. It was also pointed out that some of these families relocate to informal settlements in Kanana. The level of poverty and need in Kanana is more pronounced and evident.

However as it was indicated in a number of interviews, there are also OVC in Vaal Reefs. According to one interviewee, there may be more orphans and vulnerable children in Vaal Reefs than is realised. The interviewee pointed out that there are some street children in Orkney town who are from Vaal Reefs. As can be seen from Table 9 as well, the number of people who have lost a father is much higher in Kanana than in Vaal Reefs (13.2% for the 0–17 year olds and 59.0% for the 18+ in Kanana vs 3.3% for the 0–17 year olds and 58.1% for the 18+ in Vaal Reefs).

Table 9: Individuals with father alive/not alive in Kanana and Vaal Reefs

Kanana	Yes	No	% with father dead	Total
0–17	21 142	3206	13.2	24 347
18+	17 471	25 120	59.0	42 591
Total	38 613	28 326	42.3	66 938
Vaal Reefs	**Yes**	**No**	**% with father dead**	**Total**
0–17	2 615	88	3.3	2 703
18+	3 616	5 021	58.1	8 637
Total	6 231	5 109	45.1	11 341

Source: Statistics South Africa, Census 2001.

Various stakeholders interviewed described the conditions under which OVC live as far from desirable. Most OVC reside in informal settlements, although not exclusively. Some of the problems cited include lack of physical and emotional care and abuse and exploitation of OVC. Generally, a number of people interviewed felt that it takes a long time for grants to be processed. For instance, one of the carers interviewed has been waiting for her grandchild's (who is an orphan) support grant since February 2003. On the other hand, social workers are taking on heavy workloads due to insufficient human resources. This further compounds the delays in the processing of grants. The courts also have huge caseloads.

There are members of the community who have given of their time and resources to assist OVC. Others have actually taken in children, with some having taken in as many as nine children. For instance, there is a woman in Kanana who has taken in more than ten children. However, together with the number of children that she is helping with food and other means, the number approaches 50. Umuzimuhle also has its own angel of mercy. These women do this out of meagre resources. However, bearing in mind the high level of children in need, more 'good samaritans' need to come forward. The next case study provides an illustration of some of the challenges faced by OVC. It is a case of what one 14- or 15-year-old girl is going through, and to a greater or lesser extent, other children in the area too, as indicated by the stakeholders interviewed.

Case study

The researchers interviewed a girl of 14 or 15-years who is an OVC at a school in Kanana. She has a younger brother who is nine-years old. When their mother died, they moved in with a relative. The girl was forced to do more work than the relative's older children. When she refused to do some of the work, the relative chased her away. Eventually social workers moved her into a shelter for orphans, homeless and other vulnerable children. The little boy is still living with the relative and he receives a child grant. The relative has accused the girl of wanting to use the little boy's money. Although the children attend the same school, the relative has forbidden any communication between the two. There are children at the school who report to the relative if the children are seen speaking to each other. According to the girl, even though her brother is receiving a support grant, he is short of a school uniform and other things, which creates the impression that the money is being misused.

According to the Children's Institute (2002), high levels of poverty and unemployment nationwide undermine the benefits of grants for the intended beneficiaries. More often than not, grants end up feeding entire families. The impression of most stakeholders is that this is common and as a result, it becomes difficult to label it as abuse or exploitation.

The high levels of poverty and unemployment have compromised the culture of care for OVC in the community. In the view of an official from the DoH, OVC are stigmatised, for example, treated both in a patronising fashion 'ag shame' and not given any assistance, or directly mistreated by community members. Another interviewee at the DoH cited an example of a child with a disabled parent who was beaten to death by people in the community for stealing. The DoH official is of the opinion that there are not enough support systems in the community for OVC, 'A child needs more than a plate of food, they need love and supervision'.

There are a few community members who are prepared to take other children into their families. It is not easy for people in the community to take in OVC because many of the families have no member that is employed. Some families are dependent on grants for their livelihood. Another respondent perceived the responsibilities of taking in another child as a challenge because some children can be difficult to manage, control or discipline. Some stakeholders also indicated that those OVC who do not get absorbed into either extended families or other households in the community become destitute. Other stakeholders pointed out that some children become part of child-headed households. In fact a number of such cases were mentioned in a number of interviews. In the opinion of an official from the DoH, the repercussions for their mental health among children who take on adult responsibilities will be considerable in the long term.

Government departments and their services

Department of Social Development

The DSD is part of the Department of Social Services, Arts, Culture and Sports in Klerksdorp. The local DSD covers the areas of Klerksdorp, Ventersdorp, Makwassie and Potchefstroom. There are about 200 people working in the region. The DSD is responsible for the protection of all children. It provides social grants (for example, Foster Care, Disability, Care Dependency, Pensions, and Child Support Grants).

Services

The Child Support, Foster Care and Care Dependency Grants are for children. The Child Support Grant is money paid to primary caregivers for the benefit of the child. According to information supplied by the DSD, about 21 853 beneficiaries in Klerksdorp were recipients of the Child Support Grant by the end of April 2004. The Foster Care Grant is for a child who is placed under the care of a foster parent/s. Such a child either has no parent or guardian, or his or her parent or guardian cannot be traced, or was under custody of a person not fit to have custody. The DSD recommends that potential foster parents should be next of kin.

However, if next of kin cannot be located, other people who are close to the family could become foster parents. About 984 beneficiaries in Klerksdorp were receiving the Foster Care Grant by the end of April 2004. The Care Dependency Grant is for children with disabilities who need special care; 583 beneficiaries in Klerksdorp were receiving the Care Dependency Grant by end of April 2004. However, it should be noted that

the numbers receiving the three types of child grants above do not necessarily reflect the number of children who are eligible. In fact, a number of cases were noted during interviews of children not receiving these grants for a number of reasons. The most common reason provided by a number of respondents was that grants take a long time to process.

The DSD also offers services such as foster care placements, counselling services and interim social relief. The interim social relief programme involves the issuing of money or food parcels to people or families who would not survive without immediate assistance from the government. Social relief can only be issued for a period of three months, but can be extended for another three months under exceptional circumstances.

Department of Health

DoH services to OVC include free primary health care for children between the ages of 0–6 years, PMTCT, and provision of a basic nutritional product with proteins, vitamins and minerals to children who are malnourished and underweight.

Clinics are able to identify OVC when these children come for help. These cases are usually referred to the DSD. The DoH also offers vitamin supplements for newborns. The DoH ensures that every child has access to health care in the district and utilises the services of volunteers from Klerksdorp to provide home-based care to the community.

Challenges

In the view of an official from the Department, OVC are not receiving adequate health care in the communities. Enhancing the nutritional status of children is another major challenge. Nutritional deficiency-induced repeated visits are costly for the health system. Table 10 provides some figures on the status of access to the school feeding nutrition programme in Klerksdorp in the first quarter of 2003/04.

Table 10: Status of access to primary school feeding nutrition programme (PSNP)

Nutritional Programme	No./%
Total number of children on the PSNP scheme	30 612
% of schools with PSNP	76
Number of service providers for PSNP	69
% of facilities implementing vitamin A supplementation	100%

Source: Department of Health, North West Province.

Some of the OVC and their caregivers indicated difficulties with accessing food. School feeding programmes fill the gap in cases where some children may not have access to food at home. Seventy six per cent of schools (all of which are primary schools) were on the PSNP programme by the first quarter of 2003/04. Only children in Grades 1 to 5 are part of the programme, which excludes Grades 6 and 7. Most, if not all, high schools in both Kanana and Umuzimuhle do not have school feeding programmes.

What is not clear or has not been established from interviews with officials, either from the departments of health or education, is whether there are plans to extend it to Grades 6 and 7, as well as high schools. Vulnerability in the area cuts across age groups,

especially among children. Clinics face a number of challenges, including insufficient staff and high patient intake. See Appendix 7 for a list of public health facilities in Orkney.

HIV/AIDS Coordination Unit

The DoH has an HIV/AIDS Coordination Unit which coordinates HIV-related activities in Klerksdorp by focusing on prevention as well as care and support. Regarding prevention, the unit coordinates health promotion in state facilities, distributes condoms, identifies high-risk areas, and works with commercial sex workers. They also provide care and support to the sick through health promoters, who do home-based care, and by funding NGOs involved in home-based care activities. In fact, some of the NGOs profiled in this situational analysis are funded through this unit. The unit works very closely with clinics.

According to DoH figures for the first quarter of 2003/04, 10% of antenatal clinic attendees were HIV-positive. Table 11 below indicates HIV-related statistics. HIV prevalence in the North West province was 10.3% in 2002 (Nelson Mandela/HSRC Study, 2002). The PMTCT is offered in a number of clinics in Klerksdorp. (Appendix 7 lists clinics in Klerksdorp that have a PMTCT programme).

Table 11: HIV prevalence, VCT services and condom distribution in Klerksdorp

HIV-related statistics	Number/%
Prevalence of HIV among ANC attenders	10%
Number of VCT sites	14
Number of VCTs done at facilities	729
Number of clients tested positive	349
Number of condom distribution points	195

DoH, North West Province

The work of the unit is inseparable from the issues of OVC. The unit encourages patients to plan for their children's future. One of the challenges pertaining to OVC is locating relatives of children whose parents are foreigners.

Department of Education

The DoE has a working relationship with the departments of health and social development. Cases of neglect and need or other problems identified by any of the departments are referred accordingly. For instance, principals or teachers often refer cases of OVC to DSD for Child Support Grants or to clinics for medical assistance.

Two of the primary schools interviewed for the situation analysis, United and Vaal Reefs Primary Schools, have teacher-student ratios of 1:30.8 and 1:26.6 respectively. For ratios in other schools in the two townships see Table 12 on page 56. In a number of schools, teacher to student ratios are disproportionate (for example, Atamela primary school has a ratio of 1:41.5). This indicates that teachers at some schools are overstretched, thus compromising their ability to pick up cases of vulnerability in classrooms and to give individual attention to their students.

Table 12: Teacher to student ratios in Primary and Secondary Schools in Kanana and Umuzimuhle

School	Teacher : Student ratio
1. Kanana Sec. School	1:29.7
2. Selang Thuto	1:38
3. Tshebedisano Sec. Sch	1:28
4. Matlhaleng Sec. Sch	1:36.14
5. Monkeng Sec. Sch	1:39.9
6. Are-Bokeng Prim	1:37.0
7. Atamela Prim	1:41.5
8. Bathabile Primary	1:36.2
9. Ntataise Prim	1:38.4
10. Pelokgale Prim	1:34.9
11. Are-Fenyeng	1:39.1
12. Thuto-Tsebo	1:40
13 Inyathelo Prim	1:37.2
14. Reahola	1:33.9
15. United Prim	1:30.8
16. Vaal Reefs Prim	1:26.6
17. Vaal Reefs Tech	1:30.4

Department of Education: Klerksdorp

Services

In the two townships all the primary schools are part of the PSNP. (See Appendix 6 for a list of schools with the PSNP.) Only children between Grades 1 and 5 benefit from the PSNP, which is offered to disadvantaged primary schools in Greater Orkney.

In Klerksdorp the DoE worked with the DoH on the PSNP, with the DoH monitoring the programme. This relationship began on 1 April 2004 and was due to end on 31 March 2005, but owing to an underspent budget of the DoH the partnership will end in July. As from 1 August the DoE will run the PSNP single-handedly. The PSNP menu includes rice, porridge and soya mince (this might change from 1 August).

Social cluster – integrated social delivery

In order to improve service delivery the DoH, DSD and DoE work as a social cluster. The intention of the social cluster is to provide an integrated response to societal problems. For instance, DoH provides nutritional supplementation to orphaned and vulnerable children, DoE identifies children at school in need, and DSD offers safety nets in the form of grants. The social cluster works as a referral system between these three departments, for example, DoH could refer a child to DSD for a grant.

Non-governmental organisations

This section will cover NGOs interviewed during the situation analysis. These organisations work with children or with home-based care, which is inextricably linked with children.

Hospice

Hospice looks after terminally ill people and this includes cancer and other terminal illnesses such as HIV/AIDS. The organisation has had to cater for affected families as a result of AIDS, because behind every patient there is a family and the children they assist are part of these families. Hospice focuses on home-based care. At present they have 200 patients under their care. Hospice works from two adequately furnished houses in a suburb near the central business district of Klerksdorp.

The organisation does not deal directly with the DoH, but works with Tshepong Hospital in Jouberton Township. Hospice also does pre- and post-test counselling and trains volunteers involved in both home-based care and pre- or post-test counselling. Apart from nursing the ill, Hospice gives food parcels to the families they assist. It is also runs a crèche, which caters for children of patients under their care, as well as OVC. The organisation services the townships of Kanana, Jouberton, Alabama near Jouberton, and Tigane in Haartebeesfontein. Hospice is part of the local AIDS Council.

Staff and funding

Their staff component includes 10 full-time and one part-time social worker; four volunteers at the crèche; 39 volunteers doing home-based care in the townships; one full-time fundraiser; five professional nurses; one chief executive officer; one bookkeeper; one administrative person and one manager at the crèche. Hospice receives some funding from the national AIDS coffers.

Challenges

Some of Hospice's challenges include funding, doing home-based care and taking care of children whose parents are sick. They take care of 30 children. There is a lot of work but not enough resources. The work that they do can be stressful, but they debrief every two weeks. The employees also have lunch together and use this as an opportunity to discuss work. The organisation views its work as challenging and interesting at the same time.

Ondersteuningsraad

This organisation has offices in North West and in Free State province. This NGO started in the KOSH area in 1963. The organisation operates from a modest house in Klerksdorp. It is adequately furnished, with some essential equipment such as computers.

Funding

This NGO receives a subsidy from government for salaries only. Funding for running costs comes from the managing body, which is the Hervormde Kerk (Reformed Church). They are dependant on donations or fund-raising to cover other costs. The organisation's head offices and executive directors are in Pretoria; they have 26 offices nationwide.

Services

Ondersteuningsraad does generic social work involving casework, community, group care and child and family care. OVC and foster care are priorities and constitute 80% of their statutory work. The organisation works very closely with the DSD, which subsidises their programmes.

Staff
The local organisation consists of one subsidised social worker, one part-time secretary, one chief social worker and nine volunteers from the Hervormde Kerk. They receive money from the national lottery every year for certain projects.

Challenges
Some of their biggest challenges relate to one of their core functions – placing children into foster care, i.e. giving children in need of care a 'second chance to live'. There are not enough people coming forward to foster children due to financial constraints, which are aggravated by high unemployment in the area.

Guidance, Education and Youth Project (Gey-Pro)

Guidance, Education and Youth Project (Gey-Pro) is funded by the DoH and is part of the KOSH NGO Networking Forum. It attempts to access funds from other donors on a regular basis. Gey-Pro has 35 volunteers involved in its three service areas.

Services
Gey-Pro covers only Kanana. It assists 30 orphans with clothing and toys obtained from donations from community members. The organisation also runs a peer education programme in schools, and has targeted about 500 youths to benefit from it. These youths will be given skills to assist other peers in schools. Gey-Pro currently provides home-based care to 50 terminally ill patients. Furthermore it runs a support group for people living with HIV/AIDS.

Challenges
Organisational challenges include insufficient resources, both human and financial. Another challenge is retaining volunteers. This stifles their capacity to deliver services. Gey-Pro operates from the backroom of a house in Kanana. The room has one table and two chairs as well as a computer, although it does not have a printer.

Child Welfare (Orkney)

Child Welfare renders assistance to families in need in Klerksdorp, Orkney, Stilfontein and Haartebeesfontein. Some of their activities include recruiting foster parents, and foster care placements and supervision, as well as facilitating access to grants. The organisation also runs a sewing project for foster mothers, which helps these mothers to generate an income.

Staff
The office has five social workers, one cleaner, one secretary and one bookkeeper, as well as 70 volunteers who assist with screening and monitoring foster parents.

Challenges
The major challenges include lack of funding and high turnover of staff, particularly black social workers. Social workers leave for government or the private sector. The organisation works from a house located close to the central business district in Orkney.

KOSH Care and Support Group

KOSH Care and Support Group is an NGO that renders assistance to people living with HIV/AIDS, and affected families. The organisation is also part of KOSH NGO Networking Forum, a forum of NGOs funded by the DoH, which provide home-based care to people living with HIV/AIDS. KOSH Care and Support Group runs support groups for people living with HIV/AIDS (36 members) and affected people (around 40 members).

Challenges
One of their biggest complaints is the inadequate support they receive from the local municipality or council, business and the community. Funding and transport are other challenges. They have not received funding from the DoH this year for reasons unknown to them, despite having received funding before. If funding does not come through they might lose their office space. Efficient coordination of services among all stakeholders was another obstacle cited. However, in their view relations between NGOs are good – they share services and assist one another.

Imbiza Development Services

Imbiza Development Services are involved in home-based care, counselling and support to people infected and affected by HIV/AIDS. This work is funded by the DoH. Imbiza is part of the KOSH NGO Networking Forum. Imbiza Development Services has 28 volunteers, and Bread for Support (see below) is an offshoot of it. The two bodies are under the same management and they both work in the Greater Orkney and Stilfontein areas.

Bread for Support
Bread for Support receives funding from the DSD and renders material (for example food parcels and clothing) and emotional support to OVC. The organisation is currently part of a process that is setting up a child forum. This is intended to involve the local council, NGOs, religious ministers, social workers, communities, police, the DoE and other stakeholders. The intention of the exercise is to improve the well- being of orphans and children in need, by enhancing coordination among stakeholders. It is supposed to deliver a holistic service that caters for the physical and psychological needs of children. Bread for Support currently provides assistance to 40 families, and has eight volunteers.

Challenges
Just like most NGOs in the area, they have limited funds. This constrains their work, and as result they cannot help everyone who needs assistance.

Philani Health Care Centre

The Philani Health Care Centre is funded by the DoH and is part of KOSH NGO Networking Forum. The organisation started in 1998 when a group of churchwomen, some of whom were affected by HIV/AIDS, initiated home visits to pray for the sick. The idea evolved into an organisation that in 2002 received their first funding from the DoH for home-based care. Over the years they have lost volunteers due to lack of funding.

Philani Health Care Centre is located at council administration offices in Jouberton Township. They use two rooms at the offices, and have a computer, printer and fax machine as well as one desk. There are 15 volunteers in the organisation.

Services
Through home-based care Philani Health Care Centre meets OVC. It provides help to people living with HIV/AIDS and families in need. The health centre receives donations of food and other items from various organisations, which are given to the families they work with. Philani Health Care Centre works in Jouberton and in one ward in Kanana. It has given out 75 food parcels since the start of 2004. They are currently assisting 98 orphans and 118 patients, including 54 people living with HIV/AIDS who have disclosed their status. Their dream is to build a home for people with HIV/AIDS and cancer and a daycare centre for children.

Challenges
Retaining the services of volunteers is a challenge. They also do not have a fridge in which to store food.

Broad challenges for NGOs

Insufficient and insecure human and financial resources
It is a challenge for NGOs to access funding. Even when there is funding, it not always sustainable or guaranteed every financial year. One of the NGOs that was interviewed had still not received funding from the DoH for the present financial year, even though they had submitted an application. Insufficient funding makes it difficult for NGOs to retain volunteers or employees. As a result staff turnover is high in most organisations. It becomes difficult for NGOs to keep volunteers motivated when they cannot even offer stipends. There is an exodus of social workers to join the DSD because it offers better pay and more opportunities.

Lack of coordination of services
There are a lot of organisations doing the same work, which is wasteful in a situation of limited funding. A lot of the work that NGOs do depends on the direction in which the funding ship is sailing.

Poverty and unemployment
Poverty and unemployment present challenges and impact on support and care for OVC, availability of foster parents and support for the work of NGOs in general.

Conclusion

This situation analysis reveals that there are a number of challenges confronting the two communities of Kanana and Umuzimuhle townships in Orkney, North West province. These include reducing unemployment and poverty, very high HIV rates, an underdeveloped system of care, mixed levels of care in the communities, difficulties in obtaining foster parents, as well as lack of resources. There is a feeling from the NGOs in the area that more could be done to assist OVC. Everyone involved recognises the need for coordination between stakeholders. The general feeling among all the stakeholders is that everyone, from community members to local government, has a role to play.

These communities developed with the mining industry. Other economic activities were largely secondary to this. This has resulted in communities that are very diverse regarding culture, education and urban base. The communities are also very sensitive to changes in the international economic situation, especially the downturn in mining, so problems related to poverty can be expected to increase in these communities. Finally these communities are subject to high levels of in and out migration. This, combined with poverty, does create a risky scenario in relation to HIV/AIDS. In summary, the needs of these communities are likely to increase in the future, so it is urgent that effective structures for the management of HIV/AIDS and the support of OVC are put in place.

Current efforts aimed at enhancing the conditions of OVC are commendable, although not extensive enough. Four issues in particular deserve attention:

- Extending current efforts to cover and assist as many OVC as possible. Delays in the processing of grants need attention.
- A holistic approach to assisting OVC that addresses their physical and psychological needs. There is a lot work being done to cater for and help families and children

with material needs such as food and clothing, yet there is very little that addresses psychosocial needs. A number of children interviewed were still dealing with issues of bereavement and loss, with very little help from other people.

- Improving coordination among stakeholders working with children, particularly between NGOs, local municipality and government departments. There are a lot of organisations doing similar work that do not work together.

> I will have to address what needs to be addressed but the matter of orphans has to be normalisation of their conditions and the circumstances, which are not normal. As such you produce adults that are going to be abusive in nature and they are going to feel that the society does not accept them. (Youth Councillor, City Council of Klerksdorp).

Priorities for action

Government

At the level of government the issue of shortage of staff needs to be addressed. The level of need is high and the numbers of cases that need attention are too many for the current cadre of social workers in the DSD and health personnel in the DoH. The DSD needs more social workers in order to address the backlog in grant applications and processing. Even the DoH is unable to provide a full and efficient service, both at the level of clinics and the community, due to insufficient staff. For instance, two of the mobile clinics attached to a major clinic in Kanana are not functioning due to the absence of sufficient resources and staff.

For the number of children already benefiting from the primary school nutrition programme this acts as a buffer against complete hunger. Furthermore the primary school nutrition programme needs to be extended to Grades 6 and 7 and, with resources permitting, even to high schools.

NGOs

The greatest challenge faced by a number of NGOs/CBOs/FBOs is funding. Consequently these organisations are limited in what they are able to achieve. The level of need in communities is high. It was pointed out in interviews that there are many other orphaned and vulnerable children in communities who are not receiving care and assistance.

Better coordination and cooperation between NGOs is necessary because there are too many organisations doing similar work and thus creating competition over scarce funding and resources. Through coordination, resources and funding can be maximised to mitigate the impacts of orphanhood and vulnerability. Furthermore, this will close gaps where certain needs and services are currently not being addressed. For instance, concerns over the socioeconomic needs of OVC have overshadowed psychosocial needs. It was evident during interviews with OVC that a number of them were still traumatised either by the death of a parent/s or in some cases abuse (physical, sexual etc.). Through training, some NGOs could concentrate on addressing this gap.

NGOs also need training to help them do their work more efficiently. This includes training in administration-related tasks such as bookkeeping, record keeping and management of resources (financial, human or otherwise).

Community/OVC

It is crucial that interventions targeting OVC should address physiological, material and psychosocial concerns. Communities need to be educated and conscientised about children's rights and the plight of OVC. Campaigns aimed at recruiting foster parents need to be stepped up. Foster parents and other carers looking after OVC also need to be monitored, educated and sensitised to ensure that grants intended for children should not be misused – they should benefit the intended beneficiaries.

CHAPTER 6

Orphans and vulnerable children (OVC) intervention project: situation analysis – Rustenburg Local Municipality

Lebogang Letlape, Kgobati Magome, Nkululeko Nkomo and Tshepo Mdwaba

Description of the district and municipality

The Rustenburg Local Municipality (RLM) is one of five local municipalities that form the Bojanala Platinum District Municipality (BPDM) in the North West province. The Bojanala District Municipality is a District Council on the northern part of North West province. Including the RLM, BPDM consists of five local municipalities and one district Management Area:

- Meretele Local Municipality
- Madibeng Locala Municipality
- Kgetleng River Local Municipality
- Moses Kotane Local Municipality
- Pilanesberg District Management Area.

There are approximately 300 towns and villages in BPDM and the largest towns are Brits and Rustenburg, which serve as the primary activity nodes (centers of job opportunities, economic activity and services). Although mining activities have been increasing in the district, its economy has become diversified but at the same time is declining.

Mining activities are closely associated with the Merensky Reef (Platinum Belt) and are mainly concentrated in a band stretching from west of the Pilanesberg southwards through the Bafokeng area and parallel to the Magaliesberg towards Marikana and on to Brits in the east of BPDM. There is also a strong interrelationship between the industries in the area and the mining activities, as the industries are mainly supplementary to the mines.

The RLM was established in 2000 with the amalgamation of the former Rustenburg Transitional Local Council (TLC), Marikana TLC, Monakato TLC and the rural villages under the chieftainship of the following chiefs (dikgosi): Kgosi Mathope, Kgosi Monnakgotla, Kgosi Mamogale and Kgosi Ramokoka.

Demographics

The size of the population in the RLM is 387 113, with males constituting 54% and females 46% of the population (IDP, 2004). Table 13 below presents information on the total population by different race groups. Africans constitute the majority at 87%, followed by whites and Indians.

Table 13: Total population in RLM by demographic group

Demographic group	Number	Percentages
Africans	336 714	87.0
Coloureds	2 539	0.7
Indians	1 912	0.5
Whites	45 947	11.8
Total	387 113	100

Statistics South Africa: Census 2001.

Table 14 below indicates that more than half of the population residing in the RLM is between the ages of 20 and 54. Furthermore, a quarter of the population is between five and 19 years old, while very few are under the age of four and over the age of 75.

Table 14: Distribution of different age groups residing in the RLM

Persons	2001	%
0 to 4	34 349	9.4
5 to 19	95 389	24.5
20 to 34	118 078	30.1
35 to 54	108 264	27.7
55-74	25 830	6.6
75+	5 231	1.4

Statistics South Africa: Census 2001.

Although there are no figures for the RLM, the literacy rate amongst adults in the North West province is more than 60%, but is still lower than the national average of 82.8%. Table 15 below provides the highest education levels attained by individuals over 20 years of age. More than 50% have some secondary education, while 6% have tertiary qualifications.

Table 15: Highest education levels attained by individuals 20 years in North West

Persons	N	%
No school	30 272	11.8
Some primary schooling	47 459	18.4
Completed primary	19 810	7.7
Some secondary	86 150	33.5
Std 10/Grade 12	57 402	22.3
Higher	16 297	6.33
Total	257 390	100

Statistics South Africa: Census 2001.

Because of the thriving mining industry in the RLM area, there has been a proliferation of informal settlements, which are established by the many who flock to the proximity of the mines in search of employment opportunities. These informal settlements are expected to continue flourishing.

In 2004, the Bojanala district had about 45 753 (40%) informal dwellings/shacks out of a total of 113 419 households. A total of 55 042 (48.5%) structures are constructed from mud, cement brick or mortar, while the remaining are traditional dwellings, flats, RDP houses and cluster homes (IDP, 2004).

Economic profile

Rustenburg is viewed as the fastest growing city in Africa. The main driving force behind this growth is the expansion of the platinum mining industry. Even though other sectors are also showing steady growth, the platinum sector contributes about 66% of the GDP of this municipality and further accounts for about 50% of all formal sector employment opportunities. The platinum demand is expected to grow by between 4-6% per annum.

All other sectors contribute about 34% to the employment levels (IDP, 2004). Table 16 below presents information on the contributions of these other sectors. The trade (22%) and community services (23%) follow the mining sector in Rustenburg.

In 2001, general employment levels in the RLM were around 32%, while unemployment levels were at 21%. Both these percentages were lower than the figures for Bojanala District Municipality (Census 2001). These percentages account for individuals between the ages of 15 to 65 who are economically active.

Table 16: Other major economic sectors in RLM

Sectors	%
Trade	22
Community services	23
Transport	14
Manufacturing	12
Financial	17
Agriculture	6
Electricity	6

Source: Integrated Development Plan, 2004.

The district also boasts some of the most popular holiday and leisure resorts in the province, the country and the world. Of these, the Pilanesberg Game Reserve and Sun City are probably the most renowned. Others include nature reserves such as those located in the Magaliesburg and Borakalalo. The Pilanesberg Game Reserve boasts the big five, as well as a series of world renowned holiday and leisure facilities, while Sun City includes a total of four luxury hotels and a leisure resort, a variety of entertainment theme parks, a gambling facility and a simulated sea and beach facility.

HIV prevalence in the area

The 2002 Nelson Mandela/HSRC population-based survey found a prevalence of 11.4% among the total population of South Africa. In comparing different provinces across South Africa, North West province was rated the third with an HIV prevalence of 10.3%. Table 17 below presents the statistics on HIV prevalence across the nine South African provinces.

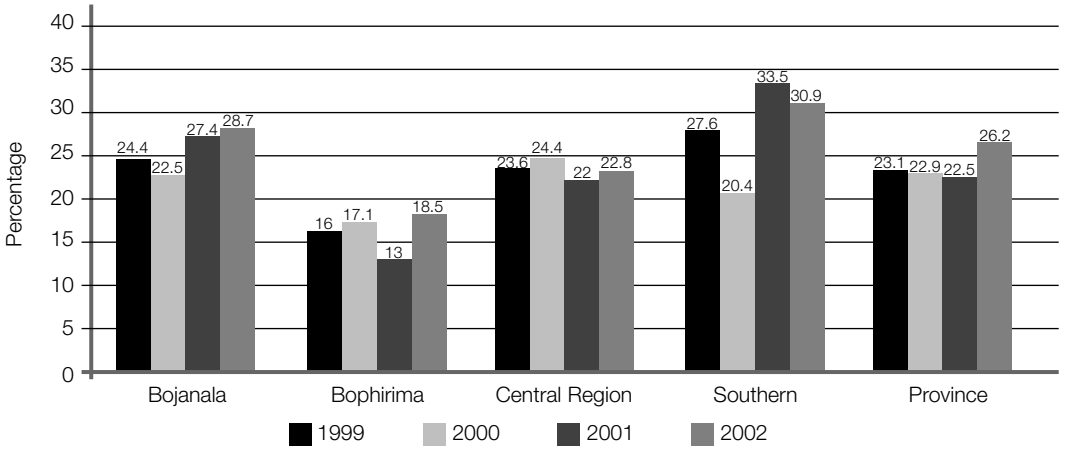
Table 17: HIV prevalence in South Africa, 2002

Province	HIV-Positive %	95% CI
Total	11.4	10.0 – 12.7
Western Cape	10.7	6.4 – 15.0
Eastern Cape	6.6	4.5 – 8.7
Northern Cape	8.4	5.0 – 11.7
Free State	14.9	9.5 – 20.3
Kwa-Zulu Natal	11.7	8.2 – 15.2
North West	10.3	6.8 – 13.8
Gauteng	14.7	11.3 – 18.1
Mpumalanga	14.1	9.7 – 18.5
Limpopo	9.8	5.9 – 13.7

Source: Nelson Mandela/HSRC study database, 2002.

Among antenatal clinic attendees in the North West province, HIV prevalence was estimated at 26.2% in 2002. This indicates an increase of 8.1% over four years – from 18.1% in 1997 to 26.2% in 2001 (North West Department of Health, 2002). These statistics indicate an HIV prevalence of 28.7% for the Bojanala district, which houses the RLM. This represents the second highest in the North West province, the highest being the Southern district with a prevalence of 30.9%. All districts in the province including Bojanala recorded increases in their prevalence in that year. (See Fig. 3 below, North West's Department of Health, 2002).

Figure 2: HIV prevalence by region in the North West province: Antenatal clinics, 1997 to 2002



Source: North West Department of Health, 2002.

According to the RLM's Integrated Development Plan (2004), the increasing number of HIV infections is fuelled by the platinum mine industry that attracts people to come in search of job opportunities.

This influx has also influenced the mushrooming of informal settlements in the area, which leads to the formation of alternative families and encourages commercial sex work. This further perpetuates the spread of HIV. This, in addition to the issues outlined below, makes the HIV and AIDS epidemic a significant issue of concern for the Bojanala district and the RLM in particular:

- high unemployment rates, which in many instances could lead women to exchange sex for money or food
- socio-cultural inequalities that allow men to have more than one sexual partner
- reluctance to use condoms
- untreated STIs, which make an individual vulnerable to contracting the virus
- illiteracy and lack of access to information
- poverty and income inequality
- sexual violence.

Table 18 presents HIV prevalence estimated by locality type. Unlike the national data from the Nelson Mandela/HSRC study, which indicate that the urban informal settlements had the highest HIV prevalence, the farms in the North West province had the highest HIV prevalence, followed by the urban informal settlements. This might also be explained by the fact that the whole North West province is predominantly rural, or by the fact that most people go back to their original home once they get sick and cannot work anymore.

Table 18: HIV prevalence by locality type, 2002

Locality	South Africa HIV-positive %	North West HIV-positive %
Total	11.4	10.3
Urban Formal	12.1	12.1
Urban informal	21.3	13.9
Tribal	8.7	7.6
Farms	7.9	25.3

Source: Nelson Mandela/HSRC study database, 2002.

The situation of OVC in the RLM

Representatives from NGOs, government departments, caregivers and OVC reported that the communities are experiencing a significant mortality rate as a result of the AIDS epidemic among others and that this causes a notable increase in the number of orphans requiring care. A high mortality rate in the adult population (whether related to AIDS or not) contributes to increasing numbers of OVC. All the people interviewed as part of this situation analysis confirmed this increase.

The number of new municipality OVC cases serviced by the DSD in 2003 was estimated at 4 000, while those serviced by NGOs were estimated at around 1 000. These figures are significant, given that they are for one year and represent new cases only. One should

also bear in mind that these figures might be an underestimation, since not all the people in the areas are aware of the services provided to them or where they can seek help.

Other than these figures reported by the interviewees, there are no reliable data on the exact number of orphans or the extent of the OVC challenge in the RLM. The 2001 census data (see Table 19) indicated that a very high number of children lost their parents in Bojanala district including the RLM, with 10 292 (8.6%) living without their fathers and 3 689 (3.1%) without their mothers. Again, a high proportion of children have also lost both parents and in the RLM, 1 387 (1.2%) of the total number of children under the age of 18 live without both parents. Based on the experiences of the NGOs and the DSD, this number has increased.

Table 19: Number of children who have lost one or both parents in BPDM, 2001

	Mother dead		Father dead		Both parents dead		Total number of children
	N	%	N	%	N	%	N
Bojanala	14 292	3.5	41 016	9.9	803	1.3	413 062
Moretele	2 368	3.3	7 696	10.7	1 238	1.1	72 089
Madibeng	3 730	3.2	10 233	8.8	1 387	1.1	11 5908
Rusternburg	3 689	3.1	10 292	8.6	1 387	1.2	11 9196
Kgetlengrivier	583	4.5	1 066	8.2	234	1.0	12 923
Moses Kotane	3 919	4.2	11 728	12.6	1 522	1.6	92 915
Pilanesburg	3	9.7	–	–	–	–	31

Source: Calculated from the Census data, 2001.

Representatives from both the DSD and NGOs also indicated that the demand for the services they provide has been increasing. Despite this assertion, both the NGOs and the DSD indicated that there are still a large number of people within villages who do not know about the services provided and where to go for help. This implies that the numbers needing the service could be even higher than is currently experienced.

The OVC in the RLM are in the care of grandparents, next of kin, volunteer foster parents and NGO children shelters. The NGO children shelters mainly house abandoned OVC, especially those under the age of six. The majority of these abandoned OVC are originally from the informal settlements surrounding the mines. Some were taken into the shelter after one or both parents died. For all these children, attempts to trace their extended families have proved fruitless. The difficulty in tracing relatives is largely due to the fact that the majority of people residing in the fast growing informal settlements are from neighboring countries, villages around Rustenburg, or even other provinces within South Africa, often with no forwarding address.

Unlike the OVC who stay with families, the situation of the children residing in the shelters is particularly unpleasant and far from ideal. Many of the shelters are overcrowded, so that the children are not able to form any real emotional bond with the caregivers.

Attempts to get community members to take over the children and foster them have proven difficult. This is said to be largely because very few people in the RLM are willing to foster children they do not know or to whom they have no relationship. Culturally, it is accepted and known that if the mother or father dies, an uncle or aunt automatically takes over the upbringing of the child. Therefore, the majority of foster parents are related to the deceased parent.

The fostering of unknown children is further made difficult by lack of knowledge about the social services provided for OVC. Most people are also discouraged by the delay in the processing of grant applications. This is particularly difficult for poor/needy families who cannot take on another child or children without the resources to support them.

Some OVC live alone in their parents' houses or child headed households – often without the supervision of an adult. These households are headed by children. The child-headed households interviewed are staying in appalling conditions. They do not have decent furniture, or beds for all the children living in the house. Some reported that they have been stigmatised by community members, and that people who used to visit them when their mothers were still alive stopped coming after their death.

Case study

The box below records a case study of a set of children from a child-headed household who were interviewed.

Case study: The researchers interviewed three OVC (girls) from a child-headed household. The interview was organised by an NGO that assists with the care of the OVC in the household. The eldest was 21 years old and had an eight-month old baby. The other two were 16 and 14 years old respectively. The mother died almost four years ago and left behind six children. While the mother was alive, all the children stayed with her – their father abandoned the family when they were all still very young. The eldest brother is working as a contract worker on a farm, where he also stays. He comes home once in a while. The two younger siblings are staying with their aunt. The oldest girl was 16 years old when the mother died. She has since been looking after her remaining two sisters.

All these children are not attending school. The oldest dropped out of school at primary level, when the mother started to fall sick. She dropped out because the mother could not continue with the 'piece jobs' she used to do and could no longer afford her school fees and other required resources. The other two siblings dropped out two years after their mother's dearth. The reason they also left school was lack of finances and school resources. They did not have anybody who could pay for their school fees or any other necessities.

The oldest brother assists with maize meal and basic toiletries, which mostly do not last for the month. Apart from their brother, their only source of help (mainly food parcels once a month) is from a social worker from the DSD and the volunteers from an NGO. They applied for social grants and have been on the waiting list for more than a year now. They were however told that the parcels they received the previous month (August 2004) were the last and they would not be receiving any more. This was disappointing for the children, also because their brother was not making enough money to help them with their basic needs.

The community is aware of this OVC situation and does not take much interest or care for them. As narrated by these OVC, 'they are not very kind to us, after our mother died, they

stopped loving us, and although they used to while she was still alive … They used to give us food and assist us here and there. Yet now they don't do it anymore. They also look down on us'. This affected the OVC negatively and they are socially isolated from their community members. Except for the visit from a social worker, which happens once in a month or two, they interact with only one family in their community. Their greatest wish and plea to their community members is for the community to talk to them and be friendly with them, even without necessarily providing for them.

These children are completely unaware of their rights or children's rights in general. Their greatest need is assistance to get back to school. They need 'money, school uniform and books and everything needed for school', said the oldest child. They also said they 'need food to eat, soap to wash and clothing to wear' like all other children.

They aspire to be educated and 'becoming somebody one day', asserted the 16-year old. They wish to complete their matric and attend tertiary education institutions. The eldest child wishes to find a job so that she can be able to help her siblings complete their studies. She also feels she is too old to get back into the classroom.

With regards to municipality services, their household has been exempted from paying services because of their situation. They receive water bills but the council has promised them they would not have to pay.

Experiences of OVC

According to those who care for these OVC, the experiences of the children in the case study were echoed by many of the OVC in the RLM. The experiences include:

Living alone or without adequate adult supervision
As indicated above, a large number of OVC live either alone, in shelters or with elderly relatives. This does not provide an adequate nurturing environment for the development of the child.

High poverty levels and hunger
The level of poverty and subsequent hunger experienced by many OVC is significantly high. The social workers and the NGO volunteers report the situation as often 'helpless'. There are times when some of them go to bed, for two days or so, without food at all, especially those in child-headed households. The foster parents, social workers and neighbours who support the OVC do so only when resources are available. Because of this lack of food and other basic resources, in most instances, boys end up getting involved in crime and girls start with sex work. In the Rustenburg area, this survival strategy is referred to as 'go phanda', which means looking for money or food to survive through any means possible, even through prostitution. This situation puts girls at increased risk of contracting HIV.

Inability to access government services
Vulnerability of OVC is perpetuated further by the fact that most cannot access the education system and many other government services without birth certificates. Some of their deceased parents were migrant workers or spouses of migrant workers, from neighbouring countries such as Lesotho and Zimbabwe and hence do not have South

African birth certificates or even identity documents. Furthermore, for some of these children, extended family members are not traceable.

Inability to attend school or stay in school

Many of the OVC, particularly those from child-headed households, reported difficulty in accessing school and staying in school. Many have dropped out of school and those who were still in school, felt demotivated and discouraged to attend, because of lack of school fees and other school resources. Even though orphans are entitled to exemption from school fees in terms of the South African Schools Act, many principals flout this legislation and insist on orphans paying school fees. This violates the children's basic right to education.

Stigma and trauma

Most of the children are emotionally and psychologically affected. Many broke down while narrating their difficult stories of learning to live alone and in isolation. Some of the OVC interviewed had become orphaned as recently as six months before the interview and some for more than four years. Despite the amount of time that had elapsed since the loss of their mother and/or father, many still showed signs of mourning and grief. Because of their situation, the community stigmatises them, labels them as those 'whose mother died of *phamokate*', thus isolating them. The children then withdraw from interacting with their community members, further isolating themselves.

Municipal plans to support OVC

Because of the increase in the HIV infection rate in the Rustenburg local municipality, the municipality has a strategic HIV/AIDS and STI plan, which provides a framework of action for the development of the local intersectoral programme. It includes the active participation of NGOs, the departments of health and education and the association of people living with HIV/AIDS.

The health service is aimed at providing HIV/AIDS education through awareness, campaigns commemorating HIV/AIDS calendar days, education talks at schools, in clinics and on local community radio stations. It will also provide treatment for STIs and opportunistic infection such as TB and pneumonia, VCT, PMTCT services and provision of male condoms.

With regards to care and support, the municipality plans to support the National Association of People living with HIV and AIDS (NAPWHA), LifeLine and the home-based care organisations and hospices that provide care and support to the infected and affected individuals. It also plans to involve the business sector in the care and support of OVC.

Government departments and their services

Department of Social Development

The DSD in the RLM has the care and social development of the citizens of the RLM as its core mandate. OVC are therefore a significant component of the department's work. All other government departments refer orphans and children made vulnerable by their home or family situation to the DSD. The DSD office in the RLM has 12 people currently working in the region and covers 31 wards out of the total of 35 wards. The remaining four wards are covered by the NGOs with whom they are working. The department is responsible for Child and Family Care and facilitates the provision of social grants such

as Foster Care, Disability, Care Dependency, Pensions and Child Support grants. The department also works closely with various NGOs in attending to some of the cases.

The departmental representative reports the size of the challenge of OVC as significant given the resources available. An estimated 4 500 children were in the department's foster care files already and could not be helped in 2003. This increased by an additional 2 000 children in the first six months of 2004. In most instances the department is not able to register children as quickly as needed because of the legal procedures that need to be followed in order for registration to occur.

The DSD offers an interim social relief programme, which provides money or food parcels to people or families who would not survive without immediate assistance from the government. The social relief service can, however, only be offered for a period of three months. The three months can be extended for another three months under exceptional circumstances, or while the beneficiary goes through the process of registering for an appropriate grant.

Department of Health

Services provided to OVC by the DoH include primary health care, school health services and provision of a basic nutritional product with proteins, vitamins and minerals to children who are malnourished and underweight. The DoH used to lead the primary school nutrition programme, which is currently run by the DoE.

The primary health care systems, school health care services and the home-based care programmes within the department are responsible for identifying OVC. Once identified, they are referred to the DSD for further support.

The general health status of children attending the health care services within the RLM has been average. In assessing indicators such as child health and nutrition, infant and child mortality rates, treatment of child illness and childhood immunization over a period of three months, not all the children are in good health. For instance, data in Table 20 indicates that the child morbidity rate currently stands at 59%, child mortality rate at 1.39% and child immunization at 85.48%. Furthermore, though the number is rather low to make conclusive remarks, the numbers of children not gaining weight and showing possible signs of malnutrition have been increasing.

Table 20: Child morbidity rate in the RLM, 2004

Data element	Period			Total
	October 04	November 04	December 04	
Child not gaining weight under 5 years	31	49	72	152
Underweight for age under 5 years	17	31	21	69
Entry in malnutrition register	30	52	38	120
Severe malnutrition	11	14	5	30

Source: BPDM, Department of health, 2004.

HIV/AID services are also provided by the DoH. All the public health clinics provide counselling and testing services. Table 21 provides statistics on HIV-related testing done and the number of those who tested HIV-positive. More than a quarter of patients (adults or children) tested within the RLM health services have tested positive. The numbers of those attending the counselling and testing services have also dropped.

Table 21: Statistics on HIV-related testing in RLM, 2004

Data element	Period			Total
	October 04	November 04	December 04	
HIV/AIDS pre-test counselling session	929	913	698	2 540
Client tested for HIV	766	785	622	2 173
Client tested HIV-positive	380	328	310	1 018
HIV test done on antenatal client	167	169	180	516
HIV-positive antenatal client – new	64	51	51	166
HIV test done on child under 5 years	38	47	9	94
HIV-positive under 5 years	4	9	9	22

Source: BPDM, Department of Health, 2004.

Department of Education

The DoE has a very close working relationship with the DSD in the RLM. The DoE's main role regarding OVC is to identify the children, ensure that they stay in school and refer them to other government departments for essential services. Teachers are required to keep a record of all children in distress and assist with seeking assistance for these children. Once a child has been identified as an OVC, they are referred to either the DoH or the DSD depending on their need. The DoH will then provide access to health care while the DSD provides social care in the form of an appropriate grant for the child.

To ensure that the OVC stay in school, the DoE facilitates the child's application for an exemption from school fees. This is a stipulation of the South African School's Act and should be adhered to by all. All principals who do not adhere to this are violating the law and should be brought to book.

While the children are in school, the DoE provides them with education to ensure that they develop as individuals and acquire personal and survival skills that enable them to prevent infection with HIV. The department provides age-appropriate life skills and HIV/AIDS education from the foundation phase onwards. There are learner support materials in the form of books, videos, etc. for learners to read and sometimes take home to their parents. This life skills and HIV/AIDS curriculum is compulsory for all learners. Parents, caregivers and the community should assist government in ensuring that all schools follow this curriculum policy.

The DoE also runs the PSNP. The programme is currently targeting primary schools, particularly those in poor and needy areas. The programme is however not able to reach every child who needs it because of insufficient resources.

Challenges faced by government departments

Insufficient capacity and inadequate resources are two of the most crucial of the challenges faced by government departments interviewed in the RLM. All three departments reported incapacity to respond to all OVC cases with the urgency deserved. The departments reported that:

- There is a backlog in the processing of applications and attending to cases from communities.
- The number of children in need of care and protection, as well as the demand for shelters has been growing over the years.
- The demand for services on prevention of HIV/AIDS and other diseases, rehabilitation and victim empowerment has increased significantly, especially for the departments of health and education.
- The number of sick people needing services from home-based carers and NGOs has increased.
- The number of those needing social grants has increased.
- There is a need for expanding access to schooling for children in need or from poor families
- They have not succeeded in matching this increasing need with appropriate resources.

NGO and CBO services

The NGOs and CBOs have always been a link between government and the private sector and civil society, especially in providing social services to community members. They have played a major role in providing most welfare services for orphans and vulnerable children. Information presented in this section is on NGOs and CBOs that have been providing services to OVC in the RLM and surrounding areas.

Tapologo HIV/AIDS Programme

Tapologo was originally established as a community-based outreach programme providing volunteer home-based care and education. It was established under the auspices of the Catholic Diocese of Rustenburg, which has managed the implementation of the programme to date. The organisation established AIDS clinics in targeted areas, such as mines and informal settlements (Freedom Park Clinic and Boitekong Clinic) and an AIDS hospice aimed at providing the necessary care for terminally ill AIDS patients. It later realized the need for providing a day care centre for AIDS orphans and HIV infected children and a full time shelter (called Eco-village) for the foster care of AIDS orphans. This centre also provides housing for the community of workers and volunteers working within the programme

The services provided at the HIV/AIDS clinics in Freedom Park and Boitekong Clinic include HIV counselling and testing, assistance in treatment of STIs, TB and other life-threatening diseases, general medical treatment, and referral of pregnant mothers to the provincial hospital for PMTCT. The outreach programme assists the community in dealing with the dramatic increase in the burden of home-based health care due to AIDS, provides counselling services to those infected and affected by HIV/AIDS and as

emotional support to those living with HIV/AIDS. The hospice is aimed at providing the necessary care for AIDS patients in the terminal phase of the disease by creating an atmosphere of compassion and caring for both patients and loved ones.

The organisation's total staff component includes 10 full time workers, six professional nurses as contract workers, and 129 volunteers for both outreach programmes and childcare provision, which also have two coordinators. Its programme partners include mining houses such as AMPLATS, Impala and Lonmin; corporate businesses such as Sun international; government departments, especially the DoH and other NGOs and CBOs that provide services to the organisation.

Monitoring and evaluation of the programmes is done through the reporting channels within each programme, according to the programme guidelines and principles. Monthly reporting is done in a format mutually agreed to with the funding agents. An external independent monitoring agent from the funding agents is also used.

Challenges faced by Tapologo are that the number of people requiring their services has been increasing. This includes home-based care because of an increasing number of terminally ill people, OVC and carers and especially grandparents. The organisation is also experiencing a backlog when coming to grant applications at the DSD. The process is hindered further by the fact that private social workers (those who work for NGOs and not for government) are not allowed to present cases in court.

Lighthouse Children's Shelter

In partnership with the greater Rustenburg community, the Lighthouse Children's Shelter provides a safe and loving shelter for abandoned, neglected and HIV-positive children. It saves the lives of many children from abuse and premature death. Many of the children in the shelter are placed in adoptive families in South Africa and abroad. It prides itself on providing hope to children who find themselves in hopeless situation.

The Lighthouse Children's Shelter has 11 board members, 23 counselors, 40 volunteers who give two to three hrs unpaid time, nine full time workers and four part time workers. The shelter started in July 2001 and has cared for 80 children, of whom 35 have been adopted into families around the world. Some of the children were placed with extended family members and the HIV-positive ones are usually kept in the shelter for medical and treatment reasons. They do, however, allow adoption of HIV-positive babies, but only to families who can prove that they would be capable of providing medical care when needed.

The organisation works in partnership with local government, the Rustenburg Child Protection Unit and other NGOs such as Tapologo and Neobirth. With Tapologo for instance, Lighthouse Children's Shelter takes in the babies of sick parents attending the Freedom Park Clinic, while in the case of Neobirth they get the babies from the mothers who decide not to abort the child but to give them up for adoption.

Their major services include caring for babies in need, facilitating the adoption process and encouraging foster caring by extended families. They also encourage families and businesses in the area to 'adopt a child' financially – meaning taking over all the financial responsibility of the child and not necessarily taking them in to their homes. This is off course aimed at reducing the financial burden of the organisation.

The Lighthouse Children's Shelter has received financial assistance and support from various individuals, churches, and corporate organisations within the North West province as well as from America and Europe. These include Anglo Platinum, Lonmin Platinum, Impalaplats, Standard Bank and Kloof Rotary Club in Rustenburg, Amalgamated Beverages Company, South African Breweries, Assembly of God World Mission organisation, USA and Australian organisations, Lasrust, Rustenburg combined services Golf day and Neobirth Crisis Pregnancy centre among others.

Godisang Home-based Care

The organisation started to operate in 2002, but began formally in 2003. The main objectives of this organisation are to care for children in distress, identifying and caring for the sick by administering their treatment and assisting with grant applications to the DSD. With regards to OVC, the organisation helps them with homework, school uniforms and grant applications. The number of OVC they are dealing with is 90, 15 of whom are from child-headed households. This number is increasing daily.

Godisang Home-based Care has 21 staff members, six of whom are executive members and 15 are volunteers. There is no stipend at all for these volunteers. The only funding was from the DSD in 2003 and none in 2004. The other source of support for the OVC is the food parcels they receive from the DSD.

Tshireletso Community Centre

Tshireletso started in 2002 at Boitekong. Originally the organisation was meant to follow up patients from the clinic and make sure that they took their medication properly. While servicing and monitoring the patients at home, the plight of the children of the sick and dying patient became apparent. The organisation then decided to include OVC as one of its focus areas.

A day care centre was then established with the aim of providing care and a balanced meal for these children. For most, there is no food at all at home. The organisation also takes care of sick children, identifies TB and HIV/AIDS patients from the clinic and helps them with the administration of their medication. It also organises a nursing sister from the local clinic to come to the centre once every two weeks to take care of the children's wellness.

It has 40 OVC, with the age range of two to six years, and supports some school-going ones, up to the age of 18 years. The organisation has seven volunteers and a manager. There is no stipend at all for these volunteers. Sponsors of the centre include Extrata company and Amplants.

Bessie Mpelegele Ngwana

Bessie Mpelegele Ngwana care centre started in February 2000 because of the need for a service specifically for children with severe disabilities. It started with three children and currently has 75. It cares for children with hyperactivity, autism, Downs Syndrome, cerebral palsy, as well as any physical challenge or multiple handicaps. The centre operates 24 hours a day and has a hostel facility.

The organisation originally planned to admit only severely disabled children between the ages of four and 22 years, but later it took in OVC with disabilities (because expanded family members or next of kin could not accommodate them, or some were abused

by relatives), although their disabilities are not as severe as the others. Of the total of 75 children staying in the centre, nine are orphans without both parents, one has only one parent and about 25 fall within the vulnerable children category (family background very bad/very poor, and some even abused). Parents/guardians are expected to pay an amount of R600 a month for tuition and accommodation, but the majority can not afford this.

The main aim of the organisation is to provide care, love and stimulation, as well as basic life skills, for example, toilet training self-feeding, playing with toys and hand work. The organisation also aims at providing a place where these children can feel that they are also human beings who need to be treated like others despite their disability. The centre has 14 volunteers who work day and night, one administrator and one manager. The volunteers attended a formal course on early childhood development, but there is still a need for courses on how to deal with disabled children.

The organisation depends greatly on parents who can afford to pay for their children, child/disability grants from the DSD (though not all children grants are paid to the centre; some are paid directly to the parents) and once off donations from companies such as Impala Mines, the National Development Agency and the national lottery.

Major needs of the organisation are linked to finances. There is a need for an appropriate building with equipment suitable for children with disabilities, as well as wheelchairs, and health specialists such as occupational and physio- therapists. Funds to run the centre are also needed – salaries, food, water and electricity, nappies, transportation, and teaching aids.

Bana Ba Kgotso

Bana Ba Kgotso was established in 1997 in Mamerotse. Its main focus is on orphans and children made vulnerable through high poverty and unemployment levels and increased adult death rate due to AIDS in their community and the surrounding areas.

The organisation helps OVC with applications of birth certificates and grants. It also provides extramural activities such as sports and cultural activities, for example, teaching traditional Tswana culture and dance. The organisation also helps these children to access food parcels from the DSD and vegetables from the gardens that they have started in the village. However, the supply of food parcels has been very infrequent and does not always reach the beneficiaries intended.

Bana Ba Kgotso has 12 volunteers, all of whom are executive committee members. The total number of OVC with whom they are involved is 85, 20 of whom have lost both parents through AIDS and another 20 have lost one parent. The organisation does not have a sponsor at all.

Hands of Compassion

Hands of Compassion is an NGO based in Tlhabane and cares for orphans and vulnerable children. The majority of the children under its care have been made vulnerable through abuse, high levels of poverty and unemployment in the township. Its main philosophy is to look after children's emotional and physical needs, give them love and make them feel at home all the time.

The manager (who runs the organisation with only one volunteer) is a former teacher and provides educational help and food for the OVC, especially after school hours. The

children meet every afternoon, Monday to Friday around 14h00, at the manager's house to have their lunch and receive help with their schoolwork.

The organisation cares for 38 children, between the ages of 2 and 12 years. Of this total number, 13 are orphans with no parents at all and are staying with grandparents or next of kin. They all sleep at their homes and only come for lunch and educational help. Hands of Compassion also help children with applications for birth certificates and social grants.

The organisation received a once-off donation from the Impala mining company, which was in the form of children's toys, a seesaw and educational puzzles. There are no recreational facilities in the township for the children of this age group and the NGO provides fun activities for children.

Youth for Christ

Youth for Christ has been in existence for 25 years and has been involved with life skills programmes in schools. Its original focus was on placing street children into schools and tracking their families. This has, however, been changing, moving more into helping child-headed households, submitting grant applications for the children in need and providing any other social services for school-going children.

The organisation works very closely with the DoE, especially on placement of school children into life skills programmes at school level. One of their programmes, named 'sithembe' helps children to trust themselves, not only from the material side, but also with their psychological and emotional fitness and strength. Its main goal is to integrate the youth into communities and families, and to facilitate foster care through the DSD.

Some of the main sponsors have been the DoH, the NMCF, the lottery Board and NEDCOR.

Ratanang Care Centre

Ratanang Care Centre started in December 2001 with 12 children and by the end of January 2002 it had about 50 children under its care. Currently the centre has 70 children and cannot accommodate any more, although the demand for their services is still increasing. Their core philosophy is to love one another and to reach out to all the orphans in their area. The organisation operates in one of the primary schools in Photsaneng and services two other villages around it, namely Mfidikwe and Thekwane. It temporarily occupies two classrooms with different age groups. The organisation also has a second branch/day care centre in Sunrise Park, which has 100 children. All these children attend the day-care centre for free.

Although its original plan included a youth skills development programme, it did not succeed because the organisation could not secure placements in companies and/or mines in the area for their trainees. It then decided to focus on a day-care centre for orphaned and vulnerable children. Besides the daily running of the day care centre, the organisation also arranges child grants and food parcels with the DSD. OVC are identified by the community councillors and members and are then referred to the centre. The majority of the children they care for are from single headed families, mainly the mother, and when she passes away, the organisation automatically takes over the care of the child.

The organisation has a staff component of seven volunteers and a manager. They all have formal training in early childhood education. The main sponsor is the Extrata mining

company, which offers the organisation operational money of R20 000 a month. This covers food, stipends and transportation of these children.

Traditional Healers HIV/AIDS Hospice

The Traditional Healer's HIV/AIDS Hospice is based in the Chaneng village. Its work is divided into three main areas, namely, treatment of people living with HIV/AIDS, traditional healer's training and OVC. The original focus was on the first two areas. The care of OVC came onto the organisation's agenda as mothers died while at the hospice and families were not managing to provide food and other resources for the children left behind because of high levels of poverty and unemployment in and around Chaneng.

The manager is a traditional healer who operates from this base in working with people living with HIV/AIDS. The PWHAs are offered treatment, the terminally ill are kept in the hospice and those with enough strength are sent home. Volunteers working with either sick people or OVC are traditional healer trainees and some are parents whose children are at the hospice.

The total number of OVC under its care is 87, whose ages range between three months to 21 years old. Of this total number, only ten are staying in the hospice and the rest come in the morning to have breakfast and collect their lunch boxes before leaving for school and then come back again in the afternoon to have lunch or a meal before going back to their homes. The number of OVC needing this help is estimated to be around 300, but the NGO cannot take in anymore. The challenge with this is that once the child is there, they cannot be sent back without providing food for them.

The main focus of the organisation with regards to the OVC is the provision of food and sometimes clothing, school resources (school fees and other resources) and reinstatement of those who dropped out of school, applications for birth certificates for those who do not have them and social grants.

The DoA has offered them land for vegetable gardens. Sun International also funded the building of their hospice. The organisation also applied for funding from the National Development Agency.

Vision for the Nation

Vision for the Nation started in June 1999 with the original focus on HIV/AIDS education and awareness. In 2001, the focus changed to home-based care and reaching out to communities around the RLM. OVC was never a focus, but the NGO started coming across the challenges faced by these children when visiting their sick parents. Currently there are 35 OVC between the age of 4 and 11 years under its care. The organisation organises food parcels and child grants for them. A social worker has just been employed with the aim of directly monitoring OVC and dealing with their issues.

The organisation has eight employees, formally trained by the DoH. They also have 39 volunteers, all divided according to the five communities that they serve. Remuneration is provided for the employees and some volunteers get a stipend. The provision of a stipend depends on the length of time a volunteer has been with the organisation and the level of skill acquired. The DoH has been the main sponsor for the organisation, mainly because of its focus on home-based care.

Challenges faced by NGOs

Almost all NGOs indicated that they need funding in order to provide basic services or expand the coverage of the services they provide to OVC. Some of the issues highlighted in this regard are:

- The provision of basic needs for OVC. Food, clothing, school resources and school transportation ranked among the most crucial needs of the OVC in the RLM.
- Inability to meet the basic needs outlined above makes it difficult for some NGOs to keep OVC, especially girls, from falling into the trap of exchanging sex for food or money. Most resort to this as a survival strategy. Ability to enable OVC to stay in school and attain economic self-sustainability is key to ensuring that they do not get back into the vicious cycle of HIV infection and AIDS.
- Distance between the villages and lack of transport makes it difficult to reach all who need services.
- Lack of infrastructural development in the villages includes children's shelters, day care centres, recreational facilities and village heritage sites, all of which would benefit OVC, either as a temporary shelter or fundraising sites.
- The challenge of the misuse and abuse of children's grants by some of the foster parents and caregivers; instead of spending the money on the child, some spend it on themselves.
- There are not enough social workers to deal with all the cases of OVC in the RLM. In some cases poor working relationships between NGOs and social workers cause delays in processing a case and this, in some instances, can hinder the legal process of fostering a child. If working relationships are good, the processing of any applications in the DSD is more speedily completed.
- Reluctance of families to adopt children in need of homes.
- The number of HIV/AIDS cases is increasing in the area, leading to an increase in the number of orphans after either or both of the parents die.
- Need for private sector involvement in helping the OVC. There is also a need to put some money aside (as loans or bursaries) for tertiary studies of these children.
- Besides the resources needed by NGOs to support OVC, there is also a need for skilled personnel within NGOs themselves to be able to deal with the day-to-day running of their work.

Conclusion

As indicated throughout this report, the number of OVC in the RLM has been increasing over the years and the challenge of responding has become significant for everyone involved. The majority of OVC are staying in already crowded shelters, some with grandparents or extended families and some alone in child-headed households, often in informal settlements or RDP houses. They live below the poverty line, are hungry, have been traumatised and most are socially isolated from other community members. Their greatest needs are food, school fees, uniforms, books and clothing.

Almost all the OVC interviewed are unaware of policies or legislation that protects them. If this is not dealt with the problem will continue to increase.

The NGOs in the RLM play a major role in addressing the issue of OVC. They however do not have the capacity to effectively address the challenge, given its magnitude. The majority of them do not have adequate resources to handle the needs. Most volunteers are themselves poor and not receiving any stipend, and if they do, it is for a very short period of time.

Besides the resources needed to provide for the OVC, most of the new NGOs need capacity building to effectively administer their programmes, and this is not only limited to financial management, but general management of work processes in the services they provide. This is important for their sustainability. In this instance, an established NGO such as Tapologo could work in close collaboration with other emerging NGOs, especially those that are currently working with OVC and their families in the villages.

While the challenge of OVC is experienced across the entire RLM, the NGOs interviewed indicated that the problems were more severe in the informal settlements and villages around the mines. This is in line with the findings of the Nelson Mandela HSRC study, which found the HIV prevalence in farms and informal settlements in the North West to be significantly higher than in other areas surveyed. The natural progression of the HIV/AIDS epidemic results in increased AIDS-related mortality in areas with high HIV prevalence. This in turn causes an increase in the number of children orphaned. This might explain the observation and experiences of the NGOs outlined above.

Priorities for action

The key findings above have implications for the targeting of responses towards OVC and their situation:

- It is important to recognise the interrelated aspects of the HIV/AIDS epidemic and poverty. The need to focus energies on fighting poverty and curbing the HIV/AIDS epidemic in rural villages and informal settlements is critical. Fighting poverty increases choices for OVC, therefore reducing the pressure to get involved in high-risk behaviour and reducing their vulnerability to HIV and violence. Containing the spread of HIV in areas of high prevalence, such as rural villages and informal settlements, is critical in order to protect the larger population of the RLM.
- It is equally critical to mitigate the impact of AIDS in these areas as a priority. As parents die and leave their children alone or with grandparents, it becomes critical for the government machinery to ensure the care and development of these children. This is essential if we are to achieve the ideals of a healthy, responsible, educated and skilled South Africa in the future.
- All government departments in the social cluster of the RLM need to take a more active role in addressing the issues of OVC. There is a need to include a holistic approach that meets the health, nutritional, psychosocial, educational and economic needs of children and the families who care for them. DoH needs to provide health, DoE to ensure that children are in school and stay in school and DSD to ensure that children's social and survival needs are addressed.
- There is a need to review the existing mechanism of collaboration to improve the sharing of information and resources between various OVC providers. This will ensure a more comprehensive provision of services and a tighter net to ensure that children do not fall out of the social service as they grow older. This forum should also foster the creation of new ideas for the interventions implemented.
- There is also a need to increase and develop human resources that deal directly with issues relating to OVC within all government departments and NGOs. This needs to be accompanied by sufficient material and administrative support, especially for new NGOs.
- At community level, OVC have matured, with responsible adults taking care of them. This requires community participation and ownership since children belong to communities. It is critical to consider strategies that strengthen communities to help themselves on these issues.

- With specific reference to OVC it is important to ensure that:
  - Their basic needs are met. This includes food, shelter, clothing, access to education and health. In order to facilitate their access to these services, it is critical to assist OVC in obtaining the necessary legal documentation such as identity documents etc..
  - They get psychosocial support to cope with grief of loss of parents and the stigma related to AIDS.
  - All stakeholders involved need to mitigate the impact of HIV and AIDS on OVC themselves. This can be done through life skills education and other vocational skills that would reduce their vulnerability to HIV/AIDS and ensure that they are economically self-sufficient.
- Finally, there is also a need for commitment from all stakeholders to monitor and evaluate the programmes that are implemented.

CHAPTER 7

Overall summary of conclusions and recommendations

Alicia Davids and Donald Skinner

The four communities that are incorporated into this report represent very different contexts, ranging from urban centres to very sparsely populated dominantly rural communities. A number of direct recommendations arise from the material. These are summarised under the following headings.

OVC and carers

Within South Africa, for many communities, there are various socio-economic and health restrictions placed on countless families. The lack of access to health-care, high rates of unemployment and the basic needs of food and shelter are seen as an everyday struggle that often cannot be met. For orphaned children and their carers, who often cannot afford to adequately care for their own children as a result of unemployment, this struggle is heightened.

As illustrated by the situation analysis conducted in various communities within South Africa, the following issues described are the main problems experienced by both the OVC and their carers/guardians or families:

Basic needs

Food, shelter, clothing and education are among the top priorities that orphaned and vulnerable children desperately need. Many of the carers of OVC cannot afford to provide adequate food and clothing for these children as they themselves already have their own children to take care of. Some of the OVC who are not placed with guardians are left without any care, therefore not getting proper meals or shelter and as a result these children roam the streets not having eaten for days on end.

For the families that have taken in OVC, although food and clothing are still seen as a daily struggle, carers now have to provide the child/children with school clothing and pay school fees, which is seen as another obstacle, as many of the carers cannot afford even the minimum amount required to send the child/children to school.

Psychological needs

A culture of care within the communities needs to be encouraged by all community members so as to sensitise them about the importance for caring for those in need, even if not related to them. OVC in the communities are often stigmatised and discriminated against, as a result of losing a parent/parents to AIDS or themselves being infected with HIV. The trauma of losing a parent(s) is further exacerbated by the stigmatisation and discrimination experienced by OVC. OVC, having lost a parent/parents, are not provided with adequate coping mechanisms or counselling which often leaves them with deep psychological scarring. Although in some communities families are helped with material

needs such as food and clothing, little help is provided with regard to psychological needs of OVC, especially children dealing with issues of bereavement and loss. There is a need for parents/guardians to be trained in HIV/AIDS, sexuality and bereavement issues in order to provide counselling and nurturance to OVC. As a result, community-based interventions also need to intensify education about HIV and other related services such as VCT, antiretrovirals and PMTCT.

Legal aspects

One of the main concerns that was stated by the majority of community members from all situation analyses conducted, was the problem experienced with processing grant applications for OVC. Applying for the identity documents that are needed in order to process a grant application is seen as a huge struggle, with little help being provided by government departments. It was further stated that many people have to wait for an unacceptably long time before they received the grant, which leaves many families destitute with no income available to rear the OVC. Therefore the grant system needs to be improved, as well as monitored to ensure that carers use the grants to the benefit of the children put in their care.

Of the OVC who were interviewed, almost all were not aware of policies or legislation that protects them. For that reason communities need to be educated and made aware of children's rights and the importance of these rights.

NGOs/CBOs/FBOs

NGOs/CBOs and FBOs form an integral part in providing essential services and interventions to communities in need. Services and interventions implemented in communities by these organisations include provision of food parcels, assistance in grant applications and creation of job initiatives, among others. However with the increase of OVC and the high levels of unemployment within these communities this task has become increasingly difficult to sustain. Problems experienced within these organisations include the following:

- Shortage of staff as a result of insufficient funding, as well as a heavy workload that results in burnout and therefore loss of staff.
- The lack of skilled staff members, therefore, training of staff members needs to be addressed in order to provide efficient services to the community.
- Coordination and communication between various NGOs in some communities is none existent, which results in the duplication of services, which in itself poses more problems. It is therefore seen as an extremely important issue to address, as some OVC may not be receiving the services needed.
- Transportation, especially when having to travel vast distances, becomes another serious obstacle, as many of the NGOs are not equipped with vehicles to travel and, because of the poor road infrastructure, vehicles become a costly resource to maintain.
- NGOs need community participation in order to deliver services effectively. Although in some communities this does occur, in most of the communities the responsibility is shifted to the NGOs with little community participation in interventions.

The greatest challenge experienced by most of the NGOs/CBOs/FBOs is funding. Insufficient funding causes serious limitations for these organisations in reaching communities' high levels of need. Through coordination, as mentioned before, resources and funding can be maximised to mitigate the impact of orphanhood and vulnerability.

Government departments

Government department such as the DoH, DoE and DSD all provide critical services needed by communities. Health, education and access to welfare services, especially in poverty-ridden communities, are seen as core priorities that need to be delivered by these government departments. However, once again, because of the rising number of OVC and high levels of poverty in communities in need, the demand of these services in an already overburdened system has amplified to levels where the various problems are experienced. This results in further difficulty in providing effective and efficient service delivery within these governmental departments.

The community perceives, as with NGOs, government departments as the main service providers and persons responsible for delivering services that are needed within the community. However very few communities see their own role in delivering and being a part of programmes implemented by government departments. As a result there is a lack of participation from these communities. Therefore communities need to be educated about the proper documents required to access certain services and need to be involved in helping OVC by acting as agents for the state services. In addition to community members participating, members can also assist in the monitoring and follow-up of cases since social workers are not always able to do so.

Beside the lack of participation by community members, there is a lack of cooperation between government departments and NGOs. Government departments and NGOs are said to have a competitive relationship whereby successes are used as a measure of which department or organisation delivers the most services to communities. This behaviour may seem to be a good motivator in delivering services to communities. However the lack of cooperation between NGOs and government departments impedes overall provision of services, so that duplication of services occurs. Government departments need to work closely together to make sure that resources are not wasted and that services are not duplicated and to achieve levels of synergy.

Other issues and concerns also experienced by NGOs that need to be addressed, are:

- Lack of staffing affects the quality of services provided. For example, social workers are unable to give attention to emotional aspects of their clients and can only provide material support.
- Recipients of government finance are not properly trained in matters related to management of businesses and as a result are unable to sustain them. Therefore training of staff is seen as an essential barrier that must be overcome, not only in government departments but NGO organisations as well.

Direct input into these communities is essential. Efforts need to be put into creating housing, extending employment, care for OVC and reducing poverty. Furthermore, community members need to be made aware of the role they can play in assisting orphaned and vulnerable children. As one of the interviewees from Kanana indicated, 'It takes the whole village to raise a child'. Therefore every community member, NGO as well as government departments need to make it their responsibility to address the plight of orphaned and vulnerable children.

APPENDIX 1

Qualitative interview schedule

Members of State Services or Government

Background of person being interviewed

Background here should be about the government services provided to the OVC and those aimed at reducing the incidence of HIV/AIDS in the areas; what is the government doing and who in the government is providing these services? If more than one government department is entrusted with providing these services, who is coordinating them?
Why the person is being interviewed.
His/her position in the community.
How he/she came to be in this position.
What is your or your organisation's role in relation to OVC?
What is your or your organisation's source of knowledge about OVC?
What work does your organisation do and how do you assist OVC?
What do you think is the size of the problem and what impact is it having on this community?

What are your major challenges, needs and concerns, and how do these relate to your own resources?

The living situation of OVC, ranging from the best off to those in the worst situations, including the number of them in the community.
Awareness of orphaned and vulnerable children.
Estimates of the number of OVC.
Housing conditions, examples of good and bad.
Access to facilities by OVC, particularly educational, health and social services.
Financial and social resources available for OVC.
Community resources available for the care of OVC.
Major threats for OVC, at the levels of physical, emotional and quality of life.

Extent of HIV/AIDS as a problem in the community

State officials, especially those who provide social services and those who work in vulnerable communities, should be aware of the magnitude of HIV/AIDS in their communities. Ask if there are statistics of situation available and if not, ask them to estimate the magnitude of the problem is. It is also important to know the impact of HIV/AIDS on resources and social functioning in general. For example, does it result in increase of orphans, does it result in family conflicts, blame and infighting with communities, accusations of witchcraft etc.
Awareness and knowledge of HIV/AIDS.
Estimates of the number of people with HIV/AIDS.
Impact of HIV/AIDS on state and organisational resources available.
Impact of HIV/AIDS on community resources available.
Impact of HIV/AIDS on the social functioning of the community.

Attitudes of the community towards OVC, especially incidents of stigma

State officials' views about the community's attitudes towards OVC and if these attitudes are negative, ask about programmes aimed at changing them.
Perceptions of OVC by the community.

Stigma against OVC.
Anger at OVC.
Positive attitudes to OVC.

Care and support structures for OVC

Indications of who is providing this care and support.
Include examination of systems at the level of the family, community, organisational, state and others that may exist.
Impact of services.
Check sustainability of these systems of care.
Desirability and effectiveness of the different structures for care and support.
Requirements of these structures to be able to provide a better service.
Indicators of success for systems of care.

Profile and evaluation questions of implementing intervention organisation

Knowledge of the intervention organisation, structure and past activities.
Perceptions of the organisation and their capacity to do the work.
Ideas of how to facilitate the organisation's work.
Indicators of success for the implementing organisation.

Challenges for the community in providing care and support

What state officials think are challenges faced by communities in providing care and support for the OVC and how these could be overcome.
Providing the basics of shelter, food, education and care.
Dealing with emotional impact of orphanhood or vulnerability, eg. mourning, PTSD.
Interactions of the OVC with others in the household/institution.
Access to resources to facilitate care.
Attitudes of carers to OVC.
Assisting the OVC to deal with stigma.
Experiences of stigma as a result of providing care to OVC.

Policy and legislation for the protection of OVC

Ask about policies and legislations aimed at protecting OVC, their views about these, including strengths and limitations and whether they would like to see them amended. If no policies and legislation currently exist, probe for reasons for this. For example, is it because OVC are not a priority in the government or that these are still in progress?
Knowledge of law, policy or pre-established practices to protect OVC.
Attitudes towards such regulations.
Implementation and support of these regulations.

Suggestions of how to help OVC in the community

Role of individuals, CBOs, NGOs, FBOs, and state structures.
What is needed to facilitate these contributions?
Assessment of the commitment on the part of these structures to assist.

Suggestions on how to limit the spread of HIV/AIDS in the community

Ask what interventions they think are required to limit the spread of HIV/AIDS in the community. Is it education, infrastructure, reduction of stigma, improvement of health services, gender equity etc.? Also, within the government who should take responsibility to provide these?
Educational and information needs.
Infrastructural needs, eg. PMTCT, VCT and condom distribution.
Interventions at the social level, eg. stigma, gender discrimination, promiscuity.
Checks on the health service.

Care and treatment of PLWHA in the community

Services provided by the government and this department (and others) for care of PLWHA. Difficulties implementing them (for example PMTCT services may not be utilised due to stigma attached to being HIV-positive). If services are available ask for details and whether PLWHA access them, are they enough; who should provide more services.
Availability of services for PLWHA.
Impact of services.
Views on VCT, PMTCT and ARVs.
Advantages and disadvantages for the PLWHA and community of being open about status.

Risks of HIV as a result of violence

Ask about the incidence of these behaviours that may place people at risk of HIV/AIDS
Child abuse.
Rape and sexual assault.
Caring for victims of violence.
Taking payment for sexual services.

APPENDIX 2

Interview schedule for three nation OVC study

Interviews as background for BSS component

The key areas to be covered in the interview are in bold. Below that are prompts that may be used to elicit discussion, plus the particular areas that need to be covered in the interview. For each interview different sections of the interview schedule will have to be prioritised, and some of the areas of discussion may fall away. Do not use the prompts unless the respondent is finding it difficult to talk about the area. Responses are sought beyond the immediate prompts as long as the discussion stays within the broad subject.

Background of person being interviewed

This should serve as an icebreaking section. Before you meet the participant you would have been given some brief information about the participant, who he/she is and how you came to interview him/her, so you might not have to ask him/her. Before asking the participant to talk about his/her experiences and needs as an OVC, first explain the study in details.
Why the person is being interviewed
Position in community.
What do you know and understand about HIV and AIDS?
Is there anything that puts you particularly at risk for contracting HIV?

Personal knowledge, beliefs and behaviour in relation to HIV

This set of questions aims to ascertain the OVC knowledge, beliefs and practices related to prevention of HIV/AIDS. Also ask if they practice any of their own beliefs eg. safer sex. Also ask about their attitudes towards people who are living with HIV/AIDS (PLWHA)
Knowledge and beliefs about HIV.
Attitudes towards safer sexual practices and PLWHA.
Past behaviour and commitments to future behaviour.

Extent of HIV/AIDS as a problem in the community

Ask participants to estimate the extent of the HIV/AIDS problem in the community. Participants might not have the exact numbers but should merely say how big/small the problem is. It is also important to know the impact of HIV/AIDS on resources and social functioning in general. For example, has it resulted in an increase in orphans, does it result to family conflicts, blame and infighting with communities, accusations of witchcraft etc.
Awareness and knowledge of HIV/AIDS.
Estimates of the number of people with HIV/AIDS.
Impact of HIV/AIDS on state and organisational resources available.
Impact of HIV/AIDS on community resources available.
Impact of HIV/AIDS on the social functioning of the community.
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Suggestions on how to limit the spread of HIV/AIDS in the community

Ask what interventions they think are required to limit the spread of HIV/AIDS in the community. Is it education, infrastructure, reduction of stigma, improvement of health services, gender equity programmes etc.? Also, who should implement these; government, NGOs, other bodies?
Educational and information needs.
Infrastructural needs, eg. PMTCT, VCT and condom distribution.
Interventions at the social level, eg. stigma, gender discrimination, promiscuity.
Checks on the health service.

Complications in protecting themselves from HIV

Knowledge about HIV/AIDS and preventative methods may not necessarily lead to behaviour change; a lot of factors may impede behaviour change. These questions ask for barriers to behaviour change. What makes people unable to protect themselves against HIV/AIDS? Is it for example, lack of information, lack of access to resources like condoms and health services or pressure not to use condoms?
Access to resources.
Confusion in information.
Social pressures, risks of judgment and stigma.

Care and treatment of PLWHA in the community

Their knowledge about care of people living with HIV/AIDS. If services are available ask for details and whether PLWHA access them. What are their views about these services and if anyone of them tests positive would they utilise them; if not what are reasons?
Availability of services for PLWHA.
Impact of services.
Views on VCT, PMTCT and ARVs.
Advantages and disadvantages for the PLWHA and community of being open about status.

Attitudes of the community towards OVC, especially incidents of stigma

Ask community members themselves, participants here should be aware of attitudes towards OVC, whether they are accepted/rejected in communities. Rejection could be either overt or covert, probe for these. If time allows try to probe for concrete examples of these issues, for example whether they know any OVC who are being treated badly either within the family or in the community.
Perceptions of OVC by the community.
Stigma against OVC.
Anger at OVC.
Positive attitudes to OVC.

Risks of HIV as a result of violence

Because this will be a focus group, it may not be necessary to ask individual participants if they have experience of this. Rather ask in general whether these practices exist in the community, who is likely to engage in them and why.
Child abuse.
Rape and sexual assault.
Caring for victims of violence.
Taking payment for sexual services.

Major sources of information on HIV and AIDS

This last section asks about sources of information about HIV/AIDS, ask them to also rank these sources, which one provides the most useful information, which one do they utilise often and how could the provision of information about HIV/AIDS be improved.
Media sources.
Organisational and state services information.
Peers and colleagues.

APPENDIX 3

List of clinics in Virginia and Welkom

Virginia

All the five clinics in Virginia are pilot research sites for prevention of mother-to-child transmission (PMTCT). They also offer voluntary counselling and testing (VCT).

1. Meloding
2. Khothulang
3. O R Tambo
4. Rearabetswe
5. Virginia L A (situated in town)

Welkom

All the clinics in Welkom offer only VCT.

1. Welkom L A (situated in town)
2. Rheederspark Clinic
3. Riebeck Stad Clinic
4. Bronville
5. Kgotsong
6. Bophelong
7. Matjhabeng
8. Thabong
9. Tshepong

APPENDIX 4

List of schools in Welkom and Virginia that have feeding schemes

Food given: Biscuits and energy drink

Welkom	
Lehakwe	Public
Polokong	Mine
Presidentbrand	Mine
Farm schools	
Adamsonvlei	
Jakkalskop	
Lombardie	
Njala	
Sandvleit	
Sekolo	
Steenwyk	
The Praire	
Vierhoek	
Virginia	
Dieketseng	Public
Eden	Public
Harmony	Mine
Virginia	Mine
Farm schools	
Josero	
Kalkvlakte	
Mosele	
Nellie	
Stilte	
Welgelee	
Wonderspruit	

List of towns in the Xhariep District Municipality

TOWN	KOFFIEFONTEIN	PETRUSBURG	JACOBSDAL	OPPERMANSGRONDE	LUCKHOFF	TROMPSBURG	EDENBURG	REDDERSBURG	FAURESMITH	JAGERSFONTEIN	PHILIPPOLIS	SPRINGFONTEIN	GARIEP DAM	BETHULIE	ZASTRON	SMITHFIELD	ROUXVILLE
KOFFIEFONTEIN	0																
PETRUSBURG	55	0															
JACOBSDAL	45	76	0														
OPPERMANSGRONDE	12	67	57	0													
LUCKHOFF	42	97	87	30	0												
TROMPSBURG	125	180	170	137	136	0											
EDENBURG	115	152	160	127	175	39	0										
REDDERSBURG	141	141	186	153	317	65	26	0									
FAURESMITH	48	73	93	60	48	77	67	93	0								
JAGERSFONTEIN	58	310	103	70	234	67	57	83	10	0							
PHILLIPOLIS	109	134	154	121	83	53	92	118	61	71	0						
SPRINGFONTEIN	147	202	192	159	158	22	61	87	99	89	42	0					
GARIEP DAM	173	242	218	199	131	62	101	127	139	129	48	40	0				
BETHULIE	177	232	222	189	188	52	91	144	129	119	100	30	52	0			
ZASTRON	283	249	328	295	325	158	171	145	235	225	235	165	187	135	0		
SMITHFIELD	215	218	260	227	257	90	82	77	167	157	167	88	119	67	68	0	
ROUXVILLE	253	256	298	318	288	128	141	115	205	195	205	135	157	105	30	38	0

Source: Xhariep District Municipality

APPENDIX 6

List of public schools in Kanana and Vaal Reefs

Kanana

Primary Schools

Are-Fenyeng*
Are-Bokeng*
Atamela*
Bathabile*
Inyatelo*
Ntataise*
Pelokgale*
Reahola*
Selang-Thuto*

Intermediate School

Thuto-Tsebo

Secondary Schools

Kanana
Matlhaleng
Monkeng
Tshebedisano

Vaal Reefs

Primary Schools
United*
Vaal Reefs*

**The Primary School Nutrition Programme is available at these schools.*

APPENDIX 7

List of clinics in the City Council of Klerksdorp

Jouberton CHC**	Esibedlela Street, Jouberton
Park Street Clinic*	Cnr Park & Delver Streets, Klerksdorp
Alabama Clinic*	65 Alex Street, Alabama
Tsholofelo Clinic*	439 Kopanong Street, Jouberton
N. M. Pretorius Clinic*	Mercury Road, Klerksdorp
Tigane CHC**	204 Molefe Street, Tigane
Delekile Khoza Clinic*	2405 Freedom Square Street, Tigane
Botshabelo CHC**	Extension 6, Khuma
Khuma Clinic*	2 Wildebeestpan Ave, Khuma
Marcus Zinzele Clinic*	Extension 8, Khuma
Orkney Clinic*	Kingsley Shakespeare Street, Orkney
Kanana Clinic*	Cnr Disele & Taust Streets, Kanana
Grace Mokhomo CHC*	Khumalo Street, Kanana
Empilisweni Clinic*	Morokapula Drive, Jouberton
Stilfontein Clinic*	Bloem Street, Stilfontein

**These clinics have a prevention of mother-to-child transmission (PMTCT) programme; voluntary counselling and testing (VCT); proteins, vitamins and minerals programme (PVM); and immunisation for children between the ages of 0-5.*

*** These clinics do not offer all the services. However, they are open 24 hours and render maternity services.*

APPENDIX 8

Occurrence of HIV/AIDS infections 2002

Mun.	Town	Age 1–14	Age 15–29	Age +30	Aids related deaths	Total
Kopanong	Bethulie	2	4	17	18	41
	Edenburg	6	20	20	3	49
	Fauresmith		8	9	2	19
	Gariepdam	0	0	2	1	3
	Jagersfontein	3	32	53	17	105
	Philippolis		1	14	n.i	15
	Reddersburg		10	12	n.i	22
	Springfontein		4	10	n.i	14
	Trompsburg	0	9	0	3	12
Letsemeng	Jacobsdal	4	3	57	4	68
	Koffiefontein	0	16	4	6	26
	Luckhoff	1	7	4	4	16
	Oppermans	1	4	3	2	10
	Petrusburg		9	24	36	69
Mohokare	Rouxville	0	6	10	1	17
	Smithfield	0	2	3	1	6
	Zastron		22	99	45	166

Source: Free State Department of Health, 2002

APPENDIX 9

Public and farm schools in Welkom and Virginia

Virginia	
Bloemskraal Primary	Farm
Boase Primary	Public
Boitekong Primary	Public
Dieketseng Primary	Public
Eden Primary	Public
Harmonie Primary	Public
Harmonie Ordinary Sec.	Public
Harmony Primary	Mine
Hentie Cilliers Ordinary Sec.	Public
Ikaheng Primary	Public
Kalkvlakte Primary	Farm
Lakeview Primary	Public
Leeudam Primary	Farm
Welkom	
Bofihla Intermediate	Public
Bronville Primary	Public
Dagbreek Primary	Public
Dalivuyo Primary	Public
Dirisanang Intermediate	Public
Dr M G Mngoma Primary	Public
Ebenpan Primary	Farm
ED-U College	Independent
Edmund Rice Primary	Independent
Embonisweni Intermediate	Public
Golden Park Primary	Public
Goudveld Ordinary Sec.	Public
Hlolohelo Intermediate	Public
HTS Welkom Tech Sec.	Public
Iketsetseng Intermediate	Public

Josero Primary	Farm
Koppie Alleen Primary	Public
Lebogang Ordinary Sec.	Public
Leboneng Specialised	Public
Lehakwe Primary	Public
Lekgarietse Ordinary Sec.	Public
Lemotso Primary	Public
Lenakeng Tech Sec.	Public
Lenyora Intermediate	Public
Lephola Comp Sec.	Public
Leseding Tech Sec.	Public
Letsete Ordinary Sec.	Public

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