A conceptual framework for the identification, support and monitoring of children experiencing orphanhood

A project of the Children's Institute, UCT

Children's Institute

Commissioned by
Save the Children (UK)

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1 Executive summary

The Children's Institute was commissioned by Save the Children (UK)SA to develop a conceptual framework for the identification, support and monitoring of children experiencing orphanhood. The framework is intended to generate thought and discussion around the roles and responsibilities of different stakeholders and to assist with identifying gaps in a service response within a given context.

The proposed conceptual framework draws on research conducted by the Children's Institute as well as a range of literature.

Any approach to addressing the needs of vulnerable children should be grounded in needs and rights based paradigms. This report provides an interpretation of the rights of children in South Africa, as contained in the South African Constitution and the United Nations Convention on the Rights of the Child. Within this context, it explores the impact of poverty and orphanhood on 7 broad categories of developmental need, namely:

1. Health and survival
2. Safety and protection
3. Stimulation and cognitive development
4. Attachment
5. Self actualisation and identity
6. Guidance and boundaries
7. Appropriate inclusion and participation

We argue that while orphans, and in particular children orphaned by AIDS, do face some unique or additional challenges, many of the factors rendering them vulnerable are poverty related and shared by children living in poverty who are not orphans. The research informing the development of the framework identified the need for a service response that is sensitive to this and to the potentially harmful consequences of directing support inappropriately at particular groups of children, at the exclusion of others, within contexts of widespread and severe poverty.

The proposed conceptual framework emphasises the importance of involving all relevant stakeholders, including children, in determining what constitutes vulnerability within local contexts and in developing a service response to the needs of vulnerable children.

The framework recognises that service providers such as teachers, nurses, social workers and home based carers come into contact with children and caregivers without always fully utilising the opportunities that this contact presents. The report explores some of the reasons for this and makes recommendations for ways in which the identification, support and monitoring of

vulnerable children could be integrated into existing programmes and standard practice. In order to achieve this without placing unrealistic additional burdens on service providers, we recommend a focus on strengthening the roles that various service providers are best placed to fulfil in terms of their existing functions.

In order to assist individuals and organisations to realise their full potential in terms of the identification, support and monitoring of vulnerable children, there is a need to explore the development of resource materials such as factsheets for service providers on appropriate responses to warning signs of vulnerability, tips on how to establish and maintain local service directories to facilitate referrals, and guidelines for strengthening community coalitions. The development of such materials could form part of the way forward.

2 The impact of HIV on children in South Africa - the scale of the problem

Studies show that there has been a steady increase in adult mortality in South Africa over the last 15 years. This increase in mortality of relatively young adults has largely been attributed to AIDS, with 40% of adult deaths (15 to 49 years) in 2000 believed to be AIDS related. Without treatment, experts predict that between 5 and 7 million people in South Africa will die of AIDS by 2010 (Dorrington, Bourne, Bradshaw, Laubscher and Timaeus, 2001).

Women are more vulnerable than men to HIV infection for biological, social and economic reasons (for every one new male infection, two women are infected). Women in Sub Saharan Africa are particularly vulnerable to infection, with 8 out of every 10 women infected globally, coming from this region (Sozi, 2001). In South Africa, mortality rates in women between the ages of 25 and 29 years were 3.5 times higher in 2000 than in 1985. The 1999 confidential enquiry into maternal deaths found AIDS to be the most common cause of maternal death in South Africa (Dorrington et al, 2001). The disaggregation of deaths by gender is particularly relevant when considering the impact of HIV on children. The HIV-positive status of a man in a household very often means a reduction in household income, but the illness and death of the primary caregiver (usually a woman) often has more severe social, emotional and economic consequences for children (Giese, Meintjes and Proudlock, 2002). The vulnerability of women to HIV infection and the recorded increase in maternal mortality therefore has a direct impact on child well-being.

"When a mother dies, children suffer". These are the words of a 9 year old boy in South Africa who has been orphaned by AIDS. In the context of HIV, the literature commonly defines 'orphans' as children under the age of 15 years who have lost a mother to AIDS. South Africa currently has an estimated 600 000 (Johnson and Dorrington, 2001) children who fall within this category and this figure is expected to peak at between 2 and 3 million children by 2015. If the definition of 'orphan' is broadened to include all children (under the age of 18 years) who have lost one or both parents, the figure is expected to be substantially greater, at 5.7 million. Due to the dependency between paternal and maternal mortality (linked to the fact that HIV is a sexually transmitted disease), we are likely to see a dramatic increase in the proportion of the orphan population that are double orphans (having lost both parents). These figures do not take into account the large numbers of fathers who are alive but absent for other reasons (Johnson and Dorrington, 2001).

It is estimated that by 2010 approximately one quarter of all learners in schools in KwaZulu Natal will be orphans (Badcock-Walters, 2001). Although there is limited understanding of the full effects of orphanhood on educational outcomes, there is evidence to indicate that orphans are particularly vulnerable to drop out, delayed

or intermittent enrolment, and poorer performance in school. These disadvantages have been linked to (among other things) an inability of caregivers to meet basic needs, a breakdown of support systems, stigmatisation, lack of parenting and moral support, household demands on children's time, and financial and psychological stresses (Kinghorn, Coombe, McKay and Johnson, 2002).

With high rates of adult mortality, the number of children in South Africa living alone and under the subsistence level, is expected to increase from approximately 46 000 in 1996 to close on 900 000 in 2011 (Haarmann, 2001).

While HIV prevalence among adults in South Africa is relatively well documented, little is known about the extent of HIV-infection in children under the age of 15 years. Models (such as the ASSA2000 model), used to calculate the number of HIV-infected individuals in South Africa, are based on the assumption that maternal to child transmission is 100% accountable for infections in children under the age of 15 years. The National HIV and Syphilis Sero-prevalence survey of women attending public antenatal clinics in South Africa (2002), estimates that approximately 80 000 babies acquired HIV through mother to child transmission during the year 2001. The cumulative number of HIV-infections in children is not known.

As a result of childhood HIV infection, increases in maternal morbidity and mortality and the socio-economic consequences of HIV and AIDS on households, overall morbidity and mortality in African children is increasing (Dray-Spira, Lepage and Dabis, 2000). This is reflected in predicted increases in both the under 5 and infant mortality rates (IMR) in South Africa (Bradshaw, Masiteng, Nannan 2000; Department of Health, 1999).

Source: Giese (2002) Factsheet – the impact of HIV/AIDS on children in South Africa

3 Terms of reference

With the recent increase in morbidity and mortality of young adults, primarily as a result of AIDS, hundreds of thousands of children in South Africa have been orphaned or are living in households with sick or dying caregivers (Dorrington, Bourne, Bradshaw, Laubscher and Timaeus, 2001).

In March 2000, a rapid appraisal of the situation of children living with HIV/AIDS in South Africa highlighted the need to investigate systems for the identification of children who have been orphaned or who are at risk of being orphaned. In April 2002, Save the Children (UK) commissioned the Children's Institute, UCT, to develop a conceptual framework for the identification, support and monitoring of children experiencing orphanhood.

The Children's Institute was approached primarily because of the role the Institute was playing in the development of national policy guidelines on health and social services for children experiencing orphanhood. This research project draws heavily on the information and insights collected through the primary research conducted to inform the development of national policy guidelines (See Giese, Meintjes, Croke and Chamberlain et al, forthcoming).

3.1 Aims and objectives

The aim of this project was to develop a conceptual framework for the identification, support and monitoring of children who have been orphaned or who are at risk of being orphaned, in order to assist service providers to address the needs of this group of vulnerable children.

The objectives were:

1. To develop a profile of the needs of children experiencing orphanhood and the factors that impact on the fulfillment of these needs.

2. To review activities within schools, health facilities and social services to identify, support and monitor children experiencing orphanhood.

3. To develop a conceptual framework for the identification, support and monitoring of children experiencing orphanhood.

While our primary research collected information mainly from and about children experiencing orphanhood, the principles and recommendations emerging can be used to generate thought and discussion on the roles of service providers in the identification, support and monitoring of more broadly defined categories of vulnerable children.

3.2 Definition of terms

For the purposes of this report, we have chosen the following functional definitions:

Children experiencing orphanhood: Children *whose care is compromised* as a result of the terminal illness and/or death of an adult who contributes to the care and/or financial support of the child. The term is chosen in part because of the way in which it reflects orphanhood as a process, which begins long before a child's parent, or caregiver dies (Giese et al, forthcoming).

Caregiver: The person(s) – adult or child – primarily responsible for providing care to a child or negotiating care or support on behalf of a child.

Household: A group of co-resident individuals. An individual is considered to be resident if he/she is present more than three nights per week. Note that boundaries to households are fluid with the movement of both people and resources across space.

Child headed household: A household in which the oldest resident is under the age of 18 years.

Identification: The process by which a peer or an adult recognises that a child is hungry, ill or otherwise in distress, or becomes aware that a child is living in circumstances that put him/her at risk of becoming distressed.

Support : Any activity that helps to meet a vulnerable child's developmental needs.

Monitoring: The observation of a child for signs of distress once a child has been referred and/or is being supported. Monitoring is required to determine whether the support is sufficient and appropriate.

3.3 Research that informed the development of the conceptual framework

The conceptual framework draws on a number of sources of information, including the following:

3.3.1 Primary research to inform the development of national guidelines for health and social services for children experiencing orphanhood

This project to develop a conceptual framework for the identification, monitoring and support of children experiencing orphanhood draws heavily on the qualitative data collected for another research project undertaken by the Children's Institute

to develop national guidelines on health and social services for children experiencing orphanhood.

The research for the development of national guidelines was conducted in six sites around the country. The sites were selected according to a set of criteria, including HIV prevalence and variability in terms of rural / urban locality and service availability. The development of the conceptual framework draws primarily on information collected from two of these six sites, namely Gugulethu (Western Cape urban area) and Tzaneen (Northern province rural / peri-urban area). The decision to draw on information from these sites was based primarily on the restrictions imposed by the agreed upon timeframes (information from these sites was collected first). However, experiences and insights from the other 4 sites also informed the development of the framework.

The primary data collection involved interviews, focus groups and child participatory research activities with:

- Children experiencing orphanhood
- Caregivers of children experiencing orphanhood (including sick caregivers)
- Teachers and principals
- Health workers
- Social workers
- Staff of non-governmental and community based organisations
- Community volunteers and home based carers
- A range of other roleplayers, including members of a street committee, local churches and members of HIV related support groups.

A detailed research methodology will be provided in the forthcoming research report, accompanied by recommendations for the development of national guidelines for health and social services for children experiencing orphanhood (Giese, Meintjes, Croke, Chamberlain et al, forthcoming).

3.3.2 Electronic and telephonic communications with programme planners and implementers

Additional information was collected through electronic and telephonic communication with contacts in South Africa, as well as elsewhere in Africa, involved in programmes linked to the identification and support of vulnerable children. Guidelines for a telephone interview were developed for the purposes of investigating a selection of identification, monitoring and support systems that exist outside of the two primary research sites. A posting was placed on two electronic networks: AF-AIDS, and CABA, requesting information on mechanisms for the identification of children experiencing orphanhood. Many of the responses to these postings helped to corroborate the general picture of identification, support and monitoring systems identified through the primary research.

3.3.3 Literature

The development of the conceptual framework also draws on a range of literature, including two earlier studies to describe mechanisms for the identification of "children in distress", commissioned by Save the Children and the Bambisinani Project (Mabude, Ndudane, Fipaza, Mfenyana, Ndukwana and Mabandla, 2001; Marston, Swartz and Sephiri, 2001).

In addition to the experiences of children who participated directly in the research, the conceptual framework was also informed by the shared experiences of children who participated in the National Children's Forum on HIV/AIDS.

The Forum was facilitated by the Children's Institute in August 2001 and brought together 90 HIV-affected children (between the ages of 7 and 18 years) from around South Africa. The children worked together over a period of 3 days, in small groups with adult facilitators. Using activities designed by experts in child participation[2], the children shared their experiences about the ways in which HIV/AIDS impacts on their lives, their coping strategies and the individuals and organisations that support them. The forum was particularly informative in terms of highlighting examples of the missed opportunities for the identification, support and monitoring of children and the 'secondary trauma' that many children face when attempting to access services and support.

4 Understanding the impact of orphanhood on children in South Africa

4.1 Interpreting children's rights

All children in South Africa have a set of basic rights, afforded special recognition in Section 28 of the Bill of Rights in the South African Constitution. All policies and laws in South Africa must conform to the principles laid out in the Constitution. The rights of children are further outlined in a number of international documents, including the United Nation's Convention on the Rights of the Child (UNCRC) which South Africa ratified in 1995. By ratifying the UNCRC, the South African government committed itself to giving high priority to the rights of children, to their survival and to their protection and development (UNICEF, 1990).

The table below expands on some of the basic rights of children in South Africa, providing brief descriptions of the ways in which these rights can be interpreted in practise.

[2] Clacherty and Associates

Table 1: Interpreting the basic rights of children in South Africa

Children in South Africa have the following basic rights	**What do these rights mean?[3]**
Everyone has the right to life[4]	The government must do all within its power to ensure that every child is able to survive and develop[5].
Every child has the right to family care or parental care, or to appropriate alternative care when removed from the family environment[6].	Children without families have the right to special protection and assistance from the government. The government has a duty to ensure some acceptable form of alternative care for the child. Parents and caregivers have a duty to care for their children and government has a duty to assist them in their responsibilities to their children. If the child's caregivers are abusing or neglecting the child, the government has a duty to step in and assist the child.
Everyone has the right to have access to health care services, including reproductive health care[7]. The Constitution gives children extra protection through providing children with a special health right: Every child has the right to basic health care services[8].	The Government must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of this right[9]. No-one may be refused emergency medical treatment[10]. Governments must do everything possible to ensure that no child is deprived of his or her right of access to health care services[11]. The government has a responsibility to assist children with disabilities to access health care services[12].
Everyone has the right to have	The government must take the necessary measures

[3] Many of the rights of children are open to different interpretations, which may not be captured in this table
[4] Section 11 of the Constitution
[5] Articles 6 of the UNCRC
[6] Section 28(1)(b) of the Constitution
[7] Section 27(1)(a) of the Constitution
[8] Section 28(1) (c) of the Constitution
[9] Section 27(2) of the Constitution
[10] Section 27(3) of the Constitution
[11] Article 24(1) of the UN Convention
[12] Article 23 of the Convention

access to social security, including, if they are unable to support themselves and their dependents, appropriate social assistance[13]. Every child has the right to a standard of living that is adequate for the child's physical, mental, spiritual, moral and social development [14]	to achieve the full realization of this right[15]. Children in especially vulnerable situations, such as children living with sick parents, children living on their own, and children living on the streets must be provided with material assistance immediately to ensure their survival and development.
Everyone has the right to have access to sufficient food[16] Every child has the right to basic nutrition[17].	Parents and caregivers must do their best to ensure that their children's basic survival needs are provided for (food, water, shelter, clothing) and that their children are provided with educational, cultural and recreational opportunities to ensure their optimal development. The government must create a society that assists parents and caregivers to provide for the basic and developmental needs of their children. If parents or caregivers are unable to provide for the basic needs of their child, or do not want to provide for these basic needs, the government has a duty to step in and assist the child.
Everyone has the right to have access to sufficient water.[18]	Everyone must be able to get at least 25 litres clean, safe drinking water per day. The water supply should not be further than 200 metres from any home[19]. Everyone must have access to proper sanitation facilities[20].
Everyone has the right to a basic education[21]	Government has a responsibility to ensure that children can go to school and that they have access

[13] Section 27(1) (c) of the Constitution.
[14] Article 27 of the UNCRC
[15] Article 26 of the UN Convention
[16] Section 27(1) (b) of the Constitution.
[17] Section 28(1) (c) of the Constitution.
[18] Section 27(1) (b) of the Constitution.
[19] The minimum standard for basic water supply services is defined in Regulations to the Water Services Act , 1997.
[20] Regulations in terms of section 9 (1) and 73(1) of the Water Services Act specify the minimum standard for basic sanitation services.

	to recreational and cultural opportunities. Government must ensure that children have access to a school near to where they live. If the school is far away, transport should be provided or made available in some way. The education provided must be of an acceptable standard Schools must be kept in an acceptable condition and have the necessary facilities No child may be refused admission to school or sent home because he/she is unable to pay school fees[22] No child may be discriminated against in any way as a result of not being able to pay school fees[23] No child may be discriminated against, treated unfairly or harassed at school because of their HIV status or because someone in their family has HIV. Teachers may not beat children [24].
Everyone is equal and has the right to equal protection[25]. Equality includes the full and equal enjoyment of all rights and freedoms[26]. Everyone has inherent dignity and the right to have their dignity respected and protected[27]	The government may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth[28]. The government has a duty to promote and achieve equality and all persons have a duty to promote equality[29].

[21] Section 29 (1) (a) of the SA Constitution
[22] Section 5 of the South African Schools Act, 1996.
[23] Section 9 of the Constitution says that everyone has the right to equality and no-one may be discriminated against just because they are poor. Section 5 of the South African Schools Act says that the school may not unfairly discriminate against learners in any way.
[24] Section 10 of the SA Schools Act prohibits corporal punishment in schools.
[25] Section 9(1) of the Constitution
[26] Section 9 (2) of the Constitution
[27] Section 10 of the Constitution
[28] Section 9 (3) of the Constitution
[29] Section 24, Promotion of Equality and Prevention of Unfair Discrimination Act, 2000.

	Government, with the assistance of the Human Rights Commission and other constitutional bodies has a clear duty to develop an awareness of the rights of people affected by HIV in order to promote a climate of understanding, mutual respect and dignity[30]. If unfair discrimination is occurring on a large scale, against a group of people, such as people with HIV, government has a duty to develop an action plan to address the unfair discrimination[31].
Everyone has the right to freedom and security of the person. This includes the right to be free from all forms of violence[32]. Every child has a right to be protected from maltreatment, neglect, abuse or degradation[33].	Children have the right to be safe and free from violence and abuse, especially in their own home. The government has a duty to take all appropriate legislative, administrative, social and educational measures to protect children from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation while in the care of parents, legal guardians or any other person[34]. Everyone (including family members) has a duty to protect children from rape and sexual abuse.
Every child has the right to rest and leisure, and to play[35]. Every child has the right to be protected from exploitative labour practices[36] Every child has the right not to be required or permitted to perform work or provide services that - are inappropriate for a person of that age;	Children should not have to work in order to survive. Society must provide a nurturing and protective environment that allows children to be children; to go to school, to play, to feel safe and happy, to rest, and not to have to bear the stress of adult responsibilities. When society has failed to provide such an environment, or in times of social emergencies such as the HIV/AIDS pandemic, the government has a duty to: ensure that the worst forms of child labour are

[30] Section 25 (1)(a), Promotion of Equality and Prevention of Unfair Discrimination Act, 2000
[31] Section 25(1) (c)(i), Promotion of Equality and Prevention of Unfair Discrimination Act, 2000
[32] Section 12(1) (c) of the Constitution
[33] Section 28(1) (d) of the Constitution
[34] Article 19 (1) of the UN Convention
[35] Article 31 of the UN Convention
[36] Section 28(1) (e) of the Constitution

or place at risk the child's well-being, education, physical or mental health or spiritual, moral or social development[37].	eradicated[38], urgently work towards creating a society in which children do not have to do any form of work in order to survive[39] ensure that children who are forced to work for survival, are provided with support in order to ensure their work does not harm their education and development[40].
Children have the right to participate in decisions that affect them[41]	The South African Government must provide opportunities for children to participate in decision-making processes that impact on them, either directly or through appropriate representatives.

Source: Giese, Meintjes and Proudlock (2002)

The Articles contained in human rights treaties and conventions ratified by South Africa, as well as Section 28 of the South African Constitution, among others, reflect many of the developmental needs of children and provide legally enforceable recognition of the fact that children have the right to have these needs met. Child development experts argue that failure to meet the basic needs of children can have a detrimental impact on long-term developmental outcomes in children (Horwath, 2001). One of the greatest threats to the fulfilment of the needs and rights of children in South Africa is the illness and death of adults responsible for their care and support, particularly in the context of severe and widespread poverty.

4.2 Understanding the impact of orphanhood on children's developmental needs within the context of poverty

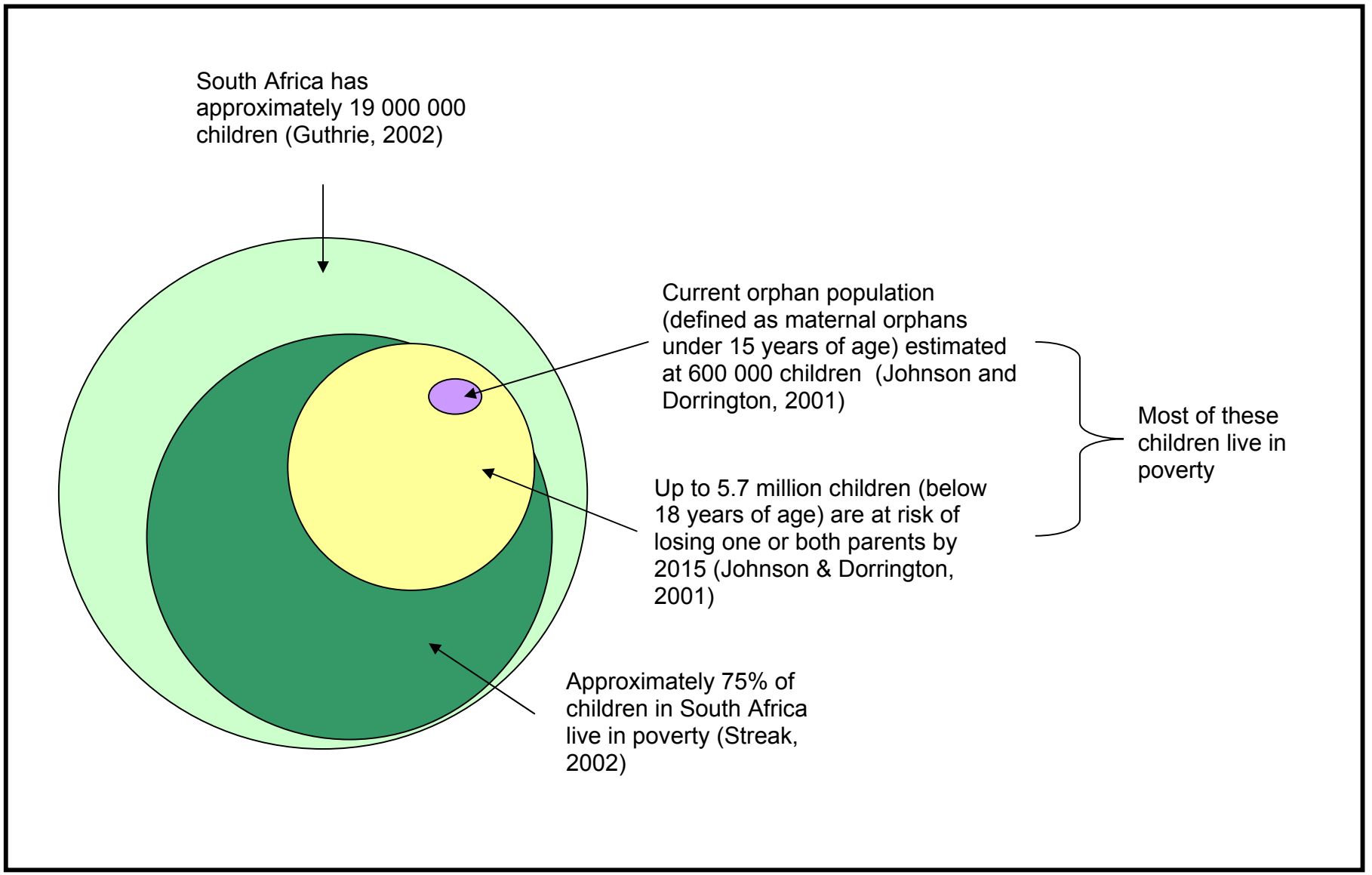
Approximately 75% of children in South Africa live in conditions of poverty (based on October Household Survey 1999 and an absolute poverty line of R400/month per capita) (Streak, 2002) and most children who have been orphaned or who are at risk of being orphaned fall within this category. While orphans, and in particular children orphaned by AIDS, do face some unique challenges, many of the areas of vulnerability that they face, such as hunger, being unable to pay school fees and poor access to health care services, are shared with children living in poverty (Ainsworth and Filmer, 2002; Giese et al, forthcoming). During the interviews it was not uncommon for research participants to understand the term "orphan" as referring to children living in poverty, whether or not their

[37] Section 28(1) (f) of the Constitution
[38] The Convention Concerning the Prohibition and Immediate Action for the Elimination of the Worst Forms of Child Labour.
[39] Article 32 of the UN Convention
[40] Section 27(1) (c) of the Constitution is one provision that can be used as authority for this statement.
[41] Article 12 of the UN Convention

biological parents were alive. Symptoms of severe poverty may therefore be more appropriate indicators of vulnerability than orphan status alone.

Figure 1 is a graphic representation of South Africa's child population, showing rough proportions of orphans and potential orphans in relation to children living in poverty.

Figure 1: Poverty and orphanhood in South Africa's child population



Very little is available in the literature on orphans that documents the impact of HIV/AIDS on the developmental outcomes of children and on various developmental stages. Such research could be used to reflect on the relative emphasis that programme planners should place on the different categories of need. Faced with a crisis of such magnitude and urgency, programmers have, until very recently, tended to take a reactive approach to addressing the needs of children experiencing orphanhood, prioritising the basic needs of children to health care, nutrition, shelter, clothing and education, and largely ignoring other key developmental needs such as the need for secure attachments and self-actualisation.

Drawing from some of the literature on childhood development and developmental assessment (Donald and Dawes, 2001; Horwath, 2001; Howe et al, 1999; Leach, 1994; Wallbank, 1992), literature on programme planning and principles (Alliance, 2002; Grainger et al, 2001; Levine, 2001(ed); UNAIDS, 2002; USAID and Synergy, 2001; Webb and Elliott, 2000; Williamson, 2000) as well as primary research conducted by the Children's Institute, we have developed a set of 7 developmental need categories against which to reflect on the impact of poverty and the impact of the loss of a caregiver on the fulfilment of the needs / rights of children in South Africa:

1. Health and survival
2. Safety and protection
3. Stimulation and cognitive development
4. Attachment
5. Self actualisation and identity
6. Guidance and boundaries
7. Appropriate inclusion and participation

Table 2 (below) provides an overview of some of the factors that may impact on the fulfilment of the developmental needs of children living in poverty as well as some of the additional factors that may impact on the fulfilment of needs of children living in poverty who are also experiencing orphanhood. While the table reflects these factors as cumulative, this is certainly not always the case and, in some instances, children's financial circumstances may in fact improve after the death of a sick caregiver (Giese et al, forthcoming).

The categories of need are listed and explained in columns 1 and 2. The 3rd column indicates some of the ways in which these needs are threatened for children living in poverty. The 4th and 5th columns list some of the *additional* ways in which these needs are threatened for children in the care of a sick or dying caregiver and children who have been orphaned.

The table presents some of the factors that *may* impact on children experiencing orphanhood. There are a number of variables, internal to and external to the child, that influence the extent to which the illness and death of a caregiver

impacts on the various developmental needs of a child eg. the age and gender of the child and the support available to the child from relatives, neighbours or teachers. Not all children who experience orphanhood are vulnerable, and those that are may be vulnerable in different ways. Our intention is to provoke thought around the broader developmental impact of orphanhood on children, and not to impose a rigid or deterministic developmental framework on all children experiencing orphanhood. Note that the table does not contain an exhaustive list of factors impacting on the fulfilment of children's needs.

The table content draws on our primary research as well as on theories, concepts and evidence from a range of other literature (Ainsworth and Filmer, 2002; Clacherty and Associates, 2001; Giese, Meintjes and Proudlock, 2002; Kinghorn, Coombe, McKay and Johnson, 2002; Maman et al, 2001; Mpanju-Shumbusho, 2001; Piwoz and Preble 2000; Smart, 2000; Sogaula, van Niekerk, Noble, Waddell et al, 2002; Sozi, 2001; Steinberg, Johnson, Schierhout, Ndegwa, Hall, Russell and Morgan, 2002; Steinberg, Kinghorn, Soderlund, Schierhout and Conway, 2000; Subbarao, Mattimore and Plangemann, 2001).

The experience of being orphaned often involves the loss of an important attachment figure and/or a disruption of other relationships. Because of this, concepts from attachment theory[42], theories of emotional development and the literature on childhood bereavement, feature quite strongly in several of the categories (Horwath, 2001; Howe et al, 1999; Leach, 1994; Wallbank, 1992; Webb, 1996). However, much of the literature drawn upon is often rooted in other contexts, and the concepts need to be interpreted with caution. Little is known about the actual effects of orphanhood on South African children's future attachments and individual development.

It is important to note that many of the needs and the factors that may impact on the fulfilment of needs are inter-related. The table does not attempt to illustrate these relationships. The table also does not explore age specific developmental needs.

[42] Attachment theory is a theory of personality development which demands that a great interest be taken in the interaction between the growing child and his or her social environment, between infants and their caregivers, between children and their families, and between individuals and other people. The character of these interactions is believed to have a profound bearing on children's social and emotional competence. (Howe et al, 1999, p. 14)

Table 2: The impact of poverty and orphanhood on the fulfilment of the developmental needs of children in South Africa

Categories of developmental needs of children	Specific needs in relation to category	Some of the factors that may impact on the fulfilment of the needs of a child living in poverty	Some of the additional factors that may impact on the fulfilment of the needs of a child living with a sick or dying caregiver	Some of the additional factors that may impact on the fulfilment of the needs of a child who has been orphaned
Health and survival	Overall physical and mental well-being: • Adequate and nutritious diet • Clothing • Shelter • Appropriate health care • Regular and clean water supply	• Lack of food security • Poor access to health care • Inadequate housing / shelter • Lack of appropriate clothing • Poor access to water • Families living in poverty may be unable to benefit from social security because they struggle to obtain the necessary documents • Vulnerability to HIV infection • Children may be forced to work to contribute to household income	• Caregiving capacity of the sick caregiver may be reduced • Increased household expenditure on health care • The average household income falls substantially • Poor health and increased rates of stunting among children living with HIV infected mothers is common • Increased risk of the child acquiring opportunistic infections and dying early in life. • Possible reluctance to access home based care and health care services because of fear of disclosure and the stigma associated with HIV/AIDS • Child may be HIV+ as a result of mother to child transmission • If the breadwinner is no	• Child may be left in the care of siblings or an elderly grandparent who may not be in a position to provide adequate care • Children who have been orphaned are less likely to be fully immunised • Unable to access health care services if attending unaccompanied by an adult • Social security benefits will be stopped if they were in the name of the deceased caregiver • Social security is largely inaccessible to children living in child headed households • Possible loss of property and inheritance • Child may experience feelings of loss and grief • Funeral costs may further impact financially on the

			longer able to work, the child may be forced to start working or to take on additional work • Child witnesses suffering of sick caregiver • Anger directed at children by sick caregiver (sometimes related to AIDS induced dementia) • Caregiver may be too ill to plant and harvest food crops	household • Child may be less able to plant and harvest food crops without the assistance of a healthy adult • Child and remaining relatives / caregivers may be unable to maintain the upkeep of the house
Safety and protection	• Protection from maltreatment, abuse, neglect and degradation	• Overcrowding because of inadequate housing • Crime linked to unemployment • Young girls / women entering into unsafe sexual relationships with older men for security or financial reasons	• Caregiver unable to offer usual care and protection due to own illness • Partner violence linked to disclosure of HIV status • Teasing and bullying by peers	• Possible increased risk of sexual abuse if child is without an adult caregiver • Risk of abuse within the care of relatives or other 'substitute' caregivers • Young girls may be more likely to enter sexual relationships early • If resources are linked to orphans then there is the risk that orphans may be exploited

Stimulation and cognitive development	• Opportunities for play and interaction • Access to learning materials • Intellectual stimulation • Schooling	• Unable to afford school fees • Unable to afford school uniforms and stationery • In poor rural areas public transport is commonly not available or when available is unaffordable • Unable to concentrate in class due to hunger • Responsibilities within households may reduce school attendance and/or performance • Lack of opportunities to be selective regarding quality of education • Unable to participate in school extra mural activities which require additional financial input	• Increased responsibilities within households (caregiving / breadwinning) may impact on school attendance and performance • Teasing by peers at school • Inability to concentrate at school because of concern for sick parent • Sick adult may be unable to negotiate on behalf of the child for school fee exemptions • Child may not inform teachers of their home circumstances because of their caregiver's reluctance to have their status known.	• Lost opportunity for intergenerational transfer of knowledge eg. agriculture • Transfer to new school may result from movement of child to new caregiver • Limited perceived benefits of schooling with urgent, more immediate needs • Emotional distress and bereavement may affect schooling and behaviour at school • Some children living with relatives are required to do excessive household chores, impacting on school attendance and time available for homework. • Loss of confidence in own abilities after long periods of absenteeism. • Absence of an adult to negotiate school fee reductions or exemptions

Attachment	• Stable and affectionate early attachments • Physical, psychological and emotional availability of caregiver • Sufficient 'good' attachment experience to develop internal security and to regulate emotions • Relationships with siblings • Appropriate friendships and relationships with peers	• Biological parents may live far away from the child because of employment or employment seeking migration • Economic stress may impact on degree to which parent/s are able to offer consistent affection and time to the child	• Loss of continuity in caregiving practice and behaviour towards the child • Possible psychological and emotional unavailability of caregiver • Loss of stability: with illness of caregiver, there may be increased movement of the child between households • Likelihood of losing both parents if one parent is HIV+ • Babies of HIV+ mothers *may* face increased risk of abandonment • Trauma of witnessing deterioration of primary attachment figure's health • Looking after caregiver may disrupt peer attachments • Fear for the future, may be linked to adult reluctance to speak to child about death	• Physical, psychological and emotional loss of an attachment figure • Possible loss of other attachment figures (e.g. siblings, friends, teachers, neighbours) • Anxiety about unknown future • Depending on age, insufficient grasp of language to access knowledge about death, or to verbalise feelings and thoughts • Stigma of HIV/AIDS, and adult reluctance to talk about death may increase likelihood of unresolved grief and complicated bereavement • Siblings may be separated after the death of a caregiver • Child may experience exploitation / abuse in alternative care • Child may experience a sense of being different from peers
Self actualisation / Identity	• Emotional attunement (i.e.acknowledgement of, and tolerance for,	• Possible lack of emotional attunement due to stresses of	• Sick caregiver may be unable to respond emotionally to the child	• Loss of person well equipped to provide child with sense of self, both

	child's full range of emotional experience, in order to provide child with sense of self) • Encouragement to play • Development of talents and interests • Safe network of relationships to return to during the development of independence and autonomy • Feelings of belonging and acceptance by family, peer group and wider society	poverty • Very few own possessions • Playing may be considered frivolous in context of economic need • Limited or no money for activities or hobbies • Less time to play where children share in time consuming household chores (in rural areas especially, children sometimes have to walk long distances to collect water / firewood)	• Sick adult's needs may overshadow child's needs • Child may be expected to take on greater load of household chores, including the care of sick adults or siblings • Child may assume adult role in household	emotionally and in terms of family identity • Possible sense of inferiority as a non-biological child in a household with children who are blood relatives of the caregiver • Difficult to obtain a birth certificate if biological parents are dead • Sense of rightful place in the world diminished • Child may have no connection to familial past
Guidance / boundaries	• Adult / parental demonstration and modelling of appropriate behaviour, control of emotions and interactions with others • Guidance and boundary setting to enable the development of own moral values and appropriate social behaviour. • Stability and containment • Available advice from caregivers	• Insecure future and ongoing changes • Caregivers being physically absent due to need to work away from home • Adult acting out behaviour linked to stress	• Loss of parental role, with very sick caregiver • Instability related to illness may disrupt boundary setting • Premature responsibility placed on child • AIDS related deterioration of mental functioning may exacerbate adult acting out behaviour	• Change of caregiving style of substitute caregivers • Children may be forced to live on the streets • Children living in child headed households often do not benefit from adult supervision • Elderly caregivers may be unable to maintain boundaries.

	• Acquisition by a child of practical, emotional and communication competencies required for increased independence.			
Appropriate inclusion / participation	• Participation in decision making and life planning	• Less flexibility regarding decisions and fewer opportunities for engaging children in decision making • Decisions may be made largely on the basis of need	• Caregiver may be unable, due to illness, to engage with the child • Child may be expected to assume "inappropriate" level of responsibility for decision making • Fears of talking about death may prevent succession planning	• Decisions regarding child's care and living arrangements may be made by other relatives or determined by social workers • Decisions may be based on the needs of others eg. relatives may move in to care for the child in an attempt to secure the household resources • Substitute carers may exploit the child

5 A conceptual framework for the identification, support and monitoring of vulnerable children

When exploring an appropriate service response to the needs of children experiencing orphanhood, and other vulnerable children, it is important to consider not only the extent to which the rights and needs of vulnerable children are violated, but also the scale of the problem as illustrated earlier. With such large numbers of potentially vulnerable children, it is crucial that opportunities for the identification, support and monitoring of vulnerable children within existing services are optimally utilised. The conceptual framework presented here is centred on the principles of maximising contact opportunities and integrating identification, support and monitoring into existing services.

5.1 Maximising contact opportunities and integrating identification, support and monitoring into services

Our research suggests that many service providers come into contact with children and their caregivers without using the opportunity that this presents, to identify, refer, support and / or monitor children who may be especially vulnerable. There are several reasons why this happens, including the fact that the responsibility for the identification and support of vulnerable children is frequently placed within the realm of social workers, volunteers and NGOs. Health workers and teachers in particular often fail to recognise the opportunity costs of not responding to warning signs in children facing difficulties at home.

As children become increasingly vulnerable, the contact opportunities often become less frequent. For example, as a child's caregiver becomes progressively sicker, the child may be forced to leave school to care for her parent or younger siblings. The school environment provides an opportunity for adults to notice changes in the child's behaviour or repeated and prolonged absenteeism. If the child drops out of school and no follow up home visit or enquiries are made, as is often the case, this opportunity is lost.

Similarly, when an adult tests HIV-positive at a health care facility, the opportunity presents itself for health workers to enquire about dependents and, at the very least, to refer the patient to agencies rendering social or financial support. Once the patient becomes too ill to walk to the clinic and no outreach services are available to provide home based care, the opportunity to identify and refer or support the patient's children is lost.

With limited capacity for home visits and outreach services in most areas of the country, contact with children and their caregivers should be viewed as crucial opportunities to identify, support (or refer) and monitor potentially vulnerable children. In order to achieve this without placing additional and unrealistic expectations on service providers, we need to devise innovative mechanisms for integrating these activities into existing programmes and standardised practice.

The proposed conceptual framework is based on the principles of maximising contact opportunities with children and caregivers and integrating the identification and support of vulnerable children, wherever possible, into the daily activities of all relevant service providers. This role could be integrated into service delivery at minimal additional cost or effort, particularly if service providers focus on what they are best placed to do.

5.2 How to use the conceptual framework

The conceptual framework is not intended as a template to fit every context or to be completed simply by filling in the blocks.

The framework and principles are intended to guide processes and discussions at various levels. Every context is different and requires that the various stakeholders come together to determine which groups of children are particularly vulnerable in their area (see 5.3 and 5.4), what services are available to them, what the inherent strengths are within these services that could be further utilised, and what the most appropriate mechanisms are to support these children. Through this "mapping" process, service gaps within a particular context should become apparent. Using the principles of maximising contact opportunities and integrating activities into services, stakeholders can explore where they are able to expand on their existing approaches to vulnerable children and where they are able to better support other service providers.

The framework may be applied at different levels, from, for example, exploring the roles and responsibilities of different stakeholders within a single school, to exploring roles and responsibilities within the whole of a school district.

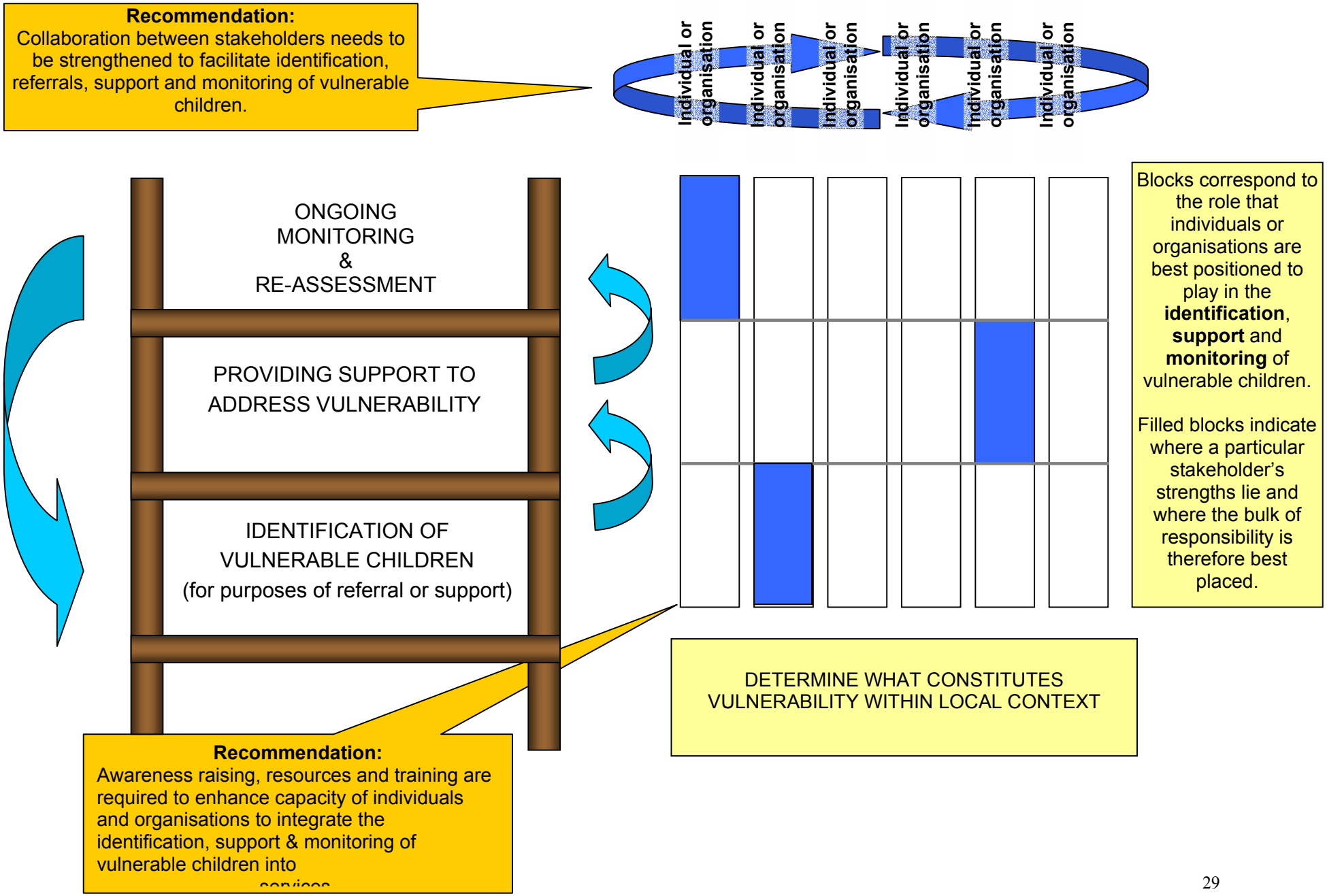
The conceptual framework is presented graphically in Figure 2 with the various potential stakeholders represented by columns on the right hand side of the page. Each column is broken into blocks, representing each of the steps in the process, i.e:

- Identifying vulnerable children (for purposes of referral and/or support)
- Providing the appropriate support to children identified as vulnerable and
- Monitoring the child to ensure that the support is sufficient and appropriate.

Each of these three steps is explored further in Sections 5.5 to 5.7.

The arrows on the diagram illustrate the fact that the process (from identification to monitoring) is not a linear one and monitoring may well lead back to identifying vulnerability or reviewing the kind of support provided.

Figure 2: Conceptual framework for the identification, support and monitoring of vulnerable children



5.3 Identifying stakeholders and determining roles and responsibilities

The framework requires users to think about the various individuals and /or organisations who could / should be involved in identification, support and monitoring activities. Stakeholders to be included will obviously depend on the context eg. If the model is being applied to a single school the stakeholders are likely to be different to those who would be included if the model were applied to a whole school district. Wherever possible, the framework should be applied as inclusively as possible and consideration should be given to including the following groups (where relevant):

- Children and youth (in all instances)
- Caregivers looking after children and youth
- Representatives from government departments (e.g. health, education, welfare, justice, social development, agriculture, home affairs), including different levels of government.
- Service providers such as health workers, teachers, social workers, magistrates, community volunteers, counsellors, pre-school / crèche workers etc.
- Representatives from non-governmental and community based organisations
- Representatives from other relevant groups eg. women's groups, street committees, support groups, traditional leaders forums, unions etc.
- Representatives from religious organisations
- Local business people

Three of the blocks in the columns in Figure 2 have been filled – illustrating the fact that different individuals / organisations are well placed to assist in different ways with the identification, support and/or monitoring of particular groups of vulnerable children. Programmes and policies dictate, to some extent, which service providers are best placed to identify, support or monitor which groups.

As an example, South Africa has a policy that provides for free basic health care for children under the age of 6 years and for pregnant and lactating women. Children under the age of 5 years are also eligible for food supplements through the clinic-based protein energy malnutrition scheme. Another clinic based programme, the immunization program, targets children between birth and 5 years of age, monitoring growth and development on a road to health card while at the same time immunizing against preventable childhood illnesses. In the course of delivering basic health care services therefore, health care facilities, and primary level health care clinics in particular, have regular contact with young children between birth and 5 years of age, and their caregivers. Health facilities are therefore ideally placed to identify young children infected with HIV through mother to child transmission and HIV+ caregivers.

Most women become infected with HIV within years of first giving birth and do not generally survive beyond ten years after that. The proportion of orphaned

children therefore rises with age, and experts predict that by 2015, more than 30% of all children in South Africa between the ages of 15 and 17 will have been orphaned and that the number of children orphaned will peak at around 11 or 12 years of age (Johnson and Dorrington, 2001). It stands to reason therefore that the agencies best placed to identify children who are experiencing the loss of a caregiver, are schools.

It is important, when deciding on the various roleplayers, to recognise the differing roles and capacity of individuals versus organisations / institutions. Many teachers, in their personal capacity, try to assist particular children by raising money to pay the children's school fees. The role that they play in supporting a child is critical but often small. Schools on the other hand are in a position to make school fee exemption procedures more accessible to all children in their school and to prohibit exclusion or discrimination of children who are unable to pay. Our research suggests that, where service providers are involved in the support of children experiencing orphanhood, their involvement is largely driven by a personal commitment or ideology and we found little evidence of broader and more sustained institutional support within particular sectors in the research sites.

5.4 Defining vulnerability

Children experiencing orphanhood are one of many groups of vulnerable children and it is essential that local consensus is reached as to which groups or categories of children are thought to be *most* vulnerable within a particular context. It is critical that local stakeholders are involved in this process and in deciding on the types of support that would be most appropriate to assist these children.

If an outside agency determines categories of vulnerability without consulting with local stakeholders, it can undermine a local sense of ownership of the problem and the solution, and risks an inappropriate and/or unsustainable response (Chambers, 1983, Edwards, 1989; Grainger et al, 2001; Subbarao, Mattimore and Plangemann, 2001).

The category of vulnerability can be as broad or narrow as required but resource restrictions should be a consideration when determining the breadth of the category. In an area with limited resources and large numbers of vulnerable children, broad targeting of all vulnerable children may not be feasible and services may instead need to focus on the ultra-vulnerable (Williamson, 2000). If the category of vulnerability is defined too broadly, many more children will be identified than can be assisted. This may raise unfair expectations and, when expectations are not realised, can cause frustration and anger and undermine future attempts at mobilising community involvement (Giese et al, forthcoming; Grainger et al, 2001).

The research that informed the development of this conceptual framework looked particularly at the needs of, and support available to, children experiencing orphanhood. The category of vulnerability was therefore defined at the outset as children (under the age of 18 years) who are orphaned or who

are living with a terminally ill caregiver. The research process itself highlighted the importance of allowing for local definitions of vulnerability. Some research participants for example commented on the fact that recent research and many of the services in the sites, focus on the needs of children who are orphaned, when in fact large numbers of non-orphaned children living in poverty are equally vulnerable. Furthermore, the research found that targeting resources (such as foster grants or food parcels) at particular children (determined by an external agency to be the most vulnerable) often leads to unintended negative repercussions which, in some instances, increases the vulnerability of the intended beneficiaries (Giese et al, forthcoming).

5.5 Identifying vulnerable children

The more regular and consistent the service provider's contact with children (such as daily contact in a school classroom), the more appropriately placed s/he is to identify signs of vulnerability. A school teacher spends hours every weekday with a class of 40+ children. S/he should know if a child is absent and should notice changes in behaviour or attitude. This places the teacher in an ideal position to observe children for signs of distress. Social workers on the other hand rely largely on referrals in order to identify a vulnerable child. They do not typically have regular contact with children, other than those with whom they are already working. Even then, the contact is usually limited to formal consultations and home visits (which mainly occurs in the case of foster placements). Caregivers either approach social workers themselves or are referred to social workers by other service providers such as home based carers, police, health workers and teachers. It would be inappropriate therefore, in most contexts, to expect social workers to identify children on the basis of warning signs related to behaviour. However, it would be entirely appropriate to expect teachers to keep a record of absenteeism and monitor a child who is repeatedly absent or who is absent for long periods of time. The teacher may then refer the case to a social worker to investigate the child's home circumstances and provide the appropriate support.

The identification of vulnerable children can be facilitated through increased awareness of warning signs of vulnerability, and through creating opportunities for children (and caregivers) to speak about and share their experiences and problems. Within health facilities for example, the history taking interview provides an opportunity for health workers to find out more about the home circumstances of a patient. Teachers can draw on a range of creative techniques in order to facilitate opportunities for children to communicate their experiences and needs for support. Some examples may include:

- Setting essay topics that provide children with opportunities to talk about personal experience if they want to, for example:
    - The challenges that I face in my life
    - How I would change my life if I could…
    - My autobiography
    - My happiest and saddest day

    - My home
- Using drawings and collective story telling to find out more about children's experiences and coping strategies
- Constructing memory boxes with children as a means to exploring their life experiences and preserving information about their pasts and that of their caregivers (Morgan, 2002).

Further ideas for how particular groups of vulnerable children could be identified within different contexts could be integrated into a booklet or training material for service providers.

5.6 Providing appropriate support to children identified as vulnerable

In most instances, identification is unhelpful if not linked to some form of support or referral. Agencies best placed to actually support children however are seldom the same agencies that are best placed to identify vulnerable children. For this reason, networking and collaboration between roleplayers are critically important. If a teacher or a nurse identifies a child as being in distress, s/he needs to know who to refer the child to, what information would be required by that person and what procedures need to be followed to complete the referral process.

Several opportunities exist for the development and expansion of programmes and practices within services to include support for vulnerable children. In some instances simply by removing the barriers to accessing services, service providers will be greatly assisting vulnerable children. User fee exemptions, free or subsidised transportation, extended operating hours and mobile services are some of the possible ways of addressing major barriers to service access. Further assistance could be provided to children through extending existing programmes, such as the school feeding scheme, emergency relief food parcels and clinic based protein energy malnutrition scheme.

These and other recommendations will be explored in more detail in the national guidelines on health and social services for children experiencing orphanhood (Giese et al, forthcoming).

5.7 Monitoring children who have been supported

Monitoring of children who have received support is necessary to ensure that the support provided is sufficient and appropriate - interventions to address vulnerability sometimes place children in situations that lead to other forms of vulnerability (Giese et al, forthcoming).

The identification and monitoring of vulnerable children are closely linked. If, for example, a teacher who identified and referred a child is given feedback on what support / intervention occurred, s/he may be in a position to monitor whether this was an appropriate response by observing the child's behaviour and attitude and watching for "warning signs". However, in some instances, intervention may result in the removal of a child from his/her home

circumstances and familiar surroundings. It is essential in such instances that the agency rendering the support establish some mechanism for ongoing monitoring eg. conducting home visits to foster parents, running foster parent groups, making contact with a teacher at the child's new school or referring the child to an NGO operating in the area.

6 Barriers to integrating identification, support and monitoring activities into services

On the face of it, schools are ideally placed to identify, monitor and refer children experiencing orphanhood and other vulnerable children. The vast majority of children go to school, and teachers are in an excellent position to notice signs of change and distress in a child, or to notice when a child is frequently absent, or leaves the school altogether. Yet, the reality is that many of the schools in our research not only fail to address vulnerability, but actually contribute to vulnerability by punishing children for not concentrating in class, for lateness or erratic attendance and for not paying school fees. Similarly, missed opportunities for the identification of vulnerable children were observed within health care services in the research sites. Some nurses for example send children home if they arrive at the clinic unaccompanied and health workers and home based carers often fail to make the connection between a terminally ill adult and potentially vulnerable dependents. In order to strengthen the roles of service providers in identifying and supporting vulnerable children, we need to understand the reasons behind these often inappropriate responses to signs of vulnerability.

Some of the factors identified through our research as impeding the identification, support and monitoring of children experiencing orphanhood are listed below. The list focuses on barriers within clinics and schools. These service providers were identified through the research as centrally important and largely unrecognised roleplayers in the identification, support and monitoring of children experiencing orphanhood.

Note that not all of the factors apply to all of the schools and health facilities involved in the research. There was great variability within and between sites and many of the individuals we encountered are doing incredible work under very difficult circumstances.

6.1 Some of the factors impeding identification, support and monitoring of children experiencing orphanhood within schools

- Extremely difficult working conditions and inadequate support for teachers
- Teachers' low levels of knowledge of children's home circumstances
- Teachers' low levels of knowledge of services available to refer children to
- A reliance on overburdened social workers to support children.
- Insufficient people or organisations to whom children experiencing orphanhood can be referred for assessment or support.

- Insufficient integration of other services, such as social workers and health workers, into the education system.
- Mistrust between teachers and children / caregivers – often exacerbated by circumstances surrounding the non-payment of school fees and especially evident where teachers live outside of the area.
- Low levels of attendance of caregivers at school meetings, often a result of the fact that the meetings are used as forums to put pressure on caregivers who have not paid school fees.
- Children's and caregivers' perceptions of schools as places of discipline and authority, rather than support
- Reluctance on the part of children to speak to teachers about their home circumstances for fear of repercussions.
- Large classes, commonly of well over 40 children
- Large numbers of vulnerable children within schools
- Increasing numbers of teachers falling ill
- Victimisation of teachers who go the extra mile. They are sometimes taunted for "*trying to be social workers*".
- Actions and attitudes of caregivers sometimes obstruct attempts at supporting children and inhibit referrals.
- Limited capacity of caregivers to play a role in the management and support of the school.
- Shortage of guidance and counselling capacity in schools.
- The role of peers in supporting one another is not fully explored.
- Silence and stigma associated with HIV/AIDS tends to prevent open discussion about the multiple effects of HIV/AIDS on teachers, caregivers and children.
- School feeding schemes struggle to function effectively
- Inability or reluctance on the part of schools to make school fee exemptions more accessible
- School budgets prevent schools from being able to support children materially eg. with uniforms and stationery.
- Perceptions of certain areas as being unsafe prevent teachers from doing home visits
- Many teachers in our research view the identification, support and monitoring of vulnerable children as an additional and overwhelming task for which they are not equipped.
- The roles that NGOs can play in schools – particularly activities providing support to vulnerable children – is not fully explored.

6.2 Some of the factors impeding identification, support and monitoring of children experiencing orphanhood within health facilities

- Low levels of awareness of the impact of HIV/AIDS on children and, more specifically, on the impact of HIV/AIDS on children within the facility's catchment area.
- Extremely difficult working conditions and inadequate support for health workers.

- History taking does not elicit as much information on socio-economic vulnerability of patients, and their dependents, as it could.
- Health facilities are not accessible to all children experiencing orphanhood, especially in rural areas where clinics and households are far apart and transport is scarce and, where available, expensive.
- Services to which patients are referred to for support eg. social workers and NGOs are often inaccessible because of poverty and transport related issues.
- Basic and essential pharmaceuticals and equipment are often not available or are available in insufficient quantities.
- Negative health worker attitudes towards patients. The attitude of some health workers is seen as a barrier to accessing services and to discussing problems with health workers.
- Negative patient attitude towards health workers.
- Inadequate or no training for health workers on talking to and counselling children.
- A lack of capacity for home visits.
- Poor infrastructure (vehicles, telephones) at clinics impedes follow up care and referrals by health workers.
- Little collaboration between health facilities and organisations that have the capacity to assist vulnerable children and their caregivers.
- Relationships between clinic based health care workers and community volunteers / home based carers are often strained.
- Health workers poor knowledge about services that exist within their catchment area.
- Insufficient people or organisations to whom children experiencing orphanhood can be referred for assessment or support
- A reliance on overburdened social workers to support children.
- The stigma around HIV/AIDS inhibits disclosure
- Confidentiality agreements often prevent effective referral of HIV-positive patients to services that could provide them and their dependants with support.
- Poor awareness of the guidelines that exist for the treatment and care of HIV-infected children.
- Health workers are overburdened and many see the identification, monitoring and support of children experiencing orphanhood as an additional and overwhelming task.
- Reluctance to treat unaccompanied children
- Lack of focus on possible indicators of social need
- The absence of a committed individual, with an awareness of the impact of HIV on children, in a position of leadership within the facility

The research highlighted exciting opportunities for integrating support activities into mainstream health and education services and for exploring the principle of maximising contact opportunities within these sectors. One of the recommendations emerging from this work is that these opportunities be explored further with input from the relevant sector representatives.

7 Conclusion and recommendations

The identification, support and monitoring of increasing numbers of vulnerable children in South Africa requires a concerted effort on the part of all service providers. The conceptual framework is intended to generate thought and discussion around the roles and responsibilities of different sectors in responding to the needs of children experiencing orphanhood and other vulnerable children.

While the research to inform the development of the conceptual framework focussed on children experiencing orphanhood and the services available to them, we strongly recommend that a service response to the needs of this group of children be integrated into a broader response to the needs of children living in poverty.

The conceptual framework is based on the principles of maximising contact opportunities and integrating activities for the identification, support and monitoring of vulnerable children into established service programmes. However, we recognise that substantial additional financial and human resources are required in many areas to supplement the efforts being made by service providers.

One of the shortcomings of the research informing the development of this conceptual framework is that it did not explore in depth the roles of other government departments, such as the Departments of Justice, Home Affairs and Agriculture, and other sectors, such as the business sector, in the identification and support of vulnerable children. Research is required to identify how these sectors can be appropriately integrated into a service response.

In order to fully utilise the existing service potential, we recommend that service providers be conscientised to the fact that contact with children and caregivers provides opportunities for the identification, support (or referral) and monitoring of vulnerable children. Gaps in the awareness, knowledge, skills and capacity of service providers – in particular health workers and teachers – impact negatively on their ability to maximise these contact opportunities.

Service providers need to be made more aware of the issues children increasingly face in the context of the AIDS pandemic and encouraged to develop environments which in themselves do not contribute to children's vulnerability. They need to develop, or be provided with, tools to assist with identifying and monitoring children's vulnerability, and for referring children to appropriate sources of support.

For this approach to work effectively, good collaboration, referral networks and working partnerships between relevant stakeholders are essential. Collaboration and referral could be facilitated through the development of local services directories and locally standardised referral guidelines. Working partnerships could be strengthened through community coalitions – guidelines

for establishing / strengthening community coalitions could prove a useful resource in this regard.

In most instances, opportunities for the integration of support activities would be sector specific eg. school based feeding schemes or clinic based protein energy malnutrition scheme and we recommend that these opportunities be explored in greater depth with the relevant sector representatives.

We strongly recommend that the ideas contained in this report be explored further with relevant stakeholders, including service providers and policy makers and that the process be piloted within a particular geographical area and reviewed accordingly.

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