SECTION B – Structure & Projects

PSAS Structure

Peer Education
- **Community**
- **Work Place**
- **Youth**

Mitigation
- **Home Based Care**
- **Orphan and Vulnerable Children**

PSASA Structure

Mission

The Project Support Association Southern Africa's mission to create community partnerships that enhance their ability to prevent, mitigate and alleviate the impact of HIV AIDS.

Vision

"To see Southern African communities equipped with skill enabling them to respond to the effects of the AIDS pandemic".

The vision will be achieved through supporting community-based HIV/AIDS prevention and mitigation approaches, which use carefully trained and supported community volunteers to deliver services. The major strategic thrust to achieve this vision will be innovation and operational excellence.

The organizations goal is to enhance the delivery of high quality, cost effective and evidence based HIV / AIDS interventions in the Southern Africa region.

Structure

Figure 7, illustrates the staff structure as at the end of 2004, staff profiles described in Appendix 1 – Staff Profiles. PSASA has striven for a lean but effective structure, allowing maximum resources to be directed to community level projects. For this reason appointed staff (especially programme directors and managers) are highly fluid in their job activities, are multi tasked, having the ability to fill programme gaps as they occur.

A board with representatives from the wider community of Mpumalanga meets at least twice a year and as necessary to provide overall support to PSASA. Ms Corrie Oosthuizen was nominated and appointed as the Coordinator (now Director) of the Project Support Association Southern Africa (now PSASA). She was previously the Deputy Director and the District Manager in the Ermelo/Bethal District for the Department of Health, a role from which she retired after 1999 to become full-time Coordinator of the PSASA. She has worked closely with provincial and district health staff in Mpumalanga for almost 40 years. She was also the Chair of the Kriel pilot project committee, upon which the provincial initiative is based.

Two Programme Directors are currently employed to oversee all programmes and projects. There are six Project Managers – one for each major programme area: Home Based Care, Orphans and Vulnerable Children (including Income Generating Activities), Peer Education, Youth Peer Education, Workplace Peer Education, and Student Peer Education. Project Managers work with Project Coordinators who are based in the respective community where the project is based who manage the zone leaders and volunteers. Each of the two Programme Directors are well versed in the management and running of the different programme area. Each of the programme areas benefit from a full time training manager who assists coordinates the many training sessions conducted reporting to the Director directly.

Within the Bethal office are a number of personnel responsible for managing and dispersing finances, documenting programme monitoring data coming from the projects, procuring items (food parcels, medicines and other forms of material support) managing and operating vehicles and the overall workings of the office itself.

PSASA Structure

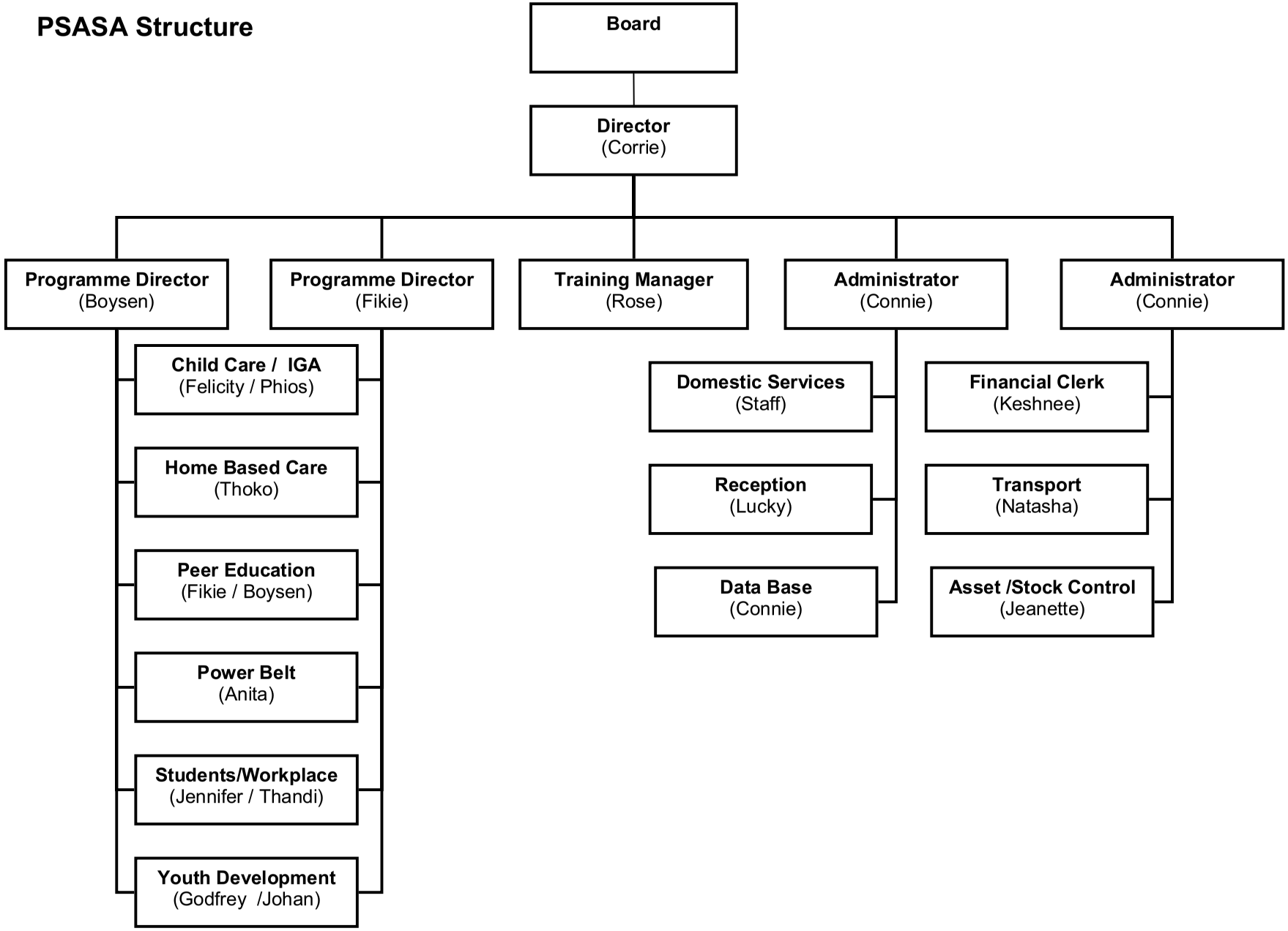

Figure 7 - PSASA Structure – 2004

Funding

1. The primary donor to PSASA has and is PSG. They in turn recruit funds from national and international donors. As a regional organization they fund partners conducting similar activities throughout Southern Africa (Malawi, Zimbabwe, Mozambique, Botswana, Namibia, Zambia and Lesotho).
2. Funds are channeled through to PSASA dependent on programme output.
3. PSASA partners with communities (either as NPO's or CBO's). It then reviews proposals and activity reports submitted by communities.
4. Funds are channeled to the respective projects once the proposal or new year business plan has been approved.
5. Projects submit 6 monthly financial reports, with each project being audited annually. Output monitoring data is collected monthly and added to the 6 monthly quarterly report.

PSASA is currently distributing over R11 million per annum into disadvantaged communities of the province.

The Project Support Group and has developed a set of application packages, contracts, monitoring and reporting forms to be used by the communities to access funds for projects. These are used as a standard for PSASA and its respective partners. Application packages are completed by communities wanting help with establishing or enhancing projects. The completed forms are then submitted to the Board who carefully reviews all budgets to assess project viability and to ensure funds are prudent and comparable across all the projects, to ensure equity. Upon full project approval, PSASA informs the community and begins the implementation of their support. The Association has developed guidelines for the composition and governing procedures for all the projects, and ensures ongoing training for its employees, to build their capacity to manage their projects.

Key Project Components

PSASA has two thematic areas for involvement. This is prevention using peer methods (community based (including high transmission areas), workplace, youth and student peer initiatives) and mitigation which includes home based care, orphan and child support and integrated with the later income generating activities. All however have similar components which includes –

1. Identification of a key area where the projects can be implemented. These are mostly areas traditionally impoverished, lacking adequate health services and where high rates of HIV AIDS are known to affect members. Workplace programmes differ in this regards.

2. Establishment of community based committees. These usually include -

    - Department of Health representative
    - Local Authority representative
    - Community members
    - Private sector representatives especially those with experience in financial management
    - Project representatives

    With each project that is established, a Community Project Committee is set up to advice the project and, mainly, to set up income generation initiatives, so as the projects are not entirely dependent on PSASA funding, but have additional sources for resourcing. These committees generally meet monthly and work alongside the projects to offer support and recruit resources.

3. Mapping of the community and identification of functional implementation zones. These maps identify areas where HIV transmission is most likely to occur (such as sheebens, bottle stores), and where facilities exist that may support care for those in the home (clinics etc.), facilitating areas of targeted interventions and links with key support partners in the community.

4. Volunteer Recruiting. From these zones key individuals are recruited as volunteers. For the many of the volunteers are recruited from formal or informal drinking centres for prevention activities, with mitigation activities from church groups. These volunteers undergo training in the project area and begin implementation of a basic package of services. This training is intentionally incomplete. Further training provides emotional support for the volunteers and re-emphasizes basic teachings to the community workers. And helps standards are maintained.

5. Individuals participate in community outreach activities. For their work, these volunteers are remunerated at about R300 per month for working between two to four hours per day. The Project Coordinator (who is supported at R550 per month for a 40 hour week) supports these volunteers. No remuneration is provided to government or other employees for any involvement with the projects.

6. Regular reporting and feedback concerning activities, along with ongoing training. Training and support meetings occur regularly (weekly or monthly), while quarterly one week trainings are held for all Project Coordinators.

7. Successful projects may become training sites for further expansion within the province or within local areas as illustrated by Kriel.

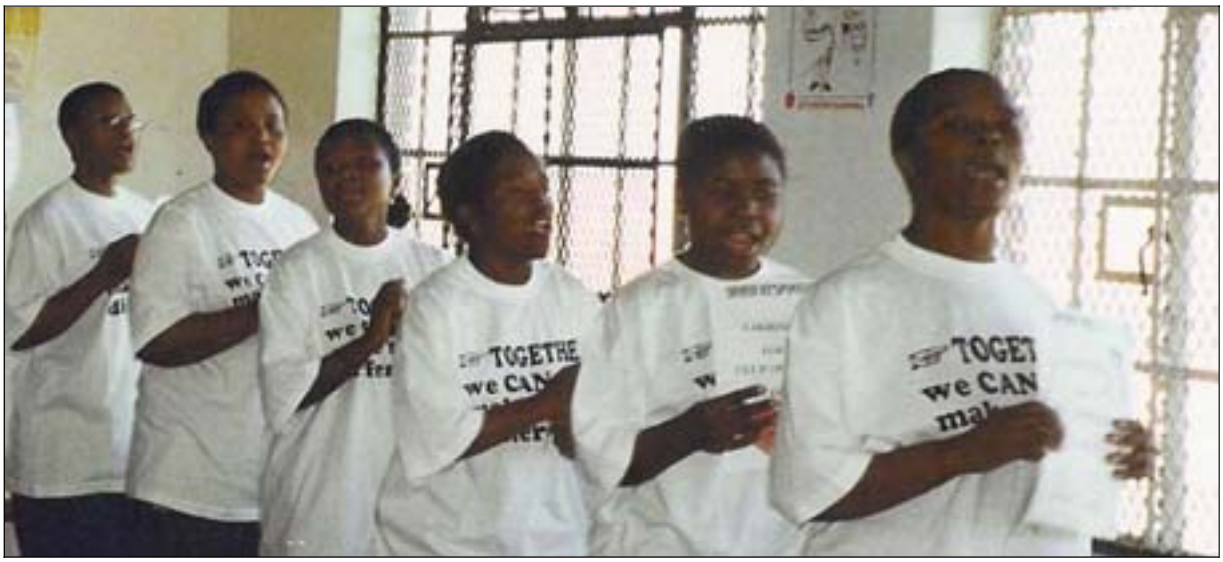

Figure 8 – Youth Prevention Programme Training

Prevention Programmes

Prevention programmes using peer education methods have the longest history of all the PSASA initiatives. Currently there are 55 community programmes with over 1100 volunteers. Project report summary is given in Appendix 5 – Peer Education .

Aims:

- To reduce STI/HIV transmission in HIV prevention partner project communities
- Foster safer sexual norms
- Large-scale condom promotion and distribution
- Improved STI treatment seeking behaviour

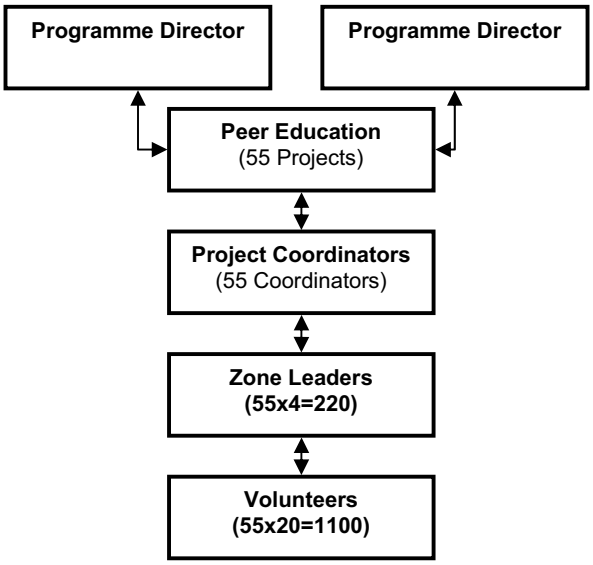

Figure9 – Prevention – Peer Education Structure

Target group and focus:

Prevention peer programmes focus on preventing current and future spread of HIV and on broader sexual health issues. There are many misconceptions about reproduction, sexual organs, sexually transmitted infection (STIs) and diseases (STDs) in the communities; safer sexual activity will immediately diminish the spread of HIV AIDS while simultaneously tackling other diseases and infections; sexual health impacts every aspect of a person, so to educate on ideals such as faithfulness to ones partner and abstinence impacts on relationships, families, household stability and so on.

The Peer Education programme aims to reach adult men and women. Although children are not directly targeted, they are often reached when they are at the location of the project outreaches. Also, volunteer recruitment is often directed at disadvantaged women, some of whom are involved with formal or informal sex work, so these volunteers also benefit and are supported in cultivating safer, healthier lifestyles.

Where:

Projects are established in a village or community. Because of Peer Education's target group, the outreaches become geographically diverse so as to extent to as great a range and quantity of people as possible. Outreaches may take place in the workplace, bars, nightclubs, homes, and in markets. Specific workplace programmes aim to reach the workers of that establishment.

How:

Request and Negotiation for Project Implementation. This process happens in a number of ways. Community members may form a group, do their best to provide for their community, and at some stage submit to PSASA for assistance. Or community members may request assistance before even getting to the stage of group formation. Alternatively, a PSASA worker (or health worker) may identify a community in need, and ask the Association to approach the community. The PSASA then enters into negotiations with a group of community people to organize the assistance and role that the Association will undertake.

Needs Identification and Survey. The next step taken in the implementation of a Peer Education Project is for the Peer Education Manager to identify the needs within the area (village, community etc) into which they are to establish a project. The manager then makes contact with the community (identifying leaders, key community players and stakeholders) in order to build relationship with them and get approval to undertake a Needs Assessment. The Needs Assessment involves surveying the community through interviews, data collection and statistical analysis in order to ascertain the extent of the need for a peer prevention initiative and community support.

Community Committee Formation. Early on in the Project establishment, a Community Project Committee is formed, consisting of community members, people directly involved with the project, and workers from the public health sector. The main role of these Committees is to devise and implement income generation strategies to support the project. This is done with the assistance of PSASA. The ideal is that the Committee becomes the driving sustainability of the project, in case funding dries out from PSASA and its funders. This also provides the projects with a sense of ownership, participation, responsibility, security and autonomy. Some Committees even become registered as CBOs, so they can themselves apply directly to funders for resources.

Mapping and Zoning. Having identified needs, gained approval from local leaders, and deduced that there is suitable community support for a Peer Education project; the next step involves mapping and zoning. This phase is for the Project Manager to map the area so as to divide it into workable zones. In order to map the area, the Project Manager walks, drives, examines and researches the community, mapping geographical, demographical, topographical and industrial conditions. This map serves to inform the Project Manager as to potential prime spots for outreaches, population spread, living conditions, commercial activity, extent of the sex industry and so on. The map is then segmented into workable zones allocated to specific volunteers. Such zones assists in the workability, accountability, reporting and progress analysis of the project.

Volunteer Recruitment. Once the area is mapped and segregated into zones, the Project Manager can ascertain the number of volunteers needed for complete area coverage, and begin to undertake the recruitment process. By this stage the Manager is well known and has established significant rapport and trust within the community. For this reason, s/he is able to successfully ask community members to volunteer as Peer Educators, with high rates of acceptance. The number of volunteers recruited will be based on the number and size of zones in the community.

Initial Volunteer Training. Recruited volunteers undergo an initial training over a five day period. This tuition educates them in a range of issues:

- Personal, home, food and environmental hygiene
- Nutrition

- Physical, social, mental and spiritual wellness
- Male and female reproductive systems
- Sexual Transmitted Infections and Diseases
- HIV AIDS issues
- Alcohol and drug issues
- Abuse
- Adolescent health

To complement this education is training in project outreach:

- Preventive counseling
- Role responsibilities
- Participatory approaches
- Organisation and implementation of community meetings
- Organisation and implementation of outreach meetings
- Organisation and implementation of home-based meetings
- Organisation and implementation of bar-based meetings
- Recording and monitoring system
- Quality assurance
- Condom use, storage and disposal
- Outreach activities
- Diagnosing and solving outreach problems
- Family planning
- Referral of health problems

Figure 10 – Youth Prevention Programme Training

Role and Zone Appointment. Throughout the training, the Peer Education Manager seeks to identify potential leaders within the group, so that at the conclusion of this initial training s/he is able to appoint a Project Coordinator to oversee the project, as well as a Zone Leader for each zone. Also, at the ending of the initial training volunteers are designated a specific zone in which they are to work.

Programme Implementation. Once all this preparatory work has been achieved, the Peer Education programme commences. Suitable venues or sites for outreach meetings need to be identified,

permission obtained for specific appointments. Groups of volunteers then gather at that agreed time and place where activities of singing and dancing, and a short drama are used to entice the audience into discussion and debate around HIV AIDS and other relevant issues. After this attention grabber, questions are asked to the audience inviting dialogue which is often relevant, applicable and re-enacted in their own lives. While the volunteers hold significant knowledge and aim to educate their audience, these discussions empower listeners to draw their own conclusions supporting positive behaviour change. After the volunteers bring the discussion to a close and summarise all that has been talked about, the audience is invited again to the next outreach, and the meeting is concluded with a song. Condoms are then distributed to those in the audience who wish to take them.

Weekly Volunteer Meetings. In order to sustain the workings of the Peer Education Projects, regular support and accountability for the volunteers is essential. Weekly meetings are held for all of the volunteers in a particular project. In these meetings, the workers cook and eat together, discuss issues that have come up, review new topics for presentations and evaluate activities. This also becomes and opportunity to forward reports from the zones to the Project Coordinator (see Appendix 5 for example of an Activities Summary and Appendix 6 for Prevention Tools). .

Ongoing Training. The project workers need to be well informed on issues relevant to their communities. Three week-long training sessions per annum are held for Coordinators in addition to weekly training. Here they liaise, support each other, and receive thorough training on issues which they will then feedback to the volunteers.

Peer education among low-income women: South Africa, Zambia, Zimbabwe[9]

The prevalence of HIV/AIDS in many African countries is particularly high among low-income women, migrants, and people who work away from home. From January 2000, IFH and the Project Support Group, the Human Resource Trust and the Mpumalanga Project Support Association trained community representatives in South Africa, Zambia, and Zimbabwe to reach their peers using role-play, games, and group discussions. The emphasis was on sharing knowledge about safe sex behaviour, distributing condoms, and referring peers to health services for STI treatment. Peer educators also provide home-based assistance to people living with HIV and address the prejudice these groups experience by raising awareness about HIV/AIDS in the wider community.

Box 3 – IFH partnership with PSASA

Roles

Volunteers: Work in team with other volunteers to conduct outreach activities. They record activities and report outputs to zone leaders during the weekly training session.
Zone Leader: Have oversight for volunteers in a defined geographical area (zone). The zone leader coordinates activities aiming to reach coverage and activities goals in their zone through supporting volunteers, assists in outreaches, and meeting weekly. They compile zonal reports to the coordinator.

Coordinator: Oversees the activities of all the volunteers (including the Zone Leaders), organize the weekly training (content, discussions and training) and fellowship meetings. They attend the coordinator week-long training with other project coordinators and feed this information back to their respective projects. They represent the volunteers and zone leaders to the project management committee and to the Programme Manager who they compile and submit the monthly report.
Project Committee: Assists the running of the project, and works with PSASA to generate income and resources for the project.

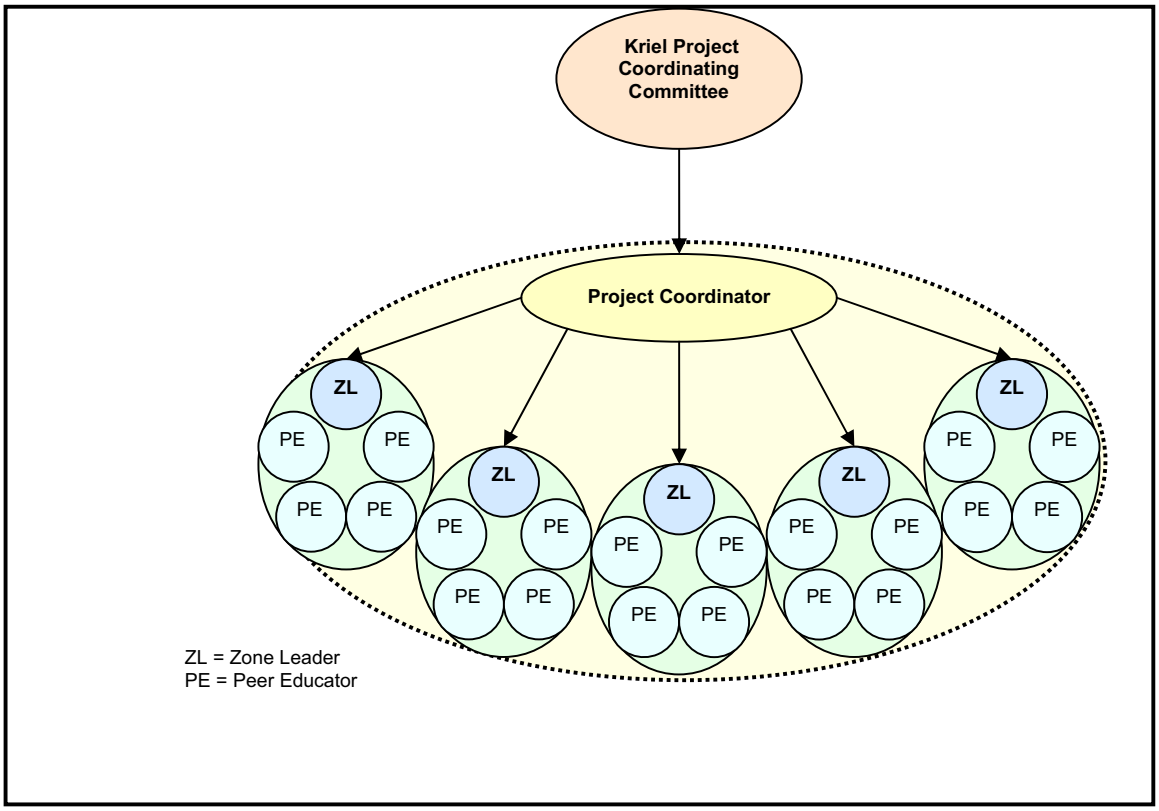

Figure 11 – General Programme Management Structure

Work Place Prevention

The impact of HIV AIDS on the business sector is significant, and because of this many companies see prevention programmes to their own workforce as cost effective interventions. Several businesses in the Mpumalanga area have elected to use PSASA supply Peer Education training within the workplaces, and in neighboring communities. Similar methods are used with the recipients receiving HIV AIDS messages in the work context. Currently there are 15 projects with 350 workplace volunteers and 60 zone leaders.

Youth Prevention

Youth prevention programmes following the peer model and process described above. Initiated in 2000, the aims and process are similar using youth to educate the youth. Because of this, the settings and content of outreaches are tailored accordingly to address youth issues and meet youth needs. Often, Youth Peer Education Project volunteers organize fun activities and sporting events, which they turn into educative opportunities. There are 14 projects each with a coordinator and approximately 280 volunteers (20 per project). An example of a monthly Youth Report is given in Appendix 6.

Student Prevention

It has been observed that early education and prevention is essential in stopping the spreading of the HIV AIDS virus. Because of this, PSASA has in 2003 year established a fresh branch in its activities – Student Peer Education projects. Here, universities and other tertiary education sites are targeted in

the same way as the other Peer Education approaches. The Protec Student programme is funded through SAPPI.

Category (Kriel Men)	Project (6 weeks)	2 Year	4 Year
(1) Knowledge of HIV	**-**	**-**	**94.76%**
(2) Attended peer education meeting in Kriel	**54.93%**	**91.43%**	**94.12%**
(3) Attended more than one peer education meeting in Kriel	**1.30%**	**9.78%**	**83.30%**
(4) Received condoms at peer education meeting in Kriel	**46.48%**	**93.13%**	**94.70%**
(5) Discussed AIDS with other people in Kriel	**68.06%**	**93.46%**	**91.00%**
(6) Perceive personal risk of getting HIV	**25.40%**	**97.25%**	**81.98%**
(7) Used condom last time with spouse	**11.76%**	**40.57%**	**73.50%**
(8) Have boyfriend/girlfriend	**85.71%**	**80.37%**	**61.62%**
(9) Used condom last time in casual/commercial sex	**44.12%**	**92.54%**	**86.63%**
(10) Had STD symptoms in last six months	**42.86%**	**26.41%**	**17.80%**

Figure 12 – Kriel 2 & 4 Year Assessment Summary

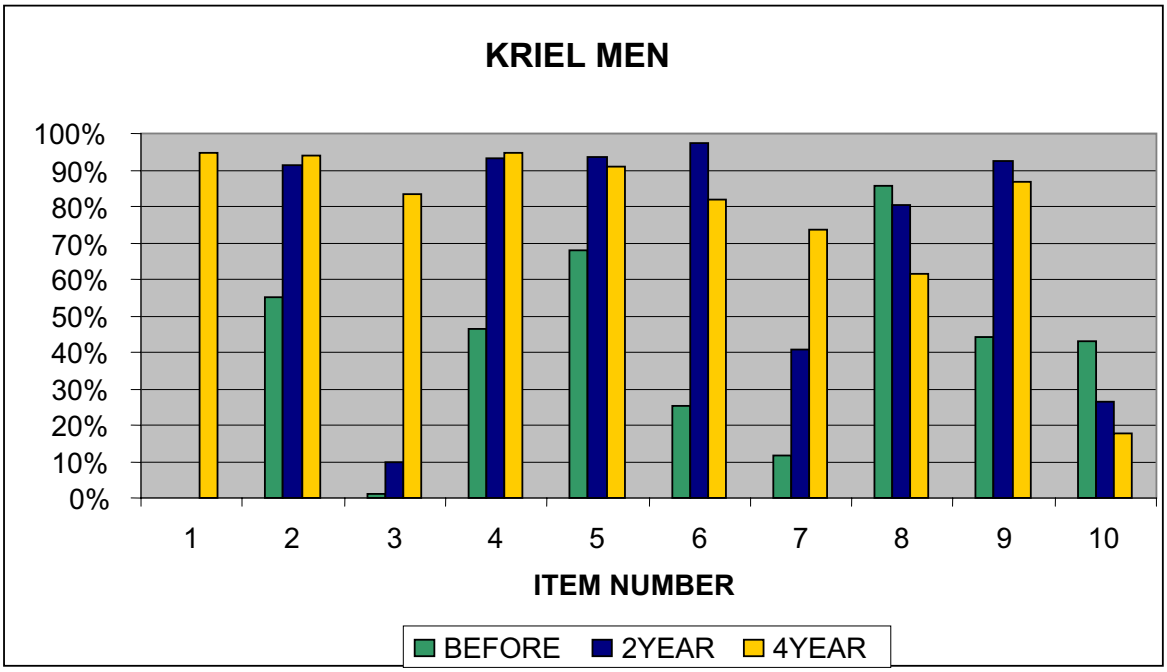

Figure 13 – Kriel 2 & 4 Year Assessment Graph

Prevention Summary

Are such prevention projects effective? Do they make a difference in preventing the spread of HIV AIDS? The lead project in Kriel was evaluated at two and four years from commencement and clearly demonstrated a marked improvement in HIV AIDS awareness and positive behavioral change among males and females in the target community (see Figures 12 & 13). Considering this and the number of projects through out the province (where an estimated 20% of the total adult population of the province have regular contact with peer education projects) an estimated 30 000 to 50 000 STI's are thought to be averted per annum because of these programmes.

Home Based Care

PSASA began to implement and support Home Based Care projects in 1999. Since then the number of projects has increased to over 60 with 1500 volunteers (including zone leaders) participating in the programme. Over the last year, some of community based peer education activities that were not specifically addressing high transmission areas have reoriented their activities into home care. Efforts have also been undertaken to add care issues to the content of some of the peer projects. The provision of home care provides an entry point to address many needs within communities.

Aims:

- To increase HIV AIDS coping capacities in mitigation project communities
- To increase the quality of HIV AIDS care and support to those infected and affected in partner project communites
- To improve knowledge and attitudes toward the needs of the infected and affected at household and community levels
- Sustainable community mobilization
- Increased access to medical and material support services to the infected and affected (includes OVC's)

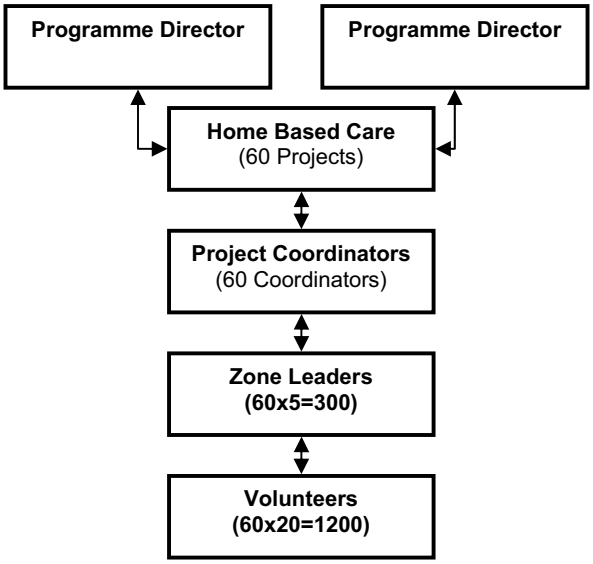

Figure 14 – Home Based Care Structure

Target group and focus:

The focus of the Home Based Care programme is to provide care for those who are chronically sick and terminally ill, care for the destitute and disabled in communities. These patients are often suffering from HIV AIDS but not exclusively. The care and dignity of the patient is foremost. Nursing is an essential part of the care given to the patients, and HBC workers are trained and resourced to provide basic health care and nursing, including DOT's. Patients are regularly monitored and evaluated in regards to their health and health needs. In situations where the medical needs of the patient exceed the nursing capacity of the workers, these workers are prepared to refer to other health care services, and are encouraged to maintain a sound relationship with these services. In addition to the nursing care, the workers also provide support to the families and household, home help and counseling.

Goals of Home Based Care[10]

Home-based or home care refers to "any form of care provided to the sick in their homes". Such care includes physical, psychosocial, palliative and spiritual activities[11]. This holistic approach can mean the 'things' a person does to manage their own care or the care given by the family or the community within the home of the needy person. The term "community home based care" [CHBC] is often used. This is where home care occurs in a community, to the community and by the community. It may occur with or without external support.

"The goal of Home Based Care is to provide hope through high-quality and appropriate care that helps family caregivers and sick family members to maintain their independence and achieve the best possible quality of life"[12]

Target of Home Based Care

In the context of this manual, comprehensive home based care refers to care of the most needy of the following –

1. **Care for the <u>afflicted</u>** [remembered by the 4 "D's"]. These are the -
   a) Dying – those who are dying for whatever reason such as HIV / AIDS, cancers, chronic diseases or just old age.
   b) Disabled – this is includes both physical and mental disabilities and includes a young child with a hearing problem to an older person who has had a stroke.
   c) Diseased – especially those who have any form of chronic disease such as diabetes, heart problems, cancers etc and is also inclusive of HIV related conditions
   d) Destitute – care for the impoverished and destitute. This includes adults and children who live in extreme poverty and specifically the neglected elderly.

1998 **Care for the <u>affected</u>**. This includes all those who are directly or indirectly affected by HIV / AIDS and may need some form of additional support.

   a) Orphans and vulnerable children in need of care
   b) Widows in need of care
   c) Elderly in need of care
   d) Other family members in need of care

Box 5 – Goals & Target of Home Based Care

The project workers are not only trained in caring for their patients, but are also trained in training others to provide high quality palliative care. They can then assist family members and neighbours to gain all that is necessary to effectively and appropriately nurse the patient, thus empowering the community with skills, knowledge and responsibility.

Many home care clients die while under HBC care. Lose of income can enhance or exacerbate poverty. Provision for economic down turn of families is an essential component of the HBC programme. Project workers are trained in establishing income generation schemes within communities, and so are able to assist the families of their patients in implementing their skills to create a new source of income to sustain them. These income generation schemes include community gardens, and arts and craft work. Such projects are also extended through to orphans and vulnerable children.

Where:

As with the Peer Education projects, Home Based Care projects are established in villages and communities, particularly in poor and poverty stricken areas in order to reach the target group. Liaising with other community services may occur wherever those services are based.

How:
The processes and procedures undertaken to establish a Home Based Care project are similar to, and based on the same model as, the launching of a Peer Education project, as described above. Key summary points includes:

Request and Negotiation for Project Implementation. The request for a Home Based Care projects usually come from within the communities. In some circumstances an outside member of a community may identify a site suitably in need of a health mitigation project. PSASA is frequently asked by community members or groups to assist with the establishment of a project. These people have identified the need to care for the ailing within their own areas, they may have already formed a group, and need the resources, education, modalities and training to meet those needs. A proposal for a Home Based Care project must be submitted to PSASA, where the funding and finance personnel examine their budget and the proposal, in order to ascertain the likelihood of project implementation. PSASA receives many applications that it is unable to approve because of limited finances. Projects cost between R45, 000 and R150, 000 per annum depending on their size, and save the health services R400, 000 to R1, 000,000 per year in averted hospital costs[13]. Social and averted clinic costs have not been included in these calculations. If and application for project establishment is successful, a Project Manager then engages in negotiations with the respective community.

Figure 14 – Home Based Care Team in Standerton 2002

Needs Identification and Survey. The next step taken in the implementation of a Home Based Care project is for the Home Based Care Project Managers to make contact with the wider community (identifying leaders and key community players and stakeholders) in order to build relationship with them and get approval to undertake a Needs Assessment. The Needs Assessment involves surveying the community through interviews, data collection and statistical analysis in order to ascertain the scope of need for a Home Based Care project, community resource availability, community acceptance of the project and so on. If there is already a PSASA scheme operating in that

location (such as a Peer Education Project), this initial step is automatically accelerated, as rapport for the Association has already been built, and the workers are very aware of the needs in the community.

Mapping and Zoning. Having identified the level of need, gained approval from local leaders, and deduced that there is suitable community support for a Home Based Care project; mapping and zoning is undertaken. The Project Manager walks, drives, examines and researches the community, mapping geographical, demographical, topographical and industrial conditions. The mapping serves to inform the Project Manager as to where the chronically and terminally ill live in the community, how the housing is dispersed, and the nature of the landscape in the area. Zones are drawn based on the mapping, taking into consideration potential recipients of care, the geographical layout of the housing, and the accessibility of the volunteers to those zones.

Volunteer Recruitment. The Project Manager can ascertain the number of volunteers needed for complete area coverage, and begin the recruitment process. By this stage the Manager is well known and has established significant rapport and trust within the community. For this reason, s/he is able to successfully ask community members to volunteer as Home Based Care workers, with high rates of acceptance. The number of volunteers recruited will be based on the number and size of zones in the community with most being recruited through the local churches.

Initial Volunteer Training. Subsequent to volunteers being recruited, the initial training of these workers begins and extends over a five-day period. This tuition educates them in a range of issues:

- HIV/AIDS transmission and prevention and basic facts
- Food safety and nutrition
- Feeding an infant
- Healthy eating for people with HIV AIDS
- Physical, emotional, and social health
- Self care
- Counseling
- Preparing for death (e.g. wills, providing for children, deeds and entitlements)
- Child care
- Referring and collaborating
- Basic nursing skills
- Distributing, administering and monitoring medical supplies
- Managing own and community resources
- Managing clinical problems and symptoms associated with AIDS
- Recording and documentation

Role and Zone Appointment. Throughout the training, the Home Based Care Manager seeks to identify potential leaders within the group, so that at the conclusion of this initial training, s/he is able to appoint a Project Coordinator to oversee the project, as well as a Zone Leader for each zone. Also, at the ending of the initial training volunteers are designated a specific zone in which to work.

Programme Implementation. Implementation involves nursing of the chronically and terminally sick by dressing wounds, administer and prescribe basic medications, monitor and ensure the administration of professionally prescribed medication, wash and clean the patient, ensure his/her personal hygiene, and assist in accessing the best possible nutrition for that person. A key activity involves the training of family members or neighbours to undertake this care.

Figure 15 – Income Generation Activities, Making Cards for Sale

Because the volunteers' nursing training is limited, it is often necessary to refer to other medical services and professionals (such as doctors, nurses and public health services) to obtain diagnosis and appropriate medication. For this reason Home Based Care workers aim to keep close and healthy relationship with other health providers. The volunteers are often required to act as advocate for their patients with medical services, and also to ensure that the prescribed treatment is being administered according to directions. Also, new patients are often referred to Home Based Care workers directly from the community, clinic or hospitals.

Care activities are also include other family members. Volunteers are trained in counseling, asset management (ensure that deeds, entitlements, wills and so on are in order before the patient passes away), and general orphan care and support.

Weekly Volunteer Meetings. Weekly meetings are held for all of the volunteers in a particular project. Key issues are discussed and new topics are presented. It provides and opportunity for submission of reports and documentation (see Appendix 7 – Home Based Care and Appendix 8 – Mitigation Tools).

Ongoing Training. Three week-long trainings per year are held for Coordinators where they liaise, support each other, and receive thorough training in relevant issues. The Coordinators then take that information back to the volunteers in their projects.

To date, PSASA supports over 60 Home Based Care projects. These projects have proved essential in the community for the support, care, and resources they provide. Care workers activities are broad and volunteers often work very hard for their communities.

Orphans and Vulnerable Children

PSASA's Orphans and Vulnerable Children programme is a childcare-focused facet that flows out from Home Based Care. **C**hildren are expected to care for their ailing parents, provide food and income, miss out on schooling and education, and are left orphaned if their parents die, meaning that in many cases young children have to take responsibility to head their own households. Home Based Care workers meet a core package of OVC care, at times however there are needs for more specialized services.

Figure 16 – OVC Concert

Core Activities for OVC's[xiv]

Care to orphans and vulnerable children, like all components of the home care programme should not separate HIV infected / affected orphans from those orphaned for all other reasons. Care for the terminally ill adult naturally progresses into the care of children both while the parent is alive and after death. Some maternal orphans [loss of mother], paternal orphans [loss of father] or dual orphans [loss of both parents] remain highly vulnerable and can suffer severe developmental consequences. Others may be taken into supportive environments where they are loved and cherished as valuable members of the new household. There are many reasons why children are described as vulnerable even in the presence of parent/s. For both orphans and vulnerable children the essential activities by the care personnel involves –

- *Identifying OVC's*
- *Registration of OVC's within the project with relevant documentation (i.e. copy of death certificate, clinic cards etc.)*
- *Assignment of care supporter to every orphan for □ounseling and support of the child through:*
  a. *Mentoring towards adulthood*
  b. *Intervention especially when there are no extended family or when they are not able to assist*
  c. *Support includes protection and advocacy for the best interest of that child, moral and spiritual support, and legal support. This may mean assisting with accessing of grants or benefits [where these are available], inheritance protection etc.*

d. *Assisting in keeping children in schools*
e. *Prevention awareness to orphans on HIV / AIDS and other relevant infections*

These are the basic areas that need to be addressed in regards to orphans. However the objective of any HBC programme should be to expand orphan activities into more practical orphan care such as food provision, school support, shelter etc.

Box 6 – Core Activities for OVC's

While children have always been a focus of Home Based Care projects in which the PSASA is involved, the development of their care as a separate function is relatively new, and is still in need of wide spread expansion throughout existing projects. Project establishment operates in much the same way as Home Based Care project establishment, the focus on the needs of the child.

An OVC volunteer's role includes:

- Ensuring that the children have shelter
- Ensuring that the children have food
- Ensuring that the children have water
- Organizing the care or placement of children with family members
- Helping the children access schooling
- Helping to access grants
- Helping get children's birth certificate
- Helping to get death certificates of parents
- Accessing appropriate medical and health care
- Helping authenticate children's housing deeds and obtain secure rights to these
- Negotiating with and advocating to other services and agencies
- Income generating activities

Aims:

- To strengthen households
- To sustain community support for orphans and vulnerable children
- To provide improved care for orphans and vulnerable children.

Christmas Parties for Orphans – 23rd of November, 2004 to 7th of December, 2004

Three Christmas parties were held through out the region. The party was attended by orphans, grandparents, foster partners and volunteers. Activities included: singing, praying, telling of the Christmas story, eating and giving of presents. The highlight of the activities was opening the presents by the children, their faces brightened up as they picked out each item one by one from the bag. They were all excited to have their photographs taken. Food was served which added to the party spirit, as the children tasted variety of eats. The orphans presented music, traditional dances and drama's which added to the life of the party. Traditional and community leaders, home care volunteers, Department of Social Welfare and local businessmen attended in supporting these activities.

Overall 3000 children benefited (20 from each of the 60 home care projects) from the Christmas parties with each receiving a small gift to the value of R20-.

Box7 – Christmas Parties -2004

Figure 17 – Delighted children with their toys at one of the many Community Christmas Parties held for Orphan Children

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