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Protecting the children: An indigenous response from churches in South Africa¹

ABSTRACT

According to UNICEF, the HIV/AIDS pandemic contributes to the estimated 143 million orphans in 93 developing countries. The Vana Vetu programme is an indigenous grassroots response to the challenge of addressing these orphans' needs by women in four Anglican Church dioceses in the Eastern Cape Province. In this article the Vana Vetu programme is evaluated according to the five core principles outlined in "The framework for the protection, care and support of orphans and vulnerable children living in a world with HIV and AIDS" (UNICEF) and concludes that Vana Vetu aligns with all five action areas and consequently aligns with both the national and international discourses on OVC. As such this programme is an example of a planned intervention as a religious response, which increases the relevance of churches, and church organisations as key role players in welfare and development in the South African context.

INTRODUCTION

Responding to the challenge of orphans and vulnerable children (OVCs) in South Africa is a daunting and sometimes overwhelming task. Although the urgency of orphans and vulnerable children is widely recognised, the challenge is intensified by a variety of contextual factors, which are interconnected, and, when combined, impact exponentially on micro levels. A major contributing factor is the HIV/AIDS pandemic (UNICEF 2006b: 39). The total number of orphans in 2005 in South Africa was estimated at 2.5 million of who almost half lost their parents due to AIDS (UNICEF, 2006a: 36; SANAC, 2007: 34). In 2005 18.8% of the adult population (15-49 years) were living with HIV (SANAC, 2007: 7). Women bear the brunt of this epidemic, specifically within the age group of 20-34 years where the infection rate is an astounding 23.9% for women 20-24 years of age, 33.3% for women 25-29 years of age and 26% for women 30-34 years of age (SANAC, 2007: 23-28). The children worst affected are those in impoverished households (SANAC, 2007: 34). This situation is exacerbated by the dire socio-economic circumstances and poor service delivery in the Eastern Cape Province. This province is not only the second largest province in terms of area and third most populated (Statistics SA, 2007b: 3, 9) but also the poorest (Statistics SA, 2000: 1). Almost three quarters of children in this province live in households that earn R800 (approximately US\$100) or less per month (Leatt, 2006: 27).

In South Africa religion as a social institution and churches as formal organisations thereof are central in the process of social development. Recent literature describes the important role of

1 This article is based on a paper presented by the authors at the 33rd International Conference of the International Council for Social Welfare (ICSW) held in Tours, France, 30 June to 4 July 2008.

churches' formal and informal responses in challenging welfare contexts in Africa (Global Health Council, 2005; Parry, 2003; German Institute for Medical Mission, 2005; Patel *et al.*, 2007). In terms of home- and community-based care and support a recent report (Giese *et al.*, 2003: 161) found faith-based organisations played a "critical role in the lives of children and caregivers in many of the households, not only because of the services they provided but because they frequently facilitated access and negotiated barriers on behalf of children and caregivers to state services (such as social workers, schools and clinics)." Foster (2004: 77-78) presents data from 690 interviews conducted with faith-based organisations where more than 90% rendered religious education and 73% school assistance in the form of school fees, uniforms, books etc. to orphans and vulnerable children. These faith-based organisations included 9,000 volunteers and 156,000 orphans and vulnerable children.

In the Eastern Cape Province a group of women in the Anglican Church have responded to the challenge of the orphans' needs. 197 childcare workers care for a total of 4,056 orphans and vulnerable children, an average of 21 children per childcare worker. These women render a variety of services to the children (Erasmus 2007a; 2007b). However, despite the admirable work done by churches and church organisations on a grassroots level in response to the challenges of OVCs in their communities, these organisations face enormous challenges. Because of the spontaneous character of these deeds, one of the challenges is that, the responses are often not aligned with requirements for social development outlined in policy documents. This article evaluates if the indigenous response by these Anglican Church women in the rural Eastern Cape Province is aligned with the five core principles outlined in *The Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS* (FPCS) (UNICEF, 2007: 31). This question will be addressed within the problematic contextual realities of the pressure of the safety nets for vulnerable children and the context of OVCs in the Eastern Cape. Thereafter the Anglican programme for OVCs (Vanu Vetu) will be described and compared to the FPCS in terms of services and support and concludes with a critical reflection of the Vanu Vetu programme. The article proposes the need to heed the call to responsibly address the challenges facing children within the context of HIV in South Africa. This should be an important agenda for Practical Theology "which proclaims itself to be explicitly committed to the realisation of a liberated and transforming Christian praxis and the dialectical interaction between theological theory and practice" (Swart & Yates, 2006: 315). This needs to be done in an accountable manner.

1. SAFETY NETS UNDER PRESSURE

The severe impact of HIV/Aids on the lives of OVCs has been described, quantitatively and qualitatively, in South African literature (Dudeni, 2007; Leickness *et al.*, 2006; Skinner & Davids, 2006a, 2006b; Norman *et al.*, 2005; Giese *et al.*, 2003). The assumption is that several layers of informal² safety nets support each child. As the impact of HIV/Aids increases so the child slips from one to the other of these informal safety nets, each time with decreased security and increased vulnerabilities. These safety nets become increasingly porous and less able to absorb the social, economic and psychological pressures caused by HIV and Aids. The table below shows that as the stability of the child's type of household decreases downward so the child is driven into possible informal safety nets which in turn cause multiple vulnerabilities for the child.

2 Informal safety nets are understood as family and community mechanisms that function, depending on area and culture. Formal refers to mechanisms and services provided by government and civil society.

Table 1: Types of households and safety nets for OVC

Types of households	Informal safety nets
Two parents	Extended family
Single parent: temporary (migration) or permanent (Aids/violence/divorce)	Grandparent(s)
No parents: Stay with extended family	Child
No parents: Stay with grandparent(s)	Community
No parents: Stay in child-headed household	Non-governmental organisations (NGOs) / Faith-based organisations (FBOs)
No parents: Live on streets	Street family

Foster's (2004, 2002) research describes the importance of these informal safety nets from an African perspective. The process of entering into various vulnerabilities normally starts during the terminal illnesses of one or both of the parents. The OVC assumes new responsibilities in terms of household chores, caring for the sick parent(s), generating income and taking care of the younger children in the household.

The first informal safety net is the extended family that takes the responsibility of parenting (the immediate uncles and aunts of the OVC). This safety net is responsible for most of the OVCs in Southern Africa and provides the most effective response to crises like OVC (Foster, 2004:65, 67). There is increased pressure on the extended family due to the vast numbers of Aids orphans and diminution of caregivers. Although there are cases of exploitation and abuse, the majority of extended families "go to considerable lengths to keep the orphans in school, including borrowing money through informal networks and selling their own assets" (Foster, 2004:68).

When the extended family is no longer able to care for the orphan they are forced to the next layer, the grandparents. Often this is a last resort because the long-term ability of the grandparents is limited because of their age and declining health (Foster, 2004:70). Often the situation of care is reversed where the OVC end up caring for the frail elderly.

By now the child has entered into various vulnerabilities and soon slips to the next phase of child-headed households where children look after themselves. When grandparents die or move in with other family, the options available are to "upgrade" to extended family or "downgrade" by either staying together as brothers and sisters or the younger ones move in with extended family while the older ones survive by themselves. The children adopt various coping strategies, which enable them to survive and also look after other younger children in the house. There are various pressures at this point including working on the streets, dropping out of school, young girls getting married or being sexually exploited.³

If there is no intervention at this point, the child is forced into the last fragile net of living on the street. All the informal safety nets would now have disintegrated and the OVC is begging, guarding cars, selling something or committing crime. Although children might end up in this situation because they have been abandoned, it is often as a result of circumstances like

3 Problems facing child-headed households: food insecurity, problems of access to education, struggle to meet material needs, absence of psychosocial support, poor life skills and knowledge, abuse and exploitation, absence of an extended family network, poor housing conditions and insecure tenure and poor access to healthcare (Foster, 2004:72).

exploitation and violence, which make them, decide to abandon the families where they stayed (Foster, 2004:73).

Between the situations of child-headed households and children ending up on the streets, either friends, neighbours, the community, Non-governmental organisations (NGOs) or Faith-based organisations (FBOs) might intervene to provide support. However, this relief is only temporary. Community groups like women's groups or church's groups can offer more sustainable support. Most of these responses grow out of concerned individuals, very often women and those rooted in religion (Erasmus, 2007a; Foster, 2002: 9). The importance of these kinds of community responses increase as the impact of Aids amplifies. The Anglican Church programme is an intervention at this level. Before describing this intervention the context of the OVC in South Africa and the Eastern Cape (the study area) will be discussed.

2. CONTEXT OF OVC IN SOUTH AFRICA AND EASTERN CAPE

Daunting challenges to the South African government remain in the second decade of democracy, specifically in the social cluster. Three documents refer to OVC in the social cluster. First, the South African Constitution provides a framework to realise socio-economic and political rights contained in the elaborate Bill of Rights (South Africa, 1996). Next, two policy documents (SANAC, 2007; DSD, 2005) regarding HIV/Aids and OVC provide situational analyses and strategic guidelines on a national level.

The South African government has put in place a statutory social support scheme of family and child benefits to prevent vulnerability. In the social security programme of the Department of Social Development, three grants impact on children's lives, namely children support grants (for children under 14 years), foster childcare grants (for children in foster care) and care dependency grants (children with severe mental or physical disabilities requiring permanent home care) (Department of Social Development, 2006).

The study of Johnson and Dorrington (2001: i), though on a national level, projects how Aids will demographically impact on OVC:

"Regardless of the definition used, the number of orphans is likely to peak around 2015 – at roughly 2 million in the case of maternal orphans under the age of 15, and at roughly 3 million in the case of maternal orphans under the age of 18. The number of paternal orphans under the age of 18 is expected to peak at 4.7 million in 2015, and the total number of children having lost one or both parents will be at its highest around 2014, at a level of 5.7 million."

Research on the needs of orphans and vulnerable children has recently been conducted in two rural areas in the Eastern Cape, Umzimkhulu (Norman *et al.*, 2005; Giese *et al.*, 2003) and Lusikisiki (Dudeni, 2007). The report of the 1998 Demographic and Health Survey contextualises the impact of OVC in the Eastern Cape Province (Hutchinson *et al.*, 2004). This report describes how the Eastern Cape Province often lags behind other provinces in terms of health and poverty indicators.⁴ Against this background of OVC in South Africa and within the Eastern Cape context where the study was conducted, the Vana Vetu intervention will be described.

3. ANGLICAN CHURCH PROGRAMME FOR OVC: VANA VETU

The Anglican Church in Southern Africa (ACSA) programme for OVCs is described in terms of background information and management structure followed by an evaluation to determine if

4 According to the 2007 Labour Force Survey (Statistics SA, 2007a:xvii) the unemployment rate in the Eastern Cape Province is 23.1%.

this programme aligns with the five core principles outlined in the FPCS (UNICEF, 2007:31). The challenges will also be critically examined.

Vana Vetu was established in 2006 in four pilot dioceses in the Eastern Cape, namely Port Elizabeth, Grahamstown, Mthatha and Umzimvubu. The goal of the Vana Vetu (meaning: *our children*) programme is to have OVCs living in a family context supported by the community and enjoying acceptable standards of social, psychological and medical care (AAHT, 2006:1). The primary emphasis of this programme is support for OVCs and training of caregivers. Target populations include OVCs (younger than 18 years); HIV and AIDS affected families and caregivers of OVCs (ASCA, 2007: 2).⁵ These beneficiaries receive interventions by trained volunteers. These volunteers know how to deal with OVCs to provide comprehensive integrated support such as psychological support, accessing child support grants, healthcare, food/nutrition and other life sustaining services (ASCA, 2007:3).

Vana Vetu currently receives financial support from The President's Emergency Plan for AIDS Relief (PEPFAR). The emphasis of the PEPFAR OVC programme is in line with that of ASCA namely strengthening communities to meet the needs of OVCs affected by HIV/AIDS, supporting community-based responses, helping children and adolescents meet their own needs and creating a supportive social environment (PEPFAR, 2007).⁶

The Anglican Aids and Healthcare Trust (AAHT) in Cape Town manages Vana Vetu. The management and organisational structure in each diocese includes childcare workers (CCWs), a team leader in each parish and a diocesan OVC coordinator for each of the four dioceses.⁷ Their responsibilities include overseeing the programme in identified parishes, training and providing supervisory support to team leaders, networking with organisations and stakeholders, organising workshops, documenting activities and maintaining a database of children that receive support. They report monthly to AAHT regarding activities of the programmes. A coordinator from AAHT regularly visits all dioceses and identified parishes to monitor and evaluate the programme.

Volunteers (team leaders and CCWs) are recruited, trained and receive mentoring to increase the local capacity of their communities.⁸ They are recruited at parish level, as well as from other FBOs (AAHT, 2008b). CCWs are responsible for assessments of households to identify and register OVCs for the programme and conduct regular home visits (at least three times a week to child-headed households and potential orphans and once a week to grandparent-headed households). They deliver services, distribute resources, refer OVCs to relevant service providers, do counselling and support, and train and mentor caregivers to increase capacity in

5 Definitions: OVC - children younger than 18 years old, either orphaned or vulnerable because of HIV/AIDS. An orphan is a child who has lost one or both parents to HIV/AIDS. Vulnerable - affected by any factors: is HIV-positive; lives without adequate adult support (in household with chronically ill parents, which has experienced a recent death from chronic illness, headed by a grandparent and/or headed by a child); lives outside of family care (in residential care or on the streets); or is marginalised, stigmatised, or discriminated against (PEPFAR, 2007). Caregivers/providers - anyone who ensures care for OVC, including those who provide, make referrals to, and/or oversee social services (parents, guardians, other caregivers, extended family, neighbours, community leaders, police officers, social workers, national, district, and/or local social welfare ministry staff, as well as healthcare workers, teachers, or community workers who receive training on how to address the needs of OVCs) (PEPFAR, 2007).

6 Data reporting on progress of programme is done semi-annually and annually according to PEPFAR (2007) guidelines, but these are not designed to provide information on all dimensions of a programme in country-specific settings.

7 A full time appointment with a monthly salary, receiving training from AAHT and responsible for setting up an OVC programme in each participating parish.

8 Team leaders and CCWs receive a very small stipend (R500 per month).

their communities (AAHT, 2006: 3). CCWs document and report all support activities and services delivered. The team leader summarises the records of services delivered and the activities of CCWs. This is reported on a weekly and monthly basis to the diocesan OVC coordinator. Against this background, the Vana Vetu programme will be discussed as it links to the core principles of FPCS.

4. VANA VETU AND THE CORE PRINCIPLES OF FPCS

The Vana Vetu programme delivers services and support to OVCs in seven core programme areas as identified by PEPFAR, namely food/nutrition, shelter and care, protection, healthcare, psychosocial support, education and economic strengthening. The FPCS identified five broad action areas that guide collective efforts for the comprehensive support of OVC in sub-Saharan Africa (UNICEF, 2006a:29).

Action area 1: Strengthening the capacity of families to protect and care for OVCs by prolonging the lives of parents and providing economic, psychosocial and other support

The intention is to prevent and mitigate the impact of AIDS on family structures and caring capacity and interventions are aimed at strengthening capacity of families (UNICEF, 2006a). This intervention corresponds with the Vana Vetu services provided under the programme area of *health* where the support has the desired outcome of a child having access to the health services including preventative and treatment healthcare (PEPFAR, 2008). Services mostly rely on existing health programmes sponsored by the South African Government (Botha, 2008a). OVCs are also counselled regarding antiretroviral therapy. CCWs assisted families with household activities and taught OVCs to care for ill family members (AAHT, 2008a, 2007a).

Efforts to *improve young children's health and nutrition* (corresponding with programme area of *Food/Nutrition*) include establishing and maintaining food gardens/community gardens for household use to ensure food security. Support includes the supply of seedlings, garden utensils and work in the garden (AAHT, 2008a, 2007a). The community gardens are often on Church premises (Erasmus, 2007a, 2007b). The Department of Agriculture trained CCWs regarding agricultural skills (AAHT, 2007b, 2007c). In the diocese of Port Elizabeth, the Department of Agriculture made plots available and 843 households received seeds to start food gardens (AAHT, 2007c). Nutritional assessments and counselling are part of the services that CCWs provide to OVCs, but no nutritionists or dieticians are employed to determine the nutritional status of OVCs in the dioceses in the Eastern Cape.

The intervention of *psychosocial support and strengthening of life and survival skills of young family members* corresponds with the programme area of *Psychosocial* in the Vana Vetu programme. Services provided are in line with the outcome of a child having human attachments necessary for normal development and cooperative participation in home and community activities (PEPFAR, 2008). Psychosocial workshops and camps for children were facilitated in all four dioceses in the Eastern Cape. Topics of workshops included life skills, development of talents, teaching of spiritual and cultural values, and teaching of coping mechanisms under difficult circumstances (AAHT, 2008b). The diocesan OVC coordinator monthly reports (AAHT, 2008a; 2007a) indicate popularity of camps with OVCs reporting that they had fun, experienced new environments and learnt skills to cope better at home. CCWs assisted with the assembling of memory boxes and referred OVCs for counselling (spiritual, anxiety, trauma, grief and bereavement) where necessary. The well-being of CCWs was addressed and they attended psychosocial support workshops regarding the mourning process of adults who care for OVCs (AAHT, 2008b).

The *intervention of succession planning* is in line with the support provided under the programme area of *Protection* where services have the outcome that a child is safe from any abuse, neglect, stigma, discrimination, or exploitation (PEPFAR, 2007). Legal issues were addressed including succession planning (ill parents were assisted in drafting a will), inheritance and insurance claims/issues (AAHT, 2007c).

Action area 2: Mobilising and support community-based responses

The community or community-level interventions are the sources of support for OVCs (UNICEF, 2006a). This corresponds with services of Vana Vetu provided by volunteers who received training in community capacity building to address the needs of OVCs (AAHT, 2008b). *Cooperative family support activities on community level* include *food assistance* (programme area: *Food/Nutrition*) amongst others, the feeding programmes within schools, at after-care programmes and churches. Food is a challenge in all dioceses and food support were leveraged from various sources. Soup kitchens are frequently supported by Church organisations (e.g. Mothers Union, Anglican Women's Fellowship). Supplementary feeding, including food parcels are provided by CCWs, private donors and companies and families are linked with the Department of Social Development to receive food parcels (AAHT, 2007c). Another *family support activity on community level* is *psychological support* to improve links between OVCs and communities by re-integrating OVCs into the community. Community childcare forums were established with stakeholders from the South African Police Service (SAPS), departments of Social Development, Health, Education and Agriculture, NGOs and FBOs. These forums address issues affecting the lives of children in different communities as collective and joint initiatives. Awareness campaigns include "Child awareness week", "Youth day", and "Child protection week". The SAPS facilitated workshops on child sexual abuse (AAHT, 2008b). The school holiday camps and kids clubs for the youth are further activities providing psychosocial support (AAHT, 2008a, 2007a, 2007c).

CCWs encourage the strengthening of family-based care models (*community care options for children without any family*) for OVCs. In a few cases children were transferred from institutional care to a family setting (AAHT, 2008a). In order to *facilitate community dialogue on HIV to reduce stigma and discrimination* and raise the awareness on acceptable treatment of OVC, community engagement workshops were presented. The topics include the elimination of stigma, denial and gender awareness. Some workshops were presented with FBOs and CBOs (Community based organisations) to strengthen a collective response in addressing the needs of OVCs (AAHT, 2008b).

Action area 3: Access for orphans and vulnerable children to essential services including education, healthcare and birth registration

This corresponds with various services in different programme areas of Vana Vetu. Services in the programme area *Education* have the outcome of a child receiving educational opportunities (PEPFAR, 2007). Services CCWs provide include removing obstacles to attending primary or secondary school for example assistance with registering for school and obtaining exemption from paying school fees. The CCWs identified OVCs that qualify for the "*School is cool*" campaign and these children received school uniforms and/or school supplies (AAHT, 2008a, 2007a). After school care includes assistance with homework and monitoring progress. Female OVCs often drop out of school to become caregivers of parents or siblings (AAHT, 2008b, and 2007c). Therefore female OVCs are focused on ensuring that they receive equal opportunities and stay in school. In some cases OVCs were removed from abusive situations. CCWs arranged protection and shelter in the community (AAHT, 2008a).

CCWs facilitated access to *birth registration, birth certificates and identification documents*

and assisted with the registration for *social grants* (AAHT, 2008a, 2008b, 2007a). The misuse of grants by other relatives were monitored and reported to social workers (Erasmus, 2007a, 2007b).

Action area 4: Ensure that Government protects the most vulnerable children through improved policy and legislation and by channelling resources to families and communities

The Vana Vetu programme builds on the six key strategies in the FPCS intended to target key action areas and provide guidance to stakeholders in developing comprehensive, integrated and quality responses for OVCs at programmatic level (AAHT, 2006:6; Department of Social Development, 2005:9). AAHT has representation on the National Action Committee for Children Affected by HIV and AIDS (NACCA) (AAHT, 2008b).

Action area 5: Raise awareness at all levels through advocacy and social mobilisation to create a supportive environment for HIV and AIDS affected children and families

This includes reducing stigma and discrimination (UNICEF, 2006a:6). Community mobilisation is classified as an indirect service to respond to OVC needs. Vana Vetu is linked with government departments, municipalities, NGOs and FBOs and share resources and information to support OVCs (ACSA, 2007). Issues such as reducing stigma, discrimination and false perceptions on HIV and AIDS are addressed in Community Forums and workshops (AAHT, 2008b). Despite these efforts, diocesan OVC coordinators reported that they experienced that stigma was still associated with HIV and AIDS (Botha, 2008b).

Activities of Vana Vetu are thus clearly aligned with the action areas of the FPCS but it is necessary to reflect on challenges within the context.

5. CRITICAL REFLECTION ON VANA VETU

The Vana Vetu OVC programme addresses all five action areas of FPCS. Various measures are built into the programme to evaluate and improve the quality of services and reporting of data. The Unit for Religion and Development Research (URDR) was appointed by AAHT to do an implementation evaluation of the programme in five pilot parishes in each of the four dioceses in the Eastern Cape. The aim was to examine the service delivery systems and ascertain whether OVCs receive services as indicated in reports (AAHT, 2008b).

Discussions, group interviews, individual interviews with all team members and observations during parish visits were helpful in identifying challenges team members face in terms of record keeping and reporting. This evaluation highlighted the need to redesign documentation to increase quality of services delivered. The layout and design of data gathering, record keeping and reporting forms (designed by AAHT) were simplified to improve the reliability and validity of data gathered and the quality of data reported. A guide on the completion of forms and reports of Vana Vetu was compiled by URDR (Botha, 2008a) and the diocesan OVC coordinators are responsible to distribute this amongst team members. The updated record system includes pictorial images and was translated into four other official languages to eliminate the possibility that team members who do not understand the reporting documents in English might compromise the quality of data. Diocesan OVC coordinators were trained in the updated record system and the implementation of this system was evaluated on parish level. Parishes are visited on a regular basis by the URDR to observe and monitor activities and the completion of data gathering forms (Botha, 2008c, 2008d, 2008e; Erasmus, 2007a, 2007b). Furthermore the record keeping and reporting of data is regularly monitored by AAHT and the URDR.

Despite measures to increase quality of services and reporting by team members some

parishes lack infra-structure (storage facilities, stationery, and photocopy facilities, facsimile and public telephones). Erasmus (2007a, 2007b) reported that this hinders communication between CCWs and diocesan OVC coordinators. A filing system would enable team leaders, coordinators and management to follow-up on cases and conduct spot checks. As honesty in reporting activities appears to be problematic, a reward/punishment system for team members could be designed and implemented (Botha, 2008c).

Volunteers in this programme experience financial hardship (Botha, 2008b, 2008c; Erasmus, 2007a, 2007b). The limited stipend they receive pays for transport (home visits are often over large distances in rural areas), photocopies of documentation and all services provided (e.g. food parcels). This causes the infrastructure of programmes in parishes to be weak and other volunteers are reluctant to join the programme (AAHT, 2008b; Erasmus, 2007a, 2007b). Hence the workload of existing volunteers increase and the ratio of 21 OVCs per CCW is more than double that which was anticipated (AAHT, 2007). This situation might improve if a higher stipend is paid and more volunteers are motivated to become OVC team members, which will lead to better quality services (Botha, 2008c).

Poverty in some communities and parishes make it impossible to mobilise support for the programme (Erasmus, 2007a). Feeding schemes often lack funding to provide frequent meals (Botha, 2008c) where for some children this meal is the only meal they receive. Therefore Vana Vetu needs to address the sustainability of this service. It is suggested that a monitoring and evaluation officer is appointed at AAHT to monitor and evaluate the programme on a continuous basis.

6. CONCLUSION

The Vana Vetu programme is one response of a church organisation to the daunting and overwhelming task of responding to the challenge of orphans and vulnerable children in South Africa. It is clear that the Vana Vetu OVC programme of the Anglican Church aligns with all five action areas set out in FPCS and consequently aligns with both the national and international discourses on OVC. Vana Vetu was conceptualised and its programme is built on the Policy Framework of the South African Government. This is commendable since many FBO programmes operate individually and in isolation from broader policy debates. This aspect makes the programme an excellent example for other grassroots church organisations responding to the challenges in their communities and reiterates the robust presence of both religion and religious organisations (churches) as key role players in welfare and development in South Africa.

Further, it is clear that CCWs and team leaders are doing commendable work rooted in and motivated by their faith. These volunteers are working with limited resources with the most vulnerable people in each community. The programme thus has an impact on the lives of many children. The Vana Vetu programme gives significance to volunteers' lives and provides a channel for their religious energy in a very constructive way.

However, there are many challenges encountered in this programme. These include both external and internal obstacles. The external difficulties are factors such as HIV infection, weak policy development, lack of service delivery and extreme socio-economic circumstances. Internal challenges are factors such as lack of funding which presents itself on several levels, weak administration and infrastructure that is symptomatic of many programmes in the FBO environment, and keeping volunteers motivated.

This article has sought to identify the strengths and challenges of an intervention programme addressing the realities presented by HIV. This evaluation process will help increase the relevance of this and other church programmes and promote accountability for engagement in

communities.

Finally, if theology is contextual then Practical Theology should involve itself with the harsh realities of orphans and vulnerable children, promoting their rights and directing change towards quality of life and emancipation.

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KEY WORDS

HIV/AIDS

Orphans and Vulnerable Children

Anglican Church

Faith-based Organisation (FBO)

Vana Vetu

Safety nets

TREFWOORDE

MIV/Vigs

Wees- en weerlose kinders

Anglikaanse Kerk

Geloofsgebaseerde Organisasies

Vana Vetu

Veiligheidsnet