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Community-based mental health support for orphans and vulnerable children in South Africa: a triangulation study

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Community-based care is receiving increasing global attention as a way to support children who are orphaned or vulnerable due to the HIV/AIDS pandemic. Using both qualitative and quantitative methodology, this study assesses community-based responses to the well-being of orphans and vulnerable children (OVC) and compares these responses with the actual mental health of OVC in order to evaluate the South African government's approach of funding community-based organisations (CBOs) that support and care for OVC. The study results show that the activities of CBOs mainly extend government services and address poverty. Although this should not be seen as insignificant, the paper argues that CBOs give very little attention to the mental health of OVC.

Keywords: community-based care; mental health; orphans and vulnerable children; community-based organisations

Introduction

The increasing number of OVC (see Skinner et al., 2006 for definition) in sub-Saharan Africa has resulted in increased pressure for community-based care initiatives. However, the emotional well-being and care of OVC has received scant attention in the literature (Campbell, Handa, Moroni, Odongo, & Palermo, 2010; Campbell, Moroni, & Webb, 2008; Cluver, Gardener, & Operario, 2007; Cluver & Orkin, 2009; Schenk & Michaelisb, 2010). Community-based responses to mental health problems were originally recognised in the mid-1980s (World Health Organisation, 1984), and recent evidence has shown that community-based mental health efforts are promising (Braathen, Vergunsta, Mjic, Mannand, & Swartz, 2013; Eaton et al., 2011; Kakuma et al., 2011). On the other hand, critiques of community-based mental health care have highlighted conflict with health professionals, inappropriate incentives, infrequent visits, lack of training of care workers, unrealistic expectations, the lack of partnerships and the remaining dominance of large psychiatric hospitals (Eaton et al., 2011; Schenk & Michaelisb, 2010; Schneider, Hlope, & van Rensburg, 2008).

Other recent research has alluded to the fact that community-based mental health can be addressed through community development (Christens, 2012) and an emphasis on human care (Jordans & Tola, 2013). Community-based health care was slow to get off the

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ground in the post-Apartheid era (post-1994), but by 2008, there were approximately 60,000 community-based care workers caring for people infected or affected by HIV/AIDS (Schneider et al., 2008). International literature suggests that cash transfers, especially to female heads of households, hold the most promising results for the mental health of OVC (Lund et al., 2011; Schenk & Michaelisb, 2010). Similarly, addressing poverty in rural settings has also been associated with better mental health outcomes (Lunda, Waruguru, & Breuera, 2013). Against this background, this paper compares responses of CBOs with the mental health care needs of OVC in Mangaung Municipality of the Free State Province, South Africa. The key question guiding our study was to uncover the main motivation behind CBO aims, objectives and activities and determine whether mental health concerns related to the OVC are addressed. We argue that a more holistic approach, which also considers the mental health of OVC, should be considered in the design and practice of community-based care programmes.

Methods

Participants and measures

Three sets of data were collected.[1] First, interviews were carried with the management and staff of five CBOs that provide care services to OVC. The organisations were selected on the basis of being the only CBOs in Mangaung that concentrate on OVC. Of the five CBOs, three were funded by the government, one was linked to an established NGO (and funded through the NGO's grant-making system), while the last one was a faith-based organisation with virtually no external funding. In addition to the interviews with management, a self-report questionnaire (with open and closed questions) was distributed among the CBO care workers. This questionnaire focused on two main elements: the problems associated with OVC and the services that the CBOs provide. Most of the questionnaires were completed in Sesotho (the language spoken by the respondents) and then translated into English.

The second data set consisted of the provincial government's funding guidelines related to CBOs. A critical analysis of these guidelines helped to ascertain the power relations and the language used by the provincial government to create the context for CBO-provided care services. A content analysis was done of key themes as identified by the primary researcher, which were then discussed with the other researchers

Third, for the quantitative portion of the study, 607 OVC (between 7 and 11 years of age) were interviewed, of which 465 were orphans and 142 were other vulnerable children. The Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997), a 25-item screening measure of emotional and behavioural disorders designed for children aged 3–17, was administered in Sesotho after being adapted and translated in accordance with published guidelines for the translation of instruments in cross-cultural research (Gjersing, Caplehorn, & Clausen, 2010; Hambleton, 2001; Hambleton, Merenda, & Spielberger, 2005; Van de Vijver & Hambleton, 1996). The Total Difficulties scores, based on the OVC's self-reports, were then analysed and used in the study (Cronbach's alpha = 0.72).

Descriptive statistics of the OVCs and their households were also generated. Subsequently, bivariate and multivariate linear regression analyses were conducted using the following variables: gender, age, adequate clothing, adequate school uniform, access to medical services, grant as a percentage of income, total expenditure and clothing and food as percentages of total expenditure. Variables which were statistically significant at $p < 0.05$ were included in the multivariate linear regression models. Three separate

linear regression models with alternating significant variables were run out of concern for co-linearity.

Results

The main problems associated with OVC according to the CBO care workers were compared with the SDQ results and the requirements laid down by the provincial government (see Table 1).

Furthermore, CBO managers were asked to provide an overview of the main services provided by their organisations. Their responses indicated that mainly tangible poverty-related needs were being addressed (accessing grants, obtaining birth certificates, providing clothing). The absence of counselling and support for the OVC's mental well-being was attributed to the limited skills within the CBOs and the fact that "that was not what government is paying us to do" (as one respondent stated). Two important points need to be made with regard to the CBOs. First, the majority of staff members were previously unemployed and had probably been attracted by the monthly stipends of R500. Second, the government funding guidelines state that the overall aim of community-based care is "[t]o assist the Department of Social Development to provide services that will mitigate the social and economic impact of HIV and AIDS" (Free State Provincial Government, 2012) (emphasis added). In order to achieve the above aim, the community-based care programme has eight main service areas (see Table 2).

Keeping the above background in mind, this is how the CBOs portrayed themselves. First, the link between the government's aim and the aims and objectives of the CBOs should be recognised. Phrases such as *to provide support* and *to provide care* (borrowed from government specifications) were commonly used by the government-funded CBOs, while they were less prominent among the other two CBOs. Second, one of the CBOs not

Table 1. Main problems associated with OVC according to CBO care workers.

Main problems associated with OVC	Number of times mentioned (n)	Percentage of total responses (%)
Lack of birth certificates/clinic cards	13	16.0
Not attending school	11	13.6
No love or care from parents or caregivers/neglectful parenting or care giving/physical or emotional abuse	10	12.3
No school uniforms	8	9.9
Ill health/no access to medicine/no hygiene	7	8.6
Hunger	6	7.4
Lack of a play area, developmental stimulation or educational play and toys	6	7.4
Difficulty in accessing government grants	5	6.2
Need help with homework	5	6.2
Children are intellectually slow/battling to understand in school	3	3.7
Sexual abuse	2	2.5
Drugs	2	2.5
Disabilities	1	1.2
Lack of adequate shelter	1	1.2
Poverty	1	1.2
Total	81	100.0

Table 2. Activities funded per service area (Free State Provincial Government, 2012).

Service area	Activities that are funded
Care services	Home visits to the frail; caring for the frail; caring for child-headed households; care programmes for children rendered vulnerable as a result of HIV & AIDS; recruitment and training (primary level); monitoring of the progress of the family and/or the frail; co-ordination of teamwork
Support services	Support groups, e.g. for life skills and information education; home visits; linking families or persons with other services
Psychosocial needs	Strengthening and supporting family and community capacity to provide vulnerable children with psychosocial support; strengthening referral mechanisms for children and youth to specialised services; counselling of all forms; ongoing support; other care and support programmes
Prevention and behaviour modification programmes	Workshops; door-to-door campaigns; exhibitions; public meetings; materials development and dissemination
Training	Training workshops; development and distribution of training materials; establishment of networks for post-training implementation of the acquired information
Social assistance	Promoting access to social grants; facilitating access to food packages; facilitating access to nutritional supplements
Community mobilisation	Establishing child-care committees to identify orphans and children in affected families; ensuring basic services to the children identified; training of committees; setting-up inter-sectoral networks for referrals; monitoring and coordination of services of subsidised service providers
Provision of care facilities	Providing temporary shelter for affected persons; care centres for the infected; day-care facilities; integrated facilities, e.g. retirement homes, day-care centres, children's homes

funded by the government described its aim as being the "creation of early childhood stimulation activities for OVC". This aim is a significant deviation from the approach followed by the other CBOs. Third, the inherent assumption among all of the CBOs was that addressing poverty would have a positive impact on the overall well-being of OVC. Finally, the concept of *community development* was only present in the aim and objectives of one of the CBOs.

Lastly, the mental health results from the SDQ were compared with the activities expected of and/or performed by the CBOs (as discussed above). In the bivariate analysis, only three of the variables showed statistically significant positive relationships with the SDQ: access to medical services ($F = 6.28$, $p = 0.01$), total expenditure ($P = 0.10$, $p = 0.009$) and food expenditure as a percentage of total expenditure ($P = 0.12$, $p = 0.002$). In the multivariate linear regression analyses, only the percentage of expenditure on food and access to medical services were positively related ($p \leq 0.05$) to better health outcomes after controlling for gender and age (OVCs living in households that were more food secure and had access to healthcare had better mental health outcomes). In the first model, OVC who had access to medical services scored 1.09 less on the SDQ scale compared to OVC with no access to medical services ($p = 0.015$, 95% CI –1.96 – –0.21). In the second model, OVCs score on the SDQ increased by 0.03 for each additional percentage of expenditure that a household spent on food ($p = 0.002$, 95% CI 0.012–0.053) (see Table 3).

Table 3. Comparison of socio-economic indicators and mental health outcomes of OVC.

Indicator	%/N	Are the CBOs expected to address this/are they actually addressing it in reality?	Relationship with the mental health of OVC according to:		
			Bivariate analysis	Multivariate linear regression model 1	Multivariate linear regression model 2
Percentage of households receiving foster care grants	37	Yes	None	None	None
Percentage of children receiving child support grants	50	Yes	None	None	None
Percentage of children with adequate school uniforms (response provided by care giver)	45	Yes	None	None	None
Children with birth certificates	97	Yes	None (although this enables access to medical services)	None (although this enables access to medical services)	None (although this enables access to medical services)
Percentage of children with three meals per day	49.1	Yes, expected to add at least one meal per day	None	None	None
Percentage of children with four meals per day	44.6				
Percentage of households receiving more than 75% of their income from grants	60.0	Indirectly through promoting grant access and providing food to OVC	None	None	None
Average percentage of total expenditure spent on food	62.3	No	Yes	None	Yes
Average percentage of total expenditure spent on clothing	15.6	No	None	None	None

(*Continued*)

Table 3. (Continued).

Indicator	%/N	Are the CBOs expected to address this/are they actually addressing it in reality?	Relationship with the mental health of OVC according to:		
			Bivariate analysis	Multivariate linear regression model 1	Multivariate linear regression model 2
Percentage of children with access to medical services (as determined by care giver)	65.1	Yes	Yes	Yes	None
Mean household expenditure	R1253[2]	Indirectly through ensuring grant access	Yes	None	None
F score	n.a	n.a	n.a	2.52	3.91
P score	n.a	n.a	n.a	0.0569	0.0088
R^2	n.a	n.a	n.a	0.0118	0.0179
SDQ self-report ("Percentage normal")	15.7	n.a	n.a	n.a	n.a
SDQ self-report ("Percentage borderline")	20.7	n.a.	n.a.	n.a.	n.a.
SDQ self-report ("Percentage diagnosable")	63.6	n.a.	n.a.	n.a.	n.a.

Conclusion

Four main conclusions can be drawn from this study. First, it seems as if the government funding guidelines influence how CBOs position themselves – presumably to ensure that they obtain funding. Second, the word "assist" in the government guidelines suggests that the government sees CBOs mainly as helping the government carry out its own work. Third, very little mention of the mental health of OVC is made in either the government guidelines or the aims and objectives of the CBOs. To a large extent, the government guidelines seem to suggest that HIV & AIDS have resulted only in socio-economic problems that can be alleviated by ensuring that children and families have access to grants, food and clothing. Fourth, in contrast with other international research, cash transfers (in terms of grants) did not have a positive relationship with the mental health outcomes of the OVC, although there was a relationship between improved food security and mental health outcomes.

The limitations of the study include the fact that it was conducted in only one of the nine provinces of South Africa, the SDQ was the only instrument used to measure mental health and no cognitive testing or pilot testing of the SDQ was undertaken. Despite these limitations, the study provides valuable new information about the disconnection between the mental needs of orphans and the mandates and perceived functions of government-supported community-based organisations.

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Notes

1. The current study was approved by the IRB boards at the University of the Free State, the University of Stellenbosch and the University of Houston.
2. At the time of resubmission in June 2013, 1USD = R10.00.

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