

Going beyond 'islands of excellence'?

NGO scaling-up: possibilities, constraints & opportunities. Case study of a child welfare NGO, in the light of the HIV/AIDS epidemic in Southern Africa



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Abstract

During the last two decades, non-governmental organisations (NGOs) have enjoyed a period of unprecedented growth. Not only have they grown dramatically in terms of numbers and size, they have secured greater influence in international political, economic and social arenas. However, the contribution of NGOs to international development has generally remained limited. Since the early-1990s, there have been increasingly strong voices in the international development community calling for NGOs to increase their impact beyond a local level, i.e. to 'scale-up'.

Using the international SOS Children's Villages organisation as a case study, this dissertation considers the relationship between paths to scaling-up and organisational factors, especially organisational culture. Furthermore, this is looked at in the context of Southern Africa, where the need for SOS to scale-up is perhaps the greatest, given the immense challenges faced by children and young people (SOS' target group) in the wake of the HIV/AIDS epidemic. These challenges greatly overshadow the present impact of SOS projects.

The academic literature proposes various strategies for scaling-up. However, there is often little or no consideration of the impact of organisational issues upon an NGO's willingness and ability to follow such strategies. In the case of SOS, it can be seen that the organisational dimension has been a significant factor in the success of scaling-up strategies in the past, but imposes some constraints on the organisation's further scaling-up in the future.

The implications of this are considered, both in terms of the range of scaling-up options that are feasible for SOS and the wider academic debate on scaling-up. In particular, the need for SOS to have a more sensitive culture, that is adaptable and responsive to changes in the wider environment is explored; and the view that lobbying and advocacy for systemic change is the 'logical choice' for NGO scaling-up is questioned.

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Declaration

This dissertation is submitted in partial fulfilment of the requirements for the award of the degree of MSc in Development, Administration and Planning. It contains no plagiarism, has not been submitted in whole or part for the award of another degree, and is solely the work of Douglas Robert Reed.

Signed: _____
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Introduction

*Only a complacent organization would be content to continue with the same job in perpetuity when it is self-evident that its contribution is not more than a drop in the ocean, however excellent a drop it may be.*¹

IN the last few decades, non-governmental organisations (NGOs) have enjoyed unprecedented growth. In OECD countries alone, the number of registered development NGOs rose from 1600 in 1980, to more than 5800 by the end of 1998.² Moreover, OECD data indicates that the total funds disbursed to developing countries by and through these NGOs increased from \$2.8 billion in 1980, to \$8.8 billion in 1999.³ However, even these figures underestimate the real contribution of these NGOs to the funding of development efforts.⁴

NGO growth has been most striking in developing countries themselves, where there are now estimated to be at least 50,000 NGOs, plus hundreds of thousands of smaller grassroots organisations (GROs).⁵ For example, in Bangladesh, the number of registered NGOs grew from 45 in 1981, to 848 in 1997.⁶ This growth has been fuelled by the fact that northern

¹ J. Clark, *Democratizing Development: The Role of Voluntary Organizations* (London: Earthscan, 1991), p.83.

² OECD, *Directory of Non-Governmental Organisations in OECD Member Countries Active in Sustainable Development, Part II: Australia, Canada, Japan, Korea, New Zealand, United States* (Paris: OECD, 1998); OECD, *Directory of Non-Governmental Organisations in OECD Member Countries Active in Sustainable Development, Part I: Europe* (Paris: OECD, 1996); P. Streeten, 'Nongovernmental organizations & development', *The Annals of the American Academy (AAPSS)*, no.554, November 1997, pp.194-195.

³ OECD, 2000 Development Cooperation Report (Paris: OECD, 2000), statistical annex: table 14; personal correspondence with OECD Development Assistance Committee, dated July 20, 2001; Streeten, 'NGOs & development', p.195.

⁴ OECD data underestimates actual flows, because: (a) It is based on figures provided by bilateral donors and ignores aid channelled through NGOs by multilateral donors; (b) Some bilateral donors, notably the United States, do not report contributions to NGOs or funds channelled through NGOs; (c) the data does not include NGOs' local income in developing countries, including direct funding bilateral donors; (d) contributions of voluntary resources, such as staff working in developed countries or mobilisation of community resources in developing countries, are not recognised. See: Overseas Development Institute, 'NGOs & official donors', *ODI Briefing Paper*, no.4, August 1995; personal correspondence with OECD Development Assistance Committee, dated July 20, 2001; L.D. Brown, 'Nongovernmental organisations as development catalysts', *Institute for Development Research Reports*, vol.9, no.1 (1992), p.1.

⁵ Streeten, 'NGOs & development', p.197.

⁶ C.Brazier, 'Building up the poor or reinforcing inequality?', *New Internationalist*, no.332, March 2001.

NGOs have increasingly sought local partners to implement projects. Furthermore, as the number and capacity of southern NGOs has grown, official donors have increased direct funding.⁷

As well as growing in number and size, NGOs have secured greater influence in international political, economic and social arenas. This has been evidenced by the impact of NGOs at various international forums, such as the 1995 World Conference on Women in Beijing, the 1995 Social Summit in Copenhagen, and the 1994 Population Summit in Cairo.⁸

Despite this growth and influence, the contribution of NGOs to international development has been limited. It has been estimated that, at best, NGOs benefit only 20% (250 million) of poor people in the developing world.⁹ For example, the Grameen Bank and the Bangladesh Rural Advancement Committee, which are often cited as model NGOs and even referred to as “local heroes”, reach less than 20% of landless families in Bangladesh.¹⁰

Typically, NGO activities start with a small project, to address a specific need of a particular group of people. Thus, their impact is usually highly localised, and, all too often, not sustainable. Even where projects are successful, this usually remains on a small scale in comparison with the scale of the wider challenges of social and economic development, and much smaller than that of government development activities.¹¹ Moreover, the structures and systems that underpin prevailing social and economic inequalities largely remain intact. In the words of Uvin *et al.*:

...scaling-up, i.e. the expansion of NGO impact beyond local level, has become an important issue. In the absence of scaling-up, NGO successes remain little more than islands of

⁷ Official donors include governments, multilateral and international government agencies. See ODI, ‘NGOs & official donors’, pp.3-4.

⁸ J.L. Fernando & A.W. Heston, ‘NGOs between states, markets, & civil society’, *The Annals of the American Academy (AAPSS)*, no.554, November (1997), p.8, pp.12-13.

⁹ A. Chowdhury, ‘Local heroes’, *New Internationalist*, no.332, March 2001, at <http://www.oneworld.org/ni/issue332/local.htm>, accessed on August 10, 2001.; Streeten, ‘NGOs & development’, p.197.

¹⁰ Streeten, ‘NGOs & development’, p.197.

¹¹ M. Edwards & D. Hulme, *Making a Difference: NGOs & Development in a Changing World* (London: Earthscan, 1992), p.14; P. Uvin, ‘Fighting hunger at the grassroots: paths to scaling-up’, *World Development*, vol.23, no.6 (1995), p.1409.

*excellence in a wider economic and institutional environment which is detrimental to the poor.*¹²

Since the early-1990s, there have been increasingly strong voices in the international development literature calling for NGOs to scale-up, and move beyond such “islands of excellence”.¹³

The academic literature suggests a number of paths that may be taken to scaling-up. These include ‘additive’ strategies, which involve expansion of an organisation’s size or programmes, and ‘multiplicative’ strategies, which involve working with and/or through other actors in the development arena.¹⁴ A clear implication of much of the literature is that the only meaningful route to scaling-up is through multiplicative strategies, in particular lobbying and advocacy for systemic change. In this light, it would seem to be the logical choice for scaling-up.

However, not all strategies are necessarily feasible for all NGOs and an organisation’s choice of strategies may be affected by various organisational issues, such as culture. Despite this, there is often little or no consideration of the impact of organisational factors such as culture upon an NGO’s willingness or ability to follow such strategies. Within the NGO literature, few writers have studied the links between organisational issues and scaling-up strategies, and, what research there is, has largely been confined to the study of UK NGOs.¹⁵

¹² P. Uvin, P.S. Jain & L.D. Brown, ‘Think large & act small: toward a new paradigm for NGO scaling-up’, *World Development*, vol.28, no.8 (2000), p.1409.

¹³ M. Morgan, ‘Stretching the development dollar: the potential for scaling-up’, *Grassroots Development*, vol.14, no.1 (1990), pp.2-11; Clark, *Democratizing Development*; M. Edwards & D. Hulme, ‘Scaling-up NGO impact on development: learning from experience’, *Development in Practice*, vol.2, no.2 (1992), pp.77-91; Edwards & Hulme, *Making a Difference*; Uvin, ‘Fighting hunger at the grassroots’; Uvin, *et al.*, ‘Think large & act small’; P.S. Jain, P. Uvin & L.D. Brown, ‘Scaling-up the impact of NGO programs’, *Institute for Development Research Reports*, vol.16, no.6 (2000).

¹⁴ Edwards & Hulme, ‘Scaling-up NGO impact on development’; Edwards & Hulme, *Making a Difference*; F. Wils, ‘Scaling-up, mainstreaming & accountability: the challenge for NGOs’, in M.Edwards & D.Hulme (eds) *Beyond the Magic Bullet: NGO Performance & Accountability* (London: Earthscan, 1995); Howes & Sattar, ‘Bigger & better?’.

¹⁵ D. Lewis, *Bridging the Gap?:The Parallel Universes of the Non-Profit & Non-Governmental Organisation Research Traditions & the Changing Context of Voluntary Action*, CVO International Working Paper No.1 (London: Centre for Voluntary Organisation, London School of Economics), p.3, at <http://www.lse.ac.uk/Depts/ccs/int-work-papers.htm>, accessed July 13, 2001; D. Billis & J. MacKeith, ‘Growth & Change in NGOs: concepts & comparative experience’, in Edwards & Hulme, *Making a Difference*; C. Dolan, ‘British development NGOs & advocacy in the 1990s’, in Edwards & Hulme, *Making a Difference*; A. Norrell, *Bridging Gaps or ‘a Bridge Too Far’? The Management of Advocacy within Service Providing NGOs in the UK*, CVO International Working Paper No.3 (London: Centre for Voluntary Organisation, London School of Economics), p.12, at <http://www.lse.ac.uk/Depts/ccs/int-work-papers.htm>, accessed July 13, 2001

One of the largest child welfare NGOs in the world is the international SOS Children's Villages organisation (or SOS-Kinderdorf International). Currently, SOS is operating 1492 projects in 131 countries around the world; including 423 SOS Children's Villages, plus 476 educational facilities, 150 social centres, 62 medical centres and 9 emergency relief programmes.¹⁶ The main focus of SOS' work is orphaned and abandoned children.

SOS provides an interesting subject for a case study on scaling-up, not only because of its size, but also from the perspective of other organisational factors. Firstly, it is based in the German-speaking world, being founded in Austria and having its headquarters there. Whereas, the academic literature on scaling-up draws mainly on the experience of NGOs based in English-speaking countries, notably Bangladesh, India and Britain.¹⁷ Secondly, SOS' operations are strongly based on a specific model, the *SOS Children's Village model*. As the 'core' project of the organisation, other activities are usually only considered where they provide some kind of support to the operation of SOS Children's Villages. Finally, and related to the two previous points, SOS' organisational culture has strengthened its adherence to the SOS model and reinforced its tendency to remain relatively closed to trends in development thinking, such as participation and scaling-up.

Using SOS as a case study, this dissertation considers the relationship between paths taken to scaling-up and the organisational dimension, particularly organisational culture. Furthermore, this is looked at in the context of Southern Africa, where the need for SOS to scale-up is perhaps the greatest, given the challenges faced by children and young people in the wake of the HIV/AIDS epidemic.

For the purposes of this study, 'Southern Africa' is taken to include Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe.¹⁸

¹⁶ As at March 2001. Figures taken from, SOSKinderdorf International, 'SOS Children's Villages Today', at <http://www.sos-kd.org/who/statistics/index.htm>, accessed on July 18, 2001.

¹⁷ For example, Bangladeshi NGOs, see: Clark, *Democratizing Development*, pp.95-96, 98-100, 104-109. Indian NGOs, see: Uvin, *et al.*, 'Think large & act small'; Jain, *et al.*, 'Scaling-up the impact of NGO programs'; Clark, *Democratizing Development*, pp.100, 109-110, 113-114, 130-133. British NGOs, see: Billis & MacKeith, 'Growth & Change in NGOs'; Dolan, 'British development NGOs & advocacy in the 1990s'.

¹⁸ It should be noted that this definition excludes the islands of Madagascar and Mauritius, which are defined by SOS' organisational structure as part of Southern Africa. Within SOS' organisational structure, its operations are divided between its Regional Office for Southern Africa I (covering Botswana, Madagascar, Malawi, Mauritius, Mozambique, Zambia and Zimbabwe) and its Regional Office for Southern Africa II (covering Angola, Lesotho, Namibia, South Africa

Furthermore, 'children' are defined as those below 15 years of age, and 'young people' as those of 15-24 years of age.¹⁹ While it can be argued that concepts of childhood and young adulthood cannot be tied to specific ages, as they are inherently culture-bound and the pace of development of each individual person is unique, it is useful to make such distinctions for the purposes of situation analysis and policy planning.

At the beginning of this dissertation, the context is set, with an overview of the HIV/AIDS pandemic, with particular reference to the epidemic in Southern Africa. The effects on children and young people are highlighted, as well as SOS' current responses to their needs.

Chapter three outlines possible routes that SOS could take to scaling-up. Paths identified in the academic literature are summarised and SOS' experience of scaling-up is reviewed. Chapter four considers the compatibility of these various paths with SOS' organisational culture, and, as a result, which kinds of strategies are likely to be feasible for SOS.

Chapter five looks at the experience of other actors in the development arena, in terms of their responses to the needs of children and young people affected by the HIV/AIDS epidemic.

Based on the preceding chapters, a menu of feasible options for scaling-up by SOS in Southern Africa is then presented in chapter six, along with responses that have already been planned.

Finally, in the conclusion, the implications for scaling-up throughout the SOS organisation are considered. While organisational culture has been a factor in the past success of SOS' scaling-up efforts, it may actually be a constraint on further scaling-up. Some scaling-up strategies, such as lobbying and advocacy, may even be prohibited. Nevertheless, other strategies may be more feasible, as indicated by the direction taken by SOS in some countries.

and Swaziland). See, SOS-Kinderdorf International *Directory of all SOS Children's Village Facilities: 2000/2001* (Innsbruck: SOS-Kinderdorf, 2000), pp.28-29.

¹⁹ Such definitions are used by major institutions within the international development community, including UNAIDS, UNICEF, & USAID. See: UNAIDS/WHO, *AIDS Epidemic Update: December 2000* (Geneva: UNAIDS, 2000), p.3; UNICEF, *The Progress of Nations 2000* (New York: UNICEF, 2000), pp.4-5; S. Hunter & J. Williamson, *Children on the Brink, 2000: Executive Summary: Updated Estimates & Recommendations for Intervention* (Washington DC: United States Agency for International Development, 2000), p.25.

Moreover, wider lessons are drawn from this case study, about the importance of the organisational dimension to scaling-up and how this affects the choice of paths that can be taken by NGOs. It could be that, for some NGOs, the 'logical choice' of scaling-up strategies is not lobbying and advocacy.

The need for scaling-up: HIV/AIDS & SOS Children's Villages in Southern Africa

Chapter

2

BY the end of 2000, 57.9 million people worldwide had been infected with HIV and 21.8 million had since died due to AIDS.²⁰ Despite being home to only 10% of the world's population, sub-Saharan Africa alone has accounted for more than 75% of AIDS deaths and is home to almost 70% of adults living with HIV/AIDS; 80% of children living with HIV/AIDS; and 95% of AIDS orphans.²¹ As declared at the end of the first UN General Assembly special session on HIV/AIDS:

*...Africa, in particular sub-Saharan Africa, is currently the worst affected region where HIV/AIDS is considered as a state of emergency, which threatens development, social cohesion, political stability, food security and life expectancy and imposes a devastating economic burden and that the dramatic situation on the continent needs urgent and exceptional national, regional and international action.*²²

The greatest challenges lie in Southern Africa. According to UNAIDS, 1-in-3 adults are infected in Botswana; 1-in-4 adults in Swaziland and Zimbabwe; 1-in-5 adults in Lesotho, Namibia, South Africa and Zambia; and 1-in-6 adults in Malawi.²³ In particular, South Africa is home to the world's largest population of people living with HIV/AIDS, with 4.8 million people infected, and has one of the fastest growing epidemics in the world.²⁴

²⁰ UNAIDS/WHO, *AIDS Epidemic Update: December 2000*, p.3.

²¹ C. Akukwe, 'HIV/AIDS in African children: a major calamity that deserves urgent global attention', *Journal of HIV/AIDS Prevention & Education for Adolescents & Children*, vol.3, no.3 (1999), p.5; G. Foster & J. Williamson, 'A review of current literature on the impact of HIV/AIDS on children in sub-Saharan Africa', *AIDS*, vol.14, suppl.3 (2000), p.S275; UNAIDS/WHO, *AIDS Epidemic Update: December 2000*, p.5.

²² United Nations General Assembly, *Declaration of Commitment on HIV/AIDS: "Global Crisis—Global Action"*, June 27, 2001, at <http://www.un.org/ga/aids/coverage/FinalDeclarationHIV/AIDS.html>, accessed on July 5, 2001.

²³ Hunter & Williamson, *Children on the Brink*, 2000, p.4; UNAIDS/WHO, *Epidemiological Fact Sheet on HIV/AIDS & Sexually Transmitted Infections, 2000 Update: Malawi*, p.3, at http://www.unaids.org/hivaidsinfo/statistics/june00/fact_sheets/pdfs/malawi.pdf.

²⁴ Department of Health, *National HIV & Syphilis Sero-Prevalence Survey of Women Attending Public Antenatal Clinics in South Africa 2000*, at <http://doh.gov.za/docs/index.html> accessed on August 1, 2001; UNAIDS, *Fact Sheet: HIV/AIDS in Africa* (UNAID, 2000), at http://www.unaids.org/fact_sheets/files/FS_Africa.htm, accessed on July 4, 2001.

Unlike other regions of the world, the majority (80% -90%) of adult infections in sub-Saharan Africa have resulted from unprotected heterosexual sex.²⁵ Consequently, women and children have been more severely affected in Africa than elsewhere. Only in Africa are the majority (55%) of adult infections among women.²⁶ Furthermore, as adult infections are greatest amongst young adults, who are at their biological reproductive peak, there is massive vertical mother-to-child transmission.²⁷ Moreover, if one parent is infected, it is likely that the other shall also be infected, and children are likely to become orphans.²⁸

This has devastating implications for SOS' target group, namely children and young people. Three main challenges affecting this group, being infant and child mortality, orphanhood, and infection amongst young people.

The effects on children & young people

Infant & Child mortality

Since the AIDS pandemic began, 5.7 million children have been infected with HIV and in 90% of cases this has been through mother-to-child transmission, either during pregnancy, labour, childbirth or breastfeeding.²⁹ Overall, mother-to-child transmission accounts for 15% of infections in sub-Saharan Africa.³⁰

Where no antiretroviral drugs such as *zidovudine* (AZT) are administered and mothers breastfeed their children, UNAIDS estimates indicate an infection rate for infants of 30%-35%.³¹ It has further been estimated that, without breastfeeding, this rate may be reduced to 20%, and that where the mother and newborn infant take AZT, the infection rate may be

²⁵ J.D. Stratigos & E. Tzala, 'Global epidemiology of HIV infection & AIDS', *Clinics in Dermatology*, no.18 (2000), p.382.

²⁶ UNAIDS/WHO, *AIDS Epidemic Update: December 2000*, p.5.

²⁷ M.L. Daniel, 'The demographic impact of HIV/AIDS in sub-Saharan Africa', *Geography*, vol.85, no.1 (2000), p.46; H. Barrett, 'Six billion & counting: trends & prospects for global population at the beginning of the twenty-first century', *Geography*, vol.85, no.2 (2000), p.113.

²⁸ Daniel, 'The demographic impact of HIV/AIDS in sub-Saharan Africa', p.46.

²⁹ UNAIDS/WHO, *AIDS Epidemic Update: December 2000*, p.3; R. Moy, 'Caring for children orphaned by AIDS', *Journal of Tropical Pediatrics*, vol.45, April (1999), p.64; Stratigos & Tzala, 'Global epidemiology of HIV infection & AIDS', p.381; UNICEF, *The Progress of Nations 2000* (New York: UNICEF, 2000), p.9.

³⁰ Barrett, 'Six billion & counting', p.113.

³¹ UNAIDS estimate, cited in: J. Adetunji, 'Trends in under-5 mortality rates & the HIV/AIDS epidemic', *Bulletin of the World Health Organization*, vol.78, no.10 (2000), pp.1200-1201.

further reduced to 9%-10%.³² However, in sub-Saharan Africa, breastfeeding is the norm, infant formula feeds are unaffordable to most mothers, and antiretroviral therapy has not only been too expensive for most developing countries but also difficult to administer.³³ In much of Southern Africa, including Botswana, Swaziland and four of the nine provinces of South Africa, about 30%-35% of pregnant women are HIV-infected. Without antiretroviral treatment 1-in-10 babies can be expected to be infected with HIV.³⁴

Figure 1 shows the estimated impact of HIV/AIDS on under-5 mortality rates in four countries in 2010.³⁵ It is estimated that the median age of death for an HIV-infected child in Africa is about 2 years and that 90% of cases will die by the age of 5 years,³⁶ significantly worse than in developed countries.³⁷

In addition to HIV-infection, HIV/AIDS may affect infant and child mortality in other ways.³⁸ For instance, many HIV-negative children may die because resources required to ensure their health care have been diverted to care for HIV-infected people. Also, the social and economic consequences of living in HIV/AIDS-affected households can affect children's health.

³² R. Baggaley & D. Needham, 'Africa's emerging AIDS-orphan crisis', *Canadian Medical Association Journal*, no.156 (1997), p.875; UNAIDS, *Questions & Answers: mother-to-child transmission (MTCT) of HIV, 5 August 1999*, at <http://www.unaids.org/publications/documents/mtct/qaweb99.html>, accessed on September 9, 2001.

³³ Stratigos & Tzala, 'Global epidemiology of HIV infection & AIDS', p.383, 386; G.D. Hussey, *et al.*, 'Survival of children in Cape Town known to be vertically infected with HIV-1', *South African Medical Journal*, vol.88, no.5 (1998), p.557.

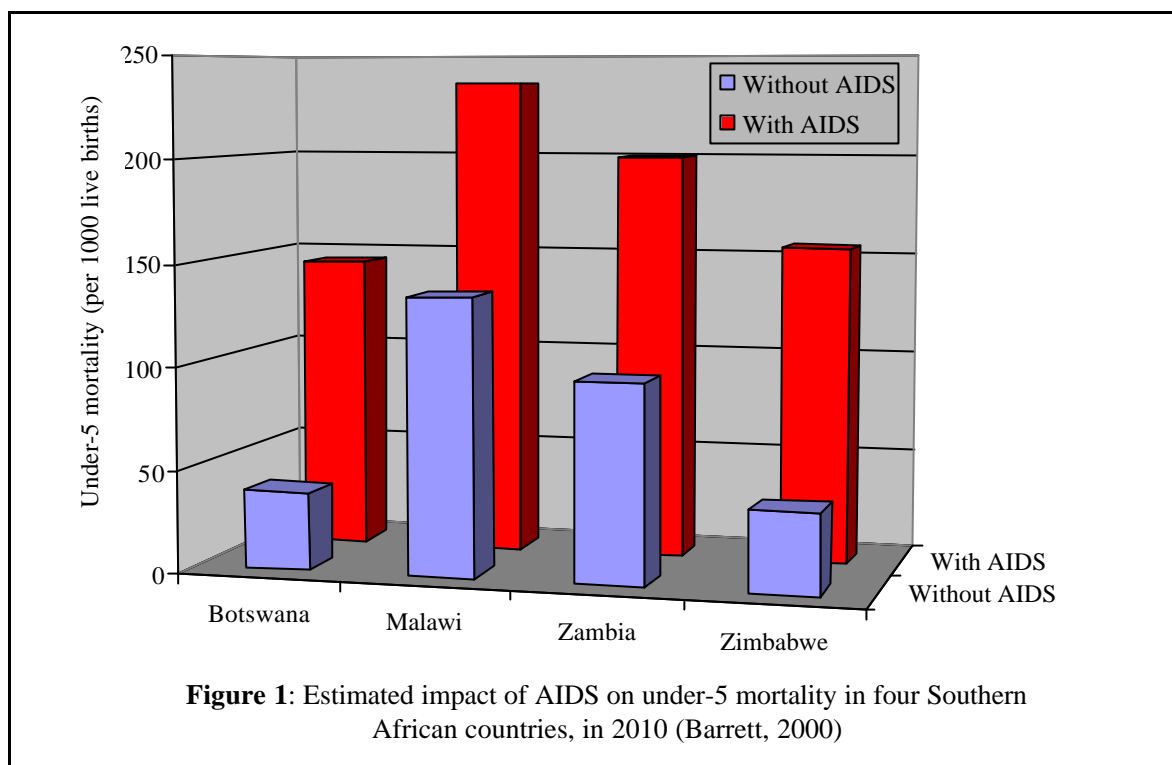
³⁴ Includes South African provinces of KwaZulu-Natal, Mpumalanga, Gauteng and Free State. See: Dept of Health, *National HIV & Syphilis Sero-Prevalence Survey of Women Attending Public Antenatal Clinics in South Africa 2000*; UNAIDS/WHO, *Epidemiological Fact Sheet on HIV/AIDS & Sexually Transmitted Infections, 2000 Update: Botswana*, p.4; UNAIDS/WHO, *Epidemiological Fact Sheet on HIV/AIDS & Sexually Transmitted Infections, 2000 Update: Swaziland*, p.4.

³⁵ Barrett, 'Six billion & counting', p.114.

³⁶ Adetunji, 'Trends in under-5 mortality rates & the HIV/AIDS epidemic', p.1201. Although studies in some countries, including South Africa, have indicated median survival of about 4 years, see: Hussey, *et al.*, 'Survival of children in Cape Town known to be vertically infected with HIV-1', p.557.

³⁷ In a study in Italy, 70% of HIV-infected infants were alive at 6 years and 50% at 9 years. A study in the United States estimated that an HIV-infected infant had a 75% chance of surviving to 5 years of age. See: Hussey, *et al.*, 'Survival of children in Cape Town known to be vertically infected with HIV-1', p.557.

³⁸ Adetunji, 'Trends in under-5 mortality rates & the HIV/AIDS epidemic', pp.1200, 1204.



Orphans

The US Census Bureau estimates that 15.6 million children in developing countries have lost their mother or both parents, many due to AIDS.³⁹ Moreover, if children who have lost their father are included, the number of orphans is 34.7 million. Of these children, 30.4 million (88%) are in sub-Saharan Africa.

By 2010, it has been further estimated that in these sub-Saharan African countries alone, 39.8 million children will have lost one or both parents.⁴⁰ More than 10 million of these orphans shall be in Southern African countries (see Figure 2).⁴¹ This being the case, between 20%-37% of children in these countries shall be orphans (see Figure 3). Such figures represent an enormous increase in the orphan population considering that, before HIV/AIDS, only about 2% of children in developing countries were orphaned.⁴²

³⁹ Including 26 sub-Saharan African countries, 3 Asian countries, and 5 Latin American and Caribbean countries. See: Hunter & Williamson, *Children on the Brink, 2000*, p.1.

⁴⁰ Hunter & Williamson, *Children on the Brink, 2000*, appendix 1: statistical tables.

⁴¹ Data for figures 1 and 2 extracted from, Hunter & Williamson, *Children on the Brink, 2000*, appendix 1.

⁴² UNICEF/UNAIDS, *Children Orphaned by AIDS: Front-line Responses from Eastern & Southern Africa* (New York: UNICEF, 1999), p.3.

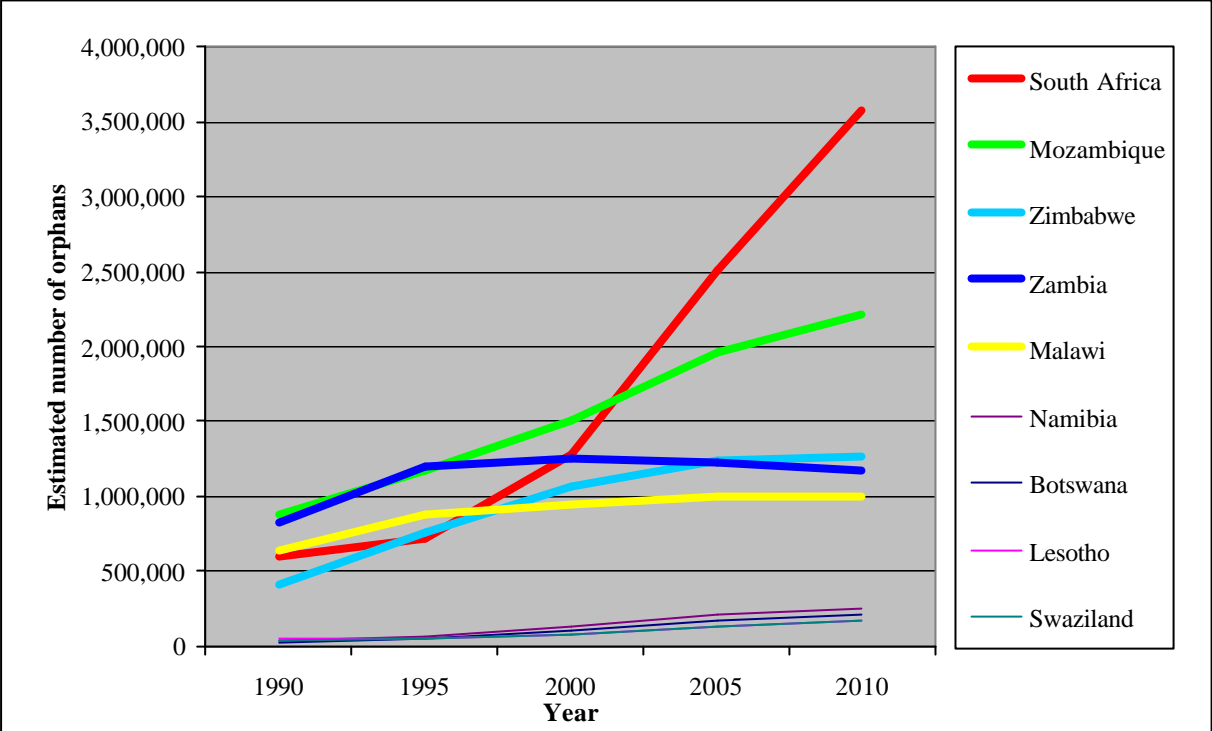


Figure 2: Estimated number of orphans in Southern African countries, 1990-2010.

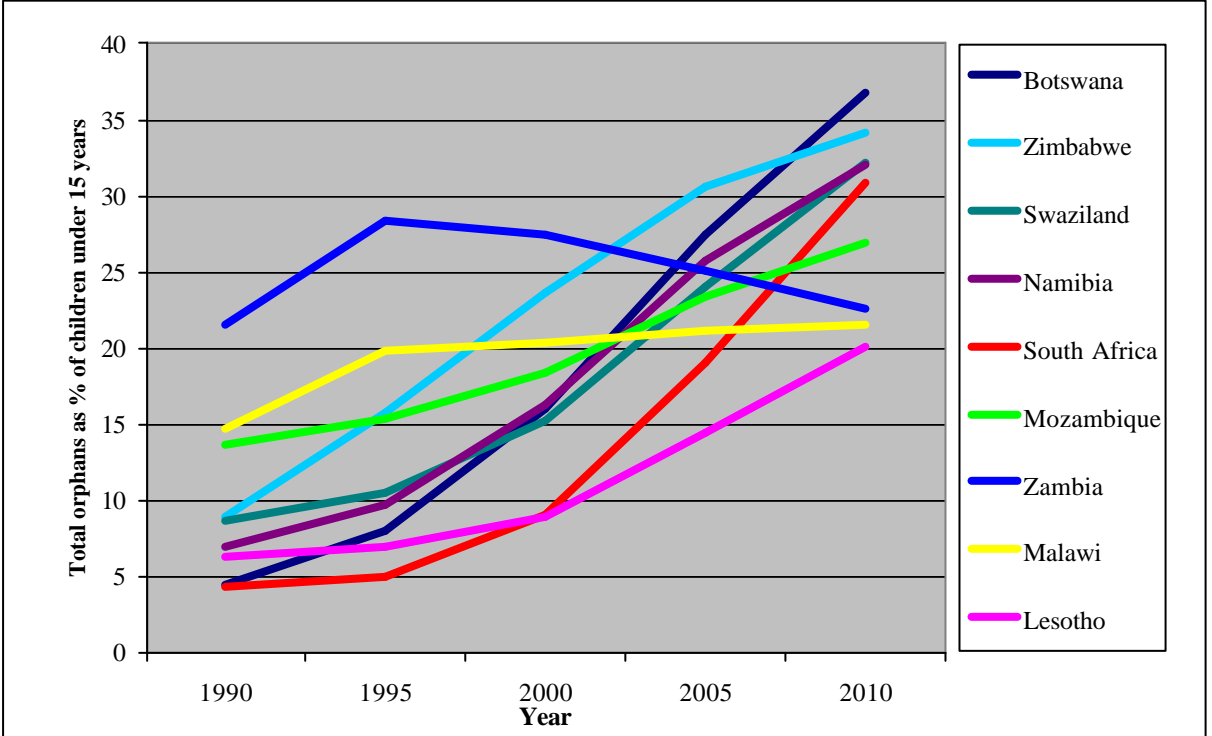


Figure 3: Estimated number of orphans as a percentage of children under 15 years of age, 1990-2010.

For children orphaned in the wake of HIV/AIDS, the effects are particularly devastating and

are felt even before their parents die. As their parent becomes symptomatic and fall ill more frequently, children often have to take on new responsibilities, such as household chores, childcare, tending livestock, cultivating fields and/or income-generating activities.⁴³ Children (particularly girls) may even be called upon to act as care-giver to their parent, accompanying them for medical treatment, administering medicine, feeding, dressing, bathing, cleaning up vomit and diarrhoea, and toileting.⁴⁴ As their parent becomes increasingly sick, children may be forced to dropout of school, so that they can either care for the parent, look after siblings, contribute to earning money for medical expenses, or simply because there is no longer enough household income to pay school expenses. When they do attend school, the emotional stress placed upon them is often so great that it is manifested in lack of attendance and behavioural problems.⁴⁵

Once orphaned, the children's predicament invariably worsens. This is exacerbated where parents made no plans to ensure that their children would be adequately cared for after their death. Unfortunately, in Africa, cultural taboos often preclude talking openly about the prospect of death.⁴⁶ Furthermore, children may be denied their rightful inheritance through 'property grabbing', as a result of traditional inheritance practices, or simply by the relatives or neighbours who take responsibility for the children.⁴⁷

Traditionally, most orphans in sub-Saharan Africa have been accommodated within the extended family network, usually by uncles and aunts, but if unavailable then by grandparents. A South African study found that more than 90% of orphans were cared for by extended family.⁴⁸ However, the scale of the current orphan crisis is stretching this traditional social safety net to breaking point.⁴⁹ The capacity of the extended family to provide care and support for these children is being undermined by the overwhelming number of orphans; the diminishing number of potential care-givers; the urbanisation of populations and the move

⁴³ Foster & Williamson, 'A review of current literature on the impact of HIV/AIDS on children in sub-Saharan Africa', p.S278.

⁴⁴ E. Robson, 'Invisible carers: young people in Zimbabwe's home-based healthcare', *Area*, vol.32, no.1 (2000), pp.59-69.

⁴⁵ Baggaley & Needham, 'Africa's emerging AIDS-orphans crisis', p.874.

⁴⁶ Foster & Williamson, 'A review of current literature on the impact of HIV/AIDS on children in sub-Saharan Africa', pp.S278-S279.

⁴⁷ Foster & Williamson, 'A review of current literature on the impact of HIV/AIDS on children in sub-Saharan Africa', pp.S278-S279; Hunter & Williamson, *Children on the Brink*, 2000, pp.4-5; UNICEF/UNAIDS, *Children Orphaned by AIDS*, p.5.

⁴⁸ Nelson Mandela Children's Fund, *Report on: A Study into the Situation & Special Needs of Children in Child-Headed Households* (Johannesburg: NMCF, 2001), p.13.

⁴⁹ J.B.K. Rutayuga, 'Assistance to AIDS orphans within the family/kinship system & local institutions: a program for East Africa', *AIDS Education & Prevention*, suppl., Fall (1992), pp.57-68; Foster & Williamson, 'A review of current literature on the impact of HIV/AIDS on children in sub-Saharan Africa', p.S279; UNICEF/UNAIDS, *Children Orphaned by AIDS*, p.3.

towards nuclear family structures; the erosion of traditional values underpinning extended family networks; widespread unemployment, and poverty.⁵⁰ As expressed by Moy:

*...the enormity of the problem has given rise to doubts about the extended family's ability to cope particularly when confronted with images of elderly grandmothers looking after a dozen grandchildren.*⁵¹

Grandparents may be seen as the care-giver of last resort, and the increasing extent to which they are being called upon to act as care-giver indicates the magnitude of the problem. The fact that they are caring for the children often means that they have already lost their own economic support system, namely their sons and daughters.⁵² Not only are grandparents often less economically productive, they are likely to be less educated and may therefore be ignorant of good nutrition and health care practices. Moreover, given their age and health status, they may not be able to provide long-term care, and their death may leave nobody within the extended family willing to take care of the children. Siblings may also be separated, to spread the burden of care amongst relatives.⁵³ In the absence of willing relatives, or if children resist being separated, the children may have to take care of themselves. While child-headed households are still relatively few, they are becoming increasingly common⁵⁴ In South Africa, census data indicates there are 95,963 child-headed households.⁵⁵

Regardless of care-giver, the children's workload usually increases, whether from economic necessity of survival or exploitation by care-givers.⁵⁶ Extra household responsibilities usually fall disproportionately on girls. Where agricultural tasks are taken over by children they are frequently unable to cope. A study in Namibia found that orphans left with livestock often

⁵⁰ NMCF, *A Study into the Situation & Special Needs of Children in Child-Headed Households*, p.37; Rutayuga, 'Assistance to AIDS orphans within the family/kinship system & local institutions', p.60.

⁵¹ R. Moy, 'Caring for children orphaned by AIDS', *Journal of Tropical Pediatrics*, vol.45, April (1999), p.64.

⁵² G. Foster, *et al.*, 'Orphan prevalence & extended family care in a peri-urban community in Zimbabwe', *AIDS Care*, vol.7, no.1 (1995), p.400.

⁵³ Foster & Williamson, 'A review of current literature on the impact of HIV/AIDS on children in sub-Saharan Africa', pp.S280-S281.

⁵⁴ NMCF, *Report on: A Study into the Situation & Special Needs of Children in Child-Headed Households*, p.13; G. Foster, *et al.*, 'Supporting children in need through a community-based orphan visiting programme', *AIDS Care*, vol.8, no.4 (1996), p.399.

⁵⁵ The Office on the Rights of the Child, *Children in 2001: A Report on the State of the Nation's Children* (Pretoria: Office on the Rights of the Child, The Presidency, 2001), p.57.

⁵⁶ Foster & Williamson, 'A review of current literature on the impact of HIV/AIDS on children in sub-Saharan Africa', p.S280.

lacked knowledge and experience to care for them properly, with the result that many animals died.⁵⁷ Siblings may be separated where older children leave home to find employment, as farm labourers, in urban areas, or as domestic workers. Girls may even be pressured into prostitution or early marriage, to provide income for their siblings. A recent South African study, reported cases of early marriage by teenage girls and children as young as 8 years of age resorting to prostitution.⁵⁸

As one would expect, orphans are less likely to attend school than other children. For example, in Mozambique, only 24% of orphans attend school, compared to 68% of other children; in Zambia, 65% of orphans and 78% of other children; in Zimbabwe 65% of orphans and 77% of other children.⁵⁹ Children may dropout of school either to care for sick relatives, to take on household or agricultural responsibilities, to seek employment, or due to lack of funds. Care-givers may even prioritise available funds, choosing to send their own children to school, rather than the orphans in their care.⁶⁰

Orphaned children are also at greater risk of poor health and nutrition. This may be because they lack sufficient means to provide for an adequate diet or required medical treatment; their care-giver, especially when elderly or an adolescent themselves, maybe ignorant of good health and nutrition practices; or, care-givers may simply neglect their health care, assuming that any health problem is HIV-related and therefore untreatable.⁶¹

Furthermore, orphans have a higher risk of HIV infection, given that they are likely engage in sexual activity from an earlier age than other children.⁶² This may be because they seek emotional comfort through sexual relationships; through lack of parental guidance and supervision; peer pressure; financial desperation, turning to prostitution; or, even sexual abuse by relatives, teachers or strangers.

⁵⁷ UNAIDS/WHO, *AIDS Epidemic Update: December 2000*, pp.13-14.

⁵⁸ NMCF, *Report on: A Study into the Situation & Special Needs of Children in Child-Headed Households*, pp.21, 26.

⁵⁹ UNICEF, *The Progress of Nations 2000*, p.30.

⁶⁰ UNICEF/UNAIDS, *Children Orphaned by AIDS*, pp.4-5.

⁶¹ Foster & Williamson, 'A review of current literature on the impact of HIV/AIDS on children in sub-Saharan Africa', p.S281; UNICEF/UNAIDS, *Children Orphaned by AIDS*, pp.4, 5; Hunter & Williamson, *Children on the Brink, 2000*, p.8.

⁶² A study in Uganda revealed that orphans experienced sexual debut at an earlier age, with 30% of orphaned girls sexually active at 12 years of age and 85% by 18 years of age, see: Foster & Williamson, 'A review of current literature on the impact of HIV/AIDS on children in sub-Saharan Africa', p.S282. Also, see: UNICEF, 'The effects of HIV/AIDS on early childhood', in *The State of the World's Children 2001* (UNICEF, 2000), at <http://www.unicef.org/sowc01/>, accessed on July 24, 2001; UNICEF/UNAIDS, *Children Orphaned by AIDS*, p.5;.

Beyond physical health concerns, orphans have to cope with the psycho-social impact of AIDS.⁶³ Their sense of loss, sorrow and grief is likely to begin long before their parent(s) dies. After experiencing the tragedy of their parent's death, their stress and trauma may be compounded by the change of care-giver; change of friends; increased workload; dropping out of school; loss of property; and social isolation due to stigmatisation.⁶⁴ When cared for by an elderly relative, children may re-experience the tragedy of death. The psychological reaction of orphans to their circumstances tends to be internalised and exhibited through such behaviour changes as low self-esteem, anxiety and depression.⁶⁵ Unfortunately, this means the psychological impact on these children may simply go unnoticed.

In addition to children whose parents have died, there are *social orphans*, whose parents have abandoned them.⁶⁶ Such parents may abandon their children in response to the future prospects of having full-blown AIDS, possibly due to fear of being unable to generate sufficient income for their children's upbringing; fear of the stigma that may surround the children when it becomes obvious to others that their parents have HIV/AIDS; fear of burdening their children with the responsibility of caring for the ill and dying; and/or may be fear of causing their children grief in death. Clearly, the reasons may be many, and, given the nature of abandonment, are little understood. Nevertheless, once abandoned, these children are likely to face many of the same problems as 'true' orphans.

Young people

UNAIDS estimates that:

*In the eight African countries where at least 15% of today's adults are infected, conservative analyses show that AIDS will claim the lives of around a third of today's 15-year olds.*⁶⁷

⁶³ UNICEF/UNAIDS, *Children Orphaned by AIDS*, p.5; Foster & Williamson, 'A review of current literature on the impact of HIV/AIDS on children in sub-Saharan Africa', p.S282.

⁶⁴ NMCF, *Report on: A Study into the Situation & Special Needs of Children in Child-Headed Households*, p.22.

⁶⁵ Foster & Williamson, 'A review of current literature on the impact of HIV/AIDS on children in sub-Saharan Africa', p.S282.

⁶⁶ UNICEF/USAID, *Eastern & Southern African Workshop on Orphans & Vulnerable Children: November 5-8, 2000*, at <http://www.unicef.org/programme/hiv/workshop.pdf>, accessed on July 10, 2001.

⁶⁷ UNAIDS/WHO, *AIDS Epidemic Update: December 2000*, p.11.

These countries are Botswana, Lesotho, Malawi, Namibia, South Africa, Swaziland, Zambia and Zimbabwe. Furthermore, Mozambique is close behind, with adult prevalence of 13.22%.⁶⁸

In Botswana and South Africa in particular, it is further estimated that:

*..today's 15-year olds have a greater than 50% chance of dying of HIV-related causes if current infection rates are not cut dramatically.*⁶⁹

This is especially disturbing given the fact that about half of the population of most Southern African countries is under 15 years of age.

Not surprisingly, these same countries occupy the top eight positions in UNICEF's *league table* of estimates for the proportion of 15-24 years olds living with HIV/AIDS.⁷⁰ In Botswana, more than 1-in-3 young women and 1-in-7 young men are HIV-infected; in Lesotho, South Africa and Zimbabwe, 1-in-4 young women and 1-in-10 young men; in Namibia and Zambia, about 1-in-5 young women and 1-in-10 young men; in Malawi and Mozambique, about 1-in-7 young women and 1-in-14 young men.

Beyond young adulthood, average life expectancy in these countries is being significantly reduced by HIV/AIDS. By 1998, life expectancy in Botswana, Malawi, South Africa, Zimbabwe and Zambia was lower than in 1975; and, by 2010, is expected to be lower than in 1960.⁷¹

⁶⁸ UNAIDS/WHO, *Epidemiological Fact Sheet on HIV/AIDS & Sexually Transmitted Infections, 2000 Update: Mozambique*, p.3, at http://www.unaids.org/hivaidsinfo/statistics/june00/fact_sheets/pdfs/mozambique.pdf.

⁶⁹ UNAIDS/WHO, *AIDS Epidemic Update: December 2000*, p.17.

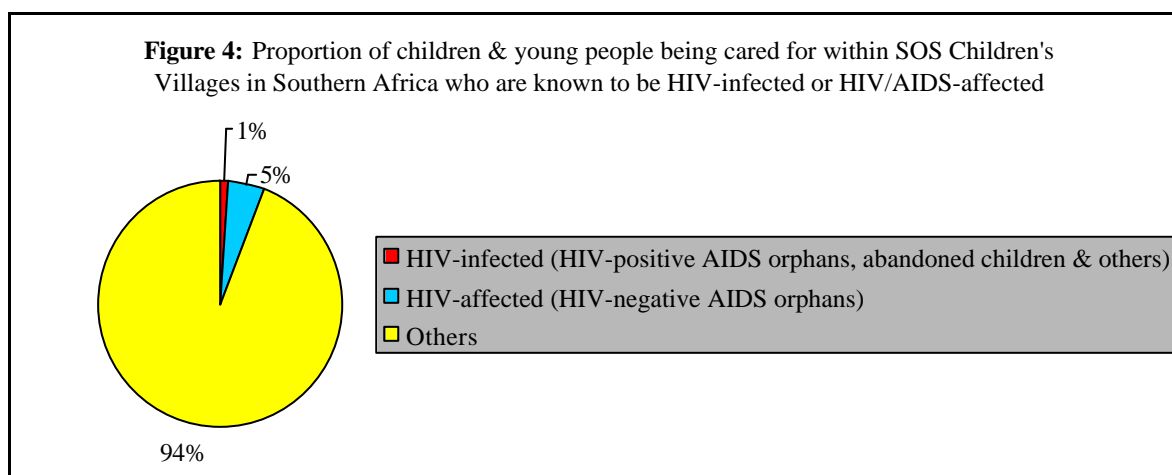
⁷⁰ For some unexplained reason, Swaziland is not included in the league table. However, if included, it would also be amongst the top countries. UNICEF, *The Progress of Nations 2000*, pp.4-5.

⁷¹ Botswana (1975=52:1998=47), Malawi (42:39), South Africa (55:54), Zambia (48:40), Zimbabwe (53:44). See: Adetunji, 'Trends in under-5 mortality rates & the HIV/AIDS epidemic', p.1200; Daniel, 'The demographic impact of HIV/AIDS in sub-Saharan Africa', p.51; UNAIDS/WHO, *Epidemiological Fact Sheet on HIV/AIDS & Sexually Transmitted Infections, 2000 Update: Malawi*, p.2; UNAIDS/WHO, *Epidemiological Fact Sheet on HIV/AIDS & Sexually Transmitted Infections, 2000 Update: Botswana*, p.2, at http://www.unaids.org/hivaidsinfo/statistics/june00/fact_sheets/pdfs/botswana.pdf; UNAIDS/WHO, *Epidemiological Fact Sheet on HIV/AIDS & Sexually Transmitted Infections, 2000 Update: South Africa*, p.2, at http://www.unaids.org/hivaidsinfo/statistics/june00/fact_sheets/pdfs/southafrica.pdf; UNAIDS/WHO, *Epidemiological Fact Sheet on HIV/AIDS & Sexually Transmitted Infections, 2000 Update: Zambia*, p.2, at http://www.unaids.org/hivaidsinfo/statistics/june00/fact_sheets/pdfs/zambia.pdf; UNAIDS/WHO, *Epidemiological Fact Sheet on HIV/AIDS & Sexually Transmitted Infections, 2000 Update: Zimbabwe*, p.2, at http://www.unaids.org/hivaidsinfo/statistics/june00/fact_sheets/pdfs/zimbabwe.pdf. Botswana (1960=46:2010=33), Malawi (38:30), South Africa (49:48), Zambia (42:30), Zimbabwe (45:33). See: Daniel, 'The demographic impact of

The response of SOS Children's Villages

Set against the challenges faced by children and young people in Southern Africa, SOS has made no concerted and coordinated response to the epidemic. SOS' contribution to the needs of children and young people has been largely been limited to the care of orphans (and social orphans) through its children's villages. These projects are based upon the SOS Children's Village model, as developed by the organisation's founder, Hermann Gmeiner, long before the epidemic was 'born'. According to this model, SOS provides care and support to orphaned and abandoned children based on the following principles:

1. *Mother: Every child is given a Mother and thus someone to turn to at all times. She lives in a family house with the children entrusted to her care and gives them love and security.*
2. *Brothers and sisters: Boys and girls of various ages grow up together as brothers and sisters. Siblings are not separated; they live in the same SOS Children's Village family.*
3. *House: Every SOS family has a house of its own. The familiar atmosphere of a home of their own encourages bonding within the families.*
4. *Village: The village community gives the children cultural roots and a feeling of belonging. The village is the bridge to society.*⁷²



HIV/AIDS in sub-Saharan Africa', p.51; M.J. Kelly, *Planning for education in the context of HIV/AIDS* (Paris: UNESCO, International Institute for Educational Planning, 2000), p.49.

⁷² SOS-Kinderdorf International, *SOS Children's Villages: Facts & figures 2001* (Innsbruck: SOS-KDI, 2000).

Currently, there are 21 SOS Children's Villages in these countries, caring for 2,710 orphaned and abandoned children and young people. Of these children and young people, only a small minority are known to be HIV-infected or otherwise HIV/AIDS-affected (see Figure 4).⁷³

Supporting the work of the children's villages in these countries are 47 educational facilities, 2 social centres, 6 medical centres and 5 emergency relief programmes. While these projects provide services to more than 47,500 members of surrounding communities, they have also not been utilised as part of a concerted response to the epidemic.⁷⁴

A notable exception has been within SOS Malawi.⁷⁵ At a national level, SOS Malawi is facilitating the establishment of a national Orphan Care Network, to support coordination of efforts to respond to the needs of orphans. At a project level, the SOS medical centre in Lilongwe has produced HIV/AIDS information brochures, prepared a booklet on living positively with HIV/AIDS, and piloted home-based care of HIV-infected children within SOS families. Furthermore, at the Lilongwe primary school, textbooks have been developed introducing an HIV/AIDS curriculum, as well as teacher-training materials for their introduction. Pending the outcome of negotiations with government, these textbooks may possibly be adapted for use throughout government primary schools.

Outlook

Clearly, the challenges posed by the HIV/AIDS epidemic are immense and greatly overshadow the present efforts of SOS projects. In this context, SOS projects would indeed

⁷³ Data gathered from survey of HIV/AIDS-related statistics for all projects in Southern Africa, as at June 30, 2001: See Appendix 1. While 'known' cases are likely to underestimate the number of actual cases, this still gives an indication of the situation and the organisation's known contribution to the care and support of HIV/AIDS-infected/affected children.

⁷⁴ Figures as at January 2001, taken from SOS Children's Villages Angola, *Annual Report 2000* (Lubango: SOS Children's Villages Angola, 2001); SOS Children's Villages Botswana, *Annual Report 2000* (Gaborone: SOS Children's Villages Botswana, 2001); SOS Children's Villages Lesotho, *Annual Report 2000* (Maseru: SOS Children's Villages Lesotho, 2001); SOS Children's Village of Malawi Trust, *Annual Report 2000* (Lilongwe: SOS Children's Village of Malawi Trust, 2001); SOS Children's Villages Mozambique, *Annual Report 2000* (Maputo: SOS Children's Villages Mozambique, 2001); SOS Children's Villages Namibia, *Annual Report 2000* (Windhoek: SOS Children's Villages Namibia, 2001); SOS Children's Villages South Africa, *Annual Report 2000* (Johannesburg: SOS Children's Villages South Africa, 2001); SOS Children's Villages Swaziland, *Annual Report 2000* (Mbabane: SOS Children's Villages Swaziland, 2001); SOS Children's Village of Zambia Trust, *Annual Report 2000* (Lusaka: SOS Children's Village of Zambia Trust, 2001); SOS Children's Villages Zimbabwe, *Annual Report 2000* (Harare: SOS Children's Villages Zimbabwe, 2001).

⁷⁵ SOS Children's Village of Malawi Trust, *SOS Children's Village of Malawi Trust & HIV/AIDS: What we Have Done & What we Plan to do* (internal progress report: not published, 2001).

seem to be “islands of excellence”, and, if serious about making a difference in this region, must consider paths to significantly scaling-up their impact.

Paths to scaling-up: Additive & multiplicative strategies

Chapter

3

NOT only is there a clear need for NGOs to scale-up, it should be a natural process. Just as private enterprises seek to maximise their profits, NGOs should seek to maximise their impact. In fact, both donors and beneficiaries shall expect this and hold them accountable for doing so.⁷⁶

Nevertheless, while the goal of increasing impact may be clear, there is no universally accepted prescription for how this should be achieved. This is reflected by the numerous models of scaling-up in the academic literature.⁷⁷

Perhaps the most common distinction is between ‘additive’ and ‘multiplicative’ strategies of scaling-up. Whereas, with additive strategies the application of additional resources brings about a proportional increase in impact, with multiplicative strategies, additional resources lead to a more than proportional increase in impact.

‘Additive’ strategies

According to this approach, impact is increased through growth of the organisation and/or its programmes. This normally involves managing larger budgets and employing more staff. Impact is increased by reaching more direct beneficiaries, and/or by improving the effectiveness and sustainability of projects (or programmes).⁷⁸

⁷⁶ Wils, ‘Scaling-up, mainstreaming & accountability’, p.53; Uvin, *et al.*, ‘Think large & act small’, p.1409.

⁷⁷ Clark, *Democratizing Development*; Edwards & Hulme, ‘Scaling-up NGO impact on development’; Edwards & Hulme, *Making a Difference*; Uvin, ‘Fighting hunger at the grassroots’; Uvin, *et al.*, ‘Think large & act small’; Jain, *et al.*, ‘Scaling-up the impact of NGO programs’; Wils, ‘Scaling-up, mainstreaming & accountability: the challenge for NGOs’; M. Howes & M.G. Sattar, ‘Bigger & better? Scaling-up strategies pursued by BRAC 1972-1991’, in Michael Edwards & David Hulme, *Making a Difference: NGOs & Development in a Changing World* (London: Earthscan, 1992); D. Mitlin & D. Satterthwaite, ‘Scaling-up in urban areas’, in M.Edwards & D.Hulme, *Making a Difference: NGOs & Development in a Changing World* (London: Earthscan, 1992); R. Chambers, ‘Spreading & self-improving: a strategy for scaling-up’, in M.Edwards & D.Hulme, *Making a Difference: NGOs & Development in a Changing World* (London: Earthscan, 1992).

⁷⁸ Uvin, ‘Fighting hunger at the grassroots’, pp.928-929; Uvin, *et al.*, ‘Think large & act small’, pp.1411-1412.

The most straightforward additive strategy is *replication* of successful projects, whereby a project model is developed and then piloted in a particular location.⁷⁹ Once the model has been refined and proven successful, it is reproduced on a large scale, in other locations, without the involvement of other organisations.

Another strategy is *functional scaling-up*, whereby the menu of activities undertaken is expanded.⁸⁰ In this way, impact may be significantly increased, whether by reaching more beneficiaries, improving the quality and/or quantity of benefits to a target group, and/or strengthening project sustainability. This can be achieved through horizontal integration, diversifying into activities not directly related to the original project, such as complementing an agricultural production scheme with a health programme. Alternatively, vertical integration may be pursued, with the addition of related 'upstream' or 'downstream' activities, such as adding a marketing component to an agricultural production scheme.

An NGO may even bring greater benefits to its target group through *substitution*, whereby a relatively simple, small-scale project is replaced by a more complex, larger-scale one.⁸¹

A further means of enhancing impact is through building *organisational sustainability*, ensuring that project activities can be maintained and expanded on a continuous basis.⁸² There are two key elements of this strategy. Firstly, functional sustainability, referring to the capacity to sustain and improve the quality and scale of project activities over time, requiring the development of organisational structures and systems, and management capacity. Secondly, financial sustainability, relating to the ability to mobilise sufficient funds to ensure that projects function at the desired level, usually requiring that existing sources of income are expanded and/or new sources are secured.

⁷⁹ Howes & Sattar, 'Bigger & better?', p.54; Wils, 'Scalingup, mainstreaming & accountability', pp.54-56; Edwards & Hulme, *Making a Difference*, pp.18-20; Jain, et al., 'Scaling-up the impact of NGO programs', pp.14-15; Uvin, et al., 'Fighting hunger at the grassroots', p. 928; Uvin, et al., 'Think large & act small', p.1411.

⁸⁰ Howes & Sattar, 'Bigger & better?', p.54; Wils, 'Scalingup, mainstreaming & accountability', pp.54-56; Edwards & Hulme, *Making a Difference*, pp.18-20; Jain, et al., 'Scaling-up the impact of NGO programs', pp.14-15; Uvin, et al., 'Fighting hunger at the grassroots', p.928; Uvin, et al., 'Think large & act small', p.1411.

⁸¹ Howes & Sattar, 'Bigger & better?', p.99.

⁸² Jain, et al., 'Scaling-up the impact of NGO programs', pp. 15-22; Uvin, et al., 'Think large & act small', p.1412; Uvin, et al., 'Fighting hunger at the grassroots', p.929.

‘Multiplicative’ strategies

With this approach, impact is ‘multiplied’ by working with and/or through other actors in the development arena. As such, an NGO may increase impact without necessarily becoming larger.

A relatively simple multiplicative strategy is *model transfer*, whereby a successful model is transferred to other organisations. The creating organisation may promote their model through such means as publications, seminars and conferences, and may even assist other organisations to establish similar projects.⁸³ However, such transfer often simply ‘happens’ rather than being ‘planned’.⁸⁴ Successful models tend to spread naturally, as other organisations hear about them and are inspired by their success. These other organisations may then further spread and improve existing models, or generate new ones. It should be noted that the unplanned and spontaneous transfer and improvement of models is referred to by some as a distinctive type scaling-up strategy in its own right, namely ‘diffusive’ strategies.⁸⁵

Another multiplicative option is *multi-actor programming*, where the NGO works together with other organisations in programme delivery.⁸⁶ This may happen when a NGO decides to raise the level of its activities from community-level, to regional, provincial or national-level. In such cases, the NGO must normally work with local government structures, and may need to cooperate with other actors in the development arena, from the private sector or civil society.

Similarly, a NGO may also use *networking*, building strong links with related projects and organisations.⁸⁷ Valuable opportunities may be created for mutual learning and support, and for coordinating development efforts. Such linkages may be vertical, with local organisations linked to regional ‘federations’ whose rules they are required to follow, or horizontal, with member organisations working at the same level and keeping their autonomy.⁸⁸

⁸³ Wils, ‘Scaling-up, mainstreaming & accountability’, p.57.

⁸⁴ Clark, *Democratizing Development*, p.95.

⁸⁵ Edwards & Hulme, *Making a Difference*, p.15.

⁸⁶ Wils, ‘Scaling-up, mainstreaming & accountability’, pp.57-58; Howes & Sattar, ‘Bigger & better?’, p.100.

⁸⁷ Clark, *Democratizing Development*, pp.99-100.

⁸⁸ Wils, ‘Scaling-up, mainstreaming & accountability’, p. 57. **22**

A further strategy is to actively *support community-level initiatives*, promoting the development of GROs or Community-Based Organisations.⁸⁹ This may involve building-up new organisations, supporting existing ones, and/or fostering links between them. As such organisations become stronger, having a greater impact that they are able to sustain over time from their own resources, the NGO may withdraw partially or completely, and divert its own resources to alternative activities. The growth of these organisations may not only enable the development of more projects, but also strengthen civil society, creating greater political impact.

The most far-reaching strategy is to work to change the wider social, political and economic environment within which development activities take place, through *lobbying and advocacy*.⁹⁰ By lobbying for change at national and international levels (governments, international governmental organisations, and official aid agencies) it is hoped that the structural causes of socio-economic inequality and underdevelopment can be eliminated. This would be impossible to achieve through projects alone. As expressed by Ellwood:

*If you see a baby drowning you jump in to save it; and if you see a second and a third, you do the same. Soon you are busy saving drowning babies that you never look up to see that there is someone throwing the babies in the river.*⁹¹

In this vein, lobbying and advocacy is considered by some as the only effective means of scaling-up. In the words of Clark:

*Conventional NGO project activities are manifestly 'finger-in-the-dyke' responses to problems that require nothing short of worldwide and whole-hearted governmental commitment to combat.*⁹²

⁸⁹ Edwards & Hulme, 'Scaling-up NGO impact on development', p. 84-85; Wils, 'Scaling-up, mainstreaming & accountability', p.56; Mitlin & Satterthwaite, 'Scaling-up in urban areas'; Clark, *Democratizing Development*, pp.102-119; Howes & Sattar, 'Bigger & better?', p.100.

⁹⁰ Edwards & Hulme, 'Scaling-up NGO impact on development', pp.82-84; Clark, *Democratizing Development*, pp.84, 120-141.

⁹¹ Ellwood, cited in Edwards & Hulme, *Making a Difference*, p.13.

⁹² Clark, in Edwards & Hulme, *Making a Difference*, p. p.200.

NGOs choosing this strategy must decide whether to adopt a confrontational *abolitionist* approach to the institutions they are lobbying, or a *reformist* approach by entering into a more constructive dialogue with them. Also, they need to choose whether to address micro-level issues relating to specific projects and programmes (such as provision of anti-retroviral therapy to HIV-infected mothers), or macro-level issues relating to the wider systemic change (such as macro-economic policy).

On a different level, NGOs may seek to influence the capabilities and behaviour of other non-state actors, such as civil society organisations (for example, traditional leaders, community groups and other NGOs) and private companies (for example, banks and multinational corporations).⁹³ While this may be through advocacy, it may also be achieved through less confrontational means, such as consultation and training.

Paths taken by SOS

Since its foundation more than 50 years ago, the SOS organisation has practised a number of scaling-up strategies. This has been part of a natural organisational development process, long pre-dating more recent debates about NGO scaling-up.

'Additive' strategies

In particular, SOS represents a classic example of *replication*. The SOS Children's Village model was the brainchild of Hermann Gmeiner, who founded the organisation, with a group of friends, with the express purpose of putting this model into practice.⁹⁴ His vision was realised in December 1949, with the opening of the first SOS Children's Village house at Imst, in Austria.

Having established and refined the SOS Children's Village model at Imst, it was then actively propagated by Gmeiner and his new organisation.⁹⁵ In 1955, the first villages were

⁹³ Jain, *et al.*, 'Scaling-up the impact of NGO programs', pp.13-14; Uvin, *et al.*, 'Think large & act small', pp.1411-1412.

⁹⁴ SOS-Kinderdorf International, *Hermann Gmeiner: Father of the SOS Children's Villages* (Austria: SOS Children's Villages, 1988), pp.16-17.

⁹⁵ SOS-Kinderdorf International, *The Future of Our Children - Our Future: 50 Years of SOS Children's Villages* (Austria: SOS-Kinderdorf International), pp.34-36; H. Gmeiner, *Hermann Gmeiner: The SOS Children's Villages* (Innsbruck-Munich: SOS-Kinderdorf, 2000), pp.125-129; SOS-Kinderdorf International, *Hermann Gmeiner: Father of the SOS Children's Villages*.

established beyond the borders of Austria, in Germany. By 1959, there were twenty villages, in Austria, Germany, France and Italy.

In 1963, the model was taken outside Europe, with the establishment of the first Asian village in South Korea, followed by the first Latin American village in Argentina. In 1970, the first African village was built in Côte d'Ivoire. By 1996, the model had reached every continent, with the establishment of villages in Australia and Oceania. Today, there are 423 SOS Children's Villages, in 131 countries worldwide.

While the SOS Children's Village model has remained at the core of SOS' activities, the organisation has also undertaken *functional scaling-up*, with the establishment of other kinds of projects. This has taken the form of vertical integration, with youth facilities, and horizontal integration, with educational facilities, medical centres, social centres, and emergency relief programmes. These additional projects have largely been established as complementary to the 'core' children's village project and usually, first and foremost, to ensure that the development needs of the children cared for within these villages are met. Projects that may not directly serve an SOS village's children are social centres and emergency relief programmes. Social centres may be considered as SOS' conventional response to the development needs of neighbouring communities, and are designed to help families (particularly women and children) to overcome poverty and to support young people in taking control of their lives. In crisis situations, such as natural disasters or war, SOS may provide emergency relief programmes to local communities, through its existing projects. However, even these two types of project may be seen as means of integrating the village into the community.⁹⁶ As such, the main focus of activities has remained orphaned and abandoned children, living within the villages, although SOS has had a limited impact on the development needs of the wider communities, through these associated projects.

This remarkable growth in the number and range of projects has been accompanied by the building of *organisational sustainability*. In terms of functional sustainability, as the organisation grew, its organisational structures, administrative systems and management practices evolved. As projects were established in different countries, SOS Children's Village

⁹⁶ SOS-Kinderdorf International, *The Future of our Children – our Future*, pp.81, 86.

Associations were formed, taking local responsibility for their operations.⁹⁷ To ensure that the original model was maintained and promoted, the international umbrella organisation was founded. Originally baptised as the “European Society of SOS-Children’s Villages”, in 1960, it had to be re-named “SOS-Children’s Village International”, in 1964, following the spread of the model beyond Europe.⁹⁸ In 1993, the organisational structure was modified, reflecting a move towards greater professionalism within the international organisation.⁹⁹ In countries where there were a number of SOS Children’s Village Associations, these were merged, to form a single National Association, as the only legal representative and member of the umbrella organisation within that country. Regional Offices were established, to oversee and coordinate the activities of the various National Associations, and to ensure consistency of structures and systems. The headquarters of the international organisation moved to a new location, the International Office, separate from that of the Austrian Association. SOS Promoting and Supporting Associations (PSAs), which had held finance and control responsibilities, relinquished those functions to the International Office. Furthermore, a universal accounting and financial control system was adopted for the worldwide organisation.

In terms of financial sustainability, the early growth of the SOS organisation was underpinned not only by the founder’s vision and strength of character, but also by his flair for fund-raising. Gmeiner pioneered many innovative fund-raising techniques, such as with his 1963 “Grain of Rice” campaign, whereby he brought a sack of rice back from Korea and sold each grain for a dollar to supporters, to fund the construction of the first Asian village.¹⁰⁰ Future expansion of activities in developing countries was planned for with the establishment of PSAs, tasked with raising the necessary funds.¹⁰¹ In 1964, such associations were founded in Germany, Denmark, Norway, Sweden, Netherlands, Switzerland and the United States. By 1996, they also included Austria, France, Luxemburg, Britain, Belgium, Canada, Finland, Italy and Spain. A further innovation was the International Child Sponsorship Programme,

⁹⁷ Reinprecht, *The Hermann Gmeiner Book*, pp.202-204.

⁹⁸ In the original German i.e. “SOS-Kinderdorf International”, now referred to as the international SOS Children’s Village organisation. Reinprecht, *The Hermann Gmeiner Book*, p.228.

⁹⁹ V. Kasturi Rangan, ‘SOS-Kinderdorf International: Caring for Orphaned Children’, *Harvard Business School Case Studies*, 9-597-079, Rev. May 30 (1997), p.7.

¹⁰⁰ SOS-Kinderdorf International, *Hermann Gmeiner: Father of the SOS Children’s Villages*, pp.38-39; Reinprecht, *The Hermann Gmeiner Book*, pp.211-213.

¹⁰¹ Reinprecht, *The Hermann Gmeiner Book*, pp.229-230; Rangan, ‘SOS-Kinderdorf International’, pp.6-7; Gmeiner, *Hermann Gmeiner: The SOS Children’s Villages*, p.126.

whereby people sponsor an individual child, making regular financial contributions towards their care.¹⁰² More recently, SOS has been promoting local fund-raising programmes within developing countries themselves, to ensure long-term financial sustainability. A notable success has been South Africa, which last year funded 71% of its expenditure from local income.¹⁰³

'Multiplicative' strategies

While SOS has vigorously pursued additive strategies to scaling-up, it has left multiplicative strategies relatively unexplored.

Although *model transfer* is an explicit goal of SOS and it regards the SOS model as something to be replicated by other organisations,¹⁰⁴ there is little, if any, evidence of this goal being realised. Family-based childcare institutions are relatively few and it is questionable those that do exist were inspired by the SOS model.

As regards, *multi-actor programming*, outside Europe SOS has limited experience of working closely with other actors in the development arena and tends to work relatively independently. Perhaps the most collaborative efforts have been during emergency relief programmes.¹⁰⁵ However, emergency relief programmes constitute a comparatively small and short-term part of SOS' work. Nevertheless, a notable example of collaboration in the context of HIV/AIDS is the working relationship developed by SOS Swaziland with the Salvation Army Community Care Team (SACCT). In recent years, SOS Mothers have worked together with SACCT Nurse Counsellors in local communities, to provide HIV/AIDS information and education, and to establish a home-based care programme.¹⁰⁶

¹⁰² Reinprecht, *The Hermann Gmeiner Book*, p.229.

¹⁰³ Excluding funds raised through International Child Sponsorship Programme, which would constitute an additional 14%. See: SOS Children's Villages South Africa, *SOS Children's Village Association of the Republic of South Africa Financial Statements for the year ended 31 December 2000* (Johannesburg: KPMG Accountants & Auditors, 2001), p.5.

¹⁰⁴ SOS-Kinderdorf International, *SOS Children's Villages: Village Handbook for Southern Africa* (Johannesburg: SOS-Kinderdorf International Regional Office for Southern Africa II, 1995), p.5.

¹⁰⁵ SOS-Kinderdorf International, *The Future of Our Children - Our Future*, pp.84-85.

¹⁰⁶ SOS Children's Villages Swaziland, *Proposal to Establish a 'Family Carer' Programme for HIV/AIDS Orphans in Swaziland, in Collaboration with the Salvation Army Community Care Team* (Project proposal prepared by SOS Swaziland, July 2001), p.2.

Similarly, SOS has relatively little experience of actively engaging in *support for community-level initiatives*, and none of playing an active role in *lobbying and advocacy*.

Outlook

The expansion of the SOS Children's Villages organisation during the last 50 years can be attributed to successful pursuit of additive strategies of scaling-up. However, in the context of the HIV/AIDS epidemic in Southern Africa, even this remarkable expansion has been insufficient to have a meaningful impact in the lives of significant numbers of children in need. As such, it is clear that SOS needs to explore other paths to scaling-up, particularly multiplicative strategies.

The organisational dimension: Constraints & opportunities

WHILE the need for scaling-up may be accepted by an NGO, it does not necessarily follow that it shall be willing or able to implement all available strategies. Any scaling-up process, whether additive or multiplicative, is likely to involve organisational change.¹⁰⁷ Such changes may be more or less feasible, depending upon certain organisational factors, notably organisational culture.

Organisational culture

Just as different nations have their own distinct cultures, so do organisations. While organisational culture has been defined in various ways, it is generally taken to refer to a set of values, norms and beliefs shared by the majority of organisational members and reflected in its structures, systems and practices.¹⁰⁸

Culture types

Organisational culture can be looked at in terms of different *organisational styles*. One such approach identifies four basic styles, from which all organisations adopt some mix; namely *club* culture, *role* culture, *task* culture and *person* culture.¹⁰⁹

In a *club culture*, the organisation is essentially an extension of its head (often the founder) and exists simply because he cannot achieve what he wants to without it. As such, the organisation is like a club of people, acting in one accord, on behalf of the head. This can be highly effective, where relationships are based on trust and communication is carried out by a kind of telepathy, as people understand one another. The head is able to pass on his vision and enthusiasm through personal contact. Consequently, little needs to be written down, and

¹⁰⁷ Billis & MacKeith, 'Growth & change in NGOs', p.118.

¹⁰⁸ C. Handy, *Understanding Organisations* (Harmondsworth: Penguin, 1993), p.182; C. Lau & H. Ngo, 'One country many cultures: organisational cultures of firms of different country origins', *International Business Review*, vol.5, no.5, pp.470-472.

¹⁰⁹ C. Handy, *Understanding Voluntary Organisations* (Harmondsworth: Penguin, 1990), pp.86-93.

there are few rules and procedures, or other forms of bureaucracy. Management take on a patriarchal role and staff a functional role.

The *role culture* organisation is hierarchal. Employees at all organisational levels have clearly defined roles and responsibilities, which fit together logically, so that the organisation is able to perform its prescribed task. Employees are viewed as 'role occupants', with job descriptions prescribing their role and responsibilities.¹¹⁰ Communication is formalised, written down and carried out between role occupants. Management set rules and procedures, to provide a clear framework of action for every work situation. Standards, controls and evaluation procedures ensure efficiency. The organisation is managed rather than led.

Task culture organisations are problem-solving organisations, bringing together human and other resources to be applied to specific tasks. In doing so, tasks receive adequate attention, so that the organisation can achieve its purpose. Employees are selected as specialists in their own area of expertise. Task groups are formed, expanded, changed or disbanded according to need. There is no standard or routine approach to tasks, creating variety across the organisation. There is little obvious hierarchy and little bureaucracy, with plans instead of procedures and progress reviews instead of performance evaluations. Management take on a strategic role, identifying tasks and allocating resources as required.

The *person culture* organisation exists to serve the needs of the individual staff. This is in direct contrast to the other three cultures, where employees are viewed as resources to be used to achieve the purposes of the organisation. Management have a coordinating role, while staff have a skilled (professional) role. This culture can work well where the skills, talents and abilities of the individual are important, such as in the professions of law and medicine.

It should be realised that no organisation possesses a single culture, but rather a *mix of cultures*. Furthermore, organisational cultures are not static; they are formed by dominant groups within an organisation and the kind of culture that suits them may well change over time. Getting the appropriate mix of cultures, at the right time, is considered a key element

¹¹⁰ Handy, *Understanding Voluntary Organisations*, p.89.

for success.¹¹¹ In the case of NGOs, it may be a key factor in determining feasibility of options for scaling-up.

SOS' organisational culture

As with other organisations, SOS' cultural mix has been shaped by its history, size, workflow, work focus, environment and people.¹¹²

An *organisation's history* (its founder, location, employees, traditions and reputation) inevitably influence its culture. In particular, its founder can have a profound impact, and, in fact, the very process of culture formation begins with him.¹¹³ Indeed, during SOS' early years, Gmeiner's charisma and strength of character ensured his vision and ideas were imprinted upon the organisation and set the course for its future development.¹¹⁴

As with other founder-dominated organisations, SOS, during Gmeiner's lifetime, had a strong club culture. Gmeiner made key appointments himself and entrusted them with responsibility for implementing his SOS Children's Village model. Communication was based on a form of telepathy, with trust that staff shared a commitment to the strong common idea and would be able to implement it. Bureaucracy was absent, little was written down and reporting systems were ill-defined. The organisation worked on the basis of strong family-like relationships.

Today, Gmeiner is remembered within SOS with a kind of reverence. His SOS model remains at the core of SOS' work, he is referred to as "the father of SOS Children's Villages" and most non-children's village facilities are named after him.¹¹⁵

Size is often the most important factor affecting any organisation's choice of culture. As organisations grow larger, structures and systems need to become more formalised, and, for this reason, size usually forces an organisation towards a role culture.¹¹⁶ As SOS' volume of work grew worldwide, it was no longer practicable to operate on an informal and unstructured

¹¹¹ Lau, *et al.*, 'One country many cultures', pp.470-471.

¹¹² Handy, *Understanding Voluntary Organisations*, pp.93-96; Handy, *Understanding Organisations*, pp.192-193.

¹¹³ E. Schein, 'The role of the founder in creating organizational culture', *Organizational Dynamics*, Summer 1983, p.17; E. Schein, *Organizational Culture & Leadership* (San Francisco: Jossey-Bass, 1992), pp.211-227.

¹¹⁴ F. Haider, *40 Years with SOS-Kinderdorf: Memories, Reflections, Observations* (SOS-Kinderdorf, 1990), pp.13-16.

¹¹⁵ SOS-KDI, *Hermann Gmeiner: Father of the SOS Children's Villages* (Austria: SOS Children's Villages, 1988).

¹¹⁶ Handy, *Understanding Voluntary Organisations*, p.94; Handy, *Understanding Organisations*, p.192.

basis. With growth, the organisation's structures, administrative systems and management practices evolved, ensuring functional sustainability (see chapter 3). National Associations, Regional Offices and specialised Departments within the International Office were established to ensure effective support and coordination of activities worldwide. Multifarious policies and procedures were developed, to ensure consistency of systems. These were reflected in the production of various organisational manuals, which tended to contain detailed policies and procedures, limiting scope for local creativity or innovation. Individual employees were given clear roles and responsibilities, with detailed job descriptions.

Linked to an organisation's size is the way that it organises its *workflow*. Where work is carried out by separate units, with an individual (or group) taking responsibility for a particular area of work, then club, task or person cultures may predominate. However, if the workflow is part of an interdependent process, with the need for more structures, systems, policies and procedures, then role culture may predominate.

Within SOS, the Regional Directors are given a great deal of responsibility for activities in their particular geographical area and the regions have historically been able to function as kinds of 'empires' within the larger organisation. This has allowed scope for club culture to be consolidated, and, in some instances, for task culture to grow. However, as SOS' operations have become more formalised, there has been a push towards interdependency, particularly through reporting structures and control mechanisms; so reinforcing shifts towards role culture.

SOS' *work focus* has also pushed it towards a role culture. As a service organisation, SOS aims to fulfil certain needs, and to do so effectively and efficiently. It strives to provide high quality services for the beneficiaries, and strong accountability to sponsors and donors. To ensure that this happens, the organisation is inevitably drawn into adopting clear reporting structures, administrative systems, financial control mechanisms, and so on.

This has been reinforced by SOS' strong adherence to Gmeiner's SOS model. As the core competency of SOS and the focus of its work, for 50 years, it has been possible to build a clear framework of structures, systems, policies and procedures around it.

The *environment* within which SOS operates has also contributed to its move towards role culture, perhaps most significantly through the influence of national culture. Studies have shown that organisations tend to reflect their national culture to some extent, and, while organisational cultures will vary within a nation, they will tend to differ even more from those of other nations.¹¹⁷ Moreover, overseas branches of organisations are likely to develop organisational cultures reflecting the national culture of their “mother” country, with little influence from the host country’s culture.¹¹⁸ Studies indicate that cultures in Austria (and Germany and Switzerland) have a strong role-orientation.¹¹⁹ As SOS was founded in Austria and is still based there, it is hardly surprising that it increasingly tended to adopt a role culture.

Having said this, the individual orientation of key *people* within the organisation is also a significant determinant in the formation of organisational culture. Considering environmental factors, this would also seem to support the move towards role culture; given that SOS has an Austrian Secretary-General and that the majority of Regional Directors originate from Austria, Germany or Switzerland.¹²⁰

SOS’ cultural mix has evolved in line with the influence of the above factors. In the early stages of its development, SOS had a strong club culture, largely due to its founder. However, over time, size, workflow, work focus, and environment pushed the organisation towards role culture.

¹¹⁷ G. Hofstede, *Culture’s Consequences: International Differences in Work-Related Values* (Beverly Hills: Sage, 1980); Lau, ‘One country many cultures’; J. van Oudenhoven, ‘Do organizations reflect national cultures? A 10-nation study’, *International Journal of Intercultural Relations*, no.25, pp.89-107.

¹¹⁸ Lau, ‘One country many cultures’, pp.469-482.

¹¹⁹ See Trompenaars’ characterisation of organisation’s in Austria and Germany as having an (role-oriented) ‘Eiffel tower’ culture: F. Trompenaars, *Riding the Waves of Culture: Understanding Cultural Diversity in Business* (London: Nicholas Brealey, 1993), pp.138-163. Also, Hofstede’s characterisation of organisation’s in Austria, Germany and Switzerland as having a (role-oriented) ‘well-oiled machine’ culture: Hofstede, *Culture’s Consequences*, pp.314-322.

¹²⁰ There are a total of 17 Regional Directors, originating from Austria (6), Southern Tyrol in northern Italy (1), Germany (3), German-speaking region of Switzerland (1), France (3), India (2), and Canada (1).

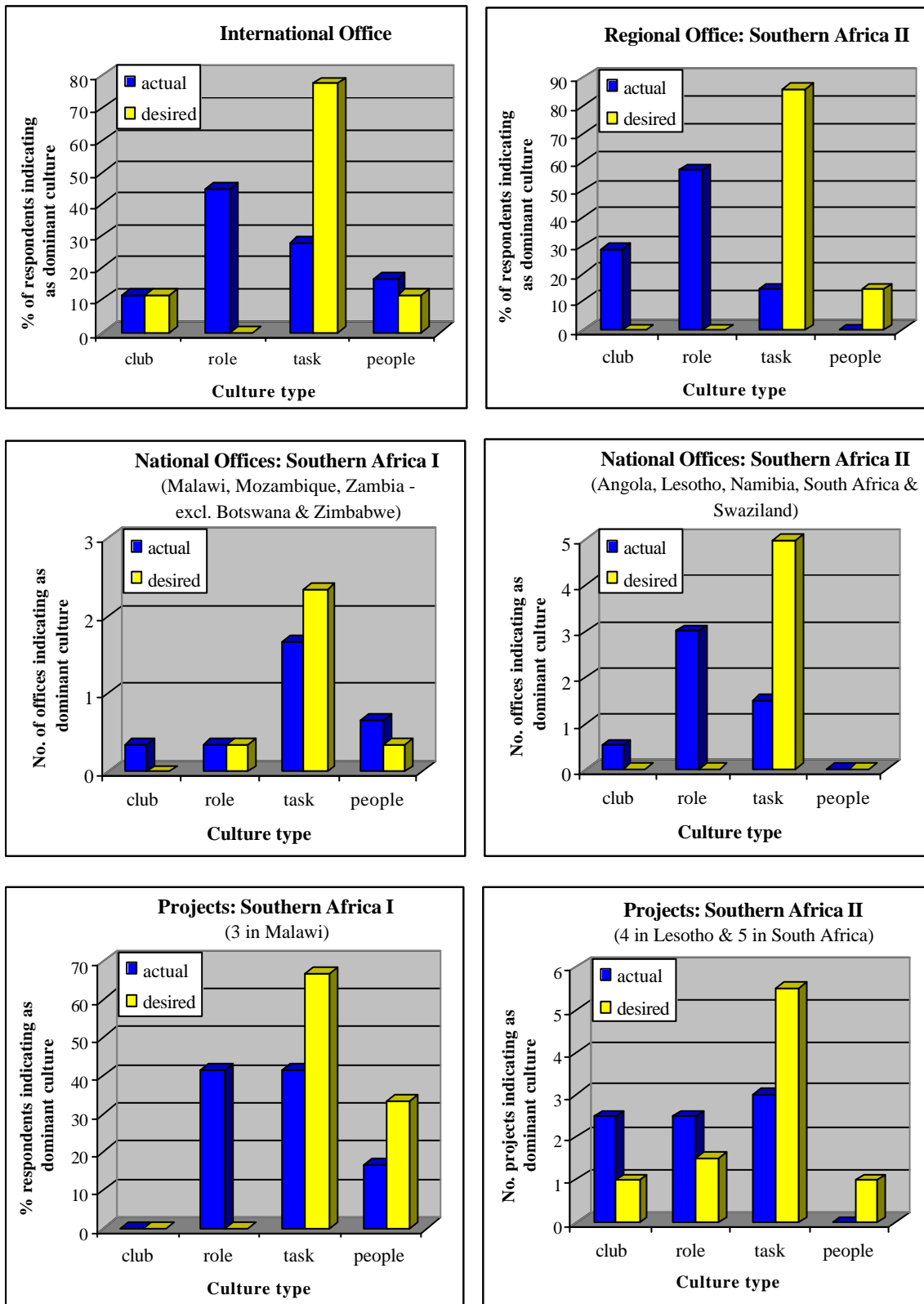


Figure 5: Organisational culture survey, summary of questionnaire responses.

The strength of role culture is evident from the results of a survey of organisational culture, conducted amongst a cross-section of staff members, at the different levels of the organisation (see Figure 5 and Appendix 2). This survey was based on a questionnaire, using the classification of organisations according to club, role, task, and person cultures.¹²¹ Results indicated that role culture was predominant at the International Office, the Regional Office for Southern Africa II, and National Offices within the region of Southern Africa II (a notable exception being Swaziland, where results show task culture to be predominant). While the survey of National Offices in Southern Africa I was incomplete, given responses from only three of the five countries required, results indicated that task culture is predominant. Within those projects surveyed in both regions, results indicated a mix of dominant culture types, with a balance of role and task orientations in Southern Africa I, and club, role and task orientations in Southern Africa II (although task culture was slightly more prevalent). Perhaps the most striking result was the overwhelming preference for task culture, as the ‘desired’ culture type of respondents at all levels of the organisation, from project-level upto International Office-level.

Implications for ‘additive’ strategies

A review of SOS’ organisational development clearly shows that its culture has been a key factor underpinning the successful implementation of additive strategies.

Replication & functional scaling-up

In the early stages of its development, SOS’ strong club culture facilitated rapid growth of the organisation. The main strengths of this culture are that the centralisation of power and short lines of communication enable rapid and intuitive responses to crises or opportunities, and the absence of bureaucratic constraints leaves the centre with ample scope for flexibility. This enabled the SOS model to be transplanted to every continent of the world and supporting projects to be developed.

¹²¹ Questionnaire taken from: C. Handy, *Understanding Organizations* (Harmondsworth: Penguin, 1999), pp.210-216.

Organisational scaling-up

The later formation of a role culture, around the core idea, gave a clear focus to SOS' work, creating stability and predictability. Not only has this enabled the organisation to concentrate on improving in its core competency and build functional sustainability, it has also fostered strong donor confidence, necessary for building financial sustainability.

This has enabled SOS to expand its operations worldwide from its own resources and to function relatively independently, without being dependent on the formation of external partnerships for resources. However, as a result, SOS has been relatively closed to involvement with other actors in the international development arena and has remained outside the 'mainstream' of development NGOs.

Furthermore, while the role culture's adherence to the core idea undoubtedly benefited SOS in terms of building a strong donor base in central Europe (notably Germany),¹²² it is also perhaps why it has been less successful in fund-raising efforts in some other countries. In particular, SOS has remained largely unknown in English-speaking countries of the developed world. Despite a longstanding presence in these countries, SOS has found it relatively difficult to gain acceptance of its idea, a necessary pre-requisite for fund-raising or establishing projects there.¹²³ One of the reasons given for this relative lack of success, at least in the United States, has been the 'deinstitutionalization' of childcare, whereby the SOS model lacks acceptance given that it is viewed as an institution.¹²⁴

Implications for 'multiplicative' strategies

While SOS' club and role cultures facilitated its rapid growth, through additive strategies, the present mix of cultures may present barriers to new scaling-up strategies. SOS' strong role-orientation, negates flexibility and innovation, which are required for other strategies.

¹²² Bundesarbeitsgemeinschaft Sozialmarketing (BSM) – German Fundraising Federation e.V., *Zahlen zum Fundraising in Deutschland* (updated August 28, 2001), at <http://www.sozialmarketing.de/zahlen.htm>, accessed on September 3, 2001; SOS-Kinderdorf e.V., *Bericht über den Jahresabschluss zum 31.12.1999* (Munich: SOS-Kinderdorf e.V., 2000); and, SOS-Kinderdorf e.V., *Zahlen+Stichworte*, at <http://www.sos-kinderdorf.de/> accessed on September 3, 2001.

¹²³ SOS has had a presence in the United States since 1961, Canada since 1969, Britain since 1968, and Australia since 1992. See Rangan, 'SOS-Kinderdorf International', p.11.

¹²⁴ Rangan, 'SOS-Kinderdorf International', pp.7-8.

Moreover, SOS' relatively independent approach may hinder those strategies requiring SOS to work with and/or through other actors in the development arena.

Lobbying & advocacy

In particular, SOS' culture may be incompatible with lobbying and advocacy, at least in terms of macro-level issues aimed at bringing about systemic change. There are a number of reasons for this. Firstly, successful lobbying at the macro-level requires NGOs to work together with a 'shared vision and ideology'.¹²⁵

However, in common with many other NGOs, SOS is likely to be reluctant to work together with other organisations. This can be attributed to the fact that NGOs often do not share the same 'vision' of the failure of global systems, nor the same development 'ideology', nor even a common vocabulary.¹²⁶ In SOS' case, these differences are magnified by the fact that it has positioned itself outside the mainstream of NGOs, and has therefore remained insulated from trends in development thinking and the associated 'development-speak'.

Furthermore, it has been argued that NGOs may be unlikely to come together due to competition, for funds and public profile.¹²⁷ SOS is no exception, even in countries where its market position is the most secure. During the last decade, the German fund-raising market as a whole has been experiencing a period of stagnation, with only a slight increase in development NGO income.¹²⁸ Instead, significant changes in income have been largely due to 'substantial displacement competition'. Such a fund-raising climate is hardly likely to push SOS towards cooperation with other (competitor) organisations.

In addition, even if SOS was willing to cooperate with other organisations in advocacy activities, it may not be able to contribute much beyond criticism of the status quo. One of the main weaknesses identified in NGO approaches to advocacy is the lack of alternatives

¹²⁵ Dolan, 'British development NGOs & advocacy in the 1990s', p.204; Norrell, *Bridging Gaps or 'a Bridge Too Far'?*, p.12.

¹²⁶ M. Edwards, "Does the doormat influence the boot?": critical thoughts on UK NGOs & international advocacy', *Development in Practice*, vol.3, no.3 (1993), p.172; Edwards & Hulme, 'Scaling-up NGO impact on development', p.83; Dolan, 'British development NGOs & advocacy in the 1990s', p.204

¹²⁷ Dolan, 'British development NGOs & advocacy in the 1990s', p.210; Edwards, 'Does the doormat influence the boot?', p.169; Edwards, 'Scaling-up NGO impact on development', p.83; Norrell, *Bridging Gaps or 'a Bridge Too Far'?*, p.9.

¹²⁸ M. Urselmann, 'Zunehmender Verdrängungswettbewerb auf stagnierendem Spendenmarkt, *bsm-Newsletter*, 4/2001, pp.12-14, at <http://www.sozialmarketing.de>, accessed on September 3, 2001.

offered to current orthodoxies, especially regarding economic development.¹²⁹ Such alternatives should be based on practical development experience, as indeed any input in lobbying. In the words of Edwards:

*...there must be a clear link between an NGO's advocacy and direct practical experience, so that influence can be exercised with some degree of authority, legitimacy, and credibility.*¹³⁰

SOS' strict adherence to its children's village model, limited experience with other kinds of projects, and its insulation from mainstream development thinking, has meant that it has little, if any, relevant experience in wider social and economic development.

Moreover, SOS may perceive lobbying for systemic change as being against its own interests. As a service-providing NGO that works within the status quo, SOS may be uncomfortable with strategies aimed at changing the status quo.¹³¹ Given SOS' rigid apolitical stance, it may share the view of some other NGOs that, as *non-governmental* organisations, they are not in a position to give input on governmental issues.¹³² Also, SOS may be wary of public perceptions of charitable giving.¹³³ Private donors normally want to see their contribution produce an immediate and tangible benefit, which may be obtained through project work, but is less clear for lobbying and advocacy. To maintain their market share of donations, they are more likely to fund-raise for project activities than try to change public perceptions.

Regardless of the above factors, it is questionable whether SOS' strong role-orientation would facilitate macro-level lobbying. Formalised hierarchical structures and bureaucratic systems tend to negate the widespread level of participation required to obtain the perspective of those disadvantaged groups on whose behalf one is lobbying.¹³⁴

Having said all this, SOS may still have the potential to engage in individual lobbying and advocacy on micro-level issues. Where SOS is able to achieve a significant impact in 'distinct areas of competence', it may have the necessary credibility and legitimacy to

¹²⁹ Edwards, 'Does the doormat influence the boot?', p.169.

¹³⁰ Edwards, 'Does the doormat influence the boot?', pp.168-169.

¹³¹ Norrell, *Bridging Gaps or 'a Bridge Too Far'?*, p.12.

¹³² Dolan, 'British development NGOs & advocacy in the 1990s', p.206.

¹³³ Dolan, 'British development NGOs & advocacy in the 1990s', pp.206-209.

¹³⁴ Billis & MacKeith, 'Growth & change in NGOs', p.125; Norrell, *Bridging Gaps or 'a Bridge Too Far'?*, p.13.

advocate on related policy issues, leading to some micro-level reforms.¹³⁵ This would include lobbying and advocacy within the community, of local government authorities, and on specific national policies and programmes.

Support community-level initiatives, networking & multi-actor programming

While less ‘radical’ multiplicative strategies still present a challenge, in light of SOS culture, given that they still demand a willingness to innovate, be flexible and work as partners with other actors in the development arena, they are perhaps more feasible. This may be especially the case where there are elements of task culture.

Those parts of the organisation that have a strong task culture are more likely to be ‘in tune’ with trends in development thinking, such as participation, strengthening local organisations and social mobilisation. Acceptance of such ideas provides a solid foundation for effective implementation of multiplicative strategies. Moreover, they are more likely to recognise changes in the environment within which SOS is working, such as the nature of the orphan crisis in the wake of the HIV/AIDS epidemic, and the need to drastically scale-up impact, to an extent not achievable through replication and functional scaling-up alone. They are also more likely to realise the relative cost-effectiveness of multiplicative strategies, required in order to achieve such an impact.

Outlook

The greatest weakness of role-oriented cultures is that they may be slow to recognise the need for change, and, even if where they do, may find it difficult to do so, perhaps compromising the organisation’s very survival. In a changing environment, SOS needs a more future-oriented culture that can be sensitive, adaptable, responsive to change and will embrace the most effective scaling-up strategies. This essentially means a greater degree of task culture. In the words of Handy:

¹³⁵ Dolan, ‘British development NGOs & advocacy in the 1990s’, p.210; Edwards, ‘Does the doormat influence the boot?’, p.170.

*To keep the organization relevant and successful, the.. ..mixed culture needs to have some.. ..task cultures dotted through it, something not always easy for (club cultures) or (role cultures) to recognise and accept.*¹³⁶

Moreover, the fact that the survey results suggest that task culture is the preferred culture type, across all levels of the organisation, it is likely that multiplicative options shall become increasingly feasible in future.

Given that pursuit of multiplicative strategies would involve working with and/or through other actors in the development arena, it is useful to consider the approaches being taken by those actors in response to the HIV/AIDS epidemic. This requires a review of the various interventions and models of care that have been adopted.

¹³⁶ Handy, *Understanding Voluntary Organisations*, p.101.

Alternative responses: Interventions & models of care

Chapter

5

AS the devastating impact of the HIV/AIDS is felt throughout Southern Africa, efforts are being made at all levels of society to halt the spread of the epidemic and to deal with the widespread social and economic consequences. At the heart of these efforts have been attempts to prevent infection of young people, to prevent mother-to-child transmission, and to care for orphaned and abandoned children.

Preventing infant & child mortality

As already discussed, while antiretroviral drugs can significantly reduce mother-to-child infection rates, these have until recently been unaffordable to most developing countries and difficult to administer.

However, since 1998, a number of pilot projects have been conducted using *short-courses* of antiretroviral drugs, including projects in South Africa, Botswana, Zambia and Zimbabwe.¹³⁷ One such study in South Africa, used a short-course of the antiretroviral drug *nevirapine*, which reduced mother-to-child infection by 47%. This treatment cost R50 and is extremely cost-effective when compared to UNAIDS estimates for the lifetime care of an HIV-infected child ranging from US\$200 to US\$1300.¹³⁸

Even though this treatment prevents almost half of mother-to-child infections, costs little, and that technical experts consulted by the World Health Organisation have recommended that “*there is no justification to restrict use of any of these (antiretroviral) regimens to pilot*

¹³⁷ R. Smart, *Children Living with HIV/AIDS in South Africa: A Rapid Appraisal* (Report prepared for the Interim National HIV/AIDS Care & Support Task Team, 2000), p.35; McIntyre & Gray, ‘Mother-to-child transmission of HIV’.

¹³⁸ McIntyre & Gray, ‘Mother-to-child transmission of HIV’.

project or research settings”,¹³⁹ developing countries have been reluctant to extend its use throughout public health facilities.¹⁴⁰

In Southern Africa, Botswana is the exception, with national policies for use of antiretroviral drugs in antenatal clinics.¹⁴¹ The furthest South Africa has gone, has been to launch a new pilot project in 2001, whereby nevirapine will be offered to pregnant HIV-positive women, in eighteen public health facilities.¹⁴²

The South African government is being lobbied to make antiretroviral treatment available to all pregnant HIV-positive women, by organisations such as the Treatment Action Campaign and the Anglican Church.¹⁴³

The other main response to reduce mother-to-child transmission has been to counsel mothers on appropriate infant feeding options. However, counselling HIV-positive mothers not to breastfeed may be inappropriate, for various reasons.¹⁴⁴ Firstly, promotion of breastfeeding has been an essential element of child health and survival strategies in recent decades, and a key factor in reducing infant and child mortality rates in many countries. Discouraging breastfeeding for some mothers may create confusion and a lack of confidence in the health care system. Secondly, where breastfeeding is the norm, a mother's use of infant formula may highlight her HIV status, inviting discrimination, which may result in violence and/or rejection by her family and community. Thirdly, infant formula is often unaffordable to mothers in developing countries, and, even where infant formula is affordable, many mothers lack the knowledge, as well as access to clean water and fuel, needed to prepare them safely.

¹³⁹ WHO, 'Preventing mother-to-child HIV transmission: technical experts recommend use of antiretroviral regimens beyond pilot projects', *WHO Press Release*, WHO/70, 25 October 2000, accessed at <http://www.who.int/inf-pr-2000-70.html>, on September 1, 2001. Afrol.com, 'South African government to provide free anti-retrovirals to mothers', *afrol.com*, January 30 (2001), at http://www.afrol.com/News2001/sa005_free_aidsdrugs.htm, accessed on August 16, 2001.

¹⁴⁰ UN Office for the Coordination of Humanitarian Affairs, 'Swaziland-AIDS: Government baulks over anti-retrovirals', *Integrated Regional Information Networks*, March 23, 2001, at <http://www.reliefweb.int/IRIN/sa/countrystories/swaziland/20010323.phtml>, accessed on September 15, 2001.

¹⁴¹ C.W. Luo, 'Strategies for prevention of mother-to-child transmission of HIV', *Reproductive Health Matters*, vol.8, no.16 (2000), p.144.

¹⁴² South African Press Agency (SAPA), 'Free nevirapine for pilot studies', 24 August 2001, accessed at <http://www.doh.gov.za/docs/news/2001/nz0824.html>, on September 1, 2001; P. Sidley, 'Drug firm is to supply AIDS drug free in South Africa', *British Medical Journal*, no.323 (2001), p.472.

¹⁴³ SAPA, 'Free nevirapine for pilot studies'; Sidley, 'Drug firm is to supply AIDS drug free in South Africa', p.472.

¹⁴⁴ UNAIDS, *Questions & Answers: Mother-to-Child Transmission (MTCT) of HIV*; M.C. Latham & E.A. Preble, 'Appropriate feeding methods for infants of HIV infected mothers in sub-Saharan Africa', *British Medical Journal*, no.320 (2000), pp.1656-1660.

Incorrect use of formula feeds may result in infections, malnutrition, and even death. Finally, use of infant formula means the mother loses the ‘natural contraceptive effect’ of breastfeeding and is more likely to become quickly pregnant again.

Moreover, recent studies in South Africa have indicated that breastfeeding in itself does not increase risks of mother-to-child transmission, compared to formula feeding.¹⁴⁵ Rather, where mothers used exclusive breastfeeding for 6 months, mother-to-child infection was shown to decrease by 44%, compared to mixed feeding. This being the case, infection rates could be reduced where mothers practise exclusive breastfeeding and avoid mixed feeding.

Generally, it is accepted that, as recommended by UNAIDS:

*...in all populations, irrespective of HIV infection rates, breastfeeding should continue to be protected and supported; counselling for women who are aware of their HIV status should include the best available information on the benefits of breastfeeding, on the risk of HIV transmission through breastfeeding, and on the risks and possible advantages associated with other methods of infant feeding; women should be empowered to make fully informed decisions about infant feeding, and they should be suitably supported in carrying them out.*¹⁴⁶

Caring for orphans

For those children who are orphaned or abandoned in the wake of the epidemic, there are various models of care and support, ranging from informal family and community-based support to formal institutional care. Nine different models can be identified.

Models of care

Firstly, an *independent orphan household*, whereby orphans stay on their own without any formal external support.¹⁴⁷ This may result from the fact that the children have nowhere else to go, or because they choose to stay together to protect their inheritance rights and/or to

¹⁴⁵ R. Bobat, ‘The breastfeeding dilemma’, *South African Medical Journal*, vol.90, no.9, September (2000), pp.859-862.

¹⁴⁶ UNAIDS, cited in Bobat, ‘The breastfeeding dilemma’, p.860.

¹⁴⁷ H. Loening-Voysey & T. Wilson, *Approaches to Caring for Children Orphaned by AIDS & Other Vulnerable Children: Essential Elements for a Quality Service* (Report prepared for UNICEF by the Institute for Urban Primary Health Care, South Africa, 2001), p.26.

avoid being separated between different relatives.¹⁴⁸ Normally, an older sibling takes on parental responsibilities for younger brothers and sisters. This is usually considered to be the ‘worst case scenario’ and not a replicable model of care.

Secondly, a *child-headed household with external supervision and support*.¹⁴⁹ Such support often takes the form of regular visits and material support from extended family members, concerned neighbours, or other volunteers. Social welfare services may even work with the older sibling, if at least 15 years old, to keep the family together.

Thirdly, *non-statutory foster care*, whereby children are cared for by community members, on an informal and voluntary basis.¹⁵⁰ Such care-givers are often extended family/kinship members and this model can be considered as the traditional (or indigenous) model of care. A recent study in South Africa found this model to cost at least R325 per child per month.¹⁵¹

Fourthly, *statutory foster care*, where children are legally placed into the care of a surrogate parent, who may or may not be a relative, and who receives foster care grants. It should be noted that there are various forms of foster care, including traditional foster care, crisis care, community family model, collective foster care, and cluster foster care.¹⁵² In South Africa, the cost of formal foster care is estimated to be at least R410 per month.¹⁵³

Fifthly, *adoption*, whereby children are permanently placed into the care of a surrogate parent. This is regarded as the most secure option for orphaned and abandoned children, particularly where adoptive parents are extended family/kinship members. This model costs the same as formal foster care.

¹⁴⁸ G. Foster, *et al.*, ‘Supporting children in need through a community-based orphan visiting programme’, *AIDS Care*, vol.8, no.4 (1996), p.400.

¹⁴⁹ Foster, *et al.*, ‘Supporting children in need through a community-based orphan visiting programme’, p.400; M. Russell & H. Schneider, *A Rapid Appraisal of Community-based HIV/AIDS Care & Support Programmes in South Africa* (Johannesburg: Centre for Health Policy, Wits University, 2000), p.26.

¹⁵⁰ Loening-Voysey & Wilson, *Approaches to Caring for Children Orphaned by AIDS & Other Vulnerable Children (OVC)*, pp.25-28.

¹⁵¹ C. Desmond & J. Gow, *The Cost-Effectiveness of Six Models of Care for Orphan & Vulnerable Children (OVC) in South Africa* (Report prepared for UNICEF by the Health Economics & Research Division, University of Natal, South Africa, 2001), pp.28-30.

¹⁵² Loening-Voysey & Wilson, *Approaches to Caring for Children Orphaned by AIDS & OVC*, p.35; Russell, *A Rapid Appraisal of Community-based HIV/AIDS Care & Support Programmes in South Africa*, p.27; Smart, *Children Living with HIV/AIDS in South Africa*, pp.79-81.

¹⁵³ Desmond & Gow, *The Cost-Effectiveness of Six Models of Care for Orphan & OVC in South Africa*, p.30.

Sixthly, *institutional care* where children are placed into a residential care setting.¹⁵⁴ Traditionally, these have been *dormitory-based children's homes*, where children are normally segregated by age and sex, and share communal living and dining areas. In contrast, more 'modern' *family-based children's homes* care for children within family units, based upon conventional western nuclear families, where children stay with 'siblings' and develop a stable relationship with one parental figure. Sometimes these 'families' are grouped together on one site, as in an SOS Children's Village, while in other cases they are located in the community. Alternative *culturally-adapted models* have also been developed. These are normally in the rural areas and create a more traditional living environment, with communal living, traditional cooking and eating arrangements, and small-scale agricultural projects. Young children may also be placed into *homes for infants and toddlers*. In Zimbabwe, a study in 1994 estimated that the cost of care in an SOS Children's Village was Z\$1,054 per month, compared to Z\$210-Z\$341 in other family-based institutions, and Z\$131 in a culturally-adapted model.¹⁵⁵ In South Africa, the cost of childcare in an SOS Children's Village is R3,344 per month, compared to at least R2,590 in other registered residential care facilities, and at least R957 in unregistered facilities.¹⁵⁶

Seventhly, *community-based support structures* for children being cared for by informal/indigenous care-givers within their community of origin.¹⁵⁷ While the nature of support varies widely, the essential functions are support given to care-givers and linking them with relevant services and resources. In South Africa, the cost of this form of support is estimated to be at least R276 per month.¹⁵⁸

Eighthly, *home-based care and support (HBC)* programmes, which have been designed to provide care to chronically ill people within their home, but are commonly extended to meet

¹⁵⁴ G.M. Powell, *et al.*, *Child & Welfare Policy in Zimbabwe* (Harare: Department of Paediatrics & Child Health, University of Zimbabwe, 1994), pp.27-28; Loening-Voysey & Wilson, *Approaches to Caring for Children Orphaned by AIDS & OVC*, pp.33-34, 37-38.

¹⁵⁵ G.M. Powell, *SOS in Africa: The Need for a Fresh Approach* (unpublished paper, 1998/99); Powell, *et al.*, *Child & Welfare Policy in Zimbabwe*, p.33.

¹⁵⁶ Figure for SOS Children's Village based on total expenditure in year 2000 divided by 12 months, divided by the number of children cared for in SOS Children's Villages and Youth Facilities, see: SOS Children's Villages Association of South Africa, *SOS Children's Village Association of the Republic of South Africa Financial Statements for the year ended 31 December 2000*, p.6. If a child is HIV-infected, then cost in registered facilities is at least R3,525, see: Desmond & Gow, *The Cost-Effectiveness of Six Models of Care for Orphan & OVC in South Africa*, p.30.

¹⁵⁷ Loening-Voysey & Wilson, *Approaches to Caring for Children Orphaned by AIDS & OVC*, pp.26-28.

¹⁵⁸ Desmond & Gow, *The Cost-Effectiveness of Six Models of Care for Orphan & OVC in South Africa*, p.30.

the needs of patients' dependents, including orphan-related care.¹⁵⁹ HBC models can be community-based or institution-based. Community-based HBC programmes recruit and train volunteers from the community to visit and care for people in their home. Institution-based HBC utilises professionals or experts from health care facilities to conduct home visits, although the additional use of volunteers is also common. A well-documented example of HBC that has extended its services to include an *orphan visiting programme* is the Family AIDS Caring Trust (FACT) in Zimbabwe.¹⁶⁰ This programme involves the registering of orphans within the community, and assessment of the material, educational, psychological and spiritual needs of the families caring for them. Limited and targeted material support may then be offered, in the form of school fees, food, clothes, blankets, seeds and building materials. Another notable HBC programme, identified by UNAIDS as an example of 'best practice', is Tateni Home Care Services in Mamelodi, South Africa.¹⁶¹ In Zambia, community-based HBC has been estimated to cost US\$2 per day, compared to US\$10-US\$40 per day for institution-based HBC, and US\$3-US\$8 for hospital (in-patient) care.¹⁶² In the second half of 1996, FACT volunteers made 9,634 visits to 3,192 orphans in 798 families, with an average cost of US\$1.55 per visit.¹⁶³ In South Africa, the cost of HBC orphan care is estimated to be at least R306 per month.¹⁶⁴

Finally, *reactive* care and support may be offered, whereby organisations assist those orphans who approach them for the provision of basic needs.¹⁶⁵

Discussion of care models

Beyond the traditional social safety net, of the extended family, the conventional response to children in need of care has been to increase the capacity of institutional care. However, institutions are overwhelmed by the scale of the HIV/AIDS epidemic. A study in 1994

¹⁵⁹ Loening-Voysey & Wilson, *Approaches to Caring for Children Orphaned by AIDS & OVC*, pp.30-32.

¹⁶⁰ Foster, *et al.*, 'Orphan prevalence & extended family care in a peri-urban community in Zimbabwe'; Foster, *et al.*, 'Supporting children in need through a community-based orphan visiting programme'; G. Foster, *et al.*, 'Perceptions of children & community members concerning the circumstances of orphans in rural Zimbabwe', *AIDS Care*, vol.9, no.4 (1997), pp.391-405; Drew, *et al.*, 'Strategies for providing care & support to children orphaned by AIDS'; Moy, 'Caring for children orphaned by AIDS'.

¹⁶¹ UNAIDS, *Comfort & Hope: Six Case Studies on Mobilizing Family & Community Care for & by People with HIV/AIDS*, UNAIDS Best Practice Collection (Geneva: UNAIDS), pp.53-64; Smart, *Children Living with HIV/AIDS in South Africa*, pp.84-86.

¹⁶² Russell, *A Rapid Appraisal of Community-based HIV/AIDS Care & Support Programmes in South Africa*, p.12.

¹⁶³ Drew, *et al.*, 'Strategies for providing care & support to children orphaned by AIDS', p.S9.

¹⁶⁴ UNAIDS2, p.30.

¹⁶⁵ Drew, *et al.*, 'Strategies for providing care & support to children orphaned by AIDS', p.S10.

indicated that there were 38 residential childcare facilities in Zimbabwe, registered to accommodate 2,274 children.¹⁶⁶ In 1997/8, the 144 registered residential childcare facilities in South Africa had a capacity of 10,700 children.¹⁶⁷ These figures are dwarfed by the number of children orphaned and abandoned in the wake of HIV/AIDS.

In addition, institutional care is the most expensive form of care. This reflects the fact that residential facilities often provide a high quality of care, in terms of material needs, such as accommodation, food and clothing. This is particularly true of SOS Children's Villages, hence their relatively higher cost.

There are also concerns that by removing children from their community of origin, institutional care results in the alienation from their cultural and social roots, and may even undermine traditional coping mechanisms and foster dependency.¹⁶⁸

Consequently, it is perhaps not surprising that institutional care is now generally regarded as the option 'of last resort'. This has been clearly expressed in orphan and childcare policies of various Southern African countries, notably Malawi, Zimbabwe and South Africa.¹⁶⁹

Nevertheless, residential care facilities will always have a role to play, as extended family care may not always be possible, or indeed appropriate (if expose children to neglect, exploitation or abuse), and as adoptive and foster placements are limited.¹⁷⁰ In particular, there is a shortage of facilities to care for HIV-infected infants.¹⁷¹ Where institutional care is

¹⁶⁶ Although some had occupancy rates of 106%-128%. See Powell, *et al.*, *Child & Welfare Policy in Zimbabwe*, p.26.

¹⁶⁷ The Office on the Rights of the Child, *Children in 2001*, p.62.

¹⁶⁸ R.S. Drew, C. Mafuka & G. Foster, 'Strategies for providing care & support to children orphaned by AIDS', *AIDS Care*, vol.10, Suppl.1 (1998), p.S10; Powell, *et al.*, *Child & Welfare Policy in Zimbabwe*, pp.32-33; Powell, *SOS in Africa: The Need for a Fresh Approach*; Rutayuga, 'Assistance to AIDS orphans within the family/kinship system & local institutions', p.61; Foster, *et al.*, 'Supporting children in need through a community-based orphan visiting programme', pp.400-401; Foster & Williamson, 'A review of current literature on the impact of HIV/AIDS on children in sub-Saharan Africa', p.S278; UNICEF/UNAIDS, *Children Orphaned by AIDS*, p.29.

¹⁶⁹ Malawi's 1992 Orphan Care Guidelines, see UNICEF/UNAIDS, *Children Orphaned by AIDS*, p.13; Zimbabwe's 1995/1999 National Policy on the Care and Protection of Orphans. UNICEF/UNAIDS, *Children Orphaned by AIDS*, p.21; South Africa's policy to place children in community or home-based care, rather than institutions, see The Office on the Rights of the Child, *Children in 2001*, pp.62-63; also, Loening-Voysey & Wilson, *Approaches to Caring for Children Orphaned by AIDS & OVC*, p.25.

¹⁷⁰ NMCF, *A Study into the Situation & Special Needs of Children in Child-Headed Households*, p.34; ; Loening-Voysey & Wilson, *Approaches to Caring for Children Orphaned by AIDS & OVC*, p.53.

¹⁷¹ The Office on the Rights of the Child, *Children in 2001*, p.92; Loening-Voysey & Wilson, *Approaches to Caring for Children Orphaned by AIDS & OVC*, p.56.

required, models that conform as far as possible to normal family life in the community are best.¹⁷²

While formal foster care has the potential to accommodate a much larger number of children, the number of foster placements is also limited.¹⁷³ In Zimbabwe, there were only 755 registered foster families in 1994. In the Southern African context, families tend to be reluctant to care for unrelated children, and awareness and recruitment campaigns shall be necessary if fostering capacity is to be increased.¹⁷⁴

Similarly, adoption of non-relatives is neither widespread nor well-accepted.¹⁷⁵ In Zimbabwe, only 187 adoptions were processed between 1988 and 1992, and only 19% to black families. This is often attributed to cultural barriers to adoption of unrelated children. In contrast to the openness of conventional 'western' adoption practice, potential adoptive parents often wish to keep such arrangements secret and create the impression that the child is their own natural child. This may stem from fear of the stigma associated with infertility and reluctance to inform the child of its adoptive status. Also, as parents prefer to adopt newborn children, many infants may lose adoption opportunities, given that investigation of abandoned infants usually takes 5-6 months. To become a viable option, adoption requires awareness and recruitment campaigns.¹⁷⁶

Informal foster care is a relatively cheap care option, but care-givers generally have least access to resources required to provide a reasonable quality of care, and this care is often beyond the supervision social welfare services.¹⁷⁷

While community-based support is the cheapest model of care, it is not the most cost-effective, given that it does not provide for all of the child's needs.¹⁷⁸

¹⁷² Powell, *et al.*, *Child & Welfare Policy in Zimbabwe*, p.37.

¹⁷³ Powell, *et al.*, *Child & Welfare Policy in Zimbabwe*, p.15; Loening-Voysey & Wilson, *Approaches to Caring for Children Orphaned by AIDS & OVC*, p.51.

¹⁷⁴ Powell, *et al.*, *Child & Welfare Policy in Zimbabwe*, p.15.

¹⁷⁵ P. Brink, *Adoption Practice in the AIDS Era: A South African Perspective* (Paper presented at the Southern African Conference on 'Raising the Orphan Generation', Pietermaritzburg, South Africa, 9-12 June 1998); Powell, *et al.*, *Child & Welfare Policy in Zimbabwe*, pp.15-16; Rutayuga, 'Assistance to AIDS orphans within the family/kinship system & local institutions', p.58.

¹⁷⁶ Loening-Voysey & Wilson, *Approaches to Caring for Children Orphaned by AIDS & OVC*, p.34.

¹⁷⁷ Loening-Voysey & Wilson, *Approaches to Caring for Children Orphaned by AIDS & OVC*, pp.39-43.

¹⁷⁸ Desmond & Gow, *The Cost-Effectiveness of Six Models of Care for Orphan & OVC in South Africa*, p.30.

Of all care models, reactive care and support is the least effective, as it is unlikely to reach the neediest children and tends to encourage dependency.¹⁷⁹

The most effective model of care in terms of achieving 'minimum standards of care' is home-based care and support.¹⁸⁰ However, HBC programmes are usually dependant upon volunteers and suffer from a high burnout rate among home-care workers.¹⁸¹ Furthermore, as revealed in a recent South African study:

*Many programmes are fragile, function on shoe-string budgets and limited capacity.*¹⁸²

To ensure an adequate and sustainable response, there is a general consensus that assistance for orphans is best targeted at supporting family and community-based coping mechanisms. Moreover, in the words of Foster *et al.*:¹⁸³

*There is a growing recognition that mobilizing and strengthening community-based initiatives such as caring for the sick and orphans are as urgent as preventing the further spread of HIV. Often, the groups best placed to strengthen family and community capacity are small grass-roots organizations, supported by non-governmental organizations.*¹⁸⁴

Preventing infection of young people

One of the main strategies used to fight the spread of HIV/AIDS worldwide has been HIV/AIDS awareness and prevention programmes targeted at children and young people. These programmes are particularly important, as children and young people:

¹⁷⁹ Drew, et al., 'Strategies for providing care & support to children orphaned by AIDS', p.S10.

¹⁸⁰ Loening-Voysey & Wilson, *Approaches to Caring for Children Orphaned by AIDS & OVC*, p.39.

¹⁸¹ Russell, *A Rapid Appraisal of Community-based HIV/AIDS Care & Support Programmes in South Africa*, pp.31-32; Loening-Voysey & Wilson, *Approaches to Caring for Children Orphaned by AIDS & OVC*, p.32.

¹⁸² Russell, *A Rapid Appraisal of Community-based HIV/AIDS Care & Support Programmes in South Africa*, p.19.

¹⁸³ NMCF, *A Study into the Situation & Special Needs of Children in Child-Headed Households*, p.37; Hunter & Williamson, *Children on the Brink*, pp.2, 7-10; UNICEF/UNAIDS, *Children Orphaned by AIDS*, pp-27-33; Moy, 'Caring for children orphaned by AIDS', pp.64-65; Rutayuga, 'Assistance to AIDS orphans within the family/kinship system & local institutions', pp.67-68.

¹⁸⁴ Foster & Williamson, 'A review of current literature on the impact of HIV/AIDS on children in sub-Saharan Africa', p.S280

*...are the window of hope for the future – even though some may already be infected, the overwhelming majority are not. The general picture is that in heavily infected countries, the individuals most likely to be HIV-free are those in the 5-14 years age group... ...the challenge... ...is to work with these disease-free children to enable them to remain so.*¹⁸⁵

A UNAIDS study confirmed that such programmes tend to delay the age at which young people first engage in sexual activity and reduce the risks of teenage pregnancy, sexually transmitted diseases and HIV infection.¹⁸⁶

As such, they are particularly necessary in Southern Africa, given already high infection rates amongst young people and even higher rates expected for children about to enter young adulthood.

HIV/AIDS awareness and prevention may be integrated into the curricula of formal school systems, as well as non-formal education programmes and local responses such as the Southern Africa AIDS Programme's 'school without walls' approach.¹⁸⁷ Such messages may also be communicated through entertainment and information media, including songs, drama, puppet shows, newspapers, radio and television.

There is increasing recognition of the contribution that children and young people themselves can make through direct involvement in HIV/AIDS-related education, prevention and care programmes. Indeed, their participation can enable more effective planning, implementation and evaluation of such programmes.¹⁸⁸ Children are best placed to identify their own knowledge, needs and priorities in a world with HIV/AIDS, so are able to provide better information as a basis for action. Key issues may be identified, which affect them, but may otherwise remain hidden. Furthermore, their personal involvement and a sense of ownership in activities shall lead to them being more committed to the process and more willing to contribute to sustained results over time.

¹⁸⁵ Kelly, *Planning for Education in the Context of HIV/AIDS*, p.35.

¹⁸⁶ Smart, *Children Living with HIV/AIDS in South Africa*, p.40.

¹⁸⁷ Kelly, *Planning for Education in the Context of HIV/AIDS*, pp.35-36.

¹⁸⁸ J. Wilkinson, *Children & Participation: Research, Monitoring & Evaluation with Children & Young People* (London: Save the Children, 2000), p.5, at <http://www.savethechildren.org/>

In addition, participation enables children and young people to learn important life skills, gain a sense of empowerment, and is beneficial to their health and well-being.¹⁸⁹ This can be particularly important for HIV/AIDS-affected children and young people, as the more empowered they feel and the greater their life skills, the more effectively they will be able to deal with the challenges posed in a world with HIV/AIDS.

There are a number of ways in which children and young people can participate in HIV/AIDS-related education, prevention and care. These include what have been termed 'youth-to-youth' approaches, including *peer communication*, *peer education*, and *peer counselling*.¹⁹⁰

A particularly relevant approach, developed to actively involve children in health promotion, is the *child-to-child programme*. This programme involves children at every stage of the planning and implementation of such activities. Child-to-child follows a step-by-step learning-action-reflection process (see Appendix 3).¹⁹¹ Experience with this approach has proven that children can make a positive contribution to health promotion, by spreading health ideas and messages to younger children in the family and community (child-to-child); to other children in the community (children-to-children); within their communities (children-and-community); and, within their family (child-with-family). Child-to-child programmes have been established in Botswana, Namibia and Zambia.¹⁹²

Related to child-to-child approaches are Anti-AIDS Clubs, which have been established in many schools in Malawi and Zambia, and enable children and young people to choose how they can best participate.¹⁹³

¹⁸⁹ M. de Winter, C. Baerveldt & J. Kooistra, 'Enabling children: participation as a new perspective on child-health promotion', *Child: Health, Care & Development*, vol.25, no.1, pp.21-22.

¹⁹⁰ National Association of Child Care Workers, 'HIV/AIDS: A unique response', *Child & Youth Care*, vol.19, no.8 (2001), p.15; Smart, *Children Living with HIV/AIDS in South Africa*, p.40.

¹⁹¹ P. Pridmore & D. Stephens, *Children as Partners for Health: A Critical Review of the Child-to-Child Approach* (London: Zed, 2000), pp.4-5; H. Hawes, *Child-to-Child: A Resource Book Part 1 & 2* (London: CTC, 1994).

¹⁹² The Little Teacher Programme Botswana, see Pridmore, *Children as Partners for Health*, pp.125-130; CTC with the Basarwa (bushmen) children, see Pridmore, *Children as Partners for Health*, pp.130-137; CTC in Namibia, see V. Johnson, *et al.*, *Stepping Forward: Children & Young People's Participation in the Development Process* (London: Intermediate Technology, 1998), pp.136-137; CTC in Zambia, see Pridmore, pp.105-107.

¹⁹³ UNICEF/UNAIDS, *Children Orphaned by AIDS*, p.14; Kelly, *Planning for Education in the Context of HIV/AIDS*, p.36; J. Colling, *Guidelines for Children's Participation in HIV/AIDS Programs* (New Jersey: National Pediatric & Family Resource Center, University of Medicine & Dentistry), at http://www.pedhivaids.org/education/children_living.html, accessed July 5, 2001.

Options for scaling-up: Possible strategies + organisational culture + available responses = ?

Chapter

5

GIVEN the impact of the HIV/AIDS epidemic on children and young people in Southern Africa, existing responses to their needs, possible strategies for NGO scaling-up and the compatibility of those strategies with SOS' organisational culture, a number of options can be identified for SOS to scale-up. These include the extension of existing 'additive' strategies, such as functional scaling-up, and exploring new 'multiplicative' strategies, such as support for community-based initiatives, networking, micro-level lobbying and advocacy.

Functional scaling-up

Emergency relief programmes: reducing mother-to-child transmission

Emergency relief programmes could be launched, to offer antiretroviral treatment to pregnant HIV-positive mothers and their newborn infants, through SOS medical centres and local public health facilities. This could almost halve mother-to-child transmission, at a relatively low cost, wherever implemented.

Social Centres: supporting family and community-based care

Further development of the few existing social centres and the establishment of new ones, could provide valuable opportunities for expanding impact, in terms of care and/or as community-based resource centres.

'Drop-in' centres could be established as a focal point for community-based HIV/AIDS-related programmes. Such centres may provide a range of services to HIV-infected mothers

and HIV/AIDS-affected families, tailored to their specific needs.¹⁹⁴ These services may include counselling, support groups, and provision of information materials. In particular, expectant HIV-positive mothers could be offered counselling on appropriate and safe infant feeding practices, and, if necessary, alternatives to child abandonment.¹⁹⁵ Through support groups, HIV-positive parents could be encouraged to plan for the future care and support of their children; discussing this with their children; making a will; identifying extended family members as potential care-givers; and, obtaining the necessary documentation for childcare grants.¹⁹⁶ The life of HIV-positive parents may be significantly prolonged, through positive-living (or 'wellness management') programmes, including education about indigenous foods that strengthen the immune system.¹⁹⁷ Training could also be provided on parenting skills, aimed at HIV-positive mothers and people caring for orphans. Families caring for orphans could be offered legal advice, material support, and help to secure childcare grants. This may involve creating awareness about entitlements, assisting care-givers to obtain necessary documentation, and negotiating with relevant welfare and health authorities.¹⁹⁸ More generally, referrals may be made to relevant welfare and health services, as required. In addition, HIV/AIDS-affected children and young people may be provided with homework support and supervision, a nutritious meal, and an opportunity to participate in peer group activities.

Mother-and-child centres could be established, to support young mothers who have been rejected by their families and communities because of their HIV-status. Here, they could receive temporary accommodation, advice, guidance and material support, to ensure the mother and child's health in the first few months after birth, and to prevent abandonment of the child.

¹⁹⁴ Russell, *A Rapid Appraisal of Community-based HIV/AIDS Care & Support Programmes in South Africa*, pp.22, 35, 37; Powell, et al., *Child & Welfare Policy in Zimbabwe*, p.42; Smart, *Children Living with HIV/AIDS in South Africa*, pp.5, 87.

¹⁹⁵ Bobat, 'The breastfeeding dilemma', p.860; Smart, *Children Living with HIV/AIDS in South Africa*, p.37.

¹⁹⁶ Smart, *Children Living with HIV/AIDS in South Africa*, pp.4, 46, 84; Russell, *A Rapid Appraisal of Community-based HIV/AIDS Care & Support Programmes in South Africa*, p.25; Loening-Voysey & Wilson, *Approaches to Caring for Children Orphaned by AIDS & OVC*, p.64.

¹⁹⁷ Moy, 'Caring for children orphaned by AIDS', p.65; Smart, p.69; Russell, *A Rapid Appraisal of Community-based HIV/AIDS Care & Support Programmes in South Africa*, p.29.

¹⁹⁸ NMCF, *A Study into the Situation & Special Needs of Children in Child-Headed Households*, p.33; Russell, *A Rapid Appraisal of Community-based HIV/AIDS Care & Support Programmes in South Africa*, pp.16, 21; Smart, *Children Living with HIV/AIDS in South Africa*, pp.81, 83; Loening-Voysey & Wilson, *Approaches to Caring for Children Orphaned by AIDS & OVC*, p.41.

Mother-and-child or drop-in centres could also run income-generating activities, to provide financial support, build vocational skills, and give a focus for support groups.¹⁹⁹

In the case of abandoned HIV-positive children, SOS could provide training and support for crisis care foster parents.²⁰⁰ Otherwise, care maybe provided through the establishment of infant-and-toddler homes and places-of-safety. While infant-and-toddler homes are not ideal, in terms of supporting the child's physical and emotional health,²⁰¹ they may still provide a better care environment than alternatives such as public hospitals.

In addition, SOS could provide day care and/or short-term respite care for orphans and HIV-positive children, who are cared for within the community, to strengthen the capacity of families to care for them.²⁰² More generally, day care and educational scholarships could be provided for children from HIV/AIDS-affected families, to support the children's education, and allow care-givers to earn an income or (if older siblings) attend school themselves.²⁰³

HIV/AIDS awareness & prevention programmes

As a child-focussed organisation, SOS is ideally placed to promote HIV/AIDS awareness and prevention programmes through such means as child-to-child programmes. These could be offered to children served by existing SOS projects and promoted within local communities. Social centres or schools may even be used as resource centres for child-to-child materials and training programmes.

Support for community-based initiatives

Working with home-based care & support (HBC) programmes

HBC programmes could provide an ideal access point into communities.²⁰⁴ Given established relationships with HIV/AIDS-affected families, they are readily able to identify and work with children affected and orphaned by HIV/AIDS. Various forms of support may be given

¹⁹⁹ Russell, *A Rapid Appraisal of Community-based HIV/AIDS Care & Support Programmes in South Africa*, pp.24-25, 33; Loening-Voysey, p.44.

²⁰⁰ Loening-Voysey & Wilson, *Approaches to Caring for Children Orphaned by AIDS & OVC*, p.51.

²⁰¹ Powell, *et al.*, *Child & Welfare Policy in Zimbabwe*, pp.28, 37.

²⁰² Loening-Voysey & Wilson, *Approaches to Caring for Children Orphaned by AIDS & OVC*, p.53.

²⁰³ Smart, *Children Living with HIV/AIDS in South Africa*, p.48; Powell, *SOS in Africa: The Need for a Fresh Approach*.

²⁰⁴ Smart, *Children Living with HIV/AIDS in South Africa*, pp.4-94.

to HBC organisations, including technical assistance and capacity-building; financial or material support; use of facilities; or working directly alongside HBC workers in providing orphan care and support.

Many HBC programmes have been started as an ‘emotional response’ to the problems created by the HIV/AIDS epidemic, and their staff often lack managerial, financial and administrative skills required to sustain effective programmes.²⁰⁵ SOS may provide such technical assistance to HBC programmes, as its projects are often relatively well-established, with relevant contacts, knowledge, skills and expertise.

In particular, SOS could make a valuable contribution in the recruitment and training of orphan care-givers and HBC workers, given relevant experience with SOS Mothers. Training resources used for comprehensive SOS Mother Training Programmes, such as those of the regional SOS Adult Training Centre in South Africa, could be drawn upon in the development and implementation of appropriate training courses.

Similarly, SOS could promote and support home-based early childhood education, using the experience and resources of SOS Kindergartens.²⁰⁶ SOS Kindergarten teacher training resources could be utilised, to develop appropriate training programmes for community volunteers, and material support given, to set-up home-based day care and pre-school facilities.

SOS social workers may play a valuable role in supporting the most appropriate placement of orphans, where possible within the extended family network.

Material support may be offered through simple schemes such as clothing banks and distribution systems, and the establishment of community gardens.

²⁰⁵ Smart, *Children Living with HIV/AIDS in South Africa*, p.87; Russell, *A Rapid Appraisal of Community-based HIV/AIDS Care & Support Programmes in South Africa*, pp.35-36; Powell, *SOS in Africa: The Need for a Fresh Approach*.

²⁰⁶ Loening-Voysey & Wilson, *Approaches to Caring for Children Orphaned by AIDS & OVC*, p.64.

In terms of facilities, HBC programmes could be offered workspace and resources at social centres to provide certain services, or even take responsibility for elements of social centre programmes. For example, a need identified by Tateni Home Care Services, in Mamelodi, is:

*...a day-care centre where clients come to get out of their homes and for exercise and income-generating activities is needed... ...for orphaned children.. ..it could serve as a soup kitchen where they could get a meal after school and interact with adults who could also supervise their homework. Orphaned children who have left school could join income-generating activities.*²⁰⁷

SOS social centres would seem ideal to meet these existing needs.

Where HBC organisations do not exist, SOS could play a role in mobilising communities towards their establishment. This would involve facilitating a process whereby communities identify their own needs and priorities, as well as possible responses using internal resources, including indigenous knowledge and skills. Needs may then be prioritised, and, if necessary, external resources identified and secured, to carry out required activities. This could be achieved through such techniques as *participatory rural appraisal (PRA)*.²⁰⁸

Networking

Working with local partners

Undoubtedly, effective networking could help ensure optimum use of available resources, so that HIV/AIDS-affected families are given as much support as possible. Partnerships should be built with all relevant local actors, such as health and welfare officials, schools, clinics and businesses, to ensure that a comprehensive safety net is created for these families.²⁰⁹

²⁰⁷ Smart, *Children Living with HIV/AIDS in South Africa*, p.85.

²⁰⁸ K. Butcher & U. Kievelitz, 'Planning with PRA: HIV & STD in a Nepalese mountain community', *Health Policy & Planning*, vol.12, no.3 (1997), pp.253-261.

²⁰⁹ Loening-Voysey, p.59; Russell, *A Rapid Appraisal of Community-based HIV/AIDS Care & Support Programmes in South Africa*, p.24.

As part of such collaborative efforts, fostering committees could be established, to select, train, supervise and support foster parents.²¹⁰

Lobbying & Advocacy

Communities

Within the community SOS could raise awareness of the plight of HIV/AIDS-affected children, and of the role of community members, organisations and institutions in responding to their needs.²¹¹ As part of this, public awareness and recruitment campaigns could be conducted to increase the number of potential adoptive and foster placements.

At the same time, awareness could be promoted within HIV/AIDS-affected families regarding children's rights, and how these should be met by family, community and public services.

Local health, welfare & education services

SOS could play a useful role in advocating unsympathetic health, welfare and education officials, to ensure that HIV/AIDS-affected children receive the services to which they are entitled.²¹² In particular, where children have a constitutional right to free education, SOS could lobby schools to meet their obligations.²¹³ Otherwise, SOS could lobby schools and education authorities to change restrictive policies regarding school fees and uniforms.²¹⁴

National government

SOS could join campaigns lobbying government to make anti-retroviral treatment available to pregnant HIV-positive women through public health facilities.

²¹⁰ Powell, *et al.*, *Child & Welfare Policy in Zimbabwe*, p.42.

²¹¹ Loening-Voysey & Wilson, *Approaches to Caring for Children Orphaned by AIDS & OVC*, p.59.

²¹² Russell, *A Rapid Appraisal of Community-based HIV/AIDS Care & Support Programmes in South Africa*, pp.17-18.

²¹³ Loening-Voysey & Wilson, *Approaches to Caring for Children Orphaned by AIDS & OVC*, p.45.

²¹⁴ Hunter & Williamson, *Children on the Brink*, pp.8-9.

Planned responses

As if to confirm the feasibility of some of the aforementioned strategies, recent months have seen the planning of some concrete responses to the HIV/AIDS epidemic, by SOS in Malawi, South Africa, Swaziland and Zimbabwe.

Swaziland

Building on established working relationships with the Salvation Army Community Care Team (SACCT), SOS Swaziland shall be launching a 'family carer' programme, in collaboration with the SACCT.²¹⁵ This programme is essentially an *orphan visiting programme*, designed to strengthen the capacity of families to care for orphans and other HIV/AIDS-affected children, within the two 'township' communities where the organisations are based. Children and families will be supported through regular visits by community volunteers, material support (such as food, blankets, fuel and school fees), and assistance with establishing income-generating projects. While the SACCT is to focus on home-based care and support, SOS will take responsibility for the programmes financial and administrative activities, as well as ongoing training support for community volunteers. SOS will employ a programme coordinator to manage the programme. The estimated cost of this programme is US\$24 per child per month and 60 families (approximately 300 children) shall be supported.

Zimbabwe

A social centre and hospice shall be established at the SOS Children's Village in Waterfalls, catering to the needs of HIV/AIDS-affected families, including child-headed households, granny-headed households, children with terminally ill parents, and terminally ill children.²¹⁶ Programmes shall be targeted at a neighbouring 'township' community, with initial support provided for 50 families. SOS will employ a field worker, to work with community volunteers, as well as community nursing staff and social workers. Children and families will be supported through regular visits and provided with material support. This support may include a monthly allowance, to enable families to cover daily living expenses (such as food,

²¹⁵ SOS Children's Villages Swaziland, *Proposal to Establish a 'Family-Carer' Programme for HIV/AIDS Orphans in Swaziland, in Collaboration with the Salvation Army Community Care Programme*.

²¹⁶ SOS Children's Villages Zimbabwe, *Pilot Project Proposal for SOS Social Centre & Hospice, Waterfalls, Harare, to Assist in the Support of Children in Difficult Circumstances, Especially Those Affected/Infected by HIV/AIDS* (Project proposal prepared by SOS Zimbabwe, July 2001).

clothing, fuel and water), until they are 'self-sustaining'. Further support may be provided in the form of assisted accommodation (rent or furnishing), school fees, vocational training for school leavers, and life skills training for care-givers.

A hospice for terminally ill children will offer support to families caring for HIV-infected children, so that they are able to stay in the community for as long as possible. However, children may be taken into the hospice when their families are no longer able to effectively meet the children's care needs.

South Africa

An existing vocational training centre at the SOS Children's Village in Mamelodi shall be converted into a social centre.²¹⁷ The centre's programmes shall be designed to strengthen family and community capacity to care for orphaned and other HIV/AIDS-affected children. They are likely to include home-based care and support through field-workers; primary health care programmes through a clinic, educational support through increased scholarships at the SOS Kindergarten; infant care through support for community-based day care facilities; and, income-generating activities. Links to Tateni Home Care Services could be considered and programmes structured accordingly.

Malawi

In addition to its existing HIV/AIDS-related activities, SOS Malawi is making a proposal for the establishment of a social centre at its SOS Children's Village in Lilongwe.²¹⁸ Social centre programmes will build on HIV/AIDS counselling provided by the SOS medical centre and be designed to strengthen the capacity of communities to help HIV/AIDS-affected families (particularly child-headed and granny-headed households), in communities around the children's village. By working through village chiefs and local government officials, SOS Malawi will explore appropriate means of assistance to be provided.

²¹⁷ SOS Regional Office for Southern Africa II, *Project Proposal for SOS Social Centre Mamelodi* (Project proposal prepared by SOS Regional Office, June 2001).

²¹⁸ Personal correspondence with the National Director of SOS Malawi, dated August 10, 2001.

Conclusion

The challenges faced by children and young people in Southern Africa in the wake of the HIV/AIDS epidemic are immense. Thus far, the response of the SOS organisation has been dwarfed by the scale of these challenges. While SOS clearly needs to scale-up its response, if it is to have any significant impact, the approaches that it can take to achieve this are not as clear-cut as some academics seem to suggest.

The academic literature proposes a various routes to scaling-up, including ‘additive’ and ‘multiplicative’ strategies. Moreover, a clear thrust in much of the literature, expressed explicitly by some (notably Clark) and implicitly by others, is that the only meaningful way of scaling-up is through multiplicative strategies, in particular through lobbying and advocacy for systemic change. As such, this would seem to be the ‘logical choice’ of scaling-up strategy for NGOs, particularly those based in the north.

However, there is often little or no consideration of the impact of organisational factors such as culture upon an NGO’s willingness or ability to follow such strategies. Within the NGO literature, few writers have ventured into studying organisational issues, let alone the links between organisational culture and scaling-up strategies.

In the case of SOS, it can be seen that the organisational dimension has been a significant factor in the success (or otherwise) of scaling-up strategies. During the early stages of its development, SOS’ strong club culture enabled the rapid growth of the organisation, through the successful replication of Gmeiner’s SOS Children’s Village model around the world and functional scaling-up by the development of supporting projects. With the organisation’s expansion, SOS moved towards a role culture, centred around the core model, which enabled organisational scaling-up, to ensure functional and financial sustainability.

However, the predominance of club and role cultures in the organisation has created a strong attachment to Gmeiner’s original idea, and to a hierarchical structure and bureaucratic

systems. The resulting inflexibility is probably the greatest weakness of the organisation's culture and has made the organisation less responsive to changes in the external environment, which, in the context of Southern Africa, clearly dictate the need for scaling-up.

At present, SOS' strong role-oriented culture effectively prohibits certain scaling-up strategies, notably lobbying and advocacy for systemic change. Nevertheless, a number of other strategies would seem to be feasible, especially the extension of existing additive strategies and the exploration of some multiplicative strategies. In terms of additive strategies, functional scaling-up, through the establishment of emergency relief programmes and social centres may significantly increase SOS' impact in the region, albeit incrementally. Beyond this, SOS could explore the multiplicative strategies of supporting community-level initiatives, networking and micro-level lobbying and advocacy. Moreover, in order to have an impact beyond local community level, SOS could consider pursuing such strategies in different locations, and at provincial and national levels; which would necessarily imply a greater level of networking and multi-actor programming.

Some of SOS' National Associations are moving in this direction, having already proposed relevant means of functional scaling-up (including targeted social centre programmes) and/or support for community-level initiatives (including support for HBC programmes). It is perhaps not coincidental that in countries that are making the most significant efforts to respond to the HIV/AIDS epidemic, such as Swaziland and Malawi, survey results for National Offices indicate that a task culture is predominant.

However, such responses need to be taken throughout the whole region, if SOS is to make a significant difference within Southern Africa. The results of the survey of organisational culture seem to suggest that these responses are most likely to grow where there is a significant element of task culture. In this light, the challenge perhaps lies in stimulating the spread of responses to other countries and projects where task culture is relatively weak.

While there may be a continuing need for an element of role culture, to effectively sustain the operation of existing projects, and any replication that may be required, this needs to be balanced by a more sensitive task culture, that is able to adapt and respond to the needs of a

changing environment. Given that survey results indicate that the preferred type of culture, at all levels of the organisation, is task culture, this would seem to be achievable.

In terms of the wider academic debate about NGO scaling-up, this case study would support the view that more consideration needs to be given to the implications of the organisational dimension on the feasibility of strategies for scaling-up. In particular, further research would be worthwhile concerning non-UK NGOs and those with a strong role culture. Also, research on the nature of charitable-giving in the various countries may also be valuable, in terms of what kinds scaling-up strategies are viable from a fund-raising perspective.

Moreover, this case study questions the view that the 'logical choice' of scaling-up strategy is macro-level lobbying and advocacy. If such views are correct, then the future of organisations such as SOS is in question, as they face the prospect of having a marginal impact, at best, or, at worst, becoming obsolete.

It is perhaps more likely that, as argued by Dolan, NGOs will continue to have a role to play, tending to build upon their particular strengths and developing 'distinct areas of competence'. As expressed by Jain *et al.*:

*If an NGO... ..is seen as the best social provider in its domain – compared to the private sector or the state (or other social actors/NGOs) – chances are high that it can continue to mobilise the required resources for expanded operations on a sustained basis.*²¹⁹

Therefore, the challenge for NGOs such as SOS is to pursue the most appropriate scaling-up strategies, to ensure that they have maximum impact and achieve the status of 'best social provider' in their particular area of competence. In considering the way forward in its work, and how to approach scaling-up, the following words of cautionary advice would seem to be especially relevant to SOS:

²¹⁹ Jain, et al., 'Scaling-up the impact of NGO programs', p. *et al.* (2000), p.19.

*Most NGOs devote an inordinate amount of energy and time to seek (a successful) model; once the model is seen to work in a situation, its replication is axiomatically accepted as appropriate both by donors and the NGO ...however... ...(studies suggest that) every NGO program and project needs to be reassessed for its fit with the specific needs of target group and target intervention. The presence of model features is no substitute for this assessment.*²²⁰

Or, in the words of Hermann Gmeiner himself:

*A global welfare network like SOS Children's Villages can only remain alive and dynamic if a continuous effort is made to respond to changing conditions in the society involved and to accept new challenges in the interest of the welfare of the children. With this ongoing process of adaptation to the various social realities of the world, the work of SOS Children's Villages will continue to lead to targeted developments in the facilities and services offered.*²²¹

²²⁰ Jain, et al., 'Scaling-up the impact of NGO programs', p. et al. (2000), p.24.

²²¹ Gmeiner, *Hermann Gmeiner: The SOS Children's Villages*, p.121.

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Appendices

Appendix 1: HIV/AIDS-related statistics for SOS projects in Southern Africa

Appendix 2: Organisational culture survey and summary of responses

Appendix 3: Child-to-child 'zig-zag' or 'four-step' approach.

Appendix One: HIV/AIDS-related statistics

The following is a summary of HIV/AIDS-related statistics that were gathered for all SOS Children's Villages and SOS educational facilities in Southern Africa:

HIV/AIDS-RELATED STATISTICS FOR SOS PROJECTS IN SOUTHERN AFRICA

Summary of information: as at June 30, 2001.

Table 1: Children and young people being cared for within SOS Children's Villages who are known to be HIV/AIDS-affected/infected.

	Total no. of children & young people	No. of AIDS orphans	No. of abandoned children	No. of HIV+ children & young people	No. of HIV+ AIDS orphans	No. of HIV+ abandoned children
Southern Africa I	1367	119	313	25	7	2
Southern Africa II	1261	16	336	1	4	2

Table 2: Children attending SOS educational facilities who are receiving SOS educational scholarships & who are known to be HIV/AIDS-affected.

	Total no. of children attending facilities	No. receiving SOS educational scholarships	No. scholarship cases who are AIDS orphans	No. scholarship cases with HIV-infected parents
Southern Africa I	9393	317	12	5
Southern Africa II	4418	412	0	2

Table 3: Children and young people within SOS Children's Villages who are known to have died from AIDS-related causes

	1994	1995	1996	1997	1998	1999	2000	2001
Southern Africa I	2	1	2	2	3	4	5	3
Southern Africa II	0	0	0	0	0	0	0	0

Table 4: SOS Mothers and Aunts who are known to have died from AIDS-related causes

	1994	1995	1996	1997	1998	1999	2000	2001
Southern Africa I	0	2	0	2	0	0	4	0
Southern Africa II	0	0	0	0	0	0	0	0

Table 5: Teaching staff within SOS educational facilities who are known to have died from AIDS-related causes

	1994	1995	1996	1997	1998	1999	2000	2001
Southern Africa I	0	0	0	0	0	0	0	1
Southern Africa II	0	0	0	0	0	0	0	0

Table 6: Other staff within SOS projects who are known to have died from AIDS-related causes

	1994	1995	1996	1997	1998	1999	2000	2001
Southern Africa I	0	0	1	0	1	3	1	3
Southern Africa II	0	0	0	0	0	0	0	0

NB: Countries included are Botswana, Malawi, Mozambique, Zambia & Zimbabwe (Southern Africa I) and, Angola, Lesotho, Namibia, South Africa & Swaziland (Southern Africa II)

It should be noted that these statistics represent cases that are *known* to be HIV/AIDS-related, and are therefore likely to under-estimate the actual number of cases. This is largely due to the fact that there is a lack of openness regarding HIV status, stemming from traditional 'taboos' surrounding discussion of sexual health and death; fear of stigmatisation; and, simply a lack of access to accurate information.

Nevertheless, such statistics may still provide an indication of the growth of the impact of the HIV/AIDS epidemic over time and the level of targeting of SOS programmes at HIV/AIDS-affected children.

Appendix Two: Organisational culture survey

Responses to the organisational culture questionnaire were received from the following:

Office/project	No. of responses	Comments
International Office (Innsbruck, Austria)	9	<input type="checkbox"/> Staff with at least 1½ years service. <input type="checkbox"/> 3 x management staff, from the various kinds of departments (communication/project coordination, construction/finance, human resources/information management). <input type="checkbox"/> 6 x non-management staff from various departments (communication, construction, finance, information management, project coordination, human resources).
Regional Office for Southern Africa II (Johannesburg, South Africa)	7	<input type="checkbox"/> All members of the Regional Office team with at least 1½ years service (except one).
National Office: Angola	1	<input type="checkbox"/> Project Director.
National Office: Lesotho	2	<input type="checkbox"/> All staff.
National Office: Namibia	3	<input type="checkbox"/> All staff.
National Office: Malawi	2	
National Office: Mozambique	3	
National Office: South Africa	3	
National Office: Swaziland	4	
National Office: Zambia	3	
SOS Children's Village: Maseru, Lesotho	1	
SOS Clinic: Maseru, Lesotho	1	
SOS Kindergarten	3	
SOS Hermann Gmeiner Primary School: Maseru, Lesotho	5	
Projects: Malawi SOS Children's Villages & Kindergarten	6	<input type="checkbox"/> Management/support staff.
SOS Children's Village: Pietermaritzburg, South Africa	5	<input type="checkbox"/> 1 x management staff <input type="checkbox"/> 3 x mothers/aunts <input type="checkbox"/> 1 x support staff
SOS Kindergarten: Pietermaritzburg, South Africa	4	<input type="checkbox"/> 1 x management staff <input type="checkbox"/> 3 x teaching/support staff
SOS Children's Village: Umtata, South Africa	7	<input type="checkbox"/> 2 x management <input type="checkbox"/> 4 x mothers/aunts <input type="checkbox"/> 1 x support staff
SOS Kindergarten: Umtata, South Africa	3	<input type="checkbox"/> 1 x management staff <input type="checkbox"/> 2 x teaching/support staff
SOS Hermann Gmeiner Primary School: Umtata, South Africa	5	<input type="checkbox"/> 1 x management staff <input type="checkbox"/> 3 x teaching staff <input type="checkbox"/> 1 x support staff

Appendix Three: The child-to-child approach

*When the history of our time is written, it will record the collective efforts of societies responding to a threat that has put in the balance the future of whole nations. Future generations will judge us on the adequacy of our response.*²²²

- President Nelson Mandela –



²²² President Nelson Mandela, speech made at the World Economic Forum session on AIDS, Davos, February 3, 1997, at <http://www.gov.za/speeches/index.html>, accessed on August 10, 2001.