

University of Cape Town



School of Management Studies

A FORMATIVE EVALUATION OF THE JAMES HOUSE PROGRAMME FOR ORPHANS AND VULNERABLE CHILDREN

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COMPULSORY DECLARATION:

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works of other people has been attributed, cited and referenced.

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EXECUTIVE SUMMARY

The increasing burden of care and support of orphaned children or those made vulnerable by HIV/AIDS remains a critical and challenging issue particularly in the South African context. A number of community based interventions have been put in place to provide both material and psychosocial support. This dissertation is a theory-driven process evaluation of a programme offering care and support to orphans and vulnerable children (OVCs). The programme is run by James House, a non-governmental organization whose main objective is to meet the basic needs of children in their service area; to protect them from abuse and exploitation, and to ensure there is no family breakdown that would lead to institutionalisation of the children. James House implements a nationally accredited model of care for OVCs called Isibindi. The James House approach involves direct support to OVCs and indirect support through referrals to complementary services. This dissertation presents the results of a formative evaluation of the James House Isibindi programme which provides some insight into the implementation and improvement of the programme.

The evaluation uses a theory-based approach. The programme theory behind the James House Isibindi programme can be explained as follows: Orphans and vulnerable children and their families improve their wellbeing if they can access essential services including education, healthcare, birth certificates/ identity cards, psychosocial support, food and nutrition support and many other kinds of support. The plausibility of the programme theory was assessed using relevant literature from previous evaluations carried out in sub-Saharan Africa including South Africa where the prevalence of orphans due to HIV/AIDS is rampant. The literature proved that the programme theory for James House was quite rational.

The evaluation attempts to answer 12 evaluation questions under three sub-headings namely, service utilisation, service delivery and organisational support. Service utilisation questions were mostly answered through interviews with 21 heads of households benefitting from the Isibindi programme, Service delivery questions were mainly answered through interviews with 7 child youth care workers and finally organisational support questions were responded to by the programme manager.

The results of the evaluation showed that James House had a mixture of success and challenges in its endeavor to deliver services to OVC. The results provide evidence that the James House programme and its Isibindi model of care is a promising approach to improving the wellbeing of OVC in the informal settlement of Hout Bay. The results suggest that James House clients are able to access education, health care, government grants and Safe Park without much difficulty. However, results also show that James House did not have enough resources to buy food parcels and provide a meal for the children in the safe park. James House has also had success in providing referral services with the exception of referrals to South African National Council on Alcoholism & Drug Dependence. There is also some indication that networking with an array of stakeholders who provide supplementary services has been crucial for the success of this programme. Lastly, the evaluation makes a number of recommendations for the improvement of the programme in the three areas of service utilisation, service delivery and organisational support as well as recommendations for a future evaluation.

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CHAPTER ONE: INTRODUCTION

The number of orphans and vulnerable children due to Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome (HIV/AIDS) is growing each day (Skinner & David, 2006; UNAIDS, 2009). Worldwide, the number of children under the age of 18 who had lost one or both parents to HIV/AIDS in 2009, stood at approximately 16.6 million (Bryant, Beard, Sabin, Brooks, Scott, Larson., ... & Simon., 2012, UNAIDS, 2011). It is estimated that more than 80% of AIDS orphans live in sub-Saharan Africa (Bryant et al., 2012; Hong, Li, Fang, Zhao, Zhao, Lin Zhang & Stanton, 2011; Shetty & Powell, 2003).

According to the UNAIDS report (2009), sub-Saharan Africa remains to a great extent the most affected region. For example, in 2008, it was estimated that more than 14.1 million children in sub-Saharan Africa, were orphans due to HIV/AIDS. In this region, AIDS affects mostly young people who are in the child bearing age who are also the bread winners in the families. As a result of lost income owing to the death of a parent or primary caregiver, orphans and vulnerable children are in greater danger of having poor health, nutrition and receiving proper care (Watts, Gregson, Saito, Lopman, Beasley & Monash, 2007). In addition, orphans are less likely than non-orphans to attend school (Monash & Boerma, 2004). Furthermore, they are also at risk of all forms of abuse and exploitation (Khulisa management services, 2008).

Monasch and Boerma (2004) referred to Southern Africa as the epicentre of the HIV epidemic. South Africa in particular, is one of the countries with the highest number of people infected with HIV/AIDS in the world (Children's Institute, 2011; UNAIDS, 2012). AIDS related illness has been ranked one of the highest causes of premature death and this trend is likely to continue in the near future (UNAIDS, 2012; UNICEF, 2004). The implication is that the number of orphans will continue to grow. In 2010, the estimated number of orphans in South Africa was 3.8 million (Meintjes & Hall, 2012). Cluver and Gardner (2006) argued that even if the incidence of HIV is brought under control by full administration of anti-retroviral therapy, the number of orphans will continue to rise for a number of years to come.

In the past decade or so, significant attention has been paid to the plight of orphans and other vulnerable children (OVC) and efforts to improve their wellbeing. In order to address the growing OVC problem, the United Nations Millennium Development Goals and the United States President's Emergency Plan for AIDS Relief (PEPFAR) incorporated an OVC agenda in their initiatives as a global response to provide services to children suffering physical, emotional and mental stress as a result of being orphaned or made vulnerable by HIV/AIDS (Schenk, Michaelis, Sapiano, Brown & Weiss, 2010; Wallis & Dukay, 2009).

Traditionally, orphaned children in Africa were taken care of by the extended family, usually the grandparents, aunts and uncles (Bray, 2003; Foster, 1998; Shetty & Powell, 2003; Yanagisawa, Poudel & Jimba, 2010). Since the number of orphans and chronically ill members of the family are on the increase in the communities, the burden of extra care and support is increasingly falling on unemployed relatives including grandparents and young siblings leading to reduced financial resources to meet their basic needs (Bryant, 2009; Heyman & Kidman, 2009; Yanagisawa, Poudel & Jimba, 2010). Therefore some form of intervention by the local governments, non-governmental organisations (NGOs), faith based organisation (FBOs) and other stakeholders is required to strengthen the abilities of such families to provide support and care to their own children as well as the orphans. According to the Department of Social Development: Policy framework for AIDS and other children made vulnerable by HIV/AIDS South Africa (2005), there is a collective commitment by the South African government, faith-based organisations (FBO), community based organisations (CBOs), civil society and the business sector to help children affected or infected by HIV/AIDS.

Among the national programmes working with children orphaned and made vulnerable by HIV/AIDS in South Africa is the Isibindi model of care (www.jameshouse.org.za/index.php/our-programmes/isibindi). Isibindi is a community based model of care for orphans and other vulnerable children developed by the National Association of Child Care Workers (NACCW). James House in Hout Bay is one of Isibindi's many implementing agencies across the provinces

of South Africa. James House is implementing the complete Isibindi model as it is without any aspects of the model added or removed.

Programme Description

The information used in this section to describe the James House programme was obtained from the following sources: interviews with the managing director and the programme manager (interview, 7 March, 2013), Interview with programme manager and fundraising manager (12 Feb, 2013), the James House website ([www. James House. org.za](http://www.JamesHouse.org.za)) and the James House programme documents.

James House is a non-governmental organisation (NGO) working with the orphans and vulnerable children and their families in the informal settlement of Imizamo Yethu, located in Hout Bay in the city of Cape Town. The programme's aim is to ensure that the vulnerable children's basic needs are met, their rights are protected and their families are given an adequate amount of support to care for them ([www. Jameshouse.org.za/Isibindi.html](http://www.Jameshouse.org.za/Isibindi.html)).

Since 1986, James House has served as a place of safety for abused, abandoned and neglected children from the community of Hout Bay. James House was named after the first child who was taken into care. When the James House programme started, it was meant to be a support group for grandmothers (the Gogo Programme). Over time, the organisation broadened its services in the context of HIV/AIDS and the rapid growth of Imzamo Yethu whose population is estimated to be between 20 000 and 30 000 people. Currently James House provides a number of services to the community. Some examples of the services according to their programme documents are; facilitating voluntary HIV Counselling and Testing (HCT) and accessing anti-retroviral treatment, helping families to access government grants; providing food parcels, offering grief counselling; ensuring that children attend school and offering life skills training. James House recruits and trains unemployed community members to work with children and

their families as child youth care workers (CYCWs). CYCWs conduct home visits in the community once or twice in a week, depending on the needs of the families.

James House's main objective is " To provide community- based care focusing on the emotional, physical, cognitive, spiritual and social wellbeing of 520 orphans and vulnerable children, as well as their care givers, so as to support the community to adequately care for children, thus avoiding family breakdown and the institutionalization of children"(James House Business Plan 2011/2012). In order to achieve this objective, James House includes three special components in its programme namely; the Safe Park, the Gogo Programme and the Liyema Ikhaya.

Components of the Isibindi programme

The Safe Park

The main goal of the safe park is to protect children from abuse and exploitation. The Safe Park, offers an after school care programme which is open to all children from the community from 13:00 to 17:00. on Mondays and Wednesdays. On Tuesdays and Thursdays the programme runs from 13:00. to 18:00 . During school terms, the Safe Park is open on Saturdays between 9:00 .and 14:00 ..Throughout school holidays the Safe Park is open from 9:00 . up to 15:00. on Mondays to Saturdays. The Safe Park grants space for up to 80 children to play in a supervised environment. The main activities that children take part in are structured play, free play, Life skills development, arts and culture. The CYCWs and some volunteers help the children with their homework as well as supervise and play with the children. In addition, the children's nutritional needs are met through the provision of a meal in the afternoon. The Safe Park is open to all children in the community and thus making it one of the methods used by James House to identify children in need.

The Gogo programme

The Gogo programme supports grandmothers who are caring for orphans and vulnerable children. The goal for this programme is to help at least 15 grandmothers through workshops on health and hygiene, children's rights, budgeting, nutrition and other topics relevant to the grandmothers' needs. Through these activities the grandmothers are equipped with some skills and knowledge to adequately care for orphaned children. The grandmothers also take part in arts and crafts projects which can help them to raise some additional income for the family. This programme takes place on 1 day a week and the grandmothers are also engaged in activities with children in the Safe Park, where they play a helpful role in the transfer of knowledge about traditional culture and values to the children.

Liyemalkhaya

The programme Liyema Ikhaya is an adolescent development programme for child headed households. The goal of this programme is to support child headed households to ensure that children in such households are adequately cared for and their education is not interrupted. Two child care workers work with at least 20 children from the child-headed households for ½ day per week. The children are equipped with the skills and knowledge to make responsible choices, to safeguard themselves against HIV infection and against abuse and exploitation.

Target Population

The target population for the James House programme are the OVC aged between 5 and 18 years and their primary care givers. Vulnerable children who are eligible for the services from James House programme include the following:

- Abused, neglected and exploited children;
- Maternal and dual orphans;
- Child-headed, youth-headed and grandparent –headed households;
- Children living with disabilities;
- Out of school children or teenagers (school dropouts);

- Children with substance abuse problems;
- Street children;
- Child sex workers; and
- Children from neighbouring countries.

Programme Duration

Children and their families participate in the James House programme for a period ranging between 9 and 12 months. Disengagement of families from the services is gradual and there is a transition to after care phase under which a lower level of support is given until families are independent. After care services are offered twice a week for a period of between 3 to 6 months. The expected outcome is that families will be able to function independently and children will be adequately cared for after disengagement. A detailed description of the services offered by James House is given below.

James Houses services to OVC and families

Access to health care

Generally OVCs have problems in accessing healthcare due to lack of money to pay for health care fees (Khulisa Management services, 2008). To ensure that children are in good health, James House helps children and their families access primary health care, immunization and treatment. In addition, James House facilitates HIV Counselling and Testing (HTC) of children and their families, and access to anti-retroviral treatment and Tuberculosis (TB) treatment where it is needed. HCT is believed by James House to play an important role in fighting against the HIV/ AIDS pandemic as it enables those who qualify for antiretroviral treatment (ART) to access it at an early stage as well as care and support services. The programme also implements campaigns to combat stigma around HIV/AIDS, bearing in mind that reduced stigma results in increased voluntary testing, counselling and treatment (James House Business Plan 2011/2012). In addition, voluntary testing is believed to ensure that clients have better health and increased longevity, resulting in fewer children being orphaned (James House Business Plan 2011/2012).

Furthermore, James House aims to refer clients who default on treatment as a result of substance abuse to NGOs such as the South African National Council on Alcoholism and Drug Abuse (SANCA). SANCA is a non-governmental organisation whose major objectives are the prevention and treatment of alcohol and other drug dependence problems within the South African population.

Access to Care

James House provides community based care to OVCs and their families. Community based care remains the preferred means of care for OVC due to the serious challenges faced by institutional care. CYCWs conduct home visits in the communities in order to meet the children's care needs as well as the needs of the guardians and care givers.

Access to education

In order to meet the educational needs of children, James House helps vulnerable children without birth certificates to obtain them from the relevant authorities. It is very important that children get birth certificates so that they can enrol at a school and apply for child social grants. In addition, James House assists in registering all children of school going age in local schools. They maintain regular contact with schools to follow up on children's progress and to identify those in need of additional education support. They also assist children in need through the provision of uniforms, school stationery, educational resources and payment of transport costs. Furthermore, they provide homework support to children who would have been identified as being in need of assistance as well as assisting children to use educational resources such as libraries and to access the internet. Furthermore, James House implements career guidance workshops for children from grade 7 to 12.

Access to food

James House attempts to meet nutritional needs of clients by running life skills programmes on nutrition for all families enrolled in the programme. Nutritional needs are important in the sense that adequate nutrition leads to improved health. Children are offered a meal when they come to the Safe Park after school and over the holidays. However due to financial constraints sometimes these meals are not readily available to the children. In addition, James House provides food parcels for short term relief while clients are waiting for their grants from the government. In the long term families are assisted to establish vegetable gardens in order to improve their food security.

Access to government grants

Children and their families are assisted by James House to apply for identity cards from Home Affairs which are a pre-requisite for the application of grants from the Department of Social Development. First time applicants are assisted to obtain necessary documentation such as birth certificates and identity documents. Moreover, James House assists clients to meet with relevant stakeholders such as the Child Welfare, Social Development and Home Affairs to solve difficulties in securing foster care grants.

Access to psychosocial support

James House ensures that all the children in the programme receive the psycho-social support that they require. Many of the children have either lost one or both parents due to HIV/AIDS. Some have lived with chronically ill parents or relatives whom they have seen dying or have been abandoned resulting in them being vulnerable and in need of psychosocial support. In order to promote the emotional wellbeing of these children; psychosocial support is offered to the identified children by the James House CYCWs. Services such as the provision of psychosocial support ensure that OVCs engage in positive humane relationships necessary for normal development similar to the other children in their communities. James House promotes emotional wellbeing of children through the following interventions: grief counselling, memory boxes, counselling to accompany HIV testing, and specialist services for example therapy, facilitated for children who require intensive support. The process of making memory boxes is believed to provide group therapy to the child. Inside the memory box the child can store some

photographs of their parents, cards, their childhood clothes and toys, the list can go on. It is believed that sometimes looking at these things can bring happy thoughts to the child and this helps them overcome their loss.

Access to protection

Lastly, James House protects children and their families from abuse and exploitation through implementation of a secure place for children to play after school and during school holidays popularly known as the Safe Park. Access to legal protection is also given to deal with cases of property grabbing after the death of parents, as well as issues of all forms of child abuse.

The James House programme's organisational plan is shown in Figure 1 below. The plan shows the functions and the activities that the programme is expected to carry out as well as the human, financial and physical resources required for the programme to deliver services to its target group. The procedure is as follows, after the OVC have been identified by the programme staff, community, clinic or schools, enrolment into the programme is usually followed by a designed needs assessment. The needs assessment is done according to the Isibindi standards and it includes an assessment of household head status, living conditions, and an individual child's nutritional, educational and financial requirements. The tailored needs assessment informs the range of services the individual OVC needs as well as the individual household needs.

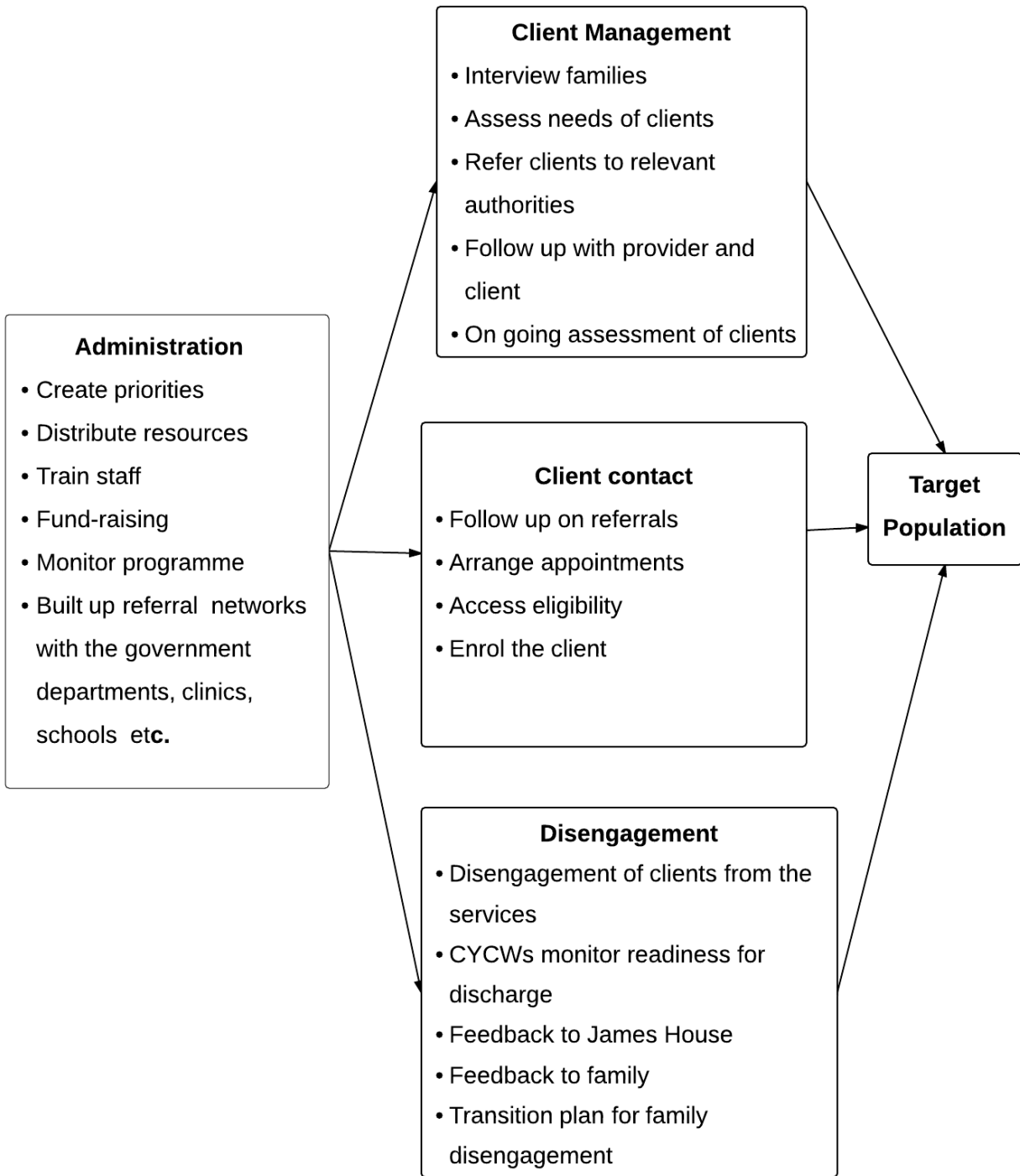


Figure 1: James House organisational plan adapted from Rossi, Lipsey and Freeman (2004)

Programme Theory

Rossi, Lipsey and Freeman (2004, p.435) define programme theory as “ The set of assumptions about the manner in which a programme relates to the social benefits it is expected to produce and the strategy and tactics the programme has adopted to achieve its goals and objectives”. Bickman, (1987, p.5) defines programme theory as “the construction of a plausible and sensible model of how a programme is supposed to work”. From the two definitions, programme theory is expected to explain why and how a programme works to produce the intended outcomes. In other words it is a way of looking inside the “black box” in order to try to understand what really is going on in the programme instead of just focusing on the outcomes of the programme (Chen, 2005). Programme theory is also often called a logic model and it is an assumption about how the programme’s actions are supposed to achieve its aims and objectives. The programme theory in Figure 2 was drawn out from the programme documents and interviews with the management of the programme.

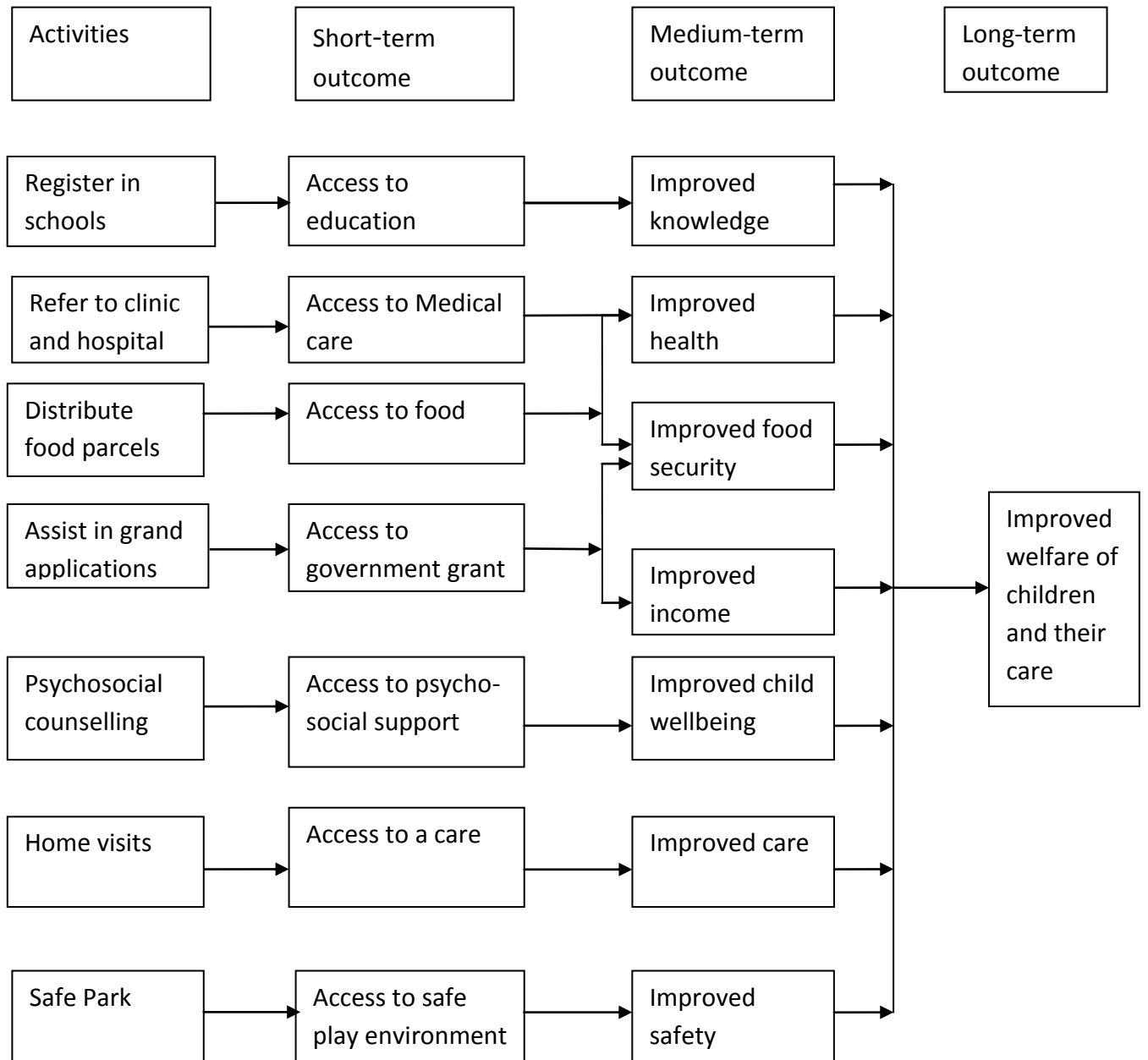


Figure 2. Client's Programme Theory

Assessment of theory plausibility and logic

The plausibility and logic of the client's programme theory in Figure 2 was assessed through a literature search on community based programmes involved in the caring and supporting of orphans and vulnerable children similar to the James House programme. This literature review aims to establish the extent to which the wellbeing of children affected by HIV/AIDS can be improved by means of community based care and support programmes, as well as the degree to which the activities of the programme under evaluation have been implemented by similar programmes. The researcher consulted a number of sources as part of the literature review such as Journal articles, text books, internet sources, research reports and unpublished documents. Search engines utilized were Google scholar, Ebsco Host and Primo UCT, and the primary key words were "Orphans and Vulnerable Children". In order to capture the current debates within the topic the researcher looked at literature published as from the year 2000 up to the present day.

A literature search revealed that a considerable amount of literature has been published on Orphans and Vulnerable Children mostly in high HIV/AIDS prevalence parts of Africa. Most research articles focused on the state of affairs of OVC and need for funding of community interventions but few studies centred on OVC programme evaluations. Programme evaluations provide evidence to inform policy makers and donors about whether their efforts are improving lives of OVC or not. Lack of literature which focuses on evaluation of OVC intervention programmes in sub-Saharan Africa has been noted by authors in the field such as Bryant, Beard, Sabin et al., (2012) and Schenk et al., (2010). Bryant, Beard, Sabin et al. (2012), mentioned lack of some baseline data and clear outcome and impact indicators as some of the obstacles in the evaluation of the interventions in the East and Southern African countries. King, De Silver, Stein and Patel (2009) stated that most of the programme implementers have limited resources and time for evaluation research. The evaluator therefore had to make use of some grey literature in some cases that was located through database and internet searches. There is a possibility that the search might have missed some recently published literature since it was conducted during the initial stages of the research in 2013. Most of the African based literature regarding care and support of orphans focused on community-based interventions (Thurman, Jarabi & Rice, 2012).

Datta (2013) argued that children should be placed at the centre of all development programmes. He further stated that the government and NGOs should supplement, rather than replace community programmes. Community based care is believed to be the most common cost effective strategy for providing care to OVC compared to institutional care (Schenk et al., 2010) In addition, among other advantages, community care keeps children in their communities close to their siblings, relatives and friends. Datta also stated that FBOs and NGOs in his study supplemented government efforts so as to improve the welfare of orphans and vulnerable children, by providing them with a wide range of services including educational support, income generating skills, food aid and counselling, protecting girl children from sexual exploitation and abuse in general.

In both published and unpublished literature, there is continuing debate about the definition of orphans and vulnerable children. The global definition of an orphan and vulnerable child as stated by the United Nations Children's Fund is as follows:

An orphan is a child below the age of 18 who has lost one or both parents. A child made vulnerable by AIDS is below the age of 18 and:

- has lost one or both parents, or
- has a chronically ill parent (regardless of whether the parent lives in the same household as the child or
- lives in a household where in the past 12 months at least one adult died and was sick for three of the 12 months before he or she died, or
- lives in a household where at least one adult was seriously ill for at least 3 months in the past 12 months, or
- lives out of family care (i.e. lives in an institution or on the streets)(UNICEF, 2009, p23)

However, there is often a key defining feature of an orphan in the majority of African traditions. Children whose parents are alive but are separated as a result of divorce or economic hardships can be classified as orphans. Skinner & Davids (2006) carried out some research on OVC definitions in South Africa, Botswana and Zimbabwe.. The definition studies were based on

focus group discussions with members of Non- Governmental Organisations (NGOs), officials from the government departments, carers and OVCs as well as community members. The discussions reached a consensus that the age limit for the definition of a child should be 18 years. They also agreed that an orphan is a child who would have lost one or both parents and is likely to be vulnerable. However, Munyati, Chandiwana, Mupambireyi, Buzuzi, Mashange, Gwini & Rusakaniko (2008) stated that there is no direct relationship between orphanhood and vulnerability. They went on to say that there are some children who are vulnerable but are not necessarily orphans and some are orphans and yet are not vulnerable. Some children are vulnerable due to being abandoned by their parents, due to poverty or disability. Andrew, Skinner & Zuma (2006) argued that there is need to go beyond addressing only AIDS related problems bearing in mind that other causes of children's vulnerability cannot be overlooked. Taking into consideration the description of the James House target population (given earlier in the programme description), there is no doubt that James House considers other forms of vulnerability besides AIDS related ones.

Schenk (2009) carried out a review of 21 evaluations based on community interventions for OVCs in African areas that are characterized by high HIV-prevalence. Each of the studies evaluated children's welfare using different evaluation methods. Some used quantitative approaches whilst others used qualitative approaches with and without comparison groups. Due to ethical considerations none of the studies used randomized control trials as it would not be acceptable to deprive some children of the services that they are entitled to and allocate them to a control group.

The review by Schenk (2009) highlighted a number of key issues around effective service delivery and organisational support. For example, the majority of the 21 interventions that Schenk reviewed worked in partnership with national governments on matters of service delivery. The importance of strong partnerships with international NGOs and local CBOs was a common theme. Most of the programmes recruited and trained community volunteers to carry out home visits to vulnerable households. Schenk (2009) reported that the trained volunteers worked with child headed households where children were unable to attend school due to care

responsibilities and they also assisted chronically ill parents or caregivers with household responsibilities. Despite the different methods used in the evaluations, generally the evaluation findings indicated that community interventions are valuable in improving both the welfare of a child and the child's family. However, Schenk (2009) advises people implementing intervention programmes not to target orphans only and pay no attention to other vulnerable children as this may result in jealousy against the orphans in the community.

Schenk et al. (2010) in their evaluation, found that OVC interventions in the following countries, Kenya, Malawi, Rwanda, Uganda, Zimbabwe, Zambia and South Africa proved that community based psychosocial support programmes and care were helpful to many members who took part in the interventions especially youth. In addition the researchers were able to develop a tool for assessing the psychosocial wellbeing of young people affected by HIV including some ethical guidelines of conducting research among children. The study recommended that future programmes for young people should include services such as HIV prevention and life skills education, health services including access to antiretroviral treatment and livelihood support.

Bryant et al. (2012) carried out five studies to evaluate the effectiveness of the President's Emergency Plan for AIDS Relief's (PEPFAR) interventions for OVCs in East Africa and Southern Africa. Four of the studies evaluated the effectiveness of the OVC programmes in Kenya, Namibia, South Africa, Tanzania, Uganda and Zambia. The fifth study was carried out in Mozambique. The studies assessed the following elements of the programmes, economic, education and psychosocial support. Although they could not demonstrate empirically the impact of most of the PEPFAR programmes because they fell short of some baseline data and clear outcome/impact indicators. They found out that the programmes had accomplished some beneficial effects such as improvement in school enrolment rates as well as improvement in the psychosocial wellbeing for the children who were enrolled into the programmes. However, they did not find the majority of the interventions to be effective. Furthermore, the researchers discovered that the programmes were thinly spread among the vulnerable children with some children receiving very little in terms of service provision.

Similarly, Kidman, Petrow and Heymann (2007) evaluated two different models of community-based care that care for orphans and their families, and emphasizing the comparative advantages of each.. The researchers' literature review and survey revealed the need to provide orphans with the following six core services: physical health, mental health, nutritional support, educational support, material support, day and after care programmes was very crucial. They further reported that the two contrasting models that they looked at namely the centralised and decentralised approaches were able to meet the six urgent needs mentioned above. For example, the pre-school children were cared for in a safe and supervised area during working hours while their guardians or care givers were away at work. The older children came to the centre to receive meals after school, to take part in skill-based activities, and receive psychosocial counselling. In addition, the children's guardians and care givers would benefit from counselling and support delivered during home visits by the social worker or child care worker. Family assistance in accessing government childcare grants and school fee waivers would also be given. These types of assistance were highly effective in improving the lives of children and their families in the short term as well as increase their ability to support themselves in the long term.

Rosenberg, Hartwig and Merson (2008) evaluated nine NGO projects in Botswana, Lesotho, Namibia, South Africa and Swaziland. The projects offered the following services to the OVC: psychosocial support, material support, training for OVC, care givers or organisations for the care of OVC; and prevention of HIV/AIDS among the youth. The nine projects had a strong emphasis on community-based solutions for caring for the OVC. The evaluation makes a conclusion that NGOs can be helpful in assisting governments to accomplish their mission of providing grants to orphans and vulnerable children. It also concluded that the NGOs worked very well as a connection between families and government for grant access; provided material support to families waiting for their grant applications to be processed and helped the government to speed up processing of applications. The evaluation emphasizes the importance of the NGOs and CBOs to have a good working relationship with both local and national government partners for sustainable projects and long term improvements in the care and welfare of OVC.

Mueller, Alie, Jonas, Brown & Sherr (2011) carried out an evaluation that focused on reducing psychosocial problems among children affected by HIV and AIDS by increasing their self-esteem, self-efficacy and HIV knowledge. The five authors conducted a quasi- experimental evaluation of a community- based art therapy intervention called MAD ('Make a difference') looking at the psychosocial health of children affected by HIV in South Africa. They found out that losing both parents and experiencing HIV/AIDS stigma had a considerable effect on a child's psychosocial health. The evaluators concluded that well implemented therapy interventions are likely to increase self-esteem, self-efficacy, and knowledge about HIV/AIDs and above all improve the children's psychological health.

After going through literature the evaluator came up with a revised programme theory for the James House programme presented in Figure 3 that illustrates the separation between the actual services provided by James House and the referral services. The direct services are those services that James House itself offers to the clients whereas the referral services are offered by partnering organisations and other stakeholders of which James House has to assist the clients with applications for those services. The services are still the same as those presented in Figure 2 and the narrative except that the evaluator decided to disaggregate them more for the purpose of monitoring of outcomes in future evaluations.

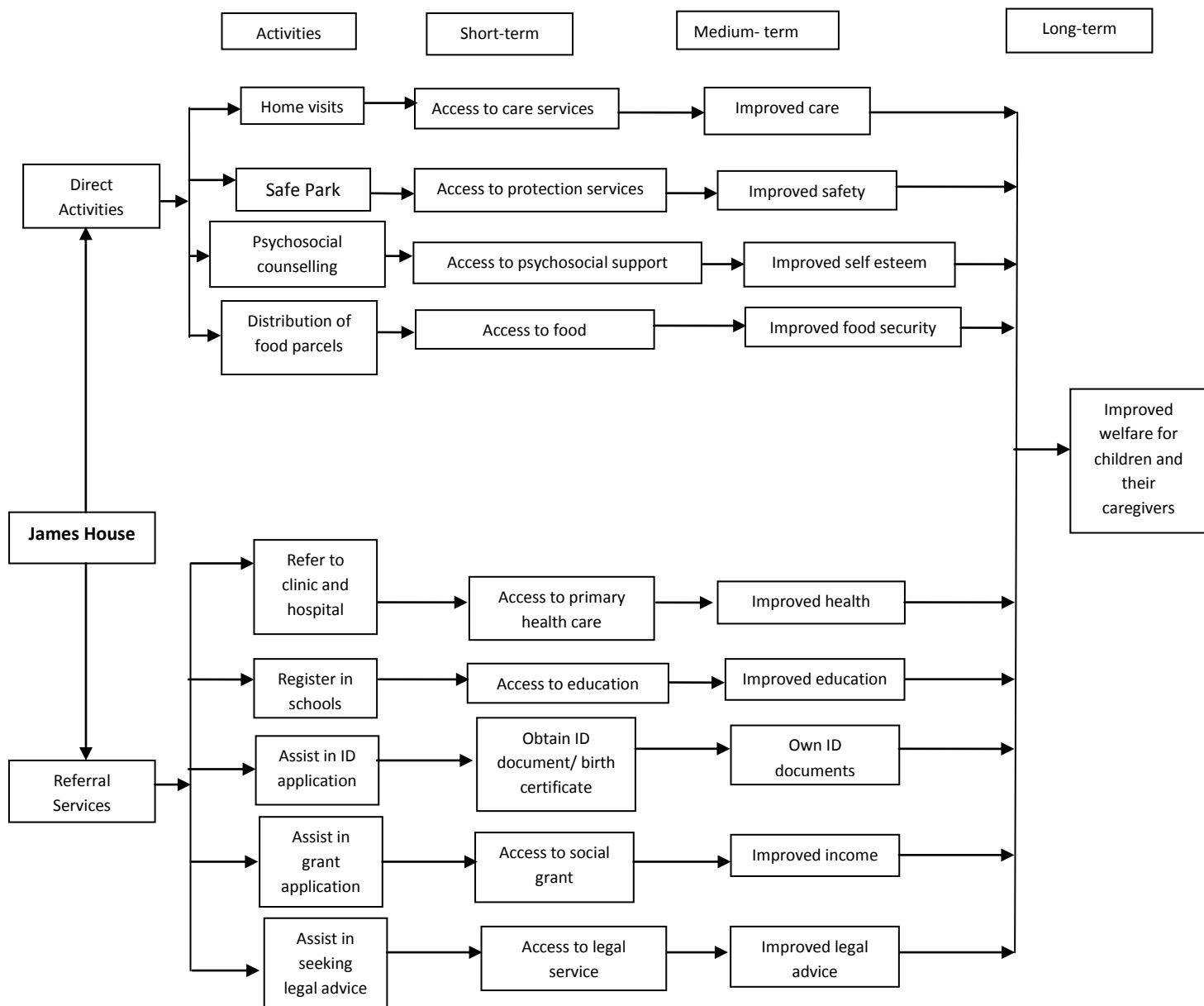


Figure 3 Revised programme theory for James House

In summary, the James House programme theory seems to be supported by the literature. Programme elements such as assistance in accessing social grants, obtaining identity documents, referrals to health care services, offering psychosocial, food and nutritional, educational and material support are reflected in the literature as being effective in improving children’s lives both in the short term and in the long term. The results of this literature review show that a good

working relationship between the NGO and relevant government departments is also crucial for the successful implementation of these programmes.

Evaluation Questions

This evaluation is formative in nature. In programme evaluation, formative research generally begins during programme development and continues through implementation and it has a cyclic nature whereby the programme is developed and checked with the target audience and some adaptations are made accordingly. Formative evaluation seeks to identify strengths and weaknesses of the programme as well as suggest quality improvements in terms of service delivery (Babbie & Mouton, 2006). This type of evaluation therefore provides programme staff with ongoing feedback for programme modifications. This formative evaluation consists mainly of a process evaluation. Process evaluation, while formative in nature, refers generally to the stage when the programme has been implemented and understandings about the processes of implementation are to be explored. Rossi, Lipsey and Freeman (2004, p. 431) define process evaluation as “A form of programme evaluation designed to determine whether the programme is delivered as intended to the target recipients”. Ross et al. (2004), state that, process evaluation involves answering questions about implementation of programme activities, service delivery and organisational support. This evaluation therefore focuses on the three mentioned components of process evaluation. The evaluation determines whether the components that were identified in the literature as critical to the success of the programme are being implemented as planned. In addition the evaluation also determines whether target populations are being reached, clients are receiving the intended services and whether staff are adequately trained to deliver the services.

Due to the fact that James House is implementing a mature Isibindi programme, they utilise a nationally standardized monitoring and evaluation system that monitors the status of the clients at engagement, disengagement and throughout the service delivery stages. Most of these data are, however, simply collected and sent off to Isibindi as part of their standard programme reporting. The programme has less information regarding the quality of services and how well the services

are being delivered to the clients. In other words there is uncertainty as to whether the manner in which the programme is delivered by programme staff is effective and whether the necessary programme services are being utilised by the target population. There is particular concern that a significant number of clients who have met the criteria for disengagement from the programme subsequently re- enter the programme at a later stage. There is a possibility that the group that re-enters the programme is bold enough to come forward and ask for more services. In actual fact there could be more clients who are still in need of services even though they met the disengagement criteria in the past. There is therefore need for a long term solution so that once a client has been disengaged he or she has necessary resources to prevent them from re-entering the programme.

The fact that clients come back for more services may suggest that the programme has been unable to make them independent.. There is need therefore to find out how the clients view the James House services, both the positive aspects as well as the negative aspects. There is also need to ask for their opinion on how the services can be improved. Similarly, opinions of the James House staff who are the service providers are equally important, as they are the best placed to comment on the strength and weaknesses of the service delivery process (Kuma, 2011). The staff morale is another aspect that the programme management is interested in assessing for the sake of improvement. In this regard the information from this evaluation will help the management to establish whether the programme is being delivered effectively to meet the needs of the target population. The information may also detect any disparity in the services that the programme is providing. However, an ideal situation would have been to do an outcome evaluation first which shows lack of results from the programme and then a process evaluation to determine these short-comings. Unfortunately the limited time frame and resources would not allow the evaluator to do so. Taking the above information into consideration, the following evaluation questions grouped into the three subsections namely, service utilisation, service delivery and organisational support were formulated in order to guide the evaluation research.

Service Utilisation

- 1) What are the socio-demographic backgrounds of the James House clients? How does utilisation of the James House services vary between different socio-demographic groups?
- 2) Since 2010, how many children and their families completed the programme, re-entered the programme after disengagement, and are currently in the programme?
- 3) Are the clients receiving services when they are needed?
- 4) Are the services being delivered by the James House programme adequately meeting the needs of the clients?

Service Delivery

- 5) What are the primary activities of the programme? Are the activities the same as those stipulated in the Isibindi model?
- 6) Is James House adequately training the child care workers to strengthen their knowledge in areas such as HIV/AIDS information, grief counselling, homework supervision as well as child rights and protection?
- 7) Do the child care workers have a good working relationship with the clients?
- 8) Are the child care workers recruiting the required number of clients in a year?
- 9) Are there any services that the programme staff are struggling to deliver, and why?

Organisational Support

- 10) Does the programme have sufficient staff to deliver services as stipulated by the Isibindi service standards and practice guidelines?
- 11) Does James House have enough financial resources to implement the programme successfully?
- 12) Does James House have enough infrastructure for the storage and distribution of food parcels, in kind donations and the Safe Park activities?

CHAPTER TWO: EVALUATION METHOD

Design

This process evaluation applied a descriptive framework. Dane (2011, p.8), states that “descriptive research involves examining a phenomenon to characterize it more fully or to differentiate it from other phenomena”. Descriptive research is mainly done to gain a better understanding of the characteristics of the target population that is being served by the programme under study as well as to describe the quality and type of services provided by the programme. Descriptive research utilises elements of both quantitative and qualitative research, and this evaluation applied a quantitative approach for all stakeholders and a cross sectional survey design using questionnaires with open ended questions, closed questions, observations as well as a review of programme documents.

Participants

Table 1 below presents summary information on the participants who provided data to all the 12 evaluation questions. Data were gathered from a sample of 21 households, 7 child youth care workers (including the care team leader) and the programme manager. The sample of 21 households included the 11 households that were currently in the programme, 7 households that completed the programme as well as 3 households that had re-entered the programme after disengagement. For questions 1, 3, 4 and 7 data were collected from a sample of 21 households.

Questions 6-9 on service delivery were responded to by 7 child youth care workers including the care team leader, who provided the services to the children and their families in the community. Question 7 required views on the working relationship between the clients and the service providers therefore data was collected from both the CYCWs and the clients. The programme manager answered questions 5, 10, 11 and 12 on organisational support.

Table 1

Summary of Data Providers

Data providers	Number of data providers	Evaluation questions	Data collection tools
Households currently in the programme	11	1,3,4,7	Questionnaire appendix 1
Households that re-entered the programme	3	1,3,4,7	Questionnaire appendix 1
Households that completed the programme	7	1,3,4,7	Questionnaire appendix 1
Care workers	6	6,7,8,9	Interview appendix 3
Team leader	1	6,7,8,9	Questionnaire & checklist, appendices 2 & 3
Programme manager	1	5,10,11,12	Checklist appendix 4
Programme records		2	Programme records

Materials and Procedures

Programme records

Data for answering question 2 were supposed to be collected from programme records with the help of both the programme manager and the child care worker team leader. A guideline for the demographic backgrounds data as well as numbers of families that had gone through the programme in a year since 2010 had been planned. Some detailed information on client needs and characteristics at the point of enrolment are collected by James House and then send to

National Association of Child Care Workers (NACCW). In addition, routine programme monitoring data which monitor the utilisation of Isibindi services by clients on a monthly basis are also collected by James House for NACCW. During the initial planning stages of the evaluation, the programme manager indicated that Isibindi monitoring data would be available for analysis. Unfortunately, it was not possible to obtain these programme records as it later transpired that no photocopies of the submitted monitoring records were kept on the James House site. The James House managing director and the evaluator contacted the NACCW in order to get these data but the records were not made available to us. Had these two forms of programme records been available, the original plan was to use them to assess how utilisation of Isibindi services varies between household types. However since these records were not available, information obtained through interviews with programme clients was used instead.

Similarly, Question 10 was supposed to be assessed through an analysis of the service delivery records for each household, which record the number of household visits received by the client on a monthly basis. Due to the unavailability of records the programme manager provided the required data for this question.

Programme beneficiary interviews

Data for questions 1, 3, 4 and 7 were collected through face to face interviews with the 21 households. A purposive sample of 21 households was selected from the programme participants of the Imizamo Yethu community. As the evaluator stated earlier, the sample consisted of 11 households who were currently in the programme, 3 households that had re-entered the programme (referred to as re-open cases by the programme) and 7 households that completed the programme. The households that had re-entered the programme after disengagement were identified as priority informants after consultation with the manager. The programme manager believed that the households could provide shortcomings in service delivery.

The sample of 21 households was selected in order to establish what the clients' perceptions of the programme were and whether these programme activities were adequately addressing their needs. The interviews took place at the James House premises in a private room that was free from noise and interruptions. The research was conducted with the help of a translator over a period of one week. The translator was briefed on the purpose of the study and trained by the evaluator on how to carry out an interview. There was no need of translating the interview questions into Xhosa language as all the participants could understand English but they had some difficulties expressing themselves here and there and that is when the translator helped. Due to the possibility of a language barrier, non-verbal cues were used where possible to elicit responses and the evaluator made use of pictures on the questionnaire as visual aids to explore the extent to which services that clients were utilising met their needs. Observations were noted during the visits in the community and the James House premises.

The evaluator asked the heads of the households for either verbal or written consent before the interview started. The proposal was approved by the Ethics in Research Committee of the Commerce Faculty at the University of Cape Town in South Africa before field work commenced. All the potential participants were informed at the start that their participation would not affect their eligibility to receive services from the programme. Respondents were identified only by number to maintain confidentiality. Similarly, James House staff gave informed consent before responding to the questionnaires. An explanation of the evaluation and the procedures involved in data collection were included in the consent form as well as the benefits of participation, confidentiality and contact details of the evaluator in case of any queries. The James House care team leader had to introduce the evaluator to the staff members so that the staff could feel free to respond to interview questions without fear that they were being evaluated on their work performance. Similarly an introduction to the programme participants was also done by the care team leader. A questionnaire was designed for the programme recipients requiring data on service utilisation such as:

- Awareness of programme services
- Accessibility of hours of operation
- Accessibility of location of the services

- Friendliness of staff
- Overall satisfaction with services

The evaluator carried out the interviews and recorded the responses on the questionnaires.

Programme staff interviews

The evaluation questions 6, 7, 8 and 9 were answered by the 7 CYCWs. All the 7 CYCWs were responsible for service delivery in various sections of the programme such as the Safe Park and the home visits and they provided information on the services that they delivered to clients. A semi-structured questionnaire with open ended questions and a structured checklist were used to guide the interview with the staff. The questionnaire for the programme staff included questions on the quality of service such as:

- Ratings of specific services delivered to clients
- Suggestions on improving service delivery

A checklist was used to gather data on organisational support from the programme manager.

Data analysis

Data from interviews were analysed using a Statistical Package for the Social Science (SPSS). The evaluator had planned to conduct more advanced statistics using programme monitoring data but since these records were not readily available, the evaluator had to work with data from interviews with clients and programme staff only. The consequence of this was that, the sample sizes of both the households and CYCWs were too small to perform more than descriptive statistics on the data. In this evaluation the household was the unit of analysis since a single household could have more than one child needing help as well as the parent or caregiver. Results were tabulated showing some frequency with which different services such as food

parcels, home based care, the Safe Park and other services were delivered to clients. Data from the interviews with programme staff were also analysed using descriptive statistics such as frequencies, percentages and averages while responses on open ended questions were thematically analysed.

CHAPTER 3: EVALUATION RESULTS

The evaluation results in this section will be presented in the order of the evaluation questions presented at the end of the introduction chapter.

Service Utilisation

Evaluation Question 1: What are the socio-demographic backgrounds of the James House clients? How does utilisation of the James House services vary between different socio-demographic groups?

The majority of the respondents in the James House programme were females with the exception of one household that was headed by a male youth. The sample consisted of the following: 1 youth, 2 married women, 2 widows, and 16 single women. All the sample members were unemployed. Their ages ranged from 18 years to 57 years. Their mean age was $M = 38.19$, $SD = 11.06$ ($n = 21$).

Sampled households had a mean number of children $M = 2.09$, $SD = .77$ ($n = 21$) who were beneficiaries of the James House programme. The ages of the children ranged from 4 months to 19 years. Figure 4 shows the frequency distribution of children in a household who were enrolled into the programme, and Table 2 shows the frequency distribution of age categories for enrolled children. Most of the children in the James House programme were aged between 5 and 10 years as shown in Table 2. The least number of programme users were in the age group ranges of 0 to 4 and 16 to 20.

The four month old baby and all the other children below the age of 4 years were only receiving clothing, toys and baby formulas from James House as they were too young to participate in other programmes such as the Safe Park.

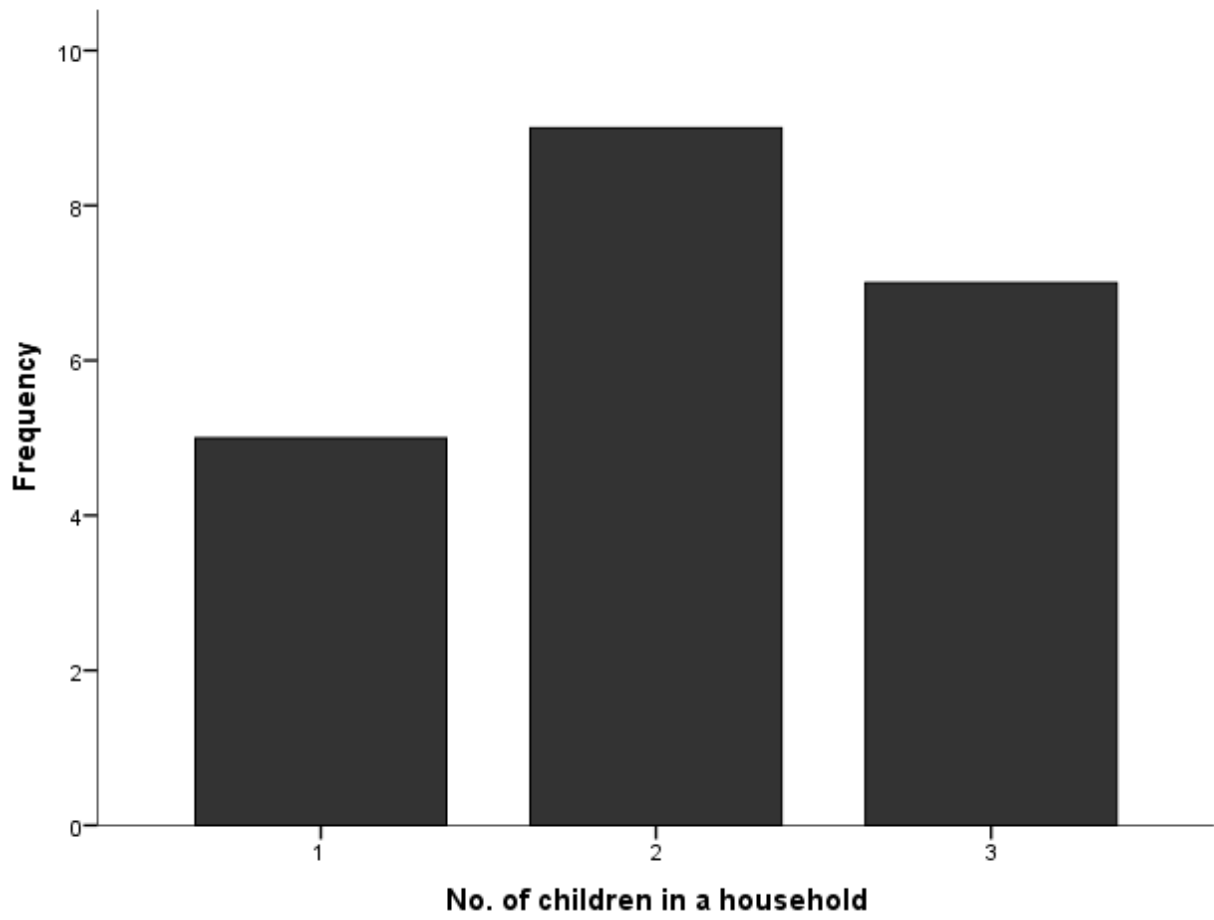


Figure 4. Number of children in the programme per household

Table 2

Number of Children in James House Programme According to Age Groups

Age Group (years)	Number of Children
0 – 4	9 (20%)
5 -10	22 (49%)
11–15	10 (22%)
16-20	4 (9%)
Total	45 (100%)

Evaluation Question 2: Since 2010, how many children and their families completed the programme, re-entered the programme after disengagement, and are currently in the programme?

The researcher could not get data to rigorously answer this particular evaluation question due to lack of data from the organisation’s programme records (see discussion in materials and methods section). Given the lack of programme monitoring data, an alternative was to solicit from programme staff their estimates as to the number and characteristics of clients who typically disengage and re-entered the programme. According to the child youth care team leader the programme was serving 60 households including 10 households in the aftercare (Personal communication, August, 29th, 2013). The majority of the families in the programme were Xhosas along with a minority from surrounding countries like Zimbabwe, Namibia, Mozambique and Botswana. According to the programme manager, the programme had just started to roll out into the coloured community where 11 families were newly recruited into the programme.

Table 3 shows the responses that were given by the child youth care workers (CYCWs) when they were asked to describe the characteristics of the clients who completed as well as those who re-entered the programme after disengagement. The child youth care workers mentioned that their clients would be disengaged from the programme when the following conditions have been

fulfilled: children are enrolled in school, child grant is in place, family is independent, family is on medication, and children's documents are in place as well as some memory boxes. However programme clients are not homogenous, some characteristics of the clients may strongly influence how they progress through the programme and also how they manage life after disengagement from the programme.

Table 3

Responses of Child Youth Care Workers on Characteristics of Clients

Question: What are the characteristics of clients who completed the programme?
Respondent 1: People who are willing to learn and can heal themselves emotionally.
Respondent 2: People who can work independently.
Respondent 3: People who are cooperative, with a vision and eager to learn.
Respondent 4: Families that can function independently.
Respondent 5: People who are willing to change and live independently.
Respondent 6: Families that follow their daily routine without supervision.
Respondent 7: People with a more positive vision of life and are willing to learn better ways of living.
Question: What are the characteristics of households who re-entered the programme?
Respondent 1: Most of them default on their medication and cannot work independently.
Respondent 2: They are difficult to work with.
Respondent 3: N/A I have not disengaged any client yet.
Respondent 4: They default on treatment and children drop out of school.
Respondent 5: They relapse into their old behaviour, default on medication or the death of the bread winner causes them to re-enter the programme.
Respondent 6: Difficult people who do not put effort to come out of their crisis.
Respondent 7: N/A, I have not disengaged any one yet.

What emerged as a common theme in the responses on characteristics of clients who completed the programme was that the families were willing to learn some life skills from the CYCWs. In addition, they displayed an ability to perform their daily routines even in the absence of the child

youth care workers' supervision resulting in a successful disengagement process. In contrast, the few families that re-entered the programme were described as those families whose members had defaulted on their medication and were leading a poor quality of life as a result of chronic illnesses. Furthermore, the clients were described as generally difficult to work with as well as lacking the intrinsic motivation to work independently.

The perspective of staff can be contrasted with the feedback received from those clients who had re-entered the programme who were interviewed by the evaluator. One client, for example, expressed her dissatisfaction with the programme staff whom she reported as being impatient with her son. The son was threatened to be left behind at school on several occasions by the James House transport. She also felt that the programme staff were getting "tired" of helping her as she is not made to feel welcome when she visits James House. In addition she felt that the food parcels she used to get were no longer given to her as regularly as before. The other two clients appreciated very much the services that they were receiving from James House, For instance they both had defaulted on their medication and through the assistance of James House staff they managed to get back on to medication and they reported that they were now more healthy.

Evaluation Question 3: Are the clients receiving services when they are needed?

To answer the above evaluation question the evaluator used the following information as proxy measures for the clients receiving services when they needed them: accessibility of the James House premises in terms of time taken to walk from the clients' home, the James House hours of operation; the frequency of visits from the CYCW each week, length of each visit as well as whether the family feels that the number of visits are adequate for their needs.

Table 4 below shows the length of time that James House clients took to walk to James House to access some of the services such as collection of food parcels and use of the Safe Park.

Table 4

Approximate Time Taken by Clients to Walk to James House Premises

Time(minutes)	0-10	11-20	21-30	31-40	41-50
Number of households	1	2	8	1	9

Home visits are the primary means for providing services to children and their families. They are also a common means of identifying and supporting OCVs. The frequency and the duration of visits to a household by a CYCW are often dependent on the needs of a specific household. On average, households should be visited by a CYCW between 8 to 10 times per month, or approximately 2 times per week (Isibindi service standards and practice guidelines, 2012). The service guideline goes on further to state that child/youth headed households should be visited more frequently, approximately 5 times a week.

In this evaluation, households with more needs reported being paid more than three visits per week. For example, the youth headed household reported getting a CYCW visiting him and his siblings almost every day in a week for the duration of 2hours per visit. Households in the aftercare and those who re-entered the programme (referred to as re-open cases by the programme) reported getting less number of visits (2-3 times per week) for the duration of 1-2 hours per visit. All 21 households reported that the number of visits were adequate for their needs as shown in Table 5. In addition the CYCW team leader reported that she and her team work flexible hours to try and meet their client’s needs. The greatest advantage being that the CYCWs live within the same community with their clients and thus making it easy for them to visit their clients very early in the morning, late in the afternoon, at night or whenever their services are required. For example, they may be required to provide transport and accompany a client to hospital at night (Care team leader, personal communication, August 29th, 2013).

The CYCWs monitor children during visits and refer children for referral services such as clinic, school or Department of Social Development (DoSD) for child support grants. They also help with household chores and at the same time extending the learning process from school by teaching and motivating the children. For example, the child care worker may ask the child to

hand her the bath soap with his/her right hand during bath times (Care Team Leader, Personal communication, August 30th, 2013). The purpose of this exercise is to help children apply their knowledge of body parts that they would have learned at school. CYCWs usually make their visits early in the morning and late in the afternoon in order to get the children ready for school in the morning and help with the preparation of meals in the evenings. They also work during weekends when the children will be at home. The fact that CYCWs are recruited within the community makes it easier for both the CYCWs and the families to interact and form a good working relationship. With the passage of time, the children would eventually build some trust towards the CYCWs.

Table 5

Proxy Measures of Clients Receiving Services when they are needed

Type of household	Current n=10	Aftercare n=7	Re-open n=3	Child/Youth headed h/h n=1
Number of visits per week	<i>M</i> =3.7 <i>SD</i> =1.06	<i>M</i> =2.29 <i>SD</i> =.76	<i>M</i> =2.67 <i>SD</i> =.58	7
Length of visit (hours)	<i>M</i> =2 <i>SD</i> =1.05	<i>M</i> =1.6 <i>SD</i> =0.98	<i>M</i> =1.67 <i>SD</i> =0.58	2
Sufficiency of visit (% hh)	Yes (100%)	Yes (100%)	Yes (100%)	Yes

Evaluation Question 4: Are the services being delivered by the James House programme adequately meeting the needs of the clients?

Table 6 shows the clients' ratings of the services offered by James House. A high percentage of the clients in the sample expressed positive perceptions of the services that they were receiving from James House, implying that James House was indeed adequately meeting their needs.

Table 6

Clients' Opinions of James House Services

Service	Respondents using services	Positive Perceptions
Hospital and clinic visits	18(85.7%)	15(83.3%)
Food parcels	21(100%)	20(95.2%)
Access to education	21(100%)	19(90.5%)
Access to home-based care services	6(28.6%)	5(83.3%)
Access to social grants	13(61.9%)	12(92.3%)
Clothing	15(71.4%)	15(100%)
Psychosocial counselling(e.g. Grief counselling)	16(76.2%)	16(100%)
Safety (Safe Park)	14(66.7%)	14(100%)
Birth Registration/ID documents	12(57.1%)	12(100%)
Legal services	3(14.3%)	3(100%)

Service Delivery

Evaluation Question 5: What are the primary activities of the programme? Are the activities the same as those stipulated by the Isibindi model?

The primary activities of the programme are those presented in Table 6. The programme manager confirmed that the activities listed in the table are the same as those stipulated by the Isibindi Model. It was brought to the attention of the evaluator that James House did not find it necessary to tailor the programme activities to suit its situation in Hout Bay (Programme manager, personal communication, August 24th, 2013).

Evaluation Question 6: Is James House adequately training the child care workers to strengthen their knowledge in areas such as HIV/ AIDS information, grief counselling, homework supervision as well as child rights and protection

Table 7 shows the number of child youth care workers that participated in the research as well as the year in which they reported to have undergone some training in the specified areas. Four of seven child care workers had gone through some formal training at the time of the study although some CYCWs could only remember the year but not the month in which they had the training. The other three reported that they had not undergone any formal training at all. The eighth child youth care worker did not take part in the research as she had just started work and was not allocated any families to work with when the interviews took place.

Table 7

James House Trainings for Child Youth Care Workers

Type of training	HIV/AIDS information	Grief counselling	Homework supervision	Child rights & protection	Behaviour Management
Child care worker 1	Sept 2011	Sept 2011	March 2009	May 2012	Sept 2012
Child care worker 2	N/A	N/A	N/A	N/A	N/A
Child care worker 3	N/A	N/A	N/A	N/A	N/A
Child care worker 4	Sept 2011	May 2012	May 2012	May 2012	N/A
Child Care worker 5	2007	2008	Oct 2007	June 2006	2009
Child care worker 6	April 2012	2008	2008	2007	2009
Child care worker 7	N/A	N/A	N/A	N/A	N/A

Evaluation Question 7: Do child care workers have a good working relationship with the clients?

A large percentage (90%) of the households reported having a good working relationship with their child youth care workers. Only 10% reported having problems with their care workers. On the other hand the child youth care workers reported having challenges with clients involved in substance abuse as reported in Table 8. Though the substance abusers did not physically or verbally abuse the child youth care workers, they abused their fellow household members including children, consequently the child care workers had to deal with issues of both physical and verbal abuse on most occasions. All seven child care workers reported that they believed that their clients were satisfied with their services.

Table 8

Responses to an Open Ended Question on Challenges faced by the CYCWs (n=7)

Type of challenge	Respondents citing	Illustrative quotes
Lack of trust in CYCWs	n =2(29%)	Some of my clients are not very open with their problems.
Drug abuse	n =1(14%)	Dealing with family members who abuse drugs is difficult.
Abuse of clients and CYCWs	n =2(29%)	Our clients are abused by their partners. Some family members can sometimes talk to us rudely.
HIV/AIDS stigma	n =2(29%)	James House is associated with HIV/AIDS. Our Safe Park is associated with poverty and lack of food at home

Evaluation Question 8: Are the child care workers recruiting the required number of clients in a year?

The child care workers reported that they each recruited an average of 4 children per month resulting in a total of 48 children per year. If in one month a CYCW recruits for example 6 children the following month he/she recruits 2 children so that the number of children recruited does not exceed the stipulated number per year. According to the Isibindi service standards and practice guidelines (2012), a qualified Isibindi CYCW is expected to maintain caseloads of between 36 and 48 children per year, whilst Isibindi CYCWs undergoing training should maintain caseloads of 12-24 children per year. The self-reports by the CYCW confirmed that they were indeed keeping up with the Isibindi requirements. However, the evaluator intended to verify the CYCW's self-reports against the James House programme records but unfortunately these records were not readily available. When the evaluator asked the CYCWs to rate the methods of recruiting children on a scale from 1-3, door to door campaigns were rated highly, followed by the Safe Park, and referrals from clinic/school/community was rated last.

Evaluation Question 9: Are there any services that the CYCWs are struggling to deliver and why?

Table 9

Effectiveness of Service Delivery and Ratings by the CYCWs

Activities	Delivered	Effective	Ranking of service as very effective(in percentages)
Initial services			
Home visits	Yes	Yes	100% (n=7)
Meals	Yes	Yes	85.7% (n=6)
Food parcels	Yes	Yes	100% (n=7)
Core activities			
Meet health needs	Yes	Yes	71.4% (n=7)
Psychosocial support	Yes	Yes	71.4% (n=5)
Meet educational needs	Yes	Yes	100% (n=7)
Meet nutritional needs	Yes	Yes	71.5% (n=6)
Child protection & Legal	Yes	Yes	57.2% (n=6)
Referral Activities			
Social Grant	Yes	Yes	85.7% (n= 6)
Clinic	Yes	Yes	71.4% (n=6)
HIV counselling	Yes	Yes	71.4% (n=5)
Birth certificate/ ID	Yes	Yes	85.7% (n=6)
Referral to SANCA	Yes	No	0% (n=4)

According to the results in Table 9, the CYCWs reported that they were successfully delivering the listed services to their clients. However, they reported that they were struggling with

referring clients with drug problems to SANCA hence their rating of the service is the worst among them all. Services such as home visits, food parcels, meeting health needs and meeting educational needs were effectively delivered by all CYCWs. Furthermore, 71% of the CYCWs reported that the Safe Park brought the most valuable change into their clients' lives. In contrast, the heads of households mentioned services such as health care, education and food parcels as services that brought the most valuable change into their families' lives. However the evaluator discovered that the Safe Park was being run without basic documents such as the attendance registers. In addition, the Safe Park was open to all the children in the community including those that are not enrolled into the programme.

Organisational Support

Evaluation Question 10: Does the programme have sufficient staff to deliver services as stipulated by the Isibindi minimum standards for service and practice guideline?

Table 10

Resource Allocation for Service Activities

Activities	Staff	Budget	Infrastructure
Initial services			
Home visits	Yes	Yes	Yes
Meals	Yes	Yes	Yes
Food parcels	Yes	No	Yes
Core activities			
Meet health needs	Yes	Yes	Yes
Psychosocial support	Yes	Yes	Yes
Meet educational needs	Yes	Yes	Yes
Meet nutritional needs	Yes	Yes	Yes
Child protection& Legal	Yes	Yes	Yes
Referral Activities			
Social Grant	Yes	Yes	Yes
Clinic	Yes	Yes	Yes
HIV counselling	Yes	Yes	Yes
Birth certificate/ ID	Yes	Yes	Yes
Referral to SANCA	Yes	No	Yes

Table 10 shows that James House is well resourced with sufficient staff, infrastructure and accompanying budget for most programme activities with the exception of the budget for food parcels of which the programme manager indicated that at times they run out of money to buy food for their clients. The same applies to the meals at the Safe Park; the programme manager reported that during times of financial difficulties, children have to go without their meals.

Evaluation Question 11: Does James House have enough financial resources to implement the programme successfully?

As shown in Table 10, the programme manager confirmed that they lacked the necessary financial resources to provide food parcels. This view was also supported by members of the household who suggested service delivery improvements. The contents of the food parcel are shown in Table 11 below. The households indicated that the amount of food was not enough for the family to last for the whole month even though it is given in addition to the child support grant.

Table 11

Items and Quantities Contained in the Client's Monthly Food Parcel

Food Items	Quantity
Mealie meal	2.5Kg
Sugar	2.5kg
Rice	2kg
Cooking oil	750ml
Pilchards	400g
Teabags	200g
Samp	2.5kgs
Dried Beans	500g

CHAPTER 4: DISCUSSION

This chapter consists of the following subsections: discussion of the main findings presented in the results chapter, some recommendations for the James House programme improvement, recommendations for future evaluations, the evaluation's contribution to knowledge, limitations of the evaluation and the conclusion for the chapter. The discussion of findings will be done in the same sequence as they were presented in chapter 3.

Service Utilisation

Evaluation Question 1: What are the socio-demographic backgrounds of the James House clients? How does utilisation of the James House services vary between different socio- demographic groups?

James House clients were mostly unemployed women as reflected by 95% of the heads of households that were interviewed. The sample may not be representative of the population of the households consisting of children orphaned and made vulnerable by HIV/AIDS that are being served by James House in terms of ethnicity and race. For instance, the programme had just been rolled out into the coloured community and the study could not include those families in the evaluation as they did not know much about the programme. The findings are in line with some literature that supports that female headed households are among the most vulnerable in the communities.

Venter & Marais (2006) stated that female headed households (FHH) are on the increase in South Africa and in 2001; about 41.9% of the households in South Africa were headed by females. Chant (2003) stated that FHHs in the development discourse have come to be generally associated with the poorest of the poor. Similarly, Schatz, Madhavan & Williams (2011), pointed out that the feminization of poverty discourse suggests that female-headed households

are the poorest of the poor and are in need of various forms of some intervention. A similar point was made by Schenk et al. (2008) that vulnerable households in their study were identified by community members as those households headed by someone who is female, elderly, widowed or disabled, those in which someone is chronically ill, and those that would have taken in orphaned children. In the same study FHHs were cited as often facing challenges when it came to providing for their households. In addition, households headed by children were also mentioned as being amongst the most vulnerable.

Generally women are mainly responsible for children's up keep and making day to day decisions for the household. Possibly, it is the reason why James House mostly works with women clients and even their recruitment policy could have taken that fact into consideration as they had 7 women CYCWs compared to only one male at the time of data collection. Thurman, Jarabi and Rice (2012), made an observation that 90% of the OVC in their study were being cared for by a female, either the biological mother or grandmother.

Meintjes & Hall (2012) stated that 60% of all orphans in South Africa are paternal orphans with living mothers. This implies that the main reason for the existence of female headed households is the death of the father. This is however counter to the literature pertaining to female headed households as a common phenomenon in South Africa. Women are often abandoned by their male partners and they often choose to have children outside of any matrimonial arrangement (Chant, 2003; Schatz et al., 2011). The James House clients displayed a similar state of affairs. According to the evaluation findings, the main reason of female headedness in the James House sample was non-marriage (76 %) compared to those who were widowed (9.5 %) and another 9.5 % were married. In most cases these women would be taking care of their own children as well as their deceased relatives' children. Non-orphaned children living with their biological parent/parents in a household that had taken in OVCs were also identified as potentially vulnerable and subsequently the whole family became eligible for the services. According to the Isibindi regulations, if one child enters Isibindi then it becomes automatic that the other children in that household would also enter Isibindi programme (Isibindi service and practice guidelines

2012). This fact justifies the James House position of caring and supporting the whole family not just the orphans, but when it comes to enrolment they only enrol the orphans on to the programme. Caregivers and guardians are often assisted with psychosocial support and counselling, testing and disclosure, referral to clinical services such ART and assistance with application for social grants from the DoSD. Consequently, fixed household resources such as the food parcel and the child support grant would be shared among more mouths to feed. Very often the child support grant forms the only source of income in the household, especially in the informal settlements where most adults are unemployed. Hall and Wright (2011) pointed out that children in informal settlements in South Africa are as poor as those in the rural areas.

The mean age of the heads of households was 38 years and their ages were within the range 38 (+/-11). This shows that most of the primary caregivers taking care of the orphaned children were not among the grandparents age group who would be expected to be over 60 years. In addition, the prevalence of child headed households in the programme was very low only one youth headed household was enrolled into the programme at the time of data collection. According to the James House programme description, priority is given to grandparents and youth headed households, but the findings show that these two types of households were the minority. Due to the absence of the programme records the evaluator could not assess how many grandparent headed households were enrolled into the programme. However, data from studies carried out in areas where the epidemic is most severe support the fact that orphaned children are often cared for by their grandparents (Bray, 2003). Studies also state that the child and grandparents headed households are among the most vulnerable households (Munyati et al. (2008). However this could also be the case in South Africa if the children and the elderly are unaware of the grants for which they are eligible (Khulisa Management, 2008).

Most households in the sample had an average of 2 children in the programme. The main reason could be that generally family sizes tend to be smaller in the cities compared to rural areas. According to the programme manager the programme's aim is to target and support OVCs between the ages of 4 and 18 years. Similarly, the South African government's policy is to target

and save OVC below the age of 18 years (DoSD, South African Policy Framework, 2005). However there were cases when the children were reported to be in the programme even though they were outside the specified age groups. For example, there was a youth aged 19 who was reported to be in the programme. According to care team leader, the youth was enrolled when he was under 18, but as he had not yet reached the point where he and his siblings could be disengaged he had been allowed to continue being in the programme. The care team leader gave an explanation that the programme still extended its services to the 19 year old youth as the youth fell behind his education due to many factors one of which could be taking time off school to care for the siblings. In recognition of this the James House programme made an exception to age limit and continued to support the OVC beyond the age of 18 especially supporting continued education as it is the only way of him and his siblings of having a brighter future. Similarly, the 0-4 year age group comprised about 20% of the children in the sample. Families with babies were assisted with baby formula, toys and clothing, although they could not come to the Safe Park and have a meal and take part in the various activities. The evaluator suggests that Isibindi needs to consider issues pertaining to children who fall outside the target group range and include them in its minimum standards for service and practice guidelines. Kidman, Petrow and Heyman (2007), evaluated two community based care programmes where preschool aged children were cared for in a safe, supervised environment during the day while the guardians were afforded time to work or care for HIV infected relatives. In the same way, James House could consider early childhood initiatives that could be delivered in homes or in the neighbourhood of the Hout Bay community.

Evaluation Question 2: Since 2010, how many children and their families completed the programme, re-entered the programme after disengagement and are currently in the programme?

James House could not provide data to enable the evaluator to answer this particular evaluation question in a rigorous manner. According to the care team leader all the paper work comprising detailed children's registration forms, family information forms and all the records of client visits up to the disengagement form are sent straight to NACCW Cape Town office. According to the

Isibindi service and practice guidelines (2012) NACCW does all the data capturing for all the children and each child is given a database number that is sent to James House in a monthly registration report. However James House does not seem to keep copies of these monthly registration reports that are sent to them. James House had maintained no copies of these records, and had no form of documentation of home visits or client demographic data in their system that was accessible to the evaluator. However, according to the Isibindi requirements some form of documentation should be kept on site and they should be kept in a place accessible to all stakeholders (Isibindi service and practice guidelines, 2012). Nevertheless, all efforts to get some data from either NACCW or James House proved to be fruitless. Without the programme records which record client characteristics it was difficult to show if the target group is indeed a group of orphans and vulnerable children. In addition, the lack of onsite programme records implies that the programme is unlikely to be able to improve their service delivery and utilization if they are not monitoring their outputs in any way. In other words, there is a complete disconnection between their monitoring platform and their programme management. Monitoring of OVC programme activities should be routine. Although, the programme seems to have sufficient resources such as the Isibindi M & E monitoring forms contained in the CYCW orientation booklet, it does not necessarily mean that they have enough capacity to collect the data.

Evaluation Question 3: Are the clients receiving services when they are needed?

Data from the households indicated that the households were within walking distance to the James House premises taking them less than an hour. In addition, the families live in informal settlements where the homes are very close together making it easier for the CYCWs to make home visits and take very little time to move from one household to the next. Clients reported their satisfaction with the frequency and duration of home visits, which are common means to the provision of care and support to OVC and their families.

Evaluation Question 4: Are the services being delivered by the James House programme adequately meeting the needs of the clients?

The food parcels and access to education were the services that the clients were utilising most. These two services were also given a higher rating by clients indicating high satisfaction with the services. However, some clients complained about the inadequate quantities of food contained in the food parcels. It is interesting to note that, Bryant et al. (2012) found that among the OVC programmes that were being supported by PEPFAR, some had beneficial effects such as improvement in enrolments in schools as a result of the interventions. However, it was not clear to the evaluator why at least 21 households were getting food parcels when they could no longer qualify as per the Isibindi service standards and practice guidelines. The Isibindi service standards and practice guidelines state that families that receive food parcels are those that will be waiting for their grant applications to be approved by the DoSD. Only 5% of the 21 households interviewed were still waiting for the grant to be approved and the rest were already in receipt of the grants. A possible explanation why James House clients continue to receive food parcels could be that they are not receiving enough support to engage in some income generating activities to supplement the child support grant. The findings also revealed that some clients did not utilise the service for application of grants because their children were already in receipt of grants at the time when they were recruited by James House.

The only services that were not often utilised were the legal services and home based care services. A possible explanation for underutilisation of legal services could be that most of the families did not have problems pertaining to inheritance of property after the death of their relatives who happen to be the parents of the children that they were looking after. This implies that cases of property grabbing after the death of a parent were very unusual in ImizamoYethu. Another explanation could be that there was nothing of value left for the children by their parents for the relatives to fight for. Mahati, Munyati, Chandiwana&Gwini (2008), cited incidences in which the OVC had all the kitchen utensils taken by the mother's relatives who claimed that it is part of their culture to do so. The relatives from the father's side would take cattle, farming implements, furniture and a whole lot of property that they wished to take. According to Mahati et al. (2008), this tradition of inheritance rights to relatives often leads to deepening poverty to

the OVC.

A possible explanation for less utilisation of home based care services could be that most of the clients were getting tested early as a result of the intervention and in addition they got access to anti-retroviral before their immune system deteriorated to the point of requiring home based care. Van Dyk (2009) stated that the massive 'access to all' campaigns helped to make ARV drugs to be readily available to all South Africans since the launch of the programme in 2004. Although the evaluation cannot give the entire credit to the James House HIV awareness campaigns in the community there is a possibility that James House efforts in both campaigns and referrals to clinics and hospital are contributing to the outcome of having less people requiring home based care due to terminal illness.

It seems that the programme was able to meet most of the needs of the target population but like any other OVC programme gaps in service delivery cannot be avoided. Though provision of shelter is not part of the programme description, the evaluator considers that it is one of the basic elements of people's survival together with food and good health (Tsheko 2007). Imizamo Yethu is an informal settlement where the residents live in shacks. During winter time when it is cold and raining this kind of shelter does not provide much protection to the vulnerable children and their families, considering the fact that some of them will already be in poor health, a formal building made with bricks would be a better option. The evaluator was informed by the programme manager that they can only refer clients to the appropriate housing authorities only in cases where the shelter would have been burnt down and the shack would be replaced by another shack. The situation is most likely exacerbated by the fact that the land on which the informal settlement is located belongs to a certain individual who is not willing to sell the land to the city council making it impossible to build permanent structures. Thus, additional attention is required on how to solve this problem of shelter for OVC. Literature supports the fact that only a few programmes deal with the shelter needs of OVC through the construction and refurbishment of houses, most programmes provide shelter assistance in emergency situations only (Khulisa Management Services, 2008). This agrees with what Munyati et al. (2008) reported in their

study, that housing conditions of OVC were in very poor conditions with most of them needing some refurbishment.

Service Delivery

Evaluation Question 5: What are the primary activities of the programme? Are the activities the same as those stipulated by the Isibindi model?

The services that are provided by James House as indicated in the programme theory include the following; health care (referral services to clinic/ hospital, SANCA), food and nutrition support, education, psychosocial support, legal protection (includes facilitation to application for birth and identification documents), and economic strengthening (application for social grants, income generating activities). The services are the same as those proposed by the Joint United Nations Programme on HIV/ AIDS (UNAIDS), the United Nations Children's Fund (UNICEF) and United States Agency for International Development (USAID), to meet basic needs of children (Bryant et al. 2013). The services delivered by the programme are also the same as stipulated by the Isibindi model. However, James House did not tailor the programme activities to suit its situation in Hout Bay, for example the implementation of a food garden is considered one of its services to ensure that families are food secure. The evaluator discovered that this is an impossible task to perform since the settlement is situated in a mountainous area and there is virtually no space for a garden. The rapid and uncontrolled growth of the informal settlement has led to very dense living conditions on land that is not even suitable for habitation (Roth & Becker, 2011). Lack of land is a major challenge but still James House takes the establishment of food gardens as one of the services that they help their clients with in order for them to be food secure after disengagement. In addition effectiveness of equipping clients with income generating projects was not clear since food gardens are stipulated as one of these initiatives where families could sell surplus to gain some income.

Evaluation Question 6: Is James House adequately training the child care workers to strengthen their knowledge in areas such as HIV/AIDS information, grief counselling, homework supervision as well as behaviour management.

James House had 8 CYCWs at the time of data collection. One of the CYCWs was not included in the data collection because she had not yet been allocated families to work with. Among the seven only 3 had received formal training. James House is aware that the child care workers need to be trained, as this is stipulated in the Isibindi framework that child care workers need to undergo formal training. CYCWs need to be trained so that they are fully equipped with skills such as dealing with children with challenging behaviour in a manner that is referred to as positive behaviour management in the Isibindi service standards. In addition CYCWs should be able to demonstrate and teach parents/ guardians specific routines about nutrition (food choices and food preparation), hygiene, safety or games that they can engage with their children at home. Training in HIV/AIDS is also very crucial so that they know how to handle HIV/AIDS cases and encourage their clients to go and get tested and access ARVs where it is necessary. In the Safe Park they are supposed to supervise the children's activities and help the children with homework. Without training the chances are high that the CYCWs provide poor quality of services. Even those who did receive some training, the need for refresher courses should be considered.

Evaluation Question 7: Do child youth care workers have a good working relationship with the clients?

With the exception of a few cases the households reported having a good working relationship with the CYCWs. CYCWs also reported having a good working relationship with families, although a few challenges were noted. According to the Isibindi minimum standards for service and practice guidelines (2012), CYCWs are encouraged to form good working relationships with

specific families that they visit in their homes. In fact they become part of the family as they get involved in a range of activities including the provision of psychosocial support, cooking, cleaning and assisting children with their homework. CYCW are also encouraged to make the children feel loved and important in order to fill that gap left by the parents in the children's lives. However, there is a possibility of some emotional consequences to children when these relationships are terminated abruptly by the programme hence the need for a transitional period to disengagement as stated by the Isibindi minimum standards for services and practice guidelines (2012).

Evaluation Question 8: Are the child care workers recruiting the required number of clients in a year?

The CYCWs reported that they were recruiting the required number of children per year. However, since there were no records to support their claims it is difficult to verify if their claims were true. CYCWs serving households with terminally ill parent/caregiver or child headed households tend to have high workloads as these families require more visits as well as long duration of visits due to their high needs. It is possible that these care workers might seek to lower their recruitment rate since they would require a longer duration of time with such families compared to other families with less needs (Isibindi service and practice guidelines, 2012). CYCWs reported that they recruit most of their clients through door to door campaigns and the Safe Park. The results are supported by previous studies as reported by Khulisa Management (2008), OVC were identified mostly through home visits, door to door campaigns, referral by schools, referral by community members or through self-referrals by the OVC themselves. This would suggest that James House is employing the acceptable methods of recruiting OVC.

Evaluation Question 9: Are there any services that the CYCWs are struggling to deliver and why?

James House has had mixed success in terms of referring its clients to services that they

outsource to SANCA. CYCWs reported having experiences of high substance abuse which are believed to be linked to a high level of domestic violence. Referral of clients to SANCA was a problem to all the child care workers who had attempted to do so. It was not clear whether it was James House that was failing to refer its clients to SANCA, if clients were being referred but the whole process failed due to lack of follow-up, or it was SANCA that was failing to help the clients to undergo treatment and outpatient-rehabilitation. In addition the evaluator came across no previous literature pertaining to referrals to SANCA by other OVC programmes. According to the programme manager this facility is well resourced, it is unlikely that lack of financial resources is the explanation (Programme manager, personal communication, 29 August, 2013). In addition, CYCWs indicated that they were facing challenges in delivering services. The common challenges were that some clients were not being very open with their problems to care workers due to lack of trust. The fact that James House was associated with HIV/AIDS was also another challenge that the CYCWs were facing during service delivery. They mentioned stigma attached by some community members to the households that were receiving visits from the James House CYCWs as causing some clients to feel uncomfortable. In a study to assess the psychological wellbeing of children orphaned by AIDS in Cape Town, South Africa, Cluver & Gardner (2006) reported that South African orphans made some statements that stigma and the secrecy surrounding AIDS caused them social isolation, bullying and shame.

Organisational Support

Evaluation Question 10: Does the programme have sufficient staff to deliver services as stipulated by the Isibindi service standards and practice guidelines?

James House informants indicated that they had sufficient staff to carry out all its activities as stipulated by the Isibindi service standards. However a few weeks after data collection, James House recruited 19 more CYCWs (personal communication, Care Team leader, 27 August 2013). When the evaluator enquired why there was such a massive recruitment, the response was that

the Department of Social Development had provided the funds to hire more CYCWs.

Evaluation Question 11: Does James House have enough financial resources to implement the programme successfully?

James House appears adequately funded in all areas except food parcels. However, the move by James House to hire more CYCWs after getting funds from DSD suggests that there might have been some need to hire more labour which was limited by a lack of funding.

Evaluation Question 12: Does James House have enough infrastructures for the storage and distribution of food parcels, in kind donations and Safe Park activities?

Though the care manager indicated that they had no problems with storage space, the fact that they would try to distribute goods as soon as they receive them is an indication that lack of storage space may be a constraining factor. The most critical resources that James House lacks, however, are the resources needed to maintain suitable programme records. The Safe Park, for example, is being run without proper records. It lacks basics such as attendance registers. In addition, it caters for the registered children as well as unregistered children making it difficult to identify the target population. However literature reveals that programmes allow all children to access services such as the after school activities at the Safe Park in an attempt to prevent stigmatising OVCs (Khulisa Management, 2008). This could be an explanation why James House open their services to all children in the Safe Park. The other reason could be that the Safe Park is one of their avenues for recruiting children into the programme. All the same, this has an implication on services delivered to the target population. Children who are not vulnerable will also have a meal and access to all the facilities in the safe park. Since resources are limited, this puts a strain on the budget.

Suggestions for Improving the Programme

This evaluation being formative in nature, one of its aims is to provide some suggestions on how the programme can be improved.

Service utilisation

There is room for improvement in service utilization. Firstly, the CYCWs selected the Safe Park as one of the services that brought the most remarkable change to the clients' lives but only 67% of the families reported that they were utilising the facility. With this particular service one cannot argue that children do not need the facility because where they live in the informal settlement there is no space for the children to play. Therefore James House needs to conduct formal or informal surveys regularly, for example during home visits, in order to understand why some children choose to attend while others do not.

Secondly, the Safe Park needs to keep a record of the number of children who are in the programme and utilising the services as well as the number of children who are not in the programme but utilising the services this is important for monitoring and evaluation purposes.

Thirdly, facilities for the children with disabilities are also required so that the Safe Park becomes user friendly for such children possibly this is the reason why some children are not using the facility. For some children the distance from their place of residence to James House could be hindering them from using the facilities. Transport that picks them at designated points and drop them off would be very helpful in that regard.

Finally, James House might consider scaling up community awareness campaigns that aim to reduce the stigma and negative perceptions attached to James House as well as the Safe Park. It was mentioned by CYCWs that James House is associated with HIV/AIDs and the Safe Park is associated with lack of food at home. Some children would therefore avoid utilising the facility

for fear of being laughed at by their peers. Therefore there is also need to address stigma manifestations, such as shame and discrimination among the James House clients.

Service delivery

Firstly, James House could try to implement its own basic monitoring system onsite as well as keeping copies of records in hard copy or soft copy so as to avoid having no programme records at all. This helps when it comes to giving their employees feedback on their performance and identifying areas that need improvements as well as tracking implementation progress over time.

Secondly, there is need to have regular training workshops for the CYCWs and refresher courses so that quality of care given to OVC is maintained at a high standard for example, quality psychosocial support needs to be delivered by well-trained CYCWs to OVC as most of them would have been traumatised by losing a parent due to HIV/AIDS, while others would have been emotionally scarred by being abandoned or abused. Administrative training and support might also be required for the efficient running of the programme.

Thirdly, the development of early childhood development activities should be considered for very young children from 0 to 4 years who are not adequately covered by the existing OVC programme.

Fourthly, there is need for James House to keep on reminding the housing authorities about the need of proper shelter for the OVC since the trend of caring for them in institutions such as orphanages is shifting to community care.

Lastly, income generating activities such as hairdressing, dressmaking, beadwork or cooking need to be scaled up for the unemployed heads of households so as to increase disposable income for their households as well reducing dependence on food hand-outs.

Organisational support

Food security in general seems to be a problem and more innovative solutions are needed in this

regard. There is need for James House to set feasible guidelines and possibly develop some partnerships with communities who have land available for food gardens as a way of dealing with issues of food security. There is also need to investigate how the clients use the food they receive in the form of food parcels. There is a possibility that clients may sell the food in order to raise money to spend on other items such as drugs or clothing.

There is also need to look into the issue of raising funds for the food parcels as well as making sure that the food parcels only go to the people who are waiting for the processing of their grant applications as stipulated by the Isibindi standards. Thus additional attention must be given to equipping the heads of households with skills that they can use to earn some cash which would enable them to buy food. There is also need to look into the issue of quantities of the food contained in the food parcel which were reported to be too little for the families as they would only last for less than two weeks. Quantities of food contained in the parcel were reported to be too little by the families; therefore there is may be need to scale up the amounts food in the food parcels depending on the number of people in a household.

Recommendations for Future Evaluation

It is recommended that when James House has implemented its programme with all the monitoring and evaluation procedures in place an outcome/ impact evaluation would be helpful to determine if James House is being successful in achieving its main objective of improving the wellbeing of vulnerable children in the community.

Expected Contribution to the Knowledge

Although a lot of literature has been written on care and support of orphans and vulnerable children in the context of HIV/AIDS within sub-Saharan Africa, specifically in South Africa and neighbouring countries such as Lesotho, Botswana and Zimbabwe, where the epidemic is most severe, a few evaluations have been carried out on the OVC intervention programmes. The few evaluations were mainly outcome or impact evaluations. This evaluation being formative in

nature has contributed in determining whether the components identified as critical in the success of the programme are being implemented as planned. The evaluation attempted to assist in the identification of strengths and weaknesses in the programme's implementation processes at the same time it prepared some ground work for an outcome evaluation in the future by developing a programme theory which makes it easy to identify outcomes of specific programme activities .

Information obtained from this formative evaluation, could be used by the James House staff to improve their programme service delivery, utilisation and organisational support as the evaluation has attempted to highlight what is working and what is not working with the programme.

Limitations of the Evaluation

The evaluation has the following limitations. Firstly, there is a possibility of the results being biased due to the use of convenience sampling. The evaluator had to make use of a convenience sample leading to the results being difficult to generalize to the James House population of clients.

Secondly, the unavailability of programme records made the evaluation extremely difficult after having planned the evaluation with the promises that the programme records would be readily available.

Thirdly, due to language barrier the evaluator could not use many open ended questions and this limited the amount of qualitative information/data/feedback obtained from the programme clients. For example the clients failed to express themselves very well in English as they would do in their mother tongue Xhosa. On the other hand the evaluator could not converse with them in their own language making follow ups on open ended questions difficult.

Lastly, the research had to be carried out within the limited time frame with very little resources.

The multidimensional nature of programmes serving OVC such as James House requires sufficient time and adequate resources.

Conclusion

In brief, Service utilisation did not vary with the socio- demographic backgrounds as most of the participants were female and also from the same Xhosa community. The services that were being delivered by James House seemed to be meeting the needs of the clients as most of them expressed some satisfaction with the services. However James House was lacking when it came to giving formal training to its child care workers so that they could go into the community fully equipped. When it came to resources to implement the programme, James House seemed to be well resourced in other areas but lacked some financial resources to provide food parcels for its clients due to the fact that they tended to give food parcel even to households that were already receiving child social grants. In addition all children who attended the safe park would get a meal including the non-orphans. The resources were more likely to be stretched as a result. Another important point to note is that a few households that re-enters the programme do so as a result of having defaulted on their medication after disengagement. Their children would still be in school and they would be in receipt of the social grants every month. Furthermore, maintaining referral linkages with complementary services such as clinics, Schools, DoSD is crucial to the success of the programme.

An important point to bear in mind is that, OVC are on the increase in South Africa and the burden of care and support is increasingly falling on vulnerable relatives who are facing severe economic challenges that limit their ability to meet the children's basic needs. Orphans and vulnerable children are more likely to face a number of challenges which include the following: be food insecure, experience educational disadvantage, have poor physical and mental health, be exploited and suffer from stigma and social exclusion. The intervention programmes are also

multidimensional and complex. The evidence highlighted in this evaluation shows that there is great potential for community interventions such as James House to improve the wellbeing of children and families affected by HIV/AIDS. However more evaluation studies are required to inform some programme improvements. Where resources and time permit, an outcome evaluation would reveal if the programme is having an impact or not on improving the lives of children who have been orphaned and rendered vulnerable by HIV/AIDS. If there is no impact, a process evaluation would reveal where the problem lies in the implementation of the programme. If there is evidence of some impact, a process evaluation can still be carried out so as to identify the services that are working and scale them up. In other words, exploring the implementation processes of OVC programmes gives the opportunity to identify strengths and weaknesses of the programmes and an opportunity to improve and deliver quality services.

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Appendix A: Letter Sent to James House's Programme Director

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School of Management Studies
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4 February 2013

TO WHOM IT MAY CONCERN

Thank you very much for your willingness to enable one of our Master's students to work with a programme from your organisation. I appreciate your contribution to the education of our students.

Please note that our students are required to work within the ethical framework of the Faculty of Commerce when collecting information from programme documents or programme recipients. This framework deals with confidentiality, sensitivity when requesting information from people and responsible reporting of results.

We also undertake and ensure you that the student will display professional behaviour at all times while working in your organisation or on your programme. At the end of the process, you will receive a useful report which will enable you to make informed decisions regarding your programme.

In order to comply with the rules of the Faculty of Commerce, we request you to sign below to indicate that the student will have access to programme records and where applicable, to programme recipients.

Thank you very much.

Yours sincerely

PROF J LOUW-POTGIETER

CONVENER: MPHIL PROGRAMME EVALUATION

AGREEMENT TO ACCESS PROGRAMME RECORDS AND/OR RECIPIENTS:

AUTHORISED PERSON

ORGANISATION

DATE

APPENDIX B: Letter of Approval from the Commerce Faculty's Ethics Committee

UNIVERSITY OF CAPE TOWN



Faculty of Commerce Ethics in Research Committee

Courier: Room 2.26 Leslie Commerce Building Upper Campus University of Cape Town
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UCT/COM/224/2013

24th July 2013

Helen Mutenheri
University of Cape Town
hmutenheri@gmail.com

Dear Researcher,

Project title: A formative evaluation of the James House programme for orphans and vulnerable children

This letter serves to confirm that the project entitled, "A formative evaluation of the James House programme for orphans and vulnerable children" as described in your final submitted protocol 2013, has been approved. You may proceed with the research.

Please note that if you make any substantial change in your research procedure that could affect the experiences of the participants, you must submit a revised protocol to the Committee for approval.

Best wishes for great success with your research.

Regards,

Harold Kincaid

Professor Harold Kincaid
Commerce Faculty Ethics in Research Committee

"OUR MISSION is to be outstanding teaching and research university,
educating for life and addressing the challenges facing our society."

APPENDIX 1: Service Utilisation Questionnaire

Instructions: Please mark the box containing your chosen answer with a tick. In question 1 two ticks are possible.

Household number _____

1. The head of the household is

Child(below 18)	Single	Widowed	female	Male	Old (65+)
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2. Which year was the head of the house born?

3. How many children (less than or equal to 18) are in your household?

4. How old are the children? How many of the children are in the programme?

Age					
In programme					

5. How did you become aware of the programme services?

Through referral	Door to door campaign	Identified through safe park
------------------	-----------------------	------------------------------

6. How many minutes does it take you to walk to James House from your home?

5-10mins	15-20mins	25-30mins	35-40mins	45-60mins
----------	-----------	-----------	-----------	-----------

7. Do the James House hours of operation suit you?

No	Yes
----	-----

8. How many times in a week do you get visited by the care workers?

Once	Twice	Three times	More than three times
------	-------	-------------	-----------------------

9. How long is each visit (in hours)

--

10. Do you feel the number of visits are enough for your needs?
















Yes	No
-----	----

If the answer is no please explain _____

11. Do you know of other children in your community who can gain from the services and support that your household is receiving from James House and are not enrolled in the programme?

Yes	No
-----	----

12. Which of the services are you receiving from James House and how do you rate them?

		Very satisfied	Mildly satisfied	Neither satisfied nor dissatisfied	Mildly dissatisfied	Very dissatisfied
						
Hospital and clinic referrals						
Food parcels						
Access to education						
Access to home-based care services						
Access to social grants						
Clothing						
Psychosocial counselling (e.g. griefcounselling)						
Safety(safe park)						
Birth registration/ID documents						
Legal services						
Other services						

13. Which of the above programme services have brought the most valuable change into your life?

--

14. How do you rate the relationship which you have with your care worker?

Very good	good	fair	bad	Very bad
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15. Name one thing you liked and one thing you did not like about the programme

Liked	
Disliked	

16. Do you think there is need to improve services? If your answer is yes, what are your suggestions for improving the services?

APPENDIX 2: Child Care Worker Questionnaire

1. How do you recruit clients into the *Isibindi* programme? Can you indicate your answer by ranking using numbers 1-3 starting with the most common method.

Through door to door campaign	Referral	Safe park	Other
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2. How many households do you recruit per month?

_____ households per month

3. Are the numbers of households you recruit per year keeping up with the targets set by your organisation?

4. Are the numbers of households you recruit every month keeping with the need or demand for the services?

5. List the services that you provide to the clients

6. Which programme activities have brought the most valuable change in the lives of your clients?

7. What type of households are you serving (child headed households, households with chronically ill care givers or all households)?

Child headed	Chronically ill care givers	All households	Other
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8. How many visits do you make to a household within a week?

_____ visits

9. How long is each visit (in hours)? _____ hours

10. What are the characteristics of clients who completed the programme?

11. What are the characteristics of households who re-enter the programme after disengagement?

12. What challenges have you encountered in delivering services to these households?

13. In your own opinion how satisfied are the clients with your services?

14. In which of these areas have you received formal training. When was your last training and what was the duration of the training?

Type of training	HIV/AIDS information	Grief Counselling	Homework supervision	Child rights protection	Other
When(month and year)					
Duration(days)					
Rank(1-5)					

15. In your own opinion how can service delivery improve?

APPENDIX 3: Service Delivery Checklist

Activities	Tick if delivered	Tick if effective	How do you rate the quality of service you are providing
Initial activities			
Home visits			
Meals			
Food parcels			
Core activities			
Meet health needs			
Psychosocial support			
Meet educational needs			
Meet nutritional needs			
Child protection and legal support			
Referral Activities			
Social grant			
Clinic			
HIV counselling			
Birth certificate/ ID			
Referral to SANCA			

- Rating**
1. very good
 2. Good
 3. Fair
 4. Poor
 5. Very poor

Which of the above programme activities have brought the most valuable change in the lives of your clients? _____

APPENDIX 4: Programme Manager's Checklist

Activities	Staff	Budget	Infrastructure
	Tick if sufficient staff, budget and infrastructure to deliver actual activities		
Initial activities			
Food parcels			
Meals			
Home visits			
Core activities			
Meet health needs			
Psychosocial support			
Meet educational needs			
Meet nutritional needs			
Child protection and legal support			
Referral Activities			
Social grant			
Clinic			
HIV counselling/treatment/testing			
Birth certificate/ ID			
Training activities			
After school supervision			
Home visits			
Home based care			

If you have any comment concerning the elements of the organizational structure in the table please feel free to do so in the space below.