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AN OUTCOME EVALUATION OF AN AFTERCARE PROGRAMME FOR HIV AND AIDS
AFFECTED CHILDREN

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A dissertation submitted in partial fulfilment of the requirements for the award of the
Degree of Master of Philosophy (Programme Evaluation)

Faculty of Commerce
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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 research proposal from the work, or works of other people has been attributed, cited and referenced.

Signature:

Date:

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EXECUTIVE SUMMARY

This dissertation is an outcome-based evaluation of an aftercare programme for children affected by HIV and AIDS, and other vulnerable children. The aftercare programme is run by a non-governmental organisation (NGO) called Ikhaya LeThemba (home of hope). Ikhaya LeThemba runs two aftercare programmes: the Intensive Programme, which is specifically for children affected by HIV and AIDS, and the General Programme for children who do not have carers or parents to care for them after school and for children who have special educational needs.

Data from programme records were used for the evaluation. Programme staff were asked to verify information on the programme records when necessary.

The evaluation used a quasi-experimental design known as the comprehensive longitudinal design. The year 2010 was used for the evaluation and information from five data points (baseline data and each of four school terms in 2010) was used to measure outcomes. The evaluation was divided into two parts: a service utilisation of the programme participants and an outcome evaluation part.

The outcomes that the evaluation focused on were the psychosocial, health and education statuses of the children who were enrolled in the Intensive Programme in 2010. The aim of the evaluation was to establish whether the children's statuses improved in 2010 due to their participation in the aftercare programme. The academic outcomes of the General Programme, and the question of whether it managed to provide a safe after care for these children, were both considered.

The findings indicated that, overall, the participants' psychosocial, health and education statuses improved in the Intensive Programme in 2010.

Although 19% of the participants in the General Programme dropped out, the remaining 81% attended the programme regularly. The academic statuses of the children in the General Programme did not improve in the year 2010.

The evaluation resulted in recommendations for improvements to programme activities, programme design and data capturing.

The study serves as a template of an evaluation of a multidimensional aftercare programme for orphans and vulnerable children affected by HIV and AIDS. It also highlights the importance of record-keeping and good monitoring systems that allow measurement of outcomes of the different facets of the programme.

The evaluation concludes with recommendations for future research on evaluation of programmes that cater for orphans and vulnerable children.

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South Africa has one of the highest Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) infection rates in the world. An estimated 5.6 million people were living with AIDS in South Africa in 2009, more than in any other country (Joint United Nations Program on HIV/AIDS [UNAIDS], 2010). As the number of people living with HIV and AIDS increased, the number of children directly and indirectly affected also increased. In the year 2010 It was estimated that there were 1.9 million AIDS orphans with one or both parents deceased in South Africa (UNAIDS Report on the global AIDS epidemic [UNAIDS], 2010). Several programmes have been started to provide relief and hope to the infected and affected children.

In response to the urgent needs and rights of children in communities affected by AIDS, support initiatives have moved from an initial focus on orphanages and residential care to strengthening and scaling up community-based support programmes for families (Donahue, 1998; Nyambedha, Wandibba, & Aagaard-Hansen, 2003; Richter, Foster, & Sherr, 2006). Typically implemented by local organisations and funded by national and international governments and non-governmental organisations, community-based programmes include multidimensional interventions that support children's health, education and psycho-social well-being; community mobilisation; income-generating activities and care-giving support for families affected and infected by HIV and AIDS (Donahue, 1998; Schenk et al., 2008).

This dissertation focuses on such a community-based support programme for children affected by HIV and AIDS. The programme is described in full below.

Programme Description

IKhaya LeThemba, Home of Hope, is a non-governmental organisation (NGO) that was established in Cape Town in 2004. Using funds from its major sponsors - such as the National Lottery, the United States President's Emergency Fund for AIDS Relief (PEPFAR) and individual donors - the NGO offers holistic care for orphans and children affected by HIV and AIDS in the township of Imizamo Yethu in Hout Bay.

Imizamo Yethu is an informal settlement in the greater Hout Bay Valley area, close to Cape Town. This settlement is 18 hectares in area and houses approximately 33 600 people, with little or no infrastructure for sustainable living. The area is characterised by poverty and generally poor standards of living. As in most informal settlements in South Africa, unemployment rates are high, with estimates showing figures in excess of 50%. Imizamo Yethu has also been affected by HIV and AIDS. Although the numbers of those affected and infected are not available, Ikhaya LeThemba provides care for 70 children who cannot be fully taken care of by their families. The main objective of Ikhaya LeThemba is to provide love and care to these children, regardless of race, colour, religion, history or current living situation. The NGO prides itself on providing multidimensional care for children: physically, socially, educationally, emotionally and spiritually.

Most of the children at Ikhaya LeThemba come from homes affected by HIV and AIDS. Orphaned children in South Africa have traditionally been cared for within the extended family (Ankrah, 1993). However, with the increase in HIV and AIDS and the negative impact of a poor economy, the extended family arrangement is crumbling. This has resulted in the affected children failing to receive individual care and love. In many cases, such children are neglected even before they are orphaned.

Ikhaya LeThemba offers two aftercare programmes for six- to thirteen-year-old children affected by HIV or AIDS. Parents, carers, teachers and local clinic workers apply, on behalf of the children, for enrolment into the programme. An application form is requested from Ikhaya LeThemba. The application form provides information about the HIV statuses of carers and parents, the vulnerability of children and the stability of the child's family unit. On the basis of their needs as established in the application form, the children are then enrolled into one of two programmes: the Intensive or the General aftercare programme. These programmes are run in parallel with school term-times of primary schools in Imizamo Yethu Township. (Ikhaya LeThemba is closed during school holidays).

Each of these programmes is described in more detail below.

The intensive programme.

This programme is specifically for children who are directly affected by HIV or AIDS. They are either HIV-infected, and/or have at least a parent or a carer who is infected with the HIV virus or has AIDS, or they have lost a parent or carer to AIDS. The Intensive Programme is aimed at the affected children within the six-to ten-year age group. When children reach the age of 10 years they are moved to the General Programme.

In the Intensive Programme, children are taken care of, Monday to Friday, from 1.30 pm to 6.30 pm when their carers fetch them when they return from work. At the centre children have access to specialised care that addresses their individual emotional, physical and educational needs. In addition to the psychological, sociological and cognitive development that the children are exposed to, the programme also meets the children's physiological need through the provision of well balanced cooked meals from the centre's organic garden. Children are also provided with a safe place to play - a home away from home. The programme enrolls a maximum of 30 children annually.

The general programme.

This programme is offered three times a week (Monday, Wednesday and Friday) from 1.30 pm to 6.00 pm for up to 40 children annually between six and thirteen years of age. The programme also caters for children who do not have carers or parents to look after them during working hours. Children do not have to be directly affected by HIV and AIDS to be enrolled in the General Programme.

With the breakdown in social fabric, children left alone in homes are vulnerable to abuse and are exposed to a number of dangers including injury from electricity or fires. The General Programme therefore aims at reducing the time the children are left on their own and are exposed to abuse and dangers.

The Intensive and General programmes have core activities, each of which falls under psychosocial support, academic support or physical health. Each of the core activities are discussed in detail below.

Psychosocial support.

Psychosocial support helps to fulfil the children's emotional, social and psychological needs. To cater for these needs the programme has four activities: Hero Books, Healthy Me, Holiday clubs and outings, and family support through a community worker who visits the children's families.

Hero books.

This is an art therapy-based programme, in which children make their own picture books starring themselves as a hero overcoming problems. Hero Books is designed to give children power over specific challenges in their life. The child is thus able to discover their strengths in identifying and solving problems, which could be behavioural, emotional or social. The programme is run once a week over a six-month period by programme staff trained in the use of Hero Books. Children are carefully monitored to identify any abnormal behaviour during the process of applying the Hero Books concept.

Healthy me.

Various child counsellors and social workers help to run the Healthy Me programme. Focusing especially on sexuality and HIV prevention, the programme teaches children to keep their bodies healthy and safe from abuse by other people. They are divided into two age groups: upper primary (10 to 13 years) and lower primary (6 to 9 years). The elder group is taught from a life-skills programme called Sara, while the younger group is taught from a skills programme called Think Twice. These programmes are run over six-month periods.

The Sara skills programme is designed to empower young people with knowledge about HIV and AIDS so that they become aware of their rights and feel empowered to assert those rights. Material used in this programme stimulates the imagination and instils an awareness of social issues at a young age. This skills programme consists of a series of comic books that provides HIV and AIDS education. The comics all feature Sara, a young girl who is faced with many challenges from the community she lives in. The girl or her friends and family experience such

issues as sexual exploitation by older men, teenage pregnancy, HIV and AIDS stigmatization, losing both parents to AIDS, and many other social issues. In each case, Sara comes up with the best solution to deal with the situation at hand. The children are encouraged to learn from Sara's experiences. In order to assess the children's skills development, each child is given an activity book to fill in. This contains a variety of activities that allow learners to learn, practise and consolidate important life skills.

The Think Twice skills programme, on the other hand, is simplified for younger primary school children to learn about HIV and AIDS. It empowers children to make responsible decisions regarding sex and relationships. Children are equipped with vital information to build self-esteem and to encourage them to achieve their dreams by making good choices every day. The Think Twice activities address major topics such as the prevention of HIV and AIDS and child sexual abuse and provide skills to support those children who are already affected.

Holiday clubs and outings.

Holiday clubs are offered twice a year and outings are offered four times a year. The holiday outings provide children with outdoor recreational activities. The children's destinations and their activities vary from year to year. The most common places for children's visits are Soetwater Centre, the Castle of Good Hope, Seal Island, Betty's Bay, and Lion's Head. All of these places are natural environments away from the hustle and bustle of the township where the children live. The environments are also peaceful ones where children are encouraged freely to discuss topics that affect them. The purpose of the outings is to allow the children to engage in physical fun outdoor activities. At these outings children are taught about HIV and AIDS and topics such as delaying sex until they are grown up and are in committed adult relationships.

Holiday clubs' activities also vary. One of the common ones is the Easter club, which takes place during the Easter holidays. The purpose of this club is to teach children life skills such as craft, music and dance. On special occasions such as World AIDS day, children form clubs to educate

one another on HIV and AIDS. Children are also divided into groups and given tasks such as presenting on certain topics related to the theme of the event.

Family support.

Family support is provided by a community worker through home visiting, and provides a link between Ikhaya LeThemba, the family and the school. The community worker visits the school fortnightly to meet with the teachers of the children in the programme in order to ascertain the children's progress in their school work. The community worker also visits parents at least once a month to discuss parenting strategies, build family cohesiveness and strengths and to support families in gaining employment.

Academic support.

The academic support activities aim to help children with their school work. This is done via two activities that teach children Mathematics and English skills.

Hands-on mathematics.

This activity is divided into two parts. The first part is a hands-on programme where children are taught mathematics. Children are taught using the clay mathematics principle. Children are given clay to use for calculations. They learn to calculate and how to break form into quantities relative to other formed objects. With the help of clay and materials such as the clay bank and exchange zones, children learn how to perform mathematical functions and manage exchanges and remainders. The use of clay makes these activities fun, flexible, and affordable. Clay mathematics is appropriate for children from a school beginner's age up to age twelve when they complete primary school level.

The second part of the activity is practical mathematics, called mathematics in the garden. Children are taken to the centre's garden and taught skills such as how to count and weigh produce from the garden and how to measure the length and width of garden beds.

Trained programme staff teach both components of hands-on mathematics once a week throughout the year, with progress recorded on a worksheet.

Reading nook.

This is an English-based reading and spelling programme that is carried out once a week throughout the year. It is based on a programme called Read America. The key concept used is phonographic: children are taught how speech sounds are useful in reading. Pictures are also used to enhance the children's reading skills. Children read to programme staff, one-on-one and also as a group. At the end of each reading a child gets a worksheet that records what they have learnt. This activity is delivered by programme staff who are trained in Read America.

Physical Health.

The physical health activity is called Kids in the Garden. This activity comprises of a feeding scheme for the children and practical activities outdoors.

Kids in the garden.

This is a food gardening programme that teaches the children about healthy eating, gardening, seed life cycles and the names of the different parts of a plant. Practical activities include planting and watering crops and preparing meals using the gardens' produce. The programme is run by programme staff once a week over a period of six months.

The overall goal of these programme activities is to offer integrated, holistic care for orphans and children affected by HIV and AIDS by means of various psychological, physical and educational activities.

Table 1 shows the differences between the Intensive Programme and the General Programme.

Table 1

Intensive and General Aftercare Programme Activities

	Intensive Programme	General Aftercare Programme
Target Population	Children directly affected or infected by HIV and AIDS. Have a parent infected by it or have lost a parent to AIDS	Children who do not have parents/carers to look after them after school. Children who perform poorly at school or have psychological problems like Attention Deficiency Hyperactivity Disorder (ADHD)
Fee Payment	R40 per term to subsidize meals	No payment
Programme Activities	<p>Psychosocial Activities:</p> <p>Hero Books</p> <p>Spiritual Activities</p> <p>Psychosocial support (Activities that encourage self esteem, help overcome anger and fear counselling,)</p> <p>Life skills</p> <p>Kids in the garden</p> <p>Holiday Outings</p> <p>Home visits once a month</p> <p>Health activities:</p> <p>Provision of lunch snack and cooked meal in the evening</p> <p>Sports</p> <p>Academic activities:</p> <p>Numeracy</p> <p>Literacy</p>	<p>Psychosocial Activities:</p> <p>Individually when necessary</p> <p>Holiday Outings</p> <p>Life skills</p> <p>Kids in the garden</p> <p>Home visits twice a months</p> <p>Health activities:</p> <p>Only Lunch snack provided, no cooked meal in the evening</p> <p>Sports</p> <p>Academic activities:</p> <p>Numeracy</p> <p>Literacy</p>
Dosage	5 days a week, Monday to Friday from 1.30pm – 6:00pm	3 days a week, Wednesday, Thursday and Friday from 1.30pm – 6.00pm

Programme Theory

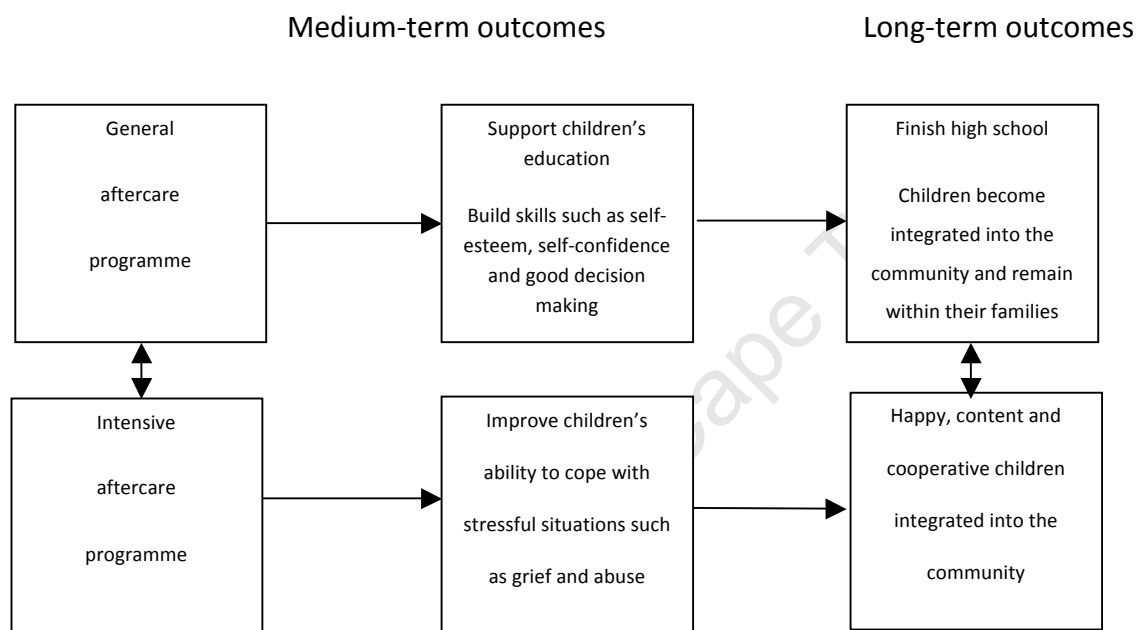
“Programme theory explains why a program does what it does and provides the rationale for expecting that doing so will achieve the desired results” (Rossi, Lipsey, & Freeman, 2004, p.134). Wholey (1987) states that programme theory identifies “programme resources, programme activities, and intended outcomes, and specifies a chain of causal assumptions linking program resources, activities, intermediate outcomes, and ultimate goals” (p.78). According to Bickman (1987) programme theory is the construction of a plausible and sensible model of how a programme is supposed to work. Donaldson (2001) on the other hand defines programme theory as the process through which programme components are presumed to affect outcomes and the conditions under which these processes are believed to operate.

These definitions highlight the importance of a programme theory in any type of evaluation. A well developed programme theory helps to frame evaluation questions and design sensitive and responsive evaluations (Donaldson & Lipsey, 2006). Donaldson and Lipsey (2006) go on to state that a programme theory helps the evaluator and programme stakeholders identify the performance dimensions most critical to the programme’s success.

The following programme theory seeks to highlight the causal relationship between the Ikhaya LeThemba programme and the benefits that should accrue to the participants from taking part in that programme. The programme theory was elicited from the Programme Director of Ikhaya LeThemba (the client). Figure 1 shows the Ikhaya LeThemba’s basic programme theory.

Figure 1

Programme theory of Ikhaya LeThemba



According to the client's theory, when orphaned and vulnerable children are given a safe place to play, learn and grow they are less vulnerable to physical, emotional and psychological abuse. The reduced vulnerability of orphans and vulnerable children enhances their integration into the community.

Plausibility of programme theory.

The programme theory of the client will be tested to review its logic and plausibility by means of a literature review focusing on evaluations of similar aftercare programmes designed to care for children affected by HIV and AIDS. This is a useful way of assessing programme theory. Rossi et al. (2004) recommend an examination of programmes through the lenses of similar concepts

associated with the programme being evaluated. They contend that this examination indicates the probability of success and allows for the identification of critical programme areas.

The results of the literature review are discussed by focusing on the programme activities relating to psychosocial support, physical health care and academic support as well as NGO resources.

Psychosocial support.

Psychosocial support will encompass socio-emotional support, childcare and safekeeping, life skills training, reading comic books as well as spiritual activities. Each of these facets will be discussed in more detail.

Socio-emotional support.

Psychosocial intervention mechanisms seek to reduce the negative impact HIV and AIDS have on orphans and vulnerable children by addressing the children's psychological as well as social needs and deficiencies (Bauman & Germann, 2005). Family Health International (FHI), 2001 reveals that children are affected emotionally and physically when their parent becomes terminally ill. In fact, most orphaned children would have endured the stress of a long and difficult parental illness as well as the stress of their death (Wild, 2001). Tsheko, Bainame, Odirile, and Segwabe (2007) noted that the lack of proper support mechanisms for a child upon the death of a parent could lead to the child experiencing a sense of loss, grief, fear and anxiety. The result of these experiences could in turn lead to long-term consequences for the child such as psychosomatic disorders, chronic depression, low self-esteem, low levels of life skills, learning disabilities and disturbed social behaviour (Deininger, Garcia, & Subbarao, 2003; Schenk, 2009; Tsheko et al., 2007).

The above studies support programmes or interventions aimed at giving psychosocial support to children affected by HIV and AIDS. In particular, psychosocial interventions help children (and families) to build self-esteem and to process and manage stressful situations such as grief and abuse (Bauman & Germann, 2005).

In an intervention aimed at providing psychosocial support to orphaned and vulnerable children between the age of 10 and 14 in Zimbabwe, Chitiyo, Changara, and Chitiyo (2007) linked psychosocial support to improvement in schooling outcomes. The results showed that prior to the intervention, class teachers described the children as showing signs of withdrawal, short temper, crying and bullying. Their school performance was described as dismal. After the intervention, class teachers revealed that children showed steady progress on monthly tests given to them. The children also recovered their confidence and self-esteem (Chitiyo et al., 2007).

In Kenya, a qualitative study of 340 NGOs in Nairobi collected data to identify strengths and challenges associated with service provision to orphans and vulnerable children (Ferguson & Heidemann, 2009). That study's findings supported the findings of Chitiyo et al. (2007) and substantiated that orphaned and vulnerable children benefited from psychosocial support interventions. A common theme identified after the interventions was an increase in self-confidence, self-esteem, better interpersonal and communication skills and an increased sense of worth among the children. In addition, the interventions increased the children's desire to excel in life and have a chance to realize their goals, dreams and full potential (Chitiyo et al., 2007).

Taking care of the children's psychosocial wellbeing is at the core of Ikhaya LeThemba's services. The psychosocial support given to the children aims to improve their educational scores. When children's psychosocial needs are taken care of, the children are likely to improve in their school performance (Chitiyo et al., 2007). Ikhaya LeThemba goes a step further with psychosocial support by assisting children with English and Mathematics skills. Aftercare programmes have helped many children to improve their mathematics and reading skills, because they allow children to focus attention on areas in which they are having difficulties (Lauer et al., 2000).

Childcare and safekeeping.

Children's participation in afterschool programmes and experiential and cooperative learning improves their social and academic development, and decreases their involvement in unhealthy

activities and increases skills for resilience among children at risk (Coolsen, Seligson, & Garbarino, 1985; Pierce, Hamm, & Vandell, 1999).

In Botswana and Malawi, a study found that in families caring for people living with AIDS, older siblings (six to fourteen years old) often had to forgo school to provide childcare (Heymann & Kidman, 2009). When older children were not available to provide childcare, parents often had no choice but to leave children home alone: 53% of HIV/AIDS caregivers reported that they left children younger than five home alone (Heymann & Kidman, 2009). In this study, HIV and AIDS caregivers, orphan caregivers, and HIV-infected parents all expressed concern about the quality of their child's care while they were at work (Heymann, 2006). Concern intensified when the child in question was HIV-infected or ill (Heymann, 2006). In the absence of quality childcare, orphan caregivers and HIV-infected parents were more likely than non-infected parents to report worrying that their children were not receiving adequate educational and developmental support or adequate emotional support (Heymann, 2006). Parents' concerns were well founded. In the same study, 68% of children whose parents were HIV and AIDS caregivers experienced accidents and emergencies while their parents were working away from home, compared to 41% of other children (Heymann, 2006).

Quality childcare can free up time for adults to be economically productive and also eliminate the need to withdraw older siblings from school to provide childcare (Deutsch, 1998). Ikhaya LeThemba's aftercare programme is designed to offer children a safe place to play and learn while their caregivers and parents are at work.

Life-skills training.

Rosen (2003) defines life skills as non-academic abilities, knowledge, attitudes and behaviours that must be learned for success in society. Rosen (2003) states that life-skills training can develop in children the ability to gain a higher sense of self-worth and competence by learning to work with others, express their feelings and solve problems (Werner & Smith, 1982).

Life-skills training is essential in reducing the vulnerability of orphans and protecting them from sexual abuse and other risks (Rotheram-Borus, Mahler, & Rosario, 1995). Life-skills training,

particularly prevention programmes, teach skills and knowledge required for the practice of preventative behaviours and the foundation of protective factors (Rotheram-Borus et al., 1995). These factors enhance the probability of positive outcomes (autonomy, high self-esteem and successful school performance) and reduce the probability of negative outcomes (risky sexual behaviour, school failure, delinquency and drug use) (Elias & Tobias, 1996).

A life skills programme called “I Want To, I Can Prevent HIV/AIDS” was implemented as part of a fourth-grade school curriculum in Mexico. The main goal of the programme was to enhance children’s ability to take responsibility, make healthier choices, resist negative pressure, and avoid high-risk behaviours. Colourful and interactive workbooks were used and in each lesson children were given exercises that helped them to analyse, express emotions, communicate, think creatively, reflect and solve problems. Participants were children from low-income Mexican elementary schools and they were divided into experimental and control groups. The results indicated that the programme had a significant impact on communication about difficult topics in all five constructs measured, namely: attitudes, norms, self-efficacy, behaviours and intentions (Pick, Givaudan, Sirkin & Ortega, 2007). As a result of taking part in this skills programme, children were empowered to overcome psychosocial barriers (for example fear and shame) and to develop competencies such as communication skills and behaviours that are proven protective factors for high-risk adolescent behaviour (Dwivedi & Harper, 2004).

Life Skills Education (LSE) is a life-skills programme that was carried out in Nigeria. It was offered to street children to help them handle issues relating to decisions about romantic relationships, anger, substance abuse, money management, self stigmatization and HIV and AIDS prevention (Olley, 2007). Baseline data was collected on the children’s knowledge about HIV and AIDS-related issues. The intervention took the form of a manualised didactic instructional session. After the intervention the children showed an increased knowledge of antisocial behaviour prevention, safe sexual practices, social roles and responsibilities and their assertiveness and communication improved (Olley, 2007).

Life-skills training is one of the key activities at Ikhaya LeThemba. These skills are taught through holiday clubs and outings as well as comic books.

Comic books.

Sara comic books are one resource often used to teach children life skills for the prevention of HIV and AIDS (McKee et al., 2003). This model, designed by UNICEF, was assessed for acceptability in eleven countries: Ethiopia, Ivory Coast, Kenya, Malawi, Mozambique, Namibia, Nigeria, South Africa, Tanzania, Zambia and Zimbabwe (McKee et al., 2003). In each country the research teams used focus groups to assess whether adolescent girls were motivated and encouraged by Sara's experiences and whether they identified with Sara. McKee et al. (2003) found that children in Nairobi, Kenya demonstrated how they were applying Sara's experiences and behaviour in their lives. The research revealed a range of life skills being developed, including risk assessment and critical thinking. In other countries girls indicated that they were influenced by Sara to use various life skills to delay sexual debut and to avoid sexual abuse.

Masiye Camp is a programme in Zimbabwe that addresses psychosocial support issues in children (Fox & Parker, 2003). It uses techniques such as role play, drawing pictures and using puppets to help children share their own stories in a safe environment. Children learn coping strategies and self-confidence from such activities (Fox & Parker, 2003).

Another resource used is the memory books, a storytelling technique that originated in Uganda (Levine, Foster & Williamson, 2005; Pillay, 2003). Memory books can be used to stimulate communication about death between adults and children. The memory book is created by the parent or caregiver and the child. The contents of this book may comprise journal entries, photographs, family trees and histories. The book may also have sections containing the personal stories of the parent and child, such as family traditions and information about other family members. Memory books help to prepare the child for the future, keep memories alive after the death of a parent and reduce the psychological anguish of orphanhood (Pillay, 2003).

Ikhaya LeThemba uses the comic book strategies in its programmes. In the Hero Books activity, children draw pictures of themselves coupled with a story of an act of heroism as they overcome personal problems. However, Ikhaya LeThemba does not involve parents in its Hero Books activity. It would be helpful if the affected children's parents were also involved in this activity. Sara Comic books is also used by Ikhaya LeThemba.

Spiritual activities.

The major religions share common ground in areas of social concern by upholding values such as respect for life, the sacredness of human beings, concern for the marginalised and the importance of community (Foster, 2005). The Bible, Quran and Vedas (Hindu primary texts) teach that God himself protects widows and orphans and urge believers to do likewise (Foster, 2005).

Aftercare programmes founded by churches often include spiritual activities in their curriculum. In western Kenya in 2007 a study was done on strategies for assisting non-governmental organizations that serve orphans and vulnerable children (Skovdal, Ogutu, Aoro & Campbell, 2009). The study revealed that the role of faith was noteworthy in helping these children cope. Many children that took part in faith-based non-governmental organisations believed that God was always there for them and God helped them to receive help unexpectedly (Skovdal et al., 2009).

Ikhaya LeThemba was founded by a church called the Vineyard Church and spiritual activities are incorporated in the programmes of care.

Physical health care.

Provisions of meals and health care.

Children require health services such as immunizations, growth monitoring and treatment for a variety of ailments and infections (Richter, Manegold, & Pather, 2004). Undernourished children may experience stunted growth, reduced resistance to disease and slow cognitive development (Richter et al., 2004).

Aftercare centres can strengthen their capacity to care for HIV and AIDS-affected children by providing meals and medical treatment. A typical example of such a centre is the Kenneth Kaunda Children of Africa Foundation that operates five day-care centres in Lusaka, Zambia (Kelly, 2003). The orphans continue to live with their caregivers but attend the centres during the day, where they get meals and basic education. They also receive medical treatment at an

AIDS clinic run by the foundation. The clinic has noted that the regular, nutritious diet it provides has protected many of the children from needing medical attention, even those who are HIV-infected (Kelly, 2003).

Ikhaya LeThemba offers the children one meal per day from its organic garden. Medical services are not provided. Children and their caregivers are referred to the local clinic for their healthcare needs.

Academic Support

Existing studies and interventions in AIDS orphans' education have focused mainly on the issue of school attendance and school completion (Tu et al., 2009). Most of the AIDS assistance programmes and economical assistance aimed at orphans have been given to households caring for orphans. Tu et al. (2009) suggest that care efforts should be developed to mitigate the negative impact of parental illness on children's school performance. Ikhaya LeThemba's programmes are unique in that they incorporate educational support as a key component of the centre's model.

NGO resources

From the literature review presented it would seem that Ikhaya LeThemba's programme has all the necessary activities that are required to provide HIV and AIDS-affected children with the multidimensional care that they require. However, NGOs like Ikhaya LeThemba often lack funding and resources to take care of children's nutritional needs. They are also usually very small in proportion to the urgent need to scale up support for HIV and AIDS-affected children. To strengthen community-based programmes in caring for children affected by HIV and AIDS, access to education, healthcare and birth registration are necessary to lessen children's vulnerability (Richter et al., 2006). Ferguson and Heidemann (2009) observed that NGOs operate in resource-deprived environments which pose many challenges to service provision. NGOs struggle to provide needs such as clothing, bedding and food. In addition, children served may suffer from numerous medical problems. Providing medical care is often challenging for the NGOs because of their lack of funds.

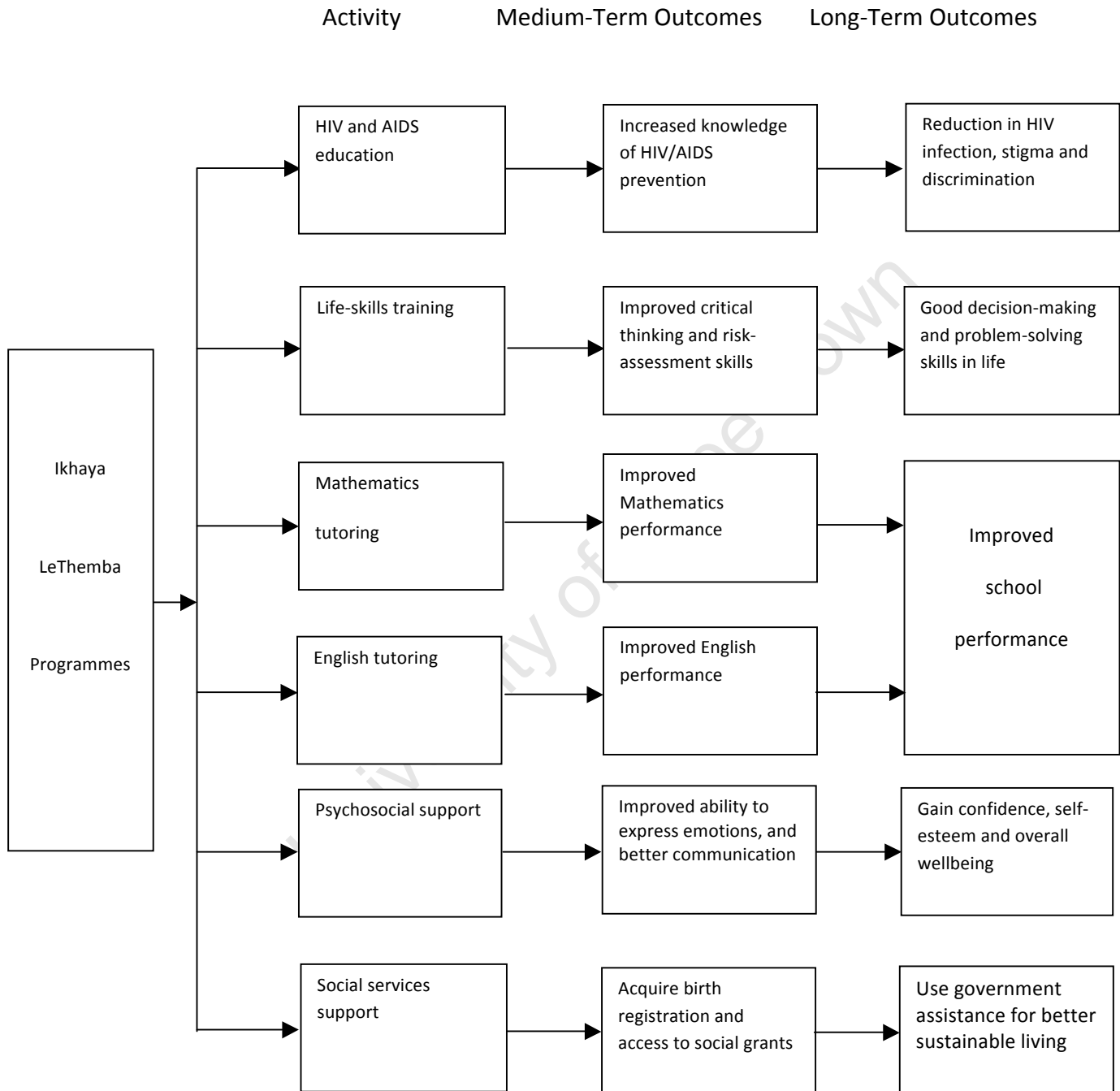
It can be concluded that Ikhaya LeThemba's programme theory is feasible. However, it is suggested that for the current programme to work, government social services should be added to the programme. Provisions such as healthcare and birth registration should be made accessible to the caregivers and the affected children so that they can acquire help such as child grants from the government, healthcare services from the government hospitals, and other benefits the South African legal framework offers to orphans and vulnerable children.

A revised theory of the Ikhaya LeThemba's programme is given below. This programme theory incorporates the suggested activities into the programme and disaggregates programme outcomes for easy monitoring.

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Figure 2

Revised Programme Theory of Ikhaya LeThemba



Type of evaluation and evaluation questions

The evaluation will be an outcome evaluation. An outcome evaluation gauges the extent to which a program produces the intended improvements in the social conditions it addresses (Rossi, Lipsey, & Freeman, 2004). Davidson (2005) defines an outcome evaluation as “the part of the evaluation that focuses on the change (or lack of change) caused by a program. It can also be an evaluation that focuses primarily or exclusively on outcomes, usually (and not prudently) omitting process evaluation, consideration of cost and so forth” (p.244).

Evaluation Questions.

Based on the programme theory, ten evaluation questions were formulated. The first six evaluation questions were service utilisation questions and the remaining four were outcome questions.

Service utilisation questions.

The service utilisation questions are asked to ascertain the extent to which the intended targets actually receive programme services (Rossi et al, 2004). The following service utilisation questions were formulated.

1. What is the target population of Ikhaya LeThemba’s Intensive Programme?
2. Who received the Intensive Programme in 2010?
3. How many dropped out of the Intensive Programme in 2010 and why?
4. What is the target population of Ikhaya LeThemba’s General Programme?
5. Who received the General Programme in 2010?
6. Who dropped out of the General Programme in 2010 and why?

Outcome Questions.

Outcome questions investigate benefits for the participants during or after their involvement with the programme. Outcomes relate to knowledge, skills, attitudes, values, behaviour, condition or status (Owen & Rodgers, 1999). The outcome questions given below were used to evaluate whether the programmes led to the intended benefits for the recipients.

7. Has the Intensive Programme provided psychosocial, health and educational support for children affected by HIV and AIDS?
8. Has the General Programme provided academic support for its participants?
9. Has the General Programme reduced the time that children spend alone without care?
10. Has the community worker established a link between Ikhaya LeThemba, families and the school by means of home visits?

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METHOD

The evaluation questions formulated earlier were used as bases for this section.

Design.

The evaluation approach was theory driven. A quasi-experimental design known as a comprehensive longitudinal design was used. This design requires collecting data on the programme group on at least four different time points during the programme. The first round of data is collected at the start of the programme. The comprehensive longitudinal design was appropriate for the evaluation because learners in South Africa receive school reports every school term. There are four terms per academic year for children in primary school. Every school term, Ikhaya LeThemba obtains participants' reports, the participants' psychosocial status is reported on, and a community worker visits the children's homes and school.

The comprehensive longitudinal design is illustrated in Table 2.

Table 2

Comprehensive Longitudinal Design

Programme	Upon Registration	Programme Starts	End of term x 4
Intensive Programme	0 ₁	x	0 ₂ 0 ₃ 0 ₄ 0 ₅
General Aftercare Programme	0 ₁	x	0 ₂ 0 ₃ 0 ₄ 0 ₅

Table 2 illustrates the points at which data were retrieved for the evaluation. The baseline data were information that the participants handed in upon registration on the programme. Data were then collected for each school term of 2010.

Data providers

Ample secondary data existed in the form of programme documents, which were the main source for evaluation data. All the data were retrieved from the records of the children that were enrolled in the programmes in 2010. Each child's records consists of forms and reports handed in by the children's parents at registration as well as those submitted on a term to term basis, all kept in a file.

Secondary data.

Below is a description of the secondary data that were used for the two programmes. The programme documents were designed by the programme management.

Registration forms.

The After School Centre Registration form was completed by the children's parents or caregivers who applied for the Intensive Programme placement in 2010. This form contains information about the child's age, school, grade, the number of people living in his or her household, and family status (whether both parents are alive, whether the child is a maternal orphan, paternal orphan or double orphan). This form also has information about the child's abilities, interests and whether they have experienced the death of someone close to them. Attached to this form was the child's most recent school report. (Please see Appendix A for the After School Centre Registration Form.)

Parents and carers who applied for their children to be enrolled in the General Programme filled in the 2010 Registration Form. This form contains information such as the child's age, school grade, the relationship of the carer to the child and the number of people living in the child's household. Attached to this form was the child's most recent school report. (Please see Appendix B for 2010 Registration Form.)

I can... form.

The *I can...* form was filled in by children in both programmes. In the *I can...* form there were data related to the child's psychosocial wellbeing and health status, as well as the child's academic performance. (Please find attached the *I can...* form in Appendix C.) This form was completed by a child or a child's parent, carer or teacher at the beginning of the programme and at the end of each school term. Table 3 provides information on which items on the *I can...* form related to psychosocial wellbeing, health status and academic performance of the children.

Table 3

Information from I can...form

Status of child	Item number on the form
Psychosocial wellbeing	3,4,7-15
Health status	5 and 6
Academic performance	1 and 2
Other additional information	16

School Reports.

These are records detailing primary school learners' progress each term. The school report contains subjects that learners are taught at the local government school. The major subjects taught are English, Mathematics, Xhosa, Afrikaans and life skills. The results on the school report are given as a symbol or code and a percentage, with a key explaining the codes. The primary schools in the Western Cape, South Africa, range the learner's marks from 1 to 4, with 1 being the lowest mark that can be achieved and 4 the highest. (1 = 0% to 34%, 2 = 35% to 49% 3 = 50% to 69%, 4 = 70% to 100%). Children from both programmes are required to submit a school report every term. For purposes of this evaluation, English and Mathematics were the only relevant subjects used.

Community Worker's reports.

The community worker's reports were available in a notebook kept by the community worker. They provided information on which children's families were visited in the year and which issues were raised during the visits. The aim of the visits was to track the child's progress against their baseline status in terms of psychosocial wellbeing, health and academic status. The number of visits and type of visits were used as a basis to establish whether a link had been created between the community worker, the parents and the school.

Attendance Records.

Attendance records of the participants in the General Programme were used to determine whether their attendance was regular, thus keeping them safe in the centre during the time their parents and carers were at work.

In terms of the evaluation the secondary data were used as follows:

Target Population / service utilisation

The programme records used to answer the service utilisation questions were the forms filled in at registration for both programmes.

Outcome evaluation

The outcome evaluation was based on a comparison of baseline data with progress data.

Table 4 presents all the data sources used for the service utilisation, baseline and progress data for the two programmes.

Table 4

Programme records used in the evaluation

	Service Utilisation	Baseline Data	Progress Data
Intensive Programme	After School Centre Registration form	After School Centre Registration form	
		<i>I can...</i> form	<i>I can...</i> form
		School Report	School report
		Community worker's reports	Community worker's reports
General Programme	2010 Registration form	2010 Registration form	
		<i>I can...</i> form	<i>I can...</i> form
		School report	School report
		Community worker's report	Community worker's reports Attendance Records

Procedure

The data collection process took place in July 2011. Before data collection, ethics clearance was granted by the Ethics Committee of the Faculty of Commerce, University of Cape Town, and by the programme director (see letters attached in Appendix D and E). The evaluator went to the programme site where programme records were kept and looked through all the participants' files, one at a time, to collect data. This was done over a 12-day period and the records reviewed dated back to 2006. All the files of the children registered in 2010 were obtained and investigated. A total of 83 participants were registered in 2010, of which 32 were in the Intensive Programme and 51 in the General Programme. All participants' records were examined.

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RESULTS

The results of the evaluation will be reported according to the evaluation questions.

Service Utilisation

Evaluation questions one to six were used to answer the service utilisation part of the evaluation.

Evaluation Question 1: What is the target population of Ikhaya LeThemba's Intensive Programme?

This programme is specifically for children aged between six and ten years who are directly affected by HIV or AIDS. They are either HIV-infected, and/or have at least a parent or a carer who is infected with the HIV virus or who has AIDS. Children who have lost a parent to AIDS and are psychologically affected by the loss are also enrolled in this programme.

Evaluation Question 2: Who received the Intensive Programme in 2010?

The After School Centre Registration forms for 2010 indicated that 32 children enrolled in the Intensive Programme. The children's ages ranged between six and thirteen years. They were all between grade one and five. All the children were Xhosa-speaking. Table 5 displays the parental statuses of the children enrolled in the Intensive Programme.

Table 5

Description of Intensive Programme Participants' Parental Status 2010

Status	Percentage
	(N=32)
Paternal orphans	08 (25%)
Maternal orphans	04 (12.5%)
Both parents alive	10 (31.3%)
Parental status not indicated on the form	05 (15.7%)
Parents' whereabouts unknown / Living with a carer	02 (6.3%)
Parents divorced	03 (9.4%)

Table 6 shows the HIV statuses of the children enrolled in the Intensive Programme in 2010.

Table 6

HIV Status of Intensive Programme Participants

Status	Percentage
	(N=32)
Affected by HIV and AIDS (that is, infected with HIV or living with an infected parent or carer)	10 (31.3%)
Not affected or infected	19 (59.4%)
Status not indicated on form	03 (9.4%)

From Table 6 it is clear that 59% of the children in the Intensive Programme were not affected or infected.

Evaluation Question 3: How many dropped out of the Intensive Programme in 2010 and why?

The programme director confirmed that four children dropped out of the programme in 2010. One of them fell pregnant and discontinued the programme, one moved out of Hout Bay, one was relocated to the Eastern Cape to live with a grandmother and one left the programme to look after her siblings.

Evaluation Question 4: What is the target population of Ikhaya LeThemba's General Programme?

The programme caters for children who do not have carers or parents to look after them during working hours. Children do not have to be directly affected by HIV and/or AIDS to be enrolled. The children in this programme are aged from six to thirteen years. They also include children with particular educational needs and/or those who perform poorly at school. The programme also enrolls children with Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) and children who come from a dysfunctional family unit. The General Programme also incorporates children older than 10 years who have graduated from the Intensive Programme.

Evaluation Question 5: Who received the General Programme in 2010?

The registration forms filled in for 2010 revealed that 51 children were enrolled in the General Programme. The children's ages ranged from seven to fourteen years. The children were between grades one and seven. All the children were Xhosa-speaking, except for one who spoke a Malawian language.

The parental statuses of the participants in the General Programme are displayed in Table 7.

Table 7

Description of General Programme Participants' Parental status 2010

Status	Percentage
	(N=51)
Both parents alive and not divorced	27 (53 %)
Parental status not indicated on the form	22 (43 %)
Parents divorced	02 (4%)

Evaluation Question 6: Who dropped out of the General Programme in 2010 and why?

Programme staff revealed that 10 of the 51 children in the General Programme dropped out in 2010. These were all boys above the age of 10.

Outcome Evaluation

Evaluation questions 7 to 10 were used to evaluate outcomes of the Ikhaya LeThemba's programmes.

The outcome evaluation required dealing with missing data. An examination of the missing data revealed that data were missing completely at random. According to Rubin (1976) data are missing completely at random when the probability of obtaining a particular pattern of missing data in the sample is not dependent on the observed data. There were no trends that showed that data were deliberately omitted for certain reasons. The missing data's absence was mainly due to misfiling by the programme staff and failure on behalf of participants and their parents to submit forms on time.

The method that was used to deal with missing data is called pairwise deletion. In this method, the maximum amount of available data is retained and cases are excluded from analysis only when data are missing on a variable that is being measured (Pigott, 2001). The pairwise deletion method was chosen because participants were missing information on only one or two variables at a time.

The benefit of using the pairwise deletion is that participants' responses are not completely discarded due to one missing variable. The drawback of using the pairwise deletion method is that the parameters of the model will be based on different sets of data, with different sample sizes and different standard errors.

Table 8 and Table 9 provide a summary of the participants' data that were available for analysis. As shown in Tables 8 and 9, there were some data missing in the participants' files. Missing data was due to misfiling by programme staff. However the data available were adequate for statistical analysis.

Table 9 shows that the General Programme did not have adequate I Can... forms for an evaluation. Hence only the I Can... forms from the Intensive Programme were analysed and used in the evaluation.

Table 8

Data Available for Intensive Programme

	Baseline	Term1	Term 2	Term 3	Term 4
	(N=32)	(N=32)	(N=32)	(N=32)	(N=32)
<i>I can... form</i>	20	20	12	0	0
School marks	22	22	20	19	17

Table 9

Data Available for General Programme

	Baseline	Term1	Term 2	Term 3	Term 4
	(N=51)	(N=51)	(N=51)	(N=51)	(N=51)
<i>I can...form</i>	3	0	0	0	0
School marks	28	28	27	26	14

Method for data analysis

Outcome evaluation questions were analysed using a programme called Statistical Package for the Social Sciences (SPSS).

Two methods were used: the repeated measure analysis of variance (ANOVA) as well as Friedman's test. Data were first checked for normality to determine the method to be used. The tests of normality that were used were the Kolmogorov-Smirnov and Shapiro-Wilk tests.

The repeated measure ANOVA was used for responses that were normally distributed. A nonparametric equivalent (Friedman test) of the repeated measure ANOVA was used for responses that were not normally distributed. Post-hoc analyses were run after performing either ANOVA or Friedman tests, these tests produced results that determined which measures were statistically different from one another. The ANOVA repeated measure test was accompanied by the Tukey's post-hoc analysis for pairwise comparisons and mean plots, while the Friedman test was accompanied by post-hoc pairwise comparisons using the Bonferroni adjusted Wilcoxon Signed Rank Tests.

A $p < .05$ level was used for the ANOVA repeated measure tests. Bonferroni adjusted reference p values were .0167 for academic and health status and .0125 for school marks. These values apply to both the Intensive Programme and the General Programme.

In answering outcome evaluation questions the type of statistical test will be given first, followed by descriptive statistics in the form of a table, and a brief description of the significance of the statistics.

Evaluation Question 7: Has the Intensive Programme provided psychosocial, health and academic support for children affected by HIV and AIDS?

Psychosocial status.

The ANOVA repeated measure was used to analyse the data for psychosocial status. Table 10 displays the mean scores of the group at each of the data collection points.

Table 10

Intensive Programme Psychosocial Status (mean scores)

Measure	95% CI			
	<i>N</i>	M (SD)	LL	UL
Baseline	20	1.32 (.79)	.95	1.70
Term 1	20	1.72 (.69)	1.39	2.05
Term 2	12	1.97 (.62)	1.57	2.37

Note. CI = Confidence Interval, LL = lower limit, UL = upper limit (Maximum possible score was 3.)

Results for the repeated measure ANOVA demonstrated significance between term two and baseline, $F(2, 49) = 3.27, p < .05$. Further post-hoc tests indicate that the baseline average was significantly different from that of term 2, $p = .047$.

Health status.

A Friedman Test was used for health status. Table 11 displays the median values for the group at each data collection point.

Table 11

Intensive Programme Health Status (median [IQR] levels)

Measure	Percentiles			
	<i>N</i>	25 th	50 th (Median)	75 th
Baseline	20	1	2	2.75
Term 1	20	1.75	2.25	3
Term 2	12	2.25	2.5	3

The Friedman test showed that there was a statistically significant difference between the measures, $\chi^2(2) = 10.10, p = .006$. There was no significant difference between the results of term two and term one, $z = -.30, p = .762$ (two-tailed). There was a significant difference between results of term one and baseline, $z = -1.78, p = .075$ (two-tailed), as well as between term two and baseline, $z = -2.45, p = .014$ (two-tailed).

Academic status.

Two measures of academic status were used, namely the items from the *I can...* form relating to academic performance and the school marks from the learners' local school.

A Friedman Test was used for academic status. Table 12 displays the median values for the group, obtained at each data-collection point. These results are from the *I can...* form.

Table 12

Intensive Programme Academic Status (median [IQR] levels)

Measure	Percentiles			
	<i>N</i>	25 th	50 th (Median)	75 th
Baseline	20	0	1	2.25
Term 1	20	0.5	1.5	2.5
Term 2	12	1.25	2	2.5

The Friedman test was significant, $\chi^2 (2) = 13.40, p = .001$, indicating a difference between the measures. The Wilcoxon tests indicated significant differences between the baseline measure and term two and between term two and term one, $z = -2.85, p = .004$ (two-tailed) and $z = -2.70, p = .007$ (two-tailed) respectively. The baseline and term one scores were not found to be significantly different from each other, $z = -1.25, p = .212$ (two-tailed).

School marks.

A Friedman Test was used for school marks. Table 13 displays the median values for the group at each data-collection point. These results are from the school reports issued to the learners at the end of each school term.

Table 13

Intensive Programme School Marks (median [IQR] levels)

Measure	Percentiles			
	<i>N</i>	25 th	50 th (Median)	75 th
Baseline	17	2	2	3
Term 1	17	2	2.5	3
Term 2	17	2	2.75	3
Term 3	17	2	2.5	3
Term 4	17	2.5	3	3

The Friedman test showed significance between the results of the baseline and the four school terms, $\chi^2 (4) = 8.83, p = .10$

Evaluation Question 8: Has the General Programme provided academic support for its participants?

A Friedman Test was used for school marks of the General Programme. Table 14 displays the median values for the group at each data-collection point. There were no scores from the *I can...* form for the General Programme. Scores were from the learners' end-of-term school reports for 2010.

Table 14

General Programme School Marks (median [IQR] levels)

Measure	Percentiles			
	<i>N</i>	25 th	50 th (Median)	75 th
Baseline	2	2	2.75	3
Term 1	20	2	2.5	3
Term 2	12	2	2.5	3
Term 3	12	2	2.75	3
Term 5	12	2	2.75	3

The Friedman test showed no significant difference between the measures, $\chi^2(4) = 4.64$, $p = .326$.

Evaluation Question 9: Has the General Programme reduced the time that children spend alone without care?

Table 15 displays the average attendance of the General Programme in 2010.

Table 15

Average Attendance of the General Programme in 2010

	Term1	Term2	Term3	Term4
Attendance	90%	88%	91%	85%

The average attendance for the General Programme was high. This high attendance means that children did not spend time alone, they spent at least 85% of the time after they left school at the centre.

Evaluation Question 10: Has the community worker established a link between Ikhaya LeThemba, families and the school by means of visits?

Table 16 below displays the type and number of visits that were done by the community worker in 2010. For each type of visit a total number of children visited is given, as well as a breakdown of how the visits were split among the children visited.

Table 16

Community Worker's Visits 2010

Programme	Total Number of visits	Home visits per child			School visits per child
		1 visit	2 visits	3 visits	1 visit
Intensive Programme	20	6	7	7	17
General Programme	28	19	8	1	20

The community worker has established a link between the centre, the school and the children's parents. Children in both programmes received school and home visits.

The two programmes of Ikhaya LeThemba were over-subscribed in 2010. However, 19% of the children dropped out of the General Programme during the year. In general, on the Intensive Programme, children's psychosocial, health and academic status showed improvement when compared to their baseline status. For the General Programme, the children's academic status remained the same. Finally, the community worker visited the school and homes of the children on both programmes.

DISCUSSION

The evaluation questions formulated earlier will be used to present the discussion section. This section will discuss whether the programme produced the intended results in the year 2010, the period under which it has been evaluated. Alternative explanations for the results as well as recommendations on how to improve the programme will also be provided.

Service Utilisation

Evaluation Question 1: What is the target population of Ikhaya LeThemba's Intensive Programme?

Evaluation Question 2: Who received the Intensive Programme in 2010?

The results of the evaluation showed that at least 31.3% of programme recipients fit the description of the intended target population. This is the percentage of parents and carers who confirmed that they or their children were affected by or infected with HIV and AIDS. These results show that the majority of the children in the programme are not affected by HIV and AIDS.

According to the programme description, this programme is intended only for children affected or infected by HIV and AIDS. Ikhaya LeThemba should consider enrolling only children affected by HIV and AIDS in the Intensive Programme. South Africa has one of highest national HIV/AIDS infection rates in the world (Joint United Nations Program on HIV/AIDS [UNAIDS], 2010). In the year 2010 It was estimated that there were 1.9 million AIDS orphans with one or both parents deceased in South Africa (UNAIDS Report on the global AIDS epidemic [UNAIDS], 2010) Although these statistics refer to the South African population in general, they indicate that there is a large number of orphans requiring care. Therefore it is expected that only children infected and affected by HIV will be enrolled in the Intensive Programme of Ikhaya LeThemba.

In order to attract the relevant target population it is recommended that Ikhaya LeThemba advertises its services through feeder schemes such as the department of social welfare, hospitals, clinics and schools in Imizamo Yethu Township and surrounding areas. There is therefore a need for more marketing and community involvement in the activities of the Intensive Programme to minimise bias and stigmatization of possible programme participants and their families. The advertising and marketing of the services would be intended at recruiting the relevant target population and not in recruiting more children than can be accommodated in the programme.

Orphaned children in the Intensive Programme total 44% but no indication is given in the After School Registration Form of whether the children were orphaned due to AIDS. As mentioned previously, 31.3% of the children enrolled in the Intensive Programme are affected by HIV and AIDS. On the surface, one might conclude that the Intensive Programme service is not used as intended. However, when these results are triangulated with the community worker's reports a different perspective emerges.

The community worker's reports indicate that most parents and carers did not fill in their HIV status or that of their child for fear of stigmatisation. Most of the carers and parents acknowledged that they were affected by HIV and AIDS when the community worker interviewed them personally on handing in their application forms. In most cases this information was not recorded on the application form by the community worker, but the evaluator gathered the information from the community worker's reports, which she wrote after home and school visits.

It is not clear how children in the Intensive Programme are affected by HIV and AIDS – that is, whether the child is HIV-infected and/or has at least a parent or carer who is infected with HIV or has AIDS or has endured psychological stress due to the death of a parent who had AIDS. The After School Registration form does not probe further to indicate how the child is affected at the time of enrolment. Parents simply indicate that the child is affected or not. Although this is usually discovered later by the community worker, the children concerned would have lost an

opportunity to get immediate help to deal with their loss. In line with the observations made by Wild (2001), it is important to minimise the time a child endures the stress suffered during the illness and subsequent death of the parent.

Ikhaya LeThemba therefore can minimise this by gathering data at an early stage of a child's enrolment rather than waiting for the community worker to discover this data at a later stage. The current, latter approach allows only for chance detection of the history of the child's experiences of the sickness and death of the parents. It is therefore important that the enrolment form questionnaire asks for information about the death of the parents: when it happened, how long the illness was, whether the other parent is alive, whether the other parent was dead when it occurred and how long ago the parent died. Furthermore, there is no section for official use. This section would allow Ikhaya LeThemba space to add more information about the child so as to allow the programme to develop an appropriate plan of action for each child enrolled.

Obtaining the relevant information on the form before registering a child would make it easy to put mechanisms in place that focus on children's individual needs. Early treatment of psychosocial-related trauma would help to prevent conditions such as psychosomatic disorders, chronic depression, low self-esteem and disturbed social behaviour (Deininger et al., 2003; Schenk, 2009; Tshenko et al., 2007). These changes to the enrolment process would also allow the centre to help the child with specific dietary needs when required. If the child is on medication, the programme staff could ensure that the child takes the medication at the right time and following the prescribed guidelines.

All children who are enrolled in the programme come from the local township of Imizamo Yethu and their home language is isiXhosa. The application forms for both programmes are in English. Some of the missing information in the forms could be attributed to the fact that parents' literacy levels may be low and they may not fully understand the requirements on the forms. It is recommended that forms are made available in both English and IsiXhosa.

Evaluation Question 3: Who dropped out of the Intensive Programme in 2010 and why?

During the year 2010, four children dropped out of the Intensive Programme. Two children left Ikhaya LeThemba because their families relocated. Another child was moved to the Eastern Cape to be looked after by a grandmother.

One child dropped out of the Intensive Programme to babysit her siblings. This result is in line with the findings of Heymann & Kidman (2009) that in families caring for people living with AIDS, older siblings (of six to fourteen years) often had to forgo school in order to provide childcare.

Overall, the drop-out rate for the Intensive Programme was low. This is most likely attributable to the high impact of HIV and AIDS on parents and carers. The centre provides meals and a safe place for children to play. The parents and carers would encourage their children to attend the centre. This is supported by Heymann (2006), whose research findings revealed that the absence of quality childcare is more likely to affect orphan caregivers and HIV-infected parents than non-infected parents, because their children require more educational, developmental and emotional support (Heymann, 2006).

Evaluation Question 4: What is the target population of Ikhaya LeThemba's General Programme?

Evaluation Question 5: Who received the General Programme in 2010?

The profiles of the candidates enrolled in the General Programme fit well with the target population of the programme description. The children in this programme were all reported not to be affected by HIV and AIDS. The community worker's reports revealed that most children were from dysfunctional families and most of them had no-one to take care of them after they left school.

In terms of the children's demographics, the General Programme managed to recruit the intended target population during the year 2010. It is important to note also that a large number of these children aged between 10 and 13 years come from the Intensive Programme. When children enrolled in the Intensive Programme reach the age of 10, they are moved to the General Programme. Due to inconsistent record-keeping it was difficult to establish the exact number of children that were transferred from the Intensive Programme.

Records from the programme do not clearly indicate the number of children with ADHD or ADD conditions or other specific educational needs. Since this is one of the criteria for enrolling children on the programme, it is suggested that children with such conditions should submit a letter from a psychologist confirming and explaining the child's condition. The registration form could include questions associated with a child's learning needs. Capturing this information would help in providing personalised assistance to the children's educational needs.

Evaluation Question 6: Who dropped out of the General Programme in 2010 and why?

In the General programme only boys older than 10 left the programme during 2010. The programme staff attributed their exit to the fact that there was a sports field in the township where boys played soccer, although this could not be verified. The boys found it more attractive to go and play soccer at a sports field in the township than to be at the centre. This situation is aggravated by the fact that children have to walk past the sports field on the way from school to the centre, which might distract them.

One of the objectives of Ikhaya LeThemba is to provide a safe aftercare for children. Children's participation in afterschool programmes decreases their involvement in unhealthy activities (Coolsen et al., 1985; Pierce et al., 1999). Soccer is not an unhealthy activity but whilst at the soccer field there is a risk that children may be involved in other dangerous activities such as drug abuse. It is therefore important that mechanisms of ensuring that the children move straight from the school to the centre are put in place.

The evaluation has already indicated that a number of children who graduate from the Intensive Programme are moved to the General Programme. This points to a second

explanation for older boys leaving the programme to play soccer. The Intensive Programme runs for the whole week from Monday to Friday while the General Programme runs for three days. Children who had previously been engaged in a five-day routine are then engaged in only three of those days. They have two extra days available for other activities such as soccer, which might quickly become more attractive to the boys than attending Ikhaya LeThemba.

It is recommended that soccer be introduced in the activities of the General Programme. The centre could also consider giving the children attending the General Programme an opportunity to play soccer at the community sports ground under the centre's direction. Supervision of the children could be done by volunteers from the community in conjunction with the centre staff. This approach could possibly allow the centre to engage the children and the community through sport and minimise the number of exists.

Overall, service utilisation of Ikhaya LeThemba needs improvement. The registration forms for both programmes should incorporate the changes that have been suggested in this section to ensure that the relevant children are enrolled into the programmes. This process could be made more effective by using computers to record the children's data. This would minimise the loss of records and allow a faster and more rigorous approach to data analysis. Children whose details are not complete would be flagged by the system, prompting the programme staff to complete them. Community workers' visits would also be enhanced as electronic databases would provide comprehensive information about each visit.

It is also recommended that the community worker takes down substantial notes during all interviews with parents at the enrolment stage. This will help capture information relayed verbally instead of relying only on registration forms, for information such as HIV statuses. The programme staff and especially the community worker could help parents and caregivers to complete the enrolment forms at the time of applying for enrolment. This might provide an opportunity for the community worker to create a relationship with the parents or caregivers from the time of enrolment. Such a relationship could prove beneficial to the child's wellbeing in future as the centre works with caregivers and parents to help meet children's needs.

Ikhaya LeThemba does not keep accurate records of the reasons that children leave the programmes. Tracking and keeping records of drop-outs is important because drop-out rates may be an indicator of clients' dissatisfaction with intervention activities (Rossi et al., 2004). It is recommended that exit interviews are done with children and their parents or caregivers when they decide to leave the programme. The exit interview would be used to identify how the child perceived the centre and where the child will be going. Ikhaya LeThemba could use that information to improve their operations and, most importantly, to provide other institutions with information about the child and what can be done for them.

Outcome Evaluation

Evaluation Question 7: Has the Intensive Programme provided psychosocial, health and academic support for children affected by HIV and AIDS?

Psychosocial status.

The children's psychosocial status improved significantly ($p = .047$) during 2010, particularly in term two.

Psychosocial support is associated with improved academic scores. Research on orphans and children affected by HIV and AIDS has shown that there is a positive correlation between improved psychosocial needs and overall school performance (Chitiyo et al., 2007). In this evaluation, psychosocial status improved with a corresponding improvement in academic performance in the Intensive Programme group. Although there was no correlation test done to compare academic performance and psychosocial support (due to missing data which made the two scores not comparable for a t-test), the evaluation results support a correspondence between increased psychosocial status and improved academic status.

Health status.

The health status of the children in the Intensive Programme improved in 2010. Improvements in the median (IQR) levels were greater in term two than in term one (2.25 and 2.5 respectively) compared to 2 at baseline.

It is recommended that children have clinic health cards and that they are encouraged to visit the clinic regularly in addition to the current health-oriented activities. Children require health services such as immunizations, growth monitoring and treatment for a variety of ailments and infections (Richter et al., 2004). If possible, arrangements should be made to have a nurse visit the centre regularly to help check the children's general health and train the staff to monitor the children's health. According to Kelly (2003), aftercare centres can strengthen their capacity to care for HIV-affected children by providing medical treatment.

Academic performance.

The academic performance of the Intensive programme participants improved over the year when compared with baseline performance, particularly between term one and term two ($p = .004$, $p = .007$ respectively). It would seem that the academic status (and psychosocial and health status) of the children on the Intensive Programme did not improve significantly from baseline measure to the first performance. Improvements took time: only by term two was a significant improvement in status evident.

According to the U.S Department of Health and Human Services (2003), vulnerable children are likely to improve much more slowly academically than children who are less vulnerable. Disadvantaged children are at great risk of poor educational outcomes throughout their school years, particularly those who suffer multiple risk factors (U.S Department of Health and Human Services, 2003). The academic improvements made by the children in the Intensive Programme, although not very big, can be said to be encouraging given that most children come from families that are not only affected by HIV and AIDS but are also low-income and may be dysfunctional. These findings are not different from the norm, as HIV-affected children who get

similar interventions show steady progress on monthly school tests even though some may still be below average (Chitiyo et al., 2007).

Evaluation Question 8: Has the General Programme provided academic support for its participants?

The academic performance of the children in the General Programme did not change in 2010. However, the school reports for the General Programme revealed an unusual trend. During term one and term two the children's performance improved while in term three and term four the results declined. This regression cancelled out the improvements in the first two terms, resulting in a statistically insignificant change in the General Programme participants' academic status ($p = .326$). This trend suggests that the problem may lie with the local school and not necessarily Ikhaya LeThemba (all the children, except for two go to the same local school).

The General Programme experienced a drop-out rate of 19% and most drop outs occurred toward the end of the year. This could explain why the overall performance of the children became negative. The 2010 Soccer World Cup, hosted by South Africa, introduced an enthusiasm for soccer that gripped the entire country, including children from all walks of life. South African schools were allowed to follow a special calendar that gave schools a long holiday of six weeks during the World Cup period. This might have detracted from the children's school performance, particularly those who dropped out to play soccer at the local field. This suggests that Ikhaya LeThemba will be affected by major community events that attract children's attention.

Evaluation Question 9: Has the General Aftercare Programme reduced the time that children spend alone without care?

Attendance was relatively high, with an average of 85% for children who stayed in the General Programme throughout the year. However, as indicated earlier, the drop-out rate was 19% in the General Programme most likely these children that dropped out were not in regular

attendance. The community worker visited the families of children who had low attendance at the centre to investigate reasons for absenteeism.

Evaluation Question 10: Has the community worker established a link between Ikhaya LeThemba, families and the school by means of visits?

Community worker's visits

The community worker's reports showed that at least 53% of the children in the General Programme received at least one form of visit from the community worker in 2010 (58% in the Intensive Programme). The community worker's reports indicate that the most vulnerable children are those who had more than one home and school visit in the year. These children had low attendance records, were ill or showed signs of being withdrawn or aggressive or any other type of unusual behaviour.

Communication with the community worker revealed that more visits had been done than were recorded. The community worker has established a link between Ikhaya LeThemba, the local school and parents of the children enrolled in the centre. This link has been vital in discovering which children require special attention. However, the community worker is faced with the challenge of not being able to find children's parents at home when making home visits. When parents are not found at home, the community worker writes a letter to them asking them to come to the centre for an appointment. Some parents do not heed this call. It is recommended that the centre keeps telephone lists with parents' contact details and that these are updated regularly. Each child should have at least one principal contact and an alternative contact.

Further Recommendations

Ikhaya LeThemba use the *I can...* form as the main way to monitor children's psychosocial, health and academic status. However, this form needs to be improved. Record-keeping also needs improvement as there were many *I can...* forms missing in the children's files.

Recommendations are given below that will help to improve the measurement of children's psychosocial, health and academic status outcomes.

Currently the *I can...* forms are filled in by different people in different terms of the school year. This may lead to distortion of scores, depending on who scores the child. This could be avoided if the parents, teachers and children kept separate *I can...* forms. If forms are filled in by all three parties every term and they are filed away, information can be triangulated. It would also be beneficial to provide training for all parties that fill in the *I can...* form to ensure that terms are understood in the same way by all parties.

Ikhaya LeThemba could also consider checking the validity and reliability of the *I can...* form to ensure that it provides the necessary information. The form could be revised to make it more valid and reliable.

An alternative to the *I can...* form would be a more robust index to measure the children's psychosocial, health and educational status, such as the Child Status Index (CSI). The CSI was developed by Measure Evaluation, the United States Agency for International Development (USAID) Global Health Bureau's primary vehicle for supporting improvements in monitoring and evaluation in population, health and nutrition worldwide. The CSI toolkit assesses the vulnerabilities, needs and outcomes of orphaned and other children made vulnerable by HIV and AIDS. It provides a framework for identifying these children's needs, creating service plans, and assessing outcomes. It is a comprehensive tool that provides measures for health, education, shelter, child protection and psychosocial status.

The CSI was successfully tested for inter-rater reliability and construct validity in Kenya and Tanzania. It has been used successfully in Ethiopia, Rwanda, India and Cambodia and can be adapted for use in different geographical and cultural contexts (Measure Evaluation, 2011). A sample of the CSI record form is attached in Appendix F.

As recommended earlier under the service utilisation section, all the programme records that Ikhaya LeThemba uses to measure outcomes of its activities should be in electronic form.

Ikhaya LeThemba has two important activities in its programme theory that need to be monitored effectively: life-skills training and HIV and AIDS education. Life skills training, is provided by various children's counsellors that visit the centre, but children's progress in life-skills training is not recorded. Life skills' training is important for children affected by HIV and AIDS because when they are orphaned they are left without life-skills and with little guidance in acquiring such skills (Werner and Smith, 1982). It is therefore imperative that measures are put in place to track children's progress in terms of life skills learnt. Life-skills training increases the probability of positive outcomes (autonomy, high self-esteem, and successful school performance) and reduces the probability of negative outcomes (risky sexual behaviour, school failure, delinquency and drug use) (Elias & Tobias, 1996). It is important, therefore, to put measures in place to track children's life skills-outcomes. Children could be tested on what they learn in the life-skills activities and receive certificates for life-skills courses completed. Records of those certificates should be kept at the centre.

HIV and AIDS education is another important activity carried out at Ikhaya LeThemba. The centre uses activities such as Hero Books and the Sara comic book, which have proven excellent tools for empowering young people with knowledge about HIV and AIDS and empowering them to assert their rights (Mckee et al., 2003). Ikhaya LeThemba has proof that these activities are carried out regularly in the children's files, in the form of the Hero Books compiled by the children as well as the activity books they used for the Sara activity. However, there are no measures to monitor progress or to check how much knowledge the children gained and retained from these activities. Children should be given tests at the end of each Sara comic book exercise. At the end of the course they should be awarded with certificates for completing all the exercises in the book. All records of certification should be kept at the centre.

Limitations of the Evaluation

A major limitation of the evaluation was missing data. This limited the statistical methods that could be used to analyse the data.

The evaluation used mainly quantitative measures to analyse outcomes. Missing qualitative data from the community worker would have allowed alternative explanations that are not included in quantitative data, thereby strengthening the results of the evaluation. An example of missing qualitative data is the meetings that the community worker had with parents and carers, which were not recorded.

This evaluation was outcome-based. There was no focus on the quality of programme inputs. It is suggested that a follow-up evaluation is done on programme implementation. This will consolidate the findings of this evaluation by verifying that the positive outcomes found in this evaluation were due to proper programme implementation.

Evaluation Contribution

The evaluation findings support previous research that orphans and vulnerable children should be given psychosocial, health and educational support to improve their overall wellbeing. This evaluation will add knowledge about which activities work on similar programmes that aim to improve the wellbeing of orphans and vulnerable children.

The evaluation will contribute to the literature on programme evaluation and monitoring in South Africa, as there is limited published and unpublished material on programme evaluation.

Conclusion

The evaluation of Ikhaya LeThemba has shown the importance of including relevant activities in interventions that support orphans and vulnerable children. In order to improve overall wellbeing of orphans and vulnerable children, a holistic approach is required, such as the one adopted by the Ikhaya LeThemba programme. The evaluation has also highlighted the challenges of putting in place control and monitoring systems to allow a multidimensional approach to caring for orphans and vulnerable children. NGOs in similar fields who wish to know whether their programmes work must implement monitoring systems, which will make it easier to measure and track programme outcomes. This evaluation provides a template of important guidelines that can be used in implementing monitoring systems in similar programmes.

Overall, the Ikhaya LeThemba programme has yielded positive results over the period under evaluation. A follow-up evaluation could examine the long-term impact of the Ikhaya LeThemba model. This could investigate how children who have graduated from Ikhaya LeThemba negotiate the transition from school to adult life.

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University of Cape Town

APPENDIX A: AFTER SCHOOL CENTRE REGISTRATION FORM



After School Centre Registration

Child's Name:

Date of Birth:

School:

Grade:

ID Number:

	Mother-or other carer	Father-or other carer
Name		
Contact phone number		
Employer		
Position		
Employer's phone number		
ID Number		
Please indicate your marital status	Married Separate	Divorced Never Married

Information about Your Child

Why do you want a place at IKhaya leThemba for your child?

What is your child good at?

What does your child need help with?

What do you like to do with your child?

What does your child like to do with their friends?

Has your child experienced the death of someone close to them? Who?

Has your child been attending any of our afternoon programs? Which ones?

Information about your Family

Please list everyone living in your house and the ages of any children:

Name	Mother/Father/Aunt/ Uncle/Grandparent/ Brother-age/Sister-age

1. Do both parents live with your child? YES NO

* If you answered NO then please explain:

2. Are you applying for a free placement on the basis of your family being impacted by HIV and AIDS? YES NO

* If you answered YES then please explain:

3. Please indicate your combined household monthly earnings:

R0-500	R500- R1000	R1000- R1500	R1500- R2000	R2000- R2500	R2500- R3000	R3000+
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Please attach the following documents:

1. ID document or birth certificates for the child.
2. ID documents or birth certificates for the parent or carer applying.
3. Most recent school report for child.
4. Copy of recent bank statement

If you are applying for a free position because your family has been impacted by HIV and AIDS then please provide the following:

1. Letter of support from at least one care worker, clinic sister or teacher stating clearly how this child has been impacted.
2. Any other relevant documents you possess such as medical report in the case of illness and certificate of death if a family member is deceased due to AIDS.

After you have submitted your application, you and your child will be invited for an admission interview. At this interview your application will be reviewed and fees will be discussed. You will be notified after this interview about whether your child has been accepted.

IKhaya leThemba has the right to refuse or accept children for placement according to our own criteria of assessment. We are particularly concerned for children who show the greatest need for intensive support and will not award places on a first come-first gained basis.

APPENDIX B: 2010 REGISTRATION FORM



2010 Registration

Wednesday Reading, Thursday Food Garden. Friday Skills for Life

Child's Name

Child Information:

Birthday	
Grade	
School	
First School language	
Home language	

Family Information:

Parent/ Carer Name		
Relationship to child		
People in Household	Adults	Children
Do both parents live at home?	Yes	No
Contact Phone Number		

If your family has been affected by HIV/AIDS or is in difficult circumstances your child may be eligible for our after school facility providing care every school afternoon from 1-6pm. Would you like a registration form? Yes / No

Please attach a copy of your child's:

- **Birth Certificate**
- **Recent School Report**

APPENDIX C: ICAN... FORM

I can... Child/Parent/Teacher

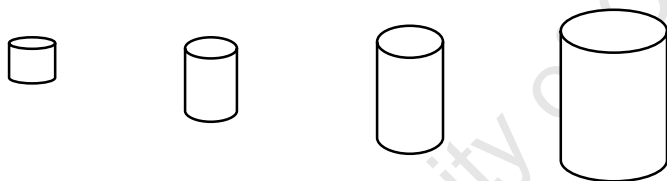
Name of Child: _____

Date: _____

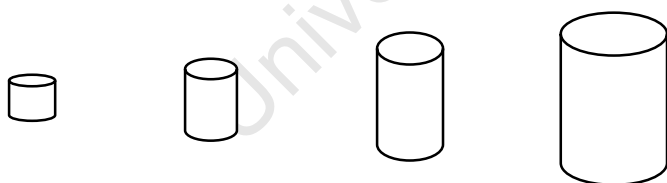


Read the question carefully. The jars show how well the child can do each activity. A big jar shows they are very able to do it, a small jar show that they are only just starting to be able to do it.

1. I can read and write in my first language (English/ isiXhosa)



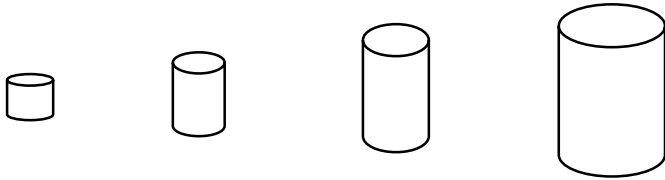
2. I can do Maths



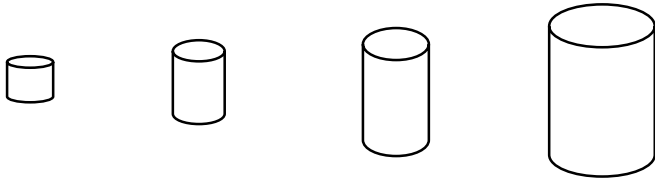
3. I can make and keep friends



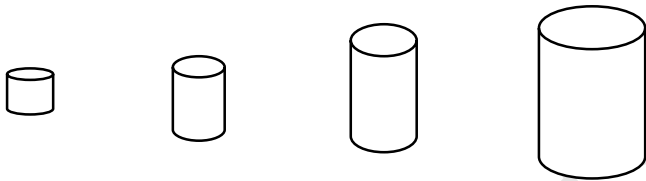
4. I can listen and following instructions



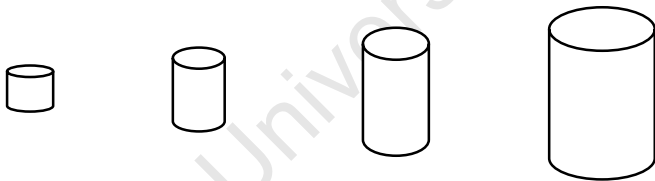
5. I can use my body well (running, skipping, climbing, ball skills)



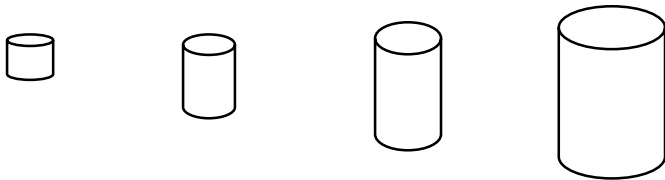
6. I can use my hands well (writing, cutting, getting dressed)



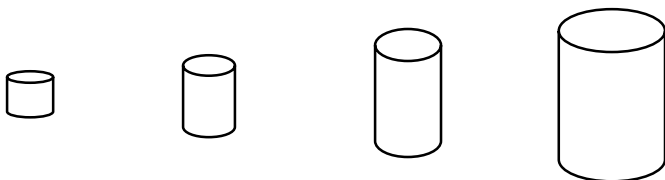
7. I can take care of my sad, worried, angry feelings so they don't get too big



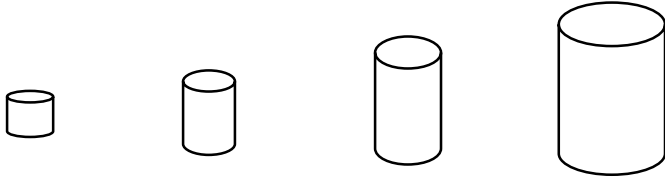
8. I can say goodbye to special people who are sick or who have died



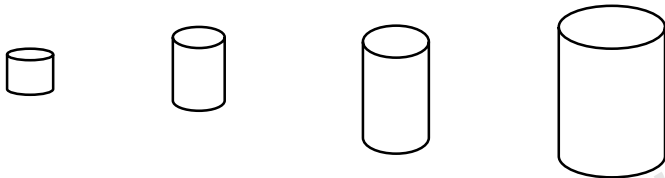
9. I can keep my hands and feet to myself



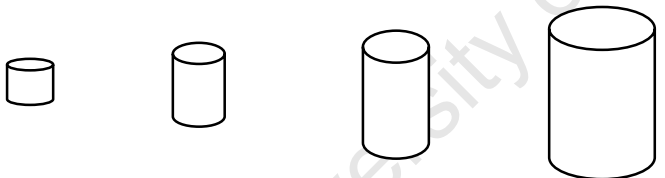
10. I can remember the rules



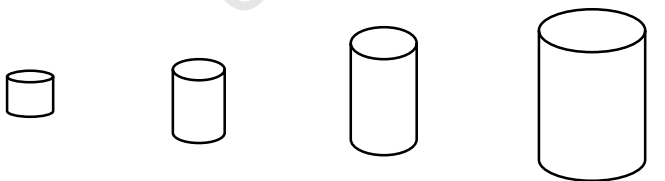
11. I feel safe and happy at home



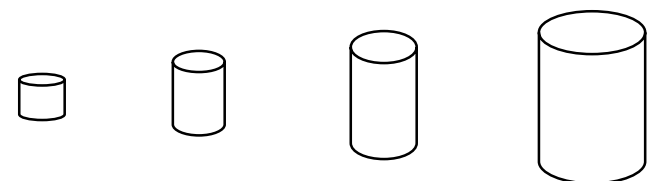
12. I can finish what I start



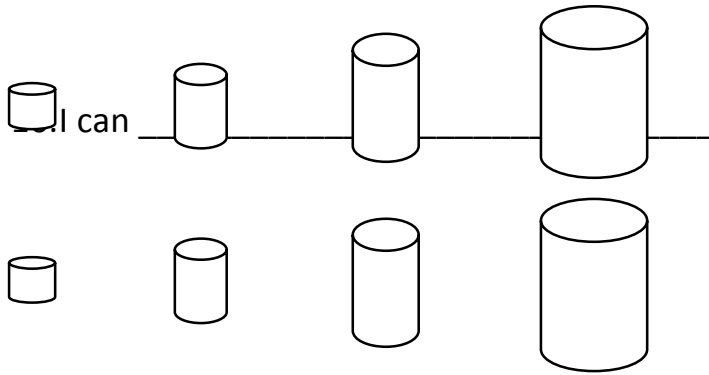
13. I can say what I think



14. I feel good about myself



15. I can imagine a good future for myself



Comments and signature:

University of Cape Town

APPENDIX D: ETHICS CLEARANCE FORM

University of Cape Town

UNIVERSITY OF CAPE TOWN



Faculty of Commerce Ethics in Research Committee

Courier: Room 2.21 Leslie Commerce Building Upper Campus University of Cape Town
Post: University of Cape Town • Private Bag • Rondebosch 7701
Email: Irwin.brown@uct.ac.za
Telephone: +27 21 650-2311
Fax No.: +27 21 689-7570
29 JULY 2011

Ms Sandra Siziwe Saungweme
School of Management Studies
University of Cape Town
Sandraphiri@gmail.com

Dear Researcher

Project title: An Outcome Evaluation of an Aftercare Programme for HIV & AIDS affected children.

This letter serves to confirm that the project entitled “**An Outcome Evaluation of an Aftercare Programme for HIV & AIDS affected children**” as described in your final submitted protocol dated 12 July 2011, has been approved. You may proceed with the research subject to the following conditions:

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,

IRWIN BROWN

Prof Irwin Brown
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 E: CLEARANCE LETTER FROM IKHAYA
LETHEMBA**

UNIVERSITY OF CAPE TOWN



School of Management Studies
University of Cape Town, Private Bag,
Rondebosch 7701
Telephone: +27 21 650-5218
Fax: +27 21 689-7570
4 February 2010

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

DR S GOODMAN
HEAD: SECTION OF ORGANISATIONAL PSYCHOLOGY

AGREEMENT TO ACCESS PROGRAMME RECORDS AND/OR RECIPIENTS:

AUTHORISED PERSON	ORGANISATION	DATE
		17 th Feb 2011

