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OUTCOME EVALUATION OF THE BEAUTIFUL GATE MINISTRIES' PROGRAMME  
FOR VULNERABLE CHILDREN

ACKNOWLEDGEMENTS

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A dissertation submitted in partial fulfilment of the requirements for the award of the Degree  
of Master of Commerce in Organisational Psychology

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 dissertation from the work, or works of other people has been attributed, cited and referenced.

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## ABSTRACT

This report presents the findings of the outcome-based evaluation of the Beautiful Gate programme for vulnerable children. The evaluation seeks to ascertain the extent to which the programme is producing the intended results and whether those results include unintended side effects.

The Beautiful Gate programme is a social programme aimed at providing care to vulnerable children, their families and the community. The objectives of the programme are to meet the medical, physical, emotional and social needs of vulnerable children, particularly those that are affected by HIV/AIDS in the communities of the Nyanga Health District in Cape Town, South Africa. The programme provides an interim safe environment for children, whilst actively working towards their reintegration into society.

The evaluation utilised a descriptive design. Multiple data collection methods were used, which included a questionnaire-based survey and review of programme records. A paper-based questionnaire was administered to the programme staff, which consisted of caregivers, administration staff and pre-school teachers.

Results from this evaluation study revealed that children who participate in this programme exhibit improved quality of life. Research findings have shown that the children's welfare, personal development and social conditions significantly improved through access to a safe environment, proper nutrition, medical services, education, as well as psychosocial support.

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## ACRONYMS

ARV	Antiretroviral
ART	Antiretroviral treatment
AIDS	Acquired Immunodeficiency Syndrome
DOH	Department of Health
HIV	Human Immunodeficiency Virus
IT	Information technology
NGO	Non governmental organisation
UN	United Nations
UNICEF	United Nations Children's Fund
RDP	Rural development plan
SPSS	Statistical Package for the Social Sciences
SD	Standard deviation

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## CHAPTER 1

### INTRODUCTION

This chapter provides a contextual description of the Beautiful Gate Ministries' programme which forms the basis for this outcome evaluation. The programme under evaluation is a social programme for vulnerable children.

This evaluation adopts the evaluative framework of Rossi, Lipsey and Freeman (2004) who provided a guideline for components that are required to be included in a programme description. A more detailed description of the programme under evaluation will be provided in the following sections.

#### *Needs Assessment*

Before the inception of the programme, Beautiful Gate conducted a needs assessment which revealed that the communities within the Nyanga Health District in the Western Cape Province in South Africa suffer from high unemployment, low income levels, poor access to health care and educational opportunities (Mac Aid Proposal, 2008). The district has a high HIV/AIDS infection rate which has led to increasing number of orphans which exacerbates the social problems mentioned above (Mac Aid Proposal).

Table 1 shows the statistics on the HIV/AIDS prevalence in Cape Town.

Table 1

*HIV Prevalence Trends by Area: Cape Town Metropole District*

<b>Area</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>
Blaauwberg	0.6	8.2	4.4	1.2	7.3
Cape Town Central	3.7	11.9	11.6	13.7	11.5
Greater Athlone	6.8	8.9	10.1	16.4	17.7
Helderberg	19.0	19.1	19.1	18.8	12.8
Khayelitsha	22.0	24.9	27.2	33.0	32.6
Mitchell's Plain	0.7	4.0	6.3	12.9	5.1
<b>Gugulethu / Nyanga</b>	<b>16.1</b>	<b>27.8</b>	<b>28.1</b>	<b>29.1</b>	<b>29.1</b>
Oostenberg	5.7	14.5	16.1	14.8	16.2
South Peninsula	5.9	6.0	9.3	10.8	12.4
Tygerberg Eastern	6.1	10.4	8.0	12.7	15.2
Tygerberg Western	7.9	12.7	8.1	15.1	15.0
<b>Western Cape Province</b>	<b>9.2</b>	<b>12.2</b>	<b>12.6</b>	<b>14.8</b>	<b>15.03</b>

According to the Western Cape Department of Health (2006), the Nyanga Health District was the most affected by HIV/AIDS in comparison with other health districts in the Western Cape between 2002 and 2003. In 2005 the HIV prevalence in Nyanga Health District was estimated to be 29.1%, almost double the Western Cape provincial average. These findings emphasise the need to tailor intervention programmes to the local situation, based on local evidence and focusing on the context in terms of locally relevant groups, new infections and risk behaviours (Western Cape Department of Health). Research has shown that little work has been done to monitor and evaluate national interventions in response to the needs and rights of children made vulnerable by HIV/AIDS (Strebel, 2004). Much of the focus in relation to HIV/AIDS and children has been on the prevention of the pandemic and not on the impact of HIV/AIDS on the lives of children.

***Programme Description: Beautiful Gate Programme***

Beautiful Gate is an international, interdenominational Christian organisation that provides care and support to vulnerable children, their families, and the community (DGMT Proposal, 2009). The programme was established in 1994 and is based in Cape Town. When Beautiful Gate was founded in 1994, it operated as a hospice for children with HIV/AIDS whose families could no longer care for them (Annual Report, 2008; DGMT Proposal). Over the years, the programme has developed and adopted other community development initiatives that are aimed at educating and capacitating members of the community to deal with HIV/AIDS related problems.

Through programme implementation, Beautiful Gate realised that children are best cared for by supporting their families, and that families are best supported through building and capacitating the community (DGMT Proposal, 2009). Strategies to provide care and support to children, families as well as the community have been developed and implemented.

The assimilation of community support activities into the Beautiful Gate programme highlights the importance of community-based intervention programmes for vulnerable children (Firelight Foundation, Bernard van Leer Foundation, American Jewish World Service, & Pan Africa Children's Fund, 2005; Richter, Foster, & Sherr, 2006; Savaya, Elsworth, & Rogers, 2009). Researchers are in agreement that effective responses to HIV/AIDS must involve and be owned by communities (United Nations Children's Fund, UNICEF, 2006). A sense of community ownership is one of the factors that facilitate programme sustainability.

Investing in community-based programmes is one of the most significant ways that intervention programmes can make a difference in the lives of children and in the fight against HIV/AIDS (Firelight Foundation et al., 2005; Richter & Foster, 2005). Community-based solutions mobilise community members, building hope and increasing their capacity to address their own challenges and needs (Richter et al, 2006). Richter and

Foster suggest that vulnerable children interventions should aim to strengthen the capacity of families to protect and support children made vulnerable by HIV/AIDS and mobilise community-based support and responses in the fight against HIV/AIDS.

### ***Aim and Objectives***

The broad objective of the Beautiful Gate programme is to meet the medical, physical, emotional, social and psychological needs of vulnerable children, particularly those affected by and/or living with HIV/AIDS (Annual Report, 2003; Mac Aids Proposal, 2008). The specific objectives of the programme are to:

- Provide an interim safe environment for displaced children, whilst actively working towards reunification and foster placement.
- Empower and strengthen families within their community, so that they remain unified and become self-reliant
- Mobilise local churches and civil society to support families in need
- Provide or facilitate access to health care for children living with HIV/AIDS

### ***Target Population***

One of the important steps in assessing the need for a programme is to identify the target population (Rossi et al., 2004). The identification of a target population according to Rossi et al. will help in "...directing services to that population and screening out individuals" (p.118) that are not supposed to participate in the programme.

The target population for the Beautiful Gate programme is vulnerable children. Participants are selected into the programme based on their age, area of residence, children from poor or broken families, children living with or affected by HIV/AIDS affected children, and abandoned or displaced children (Annual Report, 2003; Mac Aids Proposal, 2008). Selection into the programme is conducted through social workers, the police, local churches, community leaders and through referrals from local clinics.

### ***Location and Resources***

The programme operates from Cape Town within the Nyanga Health District. Areas covered by the programme include the communities of Old Crossroads, Lower Crossroads, Phillipi, Brown's Farm and Barcelona which consists mainly of informal settlements (Mac Aids Proposal, 2008). Access to the programme is limited to children, families and communities from the Nyanga Health District.

According to the programme website, the programme is funded through donors, sponsors and well-wishers (Mac Aids Proposal, 2008). Financial assistance is also obtained from Beautiful Gate International as well as through partnerships with local non-governmental organisations (NGOs).

Beautiful Gate is headed by a director who reports to the Board of Directors for policy and direction. The programme has a staff complement of 55 full-time employees, volunteers and part-time employees. The staff consists of community social workers, care-giving staff, medical staff (nurses and doctors), pre-school teachers and administration staff.

### ***Programme Stakeholders***

Programme stakeholders, according to Rossi et al. (2004) are "...individuals, groups, or organisations that have a significant interest in how well a programme functions" (p.18). Table 2 outlines the different stakeholders that are involved with the Beautiful Gate programme.

Table 2

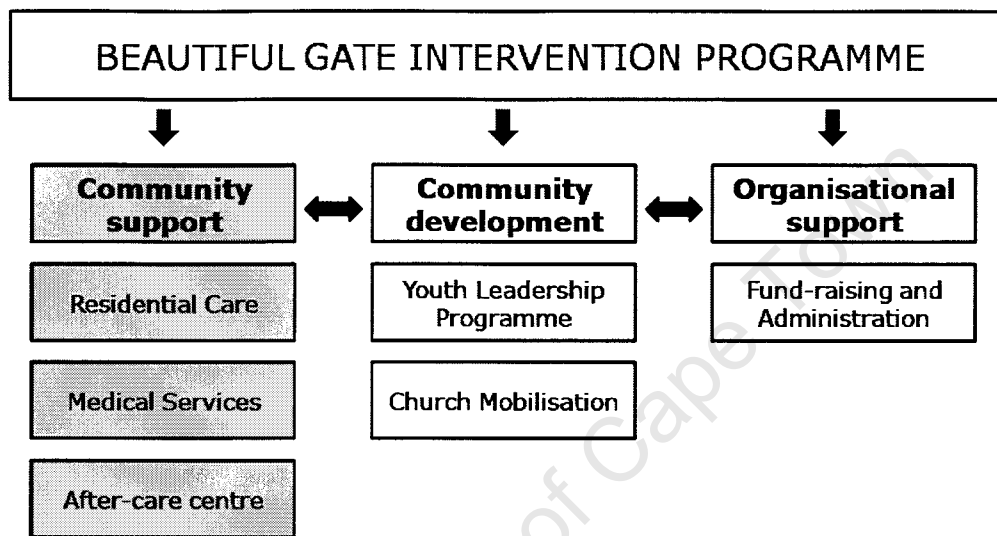
#### *Beautiful Gate Programme Stakeholders*

<b>Stakeholders</b>	<b>Contribution</b>
Beautiful Gate International	Provides funding, expertise and support
Department of Social Services	Provides support through facilitation of applications for social grants
City Health Department (Cape Town)	Community clinics host support groups and refer cases to social workers
Etafeni	Provides trained counselors
Reconstruction Development Plan (RDP)	The programme is liaising with the RDP so that allocation of houses for children of HIV positive parents can be prioritized
Department of Education (Western Cape)	Promoting awareness of HIV/AIDS in schools and discouraging discrimination and stigma against children living with HIV/AIDS
Lerato Hope	Local NGO that provides food parcels to programme participants
Kidzpositive	Local NGO that has partnered with Beautiful Gate in running the Pediatric HIV/AIDS clinic.
Local Churches	Work with members of the community to identify children and families that are vulnerable

### *Programme Activities*

The Beautiful Gate programme encompasses all the activities that aim to empower the community to take ownership of the challenges they face and equip them with the necessary skills on how to deal with HIV/AIDS related problems (Annual Report, 2006).

Figure 1 presents the programme components and activities.



*Figure 1.* Beautiful Gate Programme Components and Activities

The Beautiful Gate programme consists of three main departments that implement and monitor different activities. The community support and community development departments are supported by the organisational support department through resource mobilisation, human resources and facilities management (DGMT Proposal, 2009; Mac Aids Proposal, 2008). The organisational support department encompasses the various support services that are required by the organisation to enable it to operate efficiently. Activities under organisational support include finance, fundraising, human resources and administration (Mac Aid Proposal).

The community development department includes youth leadership and life skill development, peer education and community service (DGMT Proposal, 2009). It also mobilises and give training to local churches on how they can deal with HIV/AIDS related problems so that they can reach out to other members of the community who are in need. Home-based caregivers are taught about antiretroviral treatment (ART), adherence and support.

The programme provides practical assistance in the form of food parcels to families that are in need (Annual Report, 2008). Long-term support is also provided to poor families such as child-headed households. Community members who run support groups are provided with emotional support, training and advice. HIV/AIDS training is provided in collaboration with other community-based organisations such as churches and support groups. This model is consistent with the view that participatory methods of HIV/AIDS education should be used in training youth groups, local churches and church volunteers to support home-based care and orphan visiting programmes (Strebel, 2004). As a result, the programme has activated multi-sectoral efforts by communities affected by HIV/AIDS, including home-based care, resource mobilisation to increase income and food security, psychosocial support, and community-wide HIV/AIDS education.

The main focus of this evaluation report is on the community support programme activities that directly impact vulnerable children. Programme components under community support include residential care, pediatric HIV/AIDS clinic and the after-school activity centre.

### ***Residential Care***

The programme provides vulnerable children with residential care in cases that warrant children to be provided with shelter and care (Annual Report, 2003). The main objective of providing residential care is to provide interim care and support to displaced children before they are reunited with their families (Mac Aid Proposal, 2008). During the children's stay in residential care, they are provided with medical care, education and

basic support whilst the programme identifies their families to facilitate the reunification process.

The residential care facility emulates a normal family and community environment for children by grouping them as family units under the care of a foster mother or caregiver (T. Tadokera, personal communication, May, 2009). The programme has eight family units/cottages which on average accommodate five children each. These are grouped in clusters of separate buildings or housing units. The strength of this model is that it provides a home environment for children who have no relatives or families capable of raising them (Beard, 2005).

The residential facility is fenced off by a brick wall with an automated electric gate that is manned by a security guard. The cottages have tap water, flush toilets and electricity.

Efforts are made to identify the child's family and encourage child-family visiting during the child's stay in residential care (Annual Report, 2003). Before a child is reunited with his/her family, the receiving family members go through counseling and training to ensure a smooth reintegration process (Annual Report, 2008). Follow-up visits are done after the reunification to ensure that the child has settled well. In situations where the programme fails to identify the child's family or relatives, the child is placed into foster care. The adoption process is done through the formal court channels.

Support is also given to reintegrated children through facilitating applications for Government social grants (Annual Report, 2003).

#### ***Medical Care Activities: Onsite Clinic***

The programme operates an onsite clinic that provides primary healthcare to children in residential care (Annual Report, 2006). The clinic is staffed by nurses who ensure that child care workers are supported and that all children who are on treatment receive the right medication each day. Children with medical complications are referred to the

pediatric HIV/AIDS clinic or other hospitals such as Tygerberg Hospital for special care (Annual Report, 2005).

#### ***Medical Care Activities: Pediatric HIV/AIDS Clinic***

The programme provides support to the Crossroads II Pediatric Clinic by supplying two doctors and two nurses twice a week (Annual Report, 2007). The pediatric clinic is operated in partnership with a local government clinic and Kidzpositive (Annual Report, 2003). This support ensures that ART and other related medical services are available in the local community for children living with HIV/AIDS. It also enables the programme to screen and identify families that are in need of additional support.

#### ***After-school Activity Centre***

The activity centre provides after-school care and holiday activities to vulnerable children in residential care and those from the local community (Annual Report, 2008). Children are taught life skills and self-confidence alongside specific HIV/AIDS education. These activities are designed to divert children from risky behaviours and to teach them to make right choices.

The main goal of introducing the after-school care activity centre was to provide a safe place for children to play games and sports, receive help with homework and to provide them with spiritual and emotional support (Annual Report, 2008). Children in residential care interact with those from the local community through sports such as soccer, rugby and cricket, as well as holiday clubs, camping and drama (Annual Report, 2006).

Voluntary therapists help children with special needs through activities such as music, speech and play (Annual Report, 2003). Children also get psychosocial support and learn life skills such as drawing and creative art (Annual Report, 2006).

The programme operates an onsite library that is used by the children who live in residential care and those who come from nearby communities for after-school activities (Newsletter, 2008).

The programme has managed to provide a play ground at the back of the site. An IT training programme was launched in 2008 and is equipped with six computers and a printer (Annual Report, 2008).

The programme also operates an onsite pre-school that is aimed at developing the children’s motoring skills and mental abilities and to prepare them for primary education (Annual Report, 2003).

***Plausibility of Programme Theory***

Programme theory refers to the assumptions of how a programme achieves its desired outcomes (Rossi et al., 2004). Figure 2 illustrates the programme theory underlying the Beautiful Gate programme.

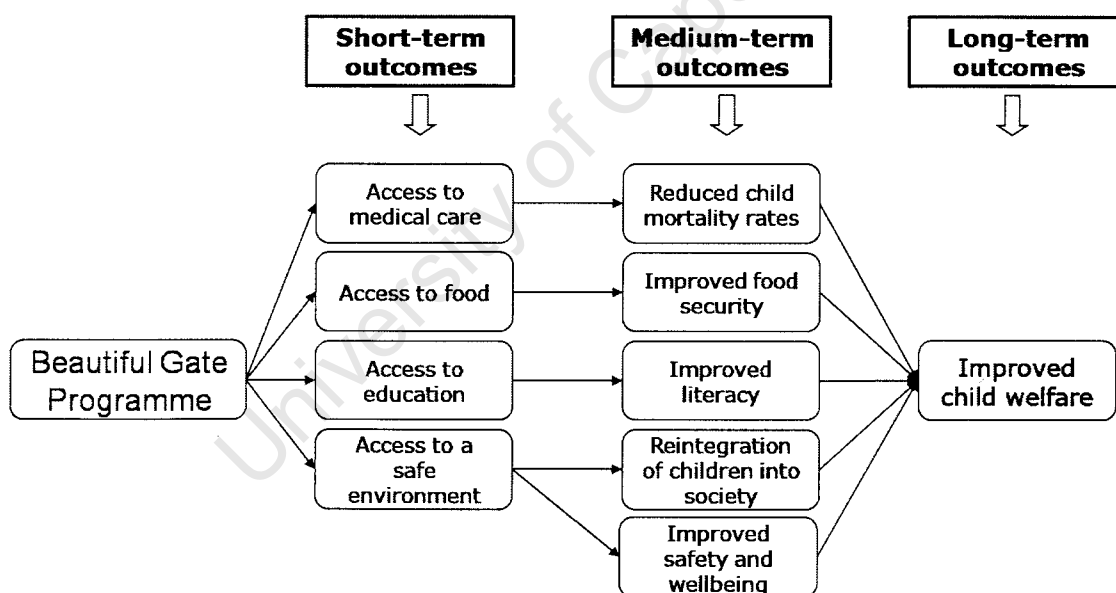


Figure 2. Logic Model for Beautiful Gate Programme

The Beautiful Gate programme is aimed at meeting the medical, physical, emotional and social needs of vulnerable children, particularly those that are affected and/or living with HIV/AIDS. The underlying logic of the programme is that the intervention, which is made up of activities described earlier, will improve vulnerable children’s access to food,

education, medical services and a loving and caring social environment (Annual Report, 2003). This, in turn, will improve vulnerable children's welfare. This constitutes the causal theory underlying the cause-and-effect sequence of the Beautiful Gate programme.

Vulnerable children, as defined in the programme's Annual Report (2003) refer to:

Children who are risk due to social and economic circumstances, abandoned babies, children living on the streets, families grappling with the impact of HIV/AIDS orphans and children who are deprived of education. (p.1)

This definition is in line with Andrews, Skinner and Zuma (2006) who defined vulnerability in terms of children who are affected or living with HIV, school drop-outs, as well as children that are experiencing development problems through lack of food. Children become poorer as a result of the illness and death of family members, and in many cases it is the income-earning adults who are lost (Lyons, 2008). Established measures of child vulnerability indicate that large numbers of children in Africa lack access to medical care and treatment, are malnourished, out of school or involved in child labour (Lyons; Richter et al., 2006).

Established measures of child vulnerability indicate that large numbers of children living with HIV/AIDS lack access to medical care, food, education and have emotional, material and social problems (Andrews et al., 2006; Lyons, 2008; Richter et al., 2006; Richter & Foster, 2005; Shisana et al., 2006;). Greater understanding of the impact of HIV/AIDS on children is important in the design and evaluation of programmes to support vulnerable children (Beard, 2005; Savaya et al., 2009; Strebel, 2004). These studies concluded that vulnerable children interventions should be linked to and include efforts that address HIV/AIDS prevention.

There is extensive literature that focus on children's welfare ranging from education (Pendlebury, Lake & Smith, 2009; Strebel, 2004), institutional care (Richter et al., 2006; Strebel; UNICEF, 2005) and health services (Richter, 2004; Richter & Foster, 2005; UNICEF). Other studies have focused on children's psychosocial and physical wellbeing

(Richter et al.; Richter; Snider & Dawes, 2006; UNICEF) and the well-being of children made vulnerable by HIV/AIDS (Giese et al., 2003; Strebel). These studies have shown that HIV/AIDS has made children vulnerable and has restricted children's access to basic materials such as education, medical care and food.

The expected outcomes from running the pediatric and the onsite clinics are to facilitate access to ART and other medical treatment for children living with HIV/AIDS and ultimately reducing child mortality rates (Annual Report, 2007). Previous studies have shown that the HIV/AIDS epidemic has contributed to rising child mortality, sharp reductions in life expectancy, increased poverty and vulnerability and has affected a lot of children (Andrews et al., 2006; Pendlebury et al., 2009).

One of the expected outcomes of the programme is to improve children's food security and nutrition. HIV/AIDS is a threat to food security since food is the most urgent need for people living with HIV/AIDS (East, Central, and Southern African Health Community (ECSA-HC), Food and Nutrition Technical Assistance Project (FANTA), & LINKAGES Project, 2008; Piwoz & Preble, 2000; Richter & Foster, 2005). The inability to maintain diversity in diet is generally seen as the first sign of problems, followed by reduction in the size of meals, then skipping meals, and going without food for days (UNICEF, 2005). Nutrition interventions can help in preventing malnutrition in children living with HIV/AIDS by strengthening immune response, promoting response to treatment, supporting management of symptoms, and improve their response to antiretroviral therapy and other medical treatment (ECSA-HC et al.).

One of the programme's expected outcomes is to improve children's access to education. Literature has shown that poverty and HIV/AIDS have a negative impact on the education of affected children (Pendlebury, et al., 2009; UNICEF, 2005). These studies have shown that HIV/AIDS orphans and other vulnerable children have less access to education and lower enrollment rates compared to other children. In most cases, vulnerable children are not able to afford schools fees, uniforms or other basic requirements to attend school.

The expected outcomes for the after-care activity centre are to provide educational and psychosocial support to children (Annual Report, 2008). Psychosocial well-being is essential for the survival and development of children (Richter & Foster, 2005) and is one aspect of vulnerable children interventions which is often mentioned as crucial, although it has not received much attention in documented evaluations (Strebel, 2004). Vulnerable children suffer deprivation, overwhelming loss and grief, upheaval, discrimination and social exclusion.

Psychosocial well-being of children is recognised as essential to ensuring their healthy growth and development, and the ability to achieve their full potential (Richter, 2004; Richter & Foster, 2005; Snider & Dawes, 2006; UNICEF, 2005). Measuring psychosocial support and well-being of children made vulnerable by HIV/AIDS is one of the most complicated issues in vulnerable children interventions (UNICEF). Children's well-being and healthy development depend on the interplay of related factors which include physical, emotional, cognitive, material, social and spiritual factors (Richter). Psychosocial care and support interventions should enable children to experience love, protection and support that allow them to have a sense of self-worth and belonging (Richter & Foster). These are essential in order for children to learn and develop life skills.

The expected outcome for providing residential care is to improve children's access to a safe environment (Annual Report, 2003). Literature suggests that residential care should be provided as a temporary respite for the care of abandoned children until suitable family placements are found (Richter, 2004; Strebel, 2004; UNICEF, 2005). These researchers argued that children in institutional care face the risk of being divorced from their cultural and social spheres, and show attachment disorders later in life, as well as difficulty in forming appropriate relationships. Institutional care is expensive in that it draws away the resources that would have benefited a large number of children to just a few individuals (Beard, 2005; Richter et al., 2006).

One of the programme's outcomes is to improve children's access to a safe environment through family reunification (Annual Report, 2003). Family reunification, as defined by

Maluccio, Abramczyk, and Thomlison (1996), refers to the “...physical reunion of children in foster care with their families of origin to help them achieve their optimal level” (p.288). Several studies have focused on the evaluation of programmes for vulnerable children and the reintegration of children into society (Barth & Jonson-Reid, 2000; Maluccio et al.; Richter et al., 2006; Shisana et al., 2006; Stone, 2006; Strebel, 2004; Wells, 2001). These researchers are in agreement that the family is the preferred child-rearing unit and that families can give care to their children as long as they receive appropriate support.

The increased risk of malnutrition, inadequate shelter, clothing and schooling are commonly cited as impacts of the HIV/AIDS pandemic on children (Richter & Foster, 2005; UNICEF, 2005). This view was also supported by the United Nations General Assembly Special Session on HIV/AIDS which proposed that national governments should:

Strengthen family and community capacities to provide a supportive environment for orphans and girls and boys infected and affected by HIV/AIDS, including by providing appropriate counseling and psychosocial support; ensuring their enrolment in school and access to shelter, good nutrition and health and social services on an equal basis with other children; and protect orphaned and vulnerable children from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance. (United Nations, UN, 2001, p.29).

From the literature reviewed in this study, evidence indicates that children who participate in interventions such as the Beautiful Gate programme exhibit improved quality of life, personal development and social conditions through improved access to education, food, medical services and other basic materials. This implies that the programme theory for the Beautiful Gate programme is plausible.

### *Evaluation Questions*

An important step in designing an evaluation is to determine the questions the evaluation seeks to answer (Rossi et al., 2004). A carefully developed set of questions provides the direction and foundation of the evaluation.

The first step in an evaluation is to identify the major outcomes that have to be examined for the programme under evaluation (Rossi et al., 2004). Secondly, the evaluator has to choose the outcomes to be examined and prioritise them according to the level of impact on the recipients. Lastly, for each outcome, observable measures or indicators are specified to indicate the level of success the programme is achieving in realising its outcomes.

The following outcomes were used to measure children's welfare in this evaluation study:

- Improved children's access to medical services
- Improved food security and nutrition
- Improved children's access to education
- Improved children's access to a safe environment

An important step in designing an evaluation is to determine the questions the evaluation seeks to answer (Rossi et al., 2004). This evaluation seeks to answer the following evaluation questions:

- Has the programme managed to improve vulnerable children's access to medical services?
- Has the programme managed to improve vulnerable children's food security and nutrition?
- Has the programme managed to improve vulnerable children's access to education?
- Has the programme managed to improve vulnerable children's access to a safe environment?

### ***Outcome Indicators***

Outcome indicators are essentially the observable attributes that can be measured or assessed to see the progress or changes being made by the programme (Rossi et al., 2004). Outcome indicators for the Beautiful Gate programme are presented in Table 3.

Table 3

### *Outcomes and Indicators for the Beautiful Gate Programme*

<b>Outcome</b>	<b>Indicators</b>
Improving children's access to medical services	<ul style="list-style-type: none"><li>• Child mortality rate</li><li>• Number of children accessing ART</li><li>• Number of children who received all primary vaccines</li><li>• Distance to the nearest health centre</li></ul>
Improving food security and nutrition	<ul style="list-style-type: none"><li>• Number of meals per day</li><li>• Number of meals with nutritious foods per day</li></ul>
Improving children's access to education	<ul style="list-style-type: none"><li>• Number of children enrolled in primary education</li><li>• Number of children enrolled in pre-school</li><li>• Distance between school and home</li><li>• Learner-to-educator ratio</li><li>• Number of children involved in after-school activities</li></ul>
Improving children's access to a safe environment	<ul style="list-style-type: none"><li>• Number of children in residential care</li><li>• Number of children reintegrated into society</li><li>• Psychosocial wellbeing</li><li>• Safety and physical wellbeing</li><li>• HIV Stigma</li></ul>

This chapter provided the programme description for the Beautiful Gate Ministries' programme to establish the context for this evaluation. The following chapter will discuss the method used to collect the data.

## CHAPTER 2

### METHOD

This chapter describes the research design and data collection tools used for the evaluation.

#### *Research Design*

This outcome evaluation study utilised a descriptive design (Blanche, Durrheim, & Painter, 2006). A descriptive design provides descriptions of the variables in order to show statistical relationships between the variables (Blanche et al). The aim is to describe phenomena accurately through narrative type descriptions, classification, or measuring relationships. Whilst experimental and quasi-experimental designs are used to determine causality, descriptive designs seek accurate observations, and the validity and reliability of those observations.

#### *Data Providers*

Data providers consisted of the Beautiful Gate programme staff and programme records. The programme staff consisted of full-time employees who included caregivers, programme managers and administration staff, social workers and medical staff.

Fifty-five questionnaires were administered to the whole population of programme staff and 34 people responded, indicating a response rate of 62%. Efforts to increase the response rate were made through administering another 20 questionnaires but no feedback was received.

The population indicated a predominantly female and mature staff group, with 74% of the respondents being females. The average age of the respondents was 38 years.

The respondents formed a stable and experienced staff group, with 82% of programme staff having held their positions for at least three years.

The majority of the respondents were care-giving staff as reflected in Table 4.

Table 4

*Characteristics of the Participants (N = 55)*

<b>Job Category</b>	<b>Number</b>	<b>% of Respondents</b>
Caregiver	20	59
Admin staff	6	17
Reunification	2	6
Pre-school teacher	2	6
Other	1	3
Missing information	3	9

The sample consisted mainly of experienced, mature women who are engaged in various care-giving roles.

***Measurement Tools***

The evaluation study utilised a combination of qualitative and quantitative data. Researchers are in agreement that integrating the two types of data can often be the best vehicle for meeting a programme's information needs (Baker, 2000). Qualitative data provides practical insights or reasons behind certain results obtained from quantitative analysis (Baker).

***Study Period***

Due to data constraints, the study period was restricted to the period ranging between 2003 and 2008. Although the programme was established in 1994, suitable and reliable data was only collected for the 2003-2008 period.

### ***Qualitative Data***

Qualitative data were collected through the analyses of programme records. The following programme records were used:

- Annual Report 2003
- Annual Report 2005
- Annual Report 2006
- Annual Report 2007
- Annual Report 2008
- Newsletter November 2008 Issue 9
- Newsletter May 2007
- Mac Aid Project Proposal (2008)
- DG Murray Trust (DGMT) Proposal (2009)

The programme's annual reports, fund-raising proposals and the website provided information and insight on programme activities. The use of these records facilitated the extraction of comprehensive and historical information about the programme (Rossi et al., 2004).

The programme's annual reports provided information regarding the amount and quality of medical services the children are receiving, and this included the children's access to ART and other medical treatment. The annual reports also informed the evaluation question on the children's access to educational facilities and the number of children accessing such services. The number of children that have been placed into foster care or reunited with their families was also established through the programme's annual reports.

### ***Quantitative Data***

Quantitative data were collected through the use of a questionnaire-based survey. The questionnaire targeted the programme staff which consisted of caregivers, social workers, pre-school teachers, medical and administration staff. These were identified to be the key informants whose positions and experience provide them with some knowledge of the

magnitude of the programme and distribution of its services (Richter, 2004; Rossi et al., 2004). The data providers were self-selected to participate in the survey.

The questionnaire sought to extract information about the children's nutrition and food security, medical care, psychosocial wellbeing, safety and physical wellbeing as well as HIV stigma. The questionnaire had 44 items and is presented in appendix 1. Four scales were developed to inform evaluation questions on the children's access to a safe environment as well as food security and nutrition. Access to a safe environment was measured by the psychosocial wellbeing scale, safety and physical wellbeing, as well as HIV stigma scales. These are discussed in detail in the following section.

#### ***Access to medical services***

Access to medical care was measured using questions adapted from the report prepared by The Task Force for Child Survival and Development (2001). The first two questions asked recipients about how often the children visit health centres or medical practitioners and had a five-point response format (*Daily, weekly, monthly, not often, never*). The responses were scored from (1 = *Daily*, 2 = *Weekly*, 3 = *Monthly*, 4 = *Not often*, 5 = *Never*), with high scores reflecting improved health.

The second set of questions was adapted from the report prepared by The Task Force for Child Survival and Development (2001). The questions asked the respondents about the immunisation status of the children and whether there are any services the programme's onsite clinic is failing to provide. No changes were made to these questions. The response scale and had a three-point response format (1 = *Yes*, 2 = *Don't know*, 3 = *No*).

#### ***Nutrition and food security***

Access to food and nutrition was measured using four questions adapted from Schenk, Ndhlovu, Tembo, Nsune, Nkhata, Walusiku and Watts (2008) and The Task Force for Child Survival and Development report (2001). The questions were modified to indicate the types of foods available in South Africa and the lists of foods provided were informed by Piwoz and Preble (2000) who reported the types of foods and nutritional requirements suitable for children living with HIV/AIDS.

The response scale was given as (*Every meal; One meal; Two meals; Never; Don't know*). The responses were scored from 4 = (*Every meal*) to 0 = (*Don't know*) with higher scores reflecting high food security levels.

The Cronbach alpha for the nutrition and food security scale was .67 indicating adequate internal consistency (Pallant, 2001).

### ***Psychological wellbeing***

Psychosocial wellbeing was measured with questions adapted from Snider & Dawes (2006). The first four questions sought to obtain information about the caregivers' psychosocial wellbeing whilst the remaining five questions asked caregivers about the children's behaviour and experiences. The response format was changed from a 4-point response format [*weekly, monthly, less often, never*] to a five-point response format [*daily, monthly, weekly, not often, never*] to give the respondents more response options. The items were scored from 1 = (*Daily*) to 5 = (*Never*), with high scores indicating high psychosocial wellbeing.

The Cronbach alpha for the psychosocial wellbeing scale was .61 indicating adequate internal consistency (Pallant, 2001). This alpha was calculated on the 5 questions that asked caregivers about the children's behaviour and experiences

### ***Safety and physical wellbeing***

The children's safety and physical wellbeing was measured with five items adapted from Snider and Dawes (2006). The original scale used a binary response and was changed to a 5-point response format (*daily, weekly, monthly, not often and never*) to give respondents more options. Items were scored on a 5-point scale ranging from (*Daily, weekly, monthly, not often, never*). The scores ranged from 1 (*daily*) to 5 (*never*), with high scores indicating high safety and physical wellbeing.

The Cronbach alpha for the safety and physical wellbeing was .39. This alpha was calculated on the first three items of the safety and wellbeing scale. Items (d) and (e) in the scale were treated as single items.

### ***HIV stigma***

HIV stigma was measured using questions adapted from Kalichman, Simbayi, Jooste, Toefy, Cain, Cherry and Kagee (2005) and Nyblade, MacQuarrie, Kwesigabo, Jain, Kajula, Philip, Tibesigwa, and Mbwambo (2008). The first three questions were adapted from Kalichman et al. and the items were scored on a 3-point scale ranging from 1 (*agree*), 2 (*Don't know*) and 3 (*disagree*).

The second set of questions was a nine-item scale adapted from Nyblade et al. (2008) and no changes were made to these questions. The items were scored on a 3-point scale ranging from 1 (*no fear*), 2 (*Don't know*) and 3 (*have fear*).

The Cronbach alpha for the nine-item HIV stigma scale adapted from Nyblade et al. (2008) was .68, indicating adequate internal consistency (Pallant, 2001).

### ***Procedure***

The university's Faculty of Commerce Ethics Committee approved all study procedures relating to the protection of human participants.

A paper-based questionnaire was administered to the programme staff. Assistance from programme managers in questionnaire administration was secured. The questionnaires were distributed to the respondents at the Beautiful Gate programme site in Phillipi. Some of the questionnaires were given to the caregivers' team leader to distribute to the caregivers working night shifts.

The data providers were notified ahead of time about when they will receive the questionnaire and that the information obtained was going to be used for academic purposes only.

The respondents were informed that participating in the survey was voluntary and that there were no known risks associated with participating in the survey. The respondents were provided with a written consent informing them that participating in the survey was voluntary and that they were free to withdraw from the survey at any time.

The respondents were assured that their participation and responses were going to be treated with confidentiality. To protect the anonymity and ensure confidentiality of information, the respondents were not asked to write their names on the questionnaire, to ensure that the information obtained is not traceable to individual persons. However, for administration purposes, the questionnaires were numbered to allow follow-ups on those who failed to return the questionnaires on time.

The respondents were given instructions on how to complete the survey. The respondents were given a full explanation of the tasks expected of them so that they could make informed decisions to participate in the research. The researcher was available to answer respondents' questions.

### ***Data Analysis***

Data analyses was performed to transform the data into a more meaningful manner with the aim to provide answers to the evaluation questions (Blanche et al., 2006).

Content analysis was used to analyse programme records (Baker, 2000; Blanche et al, 2006). Content analysis, as defined by Weber (1990) refers to the systematic analysis of textual information in a standardized way that allows evaluators to make inferences about a programme. Thematic content analysis was used to analyse programme records (Brandt, Dawes, Africa, & Swartz, 2004). According to Brandt et al., thematic content analysis is the descriptive presentation of qualitative data that involves the reducing of data to manageable categories and themes, which form the basis of analysis. The identified themes were aligned to, and informed by the evaluation questions.

Statistical analysis was carried out using the Statistical Package for the Social Sciences (SPSS) version 17.0. Descriptive statistics were analysed from quantitative data. The initial analyses included an inspection of item response rates. To examine the reliability of the scales, the Cronbach coefficients ( $\alpha$ ) for all the measurement scales were determined.

This chapter discussed the data collection method and tools used to collect data for the evaluation, including the scales that were developed and used. The following chapter provides the results obtained from the evaluation.

University of Cape Town

## CHAPTER 3

### RESULTS

This section presents the findings of the outcome evaluation of the Beautiful Gate programme for vulnerable children. The results will be presented in terms of the evaluation questions.

#### *Descriptive Statistics*

In the first step, means, standard deviations, skewness and kurtosis were determined to describe the data. The results are presented in Table 5.

Table 5

#### *Descriptive Statistics*

	<b>N</b>	<b>Min</b>	<b>Max</b>	<b>Mean</b>	<b>SD</b>	<b>Skewness</b>	<b>Kurtosis</b>	<b>A</b>
Years Worked	34	1	10	5.99	3.03	-0.31	-1.19	
Age	31	25	55	38.1	8.79	0.55	-0.92	
Food & Nutrition	32	4	14	11.28	2.23	-1.42	2.66	0.67
HIV stigma	32	16	27	19.9	3.15	0.27	-0.78	0.68
Psycho social	27	23	32	29.5	2.29	-1.16	1.4	0.61
Safety & physical	32	17	20	19.4	1.13	-1.6	0.85	0.56

#### *Access to Medical Services*

The first evaluation question sought to establish if the programme has managed to improve children's access to medical services. The results for this evaluation question will be reported in terms of the relevant indicators, namely:

- Child mortality rate,
- Number of children accessing ART,
- Number of children who received primary vaccines.

### ***Child mortality rate***

Since 2003, only three have children died compared to nine children who died in 2002 (Annual Report, 2003). Only one child has died between 2003 and 2008 (Annual Report, 2008).

### ***Number of children accessing ART***

The pediatric clinic has provided ART and other related medical services to approximately 270 children between 2007 and 2008 (Annual Report, 2007). This number includes children from the surrounding community and those in residential care (Annual Report, 2007). The pediatric centre was reported to have maintained a 94% patient retention rate.

Fifty-nine percent of the participants reported that the children visit the health centre on a monthly basis whilst 15% reported that children do not visit clinics and health centre that often.

### ***Number of children who received primary vaccines***

Fifty percent of the respondents reported that children do not get hospitalised often whilst 32% reported that children get hospitalised on a monthly basis. Ninety-one percent of the respondents reported that all children have immunisation cards.

Fifty percent of the respondents indicated that no other medical services are required for the onsite clinic, implying that there are no special services that the onsite health centre is failing to provide. However, 79% also reported that there are other medical services that the onsite clinic is failing to provide. Twenty-one of the participants reported that all three medical services were required (that is, healthcare, medicine and immunisation). Table 6 presents the participant responses to the medical services required.

Table 6

*Medical Services Required*

<b>Medical Service</b>	<b>Frequency</b>	<b>Percentage (%)</b>
Healthcare	5	15
Medicine	12	35
Immunisation	2	6
All three	7	20.5
Other	1	3
Missing information	7	20.5

***Food Security and Nutrition***

The second evaluation question sought to establish if the programme has managed to improve children’s access to food security and nutrition. The results for this evaluation question will be reported in terms of the relevant indicators, namely number of meals per day and number of meals with nutritious foods per day.

***Number of meals per day***

Ninety-four percent of the respondents reported that children have at least three meals a day. Fifty-six percent of the participants reported that children eat protein-giving foods such as fish, eggs and milk in every meal. Twenty-four percent of the respondents indicated that the children have protein-giving foods in one meal per day.

***Number of meals with nutritious foods per day***

Fifty-six per cent of the respondents reported that children have fruits in one meal per day, whilst 21% reported that children eat fruits in two meals in a day. Seventy-one percent of the participants reported that children eat vegetables in one meal per day.

### *Access to Education*

The third evaluation question sought to establish if the programme has managed to improve children's access to education. The results for this evaluation question will be reported in terms of the relevant indicators, namely:

- Number of children enrolled in primary education
- Number of children enrolled in pre-school
- Distance between school and home
- Learner-to-educator ratio
- After-school care

#### *Number of children enrolled in primary education*

According to available records, 21 children in residential care were attending school in 2005, whilst the number increased to 25 in 2006 (Annual Report, 2006, 2005, 2003).

Table 7

#### *Number of Children Attending School*

<b>Year</b>	<b>Number of children</b>
2003	10
2004	-
2005	21
2006	25
2007	-
2008	-

Although the data for 2004, 2007 and 2008 could not be established, the programme aims to send all children of the school-going age to school (T. Tadokera, personal communication, September 29, 2009). The children attend local public primary schools which include Vukani, Kwakafu, Noluthando, Lantana and Zanefundo primary schools. Children that have special education needs attend Noluthando school, which is a special needs school for the deaf. The number of children attending school depends on the number of children in residential care at a given time.

### ***Number of children enrolled in pre-school***

All infants attend the onsite pre-school at the programme site in Phillipi. The number of children enrolled in pre-school varies with the number of children in residential care at a given time.

### ***Distance to the nearest school***

All the schools are within a radius of 3km from the programme site in Phillipi and the children are provided with transport to and from school (T. Tadokera, personal communication, September 29, 2009).

### ***Learner-to-educator ratio***

The learner-to-educator ratio was estimated to average 30:1 for all the schools that the children attend (T. Tadokera, personal communication, September 29, 2009).

### ***After-school care activities***

All children in residential care are involved in after-care activities. On average, the programme aims to have two holiday clubs per quarter targeting up to 400 children (DGMT Proposal, 2009). Children from the local community also attend after-school activities.

### ***Access to a Safe Environment***

The results for this evaluation question will be reported in terms of the relevant indicators, namely:

- Number of children in residential care
- Number of children reintegrated into society,
- Psychosocial wellbeing,
- Safety and physical wellbeing
- HIV stigma.

### ***Number of children in residential care***

On average the residential care facility accommodates a maximum of 40 children at any given time. The average ratio for child-to-caregiver is 6:1 (T. Tadokera, personal communication, September 29, 2009). Table 7 presents the number of children in residential care between 2003 and 2008. The data for 2004, 2007 and 2008 were missing. Although the total figure for 2008 was not recorded, the programme reports that they cared for an average of 32 children per month, whilst 25 new children were admitted into care during 2008 (Annual Report, 2008).

Table 8

### ***Number of Children in Residential Care***

<b>Year</b>	<b>Number of children</b>
2003	40
2004	-
2005	41
2006	50
2007	-
2008	-

### ***Number of children reintegrated into society***

Reintegration is done through family reunifications and foster placements. Since 2005, 39 children have been reintegrated into society. Table 8 depicts the number of children that have been reintegrated into society between 2003 and 2008. Of the 20 children that were reintegrated in 2008, 75% of them were reunited permanently with their families whilst the rest were placed into foster care (Newsletter, 2008). The data for 2004 were missing.

Table 9

*Number of Children Reintegrated into Society*

<b>Year</b>	<b>Number of Children Reunited with Family</b>	<b>Number of Children Placed in Foster Care</b>	<b>Total Number of Children Reintegrated</b>
2003	2	3	5
2004	-	-	-
2005	2	1	3
2006	4	1	5
2007	6	-	6
2008	20	5	25

***Psychosocial wellbeing***

Forty-one percent of the respondents reported that they agreed with the statement that (*children in this facility often complain of headaches*), whilst 44% disagreed.

In response to the statement that (*children in this facility sometimes look unhappy, downhearted or tearful*), 50% of the participants indicated that they agreed with the statement, whilst 41% disagreed.

In response to the statement that (*children in this facility are nervous, clingy in new situations and easily lose confidence*), 27% of the participants reported that they agreed, whilst 53% of the participants disagreed.

Scores on the psychosocial wellbeing scale ranged from 23 to 32, with a mean of 29.48 (SD = 2.29), implying that on average, the majority of participants exhibited high levels of psychosocial wellbeing.

The Pearson product-moment correlation coefficient was determined to measure the relationship between the caregivers' psychosocial wellbeing and that of the children (as perceived by caregivers). A small, negative relationship was found [ $r=-.24$ ,  $n=27$ ].

### ***Safety and physical wellbeing***

The physical and safety scale scores ranged from 17 to 20, with a mean of 19.41 (SD = 1.13).

### ***HIV stigma***

Sixty-two percent of the recipients indicated that they agreed with the statement that (*It is safe for people who are living with HIV/AIDS to work with children*), whilst 21% of the respondents disagreed.

Fifty percent of the respondents agreed with the statement that (*People living with HIV/AIDS must expect some restrictions on their freedom*), whilst 41% did not agree.

The stigma scale scores ranged from 16 to 27, with a mean of 19.94 (SD = 3.15).

This chapter presented the findings obtained from the evaluation of the Beautiful Gate programme. The following chapter presents a discussion of these findings, to establish if the programme has achieved what it intended to achieve.

## CHAPTER 4

### DISCUSSION

This chapter presents a discussion of the findings obtained from the outcome evaluation of the Beautiful Gate Ministries' programme.

#### *Access to Medical Services*

The findings presented in this evaluation report indicate that the programme has managed to provide an integrated health delivery system by providing ART, child immunisation and other related medical services.

The success of the programme can be measured by its ability to reduce child mortality rates. Since the introduction of ART in 2003, only three children have died compared to nine children who died in 2002 alone. The programme has managed to provide ART to all children that are living with HIV/AIDS. Research has indicated that children living with HIV/AIDS are dying unnecessarily because of lack of access to ART (Richter & Foster, 2005).. The programme makes regular follow-ups of children on ART to monitor their susceptibility to opportunistic infections and how they respond to treatment and nutritional interventions.

While ART is undoubtedly an essential element of a comprehensive package, providing care, support and treatment for children living with HIV/AIDS clearly goes beyond simply providing medication. Although the mortality rates for the period before 2002 could not be established due to data constraints, the programme reports that they have experienced a significant decrease in admissions to hospital and an overall improvement in children's physical and emotional wellbeing (Annual Report, 2003).

Results from this evaluation have shown that all children in residential care have received all the required primary vaccinations. The provision of primary vaccinations is one of the major components of health delivery systems. This finding is consistent with previous

research which suggests that immunisation of children is a major component of comprehensive healthcare and that it is the most cost-effective clinical preventive service (Santoli, Rodewald, Maes, Battaglia & Coronado, 1999). Although the immunisation cards were not scrutinised to assess if the immunisations were on track, increasing emphasis has been placed on the importance of receiving all aspects of paediatric care for the children in residential care.

In line with the evaluation findings, the programme has successfully managed to improve the children's access to medical services by providing an onsite clinic that caters to the needs of children in residential care. The distance between a health centre and a child's household is one of the determinants of access to medical services (Pendlebury et al., 2009). It is reported that before joining the programme, the children had limited and/or no access to medical services (Annual Report, 2003). The onsite clinic facilitates prompt responses to medical emergencies given the fact that the majority of children in residential care are living with HIV/AIDS.

The success achieved in reducing child mortality rates due to HIV/AIDS and lack of immunisations demonstrates the success of the programme in establishing successful health interventions and collaborations with caregivers and other programme stakeholders.

#### ***Access to Food Security and Nutrition***

The findings of this study indicate that the programme has been successful in providing children with basic nutrition and food security. Improvements in access to basic nutrition and food security were attributed to the fact that the majority of children came from poor and broken families whose guardians or parents were not able to look after them (Annual Report, 2003). In line with the research findings, literature reports that foods such as liver, milk, meat, cereals, fish, vegetables, eggs and beans are some of the basic foods that provide basic nutrients required by children living with HIV/AIDS (ECSA-HC et al., 2008; Piwoz & Preble, 2000). These foods provide key nutrients such as carbohydrates,

proteins, fats, vitamins, minerals and water which are a critical requirement for people living with HIV/AIDS.

The common indicators of protein-energy deficiency in children such as underweight, stunting and wasting (ECSA-HC et al., 2008; Piwoz & Preble, 2000) were not observed in the children. These conditions are caused by inadequate access to food and nutrients, limited access to health services, and unhealthy environments. Literature suggests that malnutrition is the underlying cause of most child deaths and poor development amongst under-five year children (Richter & Foster, 2005). Nutrition interventions are therefore a critical component of comprehensive HIV/AIDS care and treatment.

### *Access to Education*

Results from this study indicate that the programme has managed to improve children's access to educational facilities. The programme has enhanced children's access to education through the provision of schools fees and buying of school uniforms which the children could not afford before they joined the programme. A significant improvement in the number of children attending school was realised. For example, only 10 children were attending school in 2003, compared with 21 and 25 children in 2005 and 2006 respectively.

Research shows the majority of children are not able to attend school because they cannot afford to buy school uniforms and pay school fees (Pendlebury et al., 2009; ECSA-HC et al., 2008). These are some of the major barriers to education that vulnerable children face. Education is vital for children's future and is important for their psychosocial development. Schools can provide children with a safe, structured environment, the emotional support and supervision of children, and the opportunity to learn how to interact with other children and develop social networks (UNICEF, 2005).

The results from this evaluation show that the programme has adopted an integrated approach in the provision of education to vulnerable children. This is reflected in its ability to provide not only school fees and uniforms, but also provide extra-curricular

activities through its after-school activity centre. This is in line with the programme's other objectives such as the provision of a safe environment since children who engage in after school activities are at lower risk for being exposed to violence and anti-social behaviour (Dawes, 2006). The provision of after school-care facilities and holiday programmes reduces risks to children through provision of supervision.

Findings from this research also indicate that the children are provided with transport to and from school. Such initiatives were found to be effective in improving the quality of education that children get. This finding is consistent with previous researchers who cited the distance between school and home as one of the barriers to education (Pendlebury et al., 2009). This research concluded that "...access to schools and other educational facilities is a necessary condition for achieving the right to education" (p.84).

Although the actual learner-to-educator ratio could not be ascertained for the public schools which the children are attending, it was estimated to be approximately 30:1. The learner-to-educator ratio is one of the determinants of improved access to education (Pendlebury et al., 2009). This finding is in line with the national and international recommendations where the ratio is set at a maximum of 40 learners per educator in primary schools (Pendlebury et al.).

### ***Access to a Safe Environment***

The results of the present study show that the programme has managed to provide temporary safe places for children needing a home before they are reintegrated into society. The programme has managed to provide children with decent shelter as demonstrated by its ability to provide decent housing with sanitation, water and electricity (Pendlebury et al., 2009). The provision of shelter is considered to be the core focus of the programme since its main target population is displaced and poor children whose guardians are no longer able to take care of them. Previous studies have highlighted that the provision of decent housing with water and sanitation facilities as one of the children's basic constitutional rights (Pendlebury et al.).

Findings from this research indicate that the programme has been successful in reintegrating children into society. This was achieved through family reunification and foster placements. The programme works closely with social workers, child care workers and nurses to ensure that school, medical training and other basic materials are in place before the child leaves residential care (Annual Report, 2008). This finding is consistent with previous studies which point to the family as the preferred child-rearing unit (Barth & Jonson-Reid, 2000; Maluccio et al., 1996; Richter et al., 2006; Shisana et al., 2006; Stone, 2006; Strebel, 2004).

Findings from this evaluation indicate that the programme encourage families to keep ongoing contact with their children in residential care (Annual Report, 2003). Beautiful Gate's reunification programme is consistent with findings from previous studies which reported that programmes for vulnerable children should focus on strengthening family care, family preservation and community support (Richter & Foster, 2005; Richter et al., 2006; Strebel, 2004). Children need more than physical care, they need "...affection, attention, security and social connections that only families and communities can provide" (Richter et al., p.29).

The research findings are supported by previous studies which reported that institutional care is not the best solution for vulnerable children (Beard, 2005; Richter et al., 2006). By reintegrating the children into society, the programme supports the notion that institutional care cannot substitute a natural family environment. Families are the best hope for the care of children, but they require support from outside sources for both immediate and longer-term survival needs (UNICEF, 2005). Beard reported that residential care should only be used if family care options are not adequate. This outcome highlights the children's need for a sense of belonging and identification with family structures.

Findings from this evaluation research indicate that children exhibit high levels of psychosocial wellbeing. This was determined by asking the caregivers about their psychosocial wellbeing as well as the children's behaviours and experiences. The use of more direct terms for psychosocial problems such as the actual consultation of a

counselor or health worker can be used to reflect a clinically significant distress by respondents (The Task Force for Child Survival and Development, 2001).

Although the children could not be surveyed directly, Richter (2004) reported that the interaction between the caregivers and children is essential for their psychosocial wellbeing and development. Loving and mutually responsive interaction is essential for the child to develop into an emotionally secure and confident individual. Children's emotional, cognitive and social development is learned through interaction with the people in their lives (UNICEF, 2005). These findings are also consistent with Richter's view that:

Care-giving behaviours are mediators between social, health and caregiver attributes and the child's survival, growth and development. They are a key determinant of the quality of the environment provided for children. (Richter, 2004, p.5)

Further investigations were conducted to examine the relationship between the caregivers' psychosocial wellbeing and that of children. Conclusions drawn from previous research suggest that the mental state of caregivers, exert an effect on the attitudes, emotions and behaviours of the children (Richter, 2004), suggesting a positive correlation between the caregivers' psychosocial wellbeing and that of children. This is also supported by Richter et al. (2006) who reported that:

Care-giving entails promoting strong caregiver-child relationships for children's nurture and protection, supporting children's nutrition and growth, minimising childhood illnesses, decreasing environmental threats to children's safety, providing opportunities to learn and play, increasing access to preparation for formal schooling, and promoting educational access, retention and achievement. (p.26)

The Pearson product-coefficient was determined to investigate the relationship between the caregivers' psychosocial wellbeing and that of children and the results were not consistent with findings from previous studies [ $r = -.24$ ]. The researcher suggests that further research need to be conducted to investigate this finding.

Findings from this evaluation research are consistent with findings from previous research which suggest that the child's psychosocial wellbeing can be improved by providing psychological or medical therapeutic services such as counselling, and activities that encourage children to express feelings and explore problems and their potential solutions (Maluccio et al., 1996). Activities such as social networks and children's clubs, participation in religious activities help to support and stimulate children's development.

The results also lend support to the effectiveness of children to participate in activities such as sports, school clubs, religious groups, community-organised programmes and camping. This finding is consistent with Strebel (2004) who reported that children's psychosocial wellbeing can be improved by participating in a significantly higher number of sporting and social activities. Children's morale can be improved by keeping them in school and offering sports and recreation facilities. School and other activities maintain the psychological well-being of children and reduce the burden of childcare on caregivers (Richter & Foster, 2005).

The findings from this evaluation indicate the existence of a stable and experienced staff that appears to be dedicated and satisfied with their jobs (Annual Report, 2006, 2003). This finding is consistent with Atten and Milner's (1987), as cited in Howarth (2003), that employee satisfaction contribute to promoting a safe environment for the children since job dissatisfaction and high staff turnover are key factors identified as contributing to child abuse in residential institutions. The adaptability and the vocational attitude of staff, notable for their dedication, professionalism and compassionate commitment, were regarded as particular strengths of the Beautiful Gate programme.

Findings from this evaluation indicate that children exhibit high levels of feelings of security and physical wellbeing. This finding is consistent with the view that child abuse, by use of harsh physical punishment in the home is a serious risk to children's physical and psychosocial wellbeing (The Task Force for Child Survival and Development, 2001). Howarth (2003) cites lack of training and experience of caregivers, long working hours and unrealistic shift schedules, as some of the factors that contribute to potentially abusive situations.

The low caregiver-child ratios allow care-giving staff to give more individual attention to the children. In line with the researcher's expectation, reports from the caregivers indicate that they have managed to form a bond with the children. This finding is supported by Richter (2004) who reported that the interaction of caregivers with children places them in an important and strategic position for the children's survival.

Generally respondents displayed low levels of stigma. A low score on the indicator is a fairly sound indication of low levels of stigma. Nevertheless there was considerable variability in the individual responses to the items suggesting that fear-driven stigma is still present at Beautiful Gate. This was demonstrated by the fact that fifty percent of the respondents agreed to the statement that (*People living with HIV/AIDS must expect some restrictions on their freedom*). There were no significant differences in responses between the different categories of job positions. The scale appears to assess a fairly well unified construct as demonstrated by its internal consistency.

Considerable fear was expressed around touching or sharing items with people living with HIV such as plates, food, spoons, and clothing. This finding is consistent with previous research which reported that fear of casual contact leading to HIV transmission drive individuals to alter their behaviour by purposely avoiding contact with persons with HIV (Nyblade et al., 2008). HIV/AIDS is a life-threatening illness that people are afraid of contracting. Underlying this fear is the particular concern about sweat contact, which coexists with stated knowledge that HIV cannot be transmitted through mere touching. Strong stigma is still associated with HIV/AIDS in South Africa. Strebel (2004) reported

that HIV stigma should be taken into consideration when devising community-based interventions.

### ***Recommendations***

The centrality of the family in the development and well-being of the child should be recognised in the implementation frameworks of vulnerable children interventions. The goal is to preserve families by providing assistance to families and connecting them with services that enable children to remain safely at home.

Whilst family reunification is a crucial step towards family preservation, it should be done timeously and appropriately. Unnecessary placements should be avoided. The researcher recommends that the programme should create opportunities to work closely with families during the placement period, providing support before and after the reunification, and encouraging and facilitating child-family visiting throughout the period when children are in residential care. This can also be enhanced by providing brief, intensive family-centred services so as to maintain the reunification.

Children are admitted and discharged from the programme over an observation period such as a year. A child admitted at the end of the year is less likely to be reintegrated within that same year compared to a child who was admitted at the beginning of the year. So a good indicator of improvement (and reduction of the risk of institutionalisation) is reduction in the time it takes to reintegrate a child into society. This could be tracked over time. The researcher recommends the programme to set a standard period for placement, (for example 6 months), and track the number of children reintegrated within the stipulated standard period.

The researcher recommends that process and outcome evaluations be carried out routinely as an integral part of the programme to ensure that services and facilities are in line with changes in economic, medical care provisions as well as environmental factors.

### *Limitations to the Study*

The present study has several limitations worthy of comment. As the study was small in scale, generalisations regarding practice within institutional care programmes across South Africa cannot be made. The context and understanding of children made vulnerable by HIV/AIDS varies from one cultural and socio-economic context to another and therefore tends to differ between countries and sometimes even between programmes within countries (UNICEF, 2005). The results are nonetheless useful as they reflect the views of 62% of the people that are employed by the programme and form the basis for future evaluation of programme services and facilities.

Other indicators of children's sense of security and wellbeing would also include children's responses to questions regarding their own safety. However, in the interest of time and the challenges involved in collecting data from young children, the questionnaire was designed and administered to the caregivers only.

Another factor that could have affected the results of this research was that the data was self-reported. Self-reports carry the risk of inflated relationships, perceptions and practices (UNICEF, 2005). What people actually do in the face of something as frightening as HIV/AIDS may be different from what they actually do in real situations.

Some of the indicators in this evaluation required sensitive information, for example, psychosocial wellbeing, safety and physical wellbeing as well as stigma, child abuse and neglect. It is also difficult to collect information about people's behaviours towards those with HIV. So most questions that attempt to measure stigma focus on hypothetical situations, such as the willingness to care for a relative with HIV/AIDS, or beliefs about whether people with HIV should be permitted to continue working with others (UNICEF, 2005).

Due to the small population of the programme staff, the researcher was compelled to administer the questionnaire to the whole population of staff. It was noted that although it was appropriate to ask all staff the same questions, not all of them were competent

enough to answer some of the questions. In this instance, caregivers and pre-school teachers would be expected to be more intimate with the children, as compared to administration staff. This might have posed a threat to the internal validity of the study and is therefore noted as a limitation to the study.

Another limitation was that access to medical services was measured by the frequency of visits to medical facilities. This measure does not take into account other factors that may influence a child's health status such as, for example, on time up-referrals for children who require specialised medical services. On the same note, due to time constraints, immunisation cards were not scrutinised to assess whether the immunisation were on track.

Psychological wellbeing was measured using a number of items drawn from literature. It is recommended that observers should rate individual child psychological wellbeing using scales that are designed for the age of the specific child being rated. In this study, the general welfare of all the children was established and not for each individual children. This does not provide an adequate assessment of the psychological wellbeing of children in the programme.

### ***Contribution to Research***

Although there is much literature on the impact of HIV/AIDS on children, very little research has been done on the evaluation of programmes for vulnerable children in South Africa. Far less documented work reports on evaluation of projects or the development of programmes for vulnerable children. There is a need for the development of evidence-based programmes, which incorporate ongoing evaluation, in order to optimise resource utilisation on the scale required to respond effectively to the growing problem of vulnerable children.

This evaluation research will help to examine and promote evaluation research that can help practitioners, administrators and policy makers in adopting strategies that can effectively improve programmes for vulnerable children in South Africa.

### ***Conclusion***

This evaluation study examined the extent to which the Beautiful Gate programme has managed to improve children's welfare in relation to improved access to food, medical and educational services and the provision of a safe environment.

Findings from this evaluation indicated that the programme has succeeded in improving the welfare of vulnerable children by providing them with medical care, food, education and a safe environment. The programme has significantly managed to reduce child mortality rates by providing a comprehensive health system which incorporates ART therapy, child immunisation and other related medical services. The provision of integrated health services has also been complemented by providing children with food security and adequate nutrition required by children, especially those living with HIV/AIDS.

The Beautiful Gate programme has managed to provide holistic, integrated responses to vulnerable children, rather than a narrow HIV/AIDS-specific response that provides for only one aspect of children's needs.

## APPENDIX

### Appendix 1

#### *Questionnaire Used for Data Collection*

<b>SECTION A: DEMOGRAPHIC INFORMATION</b>		
1.1	Gender	Male/Female
1.2	Occupation	10 Options
1.3	How long have you been working at your current job position?	Months/Years
1.4	Age	Years
<b>SECTION B: NUTRITION AND FOOD SECURITY</b>		
2.1	How many meals do the children have per day?	5 Options
2.2	How many times do the meals include any of the following foods per day? 1. Milk 2. Meat 3. Fish 4. Liver 5. Chicken 6. Eggs	5 Options
2.3	How many times do the meals include any of the following fruits per day? 1. Oranges 2. Lemon 3. Guava 4. Apple 5. Banana	5 Options
2.4	How many times do the meals include any of the following vegetables per day? 1. Green leafy vegetables 2. Nuts and seeds 3. Beans	5 Options
<b>SECTION C: MEDICAL CARE</b>		
3.1	How often do the children visit a health practitioner or health centre?	5 Options
3.2	How many times on average do the children get hospitalized?	5 Options
3.3	Do the children have immunization cards?	Yes/No/Don't Know
3.4	Are there any children who need medical services that the residential facility cannot provide?	Yes/No/ Don't Know
a)		
b)	What type of medical services do the children need?	4 Options
<b>SECTION D: PSYCHOSOCIAL WELLBEING</b>		
<i>Please give your answers on the basis of the child's behavior and your experiences over the past year.</i>		
4.1	How often have you felt sad?	5 Options
a)		

b)	How often have you had problems with nerves (for example, bad temper)?	5 Options
c)	How often have you had headaches or stomach aches?	5 Options
d)	How often have you felt you needed to consult a counselor or health worker (clinic nurse or doctor)?	5 Options
4.2	How often have you seen a child looking sad?	5 Options
a)		
b)	How often have you had a child having problems with nerves?	5 Options
c)	How often have you had a child complaining of headaches or stomach aches?	5 Options
d)	How often have you had a child being much more disobedient than usual?	5 Options
e)	How often has a child had a psychological problem that you felt he/she needed to consult a counselor or health worker (clinic nurse or doctor)?	5 Options
4.3 Would you agree or disagree with the following statements? <i>Please give your answers on the basis of the child's behaviour over the past year.</i>		
a)	Children in this facility often complain of headaches, stomach-aches or sickness	Agree/Disagree/Don't know
b)	Children in this facility sometimes look unhappy, downhearted or tearful	Agree/Disagree/Don't know
c)	Children in this facility are nervous, clingy in new situations and easily lose confidence	Agree/Disagree/Don't know
<b>SECTION E: SAFETY AND PHYSICAL WELLBEING</b>		
5.1 In the past year, how often have you or another adult used this method of discipline with any child in this facility...		
a)	Used a stick, belt, hairbrush or other hard item to discipline a child?	5 Options
b)	Slapped, punched or hit a child on his/her head or face?	5 Options
c)	Said you would send him/her away or kick him/her out of the house?	5 Options
d)	Withheld a meal to punish him or her?	5 Options
e)	Explained to the child why something they did was wrong?	5 Options
<b>SECTION F: STIGMA</b>		
6.1 Please indicate whether you agree, disagree or don't know in response to the following statements:		
a)	It is safe for people who are living with HIV/AIDS to work with children	Agree/Disagree/Don't know
b)	People living with HIV/AIDS must expect some restrictions on their freedom	Agree/Disagree/Don't know
6.2 Please indicate whether you have fear, no fear, not sure or don't know, in response to the following statements:		
a)	Do you have fear that you could become infected with HIV if you touch the saliva of a person with HIV or AIDS?	3 Options

b)	Do you have fear that you could become infected with HIV if you touch the sweat of a person with HIV or AIDS?	3 Options
c)	Do you have fear that you could become infected with HIV if you touch the excreta of a person with HIV/AIDS?	3 Options
d)	Do you have fear that your child could become infected with HIV if they play with a child who has HIV/AIDS?	3 Options
e)	Do you have fear that you could become infected with HIV if you eat food prepared by a person with HIV/AIDS?	3 Options
f)	Do you have fear that you could become infected with HIV by touching a person living with HIV/AIDS?	3 Options
g)	Do you have fear that you could become infected with HIV if you sleep in the same room as a person living with HIV/AIDS?	3 Options
h)	Do you have fear that you could become infected with HIV if you share eating utensils with a person living with HIV/AIDS?	3 Options
i)	Do you have fear that you could become infected with HIV if you stay near someone who is showing signs of HIV/AIDS?	3 Options
j)	Do you have fear that you could become infected with HIV if you sleep in a bed where a person living with HIV/AIDS previously slept?	3 Options
k)	Do you have fear that you could become infected with HIV by caring for a person living with HIV/AIDS who is not showing any signs/symptoms (For example, by preparing meals, cleaning dishes & utensils, sitting near, and touching)?	3 Options
l)	Do you have fear that you could become infected with HIV by caring for a person who is showing signs/symptoms of HIV/AIDS infection?	3 Options
m)	Do you have fear that you could become infected with HIV caring for a person living with HIV/AIDS such as by bathing and dressing, washing soiled clothing or bedding, cleaning vomit or diarrhea?	3 Options
n)	Do you have fear that you could become infected with HIV if you share a toilet with a person living with HIV/AIDS?	3 Options
o)	Do you have fear that you could become infected with HIV if you and someone living with HIV/AIDS were involved in an accident that caused both of you to bleed?	3 Options
p)	Do you have fear that you could become infected with HIV if you handle a razor/blade with dried blood on it from someone living with HIV/AIDS?	3 Options

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