

ISIBINDI: A LONGITUDINAL EVALUATION OF SELECTED SITES IN KWAZULU-NATAL

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KEY FINDINGS

Beneficiaries served by Isibindi program partners in KwaZulu-Natal were found to have greater access to grants, higher obtainment of material resources, and more positive support from adults in their home over time relative to a comparison group of families enrolled in a different program. All Isibindi sites were equally successful on each of these major outcomes.

No program impact was found with respect to other outcomes reflecting physical and psychological health, food security, HIV knowledge and child protection; supplemental program efforts appear necessary to address these needs.

Isibindi sites rated as high functioning by NACCW were found to provide higher quality services and better linkages to external resources than sites rated as lower functioning, suggesting that as sites gain programming experience and become better established, improvement on key outcomes is possible.

Investment in programs must continue to be coupled with careful, objective study to understand the level and nature of home visiting and other support services that are reaching beneficiaries, and identify program factors that contribute to effectiveness in service delivery, including delivery at scale.

As the national roll-out of Isibindi commences, it will be critical to continue developing a high-quality monitoring and evaluation system to facilitate timely program adjustments. By identifying and monitoring aspects of service delivery with the highest potential to influence program success, NACCW and its partners can continually strengthen their response to the needs of vulnerable families in South Africa.



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TABLE OF CONTENTS

Introduction	3
Methods	6
Study Sites and Stratification	6
Quantitative Data Collection and Study Sample	7
Qualitative Data Collection and Study Sample	9
Outcome Measures and Analyses	10
Findings	11
Frequency and Duration of Home Visits	11
Support Provided during Home Visits	13
Education	16
Physical Health	17
Economic Security	20
Psychological Health	23
Child Protection	25
Conclusions	29
Appendix A. Impact of Isibindi Relative to a Comparison Group	32
Acknowledgements	34

ACRONYMS

AIDS	Acquired immunodeficiency syndrome
AOR	Adjusted Odds Ratios
ARD	Adjusted Risk Differences
CBO	Community Based Organization
CINDI	Children in Distress Network
CSG	Child Support Grant
CYCW	Child and Youth Care Worker
DSD	Department of Social Development
FCG	Foster Care Grant
FGD	Focus Group Discussion
HIV	Human immunodeficiency virus
IDI	In-depth Interview
KZN	KwaZulu-Natal
NACCW	National Association of Child Care Workers
OVC	Orphans and Vulnerable Children
p	Probability Value
SASSA	South African Social Security Agency
USAID	United States Agency for International Development

An estimated 1.9 million children in South Africa have lost one or both parents due to AIDS. Many more children have been made vulnerable due to familial illness. These children are subject to an array of adversities, including increased risk of hunger, psychological distress, and HIV infection. In an effort to provide much-needed support to these children, the United States Agency for International Development (USAID) in Southern Africa and the Department of Social Development (DSD) have committed to supporting the expansion of the Isibindi model of care promoted by the National Association of Child Care Workers (NACCW) in 400 sites throughout South Africa from 2012-2017. Isibindi seeks to provide community-based services to orphans and vulnerable children (OVC), responding holistically and comprehensively to their needs, whilst developing and strengthening the social service workforce in South Africa (see Box 1 for further details on Isibindi). To effectively guide the scale-up of Isibindi across the country, information regarding potential variations in the provision of care across sites is of critical importance.

Focusing on 13 program sites in KwaZulu-Natal, this report describes the support offered by Isibindi Child and Youth Care Workers (CYCWs) to beneficiary families as well as changes in key measures of children's wellbeing over a two year period. We further examine differences in the provision of care and support services and changes in wellbeing between beneficiaries at high- and lower-functioning Isibindi sites, according to NACCW's own site assessment process. Qualitative data was also obtained from caregiver beneficiaries, Child and Youth Care Workers (CYCWs), and senior NACCW personnel. These focus group discussions (FGDs) and in-depth interviews (IDIs) offered a valuable opportunity for contextual exploration, and led to a greater understanding of factors that characterize service delivery between newer and established Isibindi sites. Results suggest that a complex array of both site-level and individual factors affect what CYCWs are able to accomplish and how children's lives are different as a result, and that not all of the changes may be captured in standard beneficiary surveys. This report leverages both quantitative and qualitative results in order to more fully understand how the program is working and which areas may be in need of further attention to maximize program impact on beneficiaries.

This investigation is part of a larger two-year program evaluation undertaken in KwaZulu-Natal. The broader study is designed to assess the impact of various home visiting models on service delivery and subsequent child wellbeing. NACCW and their community based organization (CBO) collaborators together represent one of three service organizations participating in the evaluation. The evaluation sought to compare home visiting services delivered by largely uncompensated volunteers with minimal or informal training to programs reliant on paraprofessional home visitors who receive regular low-level compensation, intensive and highly structured training, and other support from an organization with external resources. Isibindi was one of two paraprofessional models included in this study. The program is delivered in concert with CBO partners by a corps of CYCWs who complete 14 training modules during their first two to three years in the position. Each module lasts between 6 and 30 hours, and CYCWs receive approximately 1000 Rand a month in recompense.

Beneficiaries enrolled in the volunteer-driven programming, by contrast, approximated a study control group due to uniformly low levels of reported program exposure. While the evaluation was subject to standard limitations, its quasi-experimental design helps to establish that outcomes resulted largely from differences in how the programs were implemented between the groups; thereby allowing attribution of any differences to Isibindi rather than other factors. In the overall evaluation, paraprofessional programs, including Isibindi, showed a positive impact on measures of economic security. Specifically, beneficiaries served by paraprofessionals reported greater access to social grants and material resources. Neither model measurably affected child depression, HIV and AIDS knowledge, or food security over the course of the study period. Moreover, child maltreatment, child behavioural problems and poor family functioning were reportedly more common at follow-up across all programs. For a more detailed account of the evaluation background, methodology and results, readers are referred to the research brief: *The impact of paraprofessional versus volunteer-driven home visiting programs on the wellbeing of orphans and vulnerable children: Evidence from a longitudinal evaluation in KwaZulu-Natal, South Africa.*¹ This brief also offers detailed program implications designed to help guide future investments in service delivery.

To better understand Isibindi's effects, the outcomes described above were analyzed for Isibindi beneficiaries alone compared with those in the lowest tier volunteer-driven approach, implemented by CBO affiliates of one of the other program partners in the study. Results followed a similar pattern: Isibindi child beneficiaries were two and a half times significantly more likely to have access to the highest grant they were eligible to receive, and three times significantly more likely to have basic material needs met. Again, there was no evidence of positive impact with respect to measures of family and child psychological health, HIV knowledge or food insecurity. Outcomes of reported child maltreatment, behavioral problems and family conflict were found to worsen over time across both groups.

The Isibindi-focused analyses were further expanded to examine other desired program outcomes, including: school engagement, child and caregiver self-reported physical health, acquisition of documents required for grant applications, financial management by caregivers, and positive adult support available to children from adults in their home. Isibindi beneficiaries were found to receive significantly higher levels of positive adult support from adults in their home over time, whereas in the comparison group adult support measurably declined over the two-year study period. Specifically, there was a significant rise in reports from Isibindi children that adults in their home offered praise, listened to their ideas and engaged in fun activities with them—suggesting that the Isibindi model may be effectively facilitating these positive interactions. For the other indicators studied, no evidence of program impact from Isibindi relative to the comparison model was evident. Detailed results from the analysis comparing Isibindi to this lowest tier group are provided in Appendix A.

Following the finding that Isibindi outperforms its comparison group in roughly the same magnitude and fashion that all paraprofessional programs outperform volunteer-driven ones, we opted to further investigate the factors that may both drive this success and enhance understanding as to existing gaps. Isibindi sites in the study were classified as high- versus low-functioning based on a comprehensive assessment conducted by NACCW personnel that considered the strength of human resources, management, and available service provision, among other criteria. The differences in service delivery and subsequent changes in beneficiary wellbeing between Isibindi sites classified as high versus low functioning are examined. Follow-up focus group discussions and interviews with program stakeholders explored these results in detail and allowed stakeholders to provide additional context for the quantitative findings.

Readers are advised to consider these secondary analyses as an exploratory assessment, examining pre- and post-exposure measures among Isibindi beneficiary children without the rigorously-designed counterfactual necessary to establish individual program impact. Nonetheless, the present analysis has the potential to offer a wealth of important information to guide scale-up and program improvement: for example, how usefully does the NACCW assessment tool distinguish between sites that are working well to improve outcomes and those working less well? Are sites being held to the right set of implementation standards or might different factors matter more? How much does a site's age, staff complement, or management capacity manifest in the apparent potential of Isibindi programming to improve children's wellbeing? Through the qualitative research, we can learn even more: What factors do program staff and other stakeholders believe might be preventing positive change on anticipated outcomes? What happens during a home visit? What services do beneficiaries value most?

The research and associated work described here are part of the Compiling an Evidence Base for OVC Programming project, made possible by the generous support of the American people through USAID in Southern Africa. Tulane University School of Social Work, as the prime funding recipient, works closely with USAID Southern Africa, Impact Research International, and South African implementing partners to produce knowledge designed to improve existing practices and guide future investment in OVC programming.

¹Thurman TR, Kidman R, and TM Taylor (2013). *The Impact of Paraprofessional versus Volunteer-Driven Home Visiting Programs on the Wellbeing of Orphans and Vulnerable Children: Evidence from a Longitudinal Evaluation in KwaZulu-Natal, South Africa, New Orleans, Louisiana: Tulane University. Available at: www.hvc-tulane.org*

Box 1. An overview of the Isibindi Model of Care

Designed by the National Association of Child Care Workers (NACCW), the Isibindi program is implemented at 67 sites by 51 partner organizations in 8 provinces of South Africa as of 2012, with over 800 Child and Youth Care Workers (CYCWs) serving approximately 100,000 orphans and vulnerable children (OVC). The program develops the capacity of CYCWs to respond directly to the needs of vulnerable children, youth and families, particularly those affected by HIV/AIDS and poverty. The CYCWs receive a standardized training accredited by the Health and Welfare Sector Education and Training Authority; training comprises 14 modules of 6-30 hours each over a two to three year period and covers core competencies for working with children and youth. Throughout their training and beyond, CYCWs regularly visit beneficiaries in their homes and aim to provide comprehensive support. They devise individualized family assessments and developmental plans for each household which serve as a structure for engaging with children and their caregivers to meet care and support needs. They develop close relationships with the family, and use the day-to-day physical and social environment as a natural platform for providing developmental, therapeutic and educational services. CYCWs help link families with needed resources, including social grants, food gardens and other health and social services in the community. They teach children and families an array of life skills and encourage the family to adopt structured routines for daily living. The CYCWs also provide psychological support through a number of initiatives which include memory box activities, grief management, relationship-building, identifying needs and feelings, providing developmental care, behaviour management, risk assessment and life space counseling. Some sites also offer supplemental services, including a Safe Park—a place where children can play and receive homework assistance and education under the protective supervision of CYCWs; as well as specialized programs for adolescents, young adults, child heads of household, and children and youth with disabilities.

The program is run on a 'social franchise' basis with the NACCW entering into formal partnerships with implementing partner organisations who then replicate the Isibindi model. Applicants are screened, selected, trained and deployed as CYCWs to provide services to families in their own communities. They work under the mentorship of experienced social service professionals within NACCW, who carefully monitor and support each emerging Isibindi project and site. As part of this process, partnerships are forged between the Department of Social Development at the provincial level, donors, the community, implementing organisations and NACCW, fostering coordinated, effective service delivery.

For more information on the Isibindi model, readers can refer to <http://www.naccw.org.za/> Readers can also access a case study, *Care for Caregivers. A Psychosocial Support Model for Child and Youth Care Workers Serving Orphans and Vulnerable Children in South Africa: A Program Implemented by the National Association of Child Care Workers* that includes details on CYCW training and support services at: www.hvc-tulane.org

Study Sites and Stratification

The study included beneficiaries enrolled in programming at 13 different Isibindi sites across five districts in KwaZulu-Natal (KZN); they were drawn from a total of 18 possible active sites in the district as of 2009. Sites were selected based on the extent of enrollment of new beneficiaries, with a minimum requirement of at least 20 new children aged 10-17 enrolled between October 2009 and March 2010. These sites differ not only by physical location, but also in terms of community implementing partner, length of operation, and the quality and experience of the service workforce.

In 2012, NACCW conducted a comprehensive assessment examining the operating functionality of each of their 67 Isibindi sites. Assessments were conducted by provincial Mentors, senior NACCW personnel familiar with the sites, using a dedicated tool developed in collaboration with Pact South Africa. The assessment tool focuses on the quality of human resources, management, service provision, and child participation, among other criteria. Each site is ranked from 1 to 4 on 19 criteria, with higher scores representing better performance. In the study analysis, sites were divided into two groups based on their mean performance score for all criteria. The 6 sites with an average score of 2 or lower were considered 'low functioning' and the remaining 7 scoring with averages above 2 were considered 'high functioning.' This classification corresponds to NACCW's own site ranking system, in which sites with a score of 3 or higher are considered to meet most or all of the criteria for a functioning Isibindi project. Table 1 provides a listing of the study sites by classification as high or low functioning, with details on the implementing partner and location.

Table 1. Isibindi study sites in KwaZulu-Natal stratified by high and low functioning

Classification	District	Partner	Municipality	General Area
Low Functioning	Sisonke	Owambeni Masakhane CCC	Ingwe	Owambeni
		St Paul Multi-Purpose Centre	Umzimkhulu	St Paul
	Ugu	Masakhane Creche	Vulamehlo	Vulamehlo
	Umzinyathi	Sinozwelo Drop In Centre 1 ^a	Msinga	Douglas
		Sinozwelo Drop In Centre 2	Mvoti	Kranskop
		Sinozwelo Drop In Centre 3	Msinga	Pomeroy
High Functioning	Sisonke	Khanyiselani Development Trust	Greater Kokstad	Kokstad
	Umzinyathi	Zamimpilo Drop In Centre	Nquthu	Philani
		Sinozwelo Drop In Centre 4	Msinga	Msinga
	Uthukela	Sicelimpilo Drop In Centre	Indaka	Ladysmith
		Zwelisha Well Being Centre	Okhahlamba	Bergville
	Uthungulu	IkhayaIthemba Community Care Centre	Kwambonambi	Kwambonambi
		ThembaIethu Community Based Organisation	Nkandla	Nkandla

^a This CBO oversees four different Isibindi sites

"[New CYCWs] are not highly trained. They might be in comparison with another project, but within the Isibindi project we say they have started a journey of studying."

NACCW Headquarters Staff Member

Key characteristics differentiate the high and low functioning sites. Importantly, all high functioning sites received scores of 3 or higher on each of the individual criteria listed in Box 2. NACCW personnel reiterated that these characteristics are fundamental to a program's success, with particular emphasis on the qualifications of CYCWs. CYCW certification is a two to three year effort that includes 14 training modules completed while the CYCWs continue to serve beneficiary families in their community. Most of the lower functioning sites had training still underway for the majority of CYCWs throughout the time that this study was conducted (2010 – 2012). On the other hand, CYCWs at sites in the high functioning group had all completed the full complement of training modules before or early in the study. CYCWs at high functioning sites also demonstrated greater punctuality and adherence to reporting requirements. Team relationships and management support were stronger at these sites, with evidence of positive and supportive onsite relationships, structured team meetings, effective and accountable delegation of tasks, and ongoing team-building activities. These sites also demonstrated greater independence from NACCW and initiative in addressing beneficiary issues, such as accessing community resources to serve families. They were more likely to engage children actively in the program. Indicators of engagement include the presence of an active children's committee and/or their participation in other community forums, as well as high levels of involvement in supplemental services where children themselves have a voice in determining the activities (e.g., games played at Safe Parks). Finally, high functioning sites evidenced strengths with respect to administration and program monitoring. Sites with poor administration, on the other hand, lacked filing systems and the presence of or adherence to weekly activity plans. Similarly, inaccurate, partially complete, and untimely submission characterized the monitoring and evaluation data among sites that rated low on this indicator; many of these sites also had low scores on indicators reflecting tracking families' needs and their progression towards individual goals.

Box 2. Key Characteristics of High Functioning Sites

- Qualified, certified and registered CYCWs
- Professional work ethic
- Team cohesion
- Team functions independently
- Strong management team
- Child Participation
- Strong administration functioning
- Quality monitoring and evaluation data

Quantitative Data Collection and Study Sample

The study sample was drawn from NACCW-provided lists of newly enrolled beneficiaries at the listed sites in five districts of KwaZulu-Natal (see Table 1). Isibindi eligibility criteria places emphasis on children affected by HIV or AIDS, and principally enrolls families where either the caregiver or child is HIV-positive, the child has been orphaned as a result of AIDS, and/or a child serves as the head of household. CYCWs employ multiple strategies to identify and enroll children who meet these eligibility criteria; they establish relationships with schools, clinics, and churches to support a referral system; perform door to door campaigns; and accept self-referrals. CYCWs assess each potential beneficiary's situation individually in order to confirm his/her eligibility prior to enrollment in the program.

Across the 13 Isibindi sites, a recruitment drive was undertaken between October 2009 and March 2010 in order to increase enrollment among eligible children in these areas. All households on the resulting Isibindi beneficiary list with a child age 10-17 years were considered eligible to participate in the study. In households with more than two age-eligible children, two were randomly selected to take part. The baseline survey was administered to participant children and their primary caregivers (the parent or guardian who accepts primary responsibility for the child's care) between April and June 2010 when the children were age 10-17 years of age. A follow-up survey was administered to the same child beneficiaries and their caregivers following approximately two years of program engagement, between May and June 2012, when the children were aged 12 – 19 years.

Face-to-face interviews were conducted in isiZulu privately with each participant at his or her residence. Follow-up data were collected on 79% of Isibindi beneficiaries who were included at baseline. Baseline respondents were excluded from follow-up data collection for reasons including death, dissolution of households, or respondents moving out of the area. A 20% loss to follow-up was anticipated and built into the baseline sample size to ensure adequate numbers for follow-up analysis. The 79% of baseline respondents interviewed at both survey rounds comprised a total of 388 children, of whom 260 were enrolled at low functioning sites and the remaining 128 were enrolled at the high functioning sites.

Table 2 provides a profile of participants at baseline. In keeping with program eligibility criteria, Isibindi beneficiaries were a highly vulnerable population, though the study did not attempt to conclusively establish whether children’s vulnerability was a direct result of HIV/AIDS. The majority of Isibindi children were considered orphans by UNICEF, UNAIDS and USAID criteria (one or both parents no longer living) with a large percentage of double orphans (63%; see Table 2). Over a third of those enrolled were living with a chronically ill caregiver (i.e., caregiver reported chronic weakness/illness for at least 3 months during the 12 months prior to interview). About three-quarters of children lived in homes with a total household monthly income of 1000 Rand or less. Children were principally cared for by a female, most often their grandmother followed by their mother. Only about a fifth of caregivers were married or living with someone as if married, and approximately a third had never attended school.

While all sites were serving orphans and vulnerable children, children living without a biological parent were more prevalent among beneficiaries at lower functioning sites. Household income was also lower for the beneficiary population in these sites. These differences were controlled for in analyses so that differences observed between the groups on key outcomes do not result from the demographic differences.

Table 2. Demographic and background characteristics of children and their caregivers at recruitment by site type

	All Sites %	High Functioning Sites %	Low Functioning Sites %
Child characteristics	n=388	n=128	n=260
Chronically Ill Caregiver	36	39	31
Orphan Status***			
Maternal Orphan	17	17	17
Paternal Orphan	14	9	24
Double Orphan	63	69	52
Child living without a biological	83	91	69
Child-headed household	2	2	0
At least one of the above***	98	100	94
Monthly household income under 1000 Rand***	77	82	66
Female child	50	51	47
Age			
10-11	20	22	15
12-13	26	25	29
14-15	32	32	34
16-17	22	22	21
Relationship to caregiver***			
Parent	12	8	18
Grandparent/aunt/uncle	76	82	64
Sibling	9	8	12
Other relation	3	2	4
Caregiver characteristics	n = 254	n = 76	n = 178
Mean age	54.5	56.4	50.2
Female caregiver	97	97	97
Married/partnered	21	22	20
No formal education	28	30	24

*** $p < 0.001$ for chi-square and t-tests comparing the two site types

Qualitative Data Collection and Study Sample

In order to contextualize the findings from the surveys and add greater depth, a series of Focus Group Discussions (FGDs) and In-depth Interviews (IDIs) with Isibindi program stakeholders was conducted in March 2013. These qualitative efforts aimed to gather detailed information about the experiences with and opinions of the home visiting and support services available through the program, as well as their perceived impact. The study's qualitative component involved data collection with beneficiary caregivers, CYCWs, and onsite and headquarters staff. Separate FGDs were conducted with beneficiary caregivers and CYCWs, a total of 11 FGDs occurred.

The FGDs and IDIs were conducted at sites located in Bergville-Zwelisha, Kokstad-Khanyiselani, Pomeroy-Sinozwelo, and Umzinto-Vulamehlo. The sites were selected in consultation with NACCW Head Office staff, with the goal of including both high and low functioning sites. At each site, at least one FGD with caregivers and one FGD with CYCWs were conducted. IDIs were also completed with key staff at these sites, including mentors, supervisors, and team leaders. The table below summarizes the FGDs and IDI data collection by site. Following preliminary analyses of both the qualitative and quantitative data, an additional semi-formal FGD was conducted among NACCW head office staff to enable the research team to seek additional clarification regarding some of the patterns and trends emerging from the data.

Table 3. Total number of focus group discussions and in-depth interviews conducted at each site

SITE/ DISTRICT	NO. OF FGDs	NO. OF IDIs
UTHUKELA DISTRICT Bergville/ Zwelisha	1 FGD with CYCW 1 FGD with Caregivers	1 IDI with Team Leader 1 IDI with Supervisor 1 IDI with Mentor
UGU DISTRICT Umzinto/ Vulamehlo	1 FGD with CYCW 3 FGDs with Caregivers	1 IDI with Team Leader 1 IDI with Supervisor
SISONKE DISTRICT Kokstad/ Khanyiselani	2 FGDs with CYCW 1 FGD with Caregivers	1 IDI with Team Leader 1 IDI with Supervisor
UMZINYATHI DISTRICT Pomeroy/ Sinozwelo	1 FGD with CYCW 1 FGD with Caregivers	1 IDI with Team leader 1 IDI with Supervisor
TOTAL	5 FGDs with CYCW 6 FGDs with Caregivers 11 Total FGDs	9 IDIs

FGD and IDI data collection commenced on 14th March 2013 and ended on 26th March 2013. All FGDs and IDIs were audio-recorded using high-definition Olympus digital recorders. Semi-structured FGD guides were initially developed in English and translated into isiZulu for use onsite as required. While the FGD with headquarter staff was conducted in English, all the other FGDs were conducted in participants' native language (isiZulu). Qualitative data collection at Isibindi sites was undertaken by trained facilitators, while the FGD with Headquarter staff was conducted by a senior member of the research team. Audio-files were transcribed in the original language and isiZulu transcripts were translated into English by two independent translators. As a final step, any substantive differences between translations were reconciled in order to produce a final translated version.

Outcome Measures and Analyses

The quantitative surveys focused primarily on the experiences and wellbeing of beneficiary children, but also included household and caregiver-level variables. Outcome variables selected for inclusion were chosen based on priorities identified by NACCW and other implementing partners participating in the broader evaluation. At the outset of this study, program staff members were asked to identify the primary outcomes on which they theorized their program to have the greatest impact. NACCW staff hypothesized that Isibindi programming would influence education, physical health, economic security, psychological health and child protection indicators. Box 3 summarizes the key expected outcomes examined in this study, developed following this initial consultation with NACCW. Analyses of these outcome measures were performed to examine relative change over time between the high and low functioning Isibindi sites on these key outcomes. Respondent's reports regarding children's and caregivers' interactions with the CYCW who visited their home are also detailed. While home visiting is not the only element of the Isibindi project, the study focused primarily on home visits, and thus allowed for minimal reflection regarding child/CYCW contact outside of the home.

Comparisons of child-level outcomes, including both service exposure and program impact, were limited to children with survey data at both rounds. For a sub-set of respondents, the primary caregiver changed between survey rounds. Such cases where there were two records of caregiver data, the observations were included in the analyses of service exposure, despite the lack of caregiver continuity. When examining change in caregiver-level outcomes over time, however, analyses were limited to data from caregivers interviewed during both survey rounds. Many of these outcomes were scales, and Cronbach's coefficient alpha was employed across the full baseline sample to estimate the internal consistency (reliability) of the scales. An alpha of 0.60 or higher was considered acceptable for use in this study. Basic bivariate statistical tests (i.e., t-tests and chi-square tests) were used to test the statistical significance of differences at the two points in time between children and caregivers enrolled in low and high functioning sites' programming; we similarly tested whether exposure to and the quality of home visiting services varied by site classification. More advanced regression models were used to test for the effects of site functioning on children's wellbeing. These included variables representing site type (high functioning versus low functioning), time (baseline or follow-up), and interaction between site type and time. The interaction term captures the relative impact, or additional benefit, of being enrolled in a higher functioning site compared to a lower-

functioning site. The models also adjusted for characteristics of the participants that might differ between low and high functioning sites, and that could otherwise obscure the effect of site functioning level. These factors included the child's age, gender, orphan status and relationship to the caregiver; the caregiver's age, gender, marital status and education; and the presence of a chronically ill member in the household, dependency ratio, income category, and type of community. For child level outcomes, select gender-specific analyses were conducted to examine impact separately for boys and girls. Analyses are based on an intent-to-treat approach; that is, children are analysed based on their enrolment in a given site, regardless of whether they reported receiving program services from that site. Given the small sample size and to discern trends in potential differences between the two site types, "borderline significant" probability values (p) between .10 and .05 are highlighted in the text, although probability values of less than .05 are indicative of a statistically significant difference. Adjusted Odds Ratios (AOR) for categorical outcomes (e.g, yes/no) and Adjusted Risk Differences (ARD) for continuous outcomes (e.g., means) are provided and display the increased likelihood for the outcome among high functioning sites after controlling for the above characteristics. The quantitative analyses were enhanced with thematic content analysis from the qualitative data, and primary themes emerging from the data are presented.

Box 3. The Isibindi Program Expected Results

Education

- School Enrollment
- Better school performance

Physical health

- Improved physical health
- Increased access to needed health services
- Increased HIV knowledge

Economic Security

- Has needed documents
- Access to grants
- Improved food security
- Child has basic material needs
- Improved household money management

Psychological health

- Reduced conduct & emotional problems
- Improved sense of self worth

Child Protection

- Increased positive adult support
- Better household family relations
- Reduced child maltreatment

Frequency and Duration of Home Visits

Almost three-quarters of all Isibindi interviewees answered affirmatively when asked: “Community service organizations often engage community members who visit your home, sometimes known as caregivers, child care workers and/or aunties. You might also just know them by their first name. I refer to these people as Care Workers. Have you ever had a Care Worker visit your home?” Similar percentages of Isibindi caregivers (73%) and children (74%) reported having been visited by a CYCW (with 85% agreement of affirmative reports of ever having been visited between child and caregivers). Visit occurrence in the 12 months preceding the survey was lower: 61% of caregivers and children at Isibindi program sites reported that a CYCW visited their home in the last year. As seen in Figure 1, high functioning sites had a greater percentage of caregivers who reported ever being visited and visited in the 12 months preceding the survey, but the difference was non-significant (borderline significant, $p < .10$, for the last 12 months). Among those who were visited within the last year, about 63% of caregivers overall reported they were visited at least twice a month (see Table 4).

Figure 1. Caregiver reported visit occurrence by site type

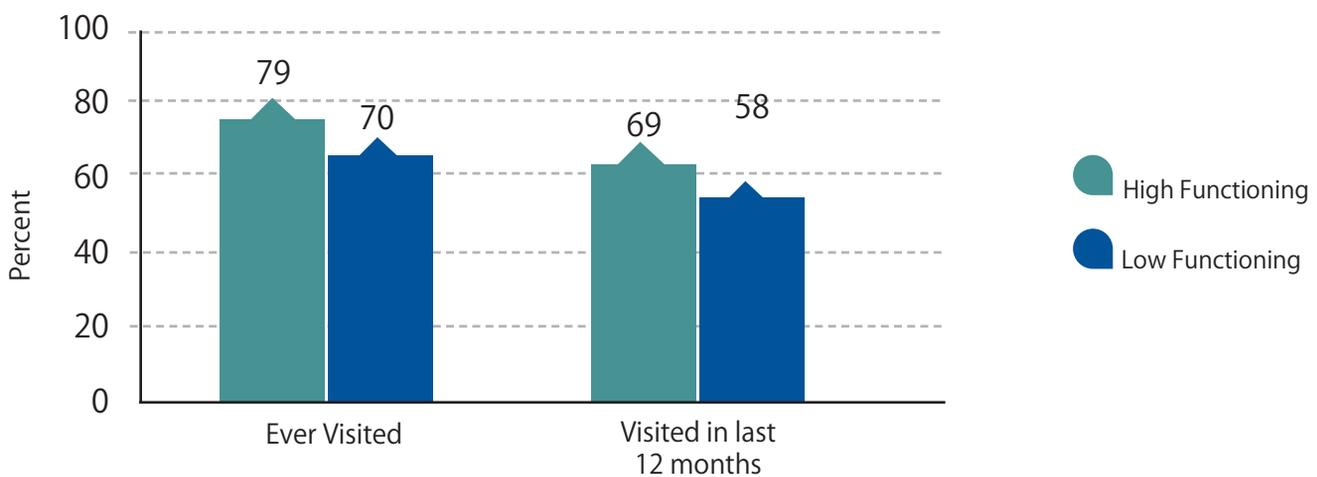


Table 4. Frequency and duration of home visits reported by caregivers served in the past year by site type

	All Sites n=177 %	High Functioning Sites n=114 %	Low Functioning Sites n=63 %
Frequency of visits*			
at least once a week	37	43	25
once every two weeks	26	24	30
about once a month	30	29	32
less than once a month	7	4	13

* $p < 0.05$ for chi square tests comparing the two site types.

NACCW headquarter staff were surprised by the lower than expected reported home visits, stressing that all households should have been visited at least initially since the children would otherwise not have been enrolled/registered with the program. It is possible that the reported level of home visits from the survey data may be subject to recall bias, as respondents may not remember the home visit or may not have associated the above generalized question with Isibindi CYCWs specifically. For instance, they may consider the CYCW a close friend and not a CYCW. Alternatively, while home visits may have occurred initially for purposes of enrollment, their frequency may not have been sustained to a sufficient degree for participants to recall the events or consider themselves to have been visited. It is also possible that some children included on the beneficiary lists at baseline had, before follow-up, graduated from programming due to their ages and/or goals had been achieved. While it is difficult to estimate how common this situation may have been, lapses in home visiting could have been in part explained by legitimate factors.

Discussions with program personnel, however, did highlight a number of issues that may affect visit frequency. Some interviewees explained that there are the occasional CYCWs who do not adhere to the guidelines specified within their work agreements. Yet, most participants commented that CYCWs do their best to maintain their care worker responsibilities, though they emphasized that doing so was challenging given personal financial constraints and contending pressures. In focus groups, CYCWs also discussed the difficulties inherent in reaching their assigned households with the desired frequency in rural and impoverished communities. They spoke about how the cost of transport and the need to walk long distances to reach beneficiaries can affect how often visits are conducted. Many CYCWs also mentioned the ongoing challenge

"I wish they could increase the stipend and transport money. We struggle because the houses are far apart. It is difficult when a family really needs you and you do not have money for transport and airtime."

Child and Youth Care Worker

"It is bad because you end up not having time for yourself and your family when you are burdened with other people's problems."

Child and Youth Care Worker

of completing their numerous job responsibilities with the limited stipend of 1000 Rand a month and low transport reimbursement, citing transport hire costs and the need to find other income sources as a hindrance to their work. Dual responsibilities—such as serving as a supervisory Safe Park attendant—in addition to conducting regular home visits were also suggested as a potential obstacle to optimum visit frequency. Competing needs of the beneficiaries and their own families was another issue that may affect home visits, as many CYCWs and other program personnel stressed during qualitative data collection that their work markedly reduced the time and energy they had available to devote to the care of their own families. Finally, CYCWs and project personnel also spoke about the temptation not to visit beneficiary families whose problems were still unresolved. For instance, CYCWs found it difficult to face a family if their grant applications were still pending. On the other hand, in interviews and discussions CYCWs also highlighted how some families may reject and discourage their continued support, particularly after the family acquired grants and no longer felt that home visits served a useful purpose..

NACCW headquarters staff further suggested that visits were scheduled based on urgency, and may be less frequent following a family's early engagement with the program. These interviewees reported that home visits were typically purpose-driven, and not simply conducted as part of a schedule unrelated to specific needs. Even as logistical and resource challenges may have limited the frequency of home visits, qualitative data participants indicated that children were receiving priority programming tailored to their needs, including many services provided on-site at schools, formal and informal Safe Parks and other places. They described how work on behalf of children often extends beyond home visiting, citing examples of visits to schools to meet with children and their teachers and the formation of study groups at this location. They further emphasized that some children's primary interaction with the CYCW may occur at informal and formal Safe Parks.

"There are several ways of working with children that require less intensive home visits. The project includes specified structured programs that are managed by CYCWs to attend to needs of children."

NACCW Project Personnel

Six sites involved in this study had a formal Safe Park—a designated, fenced location usually with some outdoor playground equipment and a container or building for indoor activities. Many sites with formal Safe Parks, and all of the remaining sites, operated informal Safe Parks—unfenced public spaces or indoor activities that take place at the homes of CYCWs. Children were asked about their attendance at Safe Parks described as: “In some communities there is a place where kids can go after school or on holidays; sometimes this is referred to as an after school center, a safe park or even just the offices or name of the community organization that supports these activities.” Only 26% of all Isibindi children reported attending such a place; attendance was significantly higher in communities that had a formal versus informal Safe Park (35 versus 21%, $p = .005$). While it is possible that extra support was provided to attendees, the potential added benefit of Safe Park engagement was not explored in this analysis due to both relatively low reports of access and the study’s primary focus on home visiting.

Support Provided during Home Visits

CYCWs spent significant time at beneficiary households when they visited. Half of caregivers who reported having a visit in the last year indicated that CYCWs typically stayed more than an hour, and another 46% indicated that the visit lasted between 30 minutes and one hour. Only 4% of these respondents reported that CYCW visits commonly lasted less than 30 minutes. There was no significant difference in the duration of visits by type of site. During visits, CYCWs reportedly offered a range of support services, often based on the individual needs of beneficiary families.

“They asked me how I provided for the children I stay with and I told them that we only eat what we have and share as a family. They were concerned, they told me they will go seek help at social workers and promised us that something might come. While they were still busy with that they got food for my family. They brought us food just before Christmas. Then they registered the child for a grant. These people are very helpful and thanks to Isibindi.”

Caregiver

CYCWs described how a plan of action for each family is derived during the first few visits. Early contact with families includes a process of family engagement where the CYCWs obtain detailed information about the family’s circumstances and they collaboratively develop an action plan. Children also contribute to the plan and are central to this initial engagement process. Soon after the plan is drafted, supervisors visit the household to gather more information and offer additional insights on the plan of action for the household. Initial family engagement was noted to be a critical stage for building trust and positive relationships with all household members, caregivers and children alike. This process also informs the type of support that the CYCW will offer the household.

During home visits, we expected CYCWs to provide support in three main ways. First, they may provide tangible support, such as food, school materials, assistance completing applications, or other aid that directly helps the recipient. Tangible support may also include assistance with household related tasks and schoolwork, mentioned often during qualitative data collection. Second, CYCWs may provide information that helps the recipient engage in personal problem-solving, such as advice on money management or education about HIV. CYCWs may also provide emotional support by building relationships with the caregiver and child and validating their feelings. For many children especially, the experience of having their feelings validated may be new and powerful and contribute to self-esteem. The following presents reports of supportive services in each of these three areas.

Tangible Assistance: Study participants who answered yes when asked if a care worker had ever visited their home were also asked what types of support they had received from care workers or others affiliated with the community based organization (see Table 5). The most common form of support was a food parcel: almost half of the caregivers who received a home visit in the past year reported receiving a food parcel (49%). For those exposed to any home visiting (i.e., answered ‘yes’ to the question on whether a care worker had ever visited their home), this was followed by help applying for a pension or grant (30%), help with school expenses (school fees, uniforms, or materials; 19%), and help obtaining needed legal documents (19%). A clear pattern emerged: beneficiaries at higher functioning sites received more support. Caregivers at these sites were more likely to report receiving a food parcel, help with obtaining documents, and assistance with school expenses. There was no difference between site types regarding help applying for a pension or grant.

“We did not have money to pay for children at school but the care workers helped us, they went to school and spoke with teachers. Now children are at school. The children would go to school hungry but they brought food.”

Caregiver

Table 5. Type of tangible assistance provided by the CYCW or anyone from the affiliated community based organization by site type

Service Provided	All Sites n=211 %	High Functioning Sites n = 72 %	Low Functioning Sites n = 139 %
Help obtaining documents*	19	26	15
Help applying for a pension or grant	30	32	29
Provision of food parcel in past year***	49	67	39
Help with school expenses***	19	32	13

* $p < 0.05$, *** $p < 0.001$ for chi-square test comparing the two site types

Note: The sample size for the food parcel question is 177, as it was asked among only those served in past year

“When they get here they do my child’s laundry, wash my dishes and do my laundry because I am sick. Then they would wait until the children get back from school, meanwhile she would be cooking for me. Afterwards they would teach the child how to do laundry and teach the child how to do many other things. Really they do teach them.”

Caregiver

“We do household duties with the children because our aim is to help them. We do not do things for them, but we help and show them how.”

Project Personnel

Another type of tangible support offered by CYCWs includes help with household management. In focus groups, caregivers repeatedly mentioned the practical support that CYCWs provided with daily activities in the home, particularly for those caregivers who were ill or elderly. Caregivers who were chronically sick or suffering from disabilities (e.g., arthritis, diabetes, bad knees) described CYCWs providing an array of assistance with domestic chores, such as washing dishes, doing laundry and pulling weeds. They also described how CYCWs helped prepare children on school days by, for example, cooking porridge, bathing very young children, ironing uniforms, and polishing school shoes. CYCWs often provided this assistance alongside beneficiary children, during which time the children were learning to do these chores themselves. Moreover, caregivers and CYCWs indicated that CYCW often help devise a chore list for household members, delegating daily homecare activities to different children and monitoring their completion. This activity was

described as also helping to minimize arguments in the home as well as providing a welcomed level of structure for the management of daily activities. CYCWs also prepared meals alongside children and caregivers, while helping them to design a menu of scheduled meals that took both nutritional needs and available funds into account. Through the development of timetables and rosters, they provided support to families with issues such as time management (e.g. when to play, do house chores and collect water, etc.), and assisted in building family relationships through division of labour and identifying shared responsibilities.

CYCWs also spent much of their afternoon visits working with the children on their homework and literacy skills. Caregivers repeatedly praised this assistance, and some indicated it was particularly valuable given they were unable to offer such support due to their own educational deficiencies. They noted how the CYCWs read to children, asked children to show them their school work and provided direct assistance with these academic tasks.

“The CYCW will teach the child or guide him with his school work and encourage him to work hard at school. They also advise the child to ask if he does not understand in order for him to pass at school.”

Caregiver

CYCWs explained that the practical assistance with schoolwork and chores not only provided general day to day support, but also served as an opportunity for “life space counselling,” where they held in-depth discussions with the children and caregivers. In these discussions, which capitalize on everyday opportunities to develop trust through shared experience, the CYCWs are able to impart skills and education on a variety of topics as well as uncover and try to address issues facing the children and other family members. The topics discussed with CYCWs are reported in the next section.

“We build a strong relationship so that they can tell us everything that is troubling them in their heart.”

Child and Youth Care Worker

Informational and Emotional Support: For those Isibindi beneficiaries exposed to any home visiting, caregivers and children were asked about emotional and informational support provided; this was expected to be reflected in the discussions that take place during home visits. A total of 84% of children reported that the

CYCW spoke to them during some or all of the home visits. Among these children, their plans for their future was the most common topic reported, with 86% of children noting discussion on this matter. CYCWs mentioned how conversations with children about their future were often delivered in the context of promoting education, as well as generally instilling hope for a better life. Caregivers reiterated this point, describing how CYCWs encouraged the children to do well at school and discussed the value of education for their futures.

Nearly three-quarters of children also mentioned discussing their feelings or emotions with the CYCW who visited their home, and CYCWs described these discussions as an opportunity for the child to overcome their grief and mitigate stress. About half of the children also reported discussing issues pertaining to family conflicts with the CYCW.

Nearly three quarters of children talked with the CYCW concerning their physical health and reducing HIV risk. Sixty-nine percent of these children also reportedly discussed care for the sick with their CYCWs. Overall, children reported discussing an average of four of the topics listed in Table 6 some or all of the time.

Table 6. Topics discussed with the CYCW as reported by caregivers and children across all Isibindi sites

	Caregivers n=177 %	Children n = 221 %
Plans for the future	55	86
Physical health	62	77
Reducing HIV risk	68	72
Feelings or emotions	58	74
Caring for the sick	67	69
Family conflicts	52	56
Communicating with children	77	--
Managing money	53	--
Grant application	50	--

-- These questions were not asked of children.

Discussions with caregivers also included the listed topics, though future plans, feelings or emotions and physical health were discussed slightly less with caregivers compared to children (see Table 6). CYCWs also spoke with caregivers about other important topics; most commonly, how to communicate effectively with children. About half of caregivers also reported discussing money management and grant applications with the CYCW. Overall, caregivers reported discussing 5 topics on average, some or all of the time.

CYCWs at high functioning sites were significantly more likely than those at low functioning sites to spend time talking with the child during home visits (90% vs. 80%, $p < 0.05$). There was a borderline significant trend ($p = 0.10$) for a greater likelihood of caregivers and children in high functioning sites to report discussing family conflicts with the CYCW; but no other differences on any particular topic or on the overall mean number of topics discussed were evident between the two site types.

Education

School is important to children’s wellbeing because it lends access to not just education, but also additional services and the means to create a better future for themselves. As highlighted above, CYCWs help to support the children’s schooling in a number of ways, including facilitating access to financial assistance, fee waivers and school materials. They also provide direct support with homework and ongoing encouragement. This section examines education-related outcomes; namely, school enrolment and performance.

“Ever since the Isibindi care workers started visiting I got a lot of help, he is making an effort to go to school even though he never wanted to go to school.”

Caregiver

School Enrolment: School enrolment was already quite high at baseline: 99% among Isibindi child beneficiaries. While it dipped slightly at follow-up to 94%, this decline was not statistically significant, once we controlled for age. School enrolment also did not vary between children enrolled at high and low functioning sites. Notably, the survey did not include questions to measure school attendance, which has substantial potential to be positively influenced by the work of CYCWs.

School Performance: Caregivers in the survey were asked a set of questions concerning children’s engagement in school. Respondents reported whether each of six behaviors reflecting interest and performance in school was usually true, sometimes true, or never true of the child (see Table 7). Results were scored as

“We like it because, some of our kids could not read and write but now everything has changed.”

Caregiver

0, 1, or 2 and totals calculated for the question set; mean totals were derived at both time points for Isibindi sites overall and for high and low functioning sites separately, with higher scores indicating better engagement. The overall mean did not vary over time at Isibindi sites. However, there was a slight decline in the average score for low functioning sites (10.25 to 9.76) whereas there was a rise in caregiver reported school performance among respondents in high functioning sites (9.75 to 10.06); this difference was borderline significant (AOR 0.71, $p = .058$). Importantly, school engagement was high overall at both survey rounds, with the majority of caregivers endorsing the statements presented in Table 7 as “usually or sometimes true” of the child.

“The CYCW helping them to study made a huge difference. My child passed her grade 12 and she got good marks. She told the child that education is the most important thing in life, if she wants a better future and to get herself out of the situation that she is in now. She said when you are educated it does not matter that you are an orphan or what, you will be able to get a job and make a good living for yourself. That really encouraged her to study hard.”

Caregiver

Table 7. School engagement as reported by caregivers at both survey rounds by site type

% reporting “Usually True” for the child:	All Sites		High Functioning Sites		Low Functioning Sites	
	Baseline	Follow-up	Baseline	Follow-up	Baseline	Follow-up
Interested in school work	89	83	92	85	88	82
Get good grades in school	74	67	72	71	75	65
Does not like to miss school	75	66	66	53	78	71
Performs well in school	78	73	75	77	80	72
Completes his/her homework on time	77	75	80	81	75	72
Works well on school work without adult support	63	65	62	68	64	64

As discussed in the previous section, home visits often included CYCWs assisting children with homework and encouraging them to do well in school. Caregivers who participated in focus groups described the emphasis they placed on school attendance and classroom performance as critically important. They highlighted how the CYCW would routinely check that children’s homework was complete and often work with them directly on this activity. They were pleased with the encouragement CYCWs gave children to work hard in school and create a better future for themselves. Many caregivers attributed the support of CYCWs to improved school performance among children, and NACCW staff members did the same.

“The teachers are saying they are seeing a huge change in the Isibindi children. Grannies are saying we are seeing a difference. We are seeing it in the school results.”

NACCW Headquarters Staff Member

Physical Health

Improving physical health among caregivers and children is an important component of programs. Access to healthcare and related services is of critical significance, particularly given that so many caregivers are living with chronic illness. Baseline research demonstrated the particular vulnerability of children with chronically ill caregivers. Ensuring effective HIV prevention is also imperative, especially given the elevated risk for infection among orphaned and otherwise vulnerable children. Both physical health and HIV and AIDS were given as common discussion points by CYCWs, and related outcomes are discussed below.

Physical Health and Access to Health Services: Self-rated health scores ranged from 1-5, with higher values indicating worse health. As seen in Table 8, children’s health was reported as consistently “good” across the study period, although children at the higher functioning sites showed significantly greater improvement in reported physical health than those at low functioning sites (AOR -.023, $p = 0.045$). Reported unmet need for health services (any health services that study participants currently needed and were not receiving) for Isibindi children overall remained fairly stable and was a concern for less than a fifth of the population.

The frailty of caregivers, however, is clearly reflected by self-reports of “poor” or “very poor” health in a third of the sample, half of whom (51%) also reported having a chronic illness. There was no difference between the high and low functioning sites on reported changes in the health status of caregivers over the study period. Across all Isibindi sites, caregivers had greater unmet need for health services over time (AOR 3.00, $p < 0.001$), with as many as half of all caregivers noting this need at follow-up. Unmet need for health services was actually higher among Isibindi caregiver beneficiaries in relation to the comparison group (see Appendix A), which may be indicative of greater awareness of health needs among Isibindi beneficiaries resulting from the education CYCWs provide. However, access to health services may be hindered by transport issues, registration and user fees at facilities, long waiting times and limited availability of quality health services. Thus, while discussions between CYCWs and caregivers about health care during home visits may have resulted in caregivers’ greater awareness of health needs over time, the ability to meet these needs ultimately depends on the availability, accessibility and acceptability of services in the community. Importantly, the rise in unmet need was greater for low functioning sites (AOR 2.27, $p = 0.063$), which suggests that perhaps CYCWs in these sites are less able to link caregivers with needed health services—either as a result of limited availability or lack of skills in facilitating access.

“When there is someone who is sick in the family we educate them about the importance of going to the clinic and taking their medication.”

Child and Youth Care Worker

“I went to a house where a little girl who was just a year old was living with her grandmother and they were both sick. I told my supervisor who then called the team leader and an ambulance was called and they were rushed to hospital.”

Child and Youth Care Worker

Caregivers who participated in focus groups commented on their own ill health and indicated that the CYCWs spent time assisting them with day-to-day tasks as a result. CYCWs described trying to address health through education, including reminding caregivers to take needed medications and encouraging them to seek clinic services rather than relying solely on traditional healers. CYCWs only described linking caregivers to health services within the context of the occasional procurement of emergency care, for which they relied on assistance from senior personnel in the organization. Given the poor health of caregivers and reported high need for services, investment in additional strategies may be necessary to facilitate health service access.

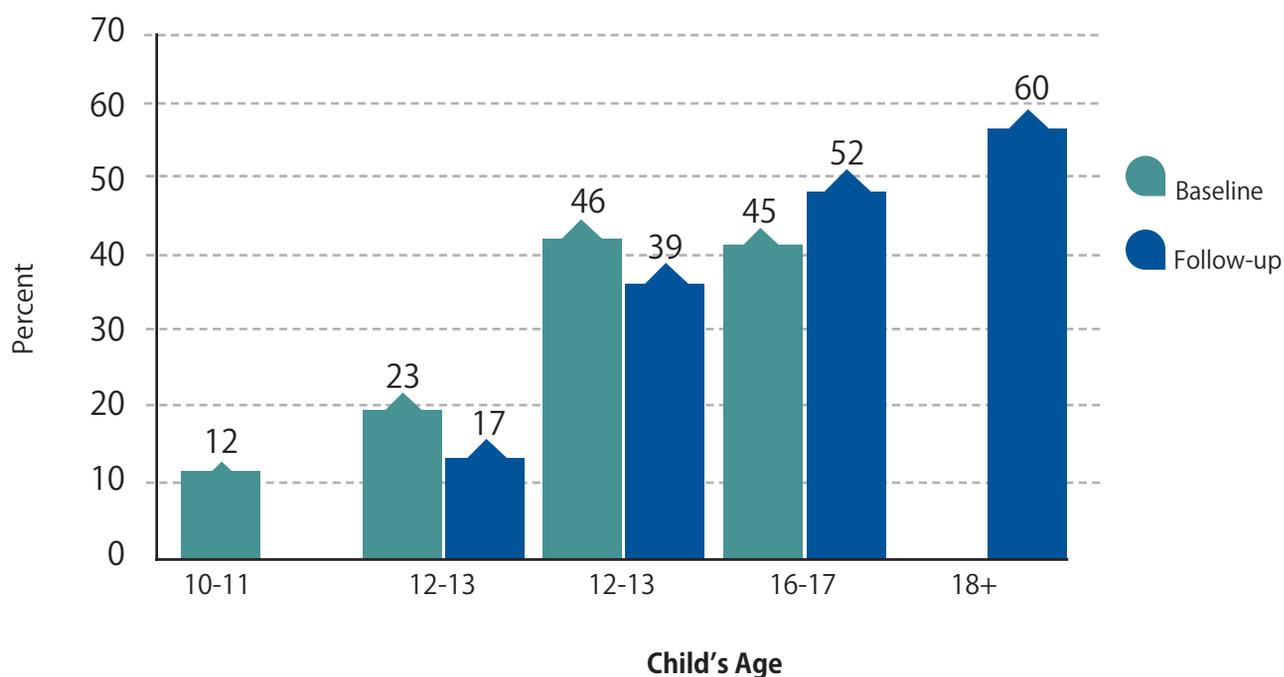
Table 8. Physical health measures at both survey rounds by site type

	All Sites		High Functioning Sites		Low Functioning Sites	
	Baseline	Follow-up	Baseline	Follow-up	Baseline	Follow-up
Access to Health Services						
Child Unmet Need	15	18	10	19	17	18
Caregiver Unmet Need*	34	50	34	42	34	53
Physical Health						
Child reported health*						
Good or Very Good	82	78	86	78	80	77
Neither Good nor Poor	16	20	12	21	17	20
Poor or Very Poor	2	2	2	2	3	3
Caregiver reported health						
Good or Very Good	31	24	33	26	31	23
Neither Good nor Poor	36	43	43	40	33	45
Poor or Very Poor	33	33	24	34	36	32
HIV Knowledge						
Child has basic knowledge*	33	42	31	48	34	40

* $p < .05$, for test comparing the two site types

HIV Knowledge and Sexual Behavior: Children were asked a series of questions adapted from the South African Demographic and Health Surveys (DHS) regarding whether they had heard of HIV or AIDS, whether there is anything that can be done to avoid being infected with HIV, and whether common myths about HIV transmission were true or false. Respondents who had heard of HIV, believed that prevention was possible, and rejected myths about transmission were counted as being knowledgeable about HIV. Overall, the prevalence of accurate HIV knowledge rose from 33% to 42%. This observed difference, however, was found in analysis to be wholly due to the population having aged two years between survey rounds. HIV knowledge was similarly common at baseline and follow-up for Isibindi children grouped by age in years (See Figure 2). Children in high functioning sites were two and a half times more likely to have gained accurate knowledge by follow-up than those in low functioning sites, adjusting for age (AOR 2.50; $p=0.026$, see Table 8). While greater improvements among children within high functioning sites were apparent, it is notable that 52% were not counted as knowledgeable. As Figure 2 shows, while knowledge increased with age, significant gaps in knowledge remained even among the oldest children; for instance, only 60% of those age 18 or older had accurate HIV knowledge.

Figure 2. Basic HIV knowledge by age among all Isibindi child beneficiaries at both survey rounds



At first glance, the gaps in HIV and AIDS knowledge seem inconsistent with the commonality of this as a discussion topic during home visits: 72% of children reported talking about HIV with a CYCW (see Table 6). This may suggest that there are gaps in CYCW knowledge or that casual discussions are not an effective way to produce lasting changes in core HIV knowledge about transmission and prevention among children. Indeed, in-depth training concerning HIV and AIDS is a supplementary module for CYCWs, and thus many of them may not complete it. Helping children to acquire accurate HIV knowledge according to international standards likely requires structured intervention with content designed around specific objectives.

Focus group data did suggest that CYCWs' discussions with children included guidance on sexual behavior. Caregivers in focus groups relayed how CYCWs advised adolescents to delay sexual activity and to use condoms in the event they decide to have sex. Caregivers mentioned how girls were taught 'self-respect' and that CYCWs held private talks with the adolescents to speak with them about the risks involved with sexual activity and encourage them to wait. At the same time, they also advised caregivers about the importance of risk reduction measures for adolescents who were sexually active. However, the effect of these discussions was not apparent in the quantitative results. The proportion of adolescents that were sexually experienced rose over the course of the study from 6% to 22%, but this was likely due to aging and did not differ from results in the original comparison group (see Appendix A). Condom use among sexually active youth enrolled in the Isibindi program (n = 83 at follow-up) was not universal: only 61% reported using a condom at last sex in the follow-up survey. There was no

"I am taking care of a girl child who is an adolescent and she wanted to start dating. I spoke to this lady from Isibindi care workers, and asked her what I should do because she wants boyfriends now. We agreed that it's better if she starts family planning than for her to drop out of school."

Caregiver

"We have reports that say that the children were given information on HIV/AIDS. Many of these children were part of the Adolescent Development Programmes that taught them about HIV/AIDS and in the individual interactions with Care Workers they learnt these things."

NACCW Headquarters Staff Member

difference by site type on either of these indicators. Thus, while CYCWs may provide advice on HIV knowledge and sexual behavior, as reported by children and caregivers, these efforts appear not to be translating into measurably greater knowledge or preventive behavior among beneficiaries. There remains a need for increased attention to HIV education and risk reduction among Isibindi beneficiaries. NACCW recognizes this need and began the roll-out of an Adolescent Development Program in KwaZulu-Natal that includes structured curriculum concerning HIV and AIDS and sexual risk behaviors; however, access to this program was limited among this population at the time this study occurred.

Economic Security

Families affected by HIV and AIDS, both those with an ill household member and those who absorb children who have been orphaned, face serious economic challenges. Isibindi makes a concerted effort to improve the economic situation of the families they serve by helping them to gather needed legal documents and access government social protection grants. Through grant receipt and supplemental efforts on the part of CYCWs, families gain greater access to material resources and greater food security. These indicators of economic wellbeing are discussed below.

"You would get to a family that is not receiving grants and children do not have birth certificates. When you do your investigations, you would find that when their parents died they were not taken to mortuary but buried immediately. In such a case we have to go to the chief/king in that area to request for a letter that proves that those who passed on were part of that community. We then take the letter to home affairs to obtain death certificates."

Child and Youth Care Worker

Document Acquisition: For all orphans, caregivers were asked if they had a death certificate for each parent who had passed away, a critical piece of documentation for grant acquisition. The number of caregivers who reported having such documentation went up slightly over time across the full sample (64 to 69%), with greater change over time in the proportion of children with documentation in high (60 to 70%) versus low functioning sites (65 to 68%) (AOR 2.84, $p=0.07$). This result corresponds with prior data on tangible assistance reported by caregivers, as a greater number of caregivers within high functioning sites also reported that CYCWs helped them to obtain needed documents (see Table 5). CYCWs described how procuring such documents often require considerable effort, such as obtaining affidavits from local authorities in instances where proof of death is lacking. Thus, findings suggest that CYCWs in higher functioning sites may be more resourceful in helping to meet beneficiary needs.

Grant Access: Grant access increased significantly over the study period and CYCWs in both types of sites were equally successful at helping families to access these resources. As Figure 3 illustrates, 77% of children in Isibindi-supported programs were receiving a grant (Child Support Grant or Foster Care Grant) at follow-up compared to just 59% at baseline. There was a large increase in access to the Foster Care Grant (FCG) in particular; FCGs have the highest monetary value but are also the most cumbersome to apply for given the extra documentation required (i.e., death certificates, legal recognition of the foster parent, a social worker to conduct an investigation and appear at court). Importantly, this is an area where Isibindi demonstrated strengths relative to the comparison group, as CYCWs were found to have significantly higher potential to link families to this substantial resource (see Appendix A).

"We are a poor family. When they started visiting our house they asked why the children were not receiving social grants from the government and I told them the problem was that the children do not have birth certificates. They helped us because they are connected to social workers, and they fixed the birth certificate problem and now the children are receiving grants."

Caregiver

"We have a good relationship with SASSA [South African Social Security Agency] and the child support grant only takes a week."

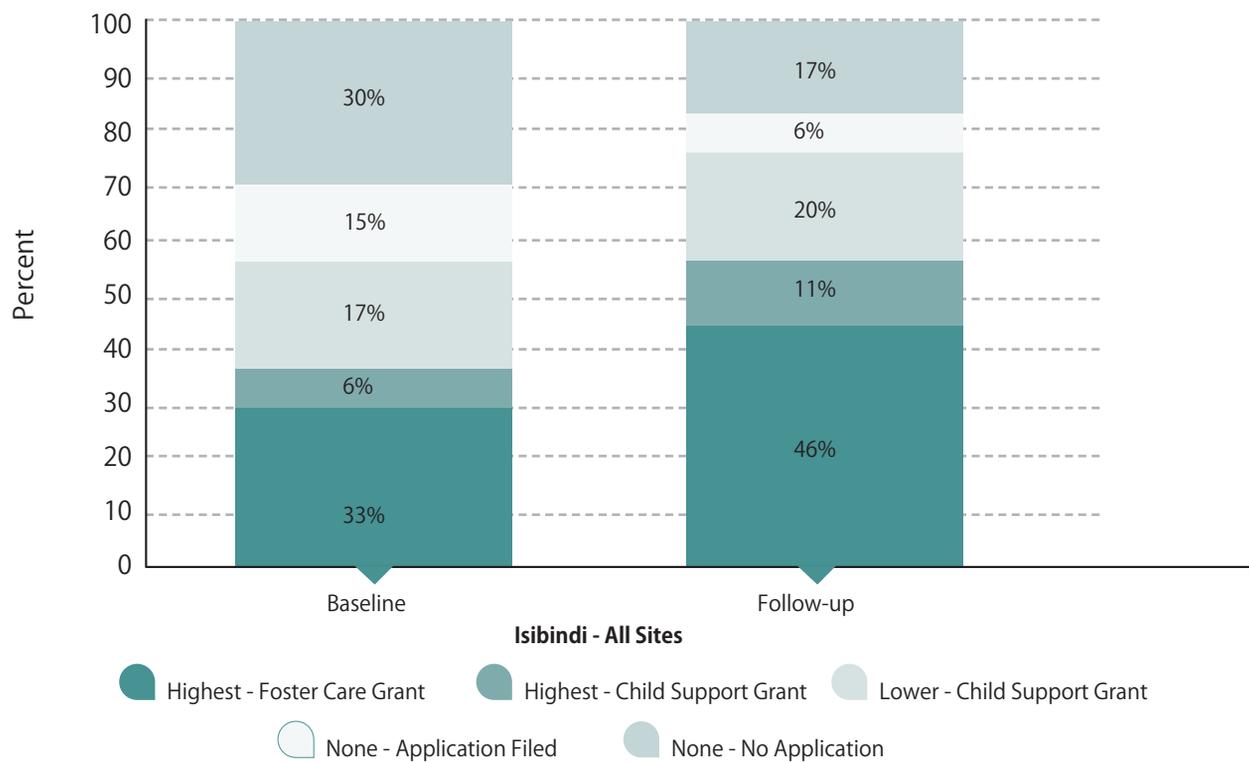
NACCW Headquarters Staff Member

Access to grants was a common type of assistance highlighted within the focus group discussions. As noted above, CYCWs described going to great lengths to help families obtain the necessary documentation. They also often accompany caregivers to government departments where they act as intermediaries and may speak on their behalf to facilitate the process of applying to become a foster parent. CYCWs discussed the importance of not just submitting applications but conducting on-going follow-up with the Department of Social Development. CYCWs commented on the challenges they faced working with the Department of Social Development, noting the sense that their work was not always respected by government social workers and that they faced bureaucratic resistance often while working to connect families to grants and other resources. NACCW headquarters staff, on the other hand, acknowledged the difficulty inherent in these processes but also felt that facilitating grant access was a consistent priority in service delivery, and often accomplished.

Overall, Isibindi beneficiaries had much greater access to grants over time, although nearly one-fifth of the study population lacked access to any grant at follow-up and another fifth were eligible for a grant with a higher monetary value than the one they were receiving (see Figure 3). Promoting 100% coverage among beneficiaries could involve additional approaches such as formalizing annual eligibility assessments for beneficiaries, offering continuing education for CYCWs to keep them abreast of changes in the grant system and further efforts to foster linkages between South African Social Security Agency, DSD and CYCWs.

Figure 3. Grant status among all eligible children at both survey rounds

(Note: bars do not add to 100% due to rounding)



Food Security: Food insecurity, measured using the Household Food Insecurity Access Scale was prevalent at baseline and stayed high over time. At baseline, 77% of households served by Isibindi were moderately or severely food insecure; this dropped to 71% by the end of the study period, a statistically insignificant change. Likewise, there was no measurable difference in household food security between high and low functioning Isibindi sites. CYCWs described encouraging families to grow food gardens, although the prevalence or productivity of such resources was not established in the study. In spite of the possibility of such gardens, the common distribution of food parcels (see Table 5) and higher obtainment of grants (see Figure 3), food insecurity remained high. Increasing the availability of food gardens with attention to ensuring their fruitfulness may help to address this critical need, as might additional efforts to promote financial gains, such as savings and loans groups or other income generating initiatives.

Basic Material Needs: Children were asked whether they had each of the following: a blanket for sleeping; a pair of shoes; and at least two sets of clothes (not including a school uniform). At baseline, only 53% of the Isibindi sample of children had all three of these items; at follow-up, 68% responded affirmatively to all three. This was a significant improvement over time ($p < 0.001$) and, as previously noted, was also significantly better than the comparison group (see Appendix A). There was no difference on this indicator between the Isibindi sites. Nearly a third still did not possess all of these items at follow-up. Shoes were the most common unmet material need at follow-up, with 24% lacking this item, followed by not possessing two sets of clothes (17%) and a blanket (14%).

Household Financial Management: As previously mentioned, just over half of caregivers who reported ever being visited by an Isibindi CYCW reported that they discussed financial management during the home visits. Focus group data also highlighted aspects of budget management and advice on spending and saving as a common discussion point. This topic was most often brought up when the family received grants, in order to help them consider the best use of these new funds. Caregivers were encouraged to make a budget and decide how to use the money. In addition, children were engaged in these discussions so that they understand the use of grant funds within their household. Caregivers remarked on the value of this child participation, as children’s awareness of the family’s financial constraints made them less demanding and was said to lessen tensions in the home about how money was spent.

Caregivers that participated in the survey were also asked three questions to determine whether they took specific steps to manage their money in the 12 months preceding the survey (see Table 9). A scale with possible scores of 1-4 was created, with higher scores indicating better financial management practices. The mean score

for all Isibindi caregivers increased slightly from baseline to follow-up, but this increase was not statistically significant. However, caregivers in the high functioning Isibindi sites showed greater overall improvement (almost one point on the scale) in financial management compared to those in the low functioning sites (ARD 0.80; $p < 0.001$, see Table 9). For instance, 67% of those in high functioning sites reported making a plan for how much they can spend at follow-up, a rise from 41% at baseline. Yet, in low functioning sites, reports of budget planning declined from 71% at baseline to only 53% at follow-up. In spite of the notable improvements seen within the high functioning sites, about one-third of the study population reported never making a budget or tracking their expenditures. Moreover, nearly half of these caregivers reported not ever saving money; caregivers in focus groups highlighted that this was often not practical given limited available resources, which reiterates the high level of impoverishment facing these families and the on-going need for economic support activities

“We would talk about the importance of saving money for the kids, money that would help them in the future. Another thing we talk about is that when we use the children’s money, we should write down what we used it for. Every year there should be money that we put aside for the child.”

Caregiver

“The child is even hopeful, because there’s money that I’m saving for her. She looks at me differently now, she knows that I don’t just deny her some of her demands. She knows that the care worker said that we should have a budget. When I come back to collecting grant money, we sit down and plan what we going to do with it. The child sees how the money is spent.”

Caregiver

Table 9. Household financial management at both survey rounds by site type

In the last 12 months, how often have you:	All Sites		High Functioning Sites		Low Functioning Sites	
	Baseline	Follow-up	Baseline	Follow-up	Baseline	Follow-up
Put money aside for a future expense:						
Often	4	13	1	12	5	13
Sometimes/rarely	37	36	29	36	41	37
Never	59	51	70	53	54	50
Make a plan for how much money you can spend:						
Often	6	16	4	16	7	15
Sometimes/rarely	55	41	37	51	63	37
Never	38	43	59	33	29	47
Keep track of money you spent:						
Often	9	16	7	16	11	15
Sometimes/rarely	52	43	38	51	57	40
Never	39	41	55	33	32	45
Mean for Financial Management Scale***	1.88	2.04	1.52	2.15	2.03	2.00

*** $p < 0.001$ for test comparing the two site types

Psychological Health

Elevated risk of child mental health problems among children affected by HIV and AIDS is well documented. As mentioned earlier, almost three-quarters of Isibindi child beneficiaries who were visited by a care worker reported commonly discussing their feelings or emotions. NACCW expects Isibindi to address the psychological health of beneficiaries by reducing the child's behavioral and emotional problems and improving their self-esteem; these outcomes are discussed individually below.

"I would say we need more counselling skills. It is difficult to just look at the child and do nothing; you end up crying with the child."

Child and Youth Care Worker

Children's Depressive Symptomology: The prevalence of depressive symptomology was calculated based on children's responses to questions from a standardized depression survey, including "in the last week, how often did you feel down and unhappy?" and "how often were you bothered by things that don't usually bother you?" At baseline and follow-up, almost one quarter of Isibindi children reported high levels of depressive

symptomology (23% and 24% respectively). Children's depressive symptomology stayed the same regardless of program site type. CYCWs in the focus groups described a need for additional counselling skills, citing their inability to address severe emotional distress. Engaging the support of experts, specialized training for a limited set of CYCWs in psychological assessment and care may help to address this need. Screening for depression coupled with appropriate referrals to psychological service providers as available, individual CYCWs trained in counselling skills or structured curriculum-based support groups could ensure children in severe psychological distress are linked with appropriate care services.

Children's Behavioral Problems: Caregivers were asked a series of questions designed to identify behavioral problems in children, including emotional, conduct, hyper-activity/inattention and peer relationship issues. The prevalence of caregiver-reported behavioural problems increased significantly from 21% at baseline to 33% at follow-up, with statistically similar results for beneficiaries from both site types. Because the increase in behavioural problems among Isibindi enrollees was similar to that in the comparison group (see Appendix A), it's unlikely that increased awareness of child behavioral problems among caregivers receiving program services explains the rise.

Table 10 provides details on the types and prevalence of behavioral issues reported by caregivers. There was a clear rise in emotional symptoms, such as worry, unhappiness and nervousness. Expressions of anger were particularly common: 62% of caregivers reported this as true of the child under their care, up from 46% at baseline. Measures of hyperactivity were also more prevalent at follow-up, with indicators of restlessness and poor concentration nearly doubling over time. Overall, the rise was greatest for the hyperactivity subscale, with more modest increases in emotion and conduct problem subscales. Peer problems rose only among beneficiaries at the higher functioning sites (ARD 1.06, $p < 0.001$).

"Respect was a difficult issue for the children, but since we have the Isibindi care workers things are getting better. When the care workers don't visit often, the children tend to go back to their old habits of disrespecting."

Caregiver

"She [CYCW] told him that in this house children do their homework. She told him that when he comes back from school he must wash his shirt and when it's dry he must take it inside the house. Secondly she said when you are told to do something you must do it. At the beginning he would complain and mumble when being advised. She was able to discipline him and now he is on the right path."

Caregiver

Some caregivers who participated in focus groups commented on the problem behavior of children in their household. They did commonly attribute children's increased willingness to assist with household chores to the CYCWs' intervention, and described incidents where CYCWs admonished children to respect their caregivers and even disciplined the children. Yet, qualitative data suggested that children may revert to disrespectful behavior in the absence of the CYCW and some caregivers even emphasized their reliance on CYCWs to provide discipline. Further, efforts by CYCWs to encourage children to participate in household duties and abide by household rules do not address the underlying issues reflected in the behavioural problems scale. As such, supplemental initiatives to address the root causes of behavioural problems among children are needed. This may be best coupled with sensitivity training for caregivers on the possible reasons for children's behavioural problems as well as positive disciplinary skill-building to help them independently manage related issues.

Table 10. Behavioral problems of all Isibindi children at both survey rounds

	USUALLY OR SOMETIMES TRUE OF CHILD	
	Baseline %	Follow-up %
Emotional Symptoms		
Complains of headaches, stomach aches, or feeling sick	58	45
Seems worried	15	24
Is unhappy, depressed, tearful	9	18
Is nervous in new situations, loses self-confidence	25	36
Has many fears, is easily scared	34	26
Conduct Problems		
Often gets very angry and loses temper	46	62
Behaves well, does what adults ask	94	93
Fights with other children	11	13
Lies or cheats	13	17
Steals things from home, school, or elsewhere	4	6
Has good attention; finishes work to the end	96	91
Hyperactivity/Inattention		
Restless, overactive, cannot be still for long	52	69
Is constantly moving, restless	24	43
Is easily distracted, has poor concentration	28	44
Thinks about things before acting	85	80
Peer Relationship Problems		
Would rather be alone than with others his/her age	24	31
Has at least one good friend	46	27
Is liked by other children	97	90
Gets along better with adults than other children	65	33

“People’s dignity has been restored with the help of this programme; they had given up and didn’t see any future for their lives.”

Child and Youth Care Worker

“I now have peace in my spirit. I now know that should I pass away, I will die in peace because I know that the children will grow up well and be taken care of. They will go to school and become successful. They (CYCWs) do really support us.”

Caregiver

Self-esteem and Hope: The survey did not adequately capture measures of self-esteem or hopefulness. However, the qualitative data suggested that this may be an area where Isibindi contributed to children’s improved wellbeing. Much of the caregiver-reported improvement in children’s self-esteem was linked to their school performance and the commitment to education that CYCWs helped to instill. Both caregivers and CYCWs spoke about children’s revived determination to finish school and dreams for a better future for themselves. They also described how children’s sense of self-worth was heightened through better school performance. CYCWS additionally felt that caregivers who were encouraged and empowered to apply for grants subsequently had higher aspirations for their own and the children’s future.

Child Protection

The effects of HIV and AIDS on a family are manifold. Children may experience decreased adult support in their lives, from the death of a parent or from competing demands facing their caregivers. Further, both illness and the absorption of orphans create stress among family members who are dealing with the emotional difficulties of chronic illness and death, as well as disruption to their household and economic stability. CYCWs provide support to families and children affected by HIV and AIDS, with the expectation that such support would lead to improved family relations and better treatment of children. As highlighted above, effective communication with children was a common topic of discussion with caregivers,, and so was resolving conflict between caregivers and children (see Table 6). Related outcomes of positive adult support, child maltreatment and family functioning are discussed below.

Positive Adult Support: Over three quarters of caregivers reported discussing effective communication with children during home visits from the CYCW. This study included three indicators of positive adult support as reported by children (see Table 11). Items were scored 0 for “not at all” and 3 for “a lot.” A cumulative score (0-9) was generated with a higher cumulative score indicating the presence of greater positive adult support. Isibindi children reported slight increases in positive adult support over time that was borderline significant (6.28 to 6.47, $p=0.063$). For instance, as Table 11 reflects, there were increases over time of 10% or more in the percentage of children who reported that their caregiver listened to their ideas and spent time doing something fun with them. There was no difference in positive adult support between high and low functioning sites; both equally improved. As previously noted, this was also an area where Isibindi had marked success relative to the comparison group (see Appendix A).

“Now children have a voice and they are listened to.”

Child and Youth Care Worker

“They started involving him (male child) in all the decisions that they make at home and that made him feel that he is an important part of the family.”

Child and Youth Care Worker

Table 11. Positive adult support among all Isibindi children at both survey rounds

In the past 12 months, how often did an adult in your household...	Baseline %	Follow-up %
Spend time doing something fun with you		
Not at all	21	14
A little/some	35	42
A lot	34	44
Listen to your ideas		
Not at all	24	12
A little/some	46	45
A lot	30	42
Praise you		
Not at all	5	6
A little/some	36	29
A lot	59	65

Family relations: Family functioning (or conflict) was reported by caregivers and included questions concerning interactions with household members, as presented in Table 12. Conflict appears to have escalated over time: the prevalence of poor family functioning increased across all sites. At baseline, 23% of families were ranked as having poor family functioning and this increased to 53% at follow-up. Interestingly, poor family functioning increased marginally more in high functioning sites relative to low functioning sites (AOR 2.31, p=0.08) (see Figure 4). Moreover, while poor family functioning rose across the entire study sample, it rose more among Isibindi beneficiaries at follow up than it did within the comparison group (see Appendix A).

As can be seen in Table 12, nearly half of caregivers at follow-up indicated they could not talk to one another about the sadness they felt, an increase from 33% at baseline. Correspondingly, reports of being able to express feelings and confide in one another declined over time. On the other hand, there were some measures of the families' strengths: indicators reflecting acceptance of one another in the family, as well as an ability to solve problems remained high over time.

CYCWs who participated in focus groups described many efforts to address family conflict. They detailed how they often initiated family conferences including all members of the household, adults and children alike, where the aim was to solve problems together. These conferences were described as a means to encourage family communication, positive interactions with children, and the delegation of household responsibilities. It is possible that such discussions contributed to increased awareness of such issues, explaining in part the greater rise seen among Isibindi beneficiaries. The conferences may have also encouraged better child-caregiver interactions, as detailed above, as well as helped families to devise helpful household routines and clearer individual expectations. Even so, communications issues that arise from the emotional strains facing family members may not be adequately addressed by the program as currently implemented. While family conflict was reportedly discussed during home visits with as many as half of the children and caregivers in the full Isibindi sample, it was not a more common discussion topic among those with poor family functioning; suggesting the need for more targeted and effective efforts to address the issue. Caregivers may also benefit from opportunities to gain increased social support and problem-solving techniques from peers facing similar challenges, such as through support groups or other forums.

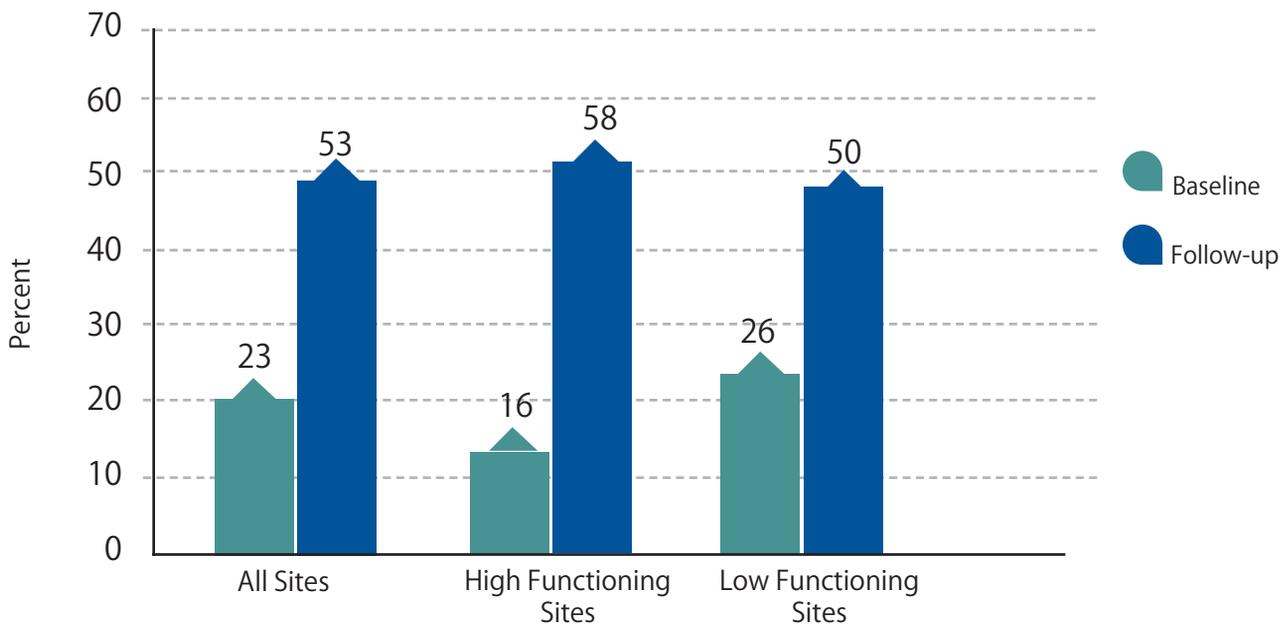
"We encourage them to talk and solve issues that concern them. We restore the culture of Ubuntu and respect so that each and every member of the family can see themselves as important as the other. We give them responsibilities so that each person can see if they are building or destroying the family. The conferences are very helpful, and we respect and listen to them and it is like they have been waiting for this for a long time because after that you could see now that they are a family. They follow their daily poster that shows them what work they are supposed to do. Then later they eat supper together, they follow the menu they did together."

Child and Youth Care Worker

Table 12. Indicators of family functioning among all Isibindi caregivers at both survey rounds

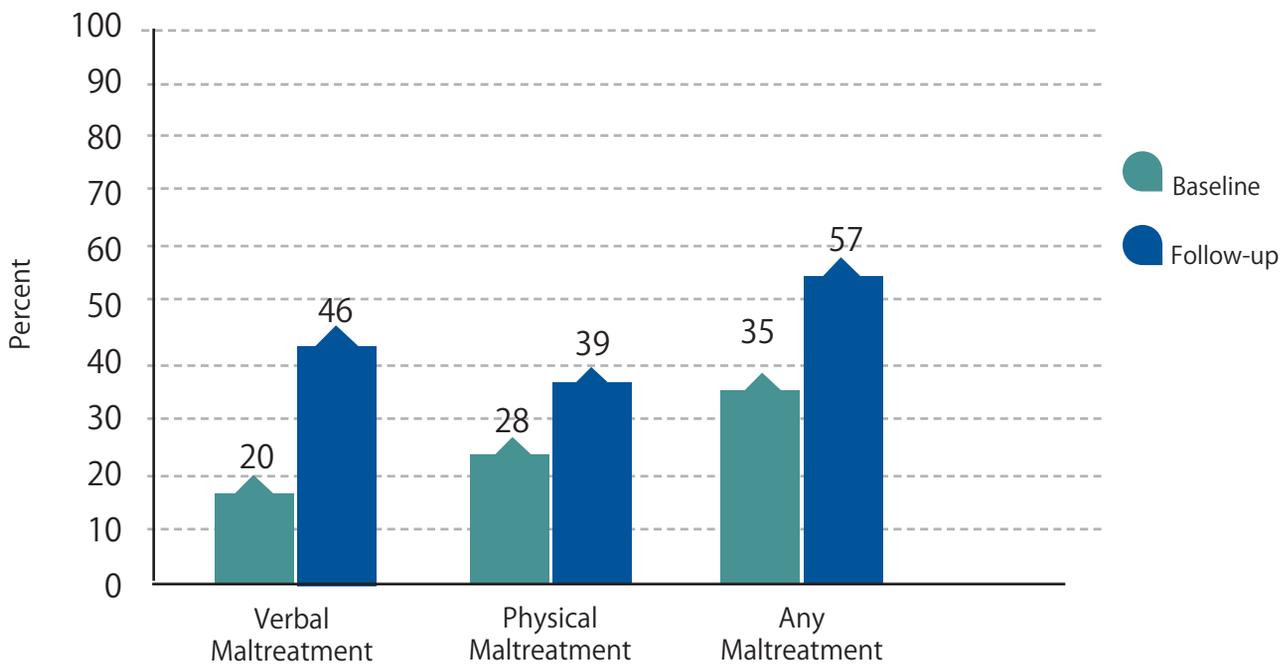
	Strongly Agree and Agree	
	Baseline %	Follow-up %
Planning family activities is difficult because you misunderstand each other	17	25
In times of crisis you can turn to each other for support	92	87
You cannot talk to each other about sadness you feel	33	47
Individuals are accepted for what they are	94	89
You avoid discussing your fears and concerns	28	36
You can express feelings to each other	90	79
There are lots of bad feelings in the family	11	26
You feel accepted for what you are	92	89
Making decisions is a problem for your family	17	29
You are able to make decisions about how to solve problems	95	83
You don't get along well together	11	23
You confide in each other	92	68

Figure 4. Rates of poor family functioning at each survey round by site type



Child Maltreatment: As Figure 5 demonstrates, Isibindi children’s reported maltreatment by adults in their household increased over time for both physical and verbal abuse. Reports of verbal maltreatment more than doubled, and there was a greater than 10% increase in reports of physical maltreatment. Rates of maltreatment overall went from 35% at baseline to 57% at follow-up. Similar patterns were seen for both girls and boys. None of these increases differed significantly between the high and low functioning program sites. Importantly, this rise was also seen in the comparison group (see Appendix A), which suggests this increase is unlikely due to increased rates of disclosure stemming from CYCW intervention.

Figure 5. Child-reported maltreatment at both survey rounds among all Isibindi children



As seen in Table 13, the rise in verbal maltreatment by adults in the household was principally due to incidents of name calling: as many as 44% of children reported such incidents at follow-up, a jump from only 18% at baseline. For physical maltreatment, the use of hard objects for disciplinary purposes also increased over time, with 12% more youth reporting it at follow-up. Fifteen per cent of children reported being slapped, punched or hit.

Table 13. Indicators of child maltreatment at both survey rounds among all Isibindi children

In the last 12 months, how often did an adult in your household:	Not at all		A little/some		A lot	
	Baseline	Follow-up	Baseline	Follow-up	Baseline	Follow-up
Threaten you by calling you dumb, lazy or other similar names	81	56	16	35	2	9
Say you would be sent away or kicked out of the house	92	85	7	10	1	5
Use a stick, belt, hairbrush or other hard item to discipline you	74	62	23	32	3	6
Slap, punch or hit you	89	85	10	12	2	3

In focus groups, CYCWs described efforts to discourage shouting, swearing and beating children, noting some isolated success stories. However, this positive change did not manifest across the survey sample. The disciplinary methods used by caregivers may be deeply ingrained and exacerbated by stressors in the home. Indeed, when referencing related advice received from CYCWs, one caregiver noted: *“Those who tell us to not to beat our children are misleading us.”* Thus, CYCWs may often serve as no more than a confidant to children for whom maltreatment is a reality. Additional efforts to promote positive child rearing practices among caregivers are a priority and could include caregiver-level interventions that provide parenting skills, coping mechanisms and increased access to social and emotional support.

While the survey did not include measures of sexual abuse, this was a common issue mentioned by CYCWs and NACCW headquarters staff during qualitative discussions, relaying both successes and challenges. Stories of identifying sexual abuse and subsequently ensuring children’s protection through connecting them with social workers were described. However, many CYCWs also detailed frustrations in addressing inter-familial sexual abuse and some also conveyed fears for their personal safety in such circumstances. Multiple CYCWs cited rape as common among this population and an area where they felt they particularly needed more support. Headquarters staff indicated that sexual violence was pervasive where they worked, and that cultural factors combined to make the problem seem especially intractable. NACCW has established linkages with child protection agencies to try to refer and treat victims of sexual abuse, and continual investment in such efforts along with strategies to support and empower CYCWs responding to this issue appear necessary.

“It is difficult to go deep with rape cases because you will be left alone. The rapist is released because the court say there is no evidence. The rapist then threatens the care worker and the child, and continues raping because he knows that they won’t do anything to him.”

Child and Youth Care Worker

“There was a child who was living with her aunt who sells alcohol at their house. This child is 11 and there was a man who used to drink alcohol there; this man raped her and gave her aunt money so that she would not tell anyone. I used to play with this child and talk to her during our life skills programs, she ended up telling me her situation. I took the matter to social workers; they then went to see the child’s house. They agreed with me that it was not a good environment to raise a child and they took the child to a place of safety.”

Child and Youth Care Worker



CONCLUSIONS

NACCW developed its program to promote optimal standards of care for orphaned and vulnerable children and their families. The organization focuses on improving the quality of services for children by building care workers' capacity, and because Isibindi is implemented via partnerships with CBOs and other community organizations, institutional capacity is strengthened at the same time. The group has invested heavily in developing and testing a model of care tailored to the needs of this highly vulnerable population, as well as the training and mentorship program that accompanies it. Both are meant to ensure that the model is delivered as designed. After almost a decade of practice and refinement within NACCW, the Isibindi model will now be established nationwide by the Republic of South Africa. Within the next five years, through the support of the Department of Social Development and USAID Southern Africa, the Isibindi program will be scaled-up to reach over 1.4 million children nationally. This massive effort will include hiring and training an additional 10,000 CYCW.

With the planned roll out in mind, this supplemental report sought to closely examine the relative impact of low versus high functioning Isibindi sites in KwaZulu-Natal. High functioning sites are generally well-established; they are rated by NACCW as having greater child participation, team cohesion, independence and resourcefulness than other sites. At high-functioning sites, most CYCWs have completed the two+ year training course. Lower functioning sites typically had many CYCWs still undergoing training, either because they were newer to the Isibindi program or due to high staff turnover. Their resource base and experience with children's health and social service programming may also be more limited than at other sites. Challenges to administrative and management capacity may result in a less cohesive workforce and less efficient service delivery. Lower functioning sites therefore better represent the quality of services (and associated child-level impacts) expected in the early wave of the national roll out, whereas the higher functioning sites may represent the expected maturation of the scale-up.

"If you find that you are dealing with a community-based [partner] organisation, a very rural organisation that is historically under-resourced, the workers struggle."

NACCW Headquarters Staff Member

Overall, high and low functioning sites appeared equally successful at facilitating grant access, obtainment of material needs and promoting positive adult support in the home. However, higher functioning sites did deliver a better quality of service, and more consistently. Children and caregivers at these sites were more likely to say they had been visited by a CYCW, to report child-CYCW interaction, and to indicate receiving greater assistance across a range of indicators (i.e, food, documentation, school expenses) compared to those at lower functioning sites. The higher quality services and better trained CYCWs seemed to result in greater improvements relative to the low functioning sites on a limited number of outcomes, including school engagement, HIV knowledge, and caregiver financial management. However, peer relationship problems and poor family functioning increased more among the higher functioning sites relative to the lower functioning sites, findings that are difficult to explain. Other outcomes, including emotional and behavioural problems and child maltreatment, worsened over time across all sites and did not differ by site type. Thus, while there is evidence of better quality services available at the higher functioning sites, the evidence is decidedly mixed on whether this translates into greater gains in child wellbeing.

"We are contributing to rural development by building Safe Parks for the kids; we have employed women. You are creating a job for them, not only a job but a career path."

NACCW Headquarters Staff Member

Some of the results that NACCW and its partners intuit may be difficult to demonstrate within this study. The research is limited to a two year period, and some important effects of the program may not have emerged within this time period, such as increased school completion rates or delays in age at first pregnancy. Similarly, qualitative interviewees suggested that the

program's greatest success stories, including children who had gone on to University in the time between baseline and follow-up, may have been systematically underrepresented in the results. This is possible and could have affected some conclusions even though the sample size remained high enough at follow-up for meaningful analysis. At the same time, the study's focus on children age 10-17 also means that the program's impact on younger beneficiaries remains unknown. Further, while outcomes utilized in this study included important economic, psychological and physical health indicators, the survey may fail to capture all of the changes that take place within the lives of beneficiaries.

Qualitatively, children’s caregivers, CYCWs and program staff alike echoed a firm belief that the program was helping caregivers to feel more empowered and offering them resources and information they did not have before. Focus groups highlighted many aspects of CYCW support, suggesting that school performance, aspirations for the future and self-worth seemed to improve among children enrolled in programming, and support with daily living activities and associated alleviation of burden were commonly cited by caregivers as Isibindi benefits. To ensure inclusion of the full impact of service delivery in outcome studies, future quantitative research might be enhanced from the inclusion of indicators stemming from preliminary qualitative work. Furthermore, NACCW staff members were justifiably proud of the program’s contributions to local infrastructure (e.g., Safe Parks) and women’s economic independence through CYCW job creation. Additional research might also seek to capture the community capacity building that is inherent in the Isibindi model.

While the study focused on home visiting and related services, as this was the central mechanism for service delivery across all programs in the broader evaluation and remains a crucial component of OVC programming in most contexts, qualitative research participants spoke often about the importance of the provision of ancillary services and activities, especially Safe Parks. However, only 26% of children in this study reported attending Safe Parks, and it is unknown to what extent children accessed other supplementary interventions, such as the Adolescent Development Program newly initiated by NACCW. Regardless, if exposure was prevalent, the impact of these services would be reflected in the study’s results even if children underreported the services they received. Future research could include focused investigation of the individual effects of specific interventions, and help determine priorities for scale-up. There may be particular value in evaluating the added benefit of other specialized support services suggested within this report, such as food gardens, parenting skills training, support groups, HIV prevention and other educational initiatives.

Notably, this study was conducted exclusively at Isibindi program sites in KwaZulu-Natal. It’s also possible that the results, both quantitative and qualitative, would be very different in a study of Isibindi programming implemented elsewhere. In KwaZulu-Natal, where rural areas dominate and HIV prevalence is the highest in South Africa, the need for effective and innovative support services for children affected by the epidemic is unparalleled. The level and seriousness of the crisis may mean that outcomes there are more hard-won; children in the study most often experienced not one or two significant disadvantages but a host of them: extreme poverty, hunger, depression, maltreatment, and limited access to healthcare, to name a few. NACCW also reported unique challenges that affect their work in this province, including the practice of ukuthwala (i.e., forced child marriage through abduction), high rates of domestic violence, cultural attitudes condoning harsh disciplinary practices, frequently interrupted funding for social service programming, and limited fluency in English. In trying to mount a comprehensive response, NACCW and its Isibindi partners might find that change is incremental at best, comes in fits and starts, and – as this analysis suggests – depends on a long list of both program and external factors.

Provincial considerations as well as differences observed between high and low functioning sites’ are also suggestive of the important role that CBO partners implementing Isibindi play in its success. In discussions and qualitative interviews, staff also indicated that while NACCW provides a structured, standardized program of training, compensation and hiring, and mentorship support, existing differences between CBO partners nonetheless affect Isibindi implementation and program outcomes. The importance of on-going support is echoed in the evaluation findings, particularly for emerging sites with reported lower levels of service capacity and resources. NACCW provides an intensive mentoring program where an experienced CYCW from the headquarter office provides regular site visits, on-going training, and an array of emotional and logistical support to Isibindi implementing partner organizations and their CYCWs.

Mentoring seems essential, and such efforts may be strengthened through the introduction of further systems to monitor how services are delivered and to encourage CYCWs’ adherence to quality standards. Examples include more intensive mentoring from headquarters at selected sites complemented with the establishment of further quality control mechanisms from site-based staff. Monitoring may also include direct contact with beneficiaries, such as quarterly visits from a senior CYCW to enrolled households to verify and ensure adequate service provision. The use of the current NACCW assessment tool also provides an opportunity to monitor site-based constraints to implementation, as it was found to be predictive of overall service quality in this evaluation.

While the comprehensive nature of the assessment tool provides a complete picture of site functioning, identifying indicators most indicative of a site's potential success may help to narrow capacity-building efforts to key competency areas. For these core indicators, collecting information on the underlying reasons for poor scores can be used to devise individualized site-based action plans. Expanding program monitoring beyond basic service delivery outputs such as the frequency of reported home visits, to include higher-level indicators of change (e.g., successful grant applications) will also help to ensure accountability and timely responsiveness to beneficiary needs. In short, collecting real-time data on both outputs and outcomes will enable NACCW and its partners to continually improve upon the services delivered to this vulnerable population. While the structure and functionality of the monitoring system hinges on available resources, other practical considerations and input from donors and other stakeholders, its importance cannot be overstated. With Isibindi planned for a national expansion, on-going technical support and program monitoring will be critical to both identify areas for improvement and maintain the fidelity of the program model.

This evaluation provides evidence that the Isibindi model reflects some important strengths relative to programs with lesser investment in human resources and training. Higher quality services were found to positively influence grant access, obtainment of material needs, and supportive interactions between children and caregivers. The Isibindi-focused analyses also highlight the potential for enhanced service delivery from more established sites. Still, for anticipated program outcomes that have been relatively impervious to change even when best practices are brought to bear, more work is clearly needed. Food security, psychological health, child maltreatment, and HIV and AIDS knowledge are all important outcomes that the program does not appear to have sufficiently addressed among the beneficiary population in KwaZulu-Natal. Supplementary efforts, such as specialized training for CYCWs and the roll-out of additional interventions, may help to address these needs. The notable achievements of the Isibindi home visiting program evidenced in this study demonstrate the program's importance and potential to improve the wellbeing of orphans and vulnerable children. However, home visiting is just one necessary strategy in a range of interventions to effectively address the full spectrum of families' needs.

APPENDIX A. IMPACT OF ISIBINDI RELATIVE TO A COMPARISON GROUP

To assess the relative impact of the Isibindi home visiting programme, a quasi-experimental design was applied and changes in outcomes of Isibindi beneficiaries over time were compared to those of a comparison group. Children and caregivers who were enrolled by 8 selected community-based organizations that were a member of Children in Distress Network (CINDI) and operating in Umgungundlovu district were utilized as the comparison group. These CBO partners receive some training and material support from CINDI; however, they often operate with limited financial and human resources. They provide home visiting to OVC households through volunteers who receive minimal training and compensation. Overall exposure to home visiting was low among this group: only 18% of children and 29% of caregivers enrolled in CINDI CBO programs within this study reported ever receiving a home visit, and only 6% of children and 14% of caregivers reported receiving a visit in the 12 months preceding the follow-up survey. Thus, given the reported low intervention exposure of the CINDI group, they closely approximate an untreated comparison group.

Advanced regression models were used to test for the effect of program quality on children's wellbeing. These included variables representing program type (Isibindi or CINDI), time (baseline or follow-up), and interaction between program type and time. The interaction term captures the relative impact, or additional benefit, of being enrolled in Isibindi compared to the volunteer-driven CINDI program. Models also adjusted for factors that might be related to both program exposure and child wellbeing, and that could otherwise obscure the effects of the program. These factors included the child's age, gender, orphan status and relationship to the caregiver; the caregiver's age, gender, marital status and education; and the household's inclusion of chronically ill members, dependency ratio, income category, and type of community (e.g., informal settlement, farming area, etc). Analyses are based on an intent-to-treat approach; that is, children are analysed based on their enrolment in a given program model, regardless of whether they reported receiving program services. Table 14 provides descriptive data for both programs at baseline and follow-up for each of the outcomes of interest. Results of the multivariate analyses are summarized in the last column. If a significant difference between the two program types was found, the coefficient and probability value (p value) of the program by time interaction is provided: this term signifies the increased likelihood of Isibindi beneficiaries to have a certain outcome relative to the comparison group. Details on the significant differences that emerged are summarized in the subscripts below the table. Many of these findings mirror those reported within the broader research report and readers are advised to refer to this report for additional methodological details, discussion and specific programmatic implications pertaining to the results.²

²Thurman TR, Kidman R, and TM Taylor (2013). *The Impact of Paraprofessional versus Volunteer-Driven Home Visiting Programs on the Wellbeing of Orphans and Vulnerable Children: Evidence from a Longitudinal Evaluation in KwaZulu-Natal, South Africa*, New Orleans, Louisiana: Tulane University. Available at: www.hvc-tulane.org

Table 14. Isibindi outcomes relative to the comparison group CINDI

Outcome	All Isibindi Sites		All CINDI Sites		Significant difference in change between Isibindi and CINDI (Yes/No)
	Baseline %	Follow-up %	Baseline %	Follow-up %	
School Engagement					
Currently attend school	99	94	98	94	No
School performance scale mean score	10.0	9.9	9.9	9.5	No
Physical health					
Unmet Need for Health Services – Caregiver	34	50	42	44	Yes: AOR=2.09, p=0.009 ^a
Unmet Need for Health Services - Child	15	18	23	19	Yes AOR=1.90, p=0.025 ^a
Child reported health					No
Good or Very Good	82	78	72	72	
Neither Good nor Poor	21	20	21	24	
Poor or Very Poor	2	2	7	4	
Caregiver reported health					No
Good or Very Good	31	24	27	22	
Neither Good nor Poor	36	43	33	45	
Poor or Very Poor	33	33	39	33	
Child has accurate HIV knowledge	33	42	27	41	No
Ever had sex	6	22	10	28	No
Economic security					
Death certificate for either parent	64	69	55	63	No
Access to highest grant eligible to receive	39	57	45	53	Yes AOR=2.48, p=0.004 ^b
Financial Management Scale mean	1.9	2.0	1.9	1.9	No
Moderately or Severely food insecure	77	71	79	75	No
Basic Material Needs: Has blanket, shoes, and two sets of clothing	53	68	65	62	Yes AOR=3.13, p<0.001 ^c
Psychological health					
Depressive symptomology	23	24	39	39	No
Behavioral problems	21	33	36	47	No
Child protection					
Positive adult support scale mean	6.3	6.5	6.2	5.9	Yes ARD=0.69, p=0.001 ^d
Poor family functioning	23	53	51	64	Yes AOR=2.48, p=0.002 ^e
Verbal Maltreatment	20	46	30	55	No
Physical Maltreatment	28	39	37	47	No
Any Maltreatment	35	57	50	66	No

a Unmet need for health services was greater among caregivers and children in Isibindi sites.

b Access to highest grant eligible to receive was higher among Isibindi beneficiaries.

c Material needs was higher among Isibindi beneficiaries.

d Positive adult support rose among Isibindi beneficiaries and declined among the comparison group.

e Poor family functioning worsened across both programs, but worsened more among Isibindi beneficiaries.

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For additional Program Implications and to obtain further details on outcomes reported here and factors influencing such outcomes, readers are advised to see the baseline and other evaluation reports:

Thurman TR, Kidman R, and TM Taylor (2013). *The Impact of Paraprofessional versus Volunteer-Driven Home Visiting Programs on the Wellbeing of Orphans and Vulnerable Children: Evidence from a Longitudinal Evaluation in KwaZulu-Natal, South Africa*, New Orleans, Louisiana: Tulane University.

Thurman T.R., Kidman, R., & Taylor, T.M. (2011). *Assessing the Impact of Interventions to Meet the Needs of Orphans and Vulnerable Children in KwaZulu-Natal, South Africa; Study Overview and Baseline Demographics*. New Orleans, Louisiana: Tulane University.

Thurman, T.R., & Kidman, R. (2011). *Child Maltreatment at Home: Prevalence among Orphans and Vulnerable Children in KwaZulu-Natal, South Africa*. New Orleans, Louisiana: Tulane University.

Kidman, R., & Thurman T.R. (2011). *Chronic Illness in the Home: Implications for Children in KwaZulu-Natal, South Africa*. New Orleans, Louisiana: Tulane University.

Thurman, T.R., & Kidman, R. (2011). *HIV and AIDS Knowledge among Orphans and Vulnerable Children in KwaZulu-Natal, South Africa*. New Orleans, Louisiana: Tulane University.

Taylor, T.M., Kidman, R., & Thurman, T.R. (2011). *Household Resources and Access to Social Grants among Orphans and Vulnerable Children in KwaZulu-Natal, South Africa*. New Orleans, Louisiana: Tulane University.

All reports are available at: www.hvc-tulane.org or on request from hvcteam@tulane.edu



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