Child Welfare South Africa
Asibavikele Program

Evaluation Report

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Executive summary

1. Background

The Asibavikele Programme is an outreach project of Child Welfare South Africa (CWSA) that operates in communities that have been deeply affected by HIV and AIDS in South Africa. The project works through community volunteers who are selected and trained to support orphans and vulnerable children and their families.

2. Research approach

This evaluation sought to identify how the project had contributed to child well-being and how it had strengthened community capacity to respond to vulnerable children. The extent to which the project contributed to child well-being was evaluated through a quasi-experimental study conducted in 9 of the 57 Asibavikele sites and in matched control (comparison) sites. The data was collected through quantitative and qualitative instruments involving a sample of 677 children aged between 8 and 18. The extent to which the project strengthened community capacity was assessed through focus groups held with volunteers, a community survey and discussions with project staff and local social workers in the 9 project sites.

3. Findings on impact on child well-being

A set of indicators of child well-being was derived from theory and discussions with project staff. Findings on impact are summarised under these indicator headings below.

3.1 Material environment/safety nets

Asibavikele played a significant role in providing material safety nets for vulnerable children in all Project sites. More project children had child support grants than Control site children. Strong evidence of Asibavikele support to access grants and the positive impact these grants had on children emerged from the qualitative data.

All families, Project and Control, lack food security. Asibavikele facilitates access to food support. However, it is also clear that food security remains a huge problem in the families supported by the project and indeed in the volunteer's homes too. Livelihood support to households was a less significant aspect of the project. Volunteers seem to put most of their energy into helping families access state support through social grants rather than livelihood support programmes.

3.2 Health and a continuum of services

The significantly higher proportion of Project children who went to a clinic or hospital combined with the fact that two-thirds of the children were assisted by an Asibavikele volunteer when they were sick suggests that Asibavikele is playing a significant role in improving children's access to formal health care. Children in the Project group are referred to other services more often than

children in the Control group suggesting that there is a continuum of services facilitated by Asibavikele.

3.3 Social ecology/normalising children's environments and routines

Involvement in a recreational group or support groups and a large social network are indicators of normalisation and integration into the community. The qualitative data shows that where the Asibavikele volunteers do run recreational and support groups they play an important protective role in children's lives. Children who are part of the Asibavikele Project have a bigger and deeper peer and adult support network. Most project group children see the volunteers as people they can trust and talk to. There is also some evidence that some children (particularly older children) do not always trust volunteers and feel that they care for the younger children more than them.

3.4 Human capacity

The quantitative data show that children who are part of the Asibavikele Project have less emotional stress than those who are in similar circumstances but not supported by volunteers. There is also evidence that older children in the Project group experience more stress than younger children. Food and support for school-going were identified, by children, as the most important services for reducing stress. The qualitative data also shows that caregivers see a difference in emotional stress levels in their own lives since they have been part of the Asibavikele project.

There is also evidence that children and caregivers worry about grief related to the death of parents and that there is a need to support this aspect of the volunteers work. Volunteers also identify this as an area that needs strengthening.

3.5 Access to school

The Asibavikele Project makes an impact in the area of school attendance, particularly in not dropping out of school. Though children in the Project and Control groups face the same barriers to school-going the Project children receive significant support both practical and emotional to go to school and to keep going. In some areas volunteers are strong advocates and monitors of orphan children's rights to access schooling.

4. Findings on strengthening community capacity to support vulnerable children

It is clear that the volunteers play a significant role in the communities in which they work in supporting vulnerable children. Volunteers identified a number of challenges which if addressed would strengthen their capacity to support children in their communities. Emotional and practical support from management (from site coordinators up to national management) were identified as important by volunteers in their deeply difficult context of poverty.

Social workers saw the volunteers as an important and often essential part of their ability to deal with the burden of cases they have to process. They

identified the fact that volunteers come from the local area and therefore understand the language and local dynamic as very important. The evaluation highlighted a number of examples of Asibavikele volunteers finding and using local resources such as commercial enterprise and police services for the benefit of vulnerable children.

5. Recommendations

It is clear that the Asibavikele Project has made a difference in the lives of vulnerable children in communities that face huge challenges. The following would improve the community capacity to support children.

If CWSA wishes to promote long-term sustainability it would be important to improve the capacity of volunteers and the local Child Welfare organisations in the area of livelihood strengthening, keeping in mind the very difficult context of deep poverty in which many volunteers work.

The Asibavikele Programme has a Lifeskills Education module developed for use with teenagers in the sites. This should be implemented as soon as possible. Children, caregivers and volunteers identify the lack of expertise in helping children cope with grief as a problem. An integrated family-based model of grief work that is simple enough for the majority of volunteers to use should be implemented. The Asibavikele work would be strengthened if volunteers' capacity to communicate with teenagers could be developed.

The Kids Club model used in the Northern Cape seems to work well for younger children. It could be implemented with contextual adaptation in the other sites. A model for recreational groups for teenagers needs to be developed and implemented.

Though stigma and the resultant discrimination are an intractable problem it is important to try to do something about it. CWSA needs to explore ways to use the strong community network and credibility that Asibavikele volunteers have in the sites to advocate at community level against abuse of poor and vulnerable children.

The roles and approaches of site coordinators, provincial managers and CWSA head office staff in relation to volunteers require attention. The dichotomy between a formal, administrative approach and the informal and locally responsive community development role of volunteers needs to be bridged more effectively and with greater sensitivity to the realities of everyday life in vulnerable and poor communities. Formal training is one strategy, but this needs to be linked with personal experiences of the day-to-day realities of volunteers. Attention needs to be given to the support of volunteers by site coordinators.

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1. BACKGROUND

1.1 The Asibavikele Programme

Child Welfare South Africa (CWSA) is a national network of member organisations and was started in 1924 when non-government child welfare societies in areas all over South Africa constituted a national structure that coordinated their services. What is unique about the Child Welfare offices all over South Africa is that the social workers often do the statutory work with or for the Department of Social Development (DSD). Today, Child Welfare South Africa has an infrastructure consisting of a national coordinating body, 263 member organisations (the local Child welfare Offices in towns and cities and rural areas) and outreach projects in unserviced and under-serviced communities. Asibavikele is one of these outreach programmes. It has the financial support of international sponsors but operates under the umbrella of CWSA member organisations. The Asibavikele Programme trains community volunteers in selected sites to support vulnerable children and their families. The Programmes Director, CWSA National describes the impetus behind it,

> *"With HIV there was more and more and more work and Asibavikele was bred out of the fact that the social workers in the local Child Welfare organisations were so overwhelmed that the needs of children were not being met. The one on one focus was not there – it was becoming a court focussed system where you go in and do the foster care and move to the next case and next. So the only way to meet that gap and deal with it was to look at the local community and with the large numbers of people in the community who were unemployed there were many people who had an interest in children and wanted to make that change in the community. So volunteers were drawn out of the community and the social workers supervised them and then dealt with severe cases."*

Asibavikele is a programme managed by the national office through provincial coordinators who run this programme as well as other national projects. Asibavikele is site based. The sites for the programme were selected by looking at the child welfare offices that were under the most stress from the growing need. Appendix 1 lists the Asibavikele sites and the annual reach at the end of 2011.

Each site has a co-ordinator who works alongside the volunteers in their day-to-day work. A social worker or auxiliary social worker from the CWSA member organisation meets with the site co-ordinator and the volunteers for regular supervision where challenging cases are discussed. Each volunteer is allocated a number of households who they visit regularly. Often they identify these needy households themselves because of their knowledge of the local community. The volunteers go through a selection process and training. The Programmes Director of the project describes the core work of the volunteers as basic.

> *"We started so basic – going into that house and speaking to the child and family and doing a small needs assessment and then visiting regularly to check up. Then, with the help of the social worker, helping families to access grants and getting children into school and linking them up to a feeding scheme in the area. That's all. But we found that the volunteers began to grow it and said now we need activities for after school, so they started that. That's a strength I think, having a core programme of simple activities and then having regular supervision and careful record keeping and then allowing people to branch out if they want. We encourage the volunteers to do no more than 8 hours of work with their families, but many do far more than that."*

Volunteers receive a small stipend to cover transport to and from the Child Welfare offices. The Programme Director describes why the cost of the project was deliberately kept low.

> *"We have tried to keep the project very low cost because the local Child Welfare Branches have very little funding – most just rely on the state grants they get alone so if the international funding stopped the local office could pick up the project and run it without national office input. "*

One of the aims of the Asibavikele project was to influence the way a community thinks about children through the subtle influence of community members by the action of the volunteers.

> *"If you move things gently then you bring about change. You can't go in and tell people that you can't get HIV from touching somebody but you can show it. This is what the community volunteers do. The volunteer keeps visiting the child who is HIV-positive and plays with her, or cleans the house for the sick mother. This begins to shift community values." (Programmes Director)*

1.2 Aim of the Asibavikele Programme

Programme documents outline the following as the aim of the programme:

> To facilitate the establishment of and strengthening of existing community based structures for the care and support of orphans and vulnerable children affected by HIV & AIDS in under or un-serviced communities through the infrastructure of Child Welfare.

The programme objectives are:

- To maintain community support, participation and ownership of the program through continuous community consultation and mobilization of Child Welfare Affiliate members.
- To build human resource capacity to implement the program through Human Capacity Development initiatives.

- To provide OVC with comprehensive care and support through community outreach services.
- To continue to raise community awareness on HIV and Aids and its impact on children, particularly OVC.
- To improve volunteer retention and sustainability in the program by maintaining high morale and motivation through the provision of mentoring and support.

2. FOCUS OF THE EVALUATION

The main questions that this evaluation sought to answer were as follows:

i) In what aspects of **child well-being** did the CWSA Asibavikele programme make the most difference; what were the most significant changes brought about by the Asibavikele programme in improving the well-being of OVC?

ii) To what extent did the CWSA Asibavikele programme succeed in **strengthening community capacity** to effectively respond to the needs of vulnerable children?

3. THE IMPACT ON CHILD WELL-BEING STUDY

3.1 Development of indicators

In order to assess impact (see item i above) a set of indicators of child well-being was developed. The indicators were based on the following:

- Aim of the Asibavikele programme
- Aim of the evaluation
- Theory around child well-being
- Workshop with staff on their understanding of outcomes

The first two bullet points are dealt with in Sections 1 and 2. The second two are outlined in more detail below.

3.1.1 Theory around child well-being

The evaluation calls for an assessment of the work of Asibavikele in the area of “child well-being”. In an attempt to refine the set of indicators used in this evaluation we felt it was important to keep in mind thinking around the concept of child well-being. We have drawn in this evaluation on two pieces of seminal work, the one done by Armstrong, Boyden, Galappatti and Hart in 2004 and the 2006 review conducted by Richter, Foster and Sher and further developed in the work of Richter and Rama (2006). Armstrong et al outline the concept of psychosocial well-being but they define it in terms beyond the psychosocial. They see well-being as consisting of three domains:

- **Social ecology.** This refers to the circumstances of children’s social worlds, including their relationships with peers, kin, neighbours and others (extent and quality), the degree and nature of social support, care, mentoring and services available to them, and the implications of

their social identity (gender, class, location, ethnicity, religion) for life experiences and events.

- **Human capacity.** This refers to the status of children's individual resources in relation to cognitive capacity, social competence, personal identity and valuation, emotional well-being, skills and knowledge – as is necessary for good functioning and interaction within their social, cultural and material environment.

- **Material environment.** This refers to the material conditions of children's lives, including those pertaining to physical environment and infrastructure, status of food and livelihood security, and degree of physical safety and comfort.

Note that for Armstrong, Boyden, Galappatti and Hart (2004) culture and values are not seen as separate entities but rather as an overarching concept that shapes the content of the three domains. Richter and Rama (2006) outline how responses to children affected by HIV/AIDS should be holistic.

Programmes should propose a continuum of responses to children living in communities affected by HIV/AIDS: at one end of the continuum, specific assistance must be provided for the relatively small number of extremely vulnerable children and their families, whilst at the other end, there is a need to advocate for strengthening of government systems that ensure children's access to health, education, social security and legal services.

Responses should include support to safety nets. Formal and informal safety nets protect children and families from the worst effects of poverty, HIV/AIDS, violence, and natural disasters. Governments and NGOs can create formal safety nets through price subsidies, public works programmes, food or micro-credit programmes, and cash transfers to targeted households. Informal safety nets are made up of donations or exchanges of cash, food, clothing, informal loans, assistance with work or child-care, accommodation, and voluntary associations and solidarity groups who provide essential support to vulnerable households. These informal safety nets are created by relatives belonging to extended families, and by community members acting either individually or corporately.

Responses should prioritise efforts to normalise children's environment and routines. Going to school regularly, engaging with other children, and being actively involved in social life and family are key to building resilience.

HIV/AIDS prevention and mitigation should be integrated into programmes for children such as basic education, primary health care and general child protection initiatives. Children should be considered in those HIV/AIDS services that have traditionally focused on adults, including provision for and access to prevention of mother-to-child transmission programmes, voluntary counselling and testing, and anti-retroviral treatment as well as home-based care and in post-test support clubs and services.

Stand-alone and one-off interventions are less helpful to children and families than integrated approaches through which health and nutrition, economic and food security, legal aid, psychosocial and spiritual support, educational assistance and other services are delivered.

3.1.2 Staff workshop around outcomes of the programme

Patton (2001) emphasises how important it is for project staff to participate in an evaluation. It is vitally important that staff members are involved in the development of indicators so that the evaluation measures what they are actually doing on the ground.

Provincial managers (and some national staff) of the Asibavikele Programme were all brought together for a workshop to discuss indicators. They were asked to outline in their own words, aside from project document objectives what they thought the outcome of the Asibavikele Programme was in their areas. This list of outcomes was fed into the development of indicators presented below.

3.2 Selected indicators

The following were selected as the indicators of impact on child well-being for this evaluation:

Material environment/safety nets
Access to social support grants
Access to food support
Access to health care
Access to documentation
Household livelihood strengthening
- Saving
- Informal business
- 'Society' contribution

Continuum of response and an integrated approach
Referral to additional services such as social workers
Working with an eco-systemic approach.

Social ecology/normalising children's environments and routines
Involvement in recreational group or support group
Social networks
- adult friends they can trust and tell problems to
- peer age friends that they can tell problems to

Human capacity
HIV and sexuality attitudes and knowledge
Emotional stress

School support
- Help with homework
- Returning to school after dropping out

4. DESIGN AND SAMPLING

4.1 Study design: Child well-being impact study

The child well-being part of the evaluation employed a mixed methods design (Creswell, 2003), and included a comparison between an intervention group (Project) and a non-intervention group (Control). The comparative component of the study employed both quantitative and qualitative elements. A questionnaire was administered with Project and Control site children (quantitative) and analysed using quantitative techniques, while focus group discussions were held with Project and Control site children (qualitative) and analysed using appropriate qualitative techniques that allow for reliable and valid comparisons to be made (Braun, Clarke, 2006).

Sampling: Quantitative

The sample was drawn using a randomised stratified multi-stage sampling with probability proportionate to size (PPS)[1]. CWSA Asibavikele OVC programme sites were stratified according to Province and Districts and a two-stage sampling technique was employed for the selection of eligible children.

Stratification of sites

The following criteria were used to stratify the Asibavikele sites

(a) the province and district; and

(b) the urban / rural settings

A multi-stage sampling procedure using measure of size (MOS) calculations based on the entire population of Asibavikele sites was conducted. In this way certain sites were selected, and within them varying numbers of children were selected proportionate with the local population of beneficiaries.

Summary of Selected Asibavikele and non-Asibavikele Sites

Table 2 below provides a summary of the selected Asibavikele and non-Asibavikele sites. These non-Asibavikele sites for the evaluation were selected from the same district as the selected Asibavikele sites. This is done in order to ensure social and cultural similarities with the selected Asibavikele sites and for ease of planning and managing travels.

Table 2
Selected Asibavikele and non-Asibavikele Sites

* Selected Asibavikele Site	District	Urban/Rural	Province	Selected non Asibavikele Sites
Mthatha	OR Tambo	Urban	Eastern Cape	Tsolo (Rural)
Bedford	Amatole	Urban	Easter Cape	
Port St Johns	OT Tambo	Rural	Eastern Cape	
Verulam	Ilembe	Urban	KwaZulu Natal	Mzimkulu – Ugu District (Semi-urban)

[1] Acknowledgements to Addis Berhanu of PACT-SA for his valuable assistance with this process. The original full version of the sampling strategy is included as Appendix 2.

KwaMashu	Ethekwini	Urban	KwaZulu Natal	
Ekubusisweni	Ugu	Rural	KwaZulu Natal	
Port Shepstone	Ugu	Rural	KwaZulu Natal	
Pampierstad	Frances Baard	Semi-urban	Northern Cape	Kuruman - Frances Baard District (Urban)
Delpoortshoop	Frances Baard	Semi-urban	Northern Cape	

Selection of eligible children

Eligible children were selected using a CWSA register for each Asibavikele selected site. The register generated from the database was used as sampling frame to undertake a random selection. Children were selected from each selected site for the evaluation. Allocation of sample size for each site is described below.

Sample size

The sample size was calculated using statistical package nQuery Advisor Version 7. It took into consideration the fact that the evaluation intends to assess the extent to which CWSA Asibavikele programme contributed to improved well-being and resilience of beneficiary children. In calculating the sample size several points were therefore taken into consideration; the magnitude of change or comparison group differences expected to be reliably measured; the degree of confidence with which it is desired to be certain that the observed change or comparison group difference of the magnitude specified above would not have occurred by chance (the level of statistical significance), and the degree of confidence with which it is desired to be certain that an actual change or difference of the magnitude specified above will be detected (statistical power).

A random sample of 639 children was selected for Group 1 (project group) and 160 for Group 2 (control group). A 10% contingency was added for non-response to the calculated sample sizes which gave $n_s = 702$ and $n_T = 176$.

To control for potential confounding variables such as the parents' place of residence, level of education, income or occupation, or the gender of the children, it would have been important to match each child in Group 1 (children who received care and support from CWSA Asibavikele programme) with one or two children in Group 2 (children who have not received services from the CWSA Asibavikele programme). However due to limited availability of resources as well as sites which are not supported by Asibavikele, a 1:4 ratio was used for paring.

The following table provides the sample size allocation for the selected sites from which children under Group 1 were sampled.

Table 3
Project and control group sample size allocations

Sites	Project site numbers	Control site numbers
Mthatha	80	
Bedford	129	
Port St Johns	160	
Tsolo		117
Verulam	26	
KwaMashu	106	
Ekubusisweni	32	
Port Shepstone	44	
Mzimkulu		34
Pampierstad	47	
Delpoortshoop	79	
Kuruman		25
Totals:	**703**	**176**

In addition to the 10% contingency referred to above, an additional margin for error was built in during fieldwork to cover unusable data, logistical challenges, mis-proportions of age groups, genders and the like. The following numbers (Table 4) of children were thus included in the final quantitative data set. The second column represents the planned numbers as reflected in the table above:

Table 4
Actual and planned numbers of children

	Actual	Planned incl 10% contingency	Planned minimum required
Control sites			
Kuruman	40	25	
Tsolo	99	117	
Umzimkulu	29	34	
TOTALS	168	176	160
Project sites			
Pampierstad	44	47	
Delportshoop	60	79	
Bedford	119	129	
Port St Johns	172	160	
Mthatha	81	80	
Port Shepstone	22	44	
Ekubusisweni	64	32	
Verulam	28	26	
Kwa Mashu	87	106	
TOTALS	677	703	639

The inclusion of a margin for error in the field was well-advised. For example, for reasons that we could not explain, an entire group in Tsolo, a control site, did not arrive as planned (Tsolo was visited on a Saturday). In Port Shepstone

a communication error resulted in a much smaller number of children being arranged, which was detected on the morning of the visit, without time to negotiate additional children with schools. A compensatory number of children was arranged in the next site, Ekubusisweni, and so while proportions might not have been preserved as planned, overall numbers were not compromised. KwaMashu also experienced considerable logistical difficulties and a planned three days spent working in schools had to be converted into a one-day ‘jamboree’ in a church hall on a Saturday. Approximately 115 children arrived, of whom a significant number were between 5 and 9 years old and were not included in the sample. Games were organised in between research work and for the young ones and everyone had an enjoyable day!

Figure 1 presents the final data set numbers graphically per site.

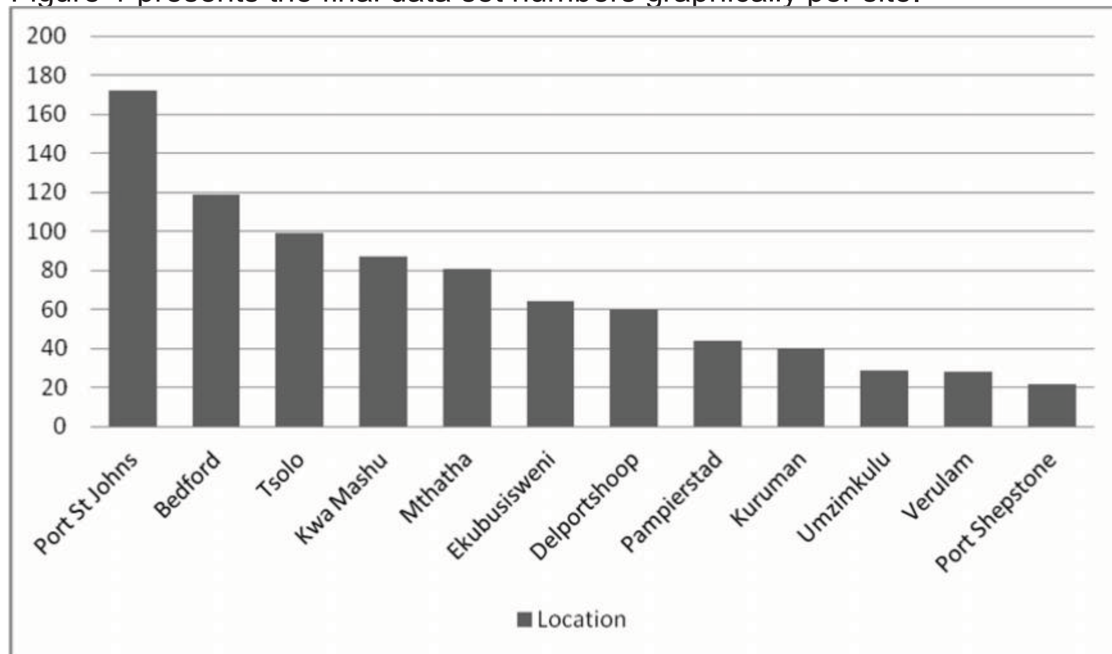


Figure 1: Actual sample sizes per site

Gender and age group sample sizes

While exact numbers per age group and gender were not requested of the field organisers (Asibavikele staff) as this level of precision was regarded as being unnecessary and onerous, attempts were made to achieve parity. Figure 2 reflects the gender balance.

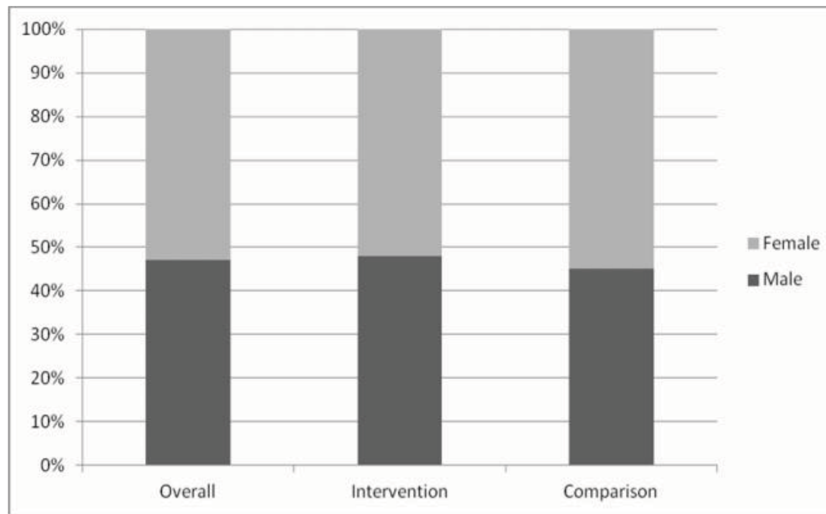


Figure 2: Overall gender balance in samples (Project and Control)

Interestingly, in both Project and Control sites, girls outnumbered boys (by around 52% (girls) to 48% (boys). Although this difference is not significant and does not affect the results, it raises the question of whether this is representative of the larger population, or whether girls are more vulnerable than boys, or whether girls self-select more willingly than boys when it comes to accessing assistance.

Age

Figure 3 shows the spread of ages for each group, the minimum and maximum ages encountered and the median ages (the blue lines). The blue boxes represent the middle two quartiles.

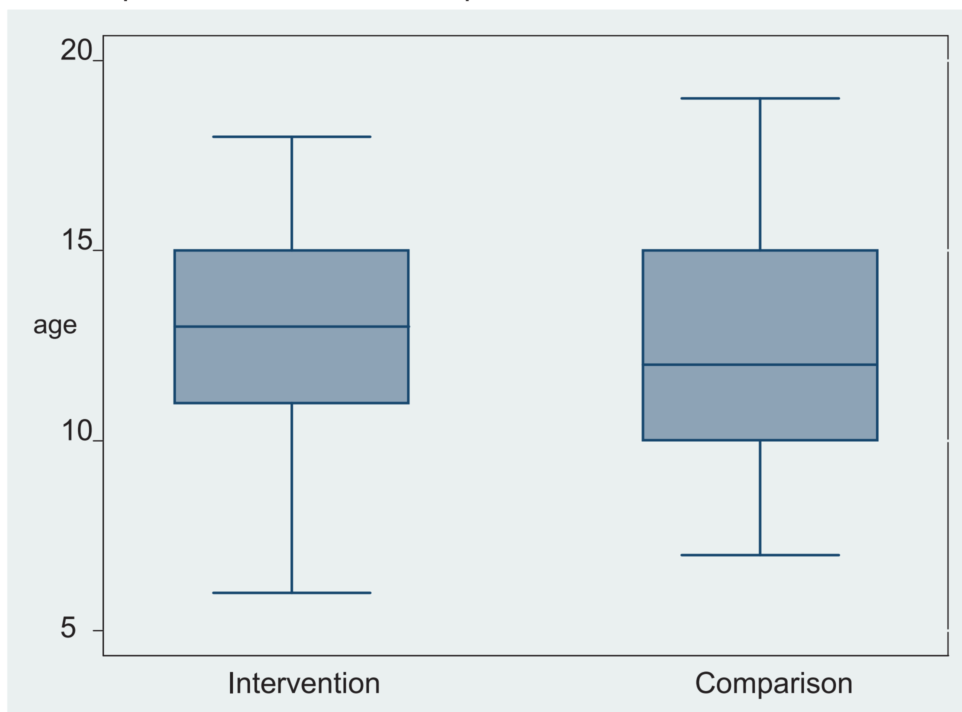


Figure 3: Ages of children in the two research groups

This figure reveals that the two groups were well balanced in terms of age. The average age in the Project group was 12.9 years, while in the Control group it was 12.5 years. There is no significant difference between these.

Sampling: Qualitative
The child well-being impact study employed purposive sampling (Patton, 2001) to obtain "information-rich" cases for the qualitative study within each of the 9 project sites. In this evaluation we selected the following categories of respondents:

- A selection of beneficiary children in each of the 9 project sites
- A selection of caregivers of beneficiary children in each of the 9 project sites
- Non-comparative data from volunteers in Project Sites

In addition to the above, and after the above research design had been developed and approved, it was decided that in addition to the quantitative comparative study work that would be done in the control sites, focus group discussions (activity-based) would be held with one group of 8-12 year-old children and one group of 14-18 year-old children in each of the 3 Control sites. This was in order to gain comparable qualitative data in the Control sites, which was lacking in the original design. Table 5 shows the number of children included in the various qualitative research groups.

Table 5
Qualitative children's group sample sizes

	Age 8-12	Age 14-18
Control sites		
Kuruman	8	11
Tsolo	14	0[2]
Umzimkulu	10	12
TOTALS	32	32
Project sites		
Pampierstad	12	13
Delportshoop	8	10
Bedford	10	12
Port St Johns	10	13
Mthatha	10	11
Port Shepstone	0	8
Ekubusisweni	9	11
Verulam	10	9
Kwa Mashu	10	15
TOTALS	79	90

[2] As mentioned in the section dealing with quantitative sampling, one group of children in Tsolo did not arrive as planned and expected.

4.2 Study design and sampling: Strengthening community capacity study

To find out how and in what way Asibavikele had influenced the community capacity to provide services for children a series of qualitative research activities were carried out.

- Focus group discussions with all Asibavikele community volunteers in the 9 sites.
- Community survey in each of the 9 project sites.
- Focus group discussion with CWSA programme staff at national level combined with Gauteng provincial staff
- Interviews with provincial CWSA staff in the three selected provinces
- Interviews with site level staff in each of the 9 project sites
- Interviews with social workers in each of the 9 project sites

5. RESEARCH PROCESS

5.1 Child-friendly approach

One of the principles behind the research done with the children was that it was suited to the age and stage of development of the children (Boyden,and Ennew,1997). We took care to introduce ourselves and explain what we were doing. We also played games before and during the focus groups and questionnaire administration. We took breaks and had refreshments. Focus groups included activities that allowed for reflection and discussion. The questionnaire used simple language and tools to help children answer the questions.

A number of ethical principles drawn from international and local research were applied in the work with the children (Boyden & Ennew, 1997; Schenk & Williamson, 2005; Clacherty & Donald, 2007).

5.2 Quantitative

The children's quantitative component of the study included the administration of a questionnaire and a version of the Reynolds Child Depression Scale (Reynolds and Graves, 1989) that had been adapted for large-group use. Scores were used normatively and not diagnostically see Appendix 2 for questionnaire. The questionnaires were carefully constructed to use simple language and not be too long. They were administered in groups of 15 to 30 in local schools attended by the Asibavikele project children. Care was taken to avoid labelling children when they were called to the room where we were working. Questionnaires were administered in a variety of localities depending on availability of space.

Answering questionnaires when there is no classroom available

The questionnaires were presented to children in the local language. Sometimes more than one language was used in the administration of the questionnaire (e.g. Tswana and Afrikaans in the Northern Cape) and local terms were used for clarity e.g. child support grant became *ikamkam* in Xhosa.

The Rapid Community Survey was conducted in order to ascertain the extent to which Asibavikele's work was known and had influenced thinking in local communities. The community surveys were carried out only in the Project sites as it could not be expected that people living in the other sites would have any knowledge of Asibavikele. This element of the evaluation is, therefore, non-comparative.

Before commencing community survey work we were careful to confirm that the area we would be working in was where volunteers worked. This was to ensure that their work ought to be known by local community members (it would have been pointless surveying where fieldworkers did not work). Fieldworkers were allocated specific areas. They engaged with people randomly, for example, people standing alongside the road or under trees, others at shops, some by knocking on their doors and politely asking permission to talk to them for a few minutes. The survey protocol is attached in Appendix 2. A total of 141 Community surveys were conducted.

5.3 Qualitative – activity-based workshops

The qualitative data from children was collected through an activity-based focus group discussion. About 8 to 10 children worked in the two age group categories with a researcher and a translator.

A number of participatory activities were developed to measure certain indicators. The groups were all run in the children's home language. All of the activities involved discussion, which was electronically recorded and

transcribed. The transcripts were qualitatively analysed in terms of emergent themes. An outline of the workshop activities is given in Appendix 2.

Drawing all the places I go in a week

The activities included the discussion of a hypothetical family of cut-out figures who received grants and food support. This allowed us to explore the children's experience of services without making them feel ashamed that they did not have food or soap in their own homes.

Another activity used large stones in a plastic bag to help concretise problems children faced in their homes and at school and to look at their levels of emotional stress. Children explored the fact that sometimes it feels as if we are carrying a large bag of stones around with us everyday. Carrying these problems around can make us stressed. The children then named the stones in accordance with their size and talked about when the bag felt heaviest (when they were most stressed) and also if anything had helped them to take the stones/problems out in the last six months.

Children also drew a map and then indicated where 'trusted people' lived by sticking a leaf on the map. This was designed to find out about peer and adult support networks.

Placing a leaf on my map to show where there are people I trust

Barriers to school-going were explored through the use of the cut-out figures and stones that were the ‘things that stop us from going to school’.

The qualitative work with volunteers included the drawing of a map showing their homes and the clients they visited. The caregivers took part in a focus group discussion that included the making of two clay models that showed ‘me before Asibavikele’ and ‘me after Asibavikele’. The clay was chosen as a creative tool as older men and women often feel ill at ease with pencils and crayons and because clay allows a deeper level of expression.

The interviews with the stakeholders were simple face-to-face interviews.

5.4 Limitations of the research

A number of limitations need to be kept in mind when looking at the research findings. These include the fact that in one Control site and one Project site only one age group was available for the focus group discussions held as part of the child well-being study.

In addition, the community survey allowed for only a cursory look at community attitudes to children and knowledge of the Asibavikele Project. It did not really allow us to test the extent to which the community capacity to respond to the needs of vulnerable children had been strengthened by the project. In exploring the second research question on community capacity we explored the role of Asibavikele Project staff and local social workers. The data looking at the extent of community capacity to care for vulnerable children would have been strengthened with data from community leaders and stakeholders such as police and local government officials.

6. PROJECT EVALUATION FINDINGS

The evaluation findings are presented under the two key research questions:

- In what aspects of **child well-being** did the CWSA Asibavikele programme make the most difference; what were the most significant changes brought about by the Asibavikele programme in improving the well-being of OVC?

- To what extent did the CWSA Asibavikele programme succeed in **strengthening community capacity** to effectively respond to the needs of vulnerable children?

6.1 Findings: Child well-being

These findings are presented under the indicators of child well-being developed for the evaluation. See 3.2. Under each indicator heading the quantitative and qualitative findings are presented separately. Some indicators were measured only with qualitative and some only with quantitative instruments.

The quotes in the qualitative sections are identified by province, age group and Project (intervention groups who are part of the Asibavikele programme) and Control. A new child speaking is indicated by a new line and the researcher's words are indicated by R:.

Non-comparative data is also reported on under indicator headings if it casts light on qualitative findings through triangulation.

6.1.1 Material environment/safety nets

Access to social support grants

Quantitative

This indicator was explored through the use of the following question in the questionnaire: Do you get a grant[3]?

A total of 845 children answered this question. Of these 639 (75.6%) do receive a child support grant, while 206 do not (24.4%). Comparatively, there were was a small but significant difference between the groups with 77.1% of Project children compared with 69.6% in the Control group receiving a grant (Chi^2 = 4.065, p = 0.044). Put differently, children in the Project group were 46% (OR=1.46, p = 0.045) more likely to receive a grant.

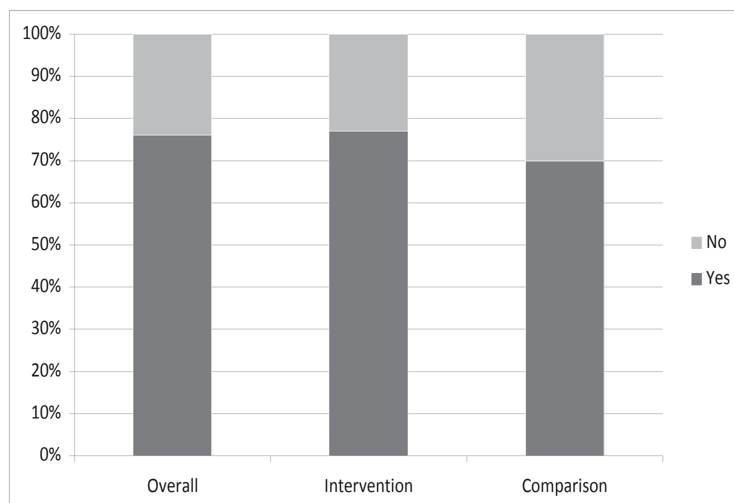


Figure 4: Do you receive a child support grant?

This result shows that in a context where a large proportion of children receive child support grants generally more Project children than non-project children receive one. One conclusion to draw from this is that Asibavikele is successful in increasing children's access to child support grants.

[3] In the administration of the questionnaire we specified that it could be a child support grant or a foster care grant – the important thing was that it was a grant for "you" for the child even though someone else may collect it every month.

Qualitative

The qualitative data showed little difference between the Project and Control group in that most children in both groups in all areas reported that they received child support grants. There were also one or two children in each group (Project and Control) who had problems with their grant applications.

> *R: How do children get food at home?*
> *They get child support grants.*
> *R: OK. Who gets that grant?*
> *S gets it. His father collects it for him.*
> *I get it.*
> *I do too.*
> *R: Put up your hand if you get it.*
> *Ok. All of you, but not you M?*
> *I don't have a birth certificate. (KZN, 8-12 Project)*

The one difference was that the children in the Project group had lots of stories about how the volunteers had helped them to access the grants and those children who were not receiving grants (in the Project groups) told how the volunteers had been working to help them to get the grants. Children in the Control groups, by contrast seemed to be quite powerless in the face of administrative difficulties with grants.

> *R: Do you remember applying for your grant? How did you get it?*
> *Auntie P (Asibavikele volunteer) helped us.*
> *The government and the welfare (Asibavikele) helped us. Auntie P helped my granny. (E Cape, 14-16 Project)*

> *I get the grant.*
> *R: And you T?*
> *My mother has my birth certificate so granny says it is hard.*
> *R: What do you do when you cannot get the grant?*
> *Silence.*
> *R: Can somebody help you?*
> *Granny says it is too much transport to get from my mother in Durban. She does not know where she is.*
> *They said my father needs to sign. My grandfather is too old. (KZN, 8-12 Control)*

When Project children talked about how they had help to solve their problems they often referred to the fact that the help from the volunteer to access the grants had improved their lives.

> *R: What are some of the problems children face here?*
> *Food and Cash.*
> *Not having clothes and shoes.*
> *R: How big is the issue of no food?*
> *Very big.*
> *Not to me, as we used to have little food in the past.*

R: How did it become better? What happened?
We are getting grants now and we can buy more food than before.
R: So before you guys received the grants, how big was the problem?
Very big. But S (volunteer) helped us to get grants and now it is better.
(N Cape, 14-16 Project)

The other interesting finding is that the Project children in two sites in the Eastern Cape knew about foster care grants. They mentioned that the volunteers had helped their grandparents to access these grants.

Two of us in my house get grants. It is me and my granny.
R: So you both get grants.
Yes, I get foster care.
Me and my siblings also get foster care.
I get foster care too.
I don't get a grant. It was closed. It was stopped when the government was dealing with the corruption in the department they said it will come back but until now it hasn't.
R: Oh dear. What will you do?
One of the child welfare ladies (volunteer) is helping my granny.
I was helped by Mrs S. she is also wearing a yellow T-shirt (volunteer).
(E Cape, 8-12 Project)

No Control group children mentioned foster care grants specifically.

Non-comparative data from the caregivers showed that Asibavikele volunteers do significant work to help them access child support and foster care grants for the children. In all of the Project sites there was at least one story, and often many, about how a volunteer had helped caregivers overcome difficulties to get a grant. Most of the difficulties were related to orphan children without documents or children receiving a grant when their parents were alive and the grant being discontinued now they had moved to live with aunts or grandparents. Volunteers seem to play an important role in helping caregivers to access the Department of Social Development and the justice system.

They (volunteer) helped me by filling in the forms for me so I can get the child support grant. (KZN, grandmother, Project)

I live with my daughter's two children… I had to travel to King Edward to get the forms and then to social services. At that time it was so hard for me to travel because we need money to go all those places. And I didn't have information on what to do exactly. Sometimes I wouldn't go to other places because of money. Then the volunteer did help me. She took me to Dududu to the magistrate and did everything for me. I got the foster care grant. I started getting it in December. (KZN, Grandmother, Project)

I have 3 children who were left by their mother they were getting child support grant. They (volunteers) helped me to get foster care grant for them. I am grateful about that because I am alone. By getting that help I can get them food and other things. My boy is doing Standard 6 - now I am very happy for them. (N Cape, Caregiver Project)

One of the interesting issues that caregivers raised illustrates how social security and the concomitant ability to give the children they care for a small treat builds relationships in the household. Caregivers in most of the groups talked about how the children know when their grant is paid and they ask for a treat. Most caregivers talked fondly of how they enjoy being able to do this for the children even though the grant money did not always buy enough food for the month.

R: I heard that they know the dates of their foster grants.
Yes, they do. (The group laughs).
They ask if I am going to get the money and the next day they tell me what to buy (she chuckles).
R: Then what do you do?
I try to buy those things – if they ask for cake or yoghurt I have to buy exactly that! (She laughs again) (E Cape, Caregiver Project)

One issue raised by volunteers and caregivers in the Eastern Cape and KwaZulu-Natal related to grants is a broader issue that probably needs broader advocacy but it was raised by a number of groups so we have reported on it here. Caregivers and volunteers described the problem of Justice Department officials wanting the father's details and permission before granting the grandparents guardianship of the child (a prerequisite to getting a foster care grant).

One of the challenges that we come across from the social development is that they need the proof of the death of one of the parents of the child, when the mother has passed away and the father is unknown. It's only the great grandmother that is staying with the child.
R: Then what do you do?
There is absolutely nothing we can do.
R: Can't you make an affidavit about the death of the parents?
Even so if you would go to the police station they would ask you to go and find the father of the child. And when you go to the granny she says she doesn't know the father of the child. (E Cape, Bedford, Asibavikele volunteer)
See Story 4: Appendix 4.

Summary discussion – grants
The quantitative data show a small but significant difference in the area of social support grants between Project and Control groups. This result shows that in a context where a large proportion of children receive child support grants generally more Project children than non-project children receive one.

One conclusion to draw from this is that Asibavikele is successful in increasing children's access to child support grants.

The qualitative data confirm this, as children in the Project group are able to identify the Asibavikele volunteer as someone who can overcome the problems of accessing grants. By contrast, Control group children seem to be powerless in the face of administrative difficulties with grants.

Caregivers, especially older grandparents, who struggle to negotiate the administrative processes, identify the help given by volunteers as significant.

Access to food support

Quantitative

This indicator was explored through the use of the following question in the questionnaire: Has any organisation or person ever helped you or your family to get food?

Of the total sample for this question of 844 children, 390 (46.2%) reported receiving help with food. There are significant differences between the groups with 49.3% of Project children compared with 33.5% of children in the Control group reporting that they received help with food. ($Chi^2 = 13.458$, $p = 0.000$). Put differently, Project children were nearly twice as likely (OR=1.93, p = 0.000) to receive help with food.

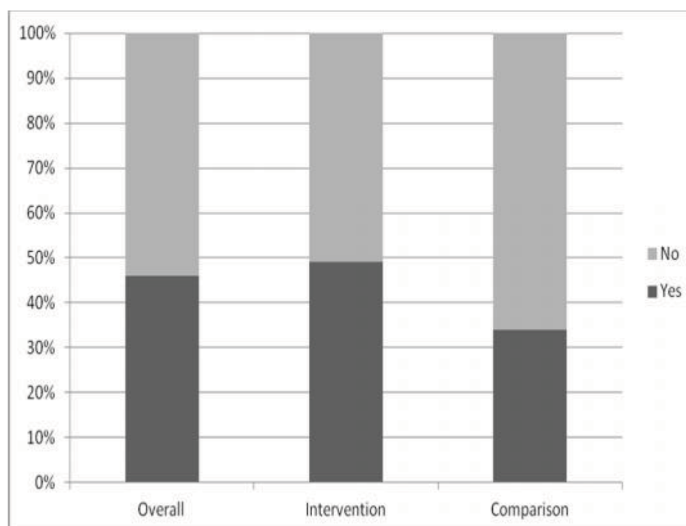


Figure 5: Has any organisation helped you or your family to get food?

Has an Asibavikele person ever helped you to get food?

This is a non-comparative question as Control group children are not supported by Asibavikele volunteers. However, 297 of a sample of 349 project children (85.1%) reported having received help from an Asibavikele person.

The difference between Project and Control groups in the area of food support suggests that the Asibavikele Project provides an important service to

vulnerable families. The qualitative data casts light on the role that this food support makes to general child and family well-being.

Qualitative

Qualitative data collected in activity-based focus groups with children aged 8-12 and 14-16 in Project and Control sites confirms the quantitative findings.

Both Project and Control site children identified lack of food, especially at the end of the month when grants had run out, as one of the biggest problems in their homes.

> *No-food is a problem.*
> *R: Ok. How big is it?*
> *It's biiiiiig.*
> *When you have to go to school with an empty stomach. (E Cape, 8-12 Control)*

> *R: What kind of problems do children have here at P?*
> *It is food.*
> *Yes, that is the biggest problem.*
> *It is very big.*
> *Yes that's the problem especially when you waiting for the grant and there is nothing.*
> *And no one is working at home. (KZN, 14-16 Project)*

Children in all nine Project sites in the younger age group (8-12) whose families are visited by Asibavikele volunteers told stories of volunteers either giving food support or helping their families to access it.

> *Somebody brings food to our house.*
> *R: What is her name?*
> *Aunty OVC. She is a lady wearing a yellow T-shirt. (E Cape, 8-12 Project)*

> *She (the volunteer) took me to town for food parcels from the social worker (at the DSD offices). (E Cape, 8-12 Project)*

Young people in the 14-16 Project groups were more hesitant to talk about food support because of the stigma attached to it but they too told stories of getting help with food.

> *Food is a problem for some children.*
> *It can be a biiiig problem. (She spreads her hands apart to show how big).*
> *R: Does anyone help you with this problem?*
> *Then the social workers (volunteers) can help to get food.*
> *B (volunteer) who visits me and my granny she took us to a place where they give food every day. (KZN, 14-16 Project)*

In the sites that had successful vegetable gardens the children often described the food support coming from the Asibavikele garden.

> *R: Does anyone help you with this problem?*
> *Aunty (volunteer) brings us spinach from the garden sometimes. She cooks for my granny. (N Cape, 8-12 Project)*

By contrast discussions with children in all three Control sites show a different pattern. A few children described links to local services that provided food support or family members that help with food but most did not mention food support at all. The transcript of a discussion from the 14-16 year old group in a Control site in KZN is typical of all of the discussions in the Control sites.

> *No-food is a problem.*
> *Yes, at the end of the month when the grant runs out.*
> *R: Does any one help you with this problem?*
> *No.*
> *There is nothing to do.*
> *Granny goes to the shop and says she will pay when the grant comes.*
> *Grandmother goes to the loan sharks.*
> *R: Are there any ways to help families who have no food?*
> *Nothing.*
> *You just go to school hungry and come home and there is no food. (14-16, KZN Control)*

Data from the focus group discussions with children in the Project groups gives evidence of the impact of food support on children's well-being. In one of the activities that looked at emotional stress in children's lives children were asked to name the stones/problems that they carried around with them. Food was always the first one mentioned (in project and Control) and children always chose to represent this problem with a huge stone. In the Project groups when children were asked "Has anything or anyone helped you to take this stone away or reduce it?" the project children all spontaneously said something like this.

> *Yes, Sis T (volunteer) did bring us food.*
> *R: So did she take the stone away?*
> *No, it is still there sometimes but we had nothing at home and none of us were getting grants. So she brought food parcels to my grandmother. Then she helped us to get foster grants so now we are better and can buy food. (E Cape, 14-16 Project)*

Discussion with caregivers in the Project sites (though not comparative) also gives evidence of the importance of the food support aspect of Asibavikele's work in the communities. Caregivers also talked about the volunteers bringing emergency food parcels when they first became part of the Asibavikele Project until they could find more long-term solutions like grants.

> *I remember B (volunteer) came to visit us to find out about our situation, she took our problem to R (site co-ordinator and social auxiliary worker). We were surprised to see R coming at night to see our situation. We had nothing. The child was eating water. We had no milk. R arrived and saw our situation. She then came with food with her car. (Grandmother who was left with an 8 year old and a 5-month-old baby when her daughter died, E Cape)*

One of the most commonly mentioned forms of food support by caregivers (who were often grandmothers) was baby formula.

> *The baby was five months old when my daughter passed away. I told A (volunteer) who was helping me that I don't have money for formula. She talked to the clinic and they gave me milk for the baby. (Caregiver, E Cape)*
> See Story 5: Appendix 4

Caregivers also talked about how they wished for further food support. This was a particular issue for people while they waited for grants to come through. Caregivers in the Bedford and the KwaZulu-Natal groups that were urban or semi-urban, mentioned this issue most often. It seems that in rural communities families grow some of their own food (such as in the Port St Johns area) and this does increase food security somewhat.

> *They (volunteers) give us a little to cook for the children and then they gave us vouchers to buy food at Spar. But now there is nothing. Even now I am hungry and even my children didn't go to school today because they don't have enough to eat. (Caregiver, KZN)*

Volunteers in all sites talked about how they cannot always meet a family's need for food. In all sites volunteers mentioned the need for emergency food provision for newly identified vulnerable families who had not yet accessed grants. In some areas the Child Welfare office could provide emergency food parcels and in areas with close links to the DSD Asibavikele staff accessed emergency food parcels through state social workers. But often volunteers simply took money from their own family resources or shared their (usually little) food with the family.

> *Sometimes you take a little food from your own house because you cannot just leave these children with nothing. I do not even tell my family I just take it to them. (Volunteer, N Cape)*

In spite of it not always being enough the impact of the food support on family well-being was highlighted by caregivers when they described the impact of the Asibavikele Project on their lives. Though very often they referred to the better general circumstances of their households because of receiving grants they also talked about emergency food relief and how that helped them.

Summary discussion – food support
All families, Project and Control, lack food security. This is one of the dominant themes across all children's groups in Project and Control sites. It is also mentioned by all caregivers' and volunteers' groups.

The quantitative data show that Asibavikele is clearly providing or facilitating access to food support. The qualitative data support this. However, it is clear that food security remains a huge problem in the families supported by the project and indeed in the volunteer's homes too.

Access to health care

Quantitative
This indicator was explored through the use of a cluster of questions in the questionnaire. The first of these is: Have you been sick in the last three weeks?

Of a total sample of 828 children for this question, 279 (33.7%) reported being sick in the last three weeks. Significantly fewer Project children (31.6%) reported being sick compared to the Control group (41.9%) significant (Pearson: $Chi^2 = 6.33$, $p = 0.012$). Put differently, Control group children were 56% ($OR=1.56$, $p = 0.012$) more likely to have reported being sick in the past three weeks.

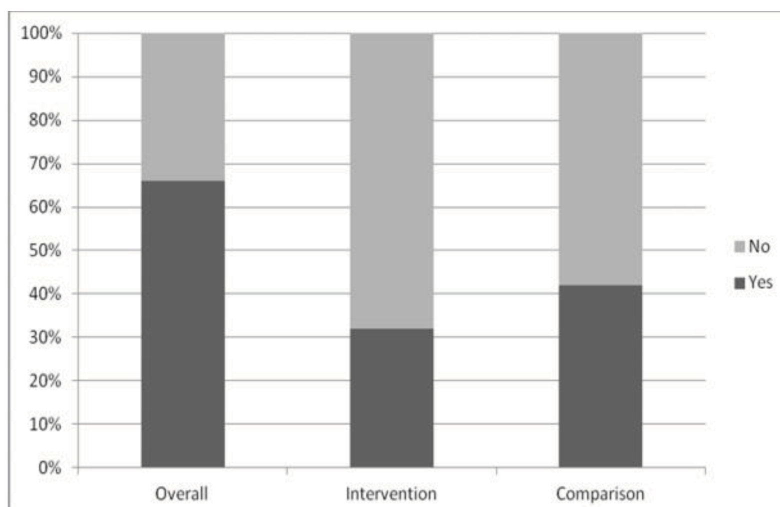


Figure 6: Have you been sick in the last three weeks?

Being sick is a derivative indicator of other factors, for example better nutrition, better access and adherence to HIV medication, greater levels of psycho-social well-being, improved housing and so on. This result is a powerful indication that Asibavikele is able to make a material difference in children's lives, to the extent that their health has improved.

This was followed by: If you were sick, did you go to a clinic or hospital?
Of a total sample of 282 for this question (a much smaller sample than the total group of children who participated because this is tracking only those who reported being sick) 182 (64.5%) reported going to a clinic or hospital,

while 100 (35.5%) did not. Project children in this “Yes, I was sick” category were much more likely to have gone to a clinic or hospital than Control group children. 145 (67.4%) Project children reported going to a clinic or hospital compared with 37 (55.2%) of the Control group children. This is a highly significant difference (Chi^2 = 3.332, p = 0.068). Put differently, Project group children who reported being sick in the previous three weeks were 68% (OR=1.679, p = 0.069) more likely to have visited a clinic or hospital than their Control group counterparts.

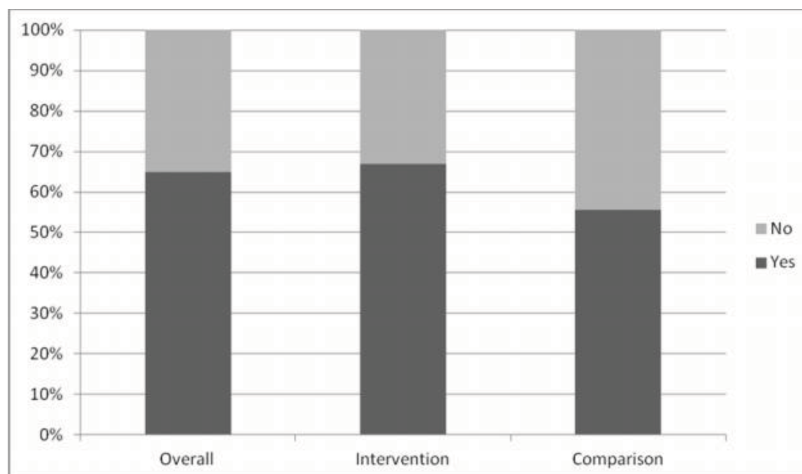


Figure 7: If you were sick, did you go to a clinic or hospital?

<u>Who went with you to the clinic?</u>
This is a non-comparative question as only Asibavikele children answered it. Of those project children who responded to this question, 145 (67.4%) said that they were assisted by an Asibavikele person.

The significantly higher proportion of Project children who went to a clinic or hospital combined with the fact that two-thirds of the children were assisted by an Asibavikele volunteer when they were sick suggests that Asibavikele is playing a significant role in improving children’s access to formal health care.

Qualitative
Discussions around access to health care were kept general with children for ethical reasons. We did not ask children to discuss their own health status in the activity-based focus groups for fear of breaking confidentiality. We did, however, ask them to tell us about any assistance they got with health issues, such as visits to the clinic. We also asked about any help the family got with sick adults.

In spite of the discussion being general in nature, there is evidence in the qualitative data of a difference between Project and Control groups. Project children report help when they or someone in the house is sick whereas Control children do not. There is also non-comparative evidence from discussions with caregivers that the Asibavikele volunteers provide considerable health support to the families in the project. In addition, evidence from volunteers about what they do in their volunteer work suggests that much of their time is spent with health support.

There is a difference between Project and Control groups when it comes to evidence of health support. One or two Project group children in at least half of the focus group discussions describe getting help to access medicines and to go to the clinic or hospital. Though this is not large numbers it probably represents those children who are chronically ill.

> *Sis B takes me to the clinic when I am sick. I go with her to get my medicine every time. We wait in the queue and then we eat chips on the way home. (E Cape, 8-12 Project)*

See the stories “A small boy who is now well” and “Two fat babies” in Appendix 4 for further evidence of this.

Project group children in almost all of the groups describe the volunteer helping someone who is ill in the household to take their medicines or go to the clinic or hospital. The children also describe the volunteer helping with young children and babies who are sick.

> *R: Do you know any family where somebody is sick?*
> *Yes, my own mother.*
> *R: Does someone help you with your sick mother?*
> *Auntie A (volunteer).*
> *Me too, it is helping because sometimes we don’t know what to do and they (volunteer) know. (N Cape, 14-16 Project)*
>
> *When my mother is sick Aunty A (volunteer) comes to our house to wash her and to get medicine. She is coming every day to help us. (N Cape, 14-16 Project)*
>
> *When granny is sick they come and cook for us.*
> *R: Who?*
> *The social workers. (volunteers) (KZN, 8-12 Project)*
>
> *Aunty B (volunteer) she takes my little brother to the hospital. (E Cape, 8-12 Project)*

By contrast, when asked if they had been helped by anyone when they were sick the Control group showed little evidence of help outside the immediate family. One or two mentioned a neighbour or an aunt helping them but most simply kept silent when asked or said that no one had helped them. Two children mentioned a teacher helping them.

> *I look after myself when I am sick. There is no one. (N Cape, 14-16 Control)*
>
> *The girl cannot go to school because she has a sick mother. Like me, I miss school too sometimes.*
> *R: Who helps you with your mother?*

Sometimes my aunty is there but mostly it is me helping her. (N Cape 14-16, Control)

When I am sick, granny takes me to the hospital. It is far in the taxi. (KZN 8-12 Control)

R: So you say one of the problems is people at home who are sick? Do you have anyone to help with this?
I look after my grandmother.
I have no one.
R: How far is the clinic?
It is not far. I take my small brother there to get his medicine.
I am looking after my sick aunt myself. (KZN, 14-16 Control)

Though not comparative data, the discussions with caregivers, particularly with grandparents in the Eastern Cape groups focussed a lot on health support with children. Volunteers had helped many grandparents to access health support for small babies and for young children who were ill. Many had also nursed the parents before they died and then gone on to help the grandparents.

I lost my child. She was looked after by one of these volunteers. My child was hiding her sickness from me. I could see that she was sick. She was in and out of the clinic. And this one A (volunteer) she would come to visit. Sometimes she would ask me to excuse myself because she wanted to talk privately with my sick child. She (the volunteer) accompanied her to the clinic. But she did hide her sickness until she passed away. Now she (the volunteer) helps me with the child and the baby. The baby was five months when my daughter passed away. One day I had no electricity – my meter box was on 2 (running low on electricity in a pre-paid meter). So she gave me a candle for light and advised me to keep the electricity to warm the baby's bottle. (E Cape, grandmother who now looks after two grandchildren)

The volunteers even helped us at a training so that when the child is having an attack, while the doctor is far away, we can be able to help - with the asthma. (E Cape, grandmother)

Caregivers in one of the Eastern Cape sites described the ongoing support of volunteers with their children's health issues as a most valuable support. The importance of volunteers living nearby is obvious here. The transcript is included here verbatim as it shows the varied nature of the health support given by volunteers.

R: So what did they (volunteers) do for your children?
For my last born they sometimes go and fetch treatment for her.
R: What treatment?
HIV treatment.
R: How old is she?

> *She was 6 years old.*
> *R: So the volunteers helped you to get the treatment?*
> *Yes, even if I have no money the volunteer would go to the clinic for me.*
> *My name is Z. My child (adult daughter) got sick and she had three children then I found out that she was HIV. Then the volunteer came and advised me to make me understand about HIV - they also gave me food parcels also Mrs T (volunteer) came to see if my daughter is eating properly and taking treatment as she is supposed to.*
> *I was helped by P (volunteer). She came when I had a child who couldn't sit so she advised me to take the child to the clinic.*
> *For me they really helped me a lot. My child was admitted four times since she was two now she is four years old. R: How does the volunteer know if you have a problem so that they come and help you?*
> *We use phones to call them at anytime.*
> *R: They come?*
> *Yes, they don't say it's night time - they just come. (E Cape, Caregivers)*
> See Story 6: Appendix 4

Summary discussion – health care
The significantly higher proportion of Project children who went to a clinic or hospital combined with the fact that two-thirds of the children were assisted by an Asibavikele volunteer when they were sick suggests that Asibavikele is playing a significant role in improving children's access to formal health care.

The qualitative data give detail about the form of the health care provided to the children. It also highlights that volunteers help adults in beneficiary households to access health care, and volunteers provide significant care themselves to sick adults. There is also evidence that Asibavikele volunteers provide health care access to children under five in the households they visit.

Access to documentation

The issue of access to documents was not included in the children's questionnaire because it was important that the questionnaire was not too long if it was to be child friendly and the issue was partly covered by looking at access to grants. Most children at this age also are not yet eligible to apply for an ID book, and many do not know whether they have a birth certificate or not. For these reasons, results from such questions would have been indeterminate.

Qualitative

In the focus groups children were asked if they had birth certificates. Some of the younger children (in both Project and Control) did not know if they had birth certificates. But most of the children over 11 years knew if they had one or not. In each of the Project groups and Control groups there was a child (in a few cases two) who was not able to access a grant because of having no birth certificate. Most of these children were orphans and the certificate had

been lost in the uncertainty of parent's illness and death and their move to live with grandparents or other relatives.

> *Aunty H did help me. It (birth certificate) was lost and she did go with my granny to get a copy. (N Cape,14-16, Project)*
>
> *I was getting the grant. Then when I came here to live it stopped. Sis A helped me to get it. She helped my granny to go and explain that my mother passed away and I moved. (KZN 14-16, Project)*

What did distinguish Project and Control groups though was that Project group children told stories of how they had been helped to get birth certificates by volunteers.

> *We have birth certificates. We were helped by Sis A (volunteer). I am not sure how she did help she and my aunt Z worked it out – I don't know the details. (E Cape, 14-16 Project)*

Many of the children in the Project groups who did not have grants were waiting for their birth certificate to be processed.

Caregiver workshops (only in Project sites) gave further detail about how volunteers had helped families to access birth, death certificates and then grants. This was a particularly difficult issue for families that lived in rural areas far from government offices as every trip needed transport money.

> *R: Do the children have a social grants?*
> *The other two have are receiving the grant but the other four are still waiting. We are still trying running around to help the children that are not getting the grant. Z (volunteer) is helping me. She is bringing food while we are waiting for the grants.*
> *I went with N who is a volunteer from here to go to the magistrate. She used her own money for transport because I didn't have money. After that I managed to get the social grant. Now the life became even better. The volunteer helped so much. She has a good heart. (E Cape, Caregivers)*

In the 14-16 year age groups in both Project and Control groups young people talked about how the schools helped them to get ID documents. Two children in the Control group in the Northern Cape worried about being able to get ID books in time to write Matric because they knew they did not have birth certificates.

Summary discussion – Documents
The qualitative data provides evidence that volunteers spend a large part of their time helping families they visit to access documents.

Household livelihood strengthening

Quantitative

One of the stated objectives of the Asibavikele Programme is to help vulnerable households to find ways to strengthen livelihoods long term by helping them to start businesses and to find employment. The issue was explored through asking a number of questions in the questionnaire.

The first was: Is there someone in your house who has a job that earns money?

In the overall sample for this question of 845 children, 53% have someone in the household who has a job. Of these, 50.7% of children in the Project group reported that someone in the house had a job versus 64.9% in the Control group reported a job. The Project group was significantly less likely to have someone in their house who has a job that earns money ($Chi^2 = 10.93$, $p = 0.001$). Put differently, households of children in the Project group were 50% (OR=.55) less likely to have a job.

It is not clear why the Asibavikele-supported households have fewer employed members than the Control groups because the Control children also come from households that are vulnerable. One explanation could be a quirk of the specific Control sites that were selected (for example, Kuruman is a Control site, but as a small urban centre it represents employment opportunities that the rural centres do not).

Does your household save any money?
A total of 845 children answered this question. Of these 475 (56.3%) said that their households did save some money, 173 (20.5%) said no, and 196 (23.2%) said they didn't know. Comparatively, 381 Project children (56.3%) and 95 (56.5%) of Control group children said that their households saved money. This is not a significant difference ($Chi^2 = 0.7145$, $p = 0.700$).

Does your caregiver have a small business?
A total of 844 children answered this question. Of these, 187 (22.1%) said that their caregiver does have a small business, while 657 (77.8%) said that they did not have a small business. Comparatively, 138 Project children (20.4%) said their caregivers have small businesses, while 49 Control group children (29.2%). This is a statistically significant difference in favour of the Control group ($Chi^2 = 5.9766$, $p = 0.014$). Put differently, Project children were about 38% less likely ($OR = 0.62$, $p = 0.015$) to live in a home with a business.

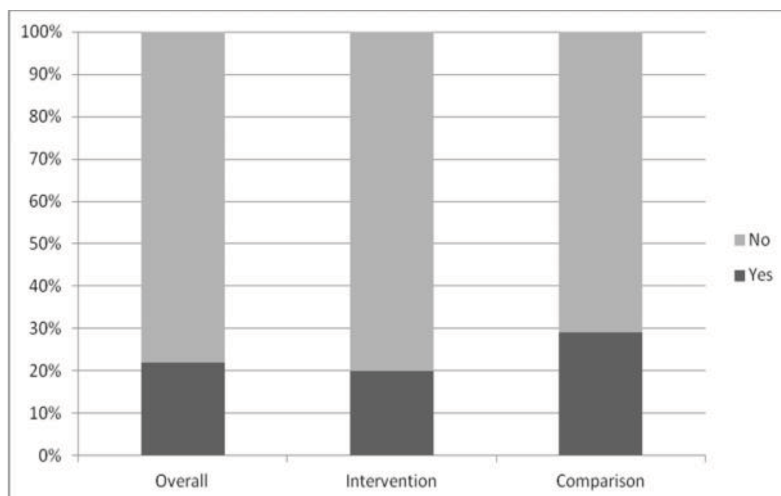


Figure 8: Does your caregiver have a small business?

This evidence about small businesses is consistent with the question about people having jobs in the household, with similar difficulties in interpreting the result, except to conclude that helping clients to find employment or start a small business is not something that Asibavikele volunteers have been able to achieve. This needs to be interpreted in the wider economic context in South Africa where unemployment is high and creating employment is one of the big challenges of the time.

Does your caregiver belong to a financial society?
A total of 844 children answered this question. Of these 446 (52.8%) said that their caregiver does belong to a financial society, 231 (27.4%) said they did not, while 167 (19.8%) said they didn't know. There is no significant difference between Project group children and Control group children: 351 (51.9%) vs. 95 (56.9%), (Chi^2 = 1.46, p = 0.482).

The qualitative data do provide some more information about this issue.

Qualitative
As part of the focus group discussions in Project and Control groups children were asked about household gardens and informal businesses. One of the reasons for exploring this issue was to find out how Asibavikele volunteers supported households with long-term livelihood strengthening.

There was no difference between Project and Control groups in this area. The main difference relates to context. Children coming from households (Project and Control) living close to towns and cities (Kuruman, KwaMashu and to a lesser extent, Port Shepstone) told stories of small informal family businesses such as *spaza* shops and roadside vegetable stalls. The exception to this pattern was Bedford, which seemed to be a completely economically depressed small town with most of the population unemployed.

Most children from households in rural areas in the Eastern Cape (Project and Control) had gardens. These did provide some form of food support but the children talked about how this was seasonal and depended on water and

fencing to keep animals out. Caregivers also talked about how they were too old or sick to keep their gardens productive. There were, however, thriving gardens in many of the Asibavikele sites that were tended by volunteers and used for sharing with vulnerable families and school feeding schemes.

Summary discussion – Livelihood support
Livelihood support to households did not seem to be a focus of the Asibavikele volunteers. This could be because, in the context of poverty that most of the sites operate in it is extremely difficult. For example, starting a business in remote and isolated communities like Delportshoop and Port St Johns is just not viable. Keeping a small productive garden with no ready access to water as in Port St Johns requires skill and commitment that many vulnerable families do not have. Volunteers seem to put most of their energy into helping families access state support through social grants.

6.1.2 Continuum of response and integrated approach

Referral to additional services such as social workers
This indicator was not explored in the focus groups because of time constraints so only quantitative data is presented below.

Quantitative
This indicator was explored through the following question: Have you ever been referred to anyone for help?

A total of 844 children answered this question. Of these, 382 (45.3%) said that they had been referred to someone for help, while 462 (54.7%) said they had not. Conparatively, 340 Project children (50.2%) said they had been referred for help, while 42 (25.2%) Control group children said they had been referred. This is a highly significant difference (Chi^2 = 33.99, p = 0.000). Put differently, Project children were 3 times more likely to have been referred for help (OR = 0.300, p = 0.000).

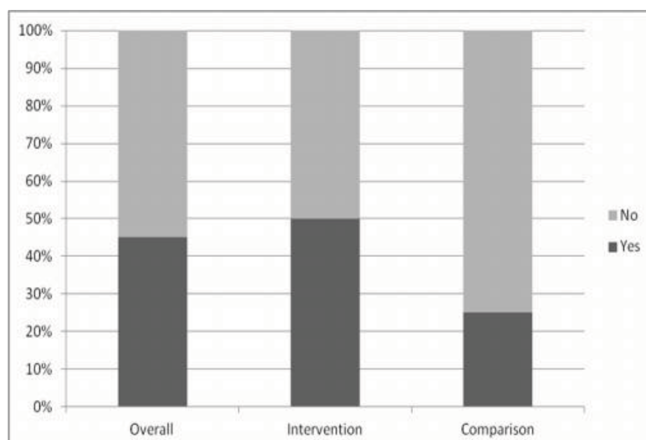


Figure 9: Have you ever been referred to anyone for help?

In the context of this indicator (providing a continuum of response e.g. referral for further help) this is a significant finding. It is evidence that the Asibavikele Programme refers children on to other services such as counselling or health services.

The 'integrated approach' indicator refers to the importance of looking at child vulnerability holistically. The importance of working with the family, the child, the school, peer groups and the community is what is important in an integrated approach.

Data to measure this indicator was collected from a number of different sources, all non-comparative. The discussions with the Project children were analysed for evidence of an integrated approach. The discussions with caregivers and volunteers were also analysed for evidence of how the Asibavikele Programme works in a systemic way to assist vulnerable children.

There is strong qualitative evidence that the Asibavikele programme works holistically and in an integrated way - children acknowledge this.

> *At our homes there are things that we are not getting, but she (volunteer) teams up with our parents and we get everything that we should. (E Cape, 14-16, Project)*

Caregivers also talk about how volunteers work with them and with the children.

> *I was very sick and the volunteer came to see how the children were and found me. She encouraged me to have a test and then she helped me with the treatment. She also helped the children with school shoes. She comes with me to the clinic sometimes and she advises me about the children. She also comes to do homework with them. (E Cape, Caregiver)*

The quotes in the section on emotional stress in 6.1.4 below are also relevant in the context of an integrated approach. Even though the volunteers focus on the children the caregivers clearly feel cared for too as their stories (see discussion on emotional stress in 6.1.4) with the clay figures show – the stories are deeply personal and relate to themselves and not only to the children. It is clear that the volunteers work to help reduce the emotional stress of caregivers and in this way contribute to child well-being.

The discussions with volunteers illustrate how an integrated approach to helping children has been internalised by most volunteers. The story below where a volunteer describes her work illustrates this point. Note how she is concerned with the entire family and the entire spectrum of needs, from health to education to psychosocial support.

> *This is my client's house. I visit them. I perform all my welfare duties here. I assist, for example the child does not have a birth certificate and*

sometimes it happens that the mother does not have an ID. I take the parent to the home affairs to apply for an ID. When the ID is back, we apply for the birth certificate. And then we apply for a grant for the child. This is a clinic when the child is sick. The child is staying with the grandmother. The grandmother finds it difficult to take the child to the clinic. I then take the child to the hospital and sometimes if there has to be a referral letter for the child to go to a specialist, I get the letter from one of the nursing sisters. This is the school. The problem here is that some of these children are going to school on an empty stomach. Most people are depending on the social grants. These children cannot concentrate at school because they are hungry. We do help with mobile soup kitchens that feed these children at school. We also do go to the school after school time and help the children with homework. (E Cape, Volunteer)

Summary discussion – An integrated approach? A continuum of response
Non-comparative data suggests that the Asibavikele volunteers take an integrated approach to supporting families. They seem to work with children and caregivers and with broader systems such as local community services.

The quantitative findings show that the children in the Project group are referred to other services more often than children in the Control group, suggesting that there is a continuum of services facilitated by Asibavikele.

6.1.3 Social ecology/normalising children's environments and routines

Involvement in recreational or support groups

Quantitative

This indicator was explored by the following question: How many groups do you belong to after school? A total sample of 845 children answered this question. Of these, the children reported belonging to a minimum of 0 groups and a maximum of 15 groups. The average number of groups was 2.2 (median = 2). There were very few differences between the Project (mean=2.24) and Control (mean=2.11) groups in terms of membership of groups. These differences are not significant (Kruskal Wallis: $Chi^2 = 1.25$, df = 1, p = 0.026).

The reason this was used as an indicator is the expectation that Project children would be more obviously and normally integrated into the life of the community and that this could be measured by the number of general recreational groups they belong to such as soccer clubs, church choirs or youth groups. Also as 3.1.1 (Theory around child well-being) suggests research shows that involvement in recreational groups is protective and builds resilience.

The quantitative data suggests that Project children are no more involved in recreational activities than Control group children. There are a number of possible explanations for this one of which is that recreational groups for young people are few and far between in the Project and Control sites so possibly there are just no groups for any of the children to belong to.

Qualitative

The qualitative data is very similar to the quantitative in that few children in Project or Control groups talked about being part of recreational groups in their areas. But what we do see from the qualitative evidence is the important role played by the recreational activities organised by Asibavikele volunteers in some of the sites.

Some of the Asibavikele sites that were part of the research have after-school clubs or homework help-groups for the Asibavikele children. The role of these after-school activities as a positive force in children's lives is clear. The three quotes below illustrate this. The first is from a group in the Northern Cape where Kids Clubs are held regularly. The second is from a Project site where there are no after-school activities. The third is from a Control site. Notice the fact that the Kid's Club does more for the children than merely provide something to do after school. The quote suggests that it allows children to relax (reduces emotional stress) and to interact with a sympathetic adult, note too the sense of identity "**my** Kid's Club".

> *R: What do you do after school?*
> *We play games.*
> *R: Where do you play games?*
> *Kids club.*
> *R: Tell me about Kid's Club.*
> *We play.*
> *We learn about TB and HIV and AIDS.*
> *We play soccer.*
> *I play games and I also sing.*
> *We make something sometimes. I do lots of things in Kids Club.*
> *Auntie B tells us stories.*
> *I have Auntie D in my Kid's Club.*
> *Auntie M!*
> *R: Tell me about the aunties (volunteers).*
> *She is nice.*
> *She teaches me stories.*
> *She likes dancing and she smiles. (She giggles).*
> *We can sing you a song!*
> *(They sing) I am so special. I need protection. Nobody touches my special body. Oh, oh oh! (N Cape, 8-12 Project)*

> *R: What do you do after school?*
> *We walk home. We cook food then we do eat.*
> *I go home.*
> *I play soccer.*

I go home to do cooking.
(Same group in another discussion)
R: What are some of the problems children here have?
Loneliness.
R: What does that mean?
No friends to play with. (KZN, 8-12 Project)

R: What do you do after school?
Nothing.
I am helping at home.
Doing housework.
I play soccer with friends.
Nothing.
R: are you with friends?
No, alone at home.
I have to go home to help my grandmother. (KZN, 14-16 Control)

Evidence also suggests that the Kid's Clubs are protective in the sense that they provide pro-social values and knowledge.

Some kids are sniffing glue.
But not so many now.
The police did stop it.
And the Asibavikele talked to children at school.
The children wake up very late because they are drinking until late last night.
This is a very big problem.
R: Where do they get alcohol?
They buy it from the shop. Some steal money from their homes.
R: Do you talk about these things anywhere?
At the kids club we get educated about drugs.
We talk about dagga, cigarettes and glue.
If this boy (referring to the cut-out figures used to get the discussion going) is going to Kids Club he is not sniffing glue? (N Cape, 14-16 Project)

Not all of the play and recreational activity described was formal. Caregivers in some of the sites also talked about how the volunteers played with the children.

R: What did they do for the children?
There is nothing they (volunteers) don't do, another thing that I didn't know about they come and ask the children to play with them I haven't seen an old woman asking a child to play with her.
(She laughs).
They are skipping the rope with the children I even asked her is that also part of their work she said yes these children needs to be happy not to think about their parents.
R: Who else had volunteers who came and played with the children?

It's me.
R: Can you tell us a little bit more?
Z comes and plays soccer with them and exercise.
On a Saturday at 2 o'clock they go to church and play soccer with them and on the weekdays they helped them with their homework.
R: What do you think about this?
It is important.
They must play and feel happy and avoid thinking about their parents.
That is true. (E Cape, caregivers)

One issue that emerged which is related to the theme of clubs and after-school activities is the labelling of the activity as one for 'orphans'. In one of the sites the volunteers had named the support and recreational group 'the OVC group'. They even had a classroom in the local primary school which they used for meetings. This was called the 'OVC room'. While it was clear that the volunteers provided positive and much-needed emotional and practical support to the children in the group the older children talked about how they sometimes felt singled out and ashamed when called to the 'OVC room'.

One of the stones (problems) we have is being an orphan.
R: These children (referring to cut-out figures) are orphans – tell me about them.
They (referring to the cut-out figures) don't feel good when they get called to OVC room.
R: Why?
We are pinpointed in the class to come here.
It makes the stone (problem of being an orphan) bigger.
R: Why?
For us the children who don't have parents it makes us feel sad. (E Cape, 14-16, Project)

Researchers also noticed that many of the songs sung by volunteers with children in these groups related to HIV and AIDS and we wondered if this linked the children directly to AIDS. We explored this with a group of 14-16 year olds.

R: Tell me about the songs you sing here.
We are singing about HIV.
And we sing hymns.
R: So are the songs good or bad?
Good. We are learning about HIV.
The other children are saying, 'Your mother died of AIDS.'
I like to sing it is taking away stress. (E Cape, 14-16, Project)

In the discussion with the children they said they appreciated the support of volunteers and liked coming to the group and meeting other children who also had problems but they asked for volunteers to be aware of the issue of stigma and labelling.

For me it would be better if I don't get called to the OVC room it would be better if I just found myself there (either chose to come here or did not get called to a room with this name).
I think when they want to talk to us they should not say children without parents they should say 'these students'.
But I know I am an orphan and the others know too.
The problem is we know this room now as the OVC room.
They must address us with our names. When they use the word 'orphan' I feel sad.
At home too they are saying I am an orphan and that makes me sad.
(E Cape, 14-16, Project)

Another theme that is linked with this discussion about support groups is the issue of discrimination and bullying. What emerged from all of the groups, Project and Control, is that vulnerable children such as those supported by Child Welfare programmes like Asibavikele are often targets of bullying because of their poverty. Children in most sites and of both ages and genders described being bullied because they had old shoes, torn and tight uniforms and also because they did not have soap to wash themselves and their uniforms or money to do their hair. One pattern that emerged is that this bullying seemed to be worse in sites close to or in urban areas (the two quotes below, for example, come from sites close to Umtata), perhaps because almost all children in rural areas are poor so there is little difference to notice.

If I don't do my hair they laugh at you.
When you have cut your hair with a pair of scissors.
R: The problem of other children laughing at you is it this big, this big or this big? (Researcher uses a simple hand scale moving her hands further and further apart)
Veeery big!
Even if you go to the feeding scheme my friends who are not going are laughing at you. (E Cape, 14-16, Project)

When other children have uniform and we don't have.
They laugh at you.
When your shoe is old and has a hole they say there is a mouse in your shoe.
If you don't have a roll-on (deodorant) they say you smell.
They laugh at you if you have your hair cut with a pair of scissors.
They laugh because we are poor and we don't have anything.
They laugh at you if you are wearing big shoes.
It is worse for orphans. (E Cape, 14-16, Project)

The Project children did describe getting help with uniform and soap (see 6.4 below) but soap ran out at the end of the month and uniforms got small and old. Children also mentioned being teased and bullied because they had

someone sick at home or simply because they were orphans, though this was not mentioned as often as bullying because of poverty.
See Story 7: Appendix 4

Summary discussion – Recreational groups
There is little difference between Project and Control groups in terms of the number of recreational groups they attend. The hope would have been that Project children attended more groups because they were more integrated into the community. This does not seem to be the case.

The qualitative data confirm this. But, the qualitative data also show that where the Asibavikele volunteers do run recreational and support groups they play an important protective role in children's lives.

The qualitative data also highlight the levels of discrimination and bullying that vulnerable children face. Given this ongoing discrimination support groups such as Kids Clubs are even more important as they give children an alternative identity, they are not 'misfits' but 'members'. They are part of groups that do exciting things and they meet other children with similar problems thus creating a sense of solidarity (Madoerin, 2008). But this is only the case if they are not labelled as 'OVC".

Social networks
Quantitative
This indicator was explored by asking two questions, one about how many friends of their age they had who they could trust and could can tell important things to, and likewise for adult friends.

How many children do you know and can you trust?
A total sample of 845 children answered this question. Of these, the children reported having a range from 0 to 20 friends with a mean of 2.3 and a median of 2. The Project group had a higher number of friends (mean=2.4) than the comparison group (mean=2.21). When the data were categorised into 'children who had no friend at all' compared to 'children who had one or more friends', a highly significant difference emerged. 26 children (15.5%) in the Control group reported that they did not have a friend that they could trust compared to 51 or 7.5% in the Project group (Pearson: $Chi^2 = 10.25$, $p = 0.001$).

Put differently, children in the Control group were 2.2 times less likely to have one friend or more that they could trust (OR = 2.25, p = 0.002).

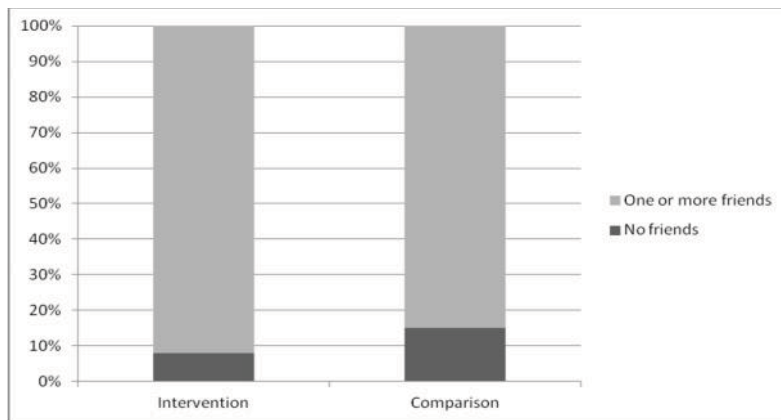


Figure 10: How many children do you know and can trust?

<u>How many adults do you know and can you trust?</u>
A total sample of 845 children answered this question. These children reported having a range from 0 to 18 adults that they know and can trust, with a mean of 2.3 and a median of 2. The Project group had a higher number of adults they could trust (mean=2.9) than the comparison group (mean=2.45).

When categorised into those who had no adult they could trust compared with those who had one or more, a highly significant difference emerged. 16 children in the Control group (9.15%) said they had no adult that they felt they could trust compared to 28 children (4.1%) in the Project group (Pearson: Chi2 = 7.86, p = 0.005). Put differently, children in the Control group were 2.4 times less likely to have one or more adults that they could trust compared to children in the Project group (OR = 2.43, p = 0.006).

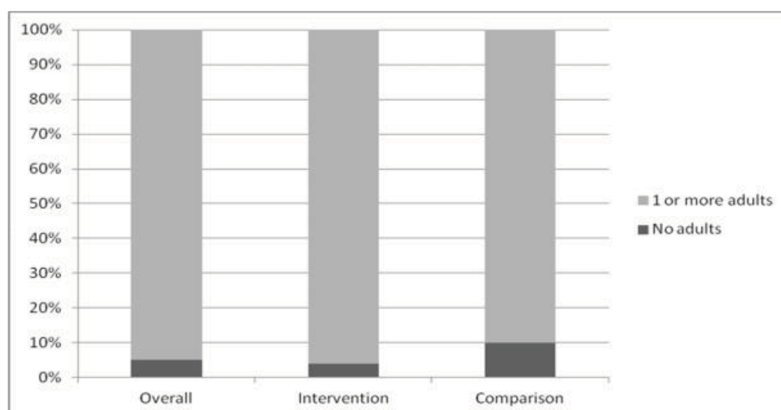


Figure 11: How many adults do you know and can you trust?

Qualitative

Peer network
The findings that emerged under this indicator show that children in Control sites had small (and in some cases non-existent) peer support networks. Most Project group children had broader peer support networks, but not all. There were some (4 sites) Asibavikele sites where Project children described similar peer network patterns to Control group children. Triangulation with volunteer and caregiver discussions seems to suggest that this is the case where

volunteers do not run after-school activities or get Asibavikele children together on a social level.

Adult networks

The findings that emerged about adult support from the mapping activity and discussion around it suggest a similar pattern to the peer networks. Children in Control groups talked about having few and often no adults they could trust and talk to. If they did have adult support it was nearly always a grandmother or mother. Almost none of them indicated that they had a supportive adult outside of the family.

> *R: Would it help you to talk about these things with someone?*
> *I really don't trust people easily. I don't talk to anyone. I just think alone about my broken heart. I sometimes feel so lonely I wish I could die. (N Cape, 14-16, Control)*
>
> *I don't have anyone that I trust. You cannot tell your secrets to anyone. They just gossip. (KZN, 14-16, Control)*

In many of the Project groups children spontaneously indicated volunteers as 'people they could trust and talk to' on their maps.

> *I put a flower (indicating that this is a person I trust) here for the man who visits (volunteer). I call him brother. Sometimes he wears a yellow t-shirt and a blue t-shirt. He says molo (hello). He comes greet me and buys something at the spaza shop because my granny has a spaza shop and sometimes I confide in him. When I ask him not to say what I told him to anybody he does not tell.*
> *I have a lady too. I call her mom. She says molweni (hello). She asks me if the uniform is still okay and ask if I have a homework.*
> *R: So if you had a problem at school would you tell her?*
> *Yes I can talk to her. (E Cape, 14-16, Project)*
>
> *R: Tell me about the lady (volunteer) who comes to visit you.*
> *She is small and she always smiles at us.*
> *She likes jokes.*
> *She is okay, she even helps me with my home-works.*
> *She is lovely.*
> *She helps me with my home-works. (N Cape, 14-16, Project)*

Drawing 1: Four social network maps from the same group of Project children. The volunteers are indicated as adults they can trust by the leaves they have stuck on to the drawing. Note the researcher's annotations – Bulelwa, Amanda and the Child Welfare building all indicate that this is an Asibavikele person the children trust. Note that in the top left hand drawing Amanda (volunteer) is the only adult this child can trust and talk to.

What is significant is that often this trust of Asibavikele adults was in the context of active discrimination and abuse from family members (especially in the Port St John's groups). Children in some of the Project groups described how volunteers intervened on their behalf in their extended families.

> *If you are an orphan and you want food, they first have to send you to the river to fetch water, before they give you the food.*
> *Your caregiver sends you to first go and do some work, so that you can bring some money, before they can give you the food.*
> *R: Has anyone helped with this problem?*
> *Yes there is somebody who has come to help.*
> *R: Who helped you?*

This woman who was here (she refers to the volunteer).
R: Oh, okay, which problem did she help you with?
This one where I was ill treated by my guardians.
R: How did she help you with the ill treatment one?
She visits us as orphans and helps us by solving our problems. What she normally does is to visit that particular family with a problem and organise a family meeting to explain what should be done and not done. (E Cape, 14-16, Project)

What also emerged from Project groups though is that not all Asibavikele children felt that the volunteers were people they could trust and talk to. In four of the sites the children did not include the volunteers on their map of trusted people and then when asked by the researcher why, they said that they did not trust them to talk to. The most common reason given was that the volunteers were adults and therefore they could not be approached by children and in the case of talking about discrimination at home in the extended family the children felt they would side with the adults in their homes (often aunts and uncles).

The thing is I don't want to stay where I am staying now (at my father's place). I want to stay at my mother's family. Because if I do something wrong here I get beaten and other children were not getting the punishment and when I ask for money to go to school trip they wouldn't give me.
R: Did you tell anyone about this problem?
No. I am scared that she (the volunteer) would tell my aunt and I would be beaten. (E Cape, 14-16, Project)

Children in these sites most often indicated that the volunteers were like 'teachers' rather than 'kind aunties'. They described the communication with volunteers as practical and cursory. They reported that the volunteers did not talk much to them but mostly talked to their caregivers and that they asked them only simple questions.

They are talking to our grandmothers.
Yes, she just asks if I get food and if I am going to school.
She asks if I have done my homework. (E cape, 14-16, Project

The reason for this could be because in traditional rural areas the barrier between children and adults is quite strictly observed. For example, children would be thought disrespectful if they treated an adult outside of the family as a friend. There was evidence though from one rural Eastern Cape Asibavikele site that young people saw the volunteers as their friends and talked easily to them about their problems. So it is possible for children and volunteers to relate outside of cultural norms. What is interesting is that in this site volunteers ran regular recreational groups with young and older children. The older children talked about how they played sport with them.

She is fun, she plays soccer with us.

> *And she sings songs and we play games with a small ball. (E Cape, 9-12, Project)*

Another issue raised by the older children in a few Project groups in this regard was that they felt the volunteers were more interested in the younger children than in them.

> *They are more interested in the little children. They do not ask about us. They ask the grandmothers about the little one.*
> *Yes, I agree, I think they are there for the babies and young children.*
> *R: Do they talk to you about teenager's things?*
> *No. We talk to our friends about that stuff. (KZN, 14-16, Project)*

When analysing the qualitative data what emerged is that in those Asibavikele sites where the volunteers actively engaged the children in after-school activities the children perceived the volunteers as friends. Note too that in most sites (even those that did not do after-school activities) that there were one or two volunteers who were clearly 'adult friends'. So it seems that the personality of the volunteer also plays a role.

Another theme that emerged around the issue of support is the support volunteers give to child-headed households. In a few Project groups children mentioned volunteers who gave considerable support to them.

> *N is helping us as we lost our mother last year we stay alone - there is no adult. But we have an uncle who helps us with food but now he is unemployed. She (volunteer) did help us to get the foster care grant and now we are surviving with it. We also got (food) vouchers while we were still waiting, even now she comes and visit us at home to see how are we doing.*
> *R: What does she do when she visits?*
> *She comes and talks to us asking how are we doing and my younger sibling was starting to misbehave so she gave her advice talking to her. Sometimes she spends almost the whole day with us. (KZN, 14-16, Project)*

Summary discussion – Social networks

A social network with peers and adults children can trust and talk to is protective and a contributor to resilience. The quantitative data shows that being part of the Asibavikele project increases children's peer and adult support network.

The qualitative data show that many of the Project group children see the volunteers as people they can trust and talk to. There is also evidence that some children (particularly older children) did not indicate that the volunteers were people they could trust, in fact some said they worried they would not keep confidentiality and that they cared more about the younger children.

6.1.4 Human capacity

HIV and sexuality knowledge
Quantitative

One of the Asibavikele programme activities is lifeskills education for the older children. Accordingly, the evaluation set out to assess the extent to which this activity might have increased knowledge and brought about more positive attitudes around sexuality and HIV/AIDS. However, in the field, or specifically at the 9 sites included in the evaluation, we found that only one site had introduced the lifeskills activity, and that only recently[4]. Although we continued with the lifeskills questionnaire in all 9 Project sites and the 3 Control sites, this data was not found to be valid for the comparative aspect of the evaluation.

The results are presented here.

The Project group scored lower (mean=5.56) in the LSQ than the comparison group (5.9). This was significantly different using the Kruskal-Wallis rank test (p=.0057). When the data were analysed in two categories (those scoring above the median of 6 i.e. 6-8) versus those scoring below the median (2-5) the same pattern emerged. More of the intervention group (43%) compared to the comparison group (31.51%) scored in the low category. This means that Project children know less about HIV and AIDS than Control children.

An important observation from the results is that children in the Asibavikele programme are clearly vulnerable in the area of sexuality and HIV/AIDS. For some reason, the Project children seem to be more vulnerable (as inferred from the questionnaire results) than the Control group children. This supports the need to implement this activity extensively and effectively.

Qualitative
This is not reported on because only one Asibavikele site had run the recently introduced lifeskills programme so it was difficult to make comparisons between Project and Control group discussions in the focus groups.

Emotional stress
Quantitative
Emotional stress was measured with a shortened version of the Reynolds Depression Scale, suitable for large group work.

Emotional Stress Score
A total sample of 844 children answered this question. Overall, scores ranged from 0 to 34 (being very happy to very depressed, respectively). Project children had a range of 0-31 and a mean of 10.1. Control group children had a range of 0-34 and a mean of 11.9. The differences between these scores is shown to be significant (Kruskal Wallis: $Chi^2 = 9.28$, df = 1, p = 0.023). Put differently, the Project children were 1.5 times more likely to have a lower

[4] Note that the lifeskill is a recently introduced programme

CDS score (<10) (i.e. to be less emotionally stressed) than the Control group children (OR = 1.51, p = 0.017).

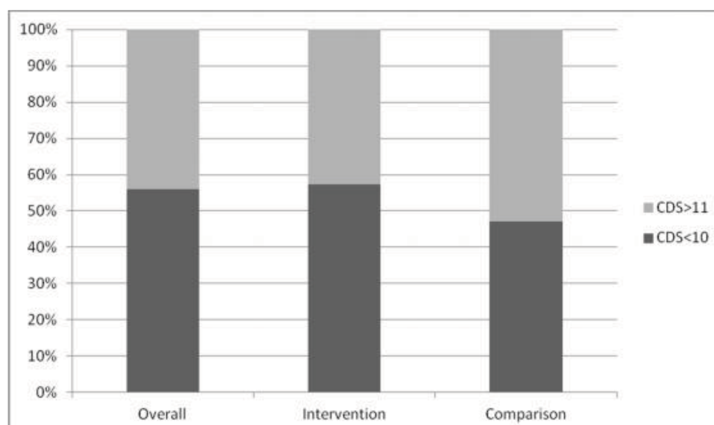


Figure 12: Emotional stress scores

It is to be expected that Project children, with the various kinds of support provided to them by Asibavikele and the impacts of that generally in their lives should be less emotionally stressed, or, simply, happier, than their Control group counterparts. This suggests that Asibavikele is making an important positive difference in their lives.

A further analysis of the emotional stress instrument was used to discern whether there are age and gender differences in the data.

Interestingly, no gender differences were found, so boys and girls in this survey seem to be equally happy. However, there was a significant age difference.

Older children in both Project and Control groups were found to have higher scores (or higher stress levels), but the difference was much more pronounced, or significant in the Project group (T-test, t = 4.08, df = 675, p = 0.0001). The Control group differences were also significant, but not quite as pronounced (t = 2.17, df = 165, p = 0.03).

This suggests a number of things. Firstly, adolescents (being adolescents) probably experience hardship in life more acutely and have become aware of the unfairness of life, while younger children have not learned to think in these ways. Secondly, it emerged from qualitative data that older Project children felt that volunteers tended to talk to and care more for younger children than them. This could be one of the reasons why their stress levels are higher than those of the younger Project children.

Qualitative

In Project and Control schools in all sites the problems that children said caused them stress were very similar. The biggest problem was always ‘no food’, then ‘no school uniform or shoes’, ‘being bullied’ and ‘thinking about my parents who have passed away’. Once children had mentioned these

problems the problems tended to be context specific. In Port St Johns many of the problems related to maltreatment by guardians, in the Northern Cape sites the problems related to 'bad friends' and 'drugs and alcohol'.

We explored the area of emotional stress caused by the problems further by asking 'When does your basket of problems (see 5.3) feel most heavy?' Many children, in Project and Control groups indicated that it was heaviest at night, 'When I am thinking that I would not be struggling if I had my parents' or 'When other children are telling about their parents and the things they buy them'.

Once all of the stones had been placed in the basket the children were asked, 'Have any of these stones been removed for you in the last year? Is your basket lighter?'

The pattern that emerged when comparing Project and Control group was very similar to the pattern in the area of social networks. Almost all children in all of the Control groups indicated that their baskets were still very heavy and that no one or nothing had helped them make them lighter. One or two mentioned that an uncle or a neighbour had helped with the 'no food' stone or the 'no school uniform' stone. But mostly the stones were still there and still big.

> *R: All these stones (problems) in the bag! Has anyone helped you to take them out?*
> *It's a little bit lighter because of my father.*
> *(Silence).*
> *Nobody is helping me.*
> *It is still big. (E Cape, 8-12, Control)*
>
> *R: Did anyone help you to take the stones out of your bag?*
> *(Silence).*
> *No one.*
> *It is heavy.*
> *R: Are all the stone still there or has someone helped to make them lighter?*
> *Still there.*
> *(Silence). (KZN 14-16, Control)*

By contrast children in most of the Project groups (though not all – see below) said the basket was lighter. When they were asked why, they spontaneously, without the researcher linking the activity in any way to the Asibavikele programme, said that a volunteer (whom they named) had helped to lighten the basket of problems, usually by giving food or facilitating a grant or helping with school uniform.

> *R: Has anybody helped you to take these stones out of the bag or are they still there?*
> *No.*

Our Mothers, Social workers, Aunty.
R: Aunty who visits you but does not live with you or aunty who lives with you?
T's mother who visits (volunteer).
R: Which stone did she help you with?
When my mother passed away, they talk to you when your mother passes away.
Some problems are being attended to. (KZN, 8-12, Project)

Children in Project groups also mentioned that volunteers helped with the stone that they often called 'feeling sad and thinking about our parents who passed away'.

R: Is there anything or any person who has helped you to take the stones out of your bag to make it lighter?
Yes.
R: Who?
The group of volunteers that help us with homework after school and during holidays, they helped a little bit.
R: Ok, so they helped a little bit. Anything else that helped you?
Sometimes Auntie A (volunteer) has come to talk to us and helps with some other things.
R: So how is your bag (of problems) now?
Very light. (N Cape, 14-16, Project)

There were a few Project groups where the children did not mention volunteers (or anyone else) as lightening their load. Note that these were also sites where Project children indicated that they did not have deep supportive networks of peers and adults. These were also the Project sites where volunteers said they felt inadequate and unable to talk about death and grief with children, particularly older children (see section 6.2.1 below on role of volunteers). In these sites volunteers asked for counselling skills.

Though it is non-comparative data the information gathered from caregivers suggests that the Asibavikele Programme also lightens their load of emotional stress. One of the activities we did with caregivers was to give them coloured clay and ask them to make two small sculptures. One to show 'me before Asibavikele' and the other to show 'me after Asibavikele. The descriptions of these small objects reveal a huge impact at an emotional level for caregivers. Time and time again in all of the sites the caregivers (mostly grandmothers, mothers, aunts and some older sisters and a few grandfathers) made thin, emaciated figures to illustrate how they were before the project intervened. These were followed by traditional-looking models with much fuller figures. The following quote is typical of what caregivers said about these figures.

Before I met the Asibavikele I was very thin. I was like this thin person. Now I am fat and I can look after my children. I am a real woman now. (N Cape, Caregiver)

Before Asibavikele I was thin but now I am a real woman!

The impact of practical help on self-image and the power to provide for oneself and the children is obvious here.

Other common images were household objects that represented control and peace such as teapots and cups, pots full of food and bowls ready for food to be dished up. Two women describe the meaning of such objects in the quote below. What is significant in the context of reduced emotional stress is the idea of stepping out of poverty and back into human dignity.

> *Before I was sitting not knowing what can I do so that my children can eat or to buy them uniform. Now this teapot it shows that now we have the grants I make a nice tea with milk in it after the women from Asibavikele have told me what to do to get the grants. Now I can sit and relax and have tea and I have milk and can invite my friends. I am like a human being again. (E Cape, Caregiver)*

Now I can relax and have tea like a human being

> *Before I used to put a pot on fire to boil water for the children because I had no food for them. Now I can but eggs and fry them for the children. This is my pan full of eggs. (E Cape, Caregiver)*

My pan full of eggs for my children

Another common object was animals. Many represented the way they felt before they were part of the Asibavikele programme through examples such as dogs.

> *Before the volunteers came I used to be like this dog – people looked down upon me. After the volunteers came the light came to my life. I even bought this vase. (E Cape, Caregiver)*

And the way they felt after being helped by the project.

> *I am now like this fat cow. I have food and so do my children. (N Cape, Caregiver)*

Though a simple reflective exercise the emotional resonance of this activity suggests deep impact of the project on caregivers lives. Another theme was the theme of support. Caregivers described the volunteers as emotionally supportive, even if they could not often solve the practical problems of no food, for example, immediately.

> *I was sad and alone and I was drinking to get rid of the stress. I was not looking after my children well. Now the volunteer has come to help me. She sits and talks with me and encourages me not to drink. We talk about things and laugh together. She has helped with school uniforms. Now I am looking after my children well and they are going to school. (N Cape, Caregiver who is a wheelchair user) (N Cape, Caregiver)*

All of the above suggests that the Asibavikele volunteers provide significant emotional support for caregivers, which obviously impacts on the stress levels in the household therefore affecting children positively.

Summary discussion

The quantitative data show that children who are part of the Asibavikele Project have less emotional stress than those who are in similar

circumstances but not supported by volunteers. Older children supported by Asibavikele experience more stress than younger children.

The qualitative data give insight into what aspects of the project are effective in reducing stress for children. Food and school support are important in this regard. The qualitative data also shows that caregivers see a difference in emotional stress levels in their own lives since they have been part of the Asibavikele project.

There is some evidence from the qualitative data that children and caregivers still worry about grief related to the death of parents and that there is a need to support this aspect of the volunteers work. Note that volunteers also identify this as an area that needs strengthening (see 6.6). Volunteers also need support in being able to relate to older children more effectively.

While no gender differences in emotional stress levels were found, significant differences between older and younger age groups were found with related comments about older children feeling less cared for than younger children.

6.1.5 School support

Quantitative

The issue of school support was explored through two questions, the first looked at dropping out of school and the second at help to get back into school.

<u>Have you ever dropped out of school?</u>

A total of 842 children answered this question. 142 (17.2%) of these said that they had dropped out of school. Comparatively, 101 (14.9%) of the Project children had dropped out of school, while 44 (26.5%) of Control group children had dropped out of school. This result is significantly different (Chi^2 = 12.51, p = 0.000). Put differently, the Project children were about 50% less likely (OR = 0.48, p = 0.000) to drop out of school than the Control group children.

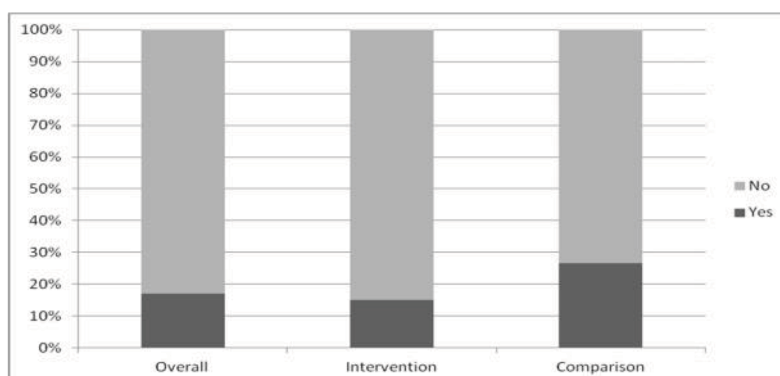


Figure 13: Have you ever dropped out of school?

<u>Did you have help to get back to school?</u>

Of those who dropped out of school, 141 responded to this question. 119 (84.4%) said they had had help in getting back into school, while 22 (15.6%)

said they had not had help. Comparatively, 81 Project children (83.5%) said they had help getting back to school, while 38 Control group children (86.6%) said they had had help. ($Chi^2 = 0.188$, $p = 0.67$). This is not a significant difference.

These two questions together reveal that Asibavikele plays a supportive and protective role in children's lives, given that children who are supported by volunteers are much less likely to drop out of school than their Control group peers. However, Asibavikele does not seem to be as effective in tackling the challenge of getting children back into school.

Qualitative

School attendance and progress were explored through an activity looking at barriers to school-going and how these were overcome. Barriers to school-going were also mentioned as one of the major problems that caused emotional stress.

Project group children and Control group children described similar barriers to school-going. The main barriers were "no school uniform or shoes" and "no certificates". Children in both Project and Control sites described how they had missed school because they did not have the correct uniform or birth certificates. Children also described how moving from one place to another when their parents died resulted in them missing school. One of the common reasons was that documents were lost in the disruption after a parent's death.

> *You can't come to school with no shoes.*
> *Socks is a problem too.*
> *They will send you home.*
> *R: Who has missed school because of no shoes?*
> *Me.*
> *And me, I had to stay home until granny could buy the shoes.*
> *R: How long did you stay home?*
> *Two weeks. (E Cape, 9-12, Project)*
>
> *R: What stops children going to school.*
> *No school uniform.*
> *R: Did that happen to any of you?*
> *Yes me.*
> *And me at the beginning of this year. No uniform to go to the secondary school.*
> *R: What did you do?*
> *My uncle sent money but I got to school late, three weeks. (KZN, 14-16, Control)*

Children in Project and Control schools also mentioned how lack of food affected school progress because children often went to school hungry and then could not concentrate. They also talked about how "thinking about our parents who have died" or "thinking about our sick mother or granny" affected their progress at school.

It is a problem to be hungry at school because you can't concentrate - you are thinking about food. (N Cape, 14-16, Project)

I am worrying about my mother who is sick. I am thinking if she is needing water or food. I cannot concentrate. Some days you miss school to look after your mother. (N Cape, 14-16, Control)

Another school-related issue that was also mentioned often in both Project and Control groups and in all sites was the issue of discrimination and teasing at school because they were poor and or orphaned. Children in both Project and Control sites described how this teasing often caused children to stop going to school.

The children stop to go to school because they are bullied. They do leave home but do not go to school.
R: Did that happen to any of you?
Yes, I was afraid to go when there was no soap to wash because they will say they do not want to sit next to you.
R: Did anyone help you with that problem?
Silence. (KZN, 14-16, Control)

The bullies stop children from going to school.
R: Tell me about that.
They laugh at you and say you have a mouse in your shoe.
They say you are smelling with no soap.
They say we are orphans and live only with old people.
R: How does that make children feel.
Very sad! (all speaking together).
R: Did anyone help you with this problem?
Auntie B did speak to the children at school.
She also helped me with soap for washing clothes.
The grant helps too. (N Cape, 14-16, Project)

As the quote above illustrates the difference between Project and Control sites around school-going emerged when children were asked if they had any help. In the activity with the stones/problems when children were asked if anyone had helped them with the problems they faced Project children in most groups commonly mentioned help with school uniforms and shoes as one of the main things that had "lightened their basket" of problems and reduced their emotional stress. This was often mentioned first.

R: What a lot of problems you have in your basket. Has anyone helped you to take any of these problems out?
Auntie M gave us school uniform and shoes.
Yes, we got uniform.
I got new shoes.
R: Who gave them to you?
Child Welfare.
Me too. (E Cape, 14-16, Project)

> *Auntie from OVC she did help with uniforms and socks. (E Cape, 14-16, Project)*

Children in Project groups also mentioned getting help with school materials.

> *Auntie R gave us books for writing so now we can write the tests. (E Cape, 8-12, project)*

By contrast, in Control groups children were almost all silent when asked if anyone had helped to lighten their load of problems. None mentioned getting help with school uniform or school materials. Though some did say that their grandmothers or aunts and uncles had been able to buy uniforms once the grant came in at the end of the month.

In at least half of the Project sites children also mentioned how volunteers had helped them with documents such as birth certificates and transfer documents from their previous schools. This was a particular issue for children who had moved to live with grandparents when their parents had died. This support was not mentioned at all in Control schools.

> *That lady who was here just now (referring to the volunteer) she helped me to get a certificate. She took me to town. My birth certificate was left with my mother's family. (E Cape, 14-16, Project)*

Apart from practical support, it also emerged that children in Project sites received homework support and encouragement to go regularly to school from volunteers.

> *She (volunteer) does ask us about school. She always asks to see our homework. She asks if we are going to school and if we have food. (N Cape, 8-12, Project)*

> *B (volunteer) does help us with our homework here at school. She also plays games with us and she brings nice things for us to eat here, (E Cape, 8-12, Project)*

In two of the sites volunteers went to the school regularly after school to help children at school with their homework. In one site this help was given to Asibavikele Project children in a special classroom set aside for them. In another school this help was given to all of the children in the Foundation Phase. This allowed volunteers to get to know the children and also to identify those that needed help. It seems that the homework support is given mostly to younger children, older children said they worked with peers to get help with homework. Project children in one site described how one of the volunteers supported them with project work for school.

She (volunteer) helps the little ones. We work with our friends and do homework together. But sometimes she can help me to find things in the library and she advises me about projects. (E cape, 14-16, Project)

The issue of discrimination at school because of orphan status and poverty remained an issue for Control group children but in many of the Project sites children described how the help with grant access and food had changed their status somewhat at school.

It (discrimination) is not so bad now because my grandmother does get the grant for us (foster care grant) so we can buy soap and new shoes. So the teasing is not so bad now. (KZN, 14-16, Project)

In one Project site where children lived with extended family after the death of their parents they told stories of how the extended family had made school attendance difficult by giving them extra work and by denying them school materials.

Other children (in the family) are getting school things and we are not getting.
R: did someone help with that?
Sis N came to ask if we were well and we told her that we were not getting (school materials and uniform) and she talked to granny.
Sis T is helping when there is a problem at home she is always the one to come and solve it. (E Cape, 14-16, Project)

Children them went on to explain how the volunteers had helped them with this issue by talking to their guardians and then monitoring that they were being allowed to go to school.

R: Did she help with school?
She did talk to my aunt and say that I must go to school.
R: Were you missing school?
Yes, I was looking after small children.
R: So Sis T did help.
Yes, and she comes and asks me if I am going to school. (E Cape, 14-16, Project)

Discussions with caregivers show too how much the support of volunteers helps them to make sure the children go to school.

I had such hardship with the child of my brother that I look after. We were struggling to get a birth certificate. My child could hardly participate in activities. She could not go to school. It felt dark at that time. Now Sis X (volunteer) helped me to get a birth certificate and to get her into school. She is a very talented child. Now she is a star. (Caregiver, E Cape)

> *So one of the volunteers helped me last year so now I have my child's grant and she also comes two or three times a week to help her with her school work. And last year it was the first time to get a school uniform. (N Cape, Caregiver)*

Caregivers also talked about how volunteers helped with homework.

> *My child was not doing well at school. Then the volunteer came to help with homework so now she is doing much better. I cannot read so I could not help her. (KZN, Caregiver)*

Summary discussion – Access to school

There is strong qualitative and quantitative evidence that the Asibavikele Project makes an impact in the area of school attendance, particularly in not dropping out of school. Though children in the Project and Control groups face the same barriers to school-going the Project children receive significant support both practical and emotional to go to school and to keep going. In some areas volunteers are strong advocates and monitors of orphan children's rights to access schooling.

The high level of discrimination that orphan children face at school from peers is addressed to some extent by the Asibavikele Project through making sure children have uniforms and grants that provide for soap and school materials. One can also assume that the emotional support provided also helps children to cope with the teasing. But, the level of bullying experienced by vulnerable children is still a concern.

However, the evidence suggests that Asibavikele is less successful in getting out-of-school children back into school. This is consistent with other findings that Asibavikele is able to provide day-to-day support and to provide immediate needs, but is less able to address systemic issues in society (for example, job creation).

6.2 Findings: Community Capacity

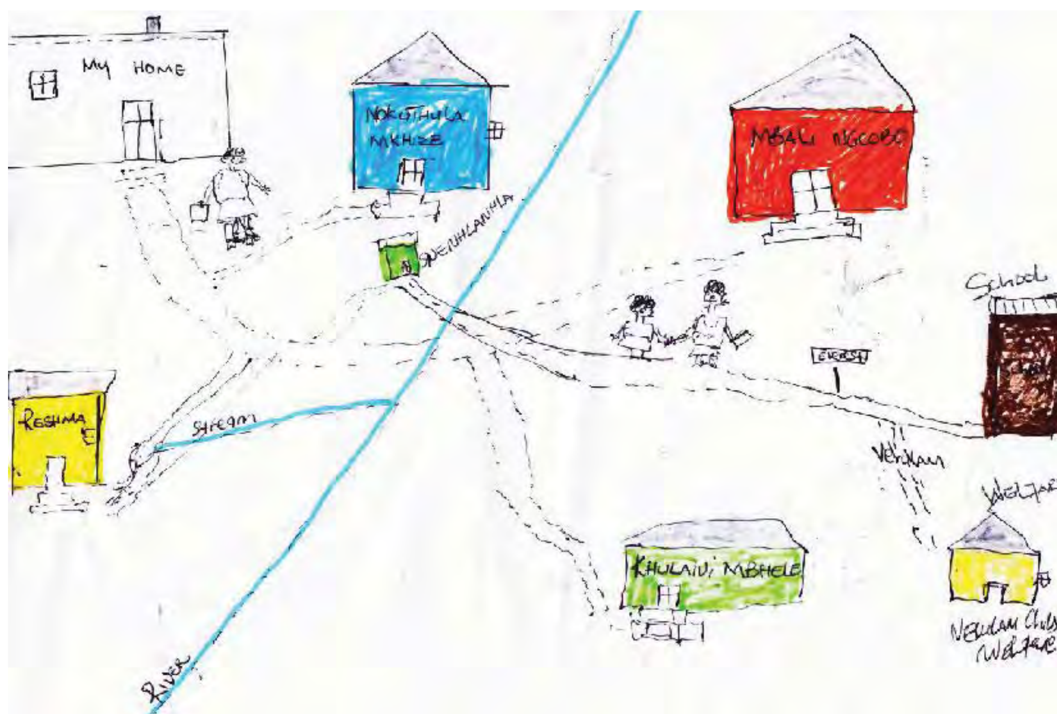
The findings presented here look at how the Asibavikele Project has developed the capacity of community members in the 9 sites to respond to the needs of vulnerable children. These findings come from focus group discussions with volunteers and from interviews with project staff and some community stakeholders such as social workers.

6.2.1 Volunteers

The key vehicle for increasing community capacity in the Asibavikele sites has been the selection and training of volunteers to work with vulnerable children and their families. The findings presented above in 6.1 show how volunteers have made very significant impacts in the lives of vulnerable families. This section of the findings looks at the kind of capacity they bring and how they work. It also looks at some of the challenges that the volunteers face and points to the ways their capacity can be strengthened.

<u>Volunteers provide the capacity to access services</u>

In order to understand what the Asibavikele volunteers do we asked them to draw a map of their house and all the families they work with. This map gave a detailed insight into the work they do but also into the challenges they face. The map below and its accompanying story are typical of those presented by volunteers in all of the sites.



Drawing 2: A map showing my house and the families I visit (volunteer)

> *This is my house here. I am going to this family here - they have 7 children. The first time I went to that family the children were staying alone, their mother was working in town and their father had died. So I worked with them helping them. Sometimes they didn't have food to eat so I used to help them together with my neighbours. Then I*

registered them as a vulnerable family and now I am working to get them grants. Once a month I can take a food parcel because we are waiting for grants to come through. Then this is another family with too many children. They were getting grants but it was not enough then I helped her to get foster care grant for the children that were not her own. Now she is getting it the situation is better. I also help with their homework because you find that their parents are not educated they can't check or help with their homework. Then in this house I am cleaning twice a week because the mother is so sick and the two children are small. I go to check that there is food cooked almost every day. (KZN, Volunteer)

Notice the range of different services the volunteer provides. She organises food for a family, she helps them access grants, she helps the children with homework and she cooks and cleans. Though some of these tasks require little capacity others such as accessing grants and organising food show knowledge and resourcefulness.

Notice too that this volunteer goes every day to one of the homes she assists. Many volunteers in all sites described going daily to some client's homes.

Here is one house I visit. Two children are staying there with their sick mother. When I go there I bath her, give her the treatment and go home after two I go back to check that the children have come home and eaten. (E cape, Volunteer)

Another role played by volunteers in the community is the garnering of community resources for vulnerable children. Story 3 in Appendix 4 is an example of how a volunteer has gone way beyond her role as an Asibavikele volunteer to start a feeding scheme. What is important is the way she has involved the local Spar supermarket and other women in the community.

Another example comes from a Northern Cape site where the issue of child drug abuse, especially the sniffing of glue was a problem. The volunteers discussed the issue among themselves and then called on the local police station for help. Together with the police the volunteers ran an awareness programme in schools and worked with the police to find effective ways of intervening with children who were sniffing glue.

It (drug abuse) used to be a big problem in our community but we have stopped it with the police. We had a big campaign and now it is much less of a problem. We held parent meetings and met with children at school and did awareness raising in the community. (Volunteer)

Children also told us about this campaign.

Drugs is a problem.
R: OK.
But not so big anymore because the police did stop it.

And we had a march at Kids Club.
Now it is not so bad. (N Cape, 8-12, Project)

So, volunteers play an important role within the community for vulnerable children. Volunteers in all sites described how they went through a selection process to become volunteers. Most identified their love for children and their desire to do something for the community as the reason they were selected. This passion for their work came through clearly in all of the focus group discussions in all of the sites (in spite of the challenges they described). They also talked about how rewarding it was to see a family's life improved or to see a child or caregiver happy because of something they had done.

We love this job. It is in our blood. It's our passion. (E Cape, Volunteer)

I can't just walk away from children who need help. (N cape, Volunteer)

When the grant finally comes through we feel good thinking about our efforts. (E cape, Volunteer)

I feel sad when the mother is crying but after we have explained everything to her you leave with a smile because you find that she was crying because she did not know where to start to look for help. (KZN, Volunteer)

This commitment to their volunteer work extends to practical help. In all sites volunteers told stories of how they had used their own resources to help vulnerable families.

I do take my son's shirts for school and give one to a child. Or old shoes. (N Cape, Volunteer)

Sometimes you find the granny staying with an orphan child. She can't do anything. She tells you she is hungry so you have to cook and clean for her if the house is dirty. You give her money for bread from your own pocket. (KZN, Volunteer)

In order to explore the issue of why volunteers stay involved in the programme we asked if the status they gained in the community was one reason for their continuing commitment. The response to this was interesting. In only two sites did volunteers feel that they had gained status through their work in Asibavikele?

When we walk on the street people appreciates us knowing that we help other people. Others also come to us with their problems to ask for help. In the community they treat us with respect. (KZN, Volunteer)

Most volunteers described how they were in fact unpopular in the community. Most often because families got impatient with the fact that grants often took a long time to come or the social worker took some time to do formal statutory

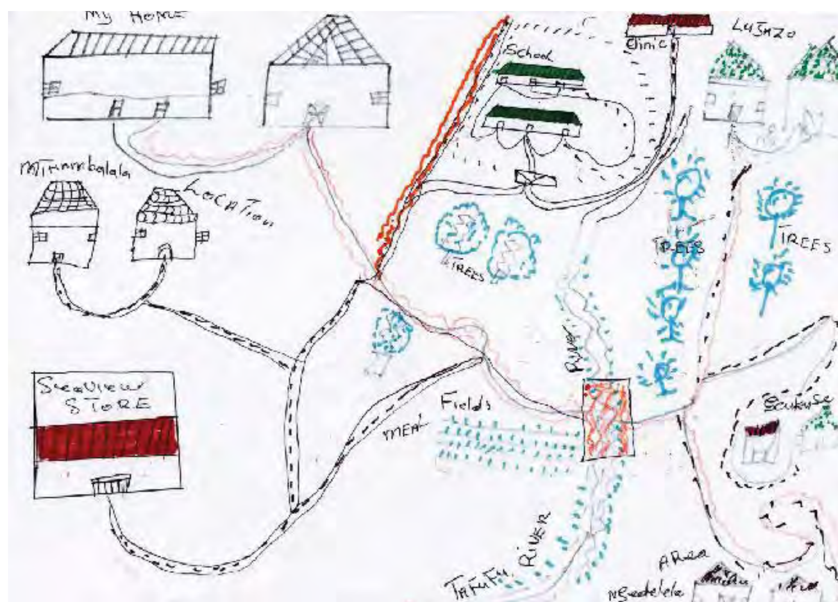
work (not out of negligence but because of the burden of work) or because volunteers did not bring regular food parcels. In a few of the sites volunteers said they were unpopular in the community because they could not help every needy family and had to focus only on the most vulnerable.

> *They call us “yellow t-shirts with empty promises”.*
> *Sometimes when they see us they quickly close the door.*
> *They say we take (listen to) their problems but we do nothing.*
> *It is mostly about food that they are angry.*
> *We don’t need on-going food but we need food for emergency. (E Cape, Volunteers)*
>
> *They sometimes take us as people who are influencing the children to rebel against parents, because we tell them about their rights.*
> *As if we are interfering.*
> *Some say no, we are not going to tell you family problems. (E Cape, Volunteer)*

The quote above comes from a context in which volunteers monitor foster care grants and often have to tell extended family off for not caring for their foster children. So it is clear that the Asibavikele uniform and role do carry some status in the community, but that this is sometimes met with resentment, which is understandable in the context of deep poverty in which most of the volunteers work. Given the fact that their role as volunteers does not give them status but in fact encourages resentment, in many cases, their ongoing commitment is striking. It is clear that the Asibavikele programme provides an opportunity for women who care about children to make their capacity available to the community.
See Story 9: Appendix 4

<u>How to increase the capacity of volunteers</u>
But, in spite of this commitment volunteers shared with us some of the significant challenges that they face. These are presented here as they provide direction about how capacity can be increased. If these issues are dealt with volunteers could be more effective.

In the Eastern Cape rural sites the biggest issue was distance. The maps drawn by volunteers in the Port St Johns site, for example, show long, long roads that volunteers walk regularly to reach the families they help.



Drawing 3: I have to walk long distances, over a river and through a forest to get to my clients

> *From home I cross the river. I walk uphill and pass through the dense forest. Sometimes the river will be full and I would not be able to cross. (E Cape, Volunteer)*

In this site and others where Home Affairs and DSD offices were far away volunteers also described the long distances they had to travel to help families deal with issues of documentation. In all of the sites volunteers described how they paid for these journeys out of their stipends.

> *One of my clients is a great-grandmother, not a grandmother. She is living with a four-year-old child who is taking ARVs. And the hospital it's very far from my location. Sometimes they can't get to the hospital, because there is only one (minibus) taxi a day. If you miss this taxi there is nothing you can do except hire a car for R100 from your own pocket. (E Cape, Volunteer)*

The long distances they had to travel relate to the call by volunteers for strong walking shoes. Many of the volunteers described how their shoes disintegrated and how grateful they would be for strong walking shoes that can withstand the rivers and mud they have to walk through. Umbrellas were another necessity in the harsh summer sun. Caregivers also mentioned this.

> *R: How can we improve the service they are rendering to you?*
> *Please get the volunteers some umbrellas, some rain coats and some comfortable shoes as they walk in bad conditions. (N Cape, Caregiver)*

Volunteers receive regular supervision around cases and can request individual help for emotional debriefing but it was obvious from the discussion with volunteers during this research that this is more effective in some sites than others. Some of the sites had regular support and debriefing but others got together only for administrative purposes such as handing over the record sheets for each family at the end of the month. The difference between

volunteer's motivation in the sites where they were supported by regular group meetings and those were there was no support was obvious to this researcher. The relationship with the site coordinator seems to be central in this regard. Some volunteers described their site coordinator affectionately.

> *We just love him. He is so supportive always advising and listening to us. (N Cape, Volunteers)*

> *It happens you find how are you going to help others when you are troubled inside. You are going to be short tempered because you can't solve your own problems at home. But we have the social worker so we talk to them before we go to help other people. (E Cape, Volunteer)*

Others described receiving little support and from their perspective the relationship between volunteer and site coordinator was a punitive one.

> *Some of us walk a long way to get here to the office and sometimes we are late. We have rules and if we are late we don't get paid. Sometimes you do not have money for transport to come to the supervision. If you do not come you do not get paid. (KZN, Volunteer)*

> *Sometimes we are just spoken to like small children. We are laughed at if we do not fill the form in right. It is very de-motivating. Some people do give up because of this. (E Cape, Volunteer)*

Volunteers described how difficult it was to stay motivated in this context. Another challenge identified by many of the volunteers was the lack of knowledge and skills particularly in the area of psychosocial support. This was mentioned in all the sites.

> *The counselling is very important because when I asked the grannies what they do when a child is crying for dead parents, one she (a granny) just cried. She said I tried to give him comfort but they are still sad. So knowing how to do counselling with small children is very important. (E Cape)*

> *Even though the child doesn't say it as an adult would you can see that she misses her parents. I don't ask it in front of the child I ask the person who is staying with the child and they say sometime the children behave different and want to sit alone and not talk so they can see they are missing their parents. But we do not know what to do. (KZN, Volunteer)*

Another issue mentioned in all of the sites was the need for the stipend of R350 to be increased. Most volunteers did not bring this up in a resentful manner but in the context of "we love our work but it would make it much easier if the stipend was bigger." For most this was related to their own need for money for their own family but many also talked about how the stipend was not enough to cover the expenses they faced within their role as

volunteer. Many described using the stipend to transport clients to Home Affairs offices and the clinics and for emergency food for clients and often for school materials for project children too. In one site it seemed that volunteers were expected to pay to photocopy some of the record forms they submitted at the end of each month.

The challenge that seemed to be the heaviest for most of the volunteers was the fact that they could not always help the children and families as much as they would like to. They described how this caused guilt; it points to why the need for emotional support for volunteers is essential. In many of the sites this was met by the site coordinator or the social worker or the group support set up in some of the sites but this was not the case in all of the sites.

> *It is very difficult because it takes a long time to finally get the certificates.*
> *It's a long and tedious process*
> *What do you do then?*
> *I take a full month without visiting them.*
> *It is very frustrating*
> *Disappointing and you feel guilty. (E Cape, Volunteers)*

6.2.2 The role of Asibavikele site co-ordinators

Discussions were held with site coordinators about their role in the project. The insight gained from these discussions shows how they contribute to the community ability to help vulnerable children (through the volunteers). But, the discussions also give pointers as to how site coordinators could be further capacitated to support the volunteers.

All of the site coordinators had a clear idea about the aims of the project and about the needs of vulnerable children. They were well informed and articulate. Some had more experience than others in development work and about how to motivate and support volunteers. What was interesting was that those who had a background in community work themselves seemed better able to support the volunteers than those who had the correct professional qualifications, though this was not the case everywhere.

Many worked alongside the volunteers using their access to transport and knowledge of statutory issues, for example to assist volunteers, some even being called on by volunteers to provide an ambulance service in the middle of the night.

In some sites, however, site coordinators played a more narrow administrative role, making sure the work was done and reports were handed in correctly and on time. A correlation was observed between the sites where coordinators played a supportive role and the volunteers' motivation. This also extended to children's sense of a supportive social network. This suggests that the site coordinators' understanding of and empathy for volunteers is essential to the effective functioning of the project.

A similar situation seemed to exist with managers of the project. Those who were in touch with the reality of the task faced by volunteers facilitated support for site coordinators and volunteers through the organisation. It seems that site co-ordinators appointed from a community background do better than a simple professional posting.

One issue raised by two site coordinators was some sense of a disconnect between the reality of the context in which volunteers worked and the understanding of national CWSA. The disconnect between the rural reality and the understanding of head office staff is best illustrated by the example of the shoes. A site coordinator describes below how she had requested a budget to buy shoes for volunteers.

> *I was sent R80. What kind of shoes can you buy for R80! I went and bought good, strong walking shoes that were R200 each. (Site coordinator)*

Another issue raised by provincial level managers was the fact that each site was different. The economic situation in an area, whether it was rural or urban, whether it supported migrant labour or not and whether services such as health were easily accessible were all issues that impacted on the work of the project. Managers emphasised how important it was for the site coordinators to be local as the issues they had to deal with in relation to volunteers and families needed local knowledge.

> *The level of stigma related to HIV is an important local issue. In one of my sites there are high levels of stigma so volunteers have to be very careful about going into homes because then everyone says there is someone there who is dying of AIDS. So we have had to deal with this issue with the site coordinator and the volunteers. In another site the issue is related more to the deep poverty and the anger of residents of the area about the lack of delivery, so residents get angry when volunteers help only the most vulnerable. So we have had to help volunteers deal with that. Every area is different. (Provincial manager)*

6.2.3 How Asibavikele contributes to the capacity of local social workers

Social workers were interviewed in most of the Project sites. Without exception they saw the volunteers as making their job easier. The quote below from a social worker in the Northern Cape is typical.

> *They definitely make my job easier. They know what the issues are here. They know how to engage a family around abuse, for example. They can also do so much of the ground-work for us. The volunteers can do all of the work to get a foster care case to court. They can explain to the family and be my go-between and this gives me time to prepare all of the papers for court. They can then support the family. It is such a help to me! (Social worker)*

6.2.4 Community understanding of needs of children affected by HIV and AIDS

Volunteers are part of the community so their attitudes and work are significant in this regard. But in addition the evaluation also explored general community attitudes.

General community awareness of the needs of orphans is not a primary focus of the Asibavikele programme. However, by creating such awareness and by building general community support for such children, the work does address one of the indicators identified for this evaluation, namely “normalising children’s environments and routines”. If Asibavikele is effective in this regard, one would expect to find more people in the local community displaying positive or caring attitudes towards orphan children, and to be more involved in caring for vulnerable children. One would also expect people to understand that vulnerable children need more than just practical support, for example money or food parcels, but also emotional support.

The community survey results are given in Appendix 5. What the data gathered from the surveys reveals is that Asibavikele is fairly well known in communities where it operates. Not everyone knows, however, exactly what Asibavikele does for vulnerable children, but an encouraging number understand Asibavikele’s work in an holistic way (practical and emotional support). This is good because it suggests that general community members see care for vulnerable children holistically.

A concern is that some people are antagonistic towards Asibavikele and suggest that it doesn’t do anything, or does things for others but not for them. A dichotomy was revealed in the responses to children affected by HIV/AIDs and orphan children. Many people were reluctant to talk about the former, but reflected fairly widespread positive attitudes towards orphans. In this case, Asibavikele seems to have influenced attitudes in positive ways.

7. CONCLUSIONS AND RECOMMENDATIONS

Before examining conclusions and recommendations it is important to remind ourselves of the focus of the evaluation:

- In what aspects of child well-being did the CWSA Asibavikele programme make the most difference; what were the most significant changes brought about by the Asibavikele programme in improving the well-being of OVC?

- To what extent did the CWSA Asibavikele programme succeed in strengthening community capacity to effectively respond to the needs of vulnerable children?

7.1 Child well-being findings

7.1.1 Areas of greatest impact

Grants

The quantitative data show a small but significant difference in the area of social support grants between Project and Control groups. This result shows that in a context where a large proportion of children receive child support grants, more Project children than non-project children receive one. One conclusion to draw from this is that Asibavikele is successful in increasing children's access to child support grants.

The qualitative data confirm this as children in the project group are able to identify the Asibavikele volunteer as someone who can overcome the problems of accessing grants. By contrast, Control group children seem to be powerless in the face of administrative difficulties with grants.

Caregivers, especially older grandparents, who struggle to negotiate the administrative processes, identify the help given by volunteers as significant.

Food support

All families, Project and Control, lack food security. This is one of the dominant themes across all children's groups in Project and Control sites. It is also mentioned by all caregivers' and volunteers' groups.

The quantitative data show that Asibavikele is clearly providing or facilitating access to food support. The qualitative data support this. However, it is also clear that food security remains a huge problem in the families supported by the project and indeed in the volunteer's homes too.

Health care

The significantly higher proportion of Project children who went to a clinic or hospital combined with the fact that two-thirds of the children were assisted by

an Asibavikele volunteer when they were sick suggests that Asibavikele is playing a significant role in improving children's access to formal health care.

The qualitative data give detail about the form of the health care provided to the children. It also highlights that volunteers help adults in beneficiary households to access health care, and volunteers provide significant care themselves to sick adults. There is also evidence that Asibavikele volunteers provide health care access to children under five in the households they visit.

Continuum of response

The quantitative findings show that the children in the Project group are referred to other services more often than children in the Control group suggesting that there is a continuum of services facilitated by Asibavikele.

Access to school

There is strong qualitative and quantitative evidence that the Asibavikele Project makes an impact in the area of school attendance, particularly in not dropping out of school. Though children in the Project and Control groups face the same barriers to school-going the Project children receive significant support both practical and emotional to go to school and to keep going.

In some areas volunteers are strong advocates and monitors of orphan children's rights to access schooling.

The high level of discrimination that orphan children face at school from peers is addressed to some extent by the Asibavikele Project through making sure children have uniforms and grants that provide for soap and school materials. One can also assume that the emotional support provided also helps children to cope with the teasing. But, the level of bullying experienced by vulnerable children is still a concern.

However, the evidence suggests that Asibavikele is less successful in getting out-of-school children back into school. This is consistent with other findings that Asibavikele is able to provide day-to-day support and to provide immediate needs, but is less able to address systemic issues in society (for example, job creation).

Emotional stress

The quantitative data show that children who are part of the Asibavikele Project have less emotional stress than those who are in similar circumstances but not supported by volunteers. There is also evidence that older children in the Project group experience more stress than younger children.

The qualitative data give insight into what aspects of the project work have reduced stress for children. Food and school support are important in this regard. The qualitative data also shows that caregivers see a difference in emotional stress levels in their own lives since they have been part of the Asibavikele project.

There is also evidence from the qualitative data that children and caregivers still worry about grief related to the death of parents and that there is a need to support this aspect of the volunteers work. Note that volunteers also identify this as an area that needs strengthening.

While no gender differences in emotional stress levels were found, significant differences between older and younger age groups were found with related comments about older children feeling less cared for than younger children.

An integrated approach
Non-comparative data suggests that the Asibavikele volunteers take an integrated approach to supporting families. They seem to work with children and caregivers and with broader local systems such as local community services.

7.1.2 Areas of less impact

Recreational groups
There is little difference between Project and Control groups in terms of the number of recreational groups they attend. The hope would have been that Project children attended more groups because they were more integrated into the community. This does not seem to be the case.

The qualitative data seems to confirm this. But, the qualitative data also shows that where the Asibavikele volunteers do run recreational and support groups they play an important protective role in children's lives.

The qualitative data also highlights the levels of discrimination and bullying that vulnerable children face. Given this ongoing discrimination support groups such as Kids Clubs are even more important as they give children an alternative identity, they are not 'misfits' but 'members'. They are part of groups that do exciting things and they meet other children with similar problems thus creating a sense of solidarity (Madoerin, 2008). But this is only the case if they are not labelled as 'OVC".

Lifeskills knowledge and attitudes
An important observation from the results is that children in the Asibavikele programme are clearly vulnerable in the area of sexuality and HIV/AIDS. For some reason, the Project children seem to be more vulnerable (as inferred from the questionnaire results) than the Control group children. This supports the need to implement this activity extensively and effectively.

Livelihood support
Livelihood support to households did not seem to be a focus of the Asibavikele volunteers. This could be because, in the context of poverty, that most of the sites operate in it is extremely difficult. For example, starting a business in remote and isolated communities like Delportshoop and Port St Johns is just not viable. Keeping a small productive garden with no ready

access to water as in Port St Johns requires skill and commitment that many vulnerable families do not have. Volunteers seem to put most of their energy into helping families access state support through social grants. Livelihood support programmes would deal with the issue of food running out at the end of the month and the ongoing call by volunteers and beneficiaries for food support.

Social networks

A social network with peers and adults children can trust and talk to is protective and a contributor to resilience. The quantitative data shows that being part of the Asibavikele project increases children's peer and adult support network.

The qualitative data show that many of the Project group children see the volunteers as people they can trust and talk to. There is also evidence that some children (particularly older children) feel that the volunteers are people they cannot trust, in fact some said they worried they would not keep confidentiality and that they cared more about the younger children than themselves.

7.2 Community capacity findings

The conclusions reached in 7.1 are relevant here as the volunteers represent "the community" and it is clear that they are making a huge impact on the lives of vulnerable children. Therefore, the Asibavikele Programme has achieved its aim to increase community capacity to improve child well-being.

The survey of community attitudes shows that the programme has done more than this though. It has also made significant impact on the general public attitudes to orphans and vulnerable children. The community is aware of the needs of children (even emotional needs) and knows who to call on when children need help.

But, volunteers also identify areas of great challenge, which, if dealt with, could increase their capacity and the capacity of the project to support vulnerable children. They need CWSA managers at all levels to come and look closely at their context so they can begin to understand why what seem like small practical issues (e.g. strong shoes) are important. CWSA also needs to acknowledge that volunteers are using their own resources to provide funds for what could be seen as project costs (e.g. transporting clients to DHA offices in town).

Social and emotional support is lacking in some sites. If site coordinators were universally supportive and encouraging the volunteers capacity to help children would be significantly increased (see point made below).

Underlying factors

It is important to try and understand what the data says about the underlying factors behind **why** there is less impact in these areas of child well-being. There seems to be a correlation between supportive social networks and

recreational groups run by volunteers. Children from sites with recreational groups have more adult and peer friends. Older children have more emotional stress than younger children in the project groups and they tell us, in some sites, that they feel volunteers do not talk to them but only to the younger children. This is linked to volunteer reflections about the need for help with psychosocial support skills. There is also a correlation between the sites where volunteers themselves feel unsupported and the smaller social networks that children have. This suggests that child well-being is linked to volunteer well-being. There is also evidence that the site co-ordinators that are supportive come from a background of community development or from the volunteers themselves, rather than as a professional posting.

Another key finding in relation to staffing is that the support of volunteers relates directly to the promoting of child well-being. Volunteers who felt supported themselves by site coordinators and managers were better able to support the children.

7.3 Recommendations

The areas of greatest impact such as health support, food support, school support, support to access social security are all effective and should continue. But the programme could be improved by exploring the following recommendations.

Recommendation One: Livelihood strengthening

If CWSA wishes to promote long-term sustainability it would be important to improve the capacity of volunteers and the local Child Welfare organisations in the area of livelihood strengthening. However, it is important to be realistic about what can be achieved in the deep poverty and environmental degradation in which most of the Asibavikele sites exist. It may not be practical to expect volunteers to add such a task to their already heavy work load. CWSA should explore linking with other national NGOs who carry out livelihood strengthening programmes and use such organisations to introduce more comprehensive and effective livelihood strengthening programmes at the Asibavikele sites.

Recommendation Two: Implement the Asibavikele Lifeskills education programme as a matter of urgency

The fact that the Project group children have a lower knowledge of HIV prevention and sexuality knowledge than the Control group children is a concern. The Asibavikele Programme has a Lifeskills Education module developed for use with teenagers in the sites. This should be implemented as soon as possible.

Recommendation Three: Develop volunteer counselling skills

Children, caregivers and volunteers identify the lack of expertise in helping children cope with grief as a problem. An integrated family-based model of grief work that is simple enough for the majority of volunteers to use should be implemented. This needs to include skills training for volunteers and caregivers on how to help children of different ages cope with grief.

Recommendation Four: Develop volunteer skills to communicate with and support teenagers

It is clear that teenagers sometimes feel neglected by volunteers. The Asibavikele work would be strengthened if volunteers' capacity to communicate with teenagers could be developed. Likewise to develop their ability to have conversations with teenagers in the way that good parents would. This could include topics like school (even if they cannot help with homework), relationships and teenagers' feelings, and the ability to support them with their particular challenges.

Recommendation Five: Start contextually appropriate recreation groups in all sites

The Kids Club model used in the Northern Cape seems to work well for younger children. It could be implemented with contextual adaptation (for example, it may not work in areas with large distances between homesteads) in the other sites. A model for recreational groups for teenagers needs to be developed and implemented.

Recommendation Six: Action to reduce stigma and discrimination

The results of this research suggest that many children experience discrimination and bullying at school and in the community because of their poverty and the perceived links they have with those who are suspected of being HIV-positive. Though stigma and the resultant discrimination are an intractable problem it is important to try to do something about it.

A programme where schools in Asibavikele sites are made aware of such bullying and develop an anti-bullying policy is one approach. This approach has been used very successfully by the Soul Buddyz Club programme in schools. CWSA may want to share the lessons learned from the Soul City Institute that runs the Soul Buddyz Club programme (www.soulcity.org.za) But apart from an anti-bullying policy in schools CWSA needs to explore ways to use the strong community network and credibility that Asibavikele volunteers have in the sites to advocate at community level against abuse of poor and vulnerable children.

Recommendation Seven: Organisational development

The roles and approaches of site coordinators, provincial managers and CWSA head office staff in relation to volunteers require attention. The dichotomy between a formal, administrative approach and the informal and locally responsive community development role of volunteers needs to be bridged more effectively and with greater sensitivity to the realities of everyday life in vulnerable and poor communities. Formal training is one strategy, but this needs to be linked with personal experiences of the day-to-day realities of volunteers. Attention needs to be given to the support of volunteers by site coordinators. The appointment of site co-ordinators with a grass roots understanding of community development principles is also important.

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APPENDIX 1: Asibavikele Sites and Annual Reach

PROVINCE	DISTRICT	SITE	Annual Reach (Oct10 - Sept'11)
Eastern Cape	Afred Nzo	Matatiele	580
	Amatole	Bedford	779
		Adelaide	442
		King Williams Town	269
		Fort Beaufort	250
		Butterworth	489
	Cacadu	Humansdorp	245
		Kenton On Sea	433
		Port Alfred	220
	Chris Hani	Tarkastad	399
		Queenstown	389
	Nelson Mandela	Motherwell	513
	OR Tambo	Mtata	484
		Port St Johns	963
			6,455
Free State	Fezile Dabi	Sasolburg	285
		Brent Park	134
	Lejweleputswa	Virginia	152
		Kgotsong	215
	Motheo	Wepener	233
	Thabo Mofutsanyane	Qwaqwa	252
	Xhariep	Rouxville	320
			1,591
Gauteng	City of Johannesburg	Midrand	153
		Jiss	68
	Ekurhuleni	Actonville	164
		Germiston	142
		Springs	135
		Boksburg	268
		Nigel	181
	West Rand	Toekomsrus	201
		Simunye	236
			1,548
KwaZulu Natal	Ugu	Umzumbe	354
	Ugu	Ekubusisweni	190
	Ugu	Margate	214
	Ugu	Port Shepstone	264
	Ethekwini	KwaMashu	641
	Ethekwini	Verulam	154
	Ilembe	Stanger	62
			1,879
Limpopo	Capricorn	Polokwane	415

	Mopani	Giyani	411
	Vhembe	Musina	565
		Thohoyandou	318
			1,709
Mpumalanga	Ehlanzeni	Graskop	139
	Nkangala	Middleburg	419
		Witbank	394
		Nelspruit	212
			1,164
North West	Dr Kenneth Kaunda	Potchefstroom	279
	Dr Ruth Segomotsi Mompati	Vryburg	208
	Ngaka Modiri Molema	Christiana	277
			764
Nothern Cape	Frances Baard	Kimberly	270
		Pampierstad	282
		Douglas	334
		Delpoortshoop	477
			1,363
Western Cape	Cape Wineland	Wellington	219
	Eden	Plettenbergbay	134
		Knysna	264
		Helderberg	33
		Albertinia	151
			801

APPENDIX 2: Research instruments

Questionnaire (Fieldworker copy, with notes in side boxes)

NB: There will be breaks for play and refreshments in between sections of this questionnaire.

Date:

Place:

Tell the children what the date is and ask them to fill it in. Then do the same with the place name.

NB: Now go around and check. This is important to see whether the children are literate and understand instructions. Tell them also that their names are not on these forms, so they can feel free to answer truthfully.

Boy **Girl**

Say "If you are a boy, draw a circle around the word "Boy". If you are a girl, draw a circle around the word "Girl".

NB: Use this to test that they know how to draw circles around words. Help them get it right.

How old are you? ………………

Ask them to write their age in years on the dotted line. Check.

1. Is there someone in your house who has a job that earns money?

Yes **No**

2. Does an old person in your house get a pension?

Yes **No**

Use a local word so that they know we are asking about the social welfare old age pension.

Ask them to draw a circle around the word yes or no to tell us whether an old person in their house gets a pension.

3. Do you get a grant?

Yes **No**

Same basic idea, use a local word for "child support grant".

4. Has any organisation or person ever helped you or your family to get food?

The same basic steps for these.

Yes **No**

Write the name of this person here

5. Have you been sick in the last three weeks?

Yes **No**

6. If you were sick did you go to a clinic or hospital?

Yes **No**

Did anyone go with you to the clinic? Write their name here.

7. If you were sick did you take medicine?

Yes **No**

Explain that when we say medicine we mean western type of medicine, not traditional medicine.

8. Does your household save any money?

Yes **No** **Don't know**

When we say save, we mean any kind of saving – in a box, under the mattress, in a bank, anything.

9. Does your caregiver have a small business?

Yes **No**

10. Does your caregiver belong to a financial society?

Yes **No** **Don't**

Use a local word to explain "financial society". It could be a stokvel or something similar.

know

11. Have you ever been referred to anyone for help?

Yes **No**

Here we mean referred to someone like a social worker or nurse or priest or teacher. Anyone who is there to help people.

12. Do you have someone to help with your homework?

Yes **No**

13. Have you ever stopped going to school for some weeks or even some months?

Yes **No**

14. Did you get help to get back in to school?

Yes **No**

15. How many meals do you normally eat every day?

1 **2** **3**

We mean meals like breakfas lunch or supper, not snacks during the day.

Ask them to put a circle arour the correct answer

16. When was the last time you ate meat?

Last few days?

A long time ago?

Give them examples of groups lik teams, cultural groups, dance gro scouts, girl guides, church youth g choir etc.

Ask them to think about and cour groups they belong to and then fil number in the box provided. Reas them that if they don't belong to a it is fine to put zero.

17. How many groups do you belong to after school time?

18. How many friends of your age do you have that you trust and can tell important things to?

Remind them to think first and count the groups they belong to and then fill in that number.

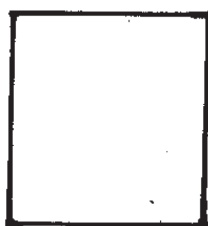
19. How many adults do you know and trust that you can tell important things to?

Feelings questionnaire

Say: "These questions are about how you feel and if you feel that way a lot of the time or not very often. Remember that your names are not on these forms, so we don't know who filled it in. Please try to be as honest as possible. Remind them that there is no right or wrong answer."

Read the four headings so they know what they are answering – almost never, sometimes, a lot of the time and all the time.

The older groups must make a mark in the correct box. The younger groups will use a visual scoring card method – they point to a card (shown below) and you fill in the score for them.



There is no wrong or right answer.

	Almost never	*Some-times*	*A lot of the time*	*All the time*
1. I feel happy				
2. I worry about school				
3. I feel lonely				
4. I feel like hiding from other people				
5. I feel like crying				
6. I feel that no one cares about me				
7. I feel like running away				
8. I feel like hurting myself				
9. I feel life is not fair				
10. I have trouble paying attention in class				
11. I have trouble sleeping				
12. I feel worried				
13. I get stomach aches				

Life skills questions – for the older groups only

Say "I will read out a sentence. Decide if it is true or false and draw a circle around the correct answer"

1. HIV and AIDS are the same thing

True **False**

2. You can get HIV/AIDS from sharing a cup with someone

True **False**

3. The immune system in our bodies helps us to fight off diseases

True **False**

4. The only way to prevent a sexually transmitted disease is with a condom.

True **False**

5. It is a good thing to tell them to stop if a person is trying to make you do something that you do not feel comfortable with, even if they are an adult.

True **False**

6. If a boy takes a girl to Nandos and pays for her food she should pay him back by sleeping with him.

True **False**

7. If a teacher asks you to have sex with him you should not tell anyone.

True **False**

8. People who are HIV-positive should not drink lots of sugary drinks like Coca Cola

True **False**

Activity-based FGD outline for children

Project and Control children
This FGD will take approximately three hours, including breaks.
10 children in each group. Half the groups will be in the 9-12 age group, while the other half will be 14-18.

Notes:

- All discussion is in children's home-language.
- All discussion is taped and transcribed.
- The purpose of the research group will be explained to participants.
- We will explain that they do not have to answer any questions of the do not feel happy to do so – environment will be fun and friendly so they can do this.
- We will start with games and introductions and intersperse games in between the activities.

Activity 1: Story-telling with large cut-out figures

Introduce two families – one lives with a grandmother and the other lives with a sick mum. Give each of them names. (Rationale: to create a context for the discussion without leading the children)

i) Getting a grant or pension.
Granny in the one house gets a pension
Little girl in other house gets a child support grant
Lead into a discussion about their own households
Does anyone have a grant? (probe: pension, foster care grant, child-care grant)
Tell me the story of how you got it. (probe: knowing where to go, having the right docs, time from application to receiving, did anyone help you?)

ii) Food support
Sometimes the scenario family gets help from a local organisation that brings food parcels. How else do families get food support in your area?
Has any organisation (not indiv and not school feeding) ever helped you or your family to get food? Who? How?
Talk about the kind of food you eat. When did you last eat beans or meat? Why?

iii) Health care
Sometimes the girl/boy gets sick
Tell me the story of the last time you were sick?
What did you do?
Sometimes the mum needs help to go to the clinic
Does any one help you or anyone else in your house to go to the clinic or hospital? Who?
Do you have any babies under one year old in your house? Have they been immunised?

iv) Accessing docs

Little girl cannot get a grant because she has no birth certificate
Who here does not have a birth certificate?
Who does? Did anyone help you get this? Tell me the story.

v) Livelihood support
Girl's brother in one family has a small spaza at home.
What else do people do to get money?
Do you have something like this to earn money?
Has anyone ever helped anyone in your family to:

- start a business
- plant a garden
- apply for a job
- anything else

Activity 2: Barriers to school-going

1. Place a large drawing of a school on the floor
2. The group is to stand on the other side of the room.
3. Place large stones (or chairs if no stones available) between the group and the school – explain that these are barriers that stop us getting to school or going to school regularly.
4. The children then go to a stone and we write the name (on masking tape) of something that gets in the way of children going to school. Stop and discuss each one. Ask if they have had the problem.
   Probe: Did it stop them going to school for how long? How did the problem get overcome?
   Did anyone help them to overcome it – who? And how?
   Do you have someone to help with your homework? Who?
   Do you have a school fee exemption?

Activity 3: Stones in the basket activity

1. Fill a basket with stones. It should be quite heavy. Place it in the middle of the discussion circle. Then ask one or two children to hold the basket on their head. Say to the children: "Sometimes in your life there are so many problems it is like a lot of stones come into your basket, making it very heavy."
2. Take the stones out of the basket. Tell the children: "These are the stones that some children carry around. What can we call these stones?" They will begin to call out things like "no food", "feeling sad", and so on. As they call out, write the labels on each stone and place it back into the basket.
3. Ask them: "Are those stones still there? Are you still carrying those worries? Is there anyone here who has been able to take some of the stones out of their basket?" Some children may still be feeling a heavy burden – tell them it's okay if they have not been able to take any stones out.
4. If they say some of the stones have been taken out, ask them: "Which stones were you able to take out? Who or what helped you to take them out?"

Activity 4: Groups I belong to

1. Play an active funny game.
2. Tell me about the recreational groups you belong to and what you do there?
3. How do you feel about the group? How did you feel when we played the game? Does the group help you feel like this or not? What does the group do for you?

Activity 5: Scenario discussion (older group only as younger ones do not do the lifeskills training)

Talk about these stories:
You are staying with your aunt and she asks you to go and buy her some beer from the local tavern. It is dark outside and you know it is not safe to go. What would you really do in real life?

Probe: Assertiveness and communication

Your friend is 16 years old and an older boy of 23 has asked her to go out with him and be his girlfriend – what would you advise her?

Probe: dating people the same age – not older

You are 20 years old and you have a girlfriend who is 18 years old. You are working and so is she. You have never had sex together but you think it is time to do this. What would you do?

Probe: talk about it together, use a condom, consent from the girl

Activity 6: Mapping

1. Hand out A3 paper and crayons
2. Draw a map of the place where you live.
3. Look at the map and think about where you have people that you really trust – people you can tell a problem to.
4. Place a small flower on your map to show this/these people and where they are. If you have no-one do not put a stone on your map. Make sure you think about adults you trust and can talk to and children your age too.
5. Tell me about the stones/people - researcher to annotate the map.

   Probe: Why do you trust them? What do they do for you? What do you do for them?

Only with project group

Activity 6: A CWSA volunteer I know

1. Draw the CWSA volunteer who visits you.
2. Talk about her

   Tell me about her?
   What kind of person is she?

What does she do?
When she visits you what does she do?
Has she ever helped you with anything? What?

Focus group discussion – caregivers
(The fgd outline for volunteers is further down)

All discussion will be in home languages and will be recorded and transcribed.

Note to fieldworkers:
Find out from local Asibavikele/CWSA staff before you start what name local people use for the Asibavikele service. Do they refer to an organisation? Or do they just understand it as the person of the volunteer? What do they call the volunteers?

1. Introductions and explanations
- Begin with a relaxing game.
- Introduce yourself.
- Explain the purpose of the group discussion.
- Explain how long it will be.
- Explain why you are using a recorder – ask for permission to use it.
- Explain confidentiality

2. Tell us about (use the local name) Asibavikele/CWSA/the volunteers who come to your house.
[This is purposefully open-ended to see what comes up.]

3. What does it/they do?
[This is also open-ended to see what they choose as most important.]

If they have not mentioned volunteers but mention the organisation only ask How does the organisation do its work?

4. Hand out small balls of clay and ask them to quickly make two small models one showing:.

My family before Asibavikele/volunteer
My family after Asibavikele/volunteer

Clay allows them to reflect a bit more deeply and the symbols they choose to present give information with more emotional depth. Clay is also more familiar than drawing for older rural women.

5. What has it done for you?
Probe:
Livelihood support
Grants

Household support

Housework
Cooking
Home nursing

Documentation support
Pension
FCG
CSG

Health support
Children who are sick
Adults who are sick
Hospital/clinic
Medicine

6. What has it done for your children?
School support
Getting drop outs back into school
School fee exemption
Help with uniform and materials

Psychosocial support

Group activities

7. What should it do differently?

Focus group discussion – volunteers

1. Introductions and explanations
    - Begin with a relaxing game.
    - Introduce yourself.
    - Explain the purpose of the group discussion.
    - Explain how long it will be.
    - Explain why you are using a recorder – ask for permission to use it.
    - Explain confidentiality

2. Who is a vulnerable child? What makes children vulnerable?

3. What do vulnerable children need?

4. What is your role in Asibavikele? What do you do?
Probe: How important are you to the project? How important are you made to feel?

5. Make two clay models to tell
one thing you really love about your work as a volunteer
one thing you find difficult

6. Tell me about the training you got?
   Probe: Adequate preparation for the work

7. What support do you get?
   Probe: Adequate?

8. What difference do you make to children in your area?

9. Talk about government officials/services who deal with children in your area.
   Probe: successes and challenges with DSD, Home Affairs, Justice System, Dept of Educ

10. What do people in the community say about vulnerable children? Have they always had this attitude? If it has changed how/why?
    Probe role of Asibavikele in changing attitudes

11. Do a large drawing of a volunteer and get them to draw and write around it what a good volunteer needs to do her job well.

Community survey

Name of community: …………………………………………………..………………

Date: …………..……………………….

1. Who helps children with problems in your area?

______ mentions volunteers or Asibavikele or Child Welfare directly

______ mentions another organisation – helper

2. What do they do with the children?

______ Food

______ Emotional support

______ Grants

School going

Other

3. Are children in your area affected by HIV/AIDS?

Yes

No

Don't know

4. Tell me about orphan children in your area.
(Tick the appropriate box – you can tick more than one)

-ve view

+ve view

they need help

specific about kind of help

don't know

5. What do children affected by HIV/AIDS need?
Tick if they mention any of these:

Food

Adult support

Help with getting to school

	Grants
	Other

6. Do you do anything to help vulnerable children in your community?

	Yes
	No

APPENDIX 3: Sampling strategy[1]

Asibavikele Program Evaluation: Child Welfare South Africa

Sampling Strategy
The sample will be drawn using a randomized stratified multi-stage sampling with probability proportionate to size (PPS). CWSA Asibavikele OVC program sites will be stratified according to Province and Districts and a two stage sampling technique will be utilized for the selection of eligible children.

I- Stratification of sites

The following criteria are used to stratify the Asibavikele sites
(a) the province and district; and
(b) the urban / rural settings

Table 1: CWSA Asibavikele OVC Program Sites

PROVINCE	DISTRICT	SITE	Annual Reach (Oct10 - Sept'11)	Urban / Rural
Eastern Cape	Afred Nzo	Matatiele	580	SEMI URBAN
	Amatole	Bedford	779	SEMI URBAN
		Adelaide	442	SEMI URBAN
		King Williams Town	269	SEMI RURAL
		Fort Beaufort	250	SEMI URBAN
		Butterworth	489	SEMI URBAN
	Cacadu	Humansdorp	245	SEMI URBAN
		Kenton On Sea	433	SEMI URBAN
		Port Alfred	220	SEMI URBAN
	Chris Hanni	Tarkastad	399	SEMI URBAN
		Queenstown	389	SEMI URBAN
	Nelson Mandela	Motherwell	513	URBAN
	OR Tambo	Mtata	484	SEMI URBAN
		Port St Johns	963	DEEP RURAL
	Total =		**6 455**	
Free State	Fezile Dabi	Sasolburg	285	URBAN
		Brent Park	134	URBAN
	Lejweleputswa	Virginia	152	URBAN
		Kgotsong	215	URBAN
	Motheo	Wepener	233	SEMI URBAN
	Thabo Mofutsanyane	Qwaqwa	252	URBAN
	Xhariep	Rouxville	320	URBAN
	Total =		**1 591**	

[1] This work was done by Addis Berhanu of PACTS-SA and is gratefully acknowledged.

PROVINCE	DISTRICT	SITE	Annual Reach (Oct10 - Sept'11)	Urban / Rural
Gauteng	City of Johannesburg	Midrand	153	URBAN
		Jiss	68	URBAN
	Ekurhuleni	Actonville	164	URBAN
		Germiston	142	URBAN
		Springs	135	SEMI URBAN
		Boksburg	268	URBAN
		Nigel	181	SEMI RURAL
	West Rand	Toekomsrus	201	URBAN
		Simunye	236	URBAN
	Total =		**1 548**	
KwaZulu Natal	Ethekwini	KwaMashu	641	URBAN
		Verulam	154	URBAN
	Ilembe	Stanger	62	URBAN
	Ugu	Margate	214	SEMI RURAL
		Port Shepstone	264	SEMI RURAL
		Umzumbe	354	RURAL
		Ekubusisweni	190	RURAL
	Total =		**1 879**	
Limpopo	Capricorn	Polokwane	415	RURAL
	Mopani	Giyani	411	RURAL
	Vhembe	Musina	565	URBAN
		Thohoyandou	318	RURAL
	Total =		**1 709**	
Mpumalanga	Ehlanzeni	Graskop	139	SEMI RURAL
	Nkangala	Middleburg	419	URBAN
		Witbank	394	URBAN
		Nelspruit	212	SEMI RURAL
	Total =		**1 164**	
North West	Dr Kenneth Kaunda	Potchefstroom	279	URBAN
	Dr Ruth Segomotsi Mompati	Vryburg	208	URBAN
	Ngaka Modiri Molema	Christiana	277	URBAN
	Total =		**764**	
Northern Cape	Frances Baard	Kimberly	270	URBAN
		Pampierstad	282	SEMI URBAN
		Douglas	334	SEMI URBAN
		Delpoortshoop	477	SEMI URBAN
	Total =		**1 363**	
Western Cape	Cape Wine land	Wellington	219	SEMI URBAN
	Eden	Pletternbergbay	134	SEMI RURAL
		Knysna	264	SEMI URBN
		Helderberg	33	SEMI URBAN
		Albertinia	151	SEMI URBAN
	Total =		**801**	

II- Multi Stage Sampling

Stage 1: Selection of Province for the evaluation

Procedure

1st - list Primary Sampling Units (province) as per the stratification above with corresponding approximate Measure of Size (MOS): total OVC served in the period Oct'10 – Sept'11

2nd - Starting at the top of the list, calculate the cumulative measure of size

3rd - Calculate the sampling interval

SI = M/a Where,

M - is the total cumulative measure = 17,274

a - is the # of PSU (provinces) to be selected = 3

SI = 5,758

4th - Select a random number (RS) between 1 and SI= 5,758 and compare the # with cumulated measure of size

5th - Random # selected, RS = 4,043

Subsequent units are chosen

RS = 4,043	RS + SI = 9,801	RS + 2SI = 15,559

Primary Sampling Units (PSU) *(Province)*	# of OVC served : Measures of Size (MoS)	Cumulative	Selection (*)
North West	764	764	
Western cape	801	1 565	
Mpumalanga	1164	2 729	
Northern cape	1363	4 092	*
Gauteng	1548	5 640	
Free State	1591	7 231	
Limpopo	1709	8 940	
KwaZulu Natal	1879	10 819	*
Eastern Cape	6455	17 274	*

*Provinces with * are selected*

(a) Selection of Sites for Eastern Cape

(i) EC Asibavikele Sites : Urban

SI = M/a where M = 5,223 and a = 2

SI = 2,612

Select a random number (RS) between 1 and SI and compare the # with cumulated measure of size; Random # selected, RS = 2,495

Subsequent units are chosen

RS = 2,495	RS + SI = 5,107

Primary Sampling Units (PSU) *(Sites)*	District	# of OVC served : Measures of Size (MoS)	Cumulative	Selection (*)
Port Alfred	Cacadu	220	220	
Humansdorp	Cacadu	245	465	
Fort Beaufort	Amatole	250	715	
Queenstown	Chris Hanni	389	1 104	
Tarkastad	Chris Hanni	399	1 503	
Kenton On Sea	Cacadu	433	1 936	
Adelaide	Amatole	442	2 378	
Mtata	OR Tambo	484	2 862	*
Butterworth	Amatole	489	3 351	
Motherwell	Nelson Mandela	513	3 864	
Matatiele	Afred Nzo	580	4 444	
Bedford	Amatole	779	**5 223**	*

*Sites with * are selected*

(ii) EC Asibavikele Sites : Rural

SI = M/a where M = 1,232 and a = 1

SI = 1,232

Select a random number (RS) between 1 and SI and compare the # with cumulated measure of size; Random # selected, RS = 1,205

Subsequent units are chosen

RS = 1,205

Primary Sampling Units (PSU) *(Site)*	District	# of OVC served : Measures of Size (MoS)	Cumulative	Selection (*)
King Williams Town	Amatole	269	269	
Port St Johns	OR Tambo	963	**1 232**	*

*Sites with * are selected*

(b) Selection for KwaZulu Natal

(j) KwaZulu Natal Asibavikele Sites : **Urban**

SI = M/a where M = 857 and a = 2
SI = 429
Select a random number (RS) between 1 and SI and compare the # with cumulated measure of size; Random # selected, RS = 85

Subsequent units are chosen

RS = 85	RS + SI = 514

Primary Sampling Units (PSU) *(Site)*	District	# of OVC served : Measures of Size (MoS)	Cumulative	Selection (*)
Stanger	Ilembe	62	62	
Verulam	Ethekwini	154	216	*
KwaMashu	Ethekwini	641	**857**	*

*Sites with * are selected*

(ii) KwaZulu Natal Asibavikele Sites: **Rural**

SI = M/a where M = 1,022 and a = 2
SI = 511
Select a random number (RS) between 1 and SI and compare the # with cumulated measure of size; Random # selected, RS = 125
Subsequent units are chosen

RS = 125	RS + SI = 636

Primary Sampling Units (PSU) *(Site)*	District	# of OVC served : Measures of Size (MoS)	Cumulative	Selection (*)
Ekubusisweni	Ugu	190	190	*
Margate	Ugu	214	404	
Port Shepstone	Ugu	264	668	*
Umzumbe	Ugu	354	**1022**	

*Sites with * are selected*

(c) Selection for Northern Cape

(i) Northern Cape Asibavikele Sites : **Urban / Semi Urban**

SI = M/a where M = 1,363 and a = 2
SI = 682
Select a random number (RS) between 1 and SI and compare the # with cumulated measure of size; Random # selected, RS = 253

Subsequent units are chosen

RS = 253	RS + SI = 935

Primary Sampling Units (PSU) *(Site)*	District	# of OVC served : Measures of Size (MoS)	Cumulative	Selection (*)
Kimberly	Frances Baard	270	270	
Pampierstad	Frances Baard	282	552	*
Douglas	Frances Baard	334	886	
Delpoortshoop	Frances Baard	477	**1,363**	*

*Sites with * are selected*

Summary of Selected Asibavikele and non-Asibavikele **Sites**

Table 2 below provides the summary of the selected Asibavikele sites.

The last column of the table below also gives the selected non-Asibavikele sites. These non-Asibavikele sites for the evaluation are selected from the same district as the selected Asibavikele sites. This is done in due consideration of ensuring social and cultural similarities with the selected Asibavikele sites and for ease of planning and managing travels.

Table 2: **Selected** Asibavikele and non-Asibavikele **Sites**

* Selected Asibavikele Site	District	Urban/Rural	Province	Selected non Asibavikele Sites
Mtata	OR Tambo	Urban	Eastern Cape	Uitenhage – Nelson Mandela District (Urban)
Bedford	Amatole	Urban	Easter Cape	
Port St Johns	OT Tambo	Rural	Eastern Cape	
Verulam	Ilembe	Urban	KwaZulu Natal	Toti/ Mzikhulu – Ugu District (Urban)
KwaMashu	Ethekwini	Urban	KwaZulu Natal	
Ekubusisweni	Ugu	Rural	KwaZulu Natal	
Port Shepstone	Ugu	Rural	KwaZulu Natal	
Pampierstad	Frances Baard	Semi Urban	Northern Cape	Kuruman - Frances Baard District (Rural)
Delpoortshoop	Frances Baard	Semi Urban	Northern Cape	

Stage 2: Selection of Eligible Children

Eligible children will be selected using a CWSA OVC register for each Asibavikele selected site. The OVC register generated from the database will be used as sampling frame to undertake a random selection. Children will be selected from each selected site for the evaluation. Allocation of sample size for each site is described below.

Sample Size

The sample size is calculated in due consideration that the evaluation intends to assess the extent to which CWSA Asibavikele program contributed to improved well-being and resilience of OVC. In calculating the sample size several points are therefore taken into consideration; the magnitude of change or comparison group differences expected to be reliably measured; the degree of confidence with which it is desired to be certain that the observed change or comparison group difference of the magnitude specified above would not have occurred by chance (the level of statistical significance), and the degree of confidence with which it is desired to be certain that an actual change or difference of the magnitude specified above will be detected (statistical power).

It is well acknowledged that CWSA has conducted the intervention program long enough for the expected results to show.

The sample size calculation is performed using statistical package **nQuery Advisor Version 7** by taking the followings into consideration:

There are 2 groups that need to be compared with regards to benefits accrued from CWSA Asibavikele OVC program.

The evaluation sample size is based on a 2-group (independent or unpaired groups) **Test of Equivalence** in **Proportions** (**with unequal n's**)

(1) The following group representations are made

Group 1: represent the group children who received care and support from CWSA Asibavikele OVC program

Standard Proportion π_S denote the proportion of children who show wellness (improved health, improved emotional well-being, etc) adequately as a result of benefiting from CWSA Asibavikele OVC program (π_S at 0.30); from program previous assessments and program follow up, it is estimated that the proportion of children (0.30) who may have shown significant change in wellness as a result of benefiting from the intervention program. This proportion of 0.30 may need a reference to be justified.

Group 2: represents the group of children in which CWSA Asibavikele OVC program has not intervened with.

Test Expected Proportion π_T denote the proportion of children who are expected to show change in wellness adequately without being given an opportunity to benefit from CWSA Asibavikele OVC program (π_T at 0.20)

(2) Level of significance α : it represents the probability/chance of rejecting the hypothesis that the observed change on wellbeing would have occurred due to CWSA Asibavikele OVC program intervention (α at 5%)

(3) Expected Difference Δ_1 : the difference in proportion of children who have received the service is likely to have acquired wellness due to the service and children who have acquired wellness regardless of the CWSA Asibavikele OVC program (Δ_1 at 0.10)

(4) Power % at 95

(5) The sample size calculated using statistical package **nQuery Advisor Version 7** by taking the above information is **n_s = 639 for Group 1 and n_T = 160 for Group 2**

Hence, a random sample of 639 children will be selected for Group 1 and 160 for Group 2. A 10% contingency is added for non-response to the calculated sample sizes which will give **n_s = 702** and **n_T = 176.**

To control for potential confounding variables such as the parents' place of residence, level of education, income or occupation, or the gender of the children, it will be important to match each child in Group 1 (children who received care and support from CWSA Asibavikele OVC program) with one or two children in Group 2 (children who have not received services from the CWSA Asibavikele OVC program). However due to limited availability of resources as well as sites which are not supported by Asibavikele OVC program, 1:4 ratio is used for paring.

nQuery Advisor

Two group test of equivalence in proportions (large unequal n's)

Column	1
Test significance level, α (one-sided)	0.050
Standard proportion, π_S	0.300
Equivalence limit difference, $\pi_T - \pi_S$, Δ_0	0.020
Test expected proportion, π_T	0.200
Expected difference, $\pi_T - \pi_S$, Δ_1	-0.100
Power (%)	95
n_S	639
n_T	160
Ratio: n_T / n_S	0.250
$N = n_S + n_T$	799

REFERENCES for PTE0U-3:

Farrington & Manning "Test statistics and sample size formulae for comparative binomial trials with null hypotheses of non-zero risk difference for non-unity relative risk" Statistics in Medicine 9(1990) pp. 1447-1454

The sample size allocation per each selected **Asibavikele site** is based on proportionate to size. The following table provides the sample size allocation for the selected sites where children under Group 1 will be sampled from.

Table 3: Group 1 OVC Sample Size Allocation for each of the Selected Asibavikele Sites

Sites : (PSU) (a)	# of OVC (Oct'10 – Sept'11) (b_i)	Proportion of OVC of a Site (c_i) = (b_i) / Total OVC (4,234)	Sample Size Allocated for Selected Site (d_i) = $n_{s/Site}$ = (702) * (C_i)
Eastern Cape			
Mtata	484	**0.11**	**80**
Bedford	779	**0.18**	**129**
Port St Johns	963	**0.23**	**160**
KwaZulu Natal			
Verulam	154	**0.04**	**26**
KwaMashu	641	**0.15**	**106**
Ekubusisweni	190	**0.04**	**32**
Port Shepstone	264	**0.06**	**44**
Northern Cape			
Pampierstad	282	**0.07**	**47**
Delpoortshoop	477	**0.11**	**79**
	Total (b) = 4,234		**n_s; Total (d) = 702**

The sample size allocation per each selected **non-Asibavikele site** is based on proportionate to size. The size used for the proportionate allocation of the sample size is the total OVC served through the Asibavikele program by provinces in the period Oct'10 – Sept'11. The following table provides the sample size allocation for the selected **non-Asibavikele** sites where children under Group 2 will be sampled from.

Table 4: **Group 2 OVC Sample Size Allocation for each of the Selected non-Asibavikele Sites**

Sites : (PSU) (a)	# of OVC served by Province (Asibavikele: Oct'10 – Sept'11) (b_i)	Proportion of OVC of a Site (c_i) = (b_i) / Total OVC (9,697)	Sample Size Allocated for Selected Site (d_i) = n_T/Site = (176) * (C_i)
Eastern Cape			
Uitenhage – Nelson Mandela District (Urban)	6,455	**0.67**	**117**
KwaZulu Natal			
Toti/ Mzikhulu – Ugu District (Urban)	1,879	**0.19**	**34**
Northern Cape			
Kuruman - Frances Baard District (Rural)	1,363	**0.14**	**25**
	Total (b) = 9,697		**n_T ; Total (d) = 176**

APPENDIX 4: Research reflections and stories from the evaluation research

This is a collection of reflections and stories written by researchers during the fieldwork. They provide insight into Asibavikele and the research process.

Story 1: Sweet pie!

J, the site-coordinator tells me that she passed a group of the children from the project on their way home from school and she asked them how the questionnaire they had done for the research had gone. “Sweet pie!!” says one of the children. “What do you mean?” She asks, “It was easy - we all got 100%!” I am so relieved that they experienced the questionnaire process as positive and that they felt as if they got everything right.

Story 2: Running a focus group on the library floor

The younger children are very shy, they don’t know each other and they don’t know us. Some have come from a neighbouring school and they feel out of place. We have to hold our focus group discussion on the narrow veranda outside the library as the other researchers are administering the questionnaire inside the library and there are no free classrooms. We play some games and try to help the children to relax. We begin to talk about our lives and who helps us with the problems we have. Tentatively they begin to talk but then it starts to rain lightly and we have to squash up under the eaves.

Then the questionnaire group finishes and we can use the library. We all have an apple and a break sitting on the floor and in no time the children are more relaxed, lying on the carpet and chatting to each other and to us. I hand out drawing paper and pens while they are still relaxed and ask them to draw all the places they go in a week and to show me where their friends live. They tell us about what they have drawn. We talk about friends. Then we talk about problems in our lives. One little girl leans up against me as she talks, quite relaxed and another boy tells me a story about how he lives with his granny and there is not always money for school things. We talk about the volunteers who visit them and how they help them. Siboniso and I reflect afterwards that it makes such a difference where you work, when you are working with children.

Story 3: A visit to the soup kitchen

"Auntie N, (volunteer) she is the person who likes to help people. She is cooking for the children here at the soup kitchen. She sometimes cooks soup, potatoes and sometimes bread and sometimes full meal. She visits at home too. When she arrives at home she always asks for me. She asked for my mother and father's names. She then requested my birth certificates. She told me that she is working under something that is helping the orphans. She has been trying to help me. She has taken my certificates and my school reports, because she wanted to go Mthatha to collect my mother's death certificate." (girl, 12, Maheng, Port St Johns)

The soup kitchen

"It's close to Port St Johns town, you will find it easily it's not far." So we decide to visit N the volunteer who runs the soup kitchen at Maheng. We leave the busy small town of Port St Johns and drive up a steep hill that keeps going up and up and up. We drive through a small coastal forest and drive up another steep hill, up and up and up and on and on – close to town? Then, across the rolling hills we see a collection of small, multicoloured, new houses. "That's Maheng!" Says Andile, the interpreter. I wonder why anyone would build a settlement out here high up on the hills so far away from town. It looks a lot like one of the removal settlements built during the apartheid era.

Andile explains, "Most of these people were living in a place close to town and the municipality wanted to sell the land to developers so they removed them here. Most of the people have moved back into town but they rented their houses here. People are very poor and they can't get into town easily as the transport costs are high. There is no school, no clinic, just nothing out here."

We drive through the houses and notice a large group of children gathered outside a bright newly painted, white house. "That's the soup kitchen," says Andile. The younger children are lined up ready with their bowls and spoons. The teenagers are lounging in the shade of the neighbouring house, chatting. A woman in an apron with bright trimming carries a huge pot of soup from the

house across the road and the little ones in the queue jump up and down. This is N. Another woman carries a pot of newly backed, pot bread, cuts it into huge slices it and hands it out. Everyone gets a bowl of soup and sits down to eat it. The teenagers come over, going back to the shade next door to eat. The owner of the next-door house arrives home from work, greeting the women and joking with the teenagers who he has to climb over to get to his front door.

"The community is so supportive of us and what we do because they know their children were just hungry before I started the soup kitchen. I moved here with my husband and children about two years ago as we just did not have money for a house anywhere else. When I got here I realised that so few people were working. Out of the 200 houses here there are maybe only five families that do ok. The rest are so so poor. The children were just going to school hungry and going to bed with no food. I was visiting as an Asibavikele volunteer so I knew there was just no food in many homes. I went to the owner of the Spar here in Port St Johns and he agreed to help me. He gave me a stove for cooking and the pots and he donates the food. I make sure we get good fresh vegetables for the soup and I get whole wheat flour and make pot bread because it is healthier. No one lives in this house so I use it for the soup kitchen. The children come before school and get porridge and after school on their way home. So they are getting two good meals a day at least. I just had to do it. My whole family helps too, even my kids. I am not the kind of person who can stand back and look at hungry children and do nothing."

As N talks she stacks the bowls and spoons into a plastic tub ready for washing and hands every child a freshly washed apple to take home. She stops to talk to particular children as she does, telling me some of their stories when she comes back to sit with me under the eaves of the white house out of the afternoon sun. "That little one there needs to go to the clinic regularly for his treatment, he is so much better now. That small girl there is one of four siblings, they had no certificates, no grants when I first visited the family. The mother did not even have an ID. So I had to take them all into Home affairs at Port St Johns, it cost so much transport … but now at least they will get certificates and we can start to get the grants."

"She started the soup kitchen so that we can eat before going to school.
We were going to school on an empty stomach
Then at school you can hardly listen to what the teacher is saying. You just answer anything because you can't think well."

Story 4: The father story
I am sitting with the volunteers in their bright yellow T-shirts in the new Asibavikele office outside Port St Johns. We are drinking juice and eating apples after our research discussion. One of the older women asks, "Can't you do something about this father issue? When we go to do the foster care applications for the grannies we have such problems because they are always saying we have to find the fathers to sign the forms before they can organise the foster care. So many of the children here the fathers left long, long ago to work in the city and they have never returned. "

"Yes, it is a big issue!"
"Yes, there is a young boy of 8 years. His mother passed away last year. Ever since then, we are trying to apply for him to get a foster care grant. We can't get it because the Department of Justice wants his father. But his grandmother doesn't know who the father is and where the father is. Now the case is just stuck there. It came to a stand-still because the magistrate said we need to write to Khumbulekaya (a television programme that traces lost people on SABC2) programme to look for him! Tsch!

The granny is living with this boy and she doesn't have any income at all, she can't cope. She has a few grandchildren without mothers. She has lost her own two children, who were daughters. We ask for donations and sometimes they do get help, but on a daily basis they are struggling. The child does have a birth certificate a death certificate of the mother, and the mother's ID, but it all got stuck when the father has to be involved. The social workers at DSD saw him and they got the grandmother to the Department of Justice. And then the magistrate said they want the father of the child!"

"I am working with four other similar cases. And each time you go to the magistrate, the magistrate says he needs a father or the magistrate needs the document that proves that the father is died. Which is impossible to the children and granny because they don't even know where the father is for many, many years."

Story 5: The two fat babies
While doing the community survey one of the fieldworkers knocked on the door of an old grandmother. These are his recollections.

I introduced myself and I asked the question about helping children. She called me inside and there on the bed were two babies – twins – one was sucking on his bottle as he slept. She just started to talk, "The only one I know is B! She helps children!" And then she started telling me everything! She was just flowing and she wouldn't let me go. She talked about her one daughter dying and the other running away and that she has five children now to look after, the twins and three older ones. And the two babies were so thin and she did not have milk for them. Then I realised that she is a client of Asibavikele because she said B, who helped her had a yellow T-shirt. The house is written 'poverty' but she was so upbeat because now the volunteer had helped her to get a foster grant and she was even paying back the loan shark to get her ID. And the other children have got uniform and school shoes and shirts and are like any other child at school.

One of the children left by the mother is sick and she did not know what to do until B took the child to clinic. She told me that the volunteers went to the school with her to tell them about the condition of the child. Now the child is lively and no longer often sick as she used to be. She said that if anything happens she calls the volunteer and she comes running and takes her or helps her. But she was most proud of the babies. She said I had to take a photo of them.

"Can you see my grandchildren now, can you see them! Now they are just fat – before they were thin and sick."

Story 6: A small boy who is now well

We are working with a group of children under large gum trees in the grounds of the local school. The school bell rings and everyone comes outside for break. We let our small group run to get their lunch and have time to play too.

One of them, a small boy comes up to us with a packet of crisps and a juice in his hands. He gives B, one of the volunteers, who is interpreting for me, a shy smile and then rushes off to a group of friends who are calling his name.
"It makes my heart happy to see him running and playing and being so well."
"Why, has he been sick?"
"Yes when I first started as a volunteer we were doing homework at the school in the afternoons and I noticed him. He just sat with his fingers in his ears as if all the noise was too much for him. He looked listless and sick. I reported to the teacher and I then did a home visit. His mother said he was ill but she did not know what was wrong with him. I put him on the OVC register and referred him to the social worker. Then I took him to the doctor with his mother and we asked permission to do a blood test. He was put on treatment. Now I take him every time for his hospital visits. His mum has another child at home who is disabled so she can't go out much."

"After doing homework at school with the children we always give them some food and one afternoon I saw him putting his food into a bag. When I asked why he didn't eat it he said, "I want to take it home for my sister." So then I

wondered if there was food at home. I visited and the mother said she was too shy to tell me but they did not have food. They lived on the sister's disability grant and it was not enough. So we organised food parcels."

As we are talking S runs past with his friend pulling on his shirt, he turns round and gently cuffs his friend on his shoulder – quite confident and at ease.

"You know at first he was a lonely child and we took him to have counselling with the social worker and look at him now. He has friends, he is just a normal little boy."

S runs past again, with his friend shouting after him and I wonder what would have happened if B had not noticed a little boy with his fingers in his ears and followed up.

Story 7: KwaMashu Saturday group programme

In KwaMashu we work on a Saturday at a local church hall with the Asibavikele children. They arrive in groups, most dressed in their best clothes. There are teenagers, eight, nine and ten year olds and lots of little brothers and sisters. We work with the volunteers to divide them into groups. Some work with Joe in a focus group. Others work with Mbuso to do the questionnaire and two volunteers take the little ones to draw pictures. One group of girls of about 11 and 12 years old spontaneously start to play games outside when the focus group discussion is over. They start with some quiet clapping games and then some traditional singing games, soon they are just jiving madly comparing dance styles. As the others finish with the questionnaires they join us in the dancing and soon we have a long snaking train going around the hall through the long grass.

Fun and games at the 'research day'

A few volunteers are making polony sandwiches and everyone sits down to juice, apples and sandwiches. We then all sing songs. The teenagers join in for a while and then sit in the shade chatting together while the little ones dance for us in the middle of the circle.

The social worker remarks how much the children have all enjoyed the morning. “I can see it was like an outing for them. They need to just get together and have fun. I think we will do this regularly, once a term, get together and play games and sing songs.”

Story 8: A small boy called BB[2]
I am given a list of the children that will work with me in the focus group discussion. As I do the teacher says, “You have BB in that group, he is very slow so he may not talk much is that ok?” “Of course, leave him in the group, all children have something to say.” As we file into the classroom another teacher taps me on the shoulder and warns me, “BB is a little slow …” I just smile. When I look at the list of children’s names I see that his name is listed as BB alone, no first name or surname – it seems that BB has become his name.

We play some games, learn each other’s names and start to discuss the small cut out figures I have brought with me. BB sits quietly not saying a word. We all draw a picture of ‘the places we go in a week’ and BB draws too. Then I place the two cut-out figures on one side of a pile of rocks and a drawing of a school on the other. I want to explore barriers to school-going with them – what stands in the way of them going to school and do they get any help with these things. The children sit in the circle and think about what the stones may be called, what barriers there are. Then BB says, in a clear and ringing voice, “Hulle moet **om**!” [They should just walk **round** (the stones).] The children laugh affectionately and slap him on the shoulder – well, yes, that is the most logical thing to do BB. We give him a clap for his good idea and go back to thinking about barriers to school-going – everyone can participate.

Story 9: Being a volunteer is hard
We are sitting in the administration area of the Child Welfare Office with the volunteers. They have drawn maps of their homes and the homes they visit as volunteers. I ask them to tell me about what they have drawn. Most begin by describing their home and their family then they go on to tell me about the families they visit.

“And if you can see this lady I have drawn, she is one of my clients. She came to me and she was very drunk. She said she wanted to tell me something. She said “Keep it within yourself, but now I am going to tell you. This is my baby, the other one is also my child. She is HIV-positive. I found that I was HIV-positive when I was pregnant with this one. So I can’t take it. That is why I am always under the influence of drugs and alcohol.” So now its granny’s responsibility to look after the children and granny can’t cook. That leaves children as the only ones to cook for themselves. What are they going to cook because there is no food in the house. I called R (site coordinator) to come and see for herself the situation. She came over and asked the children, what are you eating, they said dry porridge, in the morning, midday and in the evening.”

It is very clear that the poverty in this community is deep and the problem of alcohol abuse and domestic violence is huge. Many of the volunteers also

[2] Name Changed

support mothers who are HIV-positive to get treatment and to cope. The volunteers have a heavy task here. One of the volunteers is an older woman who starts by telling us about the large family that lives in her house. Her husband is ill from his work on the mines and now her daughter, who was the only one working, is also ill and needs to be looked after. She would like to take her to a private doctor but it costs too much.

"What makes it difficult to see the other doctor is that we have 9 grandchildren, actually 10 with the other boy that is staying with us. But the main problem in the house is last night … we went to bed without anything to eat."

She breaks down and sobs. We give her tissues and fetch her a glass of water and the site coordinator acknowledge her sadness by saying, "It's difficult to help people when you have our own problems. You try to bring smiles to these people, while you have your own challenges. It's very hard."

APPENDIX 5: Community survey results

Number of community surveys per site

Project site	Number of surveys
Pampierstad	16
Delportshoop	17
Bedford	16
Port St Johns	26
Mthatha	28
Port Shepstone	9
Ekubusisweni	10
Verulam	0
KwaMashu	19
Total	**141**

Survey results by site[3]

	Q1: Know Asibavikele?	Q2: Know what they do for children	Q3: Children affected by HIV/AIDS	Q4: Orphan children in area	Q5: What do they need?	Q6: Do you do anything to help?
Delportshoop (17)	6 know 4 another 7 both 0 DK	5 emot only 10 prac 0 both 2 DK	9 Y 2 N 6 DK	9 pos 6 neg 2 DK	0 adult suppt only 7 prac 8 both 2 DK	8 Y 9 N
Pampierstad (16)	10 know 3 another 0 both 3 DK	0 emot only 7 prac 7 both 2 DK	9 Y 2 N 5 DK	10 pos 4 neg 2 DK	1 adult suppt only 10 prac 5 both 0 DK	5 Y 11 N
Bedford (16)	9 know 0 another 3 both 4 DK	0 emot only 7 prac 2 both 7 DK	6 Y 2 N 8 DK	10 pos 0 neg 6 DK	2 adult suppt only 10 prac 4 both 0 DK	10 Y 6 N
Port St Johns (26)	18 know 2 another 0 both 6 DK	1 emot only 19 prac 2 both 4 DK	15 Y 1 N 10 DK	24 pos 2 neg 0 DK	5 adult suppt only 17 prac 4 both 0 DK	6 Y 20 N
Mthatha	17 know	7 emot	18 Y	27 pos	10 adult	19 Y

[3] Codes used in table:
Y = yes
N = no
DK = don't know
Pos = positive attitude
Neg = negative attitude

(28)	9 another 0 both 2 DK	only 12 prac 9 both 0 DK	1 N 9 DK	1 neg 0 DK	suppt only 10 prac 8 both 0 DK	9 N
Port Shepstone (9)	5 know 2 another 0 both 2 DK	1 emot only 6 prac 2 both 0 DK	8 Y 0 N 1 DK	9 pos 0 neg 0 DK	0 adult suppt only 6 prac 3 both 0 DK	3 Y 6 N
Ekubusisweni (10)	9 know 0 another 0 both 1 DK	0 emot only 2 prac 8 both 0 DK	8 Y 1 N 1 DK	10 pos 0 neg 0 DK	2 adult suppt only 8 prac 0 both 0 DK	0 Y 10 N
KwaMashu (19)	16 know 0 another 3 both 0 DK	4 emot only 2 prac 13 both 0 DK	19 Y 0 N 0 DK	16 pos 3 neg 0 DK	1 adult suppt only 9 prac 9 both 0 DK	4 Y 15 N
Totals (141)	90 know 20 another 13 both 18 DK **141**	18 em. only 65 prac 43 both 15 DK **141**	92 Y 9 N 40 DK **141**	115 pos 16 neg 10 DK **141**	21 adult suppt only 77 prac 41 both 2 DK **141**	55 Y 86 N **141**

The results reveal some interesting patterns, as the discussion of each question used in the survey below shows.

<u>Question 1 (Who helps children with problems in your area?)</u>: 63.8% of community members report that they know Asibavikele. In this survey they were required to name either Asibavikele or Child Welfare by name, or to describe the volunteers in a recognisable way, for example "the ones who wear the yellow T-shirts" in order for the fieldworker to record this response. This pattern is fairly consistent across all of the sites. This suggests that in the communities where they work, the volunteers are widely known. Indeed, even though this was not asked, several people mentioned the volunteers by name.

<u>Question 2 (What do they do with the children?)</u>: This reflects slightly more ambivalent responses. 46% report that they think Asibavikele provides practical support of some kind. In order, most of the responses listed "grants", then food and school attendance. 43.2% mentioned emotional support, and of these people, 70.6% (or 30.5% of the total group) mentioned a combination of emotional support with practical support. This is encouraging in that it reveals not only that Asibavikele is known to provide a holistic service to vulnerable children, but that people have that kind of example set. Responses to this question are not consistent across the sites. For example, in Port St Johns the responses are dominated by those who report that Asibavikele provides practical support (21 vs. 3), while in KwaMashu the ratio is 15 to 19. This is

most likely the contextual influence – in places like Port St Johns, where many of the clients are living in remote areas, practical support such as assisting with obtaining birth certificates and ID books takes on a much larger priority than in areas where basic services are much more accessible. However, this could also reflect the local emphasis within the programme.

An important response that was obtained in some places, particularly Bedford, was a somewhat antagonistic response to the question of what Asibavikele provides for children. Comments such as “They do nothing”, or “They only help their *chommies* (friends)” came through. In investigating this further it seems that Bedford is an extremely poor community, perhaps one of the poorest we have worked in, and the needs are so deep and widespread that Asibavikele, working as it does through equally poor local volunteers, simply cannot meet the need, so many feel left out and are angry about it. There seems to be a need to manage public perception in some way and also to be careful how beneficiaries are identified.

<u>Question 3 (Are children in your area affected by HIV/AIDS?)</u>: While the majority (65.2%) said that children are affected by HIV/AIDS, there were also many people who were very unsure about committing themselves. In some communities, Bedford and Port St Johns in particular, people said things like “I don’t know, but rumours are there, people hide it, but we hear about it.” Fieldworker’s reported back that people were not open and were scared to talk about it. Others reported that when asked that question, people literally started shaking. So while there is an overall acceptance that HIV/IADS is present in their community and willingness to say so, there remains a strong resistance and fear amongst others to acknowledge and face the obvious (28.4% “Did not know” and a further 6.4% flatly denied it).

<u>Question 4 (Tell me about orphan children in your area)</u>: This question prompted a very interesting response – fully 81.6% of responses were categorised as “positive” by the fieldworkers. Responses like “They are killers” and “They do house-breaking” were in the minority and were tempered by comments such as “They try to live” and “They are schooling”, with other comments such as “They need a stress and trauma workshop or a “healing the past” workshop, reflecting a sympathetic and constructive attitude. This generally positive attitude seems to contradict the ‘denialism’ that was evident in Question 3, but note that this question is about orphans, while Question 3 is about HIV/AIDS. Nevertheless, the positive attitude that this question discerns is supported by the relatively high number of responses in Question 2 that reflect a combination of practical and emotional support for children. There thus seems to be evidence that Asibavikele has indeed influenced attitudes and that this seems can be used to further normalise vulnerable children’s lives in their local communities.

<u>Question 5 (What do children affected by HIV/AIDS need?)</u>: This question also seems to separate attitudes towards orphans and towards children affected by HIV/AIDS. Orphans are generally well-received, whereas in this question, 54.6% said that what these children need is practical in nature. They

did not consider the psycho-social needs of children. Amongst the 54.6% was a significant number who answered "Treatment", and many gave that as their only answer.

Question 6 (Do you do anything to help vulnerable children living in your community?): A surprisingly high percentage of people said that they do help vulnerable children (39%), given that many would not know such children, at least not closely enough to respond to their need. Many of those who responded in this way were direct family and were acting as foster parents. Given that 65.2% agreed that HIV/AIDS affects children in their area, the fact that many are fostering children comes as no surprise.