Evaluation Report

World Vision Networks of Hope Program

Prepared by

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World Vision: Networks of Hope Program

Evaluation Report

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Technical notes

This report is accompanied by a separate volume of ***Technical Notes*** consisting of extended explanations on technical and substantive matters as necessary, tables and statistical data. This appendix has been compiled to facilitate easy reading in the main report. References to the ***Technical Notes*** are made throughout the main report and follow the sequence of the report's sections. This appendix is available from Pact South Africa (Pretoria).

Research instruments and data sets

Research instruments (questionnaires) and data sets (in SPSS format) are transferred electronically to Pact South Africa (Pretoria) for reference purposes.

PREFACE AND ACKNOWLEDGEMENTS

This evaluation of the Networks of Hope Program was conducted by Rural Outreach and Development Services (ROADS). ROADS was contracted by Pact on behalf of USAID to evaluate the World Vision's Network of Hope (NOH) Program for addressing the needs of OVC in six Area Develop Projects (ADP) with the goal of improving their quality of life and resilience in the face of the HIV/AIDS epidemic in South Africa.

ROADS is a registered Close Corporation (Reg. 2001/082389/23) for social assessment and project development and is based in Cape Town, South Africa. It conducts impact assessments, situational analyses for government departments, local authorities and development agencies in South Africa and beyond and makes recommendations for institutional development, infrastructure and systems for sustainable development.

Completion of the task was made possible by a dedicated team of role players who have all made a valuable contribution to the outcome. The following role players deserve special mention for their exceptional contribution:

- Dr Rita Sonko (Director: Monitoring, Evaluation, Reporting & Learning (MERL)), Mr Daniel Bakken (Contracts Manager) and Mr Addis Berhanu (Assistant Director, MERL) of PACT SA. As grant managing agency of PEPFAR, PACT has played a valuable role throughout the evaluation process.
- Ms Gloria Ifeoma Francis (Program Manager; NOH) and Ms Rachel Mataboge Meyer (Design Monitoring & Evaluation Officer), both at WVSA, for their assistance around implementation in particular during the field work.
- The ADP Managers for their cooperation and logistical assistance during the visits of the fieldwork team: Mr Kgetho Siphiri (Khauhelo ADP), Mr Ernest Fraser (Thaba Nchu ADP), Ms Ledile Mphahlele (Kodumela ADP), Ms Maria Kgabo (Thusalushaka ADP), Mr Xolile Mbi (Umzimvubu ADP) and Ms Lizeka Sicina (Mpofu ADP).
- The larger number of ADP staff, some of whom as specified by name in Appendix 2, who availed themselves for assisting in many ways.
- The stakeholders at the different ADPs who voluntary gave their time to participate in the stakeholder workshops or being interviewed.
- The local assistants being recruited at the ADPs for their inputs.
- The large number of guardians, home visitors and OVC who often travelled long distances to the village where they were interviewed.
- The ordinary people and local leaders, including traditional leaders who gave their wholehearted support and hospitality.
- Ms Zuki Dikeni who provided excellent services as evaluation assistant as a member of the fieldwork team.

The evaluation team consisted of the five senior consultants of ROADS who take responsibility for the entire report, conclusions and recommendations.

The evaluation was conducted under tremendous stress of time and it was of utmost importance that valid and reliable findings were registered and fair and just conclusions were reached.

We trust that the findings and recommendations will be experienced as realistic and fair to all concerned and in the best interest of World Vision, the stakeholder organisations and the ADP management and staff, and in particular the beneficiaries of the NOH Program. We submit this report in the confidence and hope that it will be of value to all readers and for the deliberations and decisions regarding the future of the NOH program.

For the ROADS team this was an invaluable experience to work on this project. We would like to express our sincere gratitude to USAID for their financial support and Pact SA for their technical advice. It is our wish that this evaluation report will assist the different role players to extend and improve their services to OVC, their families and communities in the project sites.

Frans Kotze, Director: ROADS

Pieter Cloete, Cornie Groenewald, Ilse Eigelaar-Meets and Caroline Poole, associates of ROADS

30 June 2012

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ACRONYMS

ABCD	Asset Based Community Development
ADP	Area Development Program/Project
AIDS	Acquired Immunodeficiency Syndrome
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
CBO	Community Based Organisation
CBP	Capacity Building Programme
CCC	Community Care Coalition
CCF	Community Care Forum
CDP	Community Development Project / Program
CEO	Chief Executive Officer
CHATs	Congregational Hope Action Teams
COH	Channels of Hope
CSA	Core Service Areas
CSPE	Centre for the Support of Peer Education
DHA	Department of Home Affairs
DOA	Department of Agriculture
DOH	Department of Health
DSD	Department of Social Development
FAMSA	Family and Marriage Association of South Africa
FBO	Faith-Based Organisation
FY	Funding Year
HBC	Home Based Care
HIV	Human Immunodeficiency Virus
HR	Human Resources
HV	Home visitor
KFC	Kentucky Fried Chicken
MDGs	Millennium Development Goals
MOU	Memorandum of Understanding

MTE	Mid-Term Evaluation
NACCW	National Association for Child Care Workers
NEPAD	New Partnership for Africa's Development
NGO	Non-Governmental Organisation, Non-Government Organisation
NOH	Networks of Hope
NPO	Non-Profit Organisation
OVC	Orphans and Vulnerable Children
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	People living with HIV
PLWA	People living with AIDS
PRA	Participatory Rural Appraisal
ROADS	Rural Outreach and Development Services
SA	South Africa
SAG	South African Government
SADC	Southern African Development Community
SAG	South African Government
SLA	Sustainable Livelihoods Approach
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
WV	World Vision
WVSA	World Vision South Africa

Technical note:

χ	chi-square (statistical measure for determining difference in the distribution of a variable)
df	degrees of freedom (statistical expression of the limitation of values to vary freely – as per column or per row in a table)
p	the p-value expresses the "fault" allowed in the certainty of a statistical test. Usually set at 5% (written as .05) or smaller

EXECUTIVE SUMMARY

Overview

This is a report on the evaluation of World Vision's Network of Hope (NOH) Program for addressing the needs of OVC in six Area Development Programs (ADPs) with the goal of improving their quality of life and resilience in the face of the HIV/AIDS epidemic in South Africa. ROADS was contracted by PACT SA to conduct the evaluation. PEPFAR through USAID has taken a special interest in fighting the devastating impacts of this epidemic and to assist putting in place sustainable measures for self-reliance and sustainability. Apart from inquiring about the impacts of the program, questions also arise regarding the sustainability of the program effects for the communities involved and if the communities would be able to continue and sustain the program. Continuation is an important sustainability issue because both the funders and the implementing agency see their involvement as terminating.

The evaluation questions imply both an outcome/impact evaluation and process evaluation. The questions are:

1. Did the NOH program make any **change and improvement** in the wellbeing of vulnerable children and what **aspects of child wellbeing** were affected most as a result?

2. To what extent did the NOH program succeed in **strengthening community capacity** to effectively respond to the needs of vulnerable children?

For answering the questions, ROADS designed a number of research instruments to tap the variety of data sources available for inquiring about the vulnerability status and interventions made of about 35 000 OVC on the register of World Vision in the six ADPs. The period of evaluation covered 2006 to 2011 and includes a random sample of 600 OVC that have been part of the program for 18 months. OVC's guardians (primary care givers), home visitors allocated to them (secondary care givers), community stakeholders and ADP staff in addition to teenage OVC were interviewed using questionnaires, and through group sessions and personal interviews. World Vision's data on OVC as filed in their administrative systems were also incorporated. Data capturing, processing and analysis were performed at ROADS. Field work was conducted during March 2012.

The evaluation report provides in condensed form an overview of the evaluation process, World Vision's approach to OVC vulnerability, the key findings and conclusions together with lessons learned and recommendations.

Conclusions regarding the evaluation questions

The answer to the **first question** is a qualified yes, as the profile of OVC has shown that OVC wellbeing is largely conditioned by circumstances of poverty, hardship and destitution. Not having the capacity to face the conditions of living they are exposed to, their vulnerability may be overwhelming and their chances to accomplish a winning life may be bleak. The life domains fuelled by inner strength, social forces, educational achievement and life skills may become all important to overcome the stumbling blocks of material conditions.

Therefore the answer is also a positive one. The NOH program makes provision for access to financial support, services of various kinds including health, psychological, legal, social and other services. World Vision had to approach the relevant communities in terms of their poverty status and initially followed a basic needs approach. However, the mentioned program services maintain dependency and are not sufficient for developing self-reliance and self-sustainability.

The profile of OVC points out that about 100 per cent of the OVC in the NOH program of school-going age were attending school. Just below 10 per cent of the sample observed did not progress to the next grade in the previous year. More than one third of the OVC may be regarded as too old for the grade they are in. The latter fact may have a negative effect on OVC's capacity to enter the adult world eventually as fully trained scholastically. The NOH program compensates to the scholastic backlog by facilitating vocational training, which has become one of the high frequency services of the intervention program.

The most positive aspect of the OVC profile is their health status. Only a minority needs serious attention to their neglect of personal hygiene, bodily care and a healthy life style. Home visitors should identify these children and families and address these issues. Malnutrition is a specific issue to be addressed more.

The answer to the **second question** is in doubt as already has been hinted. The community structures, such as the participating CBOs that have been created or empowered do not seem to have developed as yet the capacity to implement the program independently from the ADPs. Part of the problem is the need to facilitate access to services and resources. In this regard, a general confusion about the role of World Vision has been observed. Attention to basic needs has the risk of undermining strengthening community capacity to effectively respond to the needs of vulnerable children and consequently the sustainability of the established community structures. Dependency has thus become an unintended consequence in this program.

But there are positive results to be reported. The OVC have not only developed a good measure of wellbeing and resilience, albeit in a subjective definition thereof. Evidence came forward that social capital had been developed. Community values, ownership of the program, belief in the value of the program and its instruments, access to public services,

inclusivity and the like have established itself in the process. These are valuable and essential building blocks for community self-reliance and self-sustainability. In this sense, progress can be reported on the strengthening of capacity of the community to respond to the vulnerability issues of children.

The analysis points out though that vulnerability issues are currently defined more by the poverty context of the community than the HIV epidemic and that it is expected that the scale of OVC as a category of vulnerability is levelling down.

Therefore, we may conclude that the NOH program has been successful in addressing personal and family needs of OVC and in providing hope and resilience on the micro levels. The challenge for the NOH program is how to address sustainability in local economic capacity in order to ensure material survival and even prosperity in the long term.

Lessons learned and recommendations

Crucial lessons were learned to be taken into consideration on the future of the NOH program and when planning the course of direction to take.

1. **National trends are not necessarily a guiding principle for local action**.

Taking into consideration the profile of OVC and their households, the conclusion is that poverty has become the core issue of vulnerability and that HIV as experienced by the adult generation aggravated the situation. The assumption that HIV is still the rampant epidemic it proved to be over the last two decades in South Africa needs to be investigated critically and a proper socio-economic needs assessment is overdue. Due to interventions the needs and assets profiles of targeted communities and villages are likely to have shifted. Therefore the recommendation is that such a needs (and assets) assessment be conducted to inform the community structures of the way forward.

2. **Revisit the prioritisation of interventions in the light of needs assessments.**

The NOH program has designed and developed an impressive range of interventions to address vulnerability issues of children and families. This may be regarded as a comprehensive and holistic intervention tool providing for sustainable human development, family relationships, healthy lifestyle, and access to ART. In this sense the program is ‘doing the right things’. Data point out that education levels are not on par with the OVC age levels and that household economic strengthening is not sustainable. The recommendation is that the interventions not only be intensified, but that sustainability issues especially for livelihoods be taken more seriously. In this respect a needs assessment may assist with realistic prioritisation of interventions. In a situation where everything has become equally important and urgent, prioritisation based on sound and relevant information is imperative.

3. **Sometimes the guideline is: Back to basics.**

Despite the successes alluded to above, health conditions related to poverty, neglect, exposure and lack of parental control and personal hygiene have been observed. Malnutrition is a specific issue. It is recommended that nutritional counselling and parental guidance be refreshed and intensified in the programs that home visitors are running.

4. **Voluntarism is an inapplicable approach in a chronic poverty environment.**

The use of a home visiting system is absolutely essential for the success of the program on the OVC at family level. The home visitor system and the incumbents are in need of upgrading in terms of formalisation, orientation, capacity building, and supervision. Due to home visitors' socio-economic position it cannot be expected from them to work without compensation.

However, the basic assumption that the home visitors in this program are volunteers requires that the applicability of the term in this situation be revisited and aligned to what emerges as guidelines for the future regarding the use of community volunteers working for stipends. Currently home visitors may be technically employees as they receive regular compensation in the form of stipends for routine work performed. We found that many home visitors have seen the service as an opportunity to provide an income. This is not uncommon in situations and cases of enduring poverty. In view of the wide-spread application of this practice in South Africa and public attention to voluntarism as a human resource in service delivery the implementing agency needs to address this as a priority in the continued implementation of the NOH program.

5. **Community development principles should be known, acknowledged and adhered to**.

In essence, the NOH program is a community development program. This implies that communities ultimately participate in decisions affecting their future and take control of community structures that will affect the outcomes of interventions. The NOH program provides two streams of interventions, firstly nine core service areas including 33 specific services that provide for child and family focused programs, and secondly capacity building of community structures primarily through Community Care Coalitions and Channels of Hope programs. Each ADP project site appoints a group of home visitors who are tasked to facilitate the child and family program under the supervision of the CCCs. The ADP, i.e. staff and management, serves as the implementing agents of the program for the duration of the presence of World Vision in the project site.

An interpretation of the nine core services areas and 33 specific services justifies the conclusion that these services are primarily focused on the basic needs of OVC and their families and less on community capacity building such as organisational and sustainable livelihoods development.

With regards the second intervention stream, namely capacity building of community structures, such CBOs, NPOs and related community based projects, we observed noteworthy progress. Although community participation is not yet at the point where the communities are able to determine and drive its own programs, progress is clear regarding the development of community assets as the key building blocks towards sustainable community and village vitalization efforts. Progress in this regards includes the skills of individual volunteers networking, the development of local organisations like CBOs to provide the needed services and development, and sense of ownership, enlisting of the needed services of state departments and major institutions, like education, health, churches, etc and finally also emerging small business, farming and infrastructure needed for the activities for the implementation of the program.

Therefore in view of the above and the ultimate goal of community development the NOH program, despite the mentioned noteworthy progress, carries within itself inherent tensions. The program is perceived by community stakeholders as to be managed by World Vision although they have shown buy-in or ownership of the program. In reality, no strong evidence was coming forward that the community structures are ready as yet to take the role of owners and managers of the program. To strengthen community capacity to run and manage the program the perceived dependency on World Vision needs to be addressed. More attention is therefore needed to build capacity of and transfer responsibility to community-based structures.

1. WHAT IS THE ISSUE CALLING FOR INTERVENTION?

The trends in health, especially with regard to HIV and AIDS, nutrition and poverty, particularly in relation to children, were reason for governmental, non-governmental and international agencies to consider aid in the form of funding, development and capacity building. The primary aim of such funding is to curb the tide of human destruction towards sustainable human development evident in many parts of the developing world, of which South Africa has become part. In this section, some general trends are highlighted that serve to draw the attention of such agencies.

Following the UNAIDS reports[1] on the status of HIV and AIDS globally, as well as among nations, it seems that the overall growth of the epidemic has stabilized. The annual number of new HIV infections has been steadily declining since the late 1990s and there are fewer AIDS-related deaths due to the significant up-scale of ART over the past number of years. Despite the trend of declining numbers of new infections, the levels are still high, and with significant reductions in mortality the number of people living with HIV worldwide has subsequently increased. UNAIDS estimates that there were 33.3 million people living with HIV at the end of 2009 compared with 26.2 million in 1999 — a 27% increase. Similarly, the estimated number of children globally living with HIV increased to 2.5 million in 2009.

South Africa remains the epicentre of the global epidemic and is the country with the highest absolute number of people living with HIV - estimated to be 5.38 million people in 2011.[2] New indications suggest a slowing down of the HIV incidence rate amidst some signs of a shift towards safer sex practices among young people. The number of adults (15 years and older) receiving ART increased more than ten-fold since 2005 and totalled 1 058 399 in 2010. More than 105 000 children (0-14 years) received ART (including cotrimoxazole) in 2010.

During the last decade South Africa saw significant improvements in her demographic profile but the general picture remained worrisome. During 2001 to 2011, the infant mortality rate decreased from 53.3 to 37.9; the under 5 mortality rate from 78.8 to 54.3 and the crude mortality rate from 11.9 to 11.7; and consequently, the life expectancy at birth has risen for males to 54.9 and females 59.1 years. At the same time the total fertility rate slowed down from 2.92 to 2.35 and the population growth rate from 1.33% to 1.10% per year.

While these demographic trends indicate many positive signs for the quality of life of the population it should be remembered that ART contributed only partly to improved life chances and that the percentage AIDS deaths increased over the decade (40.5% to 43.6%). It should also be noted that Statistics South Africa estimated 1 115 284 adults (15 years and

[1] See for instance UNAIDS 2010.
[2] Estimates further on according to South African Statistics 2011a.

older) and 377 097 children (0-14 years) in need of ART in 2011 and that both these figures are representing substantial increases above the 2010 figures mentioned above. For children, a backlog of 271 974 in ART treatment is calculated based on these figures. Adults have a much smaller backlog of 56 885 because more adults were treated than estimated to be in need of ART. The median time of living from HIV infection to death currently for males is 10.5 years and females 11.5 years, which is also substantially longer than what was the case previously.

The implications of these changes in the trends of HIV infection incidence and the longevity of AIDS sufferers are that the need for health and social care, in the form of ART and home based care (HBC), has become bigger and more pro-longed. More people need care and over a longer period of time.

The aggravating aspect of the situation is the number of children affected and the harsh socio-economic and environmental conditions of living especially in rural areas. Children are becoming extremely vulnerable. Data from the general household surveys in South Africa conducted during the past decade by Statistics South Africa show that children[3] comprise 40% of the total population and many of them qualify as vulnerable. Their vulnerability is demonstrated by the fact that 19.5% of children are orphans (double, paternal and maternal). Furthermore, household structures are severely disrupted and disproportionally affected by poverty. Children are profoundly affected by this disruption, as data show that only one-third (33.5%) of children live with both parents, while 23.9% live with neither their parents, 3.3% live with their father, and 39.3% live with only their mother. About 7.6% of children live in skip-generation households with their grandparents. Older people are increasingly called upon to take over the nurturing responsibilities for their grandchildren.

Approximately 62.1% of children live in households with a per capita income of less than R570 per month. Approximately 36% of children live in households without any employed members, and social grants and remittances are vital to improve the access to food and education. Female-headed households are consistently more likely to be poor. Poverty patterns continue to be gendered and female headed households are more likely to have low incomes, to be dependent on social grants, and less likely to have employed members. Women and female-headed households are predominantly responsible for the care of children. Black African children are much more likely to experience hunger than white children (20.4% compared to 0.8%). Households which contain children, particularly child-inclusive female-headed households, are much more likely to have experienced hunger than other households.

Against this brief background, South Africa (and many other countries with AIDS driven poverty) gained developmental interventions by World Vision and its partners to address the plight of orphans and other vulnerable children that became desolated as a result of

[3] Children are defined as 0-14 years in the household surveys. See Statistics South Africa 2011b. Figures further on in this section are all from this source.

forces beyond the individual control of families and local communities. The next section provides an outline of the policy background for World Vision intervention.

2. WORLD VISION'S RESPONSE

World Vision is an international Christian relief and development organisation that operates in 98 countries with headquarters in the United States. In 2000, World Vision International launched the Hope Initiative, a global effort focused on reducing the impact of AIDS in high prevalence and high-risk countries. WVSA followed suit with core areas of focus HIV and AIDS, food security, education, economic development, water, sanitation and basic family healthcare, and advocacy. World Vision International launched the Hope Initiative in 2000[4]. WVSA is the South African partner of World Vision International and was established in 1967.

The South African Government in 2005, through the Department of Social Development (DSD), issued a policy framework and the following year a national action plan for OVC. Both the framework and action plan provide a path for addressing the social impacts of HIV and AIDS and for providing services to OVC, with a priority on family and community care, and with institutional care viewed as a last resort. Government policies and services also care for the needs of vulnerable children through the provision of free health care for children under age five, free primary school education and social grants for guardians.

The U.S. government, through USAID (United States Agency for International Development) and PEPFAR (President's Emergency Plan for AIDS Relief), complements the efforts and policies of the South African government and NGOs. As one of the largest donor efforts supporting OVC in South Africa, the emergency plan provides financial and technical support to 168 OVC programmes in South Africa.

These programmes are conducted in partnerships among the South African Government (SAG), USAID and PEPFAR and NGOs. World Vision South Africa (WVSA) has proved itself as a significant player in both the war against HIV and AIDS and OVC care. Being a child focused organization operating in 20 project sites distributed across marginalized communities of South Africa, WVSA gained a wide presence in the landscape of rural and peri-urban South Africa. These project sites are called Area Development Programs (ADPs) and are spread across South Africa as shown in Map 1.

Since 2006 PEPFAR funded WVSA to implement the Networks of Hope (NOH) program to an amount of US$20M[5]. It also provides for the mobilization of the key role players in the communities to care for and protect OVC, strengthening households to care for themselves and the training of caregivers on home-based care and psychosocial support.[6]

[4]Maleemisa Ntsala, Beverley Sebastian and Anzel Schonfeldt: Case Study of the Networks of Hope Project by Khulisa Management Services.

[5] Funding provided to WVSA to implement the NOH program amounts to 18.6M under the current grant (2006 to 2012) but also received 1.4 M in the first year under an old agreement. Information from Dr R Sonko, PACT

[6] Information from World Vision Annual Report 2010

3. WORLD VISION'S APPROACH AND PROGRAM THEORY

3.1 Program theory

A program theory explains how and why the specific program is supposed to work by design. It thus provides a logical and reasonable description of why the things you do (program implementation) should lead to the intended results or benefits. It connects inputs, activities, outputs, outcomes and impacts, and examines assumptions made at each level and finally results in adaptations to correct the path or adapt the strategies.

The program theory presented here is a construction based on the full consideration of all information gathered in this study and serves as an evaluation tool to "understanding the existing theoretical and empirical knowledge about the program and examining program theory" as indicated in the TOR for this assignment. As the NOH program is implemented within the organisational space of Area Development Programs and enhance and expand the pre-existing ADPs, the program cannot be examined apart from incorporating this reality. The theory therefore acknowledges that the NOH conduct operations in project sites organised as Area Development Programs (ADPs).

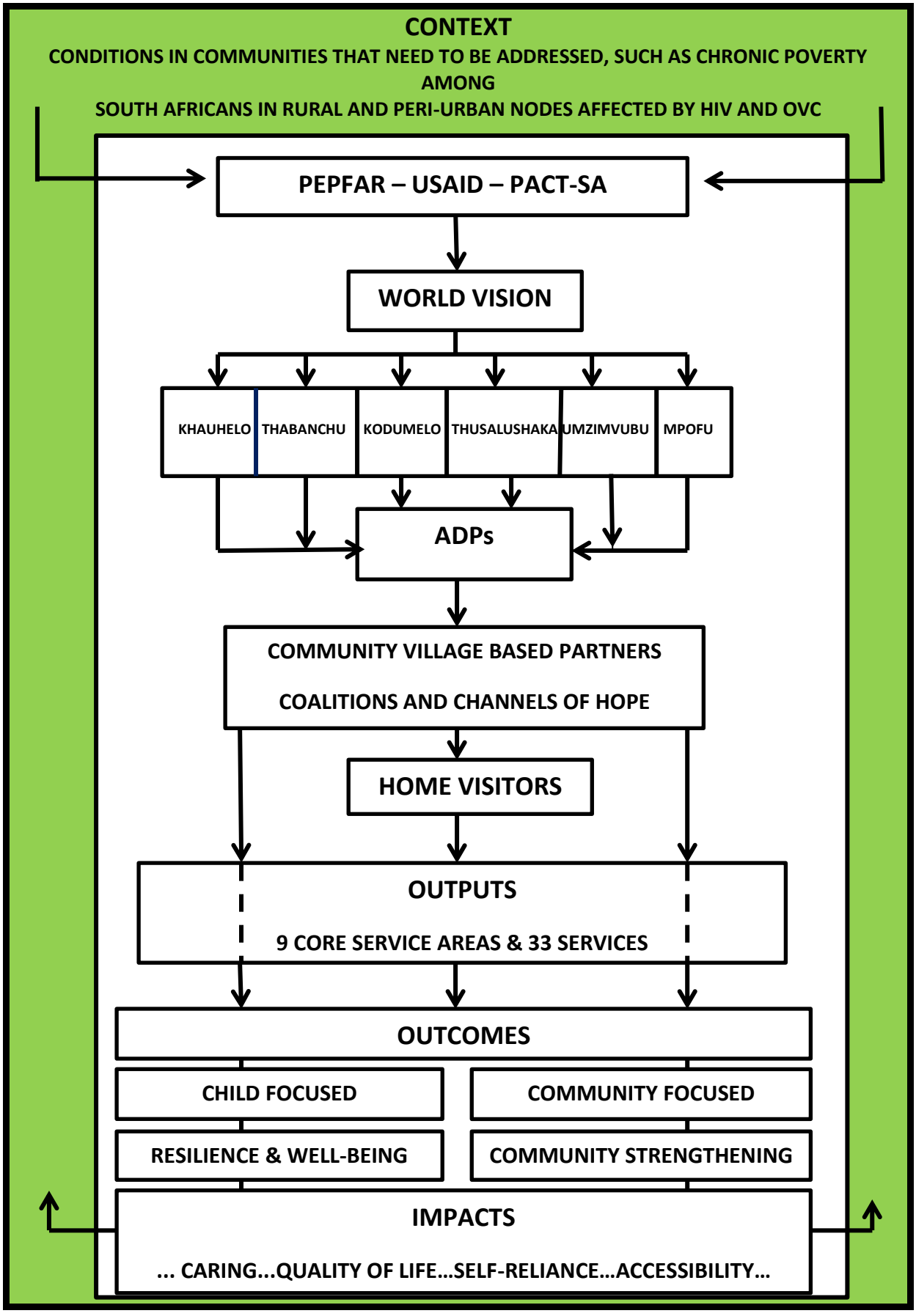
The World Vision ADP concept is interpreted as a program run over a 12 to 15 year period, covering a population from 20 000 – 80 000 and focus on improving child well-being by achieving improvements in education, health, HIV&AIDS, food security, water and sanitation, and advocating for child rights.

The period of 12 to 15 years is based on an assumption that sufficient improvement of conditions that existed at the beginning of the program can be achieved in the period that can warrant withdrawal at or towards the end of the period. This rests on the further assumption that the problems that justified the interventions were sufficiently addressed by the end of the period, and that the communities will be sufficiently empowered to drive its own initiatives.

The Networks of Hope is a project that is since 2007 being implemented by World Vision SA within six of the existing ADPs. It is focused on Orphans and Vulnerable Children (OVC) care and support, palliative care at the household level, and HIV education and prevention. Activities mobilised communities to care for and protect OVC, strengthening households to care for themselves and the training of caregivers on home-based care and psychosocial support.

The elements of the NOH program theory are depicted in Figure 3.1 for simple understanding as a flow diagram and project cycle.

Figure 3.1: Graphic depicting of the Networks of Hope project cycle



Explanatory notes on diagram:

- **Pre-existing needs and services responding to these needs.** The NOH extends and enhances services to communities to address chronic poverty, especially among black South Africans residing in peri-urban and rural nodes being affected by HIV and AIDS, and consequently also a disproportionate number of OVC.
- **Input** needed to implement the program, such as the involvement of WV International and South Africa, PEPFAR, the local ADP structures providing the institutional and organisational base for the program, its staff, stakeholders, knowledge and skills and finally also the Home Visitor system as key approach.
- **The program of activities** working in two directions:
    - **Community focus:** Creating an enabling environment through a Community Care Coalition initiated by COH/FBOs and other stakeholders developing a network mobilising and strengthening of community led response to protect and care for OVC. The Home Visitors play a crucial role in providing and facilitating in the interest of OVC and their families
    - **Child focus:** Facilitating OVC access to care services and Capacity strengthening of OVC /household to care for themselves.
- **The Outputs being the interventions and services rendered in nine categories including:** Clinical Nutritional Support, Child Protection Interventions, Child Protection Statutory, General Healthcare Referral, Healthcare Support for Access to ART, HIV Prevention Education, Psychological Support, School Support on School Attendance and Advancement and Household Economic Strengthening.
- **The Outcomes and Impacts** are the "difference" the programme makes in the lives of the children and the community / village. These are resilience and well-being, community strengthening, a caring community, quality of life, self-reliance, inclusivity and accessibility.

3.2 Program activities

The NOH program forms part of the total programme of WVSA in the ADP areas. The NOH content is determined by what PEPFAR supports and such funding is closely managed by PACT on behalf of PEPFAR. PACT has worked with WV SA as an Umbrella Grants Manager (UGM) partner over the duration of the grant and provided substantial technical and evaluation management support to the program.

Although the broad approach of the NOH program applies across the ADPs, the specifics of the program activities may vary. In the earlier phases the focus is more on effectively responding to the needs of vulnerable children while the focus in the later phases is more on strengthening community capacity as program staff and stakeholders attempt to embed the project and transfer ownership over to the community.

Community focus

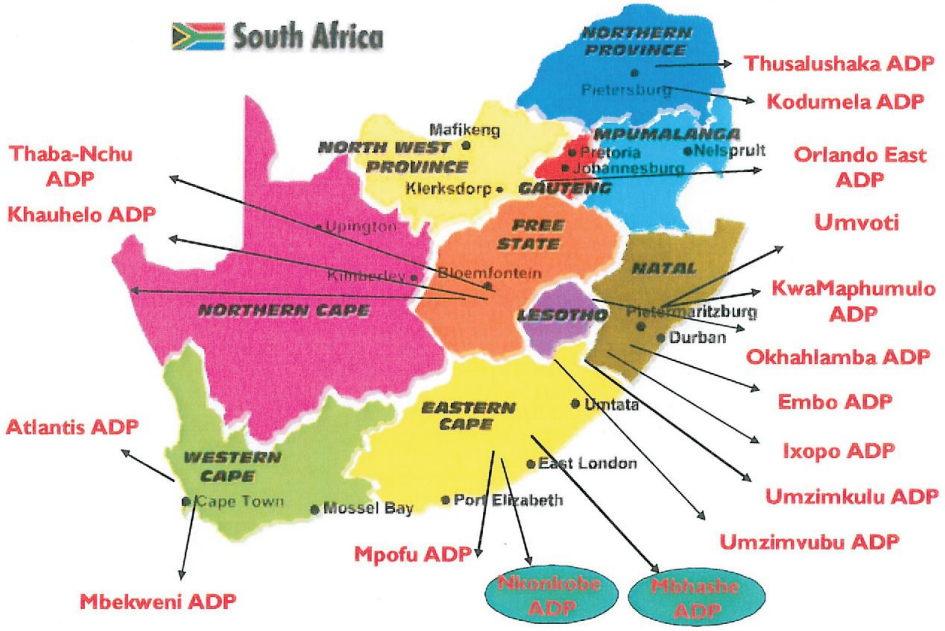
Program sites

WVSA conduct its operations in project sites organised as Area Development Programs (ADPs). The ADPs also form the organisational base from where the NOH program implements interventions to change and improve the wellbeing of vulnerable children and facilitate community capacity building to effectively respond to the needs of vulnerable children.

According to WVSA, over 35 000 OVC are supported by PEPFAR funding in six of the 20 ADPs and in three of the provinces. World Vision selected the six sites based on their relatively high HIV prevalence, large numbers of OVC, low coverage of HIV services and to ensure a mix of rural and urban areas. World Vision is facilitating access to essential services through its Community Led-Care Model to address the needs of the OVC[7]. The six ADPs are Khauhelo and Thaba Nchu (Free State), Kodumela and Thusalushaka (Limpopo), Umzimvubu and Mpofu (Eastern Cape). Background information on the ADPs is provided in Technical Notes to this report.

ADP	Number of villages included	Other information
Khauhelo	19	Botshabelo in the Mangaung Local Municipality of Motheo District Municipality, Free State Province.
Thaba Nchu	48	Part of Mangaung Local Municipality in the Motheo District Municipality, Free State Province
Kodumela	11	In the Ga-Sekoro Maruleng local municipality, Mopani district in Limpopo province. The area is 95 km from Tzaneen
Thusalushaka	24	54 km South East of Makhado/Louis Trichardt, 83 km South West of Tzaneen and 120 km from Polokwane International Airport
Umzimvubu	34	Based in Matatiele Local Municipality, which is under the Alfred Nzo District Municipality in the Eastern Cape. Matatiele town is in the far northern part of the district municipality.
Mpofu	64	Located in Seymour town, serving villages in the Mpofu area, including the surrounds of Seymour, Alice and Fort Beaufort in the Eastern Cape.

[7]Sources: World Vision Cop'10 Program Description and Implementation Plan and World Vision South Africa (WVSA) FY'11 Program Description and Implementation Plan



Map 1: Area Development Programs (ADPs), World Vision South Africa

Community Mobilization

Community mobilisation is aligned to the objective of mobilizing and strengthening community-led response to protect and care for OVC. Communities are mobilised mainly through the implementation of two strategies; Community Care Coalitions (CCCs) and Channels of Hope (COH).

- **Community Care Coalitions (CCCs)**[8] bring together churches and other faith communities, government, local business, NGOs, and CBOs. Building on efforts already underway in the community, these coalitions support volunteer home visitors who take responsibility for identifying, monitoring, assisting, and protecting OVC and as such provide an enabling environment for OVC care and support.

- **Channels of Hope (COH)**[9], originally developed by the Christian AIDS Bureau of Southern Africa (CABSA), is designed to mobilise and assist faith communities to gain the appropriate attitudes, knowledge and skills to be able to eradicate stigma and respond to the care, support and prevention needs in their congregations. COH are supposed to bring about a positive attitude towards those infected with HIV. Trained faith leaders run COH workshops in their congregations, and implement OVC

[8]World Vision. Community Care Coalitions (CCC): An effective, local and community-wide response to HIV and AIDS in Gwembe District, Zambia

[9] Brochure on World Vision Channels of Hope Methodology

programs within the churches. In so doing they contribute to the overall program goals.

Child focus

Definition and identification of OVC

The recipients of the services are the registered OVC. For the sake of clarity on definition of OVC as basis for the analyses it should be noted that OVC are identified by Home Visitors and members of the Community Care Coalitions. But there are guidelines being followed.

WVSA follows the definition recommended by USAIDS to be in line with the OVC program goal, which is to provide support aimed improving the lives of children and families affected by AIDS-related morbidity and/or mortality. Since the program focuses on those with increased vulnerabilities from HIV and AIDS, OVC are defined in the following way: a child, 0 -17 years old, who is either orphaned or made more vulnerable because of HIV and AIDS. Specifically, orphan in this context is defined as having lost one or both parents to HIV and AIDS, and vulnerable means the child is more vulnerable because of any or all of the following factors that result from HIV and AIDS:

- Is HIV-positive;
- Lives without adequate adult support (e.g., in a household with chronically ill parents, a household that has experienced a recent death from chronic illness, a household headed by a grandparent, and/or a household headed by a child);
- Lives outside of family care (e.g., in residential care or on the streets); or
- Is marginalized, stigmatised, or discriminated against.

This definition according to USAID, identifies those who are potentially eligible for services, but does not identify those most in need of services. To inform programmatic decisions, each community and program will need to prioritise those children most vulnerable and in need of further care. USAID adds that it is important to address child-development issues through age-specific child-focused programming that aims to preserve family structures as much as possible.

Home Visitors

One of the key elements of the NOH program is the channelling of access to the OVC through home visitors and is the WV version of similar involvement of home based carers in services to individuals and families infected and affected by HIV. The role of home visitors is described below[10].

Home visits are the essential activity for identifying, assisting and monitoring OVC. Visits are performed by home visitors and depending on the number of OVC allocated to a home

[10]Adapted from: Maleemisa Ntsala, Beverley Sebastian and Anzel Schonfeldt: Case Study of the Networks of Hope Project by Khulisa Management Services

visitor children are visited once a week. On average, each home visitor oversees nine to ten OVC. During the initial visit, home visitors conduct family assessments, determine the interventions needed, and assess the adequacy of food, clothing, shelter, and access to government services and schools. At subsequent visits, details of care provided and changes in the child/family situation are recorded, thereby identifying gaps and challenges and enabling WVSA to monitor and evaluate service delivery.

Typically during visits, children and guardians are offered support in solving any problems or issues that have arisen since the last visit. In cases where the home visitor cannot meet the OVC needs, the CCC or ADP is approached for further guidance and, if applicable, referrals are made for additional services.

Educational support[11]

Based on an analysis from WV Quarterly Reporting Forms for 2011 educational support is by far the most common intervention. In this year more than 22 000 OVC spread across the ADPs received assistance from WV. The interventions include negotiating school fee exemption, provision of school uniforms, stationary, vocational training, school readiness assessment and general assistance.

Drop-in Centres[12]

Drop-in centres are another mechanism used by NOH to provide services to OVC. Although Drop-In Centres are being developed by the Department of Social Development in the three provinces, World Vision supports it in many ways through provision of equipment, fencing, provision of clean water, building capacity and closely cooperate with other role players.

Peer education

One of the NOH objectives is to promote risk reduction and healthy sexual behaviour amongst young people 10-18 years. This is provided through peer education in schools and youth clubs.

Range of services to OVC

The interventions by WV and its partners in collaboration with other role players include nine categories with 33 possible interventions. These are services that OVC, once registered, may receive on recommendation of the home visitor who is in regular contact with the OVC. However, there is not a minimum package of services or a must receive list of services. In the evaluation services received over five years (2006 to 2010) were recorded per OVC. These categories of service include:

1) Clinical Nutritional Support
2) Child Protection Interventions
3) Child Protection Statutory
4) General Healthcare Referral

[11] Summary from WV Quarterly Reporting Forms: 2011

[12] Adapted from: Maleemisa Ntsala, Beverley Sebastian and Anzel Schonfeldt: Case Study of the Networks of Hope Project by Khulisa Management Services

5) Healthcare Report for access to ART
6) HIV Prevention Education
7) Psychological Support
8) School Support on School Attendance and Advancement
9) Household Economic Strengthening

The 33 interventions are listed in the Technical Notes to the report.

Capacity Building

Capacity building is spread across the NOH program and forms part of much of the work being done. It happens through capacity building of OVC, their guardians, home visitors, CBOs and FBOs, ADP staff and volunteers and through training at various levels.

The aim is to enable OVC and their households **to support themselves** in the long term and to strengthen the capacity of OVC and household members. WV facilitates in collaboration with the Department of Home Affairs (DHA) the provision of the needed documents. OVC and their households are also linked to the Department of Social Development (DSD) for further social assistance in the form of social grants, foster and disability grants.

As part of promoting food security and household economic strengthening to members of OVC households, NOH strengthened existing individual and communal projects listed per ADP in Technical Notes.

Training plays a very important role in building capacity at all levels. A number of CBOs have been registered as NPOs and were provided with organizational capacity building in different areas ranging from organizational development to financial management and others listed in Technical Notes. Most of the training modules were done by PEPFAR approved providers.

Palliative care

In terms of WV's holistic approach it identifies an objective to provide care and support to OVC family members living with HIV. This includes the strengthening of access to integrated services as a part of a comprehensive care package for People Living with HIV (PLHIV) and their families. These activities reinforce and expand services provided by CBOs and government care programs such as basic hygiene, wound care, screening for pain and symptoms, nutrition assessment and support, spiritual care and support, psychological care and promotion of the HIV preventive care package.

4. THE EVALUATION QUESTIONS, THE NATURE AND PURPOSE OF THE EVALUATION

4.1 Purpose of evaluation and the evaluation questions

The overall purpose of the evaluation is to assess the extent to which NOH program contributed to the improved wellbeing and resilience of OVC in targeted communities.

The main questions that this evaluation therefore seeks to answer are

1. Did the NOH program make any **change and improvement** in the wellbeing of vulnerable children and what **aspects of child wellbeing** were affected most as a result?
2. To what extent did the NOH program succeed in **strengthening community capacity** to effectively respond to the needs of vulnerable children?

Aspects related to these questions that needed to be included in the evaluation are summarised in the boxes below.

Extending Question 1 (change and improvement in the wellbeing of vulnerable children)

A. Extent to which NOH program services generally address needs of:
   a) OVC
   b) Guardians of OVC and
   c) Home visitors

B. If and the extent to which the NOH program improved:
   a) School attendance of OVC
   b) School performance of OVC
   c) Emotional wellbeing of OVC
   d) Self esteem of OVC

C. If and the extent to which the program:
   a) Helped in accessing legal protection in case of need
   b) Assisted in acquiring legal documents i.e. Birth registration or id
   c) Facilitated access to services to children who were denied legal status?
   d) Helped children to gain access to HIV related health care services and ART

Extending Question 2 (strengthening community capacity to effectively respond to the needs of vulnerable children)

D. About Home Visitors:
   a) Extent to which NOH program capacitate and assist Home Visitors to assist OVC and families with whom OVC stays
   b) If the strategy employed by the NOH program working with and strengthening the Home Visitors really work

E. About services to the villages targeting OVC:
   a) Any other programmes by NGOs, CBOs or projects focusing on wellbeing of OVC , and if so
   b) How well did the other programmes do in improving the wellbeing of OVC?
   c) If the needs are growing?

F. About community participation:
   a) Did the communities effectively cooperate in the service provision for OVC?
   b) What will happen with services to OVC after the expiry of the PEPFAR funding?

G. How stakeholders and staff generally assess the value of the program:
   a) Assessment of program in terms of quality, workability, accessibility, providing a serious need, if the community sees the project **as their project**

4.2 Type of evaluation

It should be noted that the two evaluation questions imply two different types of evaluation.

Both questions require **impact evaluation**[13], attending to

- the wellbeing of the OVC and what aspects of child wellbeing (of which quality of life, resilience, capacity are examples) were affected most as a result – thus outcomes in the lives of the OVC as primary beneficiaries
- change in the lives of secondary beneficiaries like the guardians, home visitors and other participating groups.

Question 2 also suggests **process evaluation** dealing with the focus of effectiveness and sustainability where it asks about the role and value of the program as instrumental to the outcomes / impacts (or lack of it).

Both the questions contain elements of continuity of outcomes as strengthening implies sustainable processes and change; thus not only change, but continued change. It is therefore important to consider whether and how the interventions should be continued, scaled down or phased out at the end of a funding phase.

[13] Notes on impact and process evaluation from: Earl Babbie and Johann Mouton: The practice of social research. Oxford, sixth impression 2006. **Chapter 12: Evaluation Research**

4.3 Criteria for evaluation

Intervention programs may be assessed according to two simple and straightforward cross-related principles that explain intervention approach and implementation. These are the principles of "Doing the right things"; and "Doing the things right".

		"Doing the right things"	
		Yes	**No**
"Doing the things right"	**Yes**	**Success**	**Inappropriate**
	No	**Ineffective**	**Failure**

"Doing the right things" is linked to the very ethos of World Vision as a faith-based and specifically Christian agency relating its work to its faith character that prompts action in terms of both helping people in need and helping towards sustainable results in development.

The first question on the change and **improvement in the wellbeing** of vulnerable children, deals with the provision of needs of OVC. The "right thing" means providing interventions leading to such improvements.

From a Transformational Development perspective poverty is an extremely complex issue. The poor are locked in a cluster of disadvantages. One of the best ways to describe the nature of poverty is to use the Chambers/Myers Poverty Trap with its six interconnected and interactive elements[14]. The trap means that the poor person lives midst conditions that render him / her powerless. These conditions are material poverty, physical weakness, isolation, spiritual poverty[15], powerlessness and vulnerability. Doing the right thing thus means to attend to the aspects affecting the OVC in a holistic manner. This again suggests the need for partnerships, coordination and collaboration as part of the program.

The second question on the extent to which the NOH program succeeds in **strengthening community capacity** (to effectively respond to the needs of vulnerable children) focuses on strengthening of capacity of role players in the target communities. The key consideration here is if provision is made for growing community participation to a point where the community will be able to determine and drive its own programs. It deals with initiatives towards the development of community assets[16] as key building blocks in sustainable community and village vitalization efforts. Progress towards this ideal includes:

- The skills of local residents (individual volunteers networking)

[14] Transformational Development – Christian Response to the Issues of Global Poverty *by S. M.* Summarised from Bryant Myers, Walking with the Poor (Orbis, 1999).
[15] Spiritual poverty refers to broken relationships with God, fellow man and self, and lack of social capital.
[16] Adapted from John P. Kretzmann and John L. McKnight, Building Communities from the Inside Out: A Path Toward Finding and Mobilizing a Community's Assets (Center for Urban Affairs and Policy Research, 1993)

- The power of local associations (the development of local organisations like CBOs to provide the needed services and development, and a sense of ownership)
- The resources of public, private and non-profit institutions (enlisting the needed services of state departments and major institutions, like education, health, churches, etc.)
- The physical and economic resources of local places (like emerging small business, farming and infrastructure needed for activities).

"Doing the things right" refers to the methodologies being followed in the implementation and how well inputs, activities and outputs are managed to lead to outcomes and impacts. This is commonly referred to as sound management such as log-frame planning, monitoring and evaluation.

The evaluation of impact at both levels (**change and improvement** in the wellbeing of vulnerable children and **strengthening community capacity)** should thus determine if and the extent to which World Vision is doing the right things and the things right. Cross-relating the two principles provide diagnostic guidelines for future action.

Networks of Hope or part of it may, in the light of evidence, thus be found:

A success	***Yes, "Doing the right things"*** **and** ***Yes "Doing the things right"***
Inappropriate	***Yes, "Doing the things right"*****, but No, Not "Doing the right things"**
Ineffective	***Yes, "Doing the right things"*****, but No, Not "Doing the things right"**
Failure	**No, Not "Doing the right things", and No, Not "Doing the things right"**

5. THE METHODOLOGY OF THE EVALUATION

This section explains the data sources, data collection instruments, sampling, data collection, data processing and analysis, and limitations in the evaluation study. Information was gathered from WVSA and PACT and during a front-end visit, field visits at the six ADPs and resulted in a range of sources that required integration and analysis around the stated questions. This combining of different methods in the same study, referred to as triangulation, helped to prevent bias and adds validity to findings. Different groups of respondents provided input on the same type of questions asked. It normally adds validity to the findings based on such observations.

5.1 Sources, instruments and methods

The data sources used in this evaluation were matched with instruments and methods as follows;

Data sources on OVC and on NOH Program[17]	
Source	**Instruments and Methods**
Baseline data	• **OVC data** partially captured and provided by World Vision SA (Access data provided in Excel format. Served as base for sampling and transfer of sampled OVC in SPSS format by research team) • **Questionnaire 1** on baseline data not available on the WVSA database captured from OVC files at ADPs • **Copies of OVC Registration forms** were provided at ADPs and directly captured on certain variables • This resulted in **baseline data** on 551 OVC approached.
Home visitors	• **Questionnaire 3: Home visitor input on OVC.** Home Visitors provided information on the changes that were observed in the well-being profile of the 602 selected OVC since registration into NOH program and expressed opinion about the effects of the program and this served to double check the validity of the information given by guardians. • **Questionnaire 5: Home Visitors Response.** The content of the questionnaire dealt with the benefits Home Visitors gained from being involved in and being trained by the NOH program and produced data on 171 Home Visitors approached.
Guardians	• **Questionnaire 2: Guardians input on OVC.** Guardians provided information on the changes that were observed in the well-being profile of the 602 selected OVC since registration into NOH program and expressed opinion about the effects of the program.

[17] See Appendix on questionnaire design

OVC (teens)	• **Questionnaire 4: Teenage OVC (13-17 years).** 108 OVC provided information input on themselves and their own experience of the program, their well-being and resilience. Interviews were facilitated in a group context, although each OVC completed his/her own questionnaire.
Stakeholders	• **Questionnaire 6: Stakeholders.** Completed at one workshop per ADP. Evaluation questions were asked to 108 stakeholders, accommodating the key questions in the evaluation.[18] • The **group discussion** that followed included the following: - Describe lessons learnt from the program. - What successes have been achieved? - What challenges have been encountered? - Should the program be transferred to the community, and if so, how can it be achieved? - How should the program in future be funded?
Staff	• **Questionnaires 7 and 8: ADP staff and management.** Completed at one workshop per ADP. Evaluation questions were asked to 75 staff members, repeating the same key questions asked to the stakeholders. The fields covered in questionnaire 7 included: - Staff member's profile - Evaluation questions asked to both stakeholders and staff, • Items listed in questionnaire 8 include a range of items relating to the ADP and its activities.
Observation	• Field reports
Project visits	• Field notes
Literature	• Documented evidence as in the numerous sources provided by World Vision and other authors as listed in the Bibliography and as footnotes.

5.2 Sampling

The OVC sample was composed as agreed with PACT as follows: 100 OVC per ADP (600 in total) consisting of four groups of 25 each representing four villages per ADP, of which two randomly selected close to the ADP centre and two randomly selected on the outer bounds of the ADP. The sample frame consisted of all registered OVC on the World Vision OVC data base that have been in the program at least 18 months (i.e. OVC on the data base from

[18] Evaluation questions in both stakeholder and staff questionnaire – See Appendix

October 2010 or earlier). The selected sample from the data base was 100 (25 x 4) OVC per ADP plus a replacement sample of 40 (10 x 4) OVC.

The OVC sample was used as selection guide for guardians and Home Visitors by including all of the two groups responsible for the selected OVC.

In addition, **stakeholder** lists were composed by ADP staff prior to the fieldwork visits and stakeholders were invited to the relevant meetings on an availability basis. This arrangement has been decided upon in ROADS' meeting with Pact and subsequently communicated with World Vision. In cases where stakeholders were not available for a group session attempts were made to follow-up with an individual visit and interview. This only materialized in a few cases, but the representation in the opinion of the fieldwork team was generally satisfactory.

All **ADP staff and managers** were invited, but in most cases the fieldwork team agreed on the manager with selected core members of the management team present.

5.3 Data collection

The field visits to the ADPs were done on the basis of two work days per ADP due to the limited time made available by WVSA. The dates of visits were:

Free State	12-13 March	ADP 1	Botshabelo (Khauhelo)
	15-16 March	ADP 2	ThabaNchu
Limpopo	19-20 March	ADP 3	Kodumela
	22-23 March	ADP 4	Thusalushaka
Eastern Cape	26-27 March	ADP 5	Umzimvubu
	29-30 March	ADP 6	Mpofu

The field work was subdivided between two teams that included a survey team and a workshop and project team. Detailed information is available in the Technical Notes.

5.4 Data processing and analysis

All the questionnaires were captured on the SPSS statistical program in eight datasets and applied in addressing the evaluation questions.

- An integrated OVC dataset consisting of records in the WV Data Base and Questionnaire 1 (494 OVC)
- Questionnaire 2: Guardians input on 602 OVC
- Questionnaire 3: Home visitor input on 602 OVC
- Questionnaire 4: Teenage OVC 13-17 years (108 cases)
- Questionnaire 5: Home Visitors Response on Self (167 cases)
- Questionnaire 6: Stakeholders (108 cases)
- Questionnaires 7: ADP staff (75 cases)

- Combined dataset of Stakeholders and Staff allowing comparison of responses on similar questions (183 cases)

5.5 Challenges, limitations and quality

The proposed field work plan provided for eight days of field work per ADP. Due to tight schedules in the work program of the ADPs only two days per ADP were feasible, a fact that challenged the field work team tremendously. Despite this restraint on the time available for data collection the team succeeded in collecting all data and to realise the sample as planned. The team had to sacrifice however some in-depth information that is only possible to collect with the availability of more time. The techniques of documenting informal observations and to implement group administered questionnaires and group interviews and discussions compensate to a large extent for this limitation.

The need to have selected OVC, their guardians and home visitors present was not always understood or sufficiently communicated. A challenge was to physically locate the selected OVC in the planned sample and the use of replacements was necessary. At occasion OVC and home visitors presented themselves for interviews but we resisted using self-selected cases. The sampling procedure for selecting a representative sample of OVC as unit of analysis agreed upon with World Vision and PACT therefore materialized and quality was not sacrificed.

Matching cases from the selected OVC with the WV national and ADP data base proved difficult due to incomplete and incorrect recording of cases such as inconsistent and duplicate numbering of OVC, age, and duration of registration in the program. This directly resulted in a limited number of OVC from this data base that could be matched with the sampled OVC. Finally, 494 OVC cases could be matched and used for analysis from the World Vision / ADP data base. This number was sufficient for statistical analysis and used as such. For purposes of interviewing however we maintained the sample of 602 OVC cases as planned.

The 602 OVC selected through the staged process of sampling eventually worked well, despite challenges mentioned above.

Field assistants for each ADP locally recruited were appointed. Four to five assistants per ADP sufficed. ADP staff assisted with the recruitment of suitable persons. The criteria specified included good grasp of the local languages as well as the English language (for translation purposes), at least a Grade 12 qualification, and experience in fieldwork. The ADP management and staff went out of their way to assist in recruiting assistants. In one workshop at one ADP (Kodumela) staff had to assist due to an unexpected large turnout of stakeholders.

6. KEY FINDINGS

In this section we report key findings relating to the evaluation questions and their associated themes. First, the socio-economic profile of OVC is presented. The impact of the NOH program on OVC and other beneficiaries is the one main theme and therefore the interventions as defined by the program are described for their characteristics. Outcomes such as improvement in the wellbeing of OVC have been measured and are described in the section. The extent to which the program is fulfilling the needs of beneficiaries also gained attention. Trends in the health status of OVC are described. Special attention is given to home visitors as a specific beneficiary group but also a group with duties of caring for OVC and their families. Finally, the question of community mobilization is addressed and the processes played out in this connection are traced and described.

6.1 Profile of OVC and their households

In profiling the OVC selected in the sample a first characteristic to be considered is the answer to the question why the child has become an OVC and registered within the NOH program data base. Answers are categorised according to the definitional criteria for OVC as presented on page 10 above. The single most frequently stated reason refers the loss of parents, both or either one of the mother or father, which amounts to 56% of the OVC. The second most frequently stated reason (22%) includes cases where HIV infected people are mentioned – parents, the child itself, vulnerability due to HIV, and chronically ill parents. Cases where the grandparent is the caregiver amount to 14% and where the child is the head of the household, to 7%. Only 1% is regarded as homeless.

When the distribution of the reasons for becoming an OVC is compared for the six ADPs, significant differences are observed. For example, for Umzimvubu, 81% (compared to 56% generally) of the reasons refer to the death of one or both parents and in the case of Khauhelo this percentage is 71%. In the case of ThabaNchu, 21% (compared to 7% generally) of the OVC are defined as Head of Household.

With respect to OVC for most of the profile characteristics, it makes sense to use ADP as a classification variable for the data. OVC home language is a clear case. It follows the geo-ethnic pattern of rural and peri-urban South Africa. In Khauhelo, Sotho speakers dominate, while in ThabaNchu a significant percentage of Tswana speakers are also found. Kodumela is nearly exclusively Pedi-speaking, while Thusalushaka appears to be more mixed with Venda, Pedi and Sotho-speakers. Mpofu has 98% Xhosa-speakers while Umzimvubu has a majority of Sotho-speakers next to Xhosa-speakers.

The average age of the OVC as per ADP is given in Figure 6.1. Note that Mpofu has the youngest average of all the ADPs. The sample does not include children below two years of age due to the requirement that an OVC should already be at least 18 months in the program. The majority of the children (all ADPS) are in the age cohort 12-17 years. The next large proportion is in the 5-11 years bracket while a minority is found in the 2-4 years

category. In the case of Mpofu, the majority percentage is located in the 5-11 years cohort and a larger percentage is found in the 2-4 years group than in any other ADP. In the cases of Kodumela and Khauhelo larger percentages are found in the 12-17 years group.

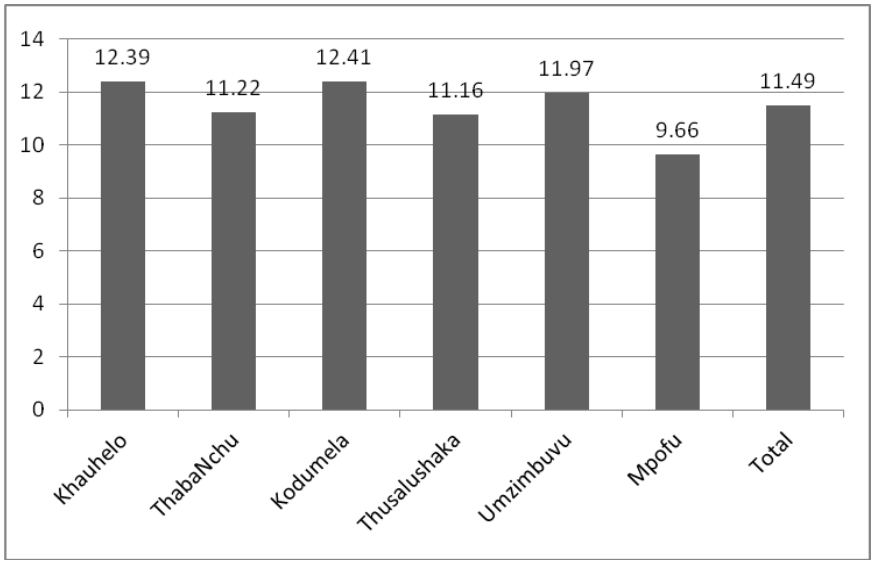


Figure 6.1: Mean age of OVC per ADP (Years)

With reference to the gender distribution of the OVC, the female population is marginally larger than the male population – 51% and 49 %. In all age groups except the 0-4 category, females appear to be the larger group. This is in line with demographic distributions elsewhere.

The age distribution compared with the actual school grade of the OVC shows that there is a serious scholastic back-log among the OVC. It was found that an estimated 36.3% of the school-going children are too old for the grade they were currently in. The highest percentages of children too old for their current grade were in grade 7, 8 and 9. About 10% of the school-going children did not pass a grade in the year before the evaluation survey (i.e. 2010). Highest percentages of not passing in the last year were found for 16 and 17 year olds or children currently in grades 9 and 10. The enrolment figure for OVC was found to be nearly 100% though.

These figures are of importance in view of the fact that the NOH program provides for facilitation of school support on school attendance and advancement, a part of the program that is highly regarded by community stakeholders. Stakeholders generally are of opinion that the program is doing well in promoting school attendance, which is borne out by the survey figures, as well as in advancing educational performance among OVC. The fact that a large proportion of OVC is too old for their grade may be attributed to two reasons, firstly that children started to attend school at a late stage or after interruptions and, secondly, that they did not pass their grade the first time or regularly. The second reason accounts for about 10% of the OVC as mentioned above. On the first reason we do not have relevant evidence but it may be surmised on reasonable grounds that this may count as a significant

factor because of the vulnerability of OVC. The reported figures point to the need for continued and intensified attention through the NOH program to the educational well-being of the OVC. Among other, it implies monitoring school attendance and after school care for learners not scholastically strong.

When looking at the guardians (primary caregivers) of OVC one finds that they are overwhelmingly female persons (87%) and mostly in the middle ages of the family life cycle (35-54 years) – 51%. The age range is extremely wide, ranging from 19 to 104 years.

In ADPs of Thusalushaka (65%) and Kodumela (61%) the middle group draws even more cases while the other age groups include relatively less guardians. Kodumela is an exception as it draws more young people as guardians and Khauhelo draws more of the older people.

In 47% of the cases of guardians they are the biological parents of the OVC and in 32% the grandparents. The rest of the guardians are all or mostly relatives of the OVC such as uncles and aunts, brothers and sisters, and step parents.

The income picture of OVC households looks extremely bleak – about 88% of the household has an income of less than R1 500 per month and of this percentage 3% does not even have an income. The sources of income are for 90% some form of state grant or pension (53% consists of Child Grants). Less than 10% therefore earn some money, of which the earnings are often seasonal.

As rural households often have natural resources to fall back on, it was important to have inquired about such resources. The disturbing fact that distilled from the inquiries points to ADPs where resources are far and in between: Thusalushaka shows 40%, and Kodumela 32%, of OVC households not having resources. Land or fields for cash cropping are not readily available (in general only 13% of the households do have access to such resources). Only Umzimvubu and Khauhelo shows a higher than average access to land. Khauhelo, as does Umzimvubu, cultivate land for producing food crops more than any other ADP. In addition, fruit trees are grown more in Khauhelo and Kodumela than other ADPs. The Eastern Cape ADPs (Umzimvubu and Mpofu) have more livestock than other provinces and ADPs.

6.2 Interventions implemented by the NOH program

The NOH program interventions are listed in Section 3 There are listed 33 interventions that make up nine core program service areas (CSA).

Data on the application of the interventions stretched over a five-year period, from 2006 to 2010. All interventions that have been implemented were recorded in a recording system of 165 items. The interventions recorded in this elaborate system are organised according to the 33 intervention types, each for their five-year period, and then summarised to an overall index counting all the recorded treatments in one variable (Technical notes, Section 1).

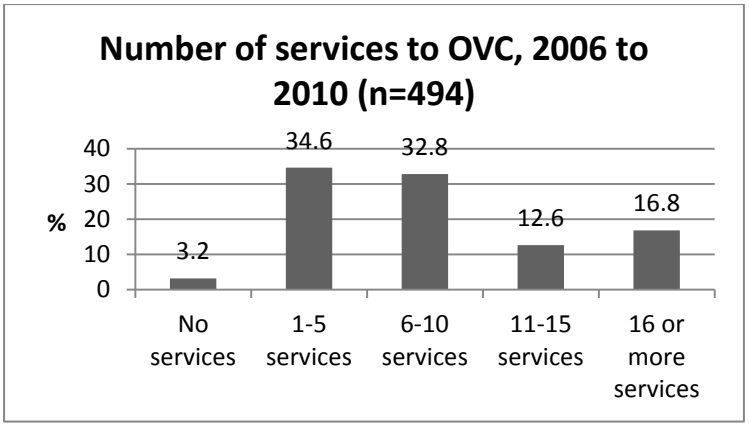


Figure 6.2: Number of services to OVC, 2006 to 2010

Although there seems to be a well-structured system of services available for OVC, there is neither a minimum package of services nor 'must receive' services. Services are accessed or provided on recommendation and action of the home visitors. This arrangement probably explains why 3.2% (n=16) OVC were registered not having received services according to the recording system.

Despite this number not receiving services an overwhelming percentage of OVC, amounting to 97%, did receive interventions over the period of observation. This period covers five years and the number of interventions reported in the figure appears to be low given the wide range of services available. The range of the number of services provided seems to be wide and dependent on the need of the individual OVC and the home visitor's alertness to these needs. To illustrate the range of services provided we may note that there is one case that received only one service over the period and another that received up to 50 services. This clearly indicates that the needs of OVC are assessed before they are serviced.

The question arises to what extent the nine CSA constitute a coherent package of services and interventions in the lives of OVC to improve their quality of life and resilience. We therefore need to first inquire about the nature of these services before we can address the evaluation question namely, did the NOH program make any change and improvement in the wellbeing of vulnerable children and what aspects of child wellbeing were affected most as a result?

Above we mentioned that a package of 33 services, clustered according to nine so-called core service areas (CSA), were available for application in the case of need by OVC. Home visitors were appointed to assess needs of OVC (and their families) and to facilitate processes according to which the needed service or intervention were to be provided. Although the nine CSA group services or interventions of the same kind together into different categories, we found it necessary to inquire about the nature of these services to determine whether they could be related to the desired outcomes of the NOH program, namely enhancing the well-being and resilience of OVC and strengthening community capacity to effectively continue providing the listed services. The technique for this inquiry is called factor analysis, which is a highly sophisticated statistical procedure to investigate to

what extent different items such as the 33 services, may be grouped together according to common and shared themes that explain their nature. In essence, the procedure identifies clusters of items (services) of the same kind. The clusters are defined as so-called factors. According to Bryman and Cramer (1977:278), characteristics which go together constitute a factor. The nine CSA and their sub-services or -interventions were used as the constituting characteristics of the factors. Four factors were identified through this procedure. Below they are described in terms of the CSA characteristics.[19] (Technical note, Section 9).

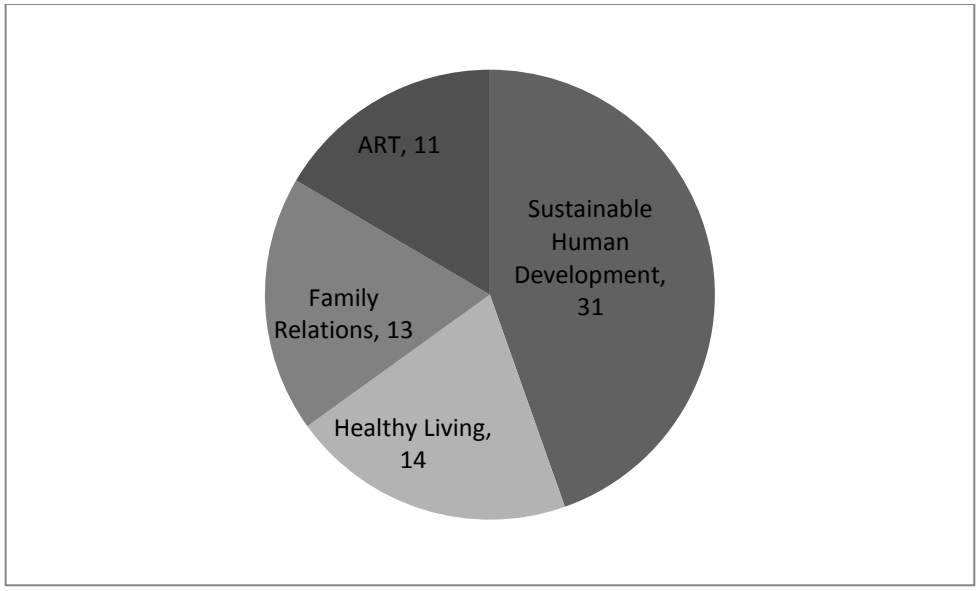


Figure 6.3: Intervention service factors of the NOH program

Factor 1 is a multi-dimensional and complex bundle of sub-factors or variables that together and in a balanced way may improve the quality and standard of life and general well-being of the individual and the household. Five CSAs, - Household Economic Strengthening, Educational Support, General Health Care Referrals, HIV Prevention Education, and Child Protection Interventions – grouped together to form this factor. These CSAs include the three essential components of human development, namely **health, knowledge and economic** means – that can be measured according to longevity, scholastic level, and income. The HIV prevention component links with a healthy life style and child protection with eliminating vulnerability. We call this factor **Sustainable Human Development**. This factor is expected to explain 31% of the variation in the outcome of the program. This means that the factor has a strong predictive value and that when it is applied one can expect that it will strongly influence outcomes as desired.

As noted, the factor groups five CSA, the most CSA of all the factors. It also includes specific services that gained the highest frequencies of application in the program. We note the high

[19] All procedures were run according to the SPSS routine for Dimension Reduction in Version 19 and guided by Alan Bryman and Duncan Cramer (1997): *Quantitative Data Analysis with SPSS for Windows*. London: Routledge (see Chapter 11).

frequency services in Table 6.1 below. The listed services were provided to high numbers of OVC often more than twice during the period of evaluation. This latter fact is expressed in an index of intensity of service provision by dividing the number of services by the number of OVC affected.[20] The table reports only the services with highest frequencies, namely:

- Asset growth and protection, savings, food gardens
- Vocational training
- Educational assistance
- Follow-up and adherence monitoring on health care referrals.

(Further details in Technical notes, Section 9 Table 11, page 59).

Factor 2 brings into association the two dimensions of human life namely the body and the soul – the biological and physiological systems in relation to the mental system. CSA Clinical Nutritional Support and Psychological Care were grouped as this factor. The interventions address the ability to overcoming life crises and internalising the maintenance of healthy living in relation to these systems. We call the factor **Healthy Living**. It is expected to explain 14% of variation in program outcomes and has therefore moderate yet significant predictive value. High intensity service activity includes nutritional assessment (see Table 6.1).

Table 6.1: Number of interventions applied, 2006-2011

Interventions (Reporting only five highest of 33 interventions)	No. of interventions to OVC	No. of OVC affected	Intensity of intervention
	A	B	A/B
Asset growth and protection, savings, food gardens	469	235	2.0
Vocational training	314	115	2.7
Educational assistance	767	390	2.0
Follow-up and adherence monitoring	326	89	3.7
Nutritional assessment	457	253	1.8
All (33)	4390	2423	1.8

Source: Technical note, Section 9 Table 11, page 59

Factor 3 is a unidimensional factor that has as its focus social relationships of children within the intimate sphere of kinship and family. It advances legal protection of the vulnerable children with the aim of restoring and/or rebuilding social relationships. The relevant CSA, only one, is Statutory Child Protection Intervention. We call this factor **Family Relationships**.

[20] In Table 6.1 this is shown by dividing column A by Column B and producing the coefficient in column A/B.

Intervention in this area is defined as legal and professional intervention and protection and requires the services of professional staff such as social workers. A small number, only five (possibly seven) OVC, were recorded as affected by activity in this area. Despite the limited service frequencies in this area, which serves to indicate low levels of need for statutory services in the field of child care, the factor shows a moderate yet significant predictive value of 13% for explaining outcomes.

Factor 4 is equally and even more so a single dimension factor – it has to do with the survival of persons suffering of the AIDS disease. It includes knowledge of the situation and access and adherence to services and treatments and as such it is a highly specialised and technical area. The factor is named **ART – Antiretroviral Treatment**. The CSA involved is Health Care Support for Access to Anti-retroviral Treatment. Only nine OVC are implied in the activities in this area and it seems not to be drawing much energy from the NOH program. Yet it has significant but small explanation and predictive value (11%) in outcomes of the program.

Many of the service areas group also into other configurations but the statistical values proved to be too small to identify them as separate factors. It should be noted however that 31% of variation in outcomes (that is equal to the predictive value of Factor 1 - Sustainable Human Development) is not covered by the analysis above and that although the factors mentioned above do have significant value in explaining there are other and scattered explanations for differentials in outcomes possible.

We may conclude however that the nine core service areas (CSA) therefore all combine and become essential in creating and delivering improved **Quality of Life** (including Standard of Living), **Wellbeing** and **Resilience** (the opposite of vulnerability). We conclude that the designed system of services incorporated by the nine CSAs, constitutes a coherent strategy for achieving the goal of the NOH program, i.e. to improve the quality of life, wellbeing and resilience levels of vulnerable children.

When the ADPs are compared with respect to the four factors above the same pattern emerges but there appears to be differences in intensity though. ThabaNchu comes out high as the ADP with more services delivered than elsewhere particularly in the service areas associated with Sustainable Human Development (Factor 1) and Healthy Living (Factor 2) with Umzimvubu as the second most active ADP. All other ADPs show lower activity in the service frequencies and intensity of service provision to OVC. (Further details in Technical Notes, Section 9, Table 12, page 62)).

Having established the coherence and functionality of the NOH program treatments we next have to determine to what extent children exposed to this treatment system indeed improve in the two intended respects of wellbeing and resilience.

6.3 The impact of NOH program – the wellbeing of children

Extent to which NOH program addresses needs of beneficiaries

Findings based on data collected from stakeholders and staff

The stakeholders participating in the Community Care Coalition and the ADP personnel are two groups that play a determining role in the implementation of the NOH program. Their response is naturally an important indicator of how effective the NOH program is and what impact it is making within the relevant communities under the administration of the ADPs. Various questions were put to these role players including an initial measure of how the NOH program addresses the need of different beneficiaries of the program. These beneficiaries include OVC, their guardians and the home visitors. The interest was to determine if the two groups of role players believe that the NOH program addresses all the needs, some of the needs, or none of the needs of the beneficiary group.

The important finding according to this inquiry is that only minority percentages of the two groups (stakeholders and staff) regard the NOH program as a program that completely fulfils the needs of the three beneficiary groups (OVC, guardians, home visitors). Stakeholders are more positive (around 40%) than staff (around 27%) in this regard. On the other hand, staff does recognise the program as able to provide in some of the needs of the beneficiary groups (around 70%). On the level of the ADPs stakeholders indicate more positive judgement than the average in the case of ThabaNchu and Mpofu. Staff was more positive in Khauhelo and Kodumela.

The stakeholders are somewhat uncertain whether the program addresses the needs of the home visitors to assist OVC families. In this respect the ADPs do not differ significantly. It should be emphasized though that the program has specific projects to strengthen the family or household and that home visitors play a key role in this regard.

The finding on the degree to which the program fulfils needs of the beneficiary groups is not overly positive and it carries a measure of qualified success for the program. However, when we interrogate the question to what degree the NOH program addresses and impacts on change and improvement of the wellbeing and associated characteristics of the OVC a far more positive picture evolves. A number of aspects related to the child's wellbeing were measured. The specific aspects inquired about include school attendance and performance, emotional wellbeing, self-esteem, legal protection, and access to health services and in particular ART. The general question asks about the extent that the NOH program impacts the beneficiary community (the OVC). The responses were categorized as 'yes, impact very much so'; 'yes, impact to an extent'; 'no, the impact is not clear'; and 'uncertain'.

The first category ('very much so') received majority percentages (between more than 50% and 60%). When the percentages of the second category ('to an extent') are added to the first category's percentages, the positive answers are gaining overwhelming support (more

than 70% to 90%). These respondents therefore endorsed overwhelmingly the following statements:

- Educational support received from NOH program improved school attendance of OVC
- Educational support received from NOH program improved school performance of OVC
- Emotional wellbeing of OVC improved as result of program
- The NOH program helped the OVC to improve self-esteem
- Program helped in accessing legal protection in case of need.

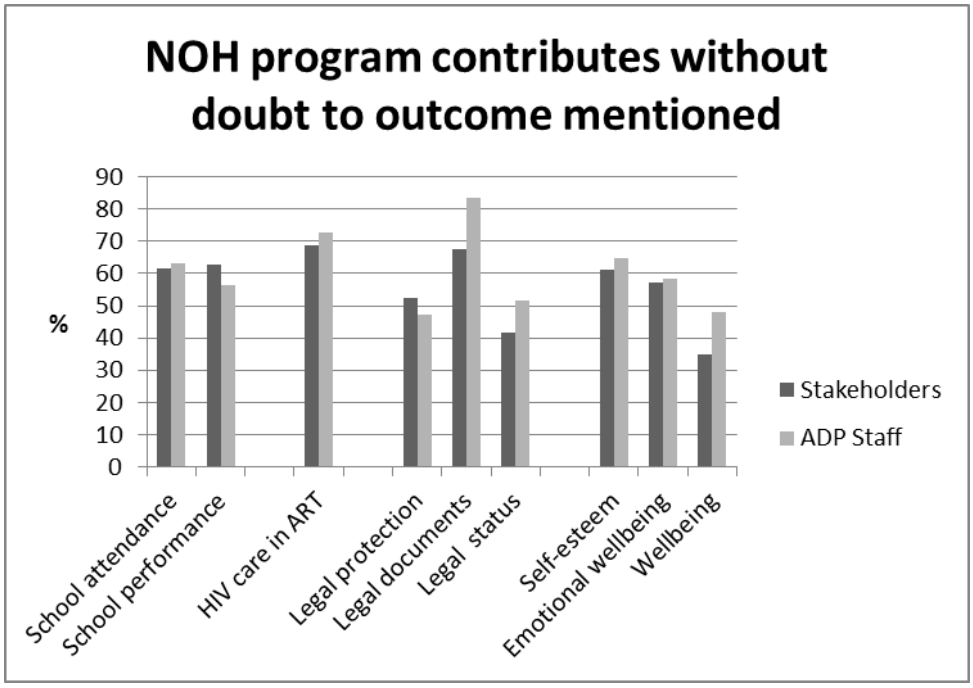


Figure 6.4: Percentage of stakeholders and ADP staff that consider NOH program to contribute to outcomes beyond doubt

On questions that follow below the same pattern was observed. Respondents (stakeholders, staff) were of opinion that the NOH program did 'very well', and 'to a certain extent' in assisting, facilitating or helping OVC to receive the services listed in the questions:

- How well did the program assist in requiring legal documents, i.e. birth registration or ID?
- How well has the program facilitated access to services to children who were denied legal status?
- How well has the program helped children to gain access to HIV related health care services in ART?

Although stakeholders (in the CCC) and staff from the ADP differ in their degree of endorsement of the statements and questions they all are positive but not in a consistent pattern (for example, sometimes the stakeholders were stronger in supporting the item; other times staff percentages were stronger). The observed differences seem to be

explained by the degree of uncertainty expressed by stakeholders on the effect the NOH program has in certain respects. For instance, relatively high levels of uncertainty were expressed by stakeholders with regard to the NOH program's impact on accessing legal protection and to services in cases where children were denied legal protection. Uncertainties were also reported by stakeholders when items refer to school attendance and HIV related health care services in ART although at a lower rate as for the items mentioned above.

Wellbeing of OVC

Findings based on data collected from OVC on their wellbeing and resilience

The findings reported above are all based on perceptions as expressed by role players and stakeholders that are key to the implementation of the program. The evaluation research design did provide for a direct measurement of OVC wellbeing and resilience. A sample of teenage OVC was selected for this purpose.

The teenager OVC group completed a questionnaire that includes two indexes, one on Wellbeing and another on Resilience. The Wellbeing index consists of 32 and the Resilience index of 25 items. The items were coded for positive and negative responses and scales were adapted accordingly. A simple summation formula was used to calculate scores. In the case of Wellbeing a 3-point scoring systems was used that provides for a minimum score of 32 and a maximum of 96; the case of Resilience a 5-point score was applied and scores range from 25 to 125. Scores turned out to be quite high for both indexes. Total scores were grouped according to fairly equal distribution; in the case of Wellbeing into three categories and Resilience, two categories to facilitate comparisons across ADPs.

The results were compared among the six ADPs to establish if there were any deviations from the general distribution of scores and differences among the ADPs. The overall scores for both measures were high, indicating high levels of self-declared Well-being and Resilience among OVC, and suggesting that the NOH program achieved its goals of contributing to these outcomes. The median score for Wellbeing is 79.5 (i.e. 88%) out of a potential maximum score of 90, while the Resilience score measured to 100.5 (i.e. 80%) out of a potential maximum score of 125.

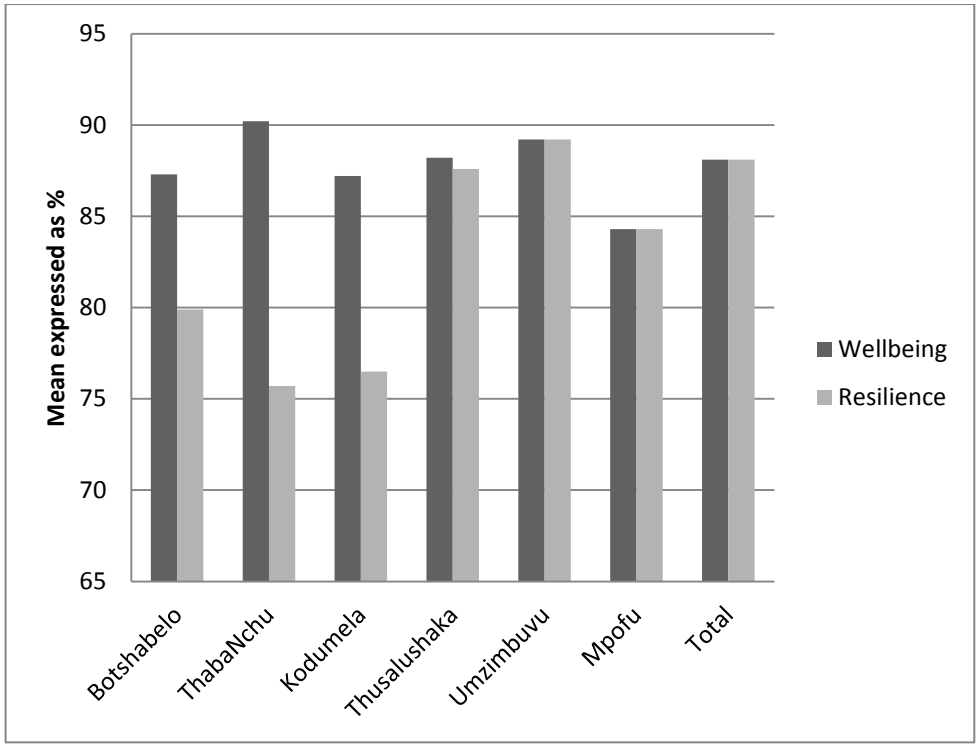


Figure 6.5: Mean wellbeing and resilience of teenager OVC per ADP

When compared for the six ADPs no significant deviations with respect to Wellbeing were found. This means that the Wellbeing score remains high for all ADPs. However, the distribution of the Resilience scores for ADPs differs significantly from the overall distribution. Thusalushaka and Umzimvubu present higher proportions for the high scores than the average while ThabaNchu, Kodumela and Botshabelo show lower scores in Resilience. This implies that Resilience among teenage OVC is stronger in the first two ADPs than in the case of the last three ADPs. The average Resilience for all ADPs remains high.

The difference of the means for Resilience between ThabaNchu and Kodumela on the one hand and Thusalushaka on the other hand has been significant on the 5% level of confidence.

The differences between the means for Wellbeing and Resilience in the cases of ThabaNchu, Kodumela and Botshabelo (see Figure 6.5) are quite noticeable and suggest that Wellbeing does not necessarily predict Resilience. This means that program elements need to be carefully analysed to identify factors supporting the development of resilience.

Findings based on data collected from guardians and home visitors regarding OVC wellbeing

If we consider the variables of wellbeing and resilience in terms of related concepts, such as the general conditions of life in the household, quality of life, health, personal and social characteristics, and education, positive perceptions were expressed by role players working

closely with OVC. The role players interviewed include the guardians of OVC and the home visitors that maintained close contact with them.

Role players were asked to compare the situation of OVC at the time of the interviews with the situation of the OVC before they were registered in the NOH program by rating the OVC's condition as better, the same or worse. In all respects measured, these two groups of role players overwhelmingly judged the situation as better with percentages higher than 70% and often more than 90% endorsing the 'better' category in the answers. A convincing majority of the role players see the improvement that OVC underwent, for instance, in their educational performance, as the direct result of the NOH program. Other aspects measured include better conditions in the household, improvement in participation in social activities, the mood of the children, their access to health, and in health status. These aspects were regarded as important dimensions in quality of life and it may be concluded that children's quality of life did improve as a result of the NOH program.

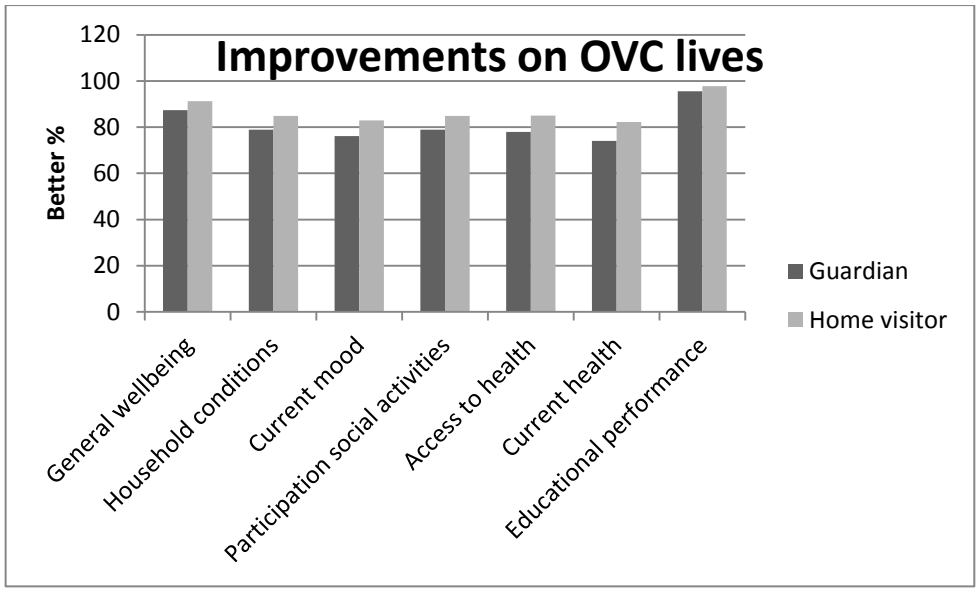


Figure 6.6: Aspect is better since enrolment to NOH program as perceived by Guardians and Home Visitors

Guardians and home visitors did differ in their degree of positive response though. It was found that home visitors consistently express a higher perception of positive improvement than the guardians across all quality of life aspects mentioned above. The pattern of the responses remain the same however as indicated (see Figure 6.6).

When the response pattern of these two role player groups is compared among the ADPs it was found that that Kodumela and Thusalushaka performed better in about all items listed above than the general level of improvement and that Khaulelo, Umzimvubu and ThabaNchu occasionally also performed above average. In some instances Mpofu come out weakest in the performance of improvement. Statistic tests for difference in the

distributions[21] on nearly all the items indicate statistically significant differences with p <= .05 [22] for the ADPs.

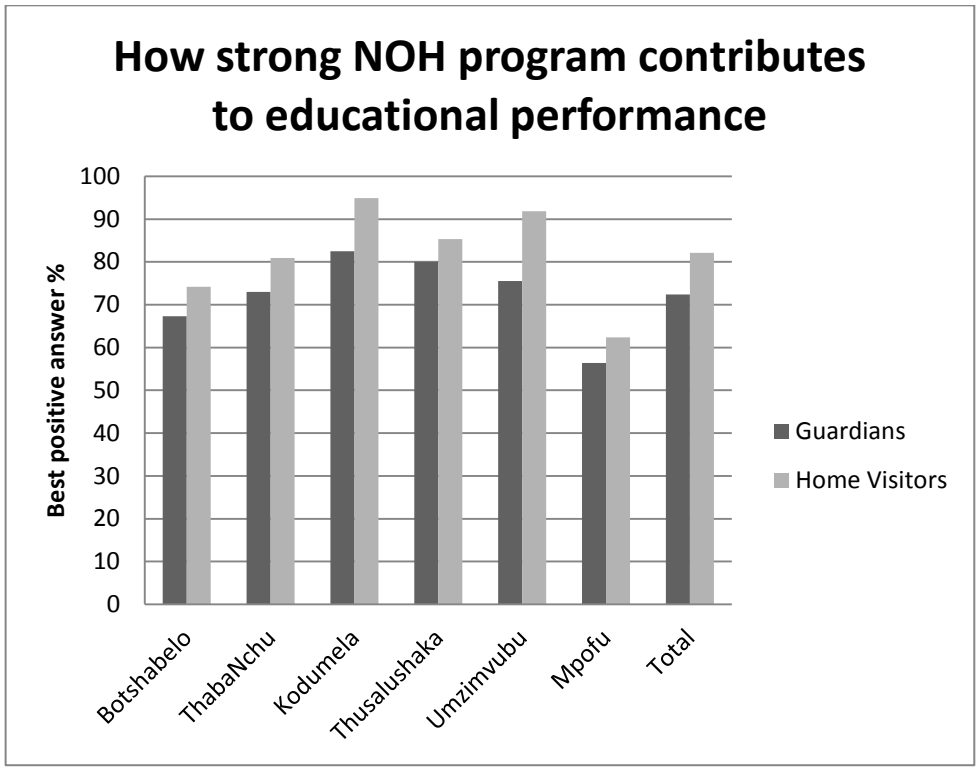


Figure 6.7: The best positive answers on opinion by Guardians and Home Visitors that NOH program contributes to educational performance of OVC

6.4 Changes in the health status of OVC

OVC have been registered in terms of the NOH program because of their specific vulnerable status. By using the various data sources identified and constructed in this evaluation a 'data trail' was designed with which the health status of OVC could be traced. The moments within this 'trail' refer to the stage before an OVC was registered and listed on the World Vision data base as kept at the ADP administration, the stage immediately following the registration (called 'at registration'), and the event of the interview of the current evaluation. The interview incorporates OVC that were in the program for at least 18 months. Furthermore, various data sources were tapped to complete this trail. The data sources include the World Vision data base information, home visitor information as provided during the interview, and guardian information also during the interview.

With respect to OVC' health status, this enables us to ask and answer the following questions:

[21] Pearson's Chi-square as performed by SPSS, Version 19.
[22] Only two exceptions were found: Participation in social activities (not in Table); and Improvement in educational performance.

- What was the OVC' health profile before registration into the NOH program, as the OVC was growing up?
- What was the health profile when the OVC became registered?
- What was the health profile of the OVC at the time of the interviews for this evaluation, as described by the home visitor as the official World Vision employee working with the OVC?
- How did the guardian of the OVC describe the OVC' health profile?

In addition, a question on the guardian's health status was also asked in order to determine if the primary caregiver of the OVC health status showed any relation to OVC health status:

- What was the primary caregiver's (guardian's) health status at the time of the registration of the OVC?

A summary table of the statistics on these questions appears in the Technical Notes (Section 10, Table 13, page 64).

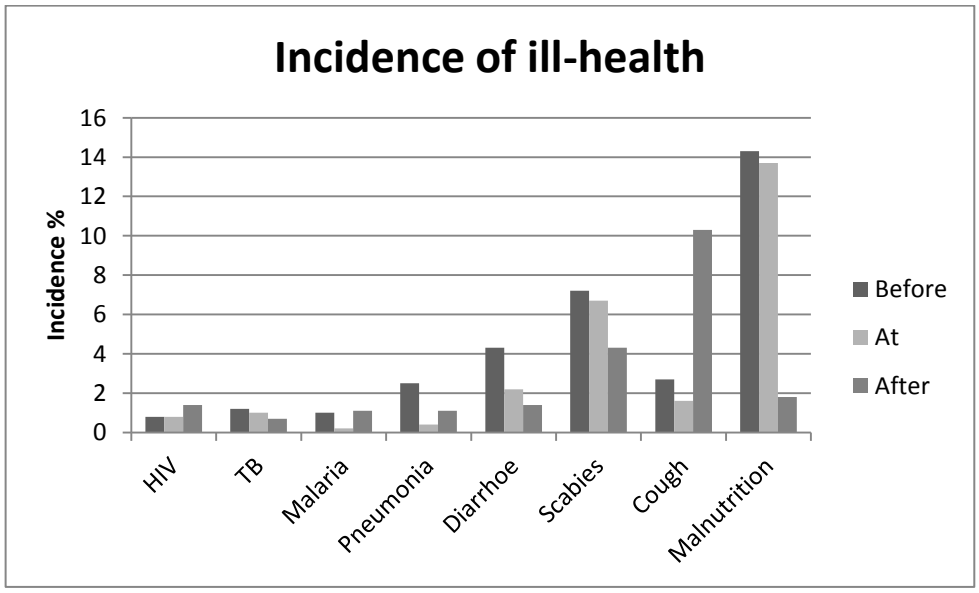


Figure 6.8: Incidence of ill-health among OVC in NOH program according to Home Visitors before, at and after registration as OVC

The data trail demonstrates a remarkable similarity and consistency of health/illness patterns among OVC. There appears to be a high majority percentage of healthy OVC. Home visitors report a very high 94% while the guardians report a lower but still significant majority percentage of about 73% not ill. The pattern of an overwhelming healthy OVC group is further supported by the pre- and at-registration data. On the day of interviewing, guardians reported that 72% of the OVC were not ill during the past month, 20% were ill and less active for a few days, while the remainder (8%) were sick often, too ill for school, work or play, or been ill most of the time.

Illnesses and ailments reported are of very low frequencies. The figures are consistent with only a marginal decrease in pre-registration figures to at-registration figures. Examples include malaria, coughing, pneumonia, diarrhoea/bilharzia, and scabies/skin rash – the latter three decreased more steeply.

Home visitors tend to report a marginally more positive health/illness profile among OVC than the guardians but the pattern pictured by these two sources remains the same.

The trend in malnutrition seems to be the only one that shows remarkable variations. Malnutrition shows the highest incidence in the pre- and at-registration figures, with a marginal decrease, and then a steep decrease in the reporting by the home visitors and the guardians (see Figure 6.8).

The ill health pattern for the guardians (as reported by themselves) is very similar to the OVC pattern except for a slightly higher prevalence HIV/AIDS persons and a significant higher percentage of malnutrition among the guardians. Malnutrition registered 26% among guardians and only 2% among OVC. These two figures were produced by the same source, namely the guardians of the OVC.

Finally, diarrhoea/bilharzia, coughing, scabies/skin rash, and malnutrition among OVC are the ill-health conditions with the higher prevalence although with variations as observed in the data.

The figures, patterns and trends above represent the situation for all six ADPs collectively. Numbers are too small to conduct significant analyses for the individual illnesses within the ADPs. However, malnutrition does provide the potential for such detailed analyses in the cases of the pre- and at-registration of OVC and of the current situation of the guardians as sufficiently large figures are available for these three moments in the data. A comparison of the six ADPs values for the three measures produced significant statistical differences. The comparison shows that ThabaNchu and Umzimvubu consistently have higher than average percentages of malnutrition in all three cases. It also shows that Khauhelo had higher than average malnutrition among OVC before their registration but since had overcome this negative situation. On the other hand, Mpofu did not have more than average malnutrition before or now for OVC but currently is registering higher than average malnutrition for guardians. Here is a figure demonstrating the pattern.

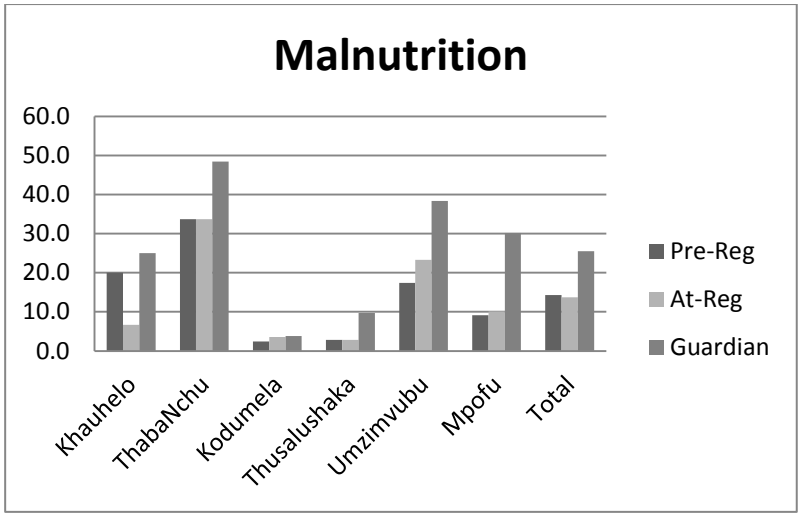


Figure 6.9: Malnutrition at different data points as per ADP

Based on the reported data above, we come to the conclusion that OVC health is largely conditioned by circumstances of poverty, hardship and destitution. Not having the capacity to face the conditions of living they are exposed to, their vulnerability may be overwhelming and their chances to accomplish a winning life may be bleak. The life domains fuelled by inner strength, social forces, educational achievement and life skills – in fact the resilience factors - may become all important to overcome the stumbling blocks of material conditions.

6.5 Findings on home visitors

Role and duties of home visitors

Home visitors play an important if not essential role in the NOH program. Home visits, performed by home visitors, are an essential activity for identifying, assisting and monitoring OVC. Depending on the number of OVC allocated to a home visitor children are visited once a week. During the initial visit, home visitors conduct family assessments, determine the interventions needed, and assess the adequacy of food, clothing, shelter, and access to government services and schools. At subsequent visits, details of care provided and changes in the child/family situation are recorded, thereby identifying gaps and challenges and enabling WVSA to monitor and evaluate service delivery. Typically during visits, children and guardians are offered support in solving any problems or issues that have arisen since the last visit. In cases where the home visitor cannot meet the OVC needs, the CCC or ADP is approached for further guidance and, if applicable, referrals are made for additional services.

Apart from being a key player in the NOH program that performs tasks as described here and elsewhere, home visitors are also beneficiaries of the program. Home visitors are community members identified fit for doing this job. Although they act as volunteers they

receive stipends and in this sense they benefit financially. They also receive training of various kinds that are meant to capacitate them in performing their tasks.

According to a previous study[23], on average, each home visitor oversees nine to ten OVC. In the current evaluation study we found that the mean OVC figure per home visitor is 26 OVC (based on n=165). Some do have small numbers of OVC to take care of (the smallest number is 4 OVC) but quite a lot of the home visitors oversee large volumes of OVC – the biggest number is 48. When compared for the different ADPs the mean number of OVC per home visitor differs significantly with Khauhelo (19 OVC) displaying the smallest mean and Thusalushaka (35 OVC) the biggest mean.

Such a heavy load of OVC to take care of may have an aggravating effect on the performance of the home visitor. Home visitors are expected to visit their OVC weekly (or at least three times a month), yet we found when interviewing guardians of the OVC about the frequency of visits by home visitors that only 60.9% of guardians declared that this was happening. For the rest of the guardians (about 40%), they experienced that home visits were less frequent. However, the overwhelming majority of guardians (82.5%) found home visitors 'very helpful'; other indicate them 'somewhat helpful' (13.5%). A few (4%) thought home visitors were not helpful at all.

Profile of home visitors

Due to their key role in service delivery they naturally formed a central information source for the evaluation. A number of 167 home visitors were interviewed both to provide information about themselves and to enlighten the evaluation team on OVC affairs. Here we provide a profile based on the information provided by them.

The demographic characteristics of home visitors are interesting. Only 6.8% are men, and therefore 93.2% women. Their age ranges from a young 19 years to an old 80 years and their mean age is 35.7 years. The biggest concentration is within the 30 to 44 years cohort.

They speak the language of the people of the ADPs due to the fact that they are nominated from the local population by the Community Care Coalition as the driving force of the program. The scholastic level of home visitors pertains mostly to secondary schooling, which they have completed (49.4%) or have partially completed (34.9%). Approximately 8% has lower qualifications (primary schooling, ABET) or in some cases post-matric diplomas (7%).

More than 75% of the home visitors have been employed in the NOH program for less than four years. The rest, nearly one-quarter, is in service for 5 to 6 years and a few for up to 12 years. As the NOH program started in 2006 these longstanding home visitors must have been in service of a similar kind in the community. Duration of the term of employment as home visitor within the ADPs varies significantly. In Umzimvubu the mean years of

[23]Maleemisa Ntsala, Beverley Sebastian and Anzel Schonfeldt: Case Study of the Networks of Hope Project by Khulisa Management Services

employment is 1.3, and in Khauhelo 4.5. The other ADPs vary between 3.2 (Kodumela) and 4.1 years (Thusalushaka). Fifty per cent of the home visitors in Mpofu have been in employment for more than 4.5 years.

Reasons offered for becoming a home visitor include the following:

- I was already looking after children in the area and World Vision approached me
- I like working with children and I approached World Vision
- I attended the World Vision training out of interest and then approached them
- I needed a job/money and this was an opportunity for earning a stipend.

Training of home visitors

Training in the form of short courses is offered to home visitors to prepare them for the job and to skill them in specific aspects related to child care. An analysis of the fieldwork data on training of home visitors shows that of the 167 home visitors who completed the questionnaire for home visitors, 148 (88.6%) indicated that they received training from World Vision.

The greatest majority of the 148 indicated that they received training in Palliative Care (85.8%), followed by Monitoring and Evaluation training (65%). Other courses include training on HIV/AIDS (44%) and 'Care of Carers' (29%).

Interesting to note is that only two home visitors in the total sample indicated that they received training from World Vision on being a home visitor. Two home visitors indicated that they received training of child care and protection and another one indicated that she received training on working with children. It should be mentioned however, that almost 10% of the home visitors who received training did receive Child and Youth Care Workers (CYCW) training.

A summary of training received by Home visitors is reflected the Technical Notes (Section 9, Table 9, page 55).

About 87% of those trained indicated that they were still in need of more skills, mostly in health related subjects. They also received various forms of support by World Vision to enable them to perform their tasks effectively. Only a small minority (2.4%) complained that they did not receive appropriate support. The overwhelming majority (81.4%) testified that they were receiving continuous support while some other indicated support in some aspects only.

Challenges for home visitors

The types of problems they have encountered demonstrate typical issues to be found in the rural and peri-urban communities suffering with endemic poverty and HIV. Some of the issues mentioned include:

- Sexuality issues with both boys and girls
- Abuse of children by family and community members
- Drug abuse among children and adults
- The challenges of poverty which seems to be widespread and pervasive in the communities
- Children not having sufficient food and clothing including school uniforms
- Cultural beliefs and practices that undermine health programs
- The expectation by parents and guardians that World Vision is there to provide and give and that the people do not have to become self-reliant
- Antagonistic relationships with the parents or guardians of the OVC; guardians accusing home visitors of doing nothing.

The exposure to the work as home visitor and the NOH program and World Vision obviously made a positive impact on the home visitor as was testified in their answer to the question if the exposure had improved them as a person. They also find fulfilment in working with the children despite of the challenges mentioned above.

The motivation and position of home visitors in the delivery system of services to OVC

Seventy three (73) of the home visitors in the sample responded to the question “How did you become a Home Visitor for the Networks of Hope Programme?” 60.3% said they like working with children and approached World Vision and 20.5% that they were already looking after children in the area and was approached by World Vision. When asked what their long-term vision for themselves were 40.5% indicated that they wish to become a manager or coordinator in the programme (thus aspiring upward in the system), 25.7% that they wish to take up a new job elsewhere, while only 18.9% said they wish to stay a home visitor.

This is an indication that the majority (65%) of home visitors consider the work they are doing as a “stepping stone” to something else. As there are very few alternatives, home visitors are unlikely to move on, unless the security of stipends should fall away.

According to Lund[24], the HIV/AIDS epidemic has placed a great strain on health services, and precipitated a move towards "home-based and community care", including use of volunteer workers. In the current situation terminology becomes confusing. "Volunteers" are often paid "stipends" or "honoraria", although they are expected to work fairly regular hours, with specific tasks to perform. Formally engaged grassroots community-based and home-based workers are recruited on widely varying pay and working conditions, even within the same programme. This seems to be an issue that needs to be dealt with, also in the World Vision environment. Lund's conclusion may apply here: "For HBCs, the boundary between 'worker' and 'volunteer' is fuzzy ... Though their work is promoted by the Government as a central plank in the new community care policy, the volunteer's employment status is ambiguous and precarious."

Perceptions regarding home visitors

Because of the key role of home visitors in addressing the needs of OVC, perceptions of staff and stakeholders were gauged in this regard. Questions asked were on the effectiveness of the role of home visitors and on the successful functioning of home visitors.

Both the stakeholders and staff expressed themselves predominantly positive regarding the home visitor system. Yet, at two ADPs there were some reservations. At Khauhelo 25% were uncertain and at Kodumela 14.3% were uncertain and 10.7% indicated that it's not clear to them if the home visitor system really works.

The staff gave a more positive rating than the stakeholders on home visitors. Apparently staff has more confidence in the home visitor system and see it as the obvious thing to do. Stakeholders in Khauhelo and Kodumela and staff in Thaba Nchu were less certain on this point.

The rating of the home visitors and perceptions about their purpose and function emerging from the stakeholder workshops contained the following points of view:

- Home visitors are an important instrument to deliver on the programs of WV. Home visitors visit the OVC and assist with various ways inter alia with the distribution of food parcels and clothing.
- Some stakeholders are of the view that although OVC are visited, not enough is done and that some home visitors are not in a position to help. There is a heavy emphasis on material assistance with little supervision and emotional support.
- It would however appear that the material support impacts positively on the self-esteem of the OVC. "They are not being ashamed any more of being poor" as they appear not different from other children. In this respect home visitors help with

[24] Francie Lund. Hierarchies of care work in South Africa: Nurses, social workers and home-based care workers. International Labour Review, Vol. 149 (2010), No. 4

school work, encourage school attendance which result in improved school performance and an improved pass rate at schools.

- The fact that OVC know that home visitors are their mentors and that they are also visited, motivates them to perform well at school. This helps to boost their self-esteem and self-confidence.

- Home visitors also provide information by bringing in special stakeholders and help people to know their communities. Consequently the view is that there is improvement in the community.
- Although they are trained and attend workshops, there seems to be a need for criteria for a better selection process. As someone noted: “They need to be interviewed when they start this job”.
- It was also said that home visitors need more support and transport was mentioned as a problem.

Conclusion on home visitors

In conclusion, we found the home visiting system an indispensable part in caring for children in relation to and cooperation with their families and therefore an input to the NOH program that should be maintained and extended. Home visitors are over extended and cannot fulfil their functions and duties to the optimum and are met with resistance in some cases. However they are also appreciated for what they contribute to the wellbeing of the children and family life. Training assists in capacitating them but the training should be better consolidated and focused to prepare home visitors for their work as family and child minders. Potential candidates for the job need to be selected in terms of clear and set criteria and an induction program needs to be followed to provide proper orientation for the work. It was not clear from data exactly how home visitors are monitored and managed and there seems to be a need for improvement in this respect.

The status of the home visitor as a volunteer should be revisited and clarified.

By the very nature of their assignment home visitors focus on strengthening the capacity of OVC and their families and therefore forms part of community mobilisation. However they are not centrally positioned to build community structures such as CBOs. These are the domain of the CCC. Therefore, home visitors play an essential but not sufficient role in mobilising the community.

6.6 Community mobilisation

Community mobilisation deals with the second focus of the NOH program, namely the community focus that is reflected in the community strengthening strategy. We report on four aspects explaining the status of the strategy. The aspects are projects and organisations, involvement of role players, training and perceptions held by stakeholders.

Projects and organisations

As part of promoting community capacity in food security and household economies, NOH strengthened existing individual and communal projects during the period of implementation.

The projects include[25]:

ADP	Projects	Beneficiaries (if stated)
Khauhelo	110 household gardens	*
ThabaNchu	Aganang Community Development	220 beneficiaries
	2 x Nail Technology projects	19 beneficiaries
	Household gardens	184 beneficiaries
	Catering project	4 beneficiaries
Kodumela	Poultry	30 households about 154 beneficiaries
	Piggery	23 households about 93 beneficiaries
	Sewing and Embroidery	10 households 50 beneficiaries
	Household/Communal Garden	189 households 567 beneficiaries
	Apprenticeship	5 household, 15 beneficiaries
	Independent Development Trust	240 households about 960 beneficiaries
	Bakery	6 households

[25] Information provided by NOH Program Manager

Thusalushaka	4 Bakery projects	40 households 160 beneficiaries
	4 Poultry projects	39 households 155 beneficiaries
	Tower garden	5 households 25 beneficiaries
	10 Piggery projects (in drop in centres)	130 households 520 beneficiaries
	Community garden in a school	14 households 56 beneficiaries
Umzimvubu	Sinathemba Home based group	20 households benefiting 340 OVC
	Philisani	27 members benefiting 600 OVC
	Vukasizwe Poultry project	15 members benefiting 64 OVC
Mpofu	Phakamaninizenzele Community Garden	25 members 100 beneficiaries
	Ntingantakandini Poultry and Community Garden	20 members 80 beneficiaries
	Masivuye Community Garden	25 members 100 beneficiaries
	Irie Community Project	7 members 28 beneficiaries
	Umsobomvu Piggery Project	10 members 30 beneficiaries
	Katriver Irrigation	10 members 40 beneficiaries
	Sivenathi Preschool	23 members*
	Sivuyiseni Preshool	21 members*

*Number of beneficiaries not provided.

Involvement of role players

Over the period of the NOH program the ADPs managed to build a network of stakeholders to assist, now and in the future, in a wide range of tasks, including access to services for OVC. This network includes individuals, organisations and institutions as well as access to infrastructure for the various activities.

In the fieldwork of the evaluation a selection of these stakeholders was invited to attend a workshop. It included representatives from CBOs established as a result of community strengthening by the NOH program as well as various sectors (all ADPs included):

- Community Based Organisations 39
- Faith Based Organisations / churches 12
- Traditional leaders 10
- Schools 8
- Department of Health / clinics 8
- Local/district municipality 6
- Committee members of Community Care Coalitions 6
- Department of Agriculture 5
- Department of Social Development 4
- Department of Education 3
- Department of Home Affairs 2
- Other 13

These stakeholders demonstrated a real concern and involvement with the OVC. They were asked to describe the role they believe they play in the program. The responses relate to a wide range of activities and involvement, such as:

Play a role:

- Chairperson, secretary, coordinator
- Church member as well as pastor
- CCC to help community with information about NOH program

Direct involvement with OVC, such as:

- Assist ADP staff to identify the OVC in the community
- Caring and helping OVC and the community
- Identify problems in village and report to ADP

- Contribute by identification of OVC and patients in community and submitting statistics
- Help OVC, receive training, work with HIV patients, do advocacy
- Helping kids with food, monitoring homes to ensure they attend school

Other tasks:

- Attend meetings
- Assist with quotation to address water shortage
- Informing residents of information required
- Facilitating ADP programmes in our school plus ECD
- Food security, give seed packets, garden tools, training and address food insecurity
- Faxing and copying
- Help farmers with technical advice. This helps them to produce enough vegetables for drop in centres
- Involving parents by planting vegetables, cleaning surroundings. Paid, able to provide for OVC
- Taking care of OVCs at school, assisting NOH presenter to involve with learners.

Training provided at ADP level

The training conducted in the last four years at all ADPs was to secure the achievement of objectives of NOH program, i.e. to build the capacity of the communities and community based organizations to provide care and support of the OVC in their communities.

The training plays a very important role in building capacity at all levels. As mentioned above a number of CBOs have been registered as NPOs and were provided with organizational capacity building in different areas ranging from organizational development to financial management and others listed below.

Most of the training modules were presented by PEPFAR approved providers over a period of five days, unless indicated differently.[26] Themes of training include:

- The courage to become ME
- Psychosocial support
- Frail care
- Pain management
- Wound care
- Primary health care
- Basic nutritional education (3 days)
- Basic health care promotion
- Early childhood development (2 weeks)
- Psycho-social support
- Financial management
- Project management
- Proposal writing
- Organizational development
- Organization self-assessment

[26] Information provided by Manager of NOH program

- HIV&AIDS education
- Peer education training
- Voluntary counselling and testing
- Home-based care (20 days)
- Palliative care (Basic and Advanced)
- Organizational capacity building
- Channels of hope
- Child protection (3 days)
- Community conversation (dialogue)
- Directly observed treatment support (TB)
- First aid (3days)
- Monitoring and evaluation (3 days)
- Child and youth care work (over period of 18 months)

Perceptions expressed by role players

Community mobilisation is aligned to the objective of mobilizing and strengthening community-led response to protect and care for OVC. Communities are mobilised mainly through the implementation of two strategies; Community Care Coalitions (CCCs) bringing together churches and other faith communities, government, local business, NGOs, and CBOs and Channels of Hope (COH), designed to specifically mobilise faith communities. Both strategies aim towards the generation of the needed cooperation from and ownership by communities.

The two questions measuring opinion in this regard were if the ADP communities effectively cooperate in the service provision for OVC and if the communities consider the projects as their own, i.e. taking ownership for it.

Both the stakeholders (i.e. participants in the CCC) and staff of the ADPs were predominantly (more than 60%) of the opinion that the communities cooperate, although around 30% agree with the option that cooperation is only “to an extent”. Stakeholders and staff are therefore in agreement about the extent of cooperation among communities within the ADPs. Cooperation seems to be successful.

On the question to what extent the stakeholders and staff perceive the NOH program as their project the two groups express virtually the same answer. Both are in agreement to the extent communities have taken ownership of the project – more than 80% in both the cases. About 45% of the respondents interviewed ‘strongly agree’ that ownership has taken root. One may conclude that community mobilisation has been successful in establishing ownership for the idea of having a networking program linked to the needs of OVC within the local ADPs.

This gives rise to the question to what extent an ADP as a management and service delivery agency may be regarded as a successful implementation tool in the NOH program. From the

questionnaire data strong confirmation was provided by both stakeholders and staff that the ADP concept is an unquestioned approach for the implementation of the program. More than 90% of both confirmed that the strategy of World Vision to strengthen the capacity of community structures through the facilitation of an ADPs really works.

Having said this, the evaluation did not find much introspection on ADP as a system of management and delivery. However, discussions held at workshops with stakeholders at the six ADPs produced some salient points regarding community mobilisation:

- According to community stakeholders, communities are assisted with infrastructure projects such as shelter, water, sanitation, toilets, crèches, schools, etc. In the minds of community members there is therefore a confusion of what the role is of WV and other development partners. This was observed in all ADPs through workshops held with them. Furthermore, there is ignorance about the difference between NOH and WV. This confusion has led community stakeholders to observe wrongly that WV is a provider of infrastructure and resources. This generalised belief among community stakeholders led to the conclusion that stakeholder community structures are not yet capacitated to the extent that they can act independently and that they still rely heavily on WV support in almost every aspect of life. This perception suggests that NOH did not gain as yet an identity beyond the ADP.

- Community mobilization takes place mainly by means of community meetings where the services of the NOH program are promoted, through dissemination of information and assisting community-based organizations to access funding from government and other sources and acquiring legal documents.

- In a positive way, it was stated that WV plays an important role as far as educational awareness, community projects and attending to basic needs are concerned. The ADPs are doing well and more and more community members are helped.

- According to stakeholders the problem however remains that not all vulnerable children in need of care are reached and supported despite the fact that OVC support services have grown.

- Poverty issues and poor health are perceived to be major challenges contributing to death and children being left orphaned. Consequently there is a constant growth and demand for health and support services to OVCs. In this regard the role of WV is seen as critical and a poverty alleviating strategy and the view is that there is improvement in these communities.

- Income generating projects, despite the fact that they are not strongly market linked, are popular and supported by communities. In this regard mention is made of a general positive view of WV and co-operation with the ADPs.

- The community coalition partners (such as the churches, the schools, NGOs and drop-in centres) seem to cooperate well in most communities.
- Mention is made of a range of capacity building skills that have been transferred to communities and CBOs such as home-based care, proposal writing, project management, communication skills, palliative care, psychosocial support, business skills, life skills, health and spiritual support, nutritional skills including food supplements.

6.7 Programs other than World Vision's initiatives

Organisations and services other than those initiated in terms of the World Vision initiative but linked with the NOH program established in the communities may be an indication as to how well the community is mobilised. Sustained delivery to OVC may also be forthcoming from other organizations or services should the term of the World Vision driven program run out. This is therefore an aspect to be pursued in terms of the second evaluation question, which is focused on strengthening community capacity to effectively respond to the needs of vulnerable children. Two questions were thus asked for input by the stakeholders and staff: if any other programs other than the NOH program focusing on wellbeing of OVC exist and how well the other programs are doing.

Staff is better informed about other role players with whom they interact, among other, through the Community Care Coalition and Channels of Hope. Far more of the staff (85%) than the stakeholders (53%) therefore indicated that they knew of other programs than the NOH program that focused in their area on the wellbeing of OVC. Across the different ADPs a large number of role players were mentioned, including CBOs, FBOs, government services, clinics, and schools.

The assessment of the contribution of these other programs, according to the responses gained from staff, indicates that nearly 50% of the staff is of opinion that these other programs are doing 'very well'. Another nearly 40% of staff was prepared to indicate that the programs were improving the wellbeing of OVC 'only to a certain extent'. It is difficult, based on the information to say if these organisations or programs will be able to continue delivery, and at what level, without the inputs from the current ADPs.

6.8 Estimates on future need

The evaluation questions for this study refer to issues of extending the program beyond the present phase such as the embedding of the project in the community following the end of the project cycle, the factors required (i.e., actions, resources, commitment, buy-in, etc.) in order to transfer ownership over to the community, and the issues, themes and topics that have arisen as a result of this program that can be considered for continued funding, or further research.

The question therefore is if the services that have been offered to the OVC will be still needed in future. This is relevant due to the program theory that funding and program implementation should be transient on the assumption that the affected community will develop capacity to sustain the development program once the development agency has withdrawn from the community. The answer to this question needs to address the assumption that the need for services remains constant. If the current program has been found to be successful the future need will obviously have to be redefined.

Another argument to be considered in addressing the future need refers to the migration of OVC through the system over time. Migration of OVC through the system is affected by demographic factors such as birth and HIV infection rates. We have already seen that the current cohort of OVC is less infected than the previous generation, i.e. their parents. This in itself implies a drop in the need for treatment such as ART as the figures on health status of OVC have shown.

The demographic argument of how many OVC will be leaving the system once they have turned 18 years and how many babies and young children will enter the system is affected by the birth rate of the relevant population. Should the birth rate have dropped in the last number of years, less additions to the system may be expected than the number of OVC leaving the program at turning 18 years. The number of the leaving OVC is affected by the birth rate of about 18 years ago.

Finally, it should be noted that poverty also impacts on the ability of beneficiary groups to provide for their own needs. Chronic poverty itself will therefore determine to what extent services will be needed in future.

Returning to the demographic argument estimates by ROADS (see Technical Notes, Section 14, page 78) based on the captured OVC demographic data indicates the following:

- Exit rate of around 10% per year in the 12 – 17 years age group;
- Entry levels smaller: 0 – 2 years age group, about 2%, and 5 – 11 years age group, around 7%;
- National statistics show a decrease in the 0 – 4 years age group that steadily spills over into the 5 – 9 year cohort;
- This implies that the demographic source for the OVC is getting smaller with the consequence of reduced needs over time and that the percentage leaving will be larger than the entering number, with the result that the target group (0-17 years) will be smaller in future.

It should be noted that a clinical assessment such as the one presented above is not necessarily supported by role players and stakeholders currently active within the program. In response to the question: Has the demand for OVC care and support services in the ADP communities grown? stakeholders and staff are strongly convinced that this is the situation (nearly 70% agree that the demand has grown; nearly 25% say that it is true ‘to an extent’).

In qualitative comments during workshops with stakeholders and staff the following points were also made:

- The services and support received from WV is appreciated especially as far as satisfying the basic needs of OVC. In this respect practical things such as clothing, school uniforms, blankets, food parcels and assistance with gardening and seedlings projects are mentioned.
- However there seems to be a view that food sustainability is inadequate and does not really generate an income due to lack of market linking.
- The involvement of WV also helps to protect OVC from abuse and teach them how to protect themselves. The general view is that WV changed the lives of OVC and their families in the villages where they are involved. Despite this, there is still a view that not enough information is made available and that more needs to be learned.
- World Vision's work is largely judged on the material benefits and services provided and only to a lesser extent on its efforts to make communities more self-sustainable.

7. GENERAL CONCLUSIONS

This Section highlights critically important aspects of the findings that were presented in the previous section and about which conclusions of the evaluation may formulated: the profile of OVC and their households, interventions of the NOH program, wellbeing and health status of OVC, home visitors, community mobilisation and future needs. Based on the observations made and impressions formed the Section offers conclusions on the program as a whole.

7.1 Characteristics of OVC and households

- **Low incidence of HIV among OVC:** The findings on reasons for being registered as OVC show a low incidence of HIV infected OVC among the present cohort of OVC. From the data it may be inferred that HIV is more prevalent in the previous generation (i.e. OVC's parents). This fact emphasizes the large scale negative consequences HIV have for caring for the children left behind, hence the need for the current program.
- **Serious scholastic backlog among OVC:** The age distribution compared with actual school grade of the OVC shows that there is a serious scholastic back-log among the OVC. The need for educational support is therefore a serious and important need with critical implications for the long term personal development of OVC as resilient and empowered individuals.
- **Low cash income levels:** The income picture of OVC households looks extremely bleak. Less than 10% earn money and the earnings are often seasonal. Ninety per cent of households survive on a state grant or pension. This includes 53% of households using Child Grants). This has the potential for the development of economic dependency and the lack of any form of sustainable livelihood. As referred in Section 1 this situation is not unique to the WV communities in the six ADPs and calls for continuous developmental intervention. WV has a tradition of acting holistically to address the poverty trap in a transformational way.
- **Limited natural resources to fall back on:** The inquiries point to ADPs where resources are far and in between: Thusalushaka shows 40%, and Kodumela 32%, of OVC households not having such resources. Land or fields for cash cropping are not readily available. In general, only 13% of the households do have access to land or fields. Observations point to reliance on subsistence micro economies and the absence of the development of cash based markets.

These conclusions make it abundantly clear that wide spread poverty in its many ramifications is the core issue when assessing the interventions. HIV and AIDS exacerbate the situation but is not the core or common problem of OVC that needs intervention.

7.2 Interventions / outputs

- In view of the above comments, interventions such as need **educational support**, which forms part of the package labelled **Sustainable Human Development**, are spot-on ("the right thing"). Educational support is one of the interventions with the

highest frequency of implementation and all role players are in agreement that the program is directly responsible for higher levels of school attendance and scholastic performance at school. The need for more input seems to be emphasized by the findings noted.

- **Household Economic Strengthening** is another particularly crucial service area that apparently has not developed adequately to impact on sustainable household economic survival. Emerging projects, such as small scale farming, were noted but apparently they did not develop (as yet) into commercially viable ventures that have entered markets in a profitable way and overcome the mere subsistence levels of enterprise. Based on the numbers of beneficiaries and the scale of enterprise these projects have not yet succeeded to provide sustainable livelihoods and to meet the overwhelming needs in the larger community regarding economic empowerment and sustenance. The focus of HES therefore should be much more on enterprise development in addition to vocational training and grant access, which seems the present line of intervention.
- The interventions promoting **Healthy Living** and **Family Relationships** were generally rated positive by the majority of respondents, although support was qualified in many cases and the frequency of use much lower. However, we need to emphasize that the building of human capital and bonding social capital are noted in literature as preconditions for sustainable personal and family development. The efforts that are going into these interventions need to be intensified and made accessible to larger numbers of OVC and their households.
- The intervention to gain access to **ART – Antiretroviral Treatment** serves an almost insignificant number of OVC. It remains however a life-saving intervention and in this sense remains an essential intervention within in the program.
- The nine core service areas (CSA) and the 33 individual component interventions touch upon all aspects of programmatic interventions to achieve improved **Quality of Life** (including Standard of Living) and **Resilience** (the opposite of vulnerability), as important aspects of **Wellbeing** among OVC and their families. However, differential frequencies and intensities of implementation have been noted with respect to the various interventions. Yet, the outcome variables measured as quality of life, resilience and wellbeing rate highly positive. The conclusion therefore is that the goals of the NOH program, building the mentioned qualities, are subjectively perceived as successfully achieved among the respondents.

The package of interventions put together for the NOH program contains all the right ingredients to address the needs of OVC, particularly with respect to their personal and family development needs. We may therefore conclude that World Vision has been "doing the right thing". The data point to differential frequencies in the application of the service areas, justified as a response to OVC needs as defined by the diagnostic intervention by home visitors.

The profile of OVC has shown that not enough has been done to address crucial areas such as scholastic progress and sustainable livelihoods. With reference to scholastic development, vocational training should receive preference in cases where OVC leave the program at the age of 18 years without having completed their school career. The intervention package makes provision for addressing legal and HIV issues among OVC,

which are essential and necessary to attend to but not priorities in terms of the prevalence of these issues. The program should therefore take note of the relative frequencies of needs and allocate the resources accordingly. Prioritisation therefore needs to be done.

7.3 Health status of OVC

- Various comparable data sources, showing trends over time and for the data sources mutually, establish that the overwhelming percentage of OVC is healthy children.
- The notable percentage of illnesses and ailments among OVC include malaria, constant coughing, pneumonia, diarrhoea/bilharzia, scabies/skin rash, with a slight decrease since registration into the program in the three last mentioned conditions.
- Malnutrition is the only condition that draws significant numbers of children. Malnutrition is also a higher frequency condition among guardians of OVC.
- ADPs show the same pattern and trends of health conditions as described above. ADPs with higher prevalence of malnutrition are ThabaNchu and Umzimvubu. Khauhelo has had a higher prevalence but it decreased since OVC became registered in the program. Mpofu shows an increase in malnutrition since OVC' registration.
- HIV is not a significant condition among OVC and is slightly higher for guardians.

Health conditions as observed from the data sources bring us to the conclusion that children are largely healthy and that health risk conditions are manifested in malnutrition, parental neglect and exposure. The emphasis on nutritional counselling and guidance is therefore correct and signs are that the application bears fruit. Parental programs in child minding seem to be still an urgent need.

7.4 Home visitors

The assessment of the role of **Home Visitors** in the HOH program produced important conclusions:

- Home visitors are an essential and necessary ingredient of the NOH program.
- Their input was rated positively by role players and stakeholders.
- They are not only serving as a program component responsible for delivering essential services to OVC and their families but are beneficiaries in their own right. Apart from the inherent value the work they perform is having for them and for the personal gratification of serving others, they receive financial compensation in the form of stipends. For many this 'voluntary' work therefore serves as a livelihood making them vulnerable should the stipends fall away.
- Provision is made for extensive training to skill home visitors. There is doubt whether the training courses match the job specifications and prepare them sufficiently for performing the tasks.
- Job description of the performance areas of home visitors seems to be lacking as well as supervision, proper orientation and induction to work expectations. Selection criteria and application thereof for appointing home visitors need attention and perhaps upgrading in many instances.

- Many home visitors carry an overload of work with an average of 26 OVC per home visitor. This is against the stated average of 9 or 10. They are also confronted with dealing with social, personal, health, educational, family and other problems that manifest the profile of destitution and hardship, telling of conditions of poverty in rural and township communities.

Therefore while the home visit system forms an indispensable part of the program and is recognised as such, many improvements can be made to upgrade the status, performance and gratification of home visitors. Upgrading includes a formalisation of the position of the home visitor, specifying work expectations, person qualities, selection and appointment criteria and procedures, induction and orientation processes, supervision arrangements, and so on. The tension between a position that is voluntary and receiving financial compensation in the form of a stipend (which probably is regarded as a payment for duties performed) needs to be thrashed out. The vulnerability of the position in so far as it is regarded as a 'job' needs to be dealt with also. Should the ability to provide stipends fall away, arrangements of how to link into governmental (or other compensatory providers) systems need to be looked into. The supervisory arrangements for home visitors also need attention – who should be responsible and empowered for this? These conclusions and recommendations are offered to enhance the capacity strengthening of home visitors as a mobilisation factor in their communities and not just a service provider to OVC and their families.

7.5 Community mobilization

- Strategies for community mobilization refer to bringing together stakeholders and role players into the Community Care Coalition and the faith based initiative of Channels of Hope. The strategies achieved a good measure of cooperation within the communities / villages as well as a strong sense of ownership of the NOH program.
- The ADP is regarded as a successful and unquestioned management control centre and administrative hub for driving the program initiatives and interventions. The CCC's role is to be the community body for driving the program. The NOH aim is to strengthen the capacity of community based structures in the form of CBOs, churches, and similar role players to collectively take the initiative forward, i.e. the CCC. Because the ADP that is currently de facto driver of the program is in a transient role, it is imperative to develop the capacity of community structures as priority.
- Various projects that are building capacity to sustain household livelihoods and assets were observed during fieldwork and listed in this report. Capacity building in the form of training in various themes and skills was also listed. Community capacity was strengthened through these measures. In addition, the fact that community structures were formalised and institutionalised as organisations (e.g. CBOs that gained NPO status) strengthened the overall capacity to attend to the needs of OVC by the community.

- Respondents give recognition to the community based and community-led processes and claim that community meetings are serving a purpose in the interest of the program.
- Recognition is also given to World Vision as facilitating the provision of infrastructure, income generations projects, and capacity building programs such as numerous trainings. On this score, there is a need to educate the communities about the proper roles of the various role players in providing for the community. For instance, it should be made clear that WV (through their ADPs) is not a provider of infrastructure but a facilitating agency to gain access to agents with such resources and powers.
- Analyses show that gaps do exist and that for instance income generation projects are not yet market related and driven. Needs are also in a growing curve. Within a poverty-stricken environment basic needs are paramount and attention to this aspect right-fully has to be given. However, this is creating unintended dependencies and works against strengthening own capacity to become self-reliant.

The conclusion on community mobilization as a capacity building and strengthening strategy is that a tension has evolved between the fact that World Vision is perceived on the one hand as the provider of services that government is responsible for and on the other hand the need for self-reliance and self-sustaining. This has the unintended consequence of creating dependency within the context of widespread poverty.

This highlights the dilemma often experienced in development approaches when confronted with extreme and enduring poverty. Such situations demand a basic needs approach at the outset which may deepen the dependency syndrome. On the other hand, members of the community need to be capacitated to become self-reliant. This dilemma is intensified when the development agency and its funders subscribe to a program theory of bridging support – as is the case with the present program. This creates the need to facilitate programs of building sustainable livelihoods.

The observation is that income generation projects seemingly have generally not achieved the status of such sustainability.

At the same time poverty is apparently on the increase.

The implications of this situation are at least twofold:

On the medium to short term, partners in development need to be brought on board that understand the role of building capacity for long term survival. The sustainable livelihood model may be a guideline for materialising this vision.

For development agencies and funders the message is that they reconsider the assumptions of their program theories to provide fully for the capacity building need in bridging development aid.

7.6 General conclusion

The two main questions that this evaluation has been set up to answer are:

1. Did the NOH program make any **change and improvement** in the wellbeing of vulnerable children and what **aspects of child wellbeing** were affected most as a result?
2. To what extent did the NOH program succeed in **strengthening community capacity** to effectively respond to the needs of vulnerable children?

The answer to the **first question** is a qualified yes, as the profile of OVC has shown that OVC wellbeing is largely conditioned by circumstances of poverty, hardship and destitution. Not having the capacity to face the conditions of living they are exposed to, their vulnerability may be overwhelming and their chances to accomplish a winning life may be bleak. The life domains fuelled by inner strength, social forces, educational achievement and life skills may become all important to overcome the stumbling blocks of material conditions.

Therefore the answer is also a positive one. The NOH program makes provision for access to financial support, services of various kinds including health, psychological, legal, social and other services. World Vision had to approach the relevant communities in terms of their poverty status and initially followed a basic needs approach. However, the mentioned program services maintain dependency and are not sufficient for developing self-reliance and self-sustainability.

The profile of OVC points out that about 100 per cent of the OVC in the NOH program of school-going age were attending school. Just below 10 per cent of the sample observed did not progress to the next grade in the previous year. More than one third of the OVC may be regarded as too old for the grade they are in. The latter fact may have a negative effect on OVC's capacity to enter the adult world eventually as fully trained scholastically. The NOH program compensates to the scholastic backlog by facilitating vocational training, which has become one of the high frequency services of the intervention program.

The most positive aspect of the OVC profile is their health status. Only a minority needs serious attention to their neglect of personal hygiene, bodily care and a healthy life style. Home visitors should identify these children and families and address these issues. Malnutrition is a specific issue to be addressed more.

The answer to the **second question** is in doubt as already has been hinted. The community structures, such as the participating CBOs that have been created or empowered do not seem to have developed as yet the capacity to implement the program independently from the ADPs. Part of the problem is the need to facilitate access to services and resources. In this regard, a general confusion about the role of World Vision has been observed. Attention to basic needs has the risk of undermining strengthening community capacity to effectively respond to the needs of vulnerable children and consequently the sustainability of the established community structures. Dependency has thus become an unintended consequence in this program.

But there are positive results to be reported. The OVC have not only developed a good measure of wellbeing and resilience, albeit in a subjective definition thereof. Evidence came forward that social capital had been developed. Community values, ownership of the program, belief in the value of the program and its instruments, access to public services, inclusivity and the like have established itself in the process. These are valuable and essential building blocks for community self-reliance and self-sustainability. In this sense, progress can be reported on the strengthening of capacity of the community to respond to the vulnerability issues of children.

The analysis points out though that vulnerability issues are currently defined more by the poverty context of the community than the HIV epidemic and that it is expected that the scale of OVC as a category of vulnerability is levelling down.

Therefore, we may conclude that the NOH program has been successful in addressing personal and family needs of OVC and in providing hope and resilience on the micro levels. The challenge for the NOH program is how to address sustainability in local economic capacity in order to ensure material survival and even prosperity in the long term.

8. Lessons learned and recommendations

In this last section, lessons learned from the course of events and processes in intervention according to the NOH program are listed and recommendations following from the evaluation and analyses are offered.

National trends are not necessarily a guiding principle for local action.

Taking into consideration the profile of OVC and their households, the conclusion is that poverty has become the core issue of vulnerability and that HIV as experienced by the adult generation aggravated the situation. The assumption that HIV is still the rampant epidemic it proved to be over the last two decades in South Africa needs to be investigated critically and a proper socio-economic needs assessment is overdue. Due to interventions the needs and assets profiles of targeted communities and villages are likely to have shifted. Therefore the recommendation is that such a needs (and assets) assessment be conducted to inform the community structures of the way forward.

Revisit the prioritisation of interventions in the light of needs assessments.

The NOH program has designed and developed an impressive range of interventions to address vulnerability issues of children and families. This may be regarded as a comprehensive and holistic intervention tool providing for sustainable human development, family relationships, healthy lifestyle, and ART. In this sense the program is 'doing the right things'. Data point out that education levels are not on par with the OVC age levels and that household economic strengthening is not sustainable. The recommendation is that the interventions not only be intensified, but that sustainability issues especially for livelihoods be taken more seriously. In this respect a needs assessment may assist with realistic prioritisation of interventions. In a situation where everything has become equally important and urgent, prioritisation based on sound and relevant information is imperative.

Sometimes the guideline is: Back to basics.

Despite the successes alluded to above, health conditions related to poverty, neglect, exposure and lack of parental control and personal hygiene have been observed. Malnutrition is a specific issue. It is recommended that nutritional counselling and parental guidance be refreshed and intensified in the programs that home visitors are running.

Voluntarism is an inapplicable approach in a chronic poverty environment.

The use of a home visiting system is absolutely essential for the success of the program on the OVC at family level. The home visitor system and the incumbents are in need of upgrading in terms of formalisation, orientation, capacity building, and supervision. Due to home visitors' socio-economic position it cannot be expected from them to work without compensation.

However, the basic assumption that the home visitors in this program are volunteers requires that the applicability of the term in this situation be revisited and aligned to what emerges as guidelines for the future regarding the use of community volunteers working for stipends. Currently home visitors may be technically employees as they receive regular compensation in the form of stipends for routine work performed. We found that many home visitors have seen the service as an opportunity to provide an income. This is not uncommon in situations and cases of enduring poverty.
In view of the wide-spread application of this practice in South Africa and public attention to voluntarism as a human resource in service delivery the implementing agency needs to address this as a priority in the continued implementation of the NOH program.

Community development principles should be known, acknowledged and adhered to.

In essence, the NOH program is a community development program. This implies that communities ultimately participate in decisions affecting their future and take control of community structures that will affect the outcomes of interventions. The NOH program provides two streams of interventions, firstly nine core service areas including 33 specific services that provide for child and family focused programs, and secondly capacity building of community structures primarily through Community Care Coalitions and Channels of Hope programs. Each ADP project site appoints a group of home visitors who are tasked to facilitate the child and family program under the supervision of the CCCs. The ADP, i.e. staff and management, serves as the implementing agents of the program for the duration of the presence of World Vision in the project site.

An interpretation of the nine core services areas and 33 specific services justifies the conclusion that these services are primarily focused on the basic needs of OVC and their families and less on community capacity building such as organisational and sustainable livelihoods development.

With regards the second intervention stream, namely capacity building of community structures, such CBOs, NPOs and related community based projects, we observed noteworthy progress. Although community participation is not yet at the point where the communities are able to determine and drive its own programs, progress is clear regarding the development of community assets as the key building blocks towards sustainable community and village vitalization efforts. Progress in this regards includes the skills of individual volunteers networking, the development of local organisations like CBOs to provide the needed services and development, and sense of ownership, enlisting of the needed services of state departments and major institutions, like education, health, churches, etc. and finally also emerging small business, farming and infrastructure needed for the activities for the implementation of the program.

Therefore in view of the above and the ultimate goal of community development the NOH program carries, despite noteworthy progress, within itself inherent tensions. The program

is perceived by community stakeholders as to be managed by World Vision although they have shown buy-in or ownership of the program. In reality, no strong evidence was coming forward that the community structures are ready as yet to take the role of owners and managers of the program. To strengthen community capacity to run and manage the program the perceived dependency on World Vision needs to be addressed. More attention is therefore needed to build capacity of and transfer responsibility to community-based structures.

APPENDICES

Appendix 1: Bibliography and list of documents reviewed

World Vision sourced documents

Documents prepared for PACT

2007 Annual Report World Vision

2007 Semi-Annual Progress Report World Vision

2008 Annual Report World Vision

2008 Semi-Annual Progress Report World Vision

2009 Annual Progress Report World Vision South Africa

2009 Semi Annual Progress Report World Vision

2010 Annual Progress Report, World Vision South Africa (Annual Progress Report to Pact SA)

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Appendix 2: List of Respondents and Participants

World Vision SA

- WVSA Group seen at frontend meeting (names and positions)

Gloria Francis	Program Manager, NOH Program
Thandi Sigxitshe	HIV/AIDS Advisor
Rachel Meyer	M & E Officer
Marion Kauta	
Kgetho Siphiri	ADP Co-ordinator
Nolubabalo Mbanga	Grant Accountant
Nano Ngwane	Training Officer
Angela Makgabo	Program Manager
Kedi Sekhabisa	Prevention Coordinator

PACT

- Seen during front-end visit (names and positions)

Rita Sonko	Monitoring, Evaluation, Reporting &Learning (MERL) Director
Addis Berhanu	MERL Director
Daniel Bakken	Contracts Manager

Fieldwork

ADP Managers

Khauhelo ADP	Kgetho Siphiri
Thaba Nchu ADP	Ernest Fraser
Kodumela ADP	Ledile Mphahlele
Thusalushaka ADP	Maria Kgabo
Umzimvubu ADP	Xolile Mbi
Mpofu ADP	Lizeka Sicina

Other respondents

There are two records and both are reflected below:

- The registers signed and participating in workshops
- Questionnaires completed

The registers signed

ADP STAFF

Khauhelo

	Name	Organisation	Position
1.	Thembeka Busakwe	World Vision	NoH Nurse
2.	Rose Ramohai	World Vision	Assistant
3.	Kgetho Sephiri	World Vision	ADP Co-ordinator
4.	Christina Jantjies	World Vision	Finance Clerk
5.	Tumeliso Ramali	World Vision	Project Accountant
6.	Thabo Kome	World Vision	Managing Co-ordinator
7.	Hleliwe Thafeni	World Vision	OVC Co-ordinator
8.	Keamogeke Modisapu	World Vision	Data Capturer
9.	Solomon Segani	World Vision	Assistant
10.	Jeanet Van Tonder	World Vision	Youth Facilitator
11.	Tankiso Mohanoe	World Vision	Facilitator

Thaba Nchu

	Name	Organisation	Position
1.	Kelebogile Mutse	WVSA	Dev. Facilitator
2.	Dimakatso Machaka	WVSA	Sponsorship Officer
3.	Keitumetse Van Heerden	WVSA	Development Worker
4.	Itumeleng Thipe	WVSA – TBN	Data Capturer
5.	Precious Mashaba	WVSA –TBN	Step User
6.	J. G Seisho	ADP	D.W
7.	N. P Thuwe	ADP	Asst. Accountant
8.	V.D Seane	WVSA – TBN	Driver
9.	Phumi Setsapolo	WVSA – TBN	Youth Facilitator
10.	Mokitimi Kgotso	WVSA – TBN	D.W
11.	Katla Mohlomola	WVSA – TBN	D.W
12.	Preety Booysen	WVSA – TBN	D.W
13.	Armanda Modise	WVSA – TBN	D.W
14.	Nosabatha Mmeko	WVSA – TBN	D.W

Kodumela

	Name	Organisation	Position
1.	Mailula Moses	World Vision	Youth Facilitator
2.	Ledile Mphahlele	World Vision	Manager
3.	Maria Mashumu	World Vision	Step User
4.	Gloria Ramphela	World Vision	Accountant

5.	Mmola Francina	World Vision	HIV/AIDS Co-ordinator
6.	Mongadi Mpho	World Vision	Finance Clerk

Thusalushaka

	Name	Organisation	Position
1.	Shai Shanganya	World Vision	Assistant Accountant
2.	Margaret Ramphago	World Vision	Grant Clerk
3.	Mosipi Thapelo Frank	World Vision	Data Capturer
4.	Yeko Phumeza	World Vision	Data Capturer/Step User
5.	Romaano Jupiter	World Vision	Youth Facilitator
6.	Mashapa Joyce	World Vision	Sponsorship Officer
7.	Munyai Grace	World Vision	HIV/AIDS Co-ordinator
8.	Maria Kgabo	World Vision	Manager
9.	Chipo Gwaze	World Vision	Social Worker

Umzimvubu

	Name	Village/Organisation	Contact No
1.	Nozipho Ntuli	Lugada	078 3544679
2.	Thobeka Phama	Letlapeng	N/A
3.	Maputle Mama Kgowa	Mahlabatleng Village	083 2063857
4.	Hoffman Nkejetseng	Qhobosheaneng	073 2142271
5.	Ntsheo Ntaoleng	Semonkong	072 4450975
6.	Xolile Mbi	World Vision	071 5854645
7.	Mateballo Letele	Mateleng	N/A
8.	Nthabiseng Mosolou	Sketlane	076 31333021
9.	Makhapetsi Dlothi	Lekhalong	N/A
10.	Puleng Sello	Moiketsi Reserve	079 9337086
11.	Ntsoaki Makoro	Majoro	N/A
12.	Nolwazi Nkoebe	Mechachaneng	078 3916507
13.	Noncedo Moyikwa	Ntoko	073 5340834
14.	Mpati Kwanzi	Liqalabang	073 0283076
15.	Tholoana Ramokoeng	Fatkina	078 8213599
16.	Kanetso Mokeqaha	Moeaneng	072 3455263
17.	MamosaThelejane	Koebung	078 2404445
18.	Thabo Ramothola	Memloloaneng	076 5891704

19.	Ndwandwa Mfuneko	Polile	078 3974126
20.	Litlhoue Sello	Likhetlane	N/A
21.	Nobomi Dladlongwana	Sijoka	073 1988479
22.	Mpolokeng Tebele	Mapoleseng	073 0607234
23.	Refilwe Mahara	WVSA	039 7373325
24.	Antonia Morai	Qhobosheaneng	039 7373375
25.	Mazai Maraulo	Likhetlane	039 7373376
26.	Thembinkosi Tenza	World Vision	039 7373376
27.	Mdemka Sakhumzi	World Vision	078 6504162
28.	Zulu Mvimbi	World Vision	076 5702249
29.	Anna Mgedeza	World Vision	071 6161778
30.	Nomsa Mavuso	Thabakudo	078 730307
31.	Naledi Sephaka	World Vision	039 7373376

Mpofu

	Name	**Organisation**	**Position**
1.	Ntombenkosi Mzati	World Vision	Development worker
2.	Permly Kapindula	World Vision	Sponsorship Officer
3.	Khuliwe Nkonzo	World Vision	Development Facilitator
4.	Nomathamsanqa Gwayi	World Vision	Development Worker
5.	Yondella Ntontela	World Vision	Data Capturer

STAKEHOLDERS

Thaba Nchu

	Name	**Organisation**	**Position**
1.	Paul Ngubeni	Kamohau Feeding Project	Project Manager
2.	Anna Mokgwetjane	Kamohau Feeding Project	Care Giver
3.	Lerato Moeng	Batho Ba Lerato	Manager
4.	Thabo Lekhooa	Batho Ba Lerato	Care Giver
5.	Maria Cholo	Aganang	Care Giver
6.	Rebecca Boqwana	Ekusasa Lethu	Director
7.	Millicent Moreki	Ekusasa Lethu	Additional Mbr.
8.	Cynthia Shuping	Ekusasa Lethu	Director
9.	Nthabiseng Shuping	Kamohau Feeding Project	Care Giver
10.	Jerry Ranoha	Dpt. Home Affairs	Official
11.	Sylvia Moroe	Kamohau Feeding Project	Care Giver

12.	Kgetho Sephiri	WV Khauhelo ADP	Manager

Kodumela

	Name	Organisation	Position
1.	Maile N. B	Ramatau S. S. School	Deputy Principal
2.	Moeig M. S	Sekororo Clinic	Prof. Nurse
3.	Moraba E. S	Kodumela Pastor Forum	Chairperson
4.	Masama K.E	P.H.C	Asst. Manager
5.	Mohlabe M. F	Molalatladi School	Teacher
6.	Moagi M. L	P.H.C	Nursing Assistant
7.	Masete M. S	Kodumela ADP	Committee Mbr.
8.	Letsoalo T. M	Mamahlola S. P School	Educator
9.	M. P Ramahlo	Letsoalo T/C	E/R
10.	Letsoalo S. D	Letsoalo T/C	Induna
11.	Letsoalo M. E	Letsoalo T/C	Headman
12.	Phaleng S. P	Civic	Asst. Secretary
13.	Modula N. P	F.B.O	Committee Mbr.
14.	Letsoalo M. L	F.B.O	Elder
15.	Moraba E. S	P.P.C	Treasurer
16.	Mongadi M. W	C.B.O	Traditional Healer
17.	Makokovopo M.	Church P.P.C	Asst. Chairperson
18.	Ramafela N.	Civic	Dep. Secretary
19.	Shai Dinau	Makgaung ADP	Committee Mbr.
20.	Kgofelo T. E	CCC	Chairperson
21.	Lewele S. M	Phafogang ADP	Chairperson
22.	Letsoalo R.	Metz L. P. School	Teacher
23.	Letsoalo G.	Malalatladi P. School	Teacher
24.	Komana Rosina	Mamokaile P. School	Principal
25.	Mashumo Audrey	Mambudi Care Centre	Care Giver
26.	Motupa Maria	Mashate Dic.	Manager
27.	Mmelle Tsororo	Masekane Care Centre	Teacher
28.	Freddy Rapola	Civic	Dep. Secretary
29.	Phetole A. Shai	Maruleng Municipality	Councillor
30.	Letsoalo T. M	Mamahlola S. P School	Educator
31.	Mohlabe M. F	Molalatladi School	Teacher
32.	Moeng M.S	Dept. Health	Prof. Nurse
33.	Simi Lewele	Phafagang Project	
34.	Kgofelo T. E	Metz	Chairperson
35.	Ramfela M. N	Metz	Dep. Secretary
36.	Masete M. J	Kodumela Committee	Additional Mbr.
37.	Phaleng S. P	Metz Civic	Additional Mbr.
38.	M. P Ramalilo	Letsoalo T/C	E/R
39.	Moraba E. S	Kodumela Pastor Forum	Chairperson

Thusalushaka

	Name	Organisation	Position
1.	Mawela V. S	Traditional Leaders	Headman
2.	Selona Jerry	Traditional Leaders	Chairperson
3.	Sekepe Mahlatse	Seco F.M	News Editor
4.	Makwarela Stephen	S.R.D.A	Co-ordinator
5.	Mamarreulela T. G	D.O.A	C.A.T
6.	Lebeya T.E	D.O.A	Agribusiness
7.	Harry	Tsogana Basadi D.I.C	Finance
8.	Mathole M. G	D.W.A.F	H.R
9.	Selae M. E	Thusalushaka	Volunteer
10.	Rabothata R. G	Thusalushaka	Volunteer
11.	Gwaze E. C	World Vision	Social Worker
12.	Mukoma A. A	Sebelaolo	Principal
13.	Mabala R. J	Sebelaolo	Educator
14.	Mashoma M. C	Sebelaolo	Educator
15.	Ramasedi N. J	Mamaila Tribal	Manager
16.	Ralekgokgo R. M	Sebelaolo	Educator
17.	Gladys M. G	Mmamotlwapele	Project Leader
18.	Christina M.	Mmamotlwapele	Agriculture
19.	Mamolatji T. J	Agang	Drop in Centre
20.	Ramabela T. P	Meyelani Dropin Centre	
21.	Moakola V.	Meyelani Dropin Centre	Co-ordinator
22.	William Masipa	Ward Committee	Agriculture
23.	Sebelemetsi Mondi	Ward 13	Ward Councillor
24.	Sekhomoane R.	Ward 18	Ward Councillor
25.	Ndima Hudson	Ward 13	Ward Committee
26.	Jane Mankabidi	Raphahlelo DIC	Teacher
27.	Kubayi Pauline	Raphahlelo DIC	Co-ordinator
28.	Sampherinyane M. D	Tswika CCC	Treasurer
29.	Raletsemo K.	Ward 15	Committee Member
30.	Satekge – Sebola M.P	Ward 15	Councillor
31.	Mathedimosa M.	Ward 15	P.R Councillor
32.	Lebepe I. M	Khudugane Section	Care Giver
33.	Senyolo M. G	Phooko Dropin Centre	Teacher
34.	Maria Kgabo	World Vision	Manager

Umzimvubu

	Name	Village/Organisation	Contact No
1.	Thozama Magadla	Sijoka	078 2224817
2.	Paula Morai	Qhoboshoaneng	071 9111947
3.	PS Petros Thelejane	Letlapeng	078 8433170
4.	Mamotshabi	Philisani	078 6550199
5.	Liziwe	Ploule	073 1582610
6.	ThapeloRaratsamai	Education Dept	082 0463754
7.	Magengenene V.	Dpt. Of Agriculture	083 4577674

8.	Chief G. K Lebenya	Bakoena T/C	082 8294413
9.	Moretete Makoro	Bakoena T/C	079 8166173
10.	Z.S Dontsa	Dpt. Of Health	083 5996750
11.	N. Gwebindlala	Dpt. Of Health	078 2198051
12.	M. Tsholele	Paballong	072 0241882
13.	R.K Mothoung	Communication SAPS	079 6876000

Mpofu

	Name	Organisation	Position
1.	Sikhumbuzo Ndayi	Dept Of Health	Educator in Traditional circumcision
2.	M. Gqirana	Dept Of Health	Traditional Health Care
3.	X. Mzimzi	Dept Of Health	Traditional Counsellor
4.	N. Xiniwe	CCC	Treasurer
5.	N. Doro	CCC	Organiser
6.	Nomawethu Hina	Ibuyambo YDP	Vice Chairperson
7.	Thembisa Thomas	CCC	End Member
8.	Phumeza Ngwena	Ibuyambo YDP	General Secretary
9.	Lizeka Sicina	World Vision	Manager
10.	Ntombentsha Kakaza	Sive Nathi CBO	Treasurer
11.	Siphokazi Qanqashe	Sive Nathi CBO	Home Visitor
12.	N. V Plaatjie	Seymour Clinic	Operational Manager
13.	N. Macanda	Sive Nathi CBO	Chairperson
14.	V. Maphaqa	World Vision	Homevisitor

Questionnaires completed

The field visits also included visits to the villages where inputs were secured from OVC, guardians, and home visitors. The staff and stakeholders who attended the workshops and staff engagements are also included in the registers. As staff and stakeholder completion of the questionnaires were voluntary the numbers won't correspond with the numbers above.

Total number of questionnaires completed as per respondent category

	Khauhelo	Thaba Nchu	Kodumela	Thusalushaka	Umzimvubu	Mpofu	Total
OVC	21	20	24	20	16	7	**108**
Guardians	49	52	51	48	50	53	**303**
Home Visitors	52	25	45	19	15	10	**166**
Stakeholders	18	10	31	27	8	14	**108**
Staff	7	15	7	9	31	6	**75**
Total	**147**	**122**	**158**	**123**	**120**	**90**	**760**