Technical Notes to Evaluation Report

World Vision Networks of Hope Program

Prepared by

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World Vision: Networks of Hope Program

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Technical notes

Technical Notes is an appendix to the ***Evaluation Report*** (also known as the Main Report) of World Vision's Network of Hope program, South Africa 2006 – 2012. ***Technical Notes*** consists 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 that 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.

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INSTRUMENTS

(provided electronically)

Questionnaire 1: Registration and intervention data on individual OVC

Questionnaire 2: Guardians input on OVC

Questionnaire 3: Home visitor input on OVC

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Questionnaire 5: Home Visitors Response

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SPSS Datasets (provided electronically)

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SECTION 1

OUTPUTS

The interventions[1] by WV and its partners in collaboration with other role players in implementing the objectives of the NOH program include nine categories with 33 possible interventions / outputs as listed below. 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 records of services received over five years (2006 to 2010) were recorded.

1) Clinical Nutritional Support	**1.** Nutritional assessment
	2. Nutritional counselling and education
	3. Recommended Nutritional Intervention
2) Child Protection Interventions	**4.** Facilitated birth registration and ID
	5. Referred for protective services
	6. Succession planning, memory work or Inheritance claims
3) Child Protection Statutory	**7.** Support the proceedings of children's courts and implementation of court orders
	8. Work to prevent separation of sibling, and to preserve the family structure through legal channels
	9. Removal of children from abusive and exploitative situations
4) General Healthcare Referral	**10.** Access to Healthcare Services
	11. Appropriate Clinical Intervention
	12. Follow up and adherence monitoring
	13. Referred for immunizations
	14. Support for TB patients
5) Healthcare Report for access to ART	**15.** ARV Literacy
	16. Access to ART
	17. Adherence Counselling
6) HIV Prevention Education	**18.** Promote abstinence and delay of sexual initiation
	19. Facilitated small groups on life skills
	20. Encourage sexually active youth to know their status
	21. Peer Outreach to youth out of school
7) Psychological Support	**22.** Clinical and psycho-therapy sessions
	23. Clinical support groups
	24. Group therapeutic sessions

[1] Information provided by World Vision SA National Office.

8) Effect of school support on school attendance and advancement	**25.** Assisted with School fee exemption
	26. Provided school uniform, stationery etc
	27. Assisted to vocational training
	28. School readiness assessment
	29. Educational assistance
9) Household Economic strengthening	**30.** Social assistance i.e. grants,
	31. Asset growth and protection i.e. savings, food gardens
	32. Income growth i.e. vocational training, market linkages
	33. Job creation etc

SECTION 2

BACKGROUND INFORMATION ON AREA DEVELOPMENT PROGRAMS

As indicated above WVSA conduct its operations in project sites organised as Area Development Programs (ADPs). The lifespan of an ADP is around a 12 to 15 year period. All the ADPs supported by PEPFAR funding now moves toward the end of the funding period. Although the NOH program content is determined by what PEPFAR supports and use of 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.

Within these parameters individual ADPs do have the flexibility to do its internal planning. In the process of planning, implementation and monitoring a range of documents emerged, some of which have been provided for the purpose of the evaluation by PACT, some by the ADP managers and other again sourced from the internet. From these documents and inputs during the fieldwork it became clear that all of the funded ADPs were already in existence at the commencement of the funding period and that they move towards the end of the funding phase. In the case of e.g. Mpofu and likely others "closing-out" arrangements are already in place, while others may continue for some time as ADP after the termination of the PEPFAR funding period.

Although the broad objectives of the NOH program apply everywhere, the specifics of the program activities may vary. As general guideline of the requirements of the closing phase, the strengthening community capacity to effectively respond to the needs of vulnerable children becomes paramount and thus program staff and stakeholders attempted to embed the project in the community and actions, resources, commitment and buy-in, in order to transfer ownership over to the community.

Staff

WVSA staff operates the NOH project from the WVSA headquarters in Johannesburg and in the six provincial-based ADPs. The ADPs all follow a similar plan as far as the staff provision is concerned. The PEPFAR grant enabled the ADPs to boost its staff and HR provision. It was not clear what positions were consistently being funded by the grant. The large number of home visitors receives stipends that apparently are PEPFAR funded. The Khauhelo and Thusalushaka ADP organograms provide for positions that appear to be almost similar throughout the ADPs regarding the job descriptions, including:

A top structure includes an ADP Manager / Coordinator working with a Committee:

- Although the ADPs are relatively autonomous and can adapt to local needs and conditions, there is a clear reporting line to WVSA. This is probably needed due to the donor dependency and the relations typical in NGO – donor relations, either through PEPFAR or other established partnerships and collaborative relationships as explained above[2].

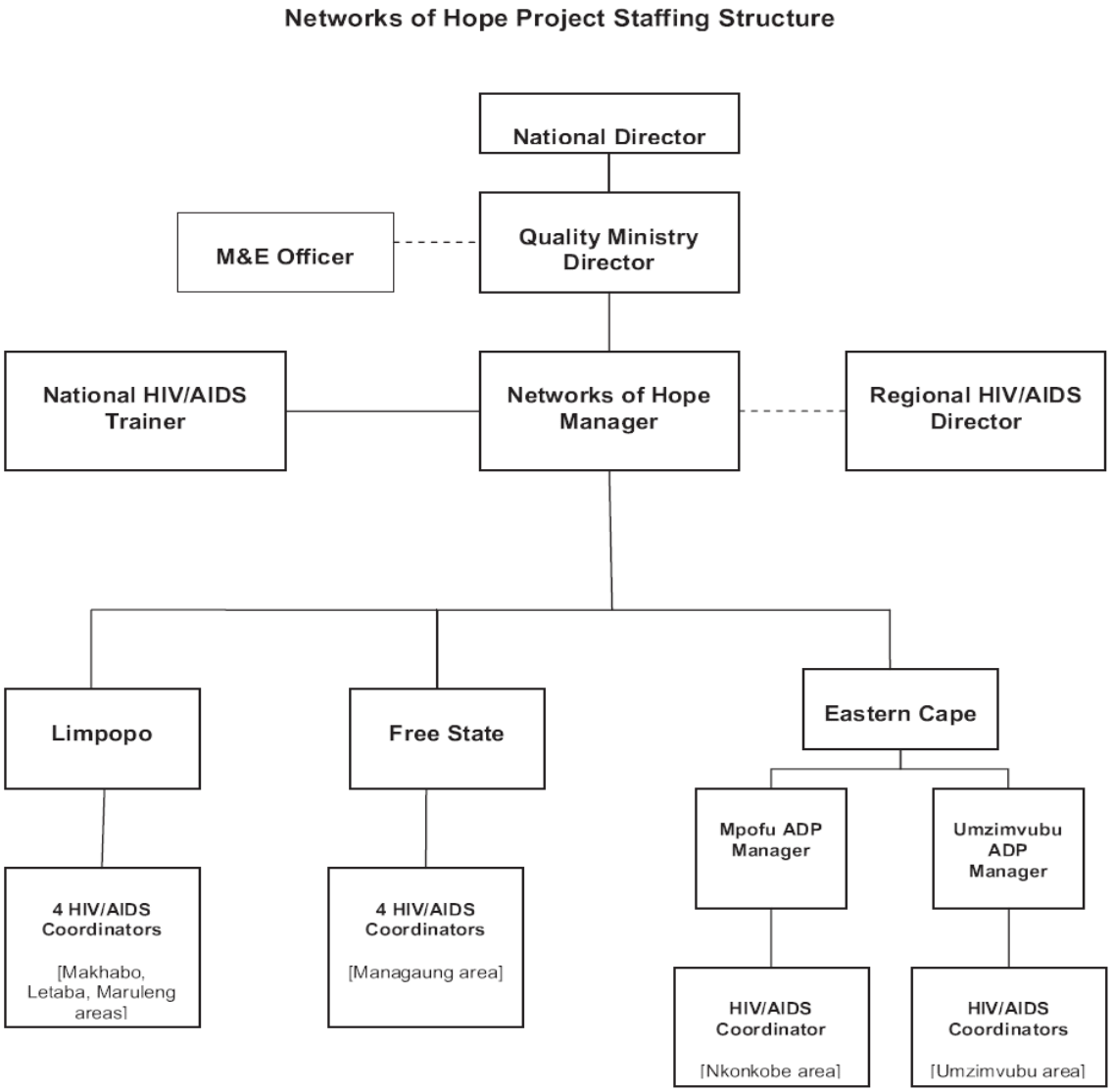


Figure 1: Staffing structure of NOH Program

[2]Maleemisa Ntsala, Beverley Sebastian and Anzel Schonfelt: A Case Study: World Vision South Africa Networks of Hope Project. Prepared by Khulisa Management Services:

A middle management group who with the Manager forms the Current ADP management: They coordinate / lead the rest of the HR component, including:

The staff component (current ADP staff including the new positions of Social Worker and Nurse – where filled)

Community Volunteers and the large number of Home Visitors who currently receives a stipend and is being managed by the ADPs.

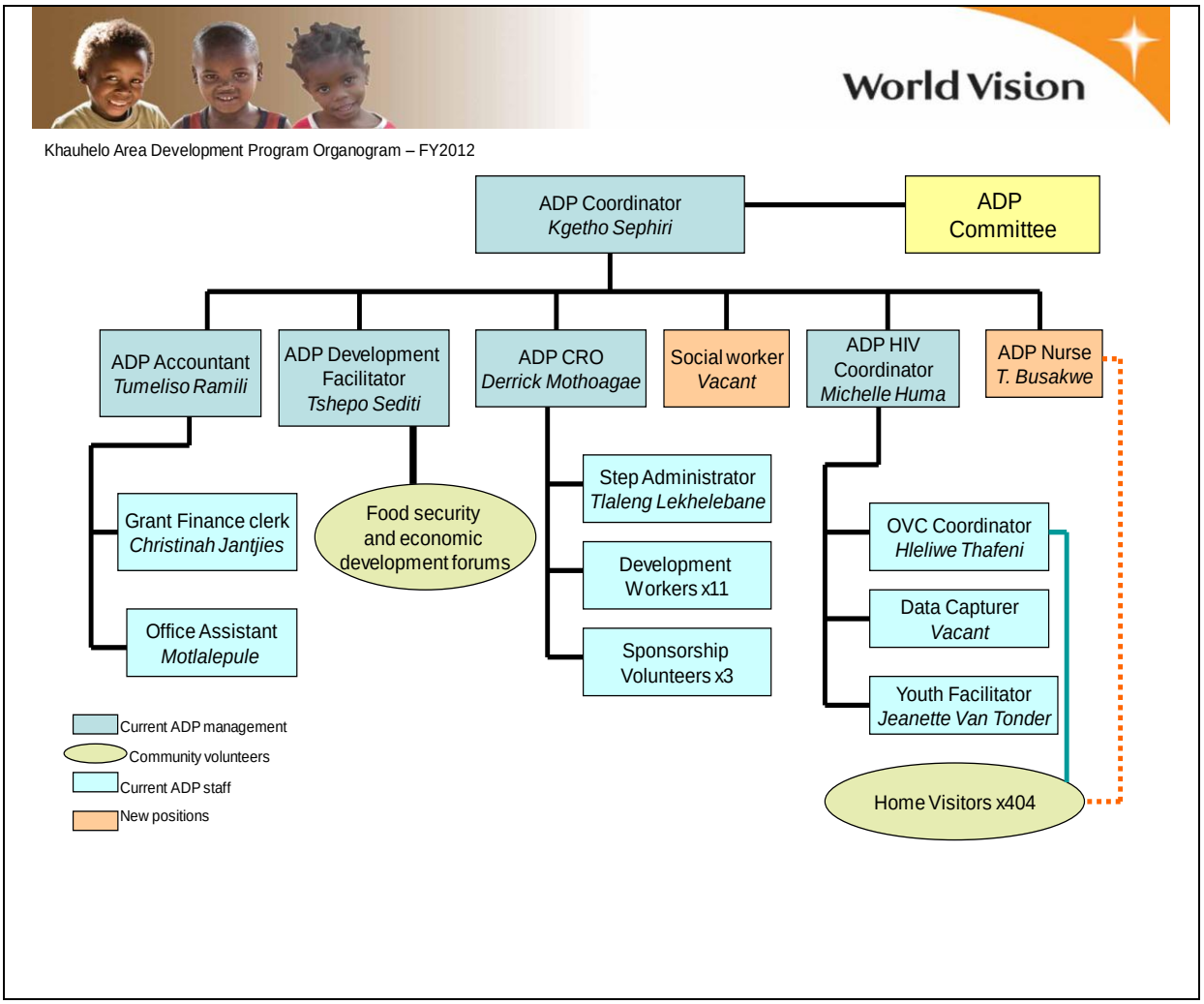


Figure 2: Khauhelo ADP: Typical Staff Structure and Organogram

Volunteers[3] are an essential part of the NOH project. They are nominated by CCCs. Following this, a panel interview is conducted by WVSA ADP staff, community members and occasionally representatives from government departments to determine their suitability. Typically, individuals already caring for OVC or participating in ADP activities are chosen to

[3] Information on volunteers adapted from: Maleemisa Ntsala, Beverley Sebastian and Anzel Schonfeldt: A Case Study: World Vision South Africa Networks of Hope Project. Prepared by Khulisa Management Services

be volunteers. Local teachers, nurses, and community members with an interest in assisting children in their communities are also generally chosen as volunteers. A prerequisite for the position is the ability to read and write, but they are also subjected to a background check before commencing work and are expected to comply with the World Vision child protection policy.

Home visitors are encouraged to provide services to OVC that live in close proximity to them. They are provided with training, mentoring, and psychosocial support to assist them in effectively supporting OVC. Training subject matter includes palliative care, community home-based care, basic and advance HIV and AIDS information, tuberculosis (TB), voluntary counselling and testing (VCT),and psychosocial support.

CCC members are also volunteers consisting of representatives from local government departments, churches, faith-based organisations (FBOs), political leaders, PLWA, and, in some instances, OVC. The NOH project provides training and mentoring to each CCC. Subject matter is based on specific challenges CCCs identify. Generally training comprises topics such as home based care, palliative care, peer support groups, prevention strategies for adolescents, organisational capacity building, M&E systems, data quality and control and assessment of children's needs.

While definitions of volunteers vary slightly[4], most definitions contain three essential elements. Volunteering is done by choice, without monetary reward, and for the benefit of the community. "Without monetary reward" does not exclude the payment of out-of-pocket expenses, which are a reimbursement for actual costs incurred rather than a reward. (In the NOH program home visitors do receive stipends.

Salient features of ADPs

The six ADPs are all housed within the peri-urban and rural areas they serve, although the areas include outlying villages and settlements that have the potential of access difficulties.

The offices are all well equipped as far as work space and equipment is concerned and the staff all have similar laptop computers. Some of the offices and buildings used are in need of maintenance, but not to the extent that it affects detrimentally the work.

- Khauhelo ADP use two offices, one in Bloemfontein (office space in an industrial area) and one in Botshabelo (centrally located in one of the villages). The purpose of having two offices is not clear to the evaluators.
- Thaba Nchu uses prefabricated structures within Thaba Nchu town, though small, apparently adequate for the work.
- Kodumela have office buildings in a village within the ADP.

[4]From Heritage Collections Council © 2000 Commonwealth of Australia on behalf of the Heritage Collections Council

- Thusalushaka also uses prefabricated structures within the ADP area, apparently adequate for the work.
- Umzimvubu ADP is housed in a fairly large former residence in Matatiele that is centrally located in the large area being served.
- Mpofu ADP has functional offices in Seymour, also centrally located in the area being served.
- The ADPs seem adequately provided with vehicles suitable for the rough terrain.

The number of villages being served by the respective ADPs is as follows:

ADP	No of villages
Khauhelo	19
Thaba Nchu	48
Kodumela	11
Thuslalashaka	24
Umzimvubu	34
Mpofu	64
TOTAL	200

Khauhelo Area Development Program

Khauhelo ADP is located in the Mangaung Local Municipality of Motheo District Municipality in the Free State Province. (Mangaung Local Municipality is made up of three towns: Bloemfontein; Botshabelo and ThabaNchu). It is about 59 kilometres from the capital Bloemfontein along N8 to Lesotho at 91km east. It includes 18 peri-urban settlements.

Khauhelo Area Development Program operation started in 1998 as a Community Development Project (CDP) and became an ADP in 2002 and will phase out by WVSA in 2017. It is one of the two ADPs' funded by World Vision Canada in the Free State Province.

The current phase of the Program (FY 2010-2014) is expected to benefit an estimated 70,000 men, women, boys and girls from an overall population of 176000 living in nine of the 18 sections of Botshabelo.

The targets are the poorest of the poor, those without basic means for sustained wellbeing especially for children.

In order to deliver quality services in collaboration with other partners, the ADP aims to continue to build on the lessons learned from their past experiences and from the recommendations of the Participatory Rural Appraisal (PRA), Mid-Term Evaluation (MTE), TDI and the area status quo report by the municipal Integrated Development Plan (IDP), and the Free State Province Agricultural Performance Plan for 2008-2011.

Thaba Nchu Area Development Program

The description below of the Thaba Nchu ADP is adapted from the Design Document, Thaba Nchu Area Development Program, dated March 2011.

Thaba Nchu ADP is part of Mangaung Local Municipality in the Motheo District Municipality within in the Free State Province. (Mangaung Local Municipality is made up of three towns: Bloemfontein; Botshabelo and Thaba Nchu). It is about 68 kilometres from the capital Bloemfontein along N8 to Lesotho and 12km from Botshabelo. The ADP includes the rural and urban villages of Thaba Nchu.

The town has retail shopping facilities, a hotel, casino and cultural amenities. Thaba Nchu was part of the Bophuthatswana Bantustan in the apartheid era. Industrial investment collapsed after 1994, mainly due to difficulties with the transfer of the industrial sites from the Northwest Province to the Free State. There are no major development activities noticeable and many of the buildings are in a state of neglect. There is a high unemployment rate; high prevalence rate of HIV and AIDS, food insecurity affecting households and children and unsafe water from the rivers.

In the rural areas of Thaba Nchu land is owned by traditional authority or individuals; very little is according to the source cited above[5]done to produce food and HIV and AIDS contributed to a high number of orphans and vulnerable children registered under Networks of Hope (NOH) project.

The population of the ADP area is around 120 000 and the target population 30 000.

Kodumela Area Development Program[6]

Kodumela ADP was established in February 2001. The program is operating in 10 villages in the Ga-Sekoro Maruleng local municipality, Mopani district in Limpopo province. The area is 95 Km from Tzaneen. The area of Ga-Sekoro is situated at the bottom of the Drakensberg Mountains, along R36 (Lydenburg road) under the leadership of Chief Sekororo and Chief Letsoalo.

The major part of the area is undulating but rises through foothills into the Drakensberg Mountain range. It is crossed by a number of rivers that are both rain and spring fed. These rivers flow into the Letaba and Olifants Rivers eventually joining the Limpopo River in Mozambique. The latter are perennial while many of the rivers in the ADP are non-perennial.

The population is estimated at 65,000 and the language predominantly spoken is Sepedi. The program targets a population of 35,000 and is currently in the third phase of 15 years lifespan (fy11to fy15)

[5]Design Document, Thaba Nchu Area Development Program, dated March 2011.

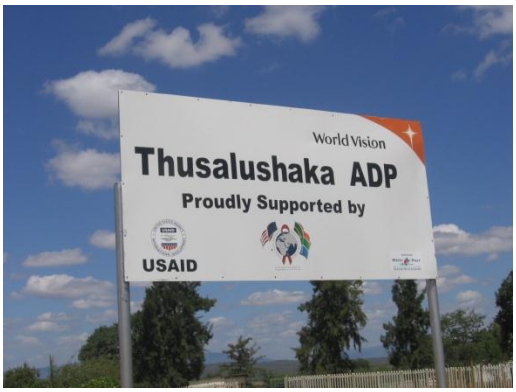
[6]Major sources:

- Kodumela Area Development Program. FY11 Detailed Implementation Plan. PHASE 111: October 2010 – September 2015. June, 2010
- NDA Website (National Development Agency)
- Own observations

Thusalushaka Area Development Program

The World Vision South Africa Ministry Quality and Integrated Ministry Directorates provided their guidance and support throughout the process of the redesign of the ADP in 2010. This report provides good insight into the ADP and its operations. The following points are based on it.

Thusalushaka ADP is a child focused and community based organization which was established in 2000 and transited from Muwaweni Community Project started by Muwaweni Women Care group in 1989.



The ADP is located 54 km South East of Makhado/Louis Trichardt, 83 km South West of Tzaneen and 120 km from Polokwane International Airport. The ADP also located in the subtropical and mountainous area and it is along the Tropic of Capricorn between Louis Trichardt and Modjadjis Kloof. There are three perennial / seasonal rivers namely Tavha River, Nwanndi River and Tshungedzi River.

Nearly 100 per cent of the villages of Thusalushaka ADP are electrified. Only 15% per cent of households have telephones. The rest have access to cell phones but some of the villages have weak signals. The ADP is served by dusty roads which are generally in bad condition.

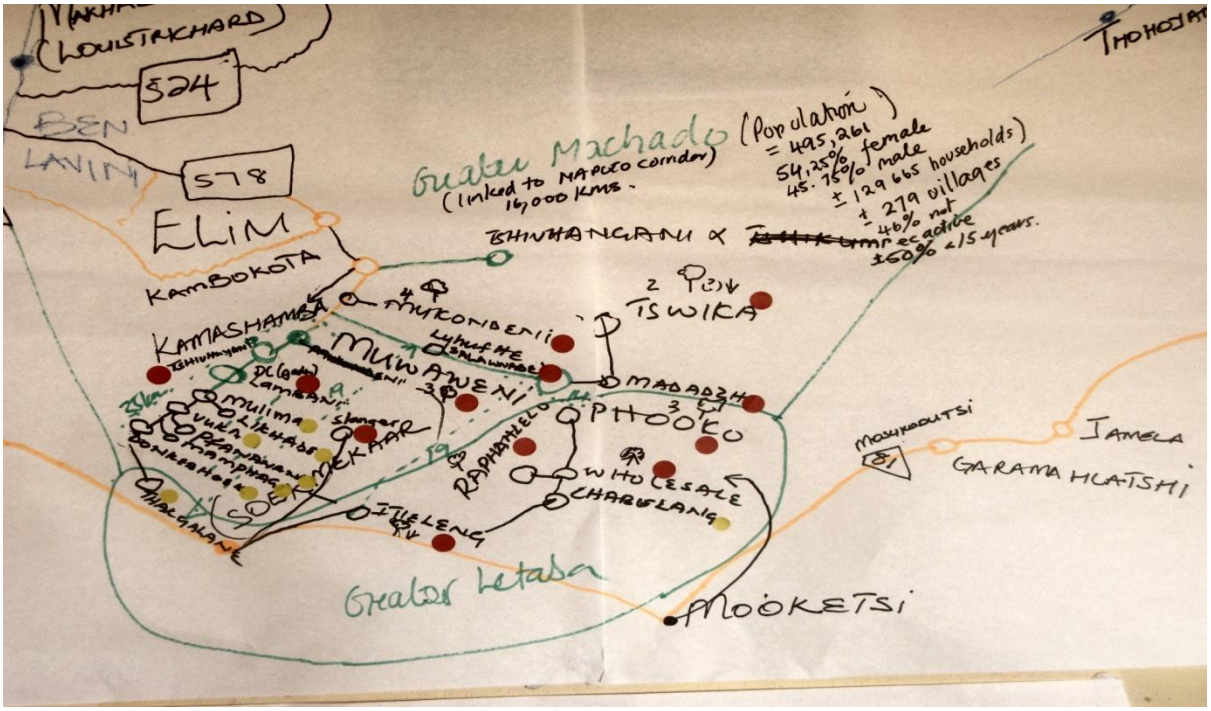
Most of men and women are self employed, buying and selling. Some 8 % of the people are working as groups in small income generating projects.

"*The villages surveyed can be characterized as generally poor and under-resourced in terms of basic service and infrastructure provision. There are high levels of unemployment (84%) and poverty, 88% of households surveyed earning less than R1500 per month and 64% derive their income from social grants. There is also evidence of uneven levels of access to social infrastructure and basic services*[7]*. Access and quality of sanitation in the villages - the maintenance of toilets and provision of rubbish collection and disposal - are viewed as issues in need of urgent attention. While access to land for household and subsistence farming are key development challenges, the non-availability of a consistent level and supply of water for domestic consumption and agricultural production appears to be a more critical challenge facing the villages. The quantitative data highlights the existence of relative diversity across*

[7]*World Vision South Africa. Program Design Document, Thusalushaka Area Development Program. September 2010,*

and between the twelve villages, with larger ones like Wholesale and Raphahlelo that are located closer to tarred roads and therefore more easily accessed, exhibiting signs of growing urbanisation and social distress. The latter is manifested by rising levels of crime, unemployment, and the visible impact of the AIDS pandemic."[8]

Map of Villages within the ADP



"The ADP began its work in 2000 with a big vision and limited resources, meaning that it operated on a shoestring budget, depending then as it still does today, on the commitment and sweat equity of village-based volunteers to implement and increasing levels of donor support to implement its chosen interventions. As a consequence the ADP got involved in many activities during its pioneer years (2001 to 2006), depending on the resources (human, material, infrastructural) of other stakeholders inside and outside of the villages to meet goals and objectives set for the ADP."

Umzimvubu Area Development Program[9]

Umzimvubu ADPis based in Matatiele Local Municipality, which is under the Alfred Nzo District Municipality in the Eastern Cape. The municipality, which covers 7 870 km² has a

[8]*World Vision South Africa. Program Design Document, Thusalushaka Area Development Program. September 2010,*

[9] Primary source: WVSA Annual Report 2009.

population of 392 189 people. Matatiele has a population of 194 628 people whereas the ADP area caters for only about 40 000 people, spread across 32 villages with an average of 176 children per village, and an average of 237 Registered Children per Development worker. Matatiele town is in the far Northern part of the District Municipality that was formerly part of the KwaZulu Natal and was amalgamated into Alfred Nzo in 2005.

Some of the defining characteristics of the area include its geographic location and rural nature and this has resulted in no major development activities undertaken by the municipality. This is evident as there is a high unemployment rate and people in rural villages rely on agriculture and government grants. Even though the area has plenty of land that belongs to either the traditional authority or individual, very little is done to plough the land for food production. This rural area has a high number of orphans and vulnerable children registered to receive assistance from World Vision. Collaboration with government departments and other organizations is mentioned as a very high priority of Umzimvubu ADP to ensure the community benefits from the government initiatives.

The source cited indicated that Umzimvubu ADP is changing the community's mind set of depending on government and hand-outs, to sustainable development. Value based life skills for children and youth are conducted to prevent early sexual engagement that lead to teenage pregnancies and HIV and AIDS infections.

Advocacy was demonstrated by the ADP through the establishment of CCC; not only to support programs on HIV and AIDS issues, but to ensure that orphans have the necessary documents to register for grants. There were many achievements in working together with other stakeholders since the establishment of the ADP in the area. This includes collaboration with the Department of Agriculture (DOA) in establishing vegetable gardens at household and communal level for consumption and sale. The reason mentioned is to ensure that children are well nourished and families have income to send their children to school. Local farmers have also been trained on food security to ensure sustainable production of vegetable using indigenous knowledge and skills acquired though WV training.

The motivation is to encourage lead farmers (who are trained) to assist emerging farmers without WV technical support.

With technical support from the Department of Education (DOE) primary schools toilets were constructed to create an improved health and learning environment. Partnering with DOE was aimed at providing value based life skills for in and out of school children so that they are enabled to make informed life decisions. Pastors and churches also came on-board, establishing a forum that aim to change behaviours and ensure that communities choose Christ first.

Mpofu Area Development Program[10]

Mpofu Area Development Program (ADP) is in a transition stage, the phase out of the ADP is expected in September 2012. The goal of the program is to improve the quality of life for 30 000 men and women, boys and girls in Mpofu area by 2012.

The ADP offices are located in Seymour town.

In order to achieve this goal the ADP in partnership with community agreed on four (4) projects to be established namely: Advocacy, Economic Development and Agriculture, HIV and AIDS and Sponsorship.

The ADP Advocacy project goal is to empower the community to fully address issues affecting the communities and the children so that they are protected and well taken care of. The targeted communities are the 38 clustered villages that the ADP is operating in. The World Vision South Africa Mpofu Area Development Program claims a change in the way communities attended and addressed issues of child protection and that parents are willing of to let their children attend school instead of them marrying and going to work at a very

[10] Primary source: World Vision South Africa. Mpofu Area Development Program. 2nd Semi Annual Report: 1 April 2011 – 30 September 2011

tender age. It also refers to a report from the Nkonkobe Child Youth Forum claiming that an increase in the number of school attendance has led to the two schools within the Nkonkobe Sub district that were closing down to remain opened. It also indicated that the number of children that were sent for seasonal jobs has decreased as compared to the previous years.

The ADP Local Economic Development (LED) and agriculture project intends to increase the efforts for capacitating the local projects towards sustainability. The LED and Agricultural project goal is to improve the economic wellbeing of households in 15 villages in Mpofu area with approximately 16000 people. As the ADP is in transition phase it is focussing on capacitating all the projects that it supports. To ensure that the projects are capacitated ADP conducted a workshop on Crop production and pest control. Forty five (45) people from a new NPO and eight different community projects that were assisted with seeds and seedlings and other two from the previous group that received seeds were trained, 16 males and 29 females were part of the training.

Program activities

The major program activities include Community Mobilization, Capacity Building, Home Visits and Drop-in (Resource) Centres, educational support, Peer education, accessing professional nursing, psychological and social work services and palliative care.[11] These activities are outlined below and linked with the objectives of the OVC program.

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) bringing together churches and other faith communities, government, local business, NGOs, and CBOs and Channels of Hope (COH), designed to specifically mobilise faith communities.

Community Care Coalitions (CCCs)[12] 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.

[11] Case Study of Networks of Hope Project

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

Communities are mobilised to form CCCs, consisting of representatives from local government departments, churches, FBOs, political leaders, PLWA, and, in some instances, OVC. NOH staff organise the formation of the CCC, and membership is secured through volunteering, nomination, and election at community meetings. Once formed and trained, CCCs monitor OVCs' general well-being, advocate for policy changes, and mobilise resources such as food, toys, books, stationery, and clothing, on behalf of children. CCCs focus on meeting the needs of OVC that have been identified through the NOH project.

WV's role is to mobilize these coalitions where necessary, strengthen their technical and general organizational capacities, provide modest amounts of financial and material support, link them to other sources of support, and advocate for more resources to be made available for their work.

The coalition works with World Vision to define criteria for assessing vulnerability within the community. The coalition then takes responsibility for identifying OVC in the community, using these criteria. The coalition recruits home visitors; caring community members committed to visiting the homes of OVC regularly. These home visitors are trained by WV and other partners to enable them to provide essential assistance. The coalition also facilitates access to education, overcoming barriers to primary school attendance (fees, uniforms, supplies, stigma and discrimination, etc.).

It brings together a wide range of stakeholders, enabling them to coordinate their efforts to address the impacts of AIDS and other causes of vulnerability in the community. Each CCC is linked with the District HIV and AIDS Task Force. The range of different people within the CCCs gives the group additional ability to leverage and influence key stakeholdersatlocalanddistrictlevelsthroughintentionalcollaborationandadvocacy.

Channels of Hope (COH), originally developed by the Christian AIDS Bureau on 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 programs within the churches. In so doing they contribute to the overall program goals.

The Channels of Hope model[13] is often seen as the 'entry model' for World Vision's HIV and AIDS projects within the communities where they work, as well as an entry point into program partnerships in communities where World Vision does not currently have a presence.

The following diagram describes the phases of implementation (see Figure 1.1 below):

[13] Brochure on World Vision Channels of Hope Methodology

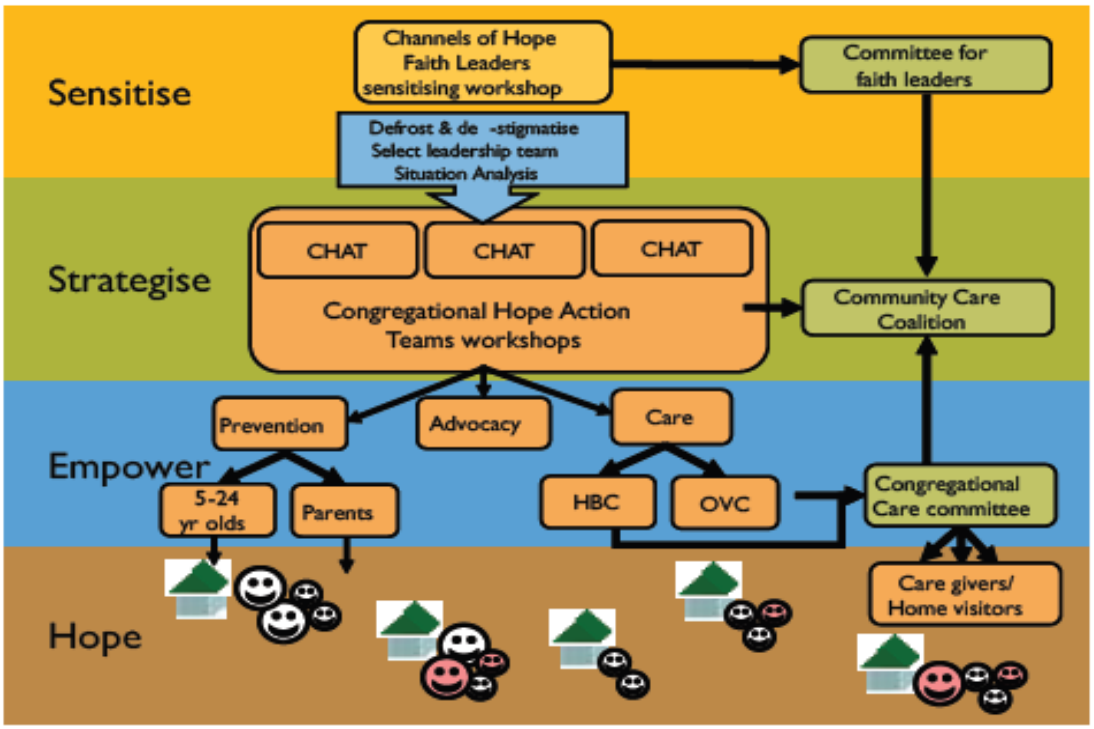


Figure : The Channels of Hope methodology

Phase 1: Sensitise

During this phase, faith leaders from a specific community walkthrough a life-changing, three-day workshop where they are challenged to move towards compassionate involvement with HIV and people living with HIV (PLHIV). During these workshops, participants receive in-depth HIV and AIDS information. Stigma and attitudes are addressed, and participants are introduced to the strategy formation phase, when congregations can develop their own action plans.

Phase 2: Strategise

Once faith leaders have been sensitised and mobilised, World Vision works with churches and faith communities to form Congregational Hope Action Teams (CHATs) within their congregations with the intention of developing implementation.

Phase 3: Empower

Once implementation plans have been developed, the need for additional empowerment is identified, and congregations are linked to other existing training and empowerment possibilities. One common avenue is the training of volunteers within the congregation to be home visitors for orphans and vulnerable children and people living with HIV. These opportunities are typically offered in partnership with the local community care coalition.

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 to care for themselves. 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.

The projects Include[14]:

ADP	Projects	Beneficiaries (if stated)
Khauhelo	110 household gardens	
ThabaNchu	Aganang Community Development	220 beneficiaries
	2 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
Thusalushaka	4 Bakery projects	40 households 160 beneficiaries
	4 Poultry projects	39 households 155 beneficiaries

[14] Information provided by NOH Program Manager

	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	Sinthemba 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
	SivuyiseniPreshool	• 21 members

- Number of beneficiaries not provided.

Training provided at ADP level is another direct form of capacity building.

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. 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 done by PEPFAR approved providers over a period of five days, unless indicated differently[15].

• 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 • 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)	• Early Childhood Development (Two weeks) • Psycho-social support • Financial management • Project management • Proposal writing • Organizational development • Organization self assessment • 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)

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[16].

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

[15] Information provided by Manager of NOH program

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

Educational support[17]

Educational support activities which included provision of school uniform, monitoring school attendance and home work support which was provided through after school clubs.

From WV Quarterly Reporting Forms for 2011 educational support is by far the most common intervention. In the year e.g. more than 22 000 OVC spread across the ADPs received assistance from WV.

The interventions include negotiating about school fee exemption, provision of school uniforms, stationary etc. vocational training, school readiness assessment and general assistance.

Drop-in Centres[18]

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.

Drop-in centres offer OVC a safe environment where they can meet, sing, dance, learn, play with other children and being assisted in the afternoons school. They also provide psychosocial help (via group counselling) and nutritional support through one or more cooked meals a day (generally before and after school). Some centres offer meals seven days a week. Resource centres allow children to learn important skills such as how to use a computer.

Most drop-in centres have vegetable gardens, the produce of which is used to feed the children.

As part of ensuring that OVC have a firm foundation before going into a formal school, WVSA assists with a phonetics literacy and numeracy program in drop-in-centres in the various communities. This program is linked to the ECD programs in schools. Literacy and numeracy program are being extended to more existing drop-in-centres while the existing drop-in-centres are being strengthened and monitored to ensure effective delivery of services.

[17]Summary from WV Quarterly Reporting Forms: 2011

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

Peer education

Program Objective 7 is to promote risk reduction and healthy sexual behaviour amongst young people 10-18 years. This is provided through peer education and youth clubs.

The program focuses on young people 10-18 years. HIV Prevention education is geared towards behaviour change and risk reduction. Peer leaders are being identified by ADP staff and trained by the Centre for the support of Peer Education (CSPE) to facilitate HIV Prevention peer education in schools. Refresher workshops are conducted to strengthen existing peer educators to enable them to continue to effectively deliver HIV prevention peer education. ADP youth facilitators mentor and monitor the peer educators and facilitate provision of needs identified by the youth.

The program expands reach to out- of- school youth by Piloting Vutshilo 1 & Vutshilo 2 life skills program. With five PEPFAR partners, CSPE designed and implemented a structured, curriculum-based 13-session group called *Vhutshilo* (Venda for "Life") in which 16-19 year old peer educators provide opportunity for highly interactive health learning (life skills and HIV prevention) and mutual psychosocial support to 10-13 year old orphans and vulnerable children (OVC)[19].

Professional nursing, psychological and social work services

Objective 5 of the NOH program is to improve OVC access to psychological, healthcare support and access to ART. This requires the inputs from professionals in the related fields.

WVSA seeks assistance of professional psychologists who can train home visitors on how to identify OVC in need of psychological support. Identified OVC are where possible provided with therapeutic psychological assistance with the help of healthcare professionals that World Vision will engage. This has now become the job of newly appointed ADP located social workers and nurses.

WVSA conducts refresher training for home visitors on how to identify OVC in need of healthcare services, train new home visitors and provide refresher training for existing home visitors on effective referral system which includes the home visitor identifying OVC with special needs, refer them to appropriate professionals using a WVSA designed referral form. Follow-up is done on all referrals and to ensure adherence to treatment and to maintain an effective referral filing system.

WVSA also identifies all OVC (0-59 months) not immunized and facilitate immunization in collaboration with Department of Health (DOH). WVSA trains home visitors on ART literacy by healthcare professionals, refers HIV+ OVC eligible to receive ART to a healthcare facility and follows up on ART referral to ensure adherence.

Palliative care

In terms of WV's holistic approach it identified 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.

[19]http://www.hsph.harvard.edu/peereducation/vhutshilo.html

World Vision has expanded its OVC care activities by increasing the coverage, scope, and quality of services to family members of HIV-infected individuals and older OVC. Emphasis areas have been community mobilization, training, and development of linkages and referral systems. The target populations are people living with HIV and AIDS. For this project, the target is to address the needs of primary caregivers of OVC, other community members and older OVC which are not covered by OVC funding. By working with community partnerships through the CCC model, World Vision will enhance their ability to prevent, mitigate and alleviate the impact of HIV and AIDS. Providing care at home and community level is a strategy within the South African Government National Strategic Plan. WVSA Palliative care is aligned with PEPFAR Palliative care guidelines.

Coordination and Collaboration

At ADP level, WVSA is collaborating with Departments of Social Development, Education, Justice and Safety and Security in the promotion of child rights and protection e.g. child trafficking. Through the participation by WVSA staff in key strategic meetings integration is enhanced with the SAG at local, district and provincial level.[20] As an organization that works with Children, WVSA community care givers report any form of abuse identified during weekly home visits to the relevant authorities, WVSA works in collaboration with the Department of Social Development to ensure that when and if needed any child abused is removed and kept in a place of safety and that the abuser is reported, arrested and prosecuted. In addition to this, WVSA creates child protection awareness in various communities where WV operates. WVSA ADPs are affiliates to a number of forums at local level, such as the Department of Social Development's Circles of Support Forum for the protection of Children and the Department of Education's Health Promoting schools programs. These are forums that are based at the local offices and are serving the children in the communities; this is aligned to World Vision's mandate.

OVC without identity documents and birth certificates are linked to Department of Home Affairs (DHA).WVSA is working in collaboration with various government departments in all six PEPFAR funded ADPs at the district level including Department of Social Development for social grants, Department of Health and the Department of Home Affairs for OVC birth certificates and identity documents.

The DHA has been conducting community imbizos where through integrated service provision children and adults get birth certificates and identity documents immediately. WVSA in partnership with the Department of Social Development has been supplying OVC with school uniforms and clothes.

WVSA trained several organisations (mostly funded by DSD) in project management, financial management, organizational capacity assessment, proposal writing, palliative care and HIV and AIDS.

In order to improve the quality of life for OVC, their carers that are involved in projects funded by Departments of Agriculture, Social Development and World Vision have been trained on Crop Production.

Among others, WVSA is represented at the Provincial Steering Committee of Eastern Cape AIDS Council, a body that reports to the Eastern Cape Legislature. Subsequent to that, WVSA is also represented in Provincial Victim Empowerment Forum that is made up of all stakeholders working with victims of violence especially women and children. It reports to the Department of Justice.

[20] We were not able to establish to what extent national strategies are integrated.

WVSA is involved with the District and Provincial Department of Education through a HIV prevention program that is running in local schools and impacting children. Eastern Cape DOE has approached World Vision to conduct HIV prevention in schools in Eastern Cape.

The Department of Environment Affairs and Development undertook a waste removal campaign together with World Vision.

In Limpopo the ADP also work closely with different departments in planning for and service provision to the OVC. The Department of Social Development provides training and support to the ADP staff and the project is monitored by the Department.

Partnerships and Sustainability

WVSA is involved in a number of partnerships at local and national level. In regards to Child Protection, WVSA is currently involved in a short term partnership with the Olive Leaf Foundation and World Hope South Africa on promoting awareness on child rights and child protection, including child trafficking.

The Centre for the Support of Peer Education (CSPE) is currently working with WVSA in the role out of peer education in 18 schools in Limpopo, Free State and Eastern Cape. CSPE trains WVSA youth facilitators, coordinators, peer educators and educators. The youth facilitators act as mentors to the peer educators. Partnership with CSPE has improved WVSA ability to deliver quality and structured peer education program in schools as lessons learnt from best practices are applied.

WVSA is also working with Childline. WVSA refers OVC in need of child protection to Childline; they have also assisted by empowering WVSA staff, volunteers and children on issues of protection e.g. human trafficking, online counselling, and children's rights within the national child protection framework.

Free State is working in partnership with St Nicholas Bana Pele on a referral basis for HIV infected OVC needing treatment. The OVC referred are only reported quarterly by Bana Pele.

WVSA ADPs are supported by World Vision Canada, World Vision US, World Vision UK, World Vision Malaysia and World Vision South Africa, the ADPs provides facilitation for the interventions such as and efforts for sustainable community development.

World Vision Umzimvubu ADP works closely with "That's It program" in conducting awareness campaigns on TB and HIV&AIDS.

World Vision Youth Facilitators work closely with Love Life ground breakers in reaching out of school youth with prevention programs.

In Limpopo drop-in-centres were established with the support of other partners. The partners are McLean Trust (Phedisang), the AIDS Foundation and the Department of Social Development. The AIDS Foundation provides funding for the food gardens, life skills and educational trips for OVC and the Department of Social Development and ABSA in ten Drop In Centres through the ADP. The communities provide sites from where the centres are operating and community members serve in the committee of drop in centres.

SECTION 3

THE KEY CONCEPT OF "TRANSFORMATIONAL DEVELOPMENT"

World Vision's faith position and values are reflected in the Vision, Mission Statement, integrated focus, core values, child well-being aspirations, and whom they serve as inserted in the Text Box below.

Vision

- Our vision for every child, life in all its fullness;
- Our prayer for every heart, the will to make it so.

Mission Statement

- World Vision is an international partnership of Christians whose mission is to follow our Lord and Saviour Jesus Christ in working with the poor and oppressed to promote human transformation, seek justice and bear witness to the good news of the kingdom of God.

Integrated Focus

- We are Christian
- We are child-focused
- We are community-based

Core Values

- We are Christian
- We are committed to the poor
- We value people
- We are stewards
- We are partners
- We are responsive

Child Well-Being Aspirations

- Enjoy good health
- Educated for life
- Cared for, Protected and Participate
- Love God and Neighbours

Serving

- World Vision serves all people regardless of religion, race, ethnicity or gender

The key concept defining World Vision's faith position is "transformational development". At a practical level it helps empower children, families and communities to identify and overcome obstacles that prevent them from living a full life and to enable the people in the communities they serve to enjoy the fullness of life with justice, dignity, peace and hope[21].

[21]Website of World Vision Canada. http://www.worldvision.ca

World Vision partners with communities in providing access to knowledge and resources needed to combat poverty and to improve the well-being of children. It works with communities to facilitate a range of interventions, including programs in health, water and sanitation, education, economic development, microfinance and agriculture among others. World Vision also responds to disasters in affected communities (see footnote 3).

Spiritual well-being is seen as an essential part of the welfare of individuals, communities and nations. World Vision's Christian identity and faith shape their view of the development process. The faith-based (Christian) development perspective has come to be known as *Transformational Development.*

"*Transformational development is the process that helps people to discover their true identity as children of God and to recover their true vocation as faithful and productive stewards of gifts from God for the well-being of all. Transformational development is seeking positive change in the whole of human life materially, socially, and spiritually."*[22]

Chester[23] *adds the following: "Christian development is distinctive because of our commitment to reconciling people to God. However, in the Bible, reconciliation with God cannot be separated from reconciliation with others. Our responsibility to God is expressed through our response to others. This is the wellspring of Christian development."*

Transformational development has a very distinct view of the nature of poverty.

From a Transformational Development perspective poverty is an extremely complex issue and no explanation of it is complete without spiritual, social and material dimensions. The understanding of what causes poverty is very important because it will define one's response to it.

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. The trap means that the poor person live midst conditions that renders him / her powerless. These conditions are:

• Material poverty	Lack of assets and too little income to sustain yourself and your family. Poverty is growing. The poor becomes poorer and the rich even richer. Handouts promote dependency.
• Physical weakness	Large families many children, including aged and disabled. Malnutrition causing poor performance in school and work.
• Isolation	Problem in rural areas and peripheral urban squatter areas and new developments. Far removed from social infrastructure (schools, medical care, employment opportunities). Inferior, unreliable transport.
• Spiritual poverty	Broken relationships with God, fellow man and self. Lack of social capital.

[22] Transformational Development – Christian Response to the Issues of Global Poverty *by S. M.* Summarised from Bryant Myers, Walking with the Poor (Orbis, 1999),

[23] Tim Chester, What Makes Christian Development Christian? May 2002 - presented at Global Connections Relief and Development Forum

- Powerlessness — Lack of influence, lack of social power, exploited by powers. Cheap labour, intimidated, dependency.
- Vulnerability — Lack of reserves, lack of choices, easy to coerce. "living from hand to mouth"

Figure 3 below illustrates the poverty trap as it affects the poor. It suggests a holistic approach to services rendered in communities.

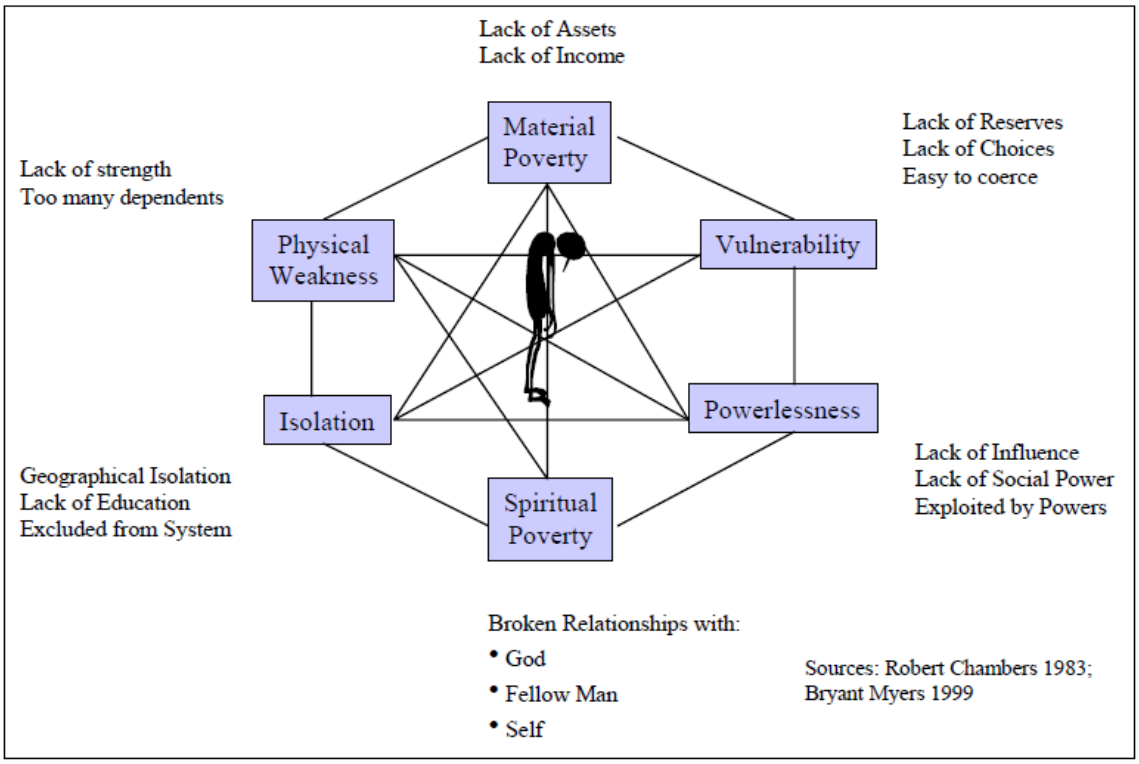


Figure 3: The Poverty Trap

Transformational development at OVC level

The overall purpose of the evaluation is to assess the extent to which NOH program contributed to improved wellbeing and resilience of OVC in the targeted communities. Literature on wellbeing and resilience can thus provide a framework for analysis here, specifically on what should change, how to achieve positive change and improvement in the wellbeing of vulnerable children and how to measure it.

Aspects of wellbeing of OVC are well defined in the Child Status Index[24]as developed with the support from the PEPFAR to Measure Evaluation by Duke University in 2008. Although not used as instrument in this study, it provides a framework for assessing improved wellbeing linked to program interventions. It also

[24]Developed by the support from the U.S. President's Emergency Fund for AIDS Relief through USAID to Measure Evaluation at Duke University. O'Donnell K., Nyangara F., Murphy R., & Nyberg B., 2008

identifies the areas of wellbeing to determine in what way the program made the biggest change. The main areas for improvement or impact are defined as in the box below.

Field	Domain and goal
FOOD AND NUTRITION	**Food Security** Child has sufficient food to eat at all times of the year.
	Nutrition and Growth Child is growing well compared to others of his/her age in the community.
SHELTER AND CARE	**Shelter** Child has stable shelter that is adequate, dry, and safe.
	Care Child has at least one adult (age 18 or over) who provides consistent care, attention, and support.
PROTECTION	**Abuse and Exploitation** Child is safe from any abuse, neglect, or exploitation.
	Legal Protection Child has access to legal protection services as needed.
HEALTH	**Wellness** Child is physically healthy.
	Health Care Services Child can access health care services, including medical treatment when ill and preventive care.
PSYCHOSOCIAL	**Emotional Health** Child is happy and content with a generally positive mood and hopeful outlook.
	Social Behaviour Child is cooperative and enjoys participating in activities with adults and other children.
EDUCATION AND SKILLS TRAINING	**Performance** Child is progressing well in acquiring knowledge and life skills at home, school, job training, or an age-appropriate productive activity.
	Education and Work Child is enrolled and attends school or skills training or is engaged in age-appropriate play, learning activity, or job.

Transformational development at community level

Hennie Swanepoel and Frik de Beer identified basic principles of community development[25]. These principles provide basic values or norms for community development. They also serve as criteria at the evaluation of community development programs, and can be used in the assessment of the NOH Program, that in essence is community development.

[25]Adapted from: Hennie Swanepoel and Frik de Beer: **Community Development: Breaking the Cycle of Poverty.** Fourth Edition. Juta, Lansdowne 2006

World Vision Canada facilitates community development mainly through its ADPs. As a model of community development, ADPs link villages that work together in regional clusters to help address the root causes of poverty. World Vision Canada supports more than 200 ADPs in Africa, Asia, Eastern Europe, the Middle East, Latin America and the Caribbean.

ADPs are child-focused, sustainable development programs for between 15,000 to 100,000 people, divided into smaller community clusters. Generally, World Vision works with communities through ADPs for 10 to 15 years.

The principles (criteria) referred to here is that developed by Swanepoel and De Beer (cited). In somewhat adapted form they are:

1) **Abstract human needs:** People living in poor communities need more than services and money. What is done with or for them should not be detrimental of their human dignity. Dignity can be enhanced by giving recognition, self-reliance and promoting self-sufficiency.
2) **Learning:** There is no teacher other than the circumstances and by doing. Learning must have significance for people's life situation. People must be involved in their own learning.
3) **Participation:** It is the right of people to be part of decision-and implementation at all steps in the development of services or projects. They must be enabled to participate.
4) **Empowerment:** Bring clients into contact with information systems and training opportunities. Empowerment should be fed by information, knowledge and experience that creates confidence in own abilities.
5) **Ownership:** Community development projects are or should become the property of the local NGO, CBO or group.
6) **Release:** Sustainability requires that local people can eventually take responsibility for their own lives. They must be freed of the traps of dependency and be released to run their own projects in order to escape the bond of poverty.
7) **Adaptiveness:** Plans should not be "cast in stone" and be adapted to the local situation.
8) **Simplicity:** In contrast to "bigger is better". Large and complex projects limit scope for learning and participation.

Facilitators, who are usually from the region, are trained to build relationships, help the community to identify needs and possible solutions, provide training to local leaders and encourage networking among civil society and government groups.

SECTION 4

SUSTAINABILITY CONSIDERATIONS AND THE ASSETS APPROACH

Sustainability

Two forms of sustainability should be considered: program as well as personal livelihoods. The two principles of ownership and release (above) support the need for sustainability.

Due to the transitory role of the development agency (in this case World Vision as well as PEPFAR as funder) **sustainability of the program initiatives** and services to OVC after the grant period may be at risk. Generally, World Vision works with communities through ADPs for 10 to 15 years and the readiness to provide continuity is not guaranteed.

A sustainability concept endorsed by World Vision is that of livelihoods at different levels and issued in evaluating data from the evaluation. The Thusalushaka Design Document[26] refers to this concept as applicable to:

- Each member of the small group and community including girls, boys, men and women will benefit as they participate in the program through the receptions of resources to improve their skills, capacities and livelihoods.
- Opportunities for community members to be united in addressing the development issues, lobby and resolve conflicts in their communities.
- The capacity of the community members to improve indecision-making with regards to planning, implementation, monitoring and implementation of development interventions, which will help ensure the community ownership and the sustainability of the program.

The **Sustainable Livelihoods Approach (SLA)**[27]draws on the main factors that affect poor people's livelihoods. The approach is associated with work and income, but integrates with the ways in which the poor and needy most likely will and can use to sustain a livelihood.

The SLA can be used in planning new development projects and in assessing the contribution that existing projects have made to sustaining livelihoods.

The guiding principles of the SLA are:

- *Be people-centered,* by analysing people's livelihoods and how they change over time. The people themselves actively participate throughout the project cycle.

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[26]*Program Design Document, Thusalushaka Area Development Program.* ***September 2010***

[27]IDS Discussion Paper 296.Robert and Gordon R Conway. Sustainable Rural livelihoods: practical concepts for the 21st century. December 1991.

The International Fund for Agricultural Development (IFAD), a specialized agency of the United Nations website http://www.ifad.org/governance/index.htm

- *Be holistic.* Acknowledging that people adopt many strategies to ensure livelihoods and that many role players and stakeholders become involved; for example the private sector, government departments, community-based organizations and NGOs.
- *Be dynamic.* SLA works with existing livelihood strategies, seeks to understand their dynamic nature, what influences them and tries to impact on it.
- *Build on strengths.* As in the SWOT analysis done above SLA builds on people's perceived strengths and opportunities rather than focusing on their problems and needs. It supports existing livelihood strategies.
- *Promote micro-macro links. Linking with* external actors such as local government, Non Governmental Organisations, corporate donors / stakeholders, etc. SLA therefore studies the influence of policies and institutions on livelihood options and highlights the need for policies to be informed by insights from the local level and by the priorities of the poor.
- *Encourage broad partnerships.* SLA encourages broad partnerships drawing on both the public and private sectors.
- *Aim for sustainability.* Sustainability is important as far as the impact of lasting poverty reduction is concerned.

The Asset-Based Community Development approach

John L McKnight and John P Kretzmann[28] challenge the traditional approach, which focuses service providers and funding agencies on the needs and deficiencies of communities. They have demonstrated that community assets are key building blocks in sustainable urban and rural community revitalization efforts.

These community assets include the skills of local residents, the power of local associations, the resources of public, private and non-profit institutions and the physical and economic resources of local places – all relevant to the progress achieved and future sustainability of the developmental initiatives in the ADP areas.

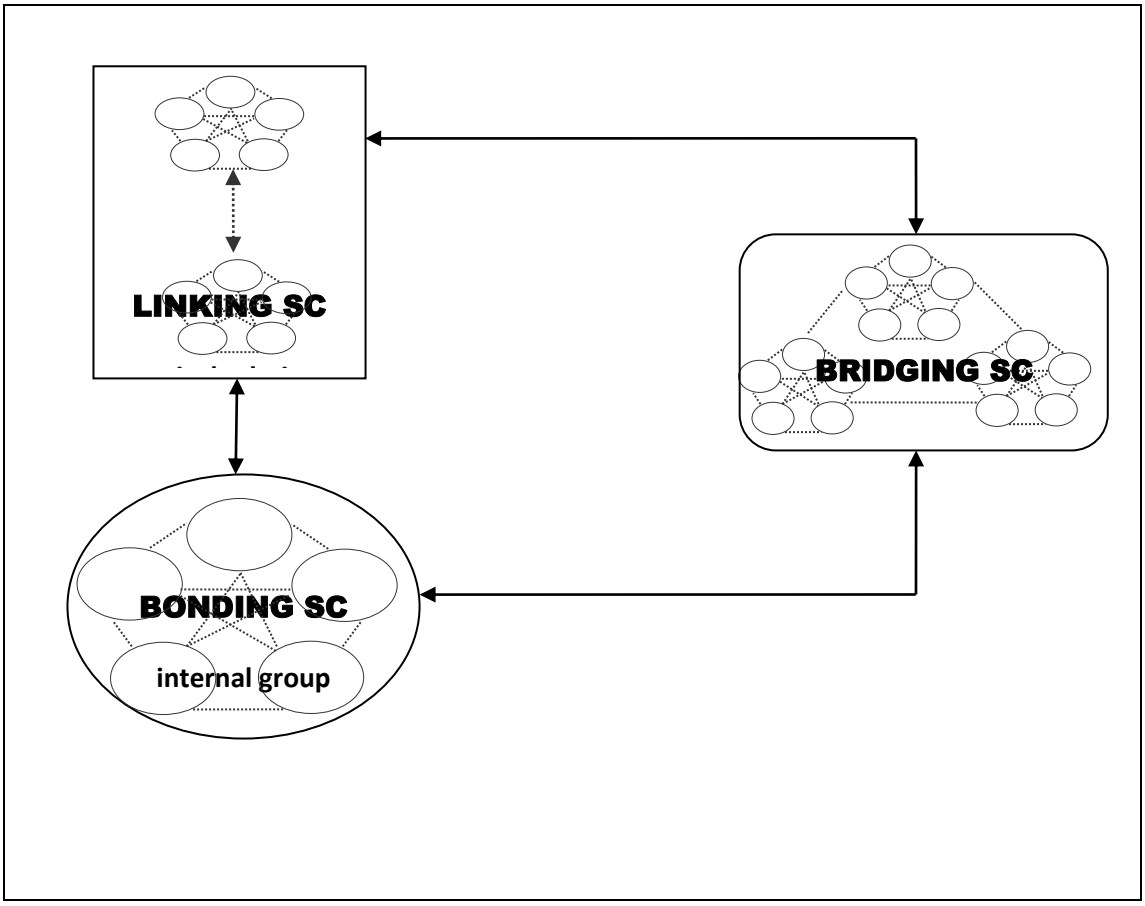
The ABCD approach build networks that refer to the connectedness of people[29] – social capital is therefore often separated into bonding, bridging, and linking capital.

- **Bonding capital** facilitates cohesive relationships and cooperation within a single social group or larger.
- **Bridging capital** brings about cohesive relationships and cooperation between social groups and communities.
- **Linking capital** does the same when a community interacts with external actors such as local government, Non Governmental Organisations, corporate donors / stakeholders, etc.

[28]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)

[29] From presentation by: Anton de Wit on Social Cohesion. Nelson Mandela Metropolitan University , and
Jacobs, Cindy. 2009. The Role of Social capital in the Creation of Sustainable Livelihoods. A Case Study of the Siyazama Community Allotment Gardening Association (SCAGA). Stellenbosch University: Masters Thesis. March 2009.

Figure 4: Three Types of Social Capital (from Jacobs, 2009)



(SC = Social Capital)

SECTION 5

GUIDING QUESTIONS AND INSTRUMENTS

The questions that guide this evaluation are as follows:

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?

Additional questions related to the two main questions specified in the TOR for the evaluation and accommodated in the instruments are grouped in the two text boxes below:

Extending main question 1 on providing care and support to OVC

- **a)** Did the program approach of identifying, referring and monitoring OVC through community-based approaches improve access to care and support of OVC?
- **b)** Has the services provided address the needs of OVC's, as well as those of their caregivers and parents? What successes have been encountered in meeting these needs? What challenges have been encountered? Were lessons documented and shared with other stakeholders?
- **c)** What were the most significant determinants of improved wellbeing linked to program interventions?
- **d)** How has the educational support received from the program improved school attendance and performance?
- **e)** Has the OVC emotional wellbeing improved? Has the program in any way helped to improve self-esteem?
- **f)** Has the program helped in accessing legal protection in case of need?
- **g)** How well did the program address the need for acquiring legal documents; like birth registration or ID?
- **h)** How well has the program facilitated access to services to children which were denied legal status?
- **i)** Has the program helped access to HIV related health care services including ART?

Extending main question 2 on creating an enabling environment and capacity development efforts for sustainable community based care and support program

a) How effective was the strategy employed by the program in working with and strengthening the Home Visitors? How effective was the strategy employed by the program in working with and strengthening the ADP?

b) How useful and adequate has the program's approach been in influencing demand to OVC care and support services in the communities and influencing increased availability and improved quality of services?

c) Did communities draw resources and effectively coordinated service provision for OVC?

d) What process was undertaken to build the capacity of NGOs, CBOs FBOs and service providers to strengthen referrals and respond to OVCs?

e) How do stakeholders perceive the project?

f) In what ways has program staff and stakeholders attempted to embed the project in the community following the end of the project cycle?

g) What factors are required (i.e., actions, resources, commitment, buy-in, etc) in order to transfer ownership over to the community?

h) What are the issues, themes or other topics that have arisen as a result of this program that can be considered for continued funding, or further research?

ROADS designed eight (8) research instruments for data collection and capturing. Their applications are listed below. The instruments (also called questionnaires) are numbered (1 - 8) for easy identification and reference.

Piloting: Questionnaires 2, 3 and 4 were piloted in Mbekweni in Western Cape among 5 - 10 OVC families (with guardians, OVC and home visitors to be involved). The purpose of the piloting was to test comprehensibility of the questions. The questionnaires were only finalized after the piloting.

Language and translation: Professional translations were used for Questionnaires 2, 3 and 4 from English into local ADP languages (Xhosa, Sotho, Pedi, Venda and Tswana).

All questionnaires were available in English and the three above-mentioned questionnaires were available in the relevant local languages.

Linkage into data system: Questionnaires 1 - 3are linked as one data file in the SPSS system, which is the data processing instrument ROADS is using. **The unit of analysis in this case is the OVC** and the sources of information include guardians and home visitors, as well as data extracted from World Vision OVC data files (via Questionnaire 1). Questionnaire 4 (OVC's) can also be linked to the integrated data file as the unit

for analysis is the same. Questionnaires for Home Visitors, Stakeholders and Staff (5- 8) are analysed with reference to the qualifying unit of analysis in each case.

The questionnaires were used as follows in the fieldwork plan:

Questionnaire 1: Registration and intervention data on individual OVC

- As the OVC data are only partially captured by World Vision onto a digital system (Access) and key information for this evaluation is only available in hard copy files, a process of extracting this information were implemented. ROADS constructed Questionnaire 1 to facilitate such a process and requested World Vision to avail ADP staff to extract the required information and capture it onto this questionnaire / form. The form was completed for the 100 sampled OVC per ADP and available at the end of the fieldwork process at each ADP.

  Copies of OVC Registration forms were provided and directly captured on the following data fields where the forms contain the data:

  - General identification: Questionnaire number, Province, ADP Name, ADP Village, OVC number (WV records), OVC Name, OVC Gender, OVC Year of birth / age in years, OVC Home language, Date of registration
  - OVC Health Status: If the child has a Road to Health chart, Illnesses while growing up, Illnesses at time of registration
  - Income and where the household get money (sources of income)

  The questionnaire aimed at capturing information on all the services provided to the OVC from the time of registration to 2010. Nine categories and 33 possible interventions were covered. The categories were:

  - Clinical Nutritional Support
  - Child Protection Interventions
  - Child Protection Statutory
  - General Healthcare Referral
  - Healthcare Report for access to ART
  - HIV Prevention Education
  - Psychological Support
  - Effect of school support on school attendance and advancement
  - Household Economic strengthening

Questionnaire 2: Guardians input on OVC

- The Survey Team met with Guardians (primary caregivers) of sampled OVC at each ADP. Questionnaire 2 formed the basis for the interview with the guardians.
- ADP staff identified the guardians involved (the primary care givers of the sampled OVC) and arranged their invitation and attendance at the respective villages.
- Guardians provided information on the changes that were observed in the well-being profile of the OVC since registration into NoH program and expressed opinion about the effects of the program.

- **The fields covered in the questionnaire included:**
  - General Information on the Guardian
  - Information on the OVC:
    - General Information
    - General Health Information
    - Current Educational Status & History
  - Guardian's general perception on impact of the Networks of Hope Program on the OVC and the household

Questionnaire 3: Home visitor input on OVC

- The Survey Team also met with Home Visitors of sampled OVC and these meetings coincided with the Guardian interviews at the villages. Questionnaire 3 formed the basis for the interview with the Home Visitors.
- As with the Guardians the ADP staff identified the Home Visitors involved (they were home visitors of the sampled OVC) and arranged their invitation and attendance at the villages.
- Home Visitors provided information on the changes that were observed in the well-being profile of the 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.

- **The fields covered in the questionnaire included:**
  - General Information on the home visitor
  - Information on the OVC:
    - General Information
    - General Health Information
    - Current Educational Status & History
  - Home visitor's general perception on impact of the Networks of Hope program on the OVC and household.

Questionnaire 4: Teenage OVC (13-17 years) input on themselves and their own experience of the program

- The Survey Team finally met with two teenage OVC groups that consisted of a smaller selection of the sampled OVC at two villages (one near and one far from each ADP centre) within each ADP. Questionnaire 4 formed the basis for the interview with the teenage OVC.
- ROADS selected the OVC (using their Registration Numbers) that qualify for attending these group interviews and the ADP staff identified the OVC involved and arranged their invitation and attendance at the two respective villages.
- The OVC provided information on their well-being and resilience.
- Interviews were facilitated in a group context, although each OVC completed his/her own questionnaire.

- The fields covered in the questionnaire included:

- General information: gender, age, home language, school grade, grade passed, if not attending school, why?
- Self measuring of experienced wellbeing: 24 statements
- Resilience: 25 statements

Questionnaire 5: Home Visitors Response

- This involved the same logistical arrangements as for Questionnaire 3 as the facilitation of these interviews coincided with those of Questionnaire 4.
- The content of the questionnaire dealt with the benefits Home Visitors gained from being involved in and being trained by the NOH program.
- The fields covered in the questionnaire included:
  - Linking Home Visitor with selected OVC
  - Personal Information of home visitor
  - Aspects related to specialised Home Visitor Training
  - General Questions on Home Visitor duties

Questionnaire 6: Stakeholders

- The Workshop and Projects Team met with the Stakeholder Group normally at the ADP office (or a central meeting facility). Questionnaire 6 formed the basis for the interviews and group discussion with the Stakeholders.
- Stakeholders were identified by the ADP staff as per ADP by making use of a Stakeholder form and grid provided by Pact for this purpose (during the ROADS visit to World Vision and Pact – week 21 - 23 February.
- The names and organizations / interest groups listed were invited to attend and meeting arrangements were made by the ADP staff.
- Each attendant completed an individual questionnaire. The various groups among the Stakeholders then divided into focus groups to discuss themes listed in the Questionnaire.
- The main theme of the Stakeholder meeting was to assess the effect of the NoH program and to assess the community capacity to sustain the initiatives by the program.
- The fields covered in the questionnaire included:
  - Stakeholder / group description
  - Evaluation questions asked to both stakeholders and staff, accommodating the questions extending the two key questions (see text box with 19 items below):
- For group discussion and report back:
  - 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?

Evaluation questions in both stakeholder and staff questionnaire

1) Extent to which NOH program services **address needs of OVC**
2) Extent to which NOH program services address **needs of the guardians/caregivers** of OVC
3) Extent to which NOH services address the needs of the **Home Visitors to assist families** with whom OVC's stays.
4) Educational support received from NOH program **improved school attendance** of OVC
5) Educational support received from NOH program **improved school performance** of OVC
6) **Emotional wellbeing** of OVC improved as result of program
7) Program helped the OVC to improve **self-esteem**
8) Program helps in **accessing legal protection** in case of need
9) How well did the program assist in **acquiring legal documents i.e. birth registration or ID?**
10) How well has the program **facilitated access to services to children who were denied legal status?**
11) Program helped children to **gain access to HIV related health care services and ART**
12) **Any other programs** of the NOH program in your area that focus on wellbeing of OVC (Yes)
13) **How well did the other programs fare** in improving the wellbeing of OVC?
14) Did **strategy employed by the NOH program working with and strengthening the Home Visitor** really work?
15) Did the **strategy of World Vision to strengthen the capacity of the ADP** really work?
16) Has the **demand for OVC care and support services** in the ADP communities grown?
17) Did the ADP **communities effectively cooperate** in the service provision for OVC?
18) Assessment of program in terms of quality, workability, accessibility, providing a serious need, if the community sees the project **as their project**
19) Will the **ADP/World Vision be able to continue with services to OVC after the expiry of the Pepfar funding?**

Questionnaires 7 and 8: ADP staff and management

- The Workshop and Projects Team met with the Staff and Management as a group at the ADP centre (or a central meeting facility) of each selected ADP. Questionnaire 7 forms the basis for the interviews and group discussion with the staff and management.
- All staff members were informed and invited to this meeting by the World Vision contact person but at most of the ADPs only the manager and key staff members attended.
- The NOH program was assessed by the questions for individual completion and general discussion followed using items listed in Questionnaire 8. The questionnaire only guided the discussion, which turned out to be fairly open with varying participation of staff members, despite the fact that the managers provided most of the responses.
- The fields covered in questionnaire 7 included:

- Staff member's profile
- Evaluation questions asked to both stakeholders and staff, accommodating the questions extending the two key questions (see text box with 19 items above):

- For group discussion:
  Items listed in questionnaire 8 include:
  - ADP Staff
  - Management
  - Home Visitors / Community care workers
  - Drop in centres
  - Channels of Hope (COH) applied in ADP
  - Community Care Coalitions
  - Cooperation with schools
  - Cooperation with healthcare facilities and services
  - Peer education, educators and youth facilitators
  - Youth clubs
  - Psychological and psychotherapy services
  - Nursing services
  - Social work services

SECTION 6

SAMPLING

The sampling procedure for selecting a representative sample of OVC as unit of analysis agreed upon with World Vision and Pact, materialized, but not without some difficulty to locate the right people locally. The 600 OVC selected through a staged process eventually worked well, despite deficiencies in the local data on OVC on the ADP database.

World Vision's help in the fieldwork process was of great value. It made the very short visit to the various ADPs much easier, however there were some minor issues of concern which were only realized in the field. The researchers are not sure to what extent the invitation from World Vision to the Guardians had an influence on their responses to the questions. Even though it was explained and reiterated that the information gathered was confidential and that it would not be discussed per individual child, we cannot be sure how the writing of the individual child's name (on the questionnaires) had affected the responses from both the guardians and the home visitors.

The sample was composed as follows: 100 OVC per ADP (six in total) consisting of four groups of 25 each representing four villages per ADP, of which two are close to the ADP centre and two are 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 18 months or longer (i.e. OVC on the data base from October 2010 or earlier). The sample frame information was received on Friday evening 02.03.2012 from World Vision and the following steps were followed:

Selected 100 (25 x 4) OVC per ADP (plus reserve sample of 40 (10 x 4) OVC) from the data base.

Selected 4 villages (or village groups); with 2 near and 2 far from ADP centre. Villages were selected randomly from lists after securing accessibility within limited two days for fieldwork per ADP. The names and distances of the villages were provided by World Vision on 02.03.2012. The rationale behind the near / far selection of villages was to exclude bias that may result from accessibility to the ADP office. See Table 1: Languages of and distance from selected villages in ADPs.

25 OVC were selected randomly from each village (village group), plus a reserve sample, also sampled randomly of 10 per village (village group). In those instances where reserve cases were selected due to non availability of OVC on the primary list(e.g. OVC sick, absent, etc.), these were taken from the top of the list as per village. Sample lists constructed by ROADS researchers, were distributed to World Vision contact personnel for making arrangements at ADP level for the various meetings with guardians, home visitors and OVC.

Identification of OVC was done by means of the registration number of the OVC as allocated by ADP staff. Names were however secured for effective communication during fieldwork and to ensure the correct matching of the data from the 5 sources. . It is important to clearly state her that the names of OVC have no value to the research team beyond the mentioned reasons and we certainly won't divulge the names of individual OVC at any stage. The fieldwork team at all the ADPs also signed a child protection protocol used by World Vision for visitors.

Home visitors and guardians (primary care givers) interviewed were those attached to the selected OVC.

Table 1: Languages of and distance from selected villages in ADPs

Province	ADP	Village	Language	Km from ADP
Limpopo	Kodumela	Metz	Sepedi	4
		Turkey 3	Sepedi	6
		Enable	Sepedi	12
		Worcester	Sepedi	15
	Thusalushaka	Chabelang	Venda and Sepedi	4
		Muwaweni	Venda and Sepedi	17
		Pfananani	Venda and Sepedi	35
		Donkerhoek	Venda and Sepedi	40
Free State	Khauhelo	Section A	Sesotho	2
		Section N	Sesotho	5
		Section D	Sesotho	5
		Section K	Sesotho	9
	ThabaNchu	Ratua	Setswana	8
		Tabale	Setswana	15
		Nogaspost	Setswana	31
		Klipfontein	Setswana	48
Eastern Cape	Umzimvubu	Liqalabeng	Xhosa and Sesotho	90
		Sijoka	Xhosa and Sesotho	12
		Mechechaneng	Xhosa and Sesotho	115
		Mahlabatheng	Xhosa and Sesotho	155
	Mpofu	Fairburn	Xhosa	8
		Balfour	Xhosa	25
		Binfield	Xhosa	74
		Melani	Xhosa	81

Table 2: Respondents in sample on OVC

Province	ADP	Village	Questionnaire 1	Questionnaire 2	Questionnaire 3	Questionnaire 4	Questionnaire 5
Limpopo	Kodumela	Metz	22	25	25	13	16
		Turkey 3	25	25	25	*	6
		Enable	24	25	25	11	14
		Worcester	23	23	25	*	9
Limpopo	**Kodumela**	**Totals**	**94**	**98**	**100**	**24**	**45**
Limpopo	Thusalushaka	Chabelang	24	25	25	11	5
		Muwaweni	23	25	25	*	6
		Pfananani	12	27	27	9	8
		Donkerhoek	18	25	25	*	5
Limpopo	**Thusalushaka**	**Totals**	**77**	**102**	**102**	**20**	**24**
Free State	Khauhelo	Section A	24	27	25	11	10
		Section N	23	25	25	*	16
		Section D	20	25	25	10	13
		Section K	17	25	25	*	13
Free State	**Khauhelo**	**Totals**	**84**	**102**	**100**	**21**	**52**
Free State	ThabaNchu	Ratua	24	25	25	10	15
		Tabale	23	25	25	*	3
		Nogaspost	25	25	25	10	3
		Klipfontein	25	25	25	*	4
Free State	**ThabaNchu**	**Totals**	**97**	**100**	**100**	**20**	**25**
Eastern Cape	Umzimvubu	Liqalabeng	25	25	25	8	2
		Sijoka	25	25	25	0	6
		Mechachaneng	25	25	25	8	4
		Mahlabatheng	25	25	25	0	3
Eastern Cape	**Umzimvubu**	**Totals**	**100**	**100**	**100**	**16**	**15**

Eastern Cape	Mpofu	Fairburn	24	27	**26**	*	4
		Balfour	24	25	25	3	3
		Binfield	24	24	24	*	2
		Melani	27	27	28	4	1
Eastern Cape	**Mpofu**	**Totals**	**99**	**108**	**108**	**7**	**10**
		Questionnaire	**Questionnaire 1**	**Questionnaire 2**	**Questionnaire 3**	**Questionnaire 4**	**Questionnaire 5**
		Grand Totals	**551**	**605**	**605**	**108**	**171**

** Area not selected for OVC interviews (Questionnaire 4)*

Stakeholders at ADP level

- In addition, stakeholder lists were composed by ADP staff 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.

ADP staff and management

- All 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.

Table 3: Respondents: stakeholders and staff

ADP	Stakeholders	Staff and management
Khauhelo	**18**	**7**
ThabaNchu	**10**	**15**
Kodumela	**31**	**7**
Thusalushaka	**27**	**9**
Umzimvubu	**14**	**6**
Mpofu	**8**	**31**
Total	**108**	**75**

Numbers: those who completed the questionnaires

SECTION 7

DATA COLLECTION TECHNIQUES

The Fieldwork Plan as explained in the Front-end report was followed as a guideline of dates and times as well as appointments with the various individuals and groups at ADP level. The research instruments presented in the previous section were intended to guide the contents and substance of the meetings and to ensure that the desired outcomes for the evaluation were achieved.

World Vision earmarked a contact person for facilitating logistic arrangements at ADP level and sites. In most cases this task was delegated to the local ADP managers and through them to staff. ROADS, however, took responsibility for its own logistics regarding transport, accommodation, questionnaire stocks, administration of money (involving local field assistants, transport and food expenses), communication and the like.

Due to the lack of sufficient information on local conditions at the time of planning we have underestimated distances and real numbers of respondents and eventually also cost. The dates of visits, however, realized as planned:

Free State	12-13 March	ADP 1	Khauhelo
	15-16 March	ADP 2	Thaba Nchu
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

Wednesdays between visits (14, 21 and 28 March) as well as the two weekends Saturdays and Sundays (17/18 and 24/25 March) were used for wrapping up outstanding business at a visited ADP and travelling to a next ADP.

Typical schedule for visit by ROADS at each ADP

A meeting was held on the day before commencing at each ADP. These meetings were held at the ADP office with the primary objective of selecting and orientate local field assistants – 4 to 5 per ADP. World Vision kindly agreed to do the selection on our behalf for Umzimvubu and Mpofu due to time needed for travelling to the two Eastern Cape ADPs

We have requested the assistance with the recruitment of the field assistants for each ADP and have communicated a guideline of the profiles we had in mind of such persons which included a good grasp of the English language, at least a Grade 12 qualification, the local languages (for translation purposes) and experience in fieldwork (Census, etc.) the most important criteria. The fieldwork team eventually settled

with the best of the available applicants, some with some tertiary training and previous fieldwork exposure. They were all given a brief orientation for the work. Despite this problems were encountered such as –

- In most cases the field assistants did not have a good grasp of the English language.
- In some cases we did not get assistants with a good academic background. *(In some cases no Grade 12)*
- In most cases the assistants did not have any research experience.

Before commencing with the fieldwork a meeting was held between the ROADS team and ADP management and staff team.

It should be noted that we divided the work between two field work teams:

- Survey team: Caroline Poole with 2 – 3 local assistants and a staff member of the ADP to provide directions. Frans Kotze and Zuki Dikeni also joined the survey team on day 2 of the fieldwork at each ADP.
- Workshop and project team: Pieter Cloete, Frans Kotze and Zuki Dikeni with 1 – 2 local assistants on day 1 of the fieldwork, with Pieter Cloete on day two visiting projects and following up on stakeholders and other unfinished aspects on day two.

It should also be noted with thanks to the ADP offices that the registration forms of OVCs as well as information as specified on Questionnaire 1 (Registration and intervention data on individual OVC) was recorded and provided by the ADP staff before our departure.

Day 1 at each ADP:

Survey team:

At two selected villages, morning and afternoon sessions (the two villages further away from the ADP office):

- Securing inputs from guardians (primary caregivers) on the selected individual 25 OVC in each of two villages, using Questionnaire 2 (Guardians input on OVC)
- Securing inputs from Home Visitors on the selected individual 25 OVC in each of two villages, using Questionnaire 3 (Home Visitor input on OVC)
- Securing inputs from Home Visitors of the selected individual 25 OVC in each of two villages, using Questionnaire 5 (Home Visitor input on own situation)
- Focus group with between 3 and 10 teenager OVC at one of the villages using Questionnaire 4 (OVC response on self).) (In some cases the OVC ages did not match the actual OVCs. The ADP datasets would indicate that the children are between the ages of 13 and 17 year, but upon calling out the OVCs we would realise that the OVCs were much younger than the age reflected in the dataset).

Workshop and project team:

- **Morning:** At ADP office or arranged venue secure input from invited individual stakeholders, using Questionnaire 6 (Stakeholder interviews) followed by a workshop securing group discussion and input from stakeholders attending.

- **Afternoon:** At ADP office or arranged venue secure input from invited individual staff and management, using Questionnaire 7 (Guideline for interview with staff, including management) followed by an open discussion based on a range of items listed on Questionnaire 8 (Guideline for discussion with management of the ADP) securing group discussion and input from staff attending followed by individual follow-up with ADP manager on information needed from ADP records. The representation in these meetings normally included all key staff members.

Day 2 at each ADP:

Survey team:

- Day one program replicated in two more villages closer to the ADP

Workshop and project team:

- Pieter Cloete on day two visiting projects and follow-up on stakeholders who did not attend the workshop, and attend to other unfinished aspects

SECTION 8

OVC AND GUARDIAN PROFILES

OVC profile

Why has the child become an OVC? Reasons according to OVC criteria for being registered as OVC are listed in the Table 00. In some cases more than one reason was noted.

Table 4: Reasons why child has been defined as OVC

Reason for being defined as OVC[a]		Responses		Percent of Cases
		N	Percent	
	Reason for OVC status: Loss of mother	99	16.1%	17.6%
	Reason for OVC status: Loss of father	161	26.2%	28.7%
	Reason for OVC status: Loss of both parents	84	13.7%	15.0%
	Reason for OVC status: Grandparent the caregiver	88	14.3%	15.7%
	Reason for OVC status: Head of household	42	6.8%	7.5%
	Reason for OVC status: Chronically ill parent	53	8.6%	9.4%
	Reason for OVC status: HIV+ parent(s)	26	4.2%	4.6%
	Reason for OVC status: Child is HIV+	3	.5%	.5%
	Reason for OVC status: Does not have a home	7	1.1%	1.2%
	Reason for OVC status: Made vulnerable by HIV/AIDS	51	8.3%	9.1%
Total		614	100.0%	109.4%

a. Dichotomy group tabulated at value 1.

Information is available on 601 OVC (1 OVC missing in this table). In 13 cases double counting prevails. For example, in the reason Loss of Mother, two Loss of Father were included; and the same for Loss of Father. In cases Head of Household (i.e. where the child is the head), three Loss of Mother were included; and also three Loss of Father. In cases Grandparent the Caregiver, two 2 Chronically Ill Parents, three Parents HIV+, and three Child Made Vulnerable by HIV/AIDS were included.

After having clarified the double counts, it is clear that most OVC qualified due to having lost one or both parents (56%). Another 6.8% indicate that the OVC is the Head of Household.

In the cases Child Head of Household (42), 22 are males and 20 are females. In three cases where there was Loss of Mother, one (double count with Child Head of Household) is male and two are female. The same numbers are found for three cases where there was Loss of Father.

When the distribution of the reasons for becoming an OVC is compared for the six ADPs, significant differences are observed. For example, for Umzimvubu, 81.3% (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 71.3%. In the case of ThabaNchu, 21.3% (compared to 6.8% generally) of the OVC are defined as Head of Household.

With respect to OVC social, demographic and economic profile, it seems to make sense to use ADP as a classification variable for the data. For instance, OVC home language clearly 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. These differences are statistically significant ($\chi^2 = 1207.683;\ df\ 25;\ p = .000$).

The average age of OVC differs only with respect to Mpofu that shows the youngest mean age of all the ADPs (see Table 00). The mean age of 9.66 years is significantly lower than the mean ages in Khauhelo (12.39), Kodumela (12.41), and Umzimvubu (11.97).

In order to perform various and relevant analyses, the data allow different configurations according to age. Three formats are used for socio-demographic analysis; the first is according to age categories used in World Vision and USAID reporting systems. The second classification makes use of applicable ages that fit the school grade system. This is particularly useful to gauge to what extent OVC ages are on par with the grades in school. The third classification is according to universal demographic 5-year age cohorts; it is also useful to compare local statistics with national populations when required. Below the WV grading system is first applied and then the demographic age categories.

Table 5: Age of OVC according to ADP (Descriptive statistics)

Q2	Mean	N	Std. Deviation
Khauhelo	12.39	97	3.442
ThabaNchu	11.22	94	3.719
Kodumela	12.41	93	3.261
Thusalushaka	11.16	97	3.812
Umzimbuvu	11.97	98	3.640
Mpofu	9.66	90	3.712
Total	11.49	569	3.708

The age cohorts according to World Vision's reporting system are used to give the age distributions per ADP. 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 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. These differences are statistically significant

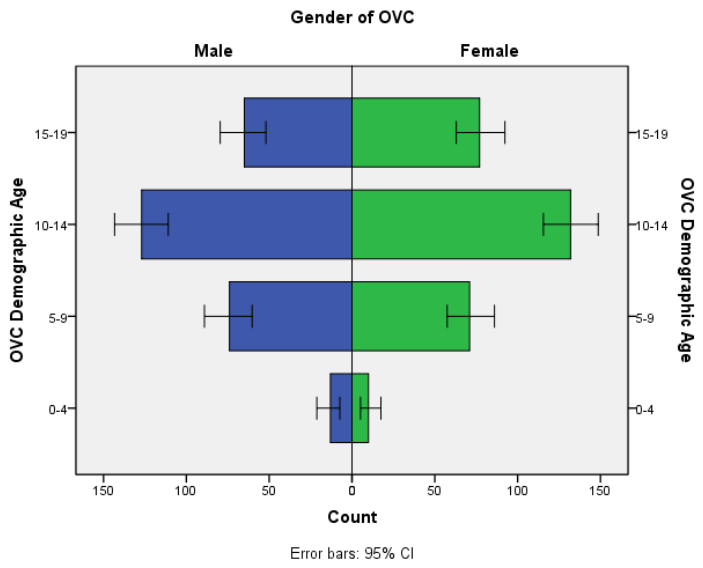
Table 6: Age of OVC according to ADP Crosstab

WV Age categories for OVC			ADP office						Total
			Khauhelo	ThabaNchu	Kodumela	Thusalushaka	Umzimbuvu	Mpofu	
	2-4 years	Count	1	3	1	5	4	9	23
		% within Q2	1.0%	3.2%	1.1%	5.2%	4.1%	10.0%	4.0%
	5-11 years	Count	35	48	31	44	37	48	243
		% within Q2	36.1%	51.1%	33.3%	45.4%	37.8%	53.3%	42.7%
	12-17 years	Count	59	42	61	47	56	33	298
		% within Q2	60.8%	44.7%	65.6%	48.5%	57.1%	36.7%	52.4%
	18-19 years	Count	2	1	0	1	1	0	5
		% within Q2	2.1%	1.1%	.0%	1.0%	1.0%	.0%	.9%
Total		Count	97	94	93	97	98	90	569
		% within Q2	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

$\chi^2 = 33.795$; df 15; p = .000

Table 7: Age and gender profile of OVC

	Gender of OVC		Total
	Male	Female	
Count: 0-4 years	13	10	23
% within Gender of OVC	4.7%	3.4%	4.0%
Count: 5-9 years	120	123	243
% within Gender of OVC	43.0%	42.4%	42.7%
Count: 10-14 years	145	153	298
% within Gender of OVC	52.0%	52.8%	52.4%
Count: 15-19 years	1	4	5
% within Gender of OVC	.4%	1.4%	.9%
Count	279	290	569
% within Gender of OVC	100.0%	100.0%	100.0%



In the table left the gender distribution is introduced for the demographic age categories. This distribution is graphically represented in the partial population pyramid. The female population is marginally larger that 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 actual school grade of the OVC shows that there is a serious scholastic back-log among the OVC. For example, for children that are supposed to be in grade 8 or 9, 31.7% (based on n=111) of the sample is actually in a lower grade. For the OVC that are supposed to be in grade 10 or 11 this percentage is 49.3% (based on n=83). For grade 12 the n-base is too small to provide a percentage but it is worth noting that 4 out the 5 cases are not in grade 12.

Guardian profile

When looking at the OVC primary caregivers, or guardians as we prefer to call them in this report, one finds that they are overwhelmingly female persons (86.6%) and mostly in the middle ages of the family life cycle (35-54 years) – 50.8%. The age range is extremely wide, from 19 to 104.

In ADPs of Thusalushaka (64.8%) and Kodumela (60.9%) 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 46.6% of the cases of guardians they are the biological parents of the OVC and in 31.9% 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 90.1% some form of state grant or pension (52.7% 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 40.5%, and Kudomela 31.5%, of OVC households not having resources. Land or fields for cash cropping are not readily available (in general only 13.5% 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 Kudomela than other ADPs. The Eastern Cape ADPs (Umzimvubu and Mpofu) have more livestock than other provinces and ADPs.

Table 8: Number of meals eaten per day according to ADP

Meals per day			ADP Office						Total
			Khauhelo	ThabaNchu	Kodumela	Thusalushaka	Umzimbuvu	Mpofu	
	1-2 meals	Count	15	40	46	22	7	47	177
		% within Q2	14.7%	40.0%	46.9%	22.2%	7.1%	46.1%	29.5%
	3 meals	Count	85	58	52	76	89	55	415
		% within Q2	83.3%	58.0%	53.1%	76.8%	90.8%	53.9%	69.3%
	4 or more meals	Count	2	2	0	1	2	0	7
		% within Q2	2.0%	2.0%	.0%	1.0%	2.0%	.0%	1.2%
Total		Count	102	100	98	99	98	102	599
		% within Q2	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

$\chi^2 = 72.646$; df 10; p = .000

The Table above shows that the majority of OVC households have three meals per day. The ADPs of Khauhelo, Thusalushaka and Umzimvubu have even bigger majority percentages. It seems that ThabaNchu, Kodumela and Mpufu struggle more than other ADPs to put food on the table as they have larger than average percentages of households offering only one to two meals a day.

SECTION 9

THE INTERVENTIONS BY THE NOH PROGRAM

Home visitors

As explained in the program outline (Chapter 1) 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.

According to a previous study[30], on average, each home visitor oversees nine to ten OVC. In our survey 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 OVC may have an aggravating effect of 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 that only 60.9% of guardians were prepared to declare that this was happening. Furthermore, guardians indicate that 24% visit OVC more than once a month, 12% only once a month and 3.2% less than a month. The overwhelming majority of guardians (82.5%) found home visitors 'very helpful'; other indicate them 'somewhat helpful' (13.5%) and only a few (4%) think home visitors are not helpful at all.

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, which imply that 93.2% are 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 in the 30 to 44 years cohort.

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

They speak the language of the people of the ADPs due to the fact that they are nominated from out of 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 three-quarters of the home visitors have been employed in the NOH program for 4 years or less; 7.7% for less than a year. The rest, nearly one-quarter, is in service for 5 or 6 years and a few for up to 12 years. The duration of employment as home visitor within the ADPs varies significantly. In Umzimvubu the mean years of employment is 1.3, and in Khauhelo 4.5. The other ADPs vary between 3.2 (Kodumelo) and 4.1 years (Thusalushaka). Fifty percent 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 (verbatim):

- 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 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 (85,81%) (n=127), followed by Monitoring and Evaluation training (64, 86% - n=96). 65 Home visitors indicated that they received HIV/AIDS Training (43.92%), with 43 (29.05%) home visitors indicating that they received 'Care of Carers' training from World Vision.

Interesting to note is that only two home visitors indicated that they received training on being a home visitor from World Vision. 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.

Summary of training received by Home visitors is reflected in the Table below.

Table 9: Training received by home visitors sampled in the evaluation

Training received	Frequency	% of total # HVs
Pallative Care	127	85.81
Monitoring and Evaluation	96	64.86
HIV Training	65	43.92
Care of Carers	43	29.05
Management and planning skills	17	11.49
Psycho social Support	16	10.81
Counselling	15	10.14
Treatment & Literacy	15	10.14
Child & Youth Careworker (CYCW)	14	9.46
Immunization	13	8.78
First Aid training	9	6.08
IPT	7	4.73
Networks of Hope training	6	4.05
Capacity building	4	2.70
Memory Work	4	2.70
Illness:TB, Malaria, etc	4	2.70
Leadership	3	2.03
RADS	3	2.03
Hygiene training	3	2.03
Home Visitor	2	1.35
Child care and protection	2	1.35
Sunday School training	2	1.35
OSA	2	1.35
Working with Children	1	0.68
Peer Education	1	0.68
Gender Equity	1	0.68

Communication	1	0.68
Food Security	1	0.68
Vutshilo	1	0.68
Sphere	1	0.68

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

The types of problems they encounter in their work 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 long term vision of home visitors includes two majors objectives, namely to become a manager or coordinator in the program or to stay a home visitor. These objectives express a view that programs such as NOH are there to stay in the mind of home visitors. A small minority is thinking of taking up a job elsewhere.

Interventions

The NOH program interventions and treatments were outlined in chapter 1. There are listed 33 treatments that make up eight core program service areas (CSA) (one area has two divisions; it could therefore also be seen as nine areas), as follows:

1. Clinical nutritional support
2. Child protection interventions
3. (or 2.a) Statutory child protection interventions
4. General health care referrals
5. Health care support for access to anti-retroviral treatment (ART)
6. HIV prevention education
7. Psychological care
8. Educational support
9. Household economic strengthening.

Treatments are spread over a five-year period, from 2006 to 2010, and noted in the evaluation recording system, creating a recording system of 165 items. The treatments recorded in this elaborate system are organised according to the 33 treatment types, each for their five-year period, and then summarised to an overall treatment index counting all the recorded treatments in one variable (see Table 3.7).

Although there seems to be a well-structured system of services available for OVC treatment, 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 16 OVC were registered not having received services according to the table.

Table 10: All treatments applied to OVC, 2006-2010

	Frequency	Percent	Valid Percent	Cumulative Percent
No treatments	16	3.2	3.2	3.2
1-5 treatments	171	34.6	34.6	37.9
6-10 treatments	162	32.8	32.8	70.6
11-15 treatments	62	12.6	12.6	83.2
16 or more treatments	83	16.8	16.8	100.0
Total	494	100.0	100.0	

Note that this table carries N=494; the reason is that the treatment data base covered the number of OVC administratively available and not the sampled 602 that were realised in the interviews. This 494 OVC form a sub-sample of the 602 OVC and could be linked to other variables in the main sample.

Despite this number not receiving services the overwhelmingly number of OVC, amounting to 96.8%, did receive treatments, services and the like over the period of observation. This period covers 5 years and the number of treatments reported in the table appears to be low given the wide range of services available. There is one case that received only one treatment and another that received up to 50 treatments. The range of the number of treatments seems to be wide and dependent on the need of the individual OVC and the home visitor's alertness to these needs.

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 or treatments 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?

To address the question on the nature of the services a factor analysis has been conducted according to the so-called principal component analysis approach with an orthogonal rotation that assumes unrelated variables as components in the analysis.[31] The component matrix produced by this procedure generates four factors that respectively loaded the following CSA. These CSA groups or individual areas will be used to define the four factors. According to Bryman and Cramer (1977:278), characteristics which go together constitute a factor. The CSA will be taken as the constituting characteristics of the factors.

[31] 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).

Table 11: Factor loadings and characteristics in the treatment complex and treatments over 2006 to 2010

Code	Factor and variable	Corr.	Sub-code	Detailed description of treatment	Number of treatments to OVC in CSA A	Number of OVC treated in CSA B	Intensity of treatments A/B
Factor 1 (Eigenvalue 2.746; 9 variables; Explaining 30.5% of variation) – Sustainable Human Development							
CSA9	HES – Household economic strengthening	.845	CSA9.1	Social assistance, grants	72	48	1.5
			CSA9.2	Asset growth and protection, savings, food gardens	469	235	2.0
			CSA9.3	Income growth and protection	70	44	1.6
			CSA9.4	Job creation	13	13	1.0
CSA8	Educational support	.777	CSA8.1	Assist with school fee exemption	18	15	1.2
			CSA8.2	Provide school uniform, stationery	149	123	1.2
			CSA8.3	Vocational training	314	115	2.7
			CSA8.4	School readiness assessment	146	102	1.4
			CSA8.5	Educational assistance	767	390	2.0
CSA4	General health care referrals	.704	CSA4.1	Access to health care services	191	101	1.9
			CSA4.2	Appropriate clinical intervention	39	24	1.6
			CSA4.3	Follow-up and adherence monitoring	326	89	3.7
			CSA4.4	Referrals for immunizations	70	38	1.8
			CSA4.5	Support for TB patients	16	14	1.1
CSA6	HIV prevention education	.671	CSA6.1	Promote abstinence and delay of sexual initiation	172	106	1.6
			CSA6.2	Facilitate small groups on life skills	196	141	1.4
			CSA6.3	Encourage sexually active youth to know their status	153	96	1.6
			CSA6.4	Peer outreach to youth out of school	40	19	2.1

CSA2	Child protection interventions	.629	CSA2.1	Facilitate birth registration and ID	69	47	1.5
			CSA2.2	Referral to protective services	123	70	1.8
			CSA2.3	Succession planning, memory work, inheritance claims	47	45	1.0
Factor 2 (Eigenvalue 1.264; 9 variables; Explaining 14.0% of variation) – Healthy Living							
CSA1	Clinical nutritional support	.830	CSA1.1	Nutritional assessment	457	253	1.8
			CSA1.2	Nutritional counselling and education	280	173	1.6
			CSA1.3	Recommend nutritional intervention	37	21	1.8
CSA7	Psychological care	.634	CSA7.1	Clinical and psycho-therapy sessions	5	4	1.3
			CSA7.2	Clinical support groups	25	21	1.0
			CSA7.3	Group therapeutic sessions	83	43	1.9
Factor 3 (Eigen value 1.131; 9 variables; Explaining 12.6% of variation) – Family Relationships							
CSA3	Statutory child protection interventions	.746	CSA3.1	Support the proceedings of children's courts and implementation of court orders	0	0	0
			CSA3.2	Work to prevent separation of sibling and to preserve family structure through legal channels	2	2	1.0
			CSA3.3	Removal of children from abusive and exploitative situations	6	5	1.2
Factor 4 (Eigenvalue 1.015; 9 variables; Explaining 11.3% of variation)							
CSA5	Health care support for access to anti-retroviral treatment (ART)	.913	CSA5.1	ARV literacy	16	9	1.8
			CSA5.2	Access to ART	9	8	1.1
			CSA5.3	Adherence to counselling	10	9	1.1

Notes:

1. **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 it's household. It includes 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. This factor may be labelled as **Sustainable Human Development**. It has drawn high intensity activity levels for the following sub-areas:

- Asset growth and protection, savings, food gardens (9.2)
- Vocational training (8.3)
- Educational assistance (8.5)
- Follow-up and adherence monitoring on health care referrals (4.3).

2. **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. The interventions address the ability to overcoming life crises and internalising the maintenance of healthy living in relation to these systems. The factor may be called **Healthy Living**. High intensity treatment activity includes nutritional assessment (1.1).
3. **Factor 3** is a unidimensional factor that has as it's focus social relationships of the child within the intimate sphere of kinship and family. It advances legal protection of the vulnerable child with the aim of restoring and/or rebuilding social relationships. We may call this factor **Family Relationships**. Treatment in this area is defined as legal and professional intervention and protection and requires the services of professional staff such as social workers. Only two OVC are recorded as affected by activity in this area.
4. **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. It may be called **ART – Antiretroviral 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.
5. The nine core service areas (CSA) therefore all combine and become essential in creating and delivering improved **Quality of Life** (including Standard of Living) and **Resilience** (the opposite of vulnerability). We conclude that the designed system of treatments that is constituted by the nine CSA, constitutes a coherent strategy for achieving the goal of the NOH program, i.e. to improve the quality of life and resilience levels of vulnerable children.
6. When the ADPs are compared (see Table 00) 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 treatments than elsewhere particularly in the service areas associated with Human Development (Factor 1) and Health Living (Factor 2) with Umzimvubu as a second most active ADP. All other ADPs show lower activity in the treatment levels and intensity of service provision to OVC.

Table 12: Service and treatment associated with the four factors and service areas according to ADPs, 2006-2011.

Factor	CSA	Values	ADP					
			Khauhelo	ThabaNchu	Kodumela	Thusalushaka	Umzimvubu	Mpofu
Factor1 – Sustainable Human Development	CSA9	Treatments	73	291	50	22	167	21
		OVC	43	67	44	14	77	17
		Intensity	1.7	4.3	1.1	1.6	2.2	1.2
	CSA8	Treatments	185	547	196	128	220	118
		OVC	72	78	79	58	80	73
		Intensity	2.6	7.0	2.5	2.2	2.8	1.6
	CSA4	Treatments	18	471	63	31	17	42
		OVC	17	83	37	20	14	27
		Intensity	1.1	5.7	1.7	1.6	1.2	1.6
	CSA6	Treatments	20	227	115	26	120	53
		OVC	17	30	56	21	71	32
		Intensity	1.2	7.6	2.1	1.2	1.7	1.7
	CSA2	Treatments	21	85	1	32	84	16
		OVC	17	26	1	26	61	15
		Intensity	1.2	3.3	1.0	1.2	1.4	1.1
Factor 2 – Healthy Living	CSA1	Treatments	124	140	105	169	175	61
		OVC	54	38	68	61	74	44
		Intensity	2.3	3.7	1.5	2.8	2.4	1.4
	CSA7	Treatments	19	0	2	86	0	6
		OVC	14	0	2	42	0	5
		Intensity	1.4	0	1.0	2.0	0	1.2
Factor 3 – Family Relationships	CSA3	Treatments	0	2	0	0	5	1
		OVC	0	1	0	0	5	1
		Intensity	0	2.0	0	0	1.1	1.0
Factor 4 - ART	CSA5	Treatments	3	1	7	6	15	3
		OVC	3	1	4	5	8	3
		Intensity	1.0	1.0	1.8	1.2	1.9	1.0

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.

SECTION 10

CHANGES IN HEALTH STATUS OF THE OVC

As explained above the aim of the NOH program is to improve the quality of life and associated aspects of life of OVC. The analysis in the previous section shows clearly that this is a multi-dimensional concept that includes various domains in the life of the OVC. One of the key aspects of in the quality of life, as has become clear in the factor Sustainable Human Development and other areas of intervention, is the health of a person. In this section we explore the situation regarding health.

As OVC have been registered as such and a data base has been compiled to provide a baseline as well as a monitoring mechanism to measure future development of OVC, the data base was considered as a useful source of information. Questionnaires that were directed at OVC' guardian and the home visitors were also linked as far as possible to information tapped from this data base.

An important sequence of data and a 'data trail' were constructed by linking the various instruments with one another. With respect to OVC' health status, this enables us to ask and answer the following questions:

- What was the OVC' health profile before registration into the NOH program, as the OVC were 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?
- What was the primary caregiver's (guardian's) health status at the time of the registration of the OVC?

The data were extracted and organised for purposes of comparison in Table 13.

Table 13: Health status of OVC and primary caregiver according to various sources

Data sources		Health conditions									
		No illness	HIV/AIDS	TB	Malaria	Pneu-monia	Diarrhoea, Bilharzia	Scabies, Skin rash	Cough 2+ weeks	Mal-nutrition	Other, yes
OVC before registration	N	488	488	494	488	488	488	488	488	488	
	f	411	4	6	5	12	21	35	13	70	
	%	84.2	0.8	1.2	1.0	2.5	4.3	7.2	2.7	14.3	
OVC at registration	N	489	489	494	489	488	498	489	489	489	
	f	406	4	5	1	2	11	33	8	67	
	%	83.0	0.8	1.0	0.2	0.4	2.2	6.7	1.6	13.7	
OVC by Home Visitor	N	534	278	278	279	277	279	281	300	281	300
	f	502	4	2	3	3	4	12	31	5	36
	%	94.0	1.4	0.7	1.1	1.1	1.4	4.3	10.3	1.8	12.0
OVC by Guardian, linked	N	494	494	493	494	494	494	494	494	494	494
	f	363	4	3	1	6	12	17	44	10	52
	%	73.5	0.8	0.6	0.2	1.2	2.4	3.4	8.9	2.0	10.5
OVC by Guardian, not linked	N	601	601	601	601	601	601	601	601	601	601
	f	437	6	5	2	7	14	18	56	12	65
	%	72.7	1.0	0.8	0.3	1.2	2.3	3.0	9.3	2.0	10.8
Guardian's own health by data base	N	458	458	458	458	458	458	458	458	458	
	f	383	12	1	7	3	3	11	4	117	
	%	83.6	2.6	0.2	1.5	0.7	0.7	2.4	0.9	25.5	

Other health conditions listed in response to the open question include a whole array of illnesses and disabilities in more or less equal frequencies from the various data sources. The disabilities refer to sight, hearing and mental challenges while respiration, congestion, intestinal, dermatological, allergic conditions are also mentioned. Symptomatic conditions such as fever, vomiting, cramps, headache, fits, allergies, and others are mentioned as well. A specific inquiry about disabilities produced only 4.5% OVC reported in the World Vision NOH program data set as such, noting OVC challenged by sight (1.6%), hearing (1.0%), mental (1.2) and mobility (0.2%) as the identified disabilities.

Notes:

1. This table demonstrates a remarkable similarity and consistency of health/illness patterns among OVC according to the different data sources applied. 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 71.7% of the OVC were not ill during the past month, 19.5% were ill and less active for a few days, while the remainder (8.8%) were sick often, too ill for school, work or play, or been ill most of the time.
2. 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.
3. 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.
4. 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.
5. With respect to the health/illness pattern of the guardians, it is very much similar to the OVC except for a slightly higher prevalence of HIV/AIDS persons and a significant higher percentage of malnutrition. Malnutrition registered 25.5% among guardians and only 2% among OVC. These two figures were produced by the same source, namely the guardians of the OVC.
6. Finally, diarrhoea/bilharzia, coughing, scabies/skin rash, and malnutrition are the health conditions with the higher prevalence (although with variations as observed). A comment gained by a vintage health officer with comparative experience among OVC in different world parts offers the following remarks:
   Orphaned and vulnerable children are exposed to the natural elements, prostitition and child labour. Many of these children have the disposition of already contracting HIV/AIDS, due to prostitution, which on its own makes them vulnerable to pneumonia, diarrhoea, skin rashes and coughing for 2+ weeks (symtom of pulmonary TB).

Diarrhoea may be contracted from eating contaminated foods from sources like dump sites, trash cans etc. , due to hunger. The ingestion of contaminated water may lead to diseases like Salmonella, Shigella and other diarrhoeal diseases.

Pneumonia may also be contracted due to poor resistance, from malnutrition. Pneumonia is the cause of death of many children in Africa, adding to the high incidents of child mortality. Hence pneumococcal vaccination has been introduced to all children from 6 months up to kerb the disease.

Billharzia could be contracted by swimming and washing in infested water in pools and standing rivers.

Skin rashes are common to unhygienic conditions, that OVC's are more often than not exposed to.

Scabies is generally found amongst children, even coming from affluent circumstances. Since it is normal for kids to be in close contact with each other, scabies is transmitted amongst children very easily. In poverty stricken circumstances and other vulnerabilities, scabies can become out of control and have serious health issues, like itching, and skin diseases due to scratching , causing skin infections.

Coughing for more than two weeks can be a leading symptom of pulmoneral tuberculosis (PTB). It is a well known fact that PTB is a disease easily transmitted in communities, due to close living conditions, malnutrition and low immunity(low CD4 count due to AIDS). South Africa, specially the Western Cape, has the highest incidents world wide of PTB.

Malnutition follows poverty and food shortage, due to no means to finances and protection of the OVC.

The figures above represent the situation for all six ADPs collectively. Numbers are too small to conduct significant analyses for the individual illnesses according to the ADPs. However, malnutrition does provide the potential for such detailed analyses in the cases of the pre- (N=70) and at- (N=67) registration of OVC and of the current situation of the guardians (N=117) as 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.

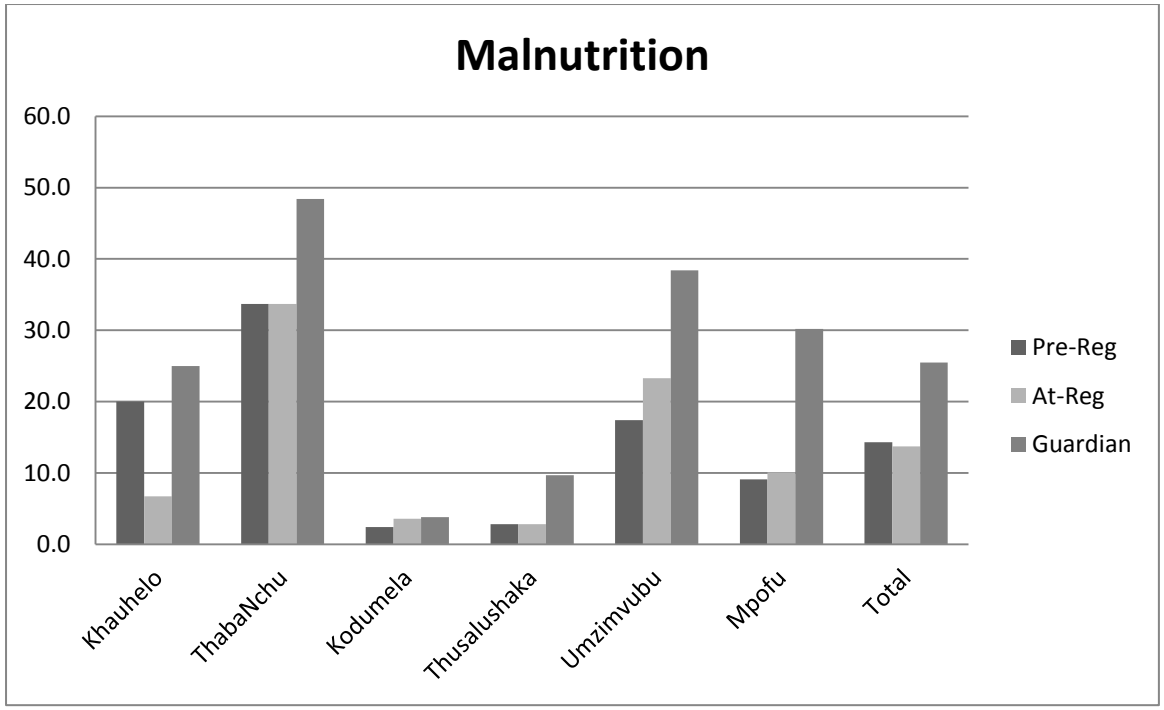


Figure 5: Malnutrition status of OVC

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 may become all important to overcome the stumbling blocks of material conditions. We report below a number of changes in a variety of life dimensions linked to the NOH program.

SECTION 11

REPORTED AND PERCEPTUAL CHANGES IN THE VARIOUS ASPECTS OF QUALITY OF LIFE OF THE OVC AND THEIR HOUSEHOLDS

Looking at the change figures in Table 14.1 – Table 14.3 it is clear that role players such as guardians of OVC and home visitors do regard the NOH program in a very positive light. All figures point to an experience and perception of improvement regarding the wellbeing of OVC. In this perception guardians and home visitors support each other with majority percentages well above 70% although home visitors consistently express a higher perception of positive improvement than the guardians.

Table 14.1: Perceptions of OVC change and improvement in the context of the NOH program

Quality of life	Role player	Better	Same	Worse	Total
Child's general **wellbeing** compared to time before registration in NOH program	Guardian	83.7	14.1	2.2	100.0
	Home visitor	91.2	7.7	1.1	100.0
Things are better now in the **household** compared to time before child's registration in NOH program	Guardian	79.9	16.9	3.2	100.0
	Home visitor	89.5	9.8	0.7	100.0
OVC's current participation in **social activities** compared to time registered in NOH program	Guardian	78.9	20.4	0.7	100.0
	Home visitor	84.8	14.0	1.2	100.0
Current **mood** compared to time when registered on NOH program	Guardian	76.1	21.6	2.3	100.0
	Home visitor	82.9	14.7	2.4	100.0

OVC's current **access to health** compared to time of registration on NOH program	Guardian	77.9	18.6	3.5	100.0
	Home visitor	85.0	11.6	3.4	100.0
OVC's current **health** compared to health at time of registration in NOH program	Guardian	74.0	24.6	1.3	100.0
	Home visitor	82.3	15.8	1.9	100.0

Table 14.2: Perceptions of OVC change and improvement in the context of the NOH program

Quality of life	**Role player**	**Yes**	**No**	**Total**
Improvement in OVC **educational performance** since registration in NOH program	Guardian	95.6	4.4	100.0
	Home visitor	97.7	2.3	100.0

Table 14.3: Perceptions of OVC change and improvement in the context of the NOH program

Quality of life –Impact of NOH Program	**Role player**	**Yes, in every respect**	**Yes, partly**	**No, not at all**	**Total**
If better educational performance is a direct **result of NOH program**?	Guardian	72.4	24.3	3.4	100.0
	Home visitor	82.1	16.7	1.2	100.0

The pattern that unfolds is very similar for the overall picture of the NOH program. However, statistic tests for difference in the distributions[32] on nearly all the items listed in Table 14.1 – Table 14.3 indicate statistically significant differences with p <= .05 .[33] It was found that Kodumela and Thusalushaka performed better in about all items than the general level of improvement and that Khaulelo, Umzimvubu and ThabaNcu occasionally also performed above average. In some instances Mpofu come out weakest in the performance of improvement.

[32] Pearson's Chi-square as performed by SPSS, Version 19.

[33] Only two exceptions were found: Participation in social activities (not in Table); and Improvement in educational performance.

It should be noted that the aspects listed in the table are composed of various types including health, mood, social activities, education, household, and wellbeing. These aspects and the measurements tap elements of Factor 1: Sustainable Human Development, as defined above, as well as elements from other factors listed.

Next we take a look at specific measurements of wellbeing and resilience among teenage OVC.

SECTION 12

MEASURED LEVELS OF WELLBEING AND RESILIENCE (TEENAGER OVC)

The teenager OVC group (N = 108) 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. Total scores were grouped according to fairly equal distribution; in the case of Wellbeing into three categories and Resilience, two categories. Cross tabulations with ADPs are presented in the next two tables. Scores turned out to be fairly high for both indexes.

Table 15: Wellbeing measured for teenager OVC

Teen Wellbeing Grouped		ADP						Total
		Khauhelo	ThabaNchu	Kodumela	Thusalushaka	Umzimbuvu	Mpofu	
Lowest wellbeing	Count	7	2	9	4	2	0	24
	% within ADP	33.3%	10.0%	37.5%	20.0%	12.5%	.0%	22.4%
Average wellbeing	Count	7	10	8	11	9	3	48
	% within ADP	33.3%	50.0%	33.3%	55.0%	56.3%	50.0%	44.9%
Highest wellbeing	Count	7	8	7	5	5	3	35
	% within ADP	33.3%	40.0%	29.2%	25.0%	31.3%	50.0%	32.7%
Total	Count	21	20	24	20	16	6	107
	% within ADP	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

The general distribution of the Wellbeing scores (see Total column) is repeated for the ADPs and deviations are not statistically significant. Mpofu does show a more positive (higher) distribution of scores but the number of cases is too small for proper analysis. Kodemela en Khauhelo tend towards lower scores.

Table 16: Resilience measured for teenager OVC

Resilience			ADP						Total
			Khauhelo	ThabaNchu	Kodumela	Thusalushaka	Umzimbuvu	Mpofu	
	Lower resilience	Count	10	15	17	4	3	5	54
		% within ADP	47.6%	75.0%	70.8%	20.0%	18.8%	71.4%	50.0%
	HIgher resilience	Count	11	5	7	16	13	2	54
		% within ADP	52.4%	25.0%	29.2%	80.0%	81.3%	28.6%	50.0%
Total		Count	21	20	24	20	16	7	108
		% within ADP	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

The distribution of the Resilience scores for ADPs differs significantly. Thusashaka and Umzimvubu present higher proportions for the high scores than the average while ThabaNchu, Kodumela and Mpofushow lower scores.

These figures suggest that the NOH program achieved its goal differentially across the ADPs.

SECTION 13

JUDGEMENTS ABOUT THE NOH PROGRAM

A number of questions were asked to determine to what extent key role players in the NOH program judge the program to impact on the beneficiaries. The analyses above have shown a number of effects, outcomes and impacts of the program and that the program is related to changes observed and experienced among OVC. These effects are not uniformly distributed across the sites of service of the program but vary according to ADP. We expect the judgements on the outcomes of the program to show the same variation.The role players that exercised the opinion on the program are stakeholders and staff of ADPs.

Table 17: Judgements on the extent that the NOH program impacts the beneficiary community (A)

Impact	Role player	Address all the needs	Address some of the needs	Address none of the needs	Uncertain	Total
Extent to which NOH program services address needs to OVC	Stakeholder	42.1	53.3	0.9	3.7	100.0
	Staff	28.8	71.2	0	0	100.0
Extent to which NOH program services address needs of the guardians of OVC	Stakeholder	39.3	52.3	3.7	4.7	100.0
	Staff	25.0	73.6	1.4	0	100.0
Extent to which NOH services address the needs of the Home Visitors to assist families with whom OVC's stays	Stakeholder	45.7	39.0	4.8	10.5	100.0
	Staff	27.4	69.9	2.7	0	100.0

None of the groups (stakeholders and staff) was prepared to give the program in the respect of the questions mentioned in the table, a majority vote. They preferred to support the qualified statement that some of the needs were addressed. There is little agreement between stakeholders and staff on the impact regarding the needs of the OVC. Stakeholders indicate more positive judgement than the average in the case of ThabaNchu and Mpofu. Staff were more positive in Khauhelo and Kodumela.

Table 18: Judgements on the extent that the NOH program impacts the beneficiary community (B)

Impact	Role player	Yes, very much so	Yes, to an extent	No, its not clear	Uncertain	Total
Educational support received from NOH program improved school attendance of OVC	Stakeholder	61.7	24.3	3.7	10.3	100.0
	Staff	62.2	32.4	2.7	2.7	100.0
Educational support received from NOH program improved school performance of OVC	Stakeholder	62.9	25.7	1.9	9.5	100.0
	Staff	55.4	32.4	6.8	5.4	100.0
Emotional wellbeing of OVC improved as result of program	Stakeholder	57.0	28.0	6.5	8.4	100.0
	Staff	57.5	37.0	5.5	0	100.0
Program helped the OVC to improve self-esteem	Stakeholder	61.0	30.5	1.9	6.7	100.0
	Staff	63.9	31.9	4.2	0	100.0
Program helped in accessing legal protection in case of need	Stakeholder	52.4	21.4	9.7	16.5	100.0
	Staff	46.6	46.6	6.8	0	100.0

Except for the last item stakeholders and staff agree on the impact of the program in the respects listed above. Agreement is more positive now. ADPs that show agreement stronger than the average are mostly Thusalushaka and Umzimvubu to a lesser extent Khauhelo, ThabaNchu, Kodumela, and Mpofu.

Table 19: Judgements on the extent that the NOH program impacts the beneficiary community (C)

Impact	Role player	Very well	Only to a certain extent	Not really	Uncertain	Total
How well did the program assist in requiring legal documents, i.e. birth registration or ID?	Stakeholder	67.6	20.0	5.7	6.7	100.0
	Staff	82.4	17.6	0	0	100.0
How well has the program facilitated access to services to children who were denied legal status?	Stakeholder	41.6	21.8	8.9	27.7	100.0
	Staff	50.7	40.6	4.3	4.3	100.0
Program helped children to gain access to HIV related health care services in ART	Stakeholder	68.6	16.7	3.9	10.8	100.0
	Staff	73.0	21.6	5.4	0	100.0

The acquiring of legal documents draws high endorsements from the first item and the third item above from staff. The pattern of responses from the ADP is varied but it seems a strong response was coming from Mpofu.

SECTION 14
IF THE NOH PROGRAM SUCCEEDED IN STRENGTHENING COMMUNITY CAPACITY?

The key question to which this chapter attempts to give an answer is if the NOH program succeeded in strengthening community capacity to effectively continue improving the wellbeing of vulnerable children, even after the PEPFAR funding phase.

Three aspects are being discussed.

- The first is to assess if the services that have been offered to the OVC will be still needed after the expiry of the current funding phase and to what extent it will be needed.
- The second deals with the mobilization of the communities, and if the program has developed sufficiently to produce the required results and continue to do so.
- The third is the implications of PEPFAR funding coming to an end and the associated close-out plan.

If the services that have been offered to the OVC will be still needed after the expiry of the current funding phase and to what extent it will be needed?

This question suggests that the need over time might have become less severe and that it will require less intervention than in the past to address it. It should also be noted that this aspect links to the migration of OVC through the system over time and that it again is affected by a possible drop in the birth and infection rates that obviously impact on the need. This may result in a net gain or loss of numbers due to the difference between entry and exit of OVC in the ADP areas. Finally it should be noted that poverty also impacts on the ability of beneficiary groups to provide for their own needs.

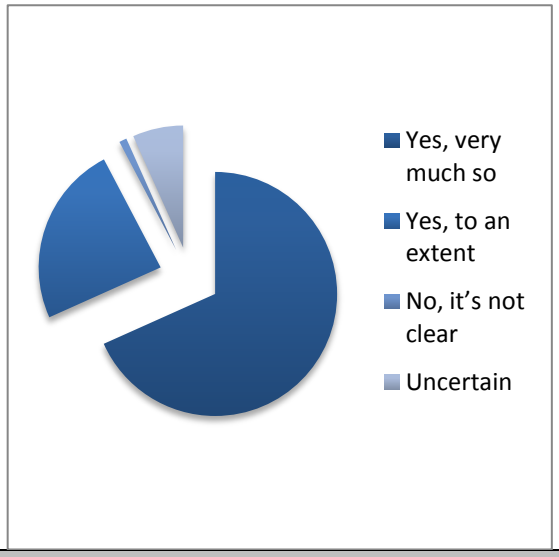
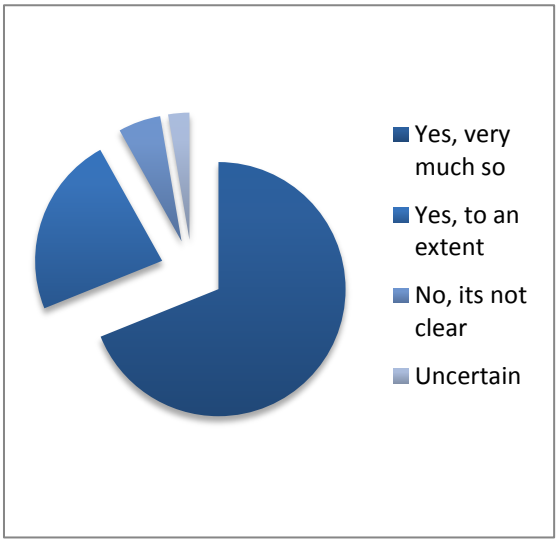
A calculation by ROADS based on the captured OVC demographic data indicates the following:

- Exit rate of around 10% per year in the 12 – 17 years age group
- Entry levels smaller: 0 – 2 years about 2%, and 5 – 11 years around 7%
- National statistics show a decrease on the 0 – 4 years that steadily spills over into the 5 – 9 year cohort.
- This implies that the source for the OVC is getting smaller

Although this evaluation has not gathered new information regarding all the factors that might impact on the need for the services it did ask both the stakeholders and staff to express them in this regard by directly asking them their impressions of the demand for OVC care and support. Their perceptions are reflected in Table 4.1 below.

Both the stakeholders and staff were predominantly of the opinion that the services are still needed as the demand still exists.

Table 20: Has the demand for OVC care and support services in the ADP communities grown?

Stakeholders		Staff	
Yes, very much so	68.3	Yes, very much so	68.9
Yes, to an extent	24.0	Yes, to an extent	23.0
No, it's not clear	1.0	No, it's not clear	5.4
Uncertain	6.7	Uncertain	2.7
Total	100.0	Total	100.0
			

Besides the structured responses, stakeholders and staff also provided qualitative comment on the need for services:

- 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.

Box: Demographics on OVC

Calculation by ROADS based on OVC captured data

Table 21: Number of household members to which OVC belong according to age

	N	%		OVC	%
Less than 2 years	100	4.5		0	0.0
2-4yrs	215	9.7		23	4.0
5-11yrs	534	24.1		243	42.7
12-17yrs	475	21.4		298	52.4
18+ yrs	893	40.3		5	0.9
Total Households	458				
Total persons	2217	100		569	100

Table 22: Black population, 2011 (mid-year estimate): percentages

	SA	Eastern Cape	Free State	Limpopo	WV OVC
0-4yrs	11.0	10.5	9.4	11.6	4.0
5-9yrs	11.2	11.3	9.4	11.1	25.5
10-14yrs	11.2	11.1	10.6	12.0	45.5
15-19yrs	10.8	12.1	10.3	12.3	25.0

Notes:

1) There are large %'s at older age categories that implies an out-going rate of around 10% per year of OVC in 12-17yrs group

2) At entry levels the % is smaller. For the 0-2yrs group it will be around 2% p.a. and the 5-11yrs group at around 7%

3) The national statistics show a decrease in %'s in the 0-4yrs group that steadily spills over into the 5-9yrs group. This implies that the source group for the OVC is getting smaller.

The mobilization of the communities, and the extent to which the program has developed to produce the required results and continue to do so

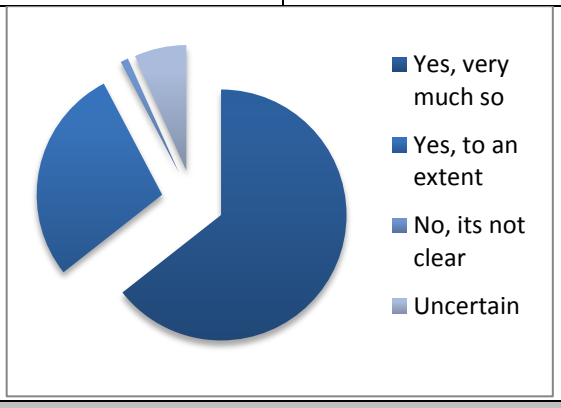
Sustainability of services in communities is also dependent on the extent to which key role players cooperate with the agencies rendering the service but also the extent to which communities "take ownership" for the services. The two questions measuring opinion in this regard were if the ADP communities effectively cooperate in the service provision for OVC and if the communities consider the projects as their own (taking ownership for it).

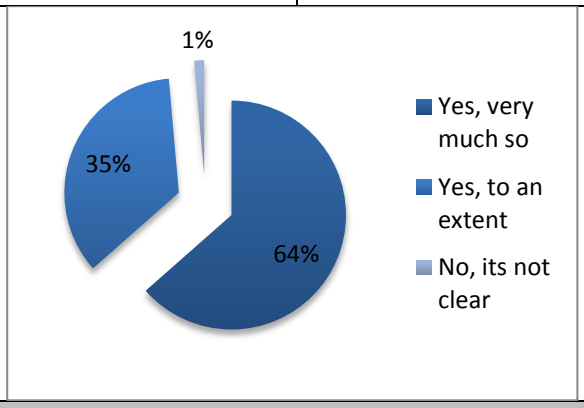
Community mobilisation is aligned to the objective of mobilizing and strengthening community-led response to protect and care for OVC. Communities are mobilised mainly through the implementation of two strategies; Community Care Coalitions (CCCs) bringing together churches and other faith communities, 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.

Both the stakeholders and staff were predominantly of the opinion that the communities cooperate, although around 30 % agree with the option that cooperation is only "to an extent".

Table 23: Did the ADP communities effectively cooperate in the service provision for OVC?

Stakeholders		Staff	
Yes, very much so	64.4	Yes, very much so	63.5
Yes, to an extent	27.9	Yes, to an extent	35.1
No, it's not clear	1.0	No, it's not clear	1.4
Uncertain	6.7	Total	100.0
Total	100.0		

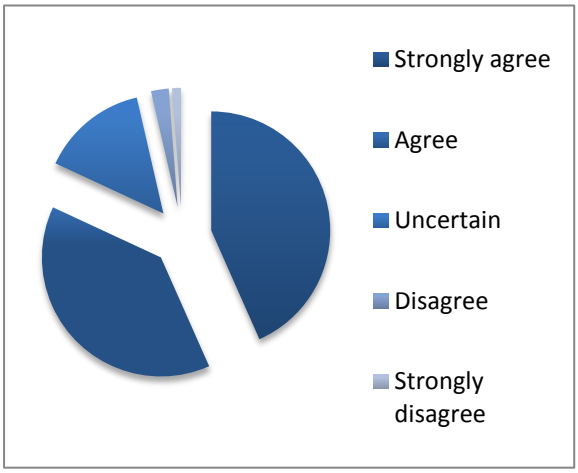


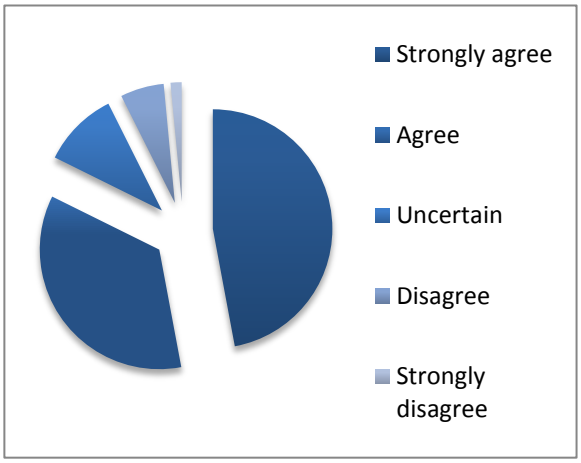


The statement on community ownership of the work shows a predominantly positive response from both groups while 10 – 14% is uncertain. See Table 4.3 below.

Table 24: How do you as a stakeholder generally perceive the project? The community sees the project as their project

Stakeholders		Staff	
Strongly agree	43.4	Strongly agree	47.1
Agree	38.6	Agree	35.3
Uncertain	14.5	Uncertain	10.3
Disagree	2.4	Disagree	5.9
Strongly disagree	1.2	Strongly disagree	1.5
Total	100.0	Total	100.0



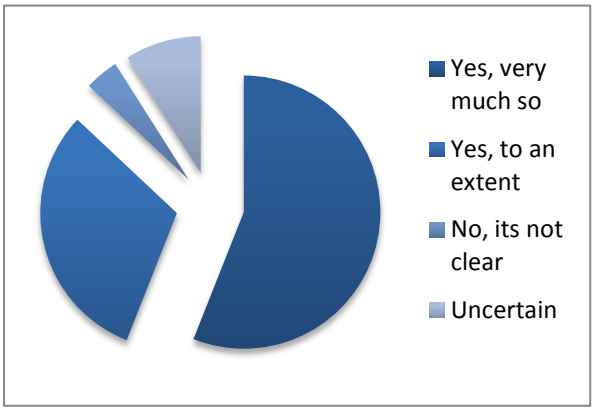
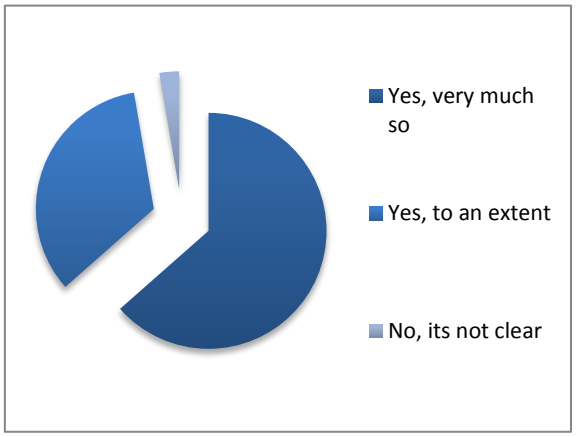


One of the key elements of the NOH program is the channelling of access to the OVC through **Home Visitors** to individuals and families infected and affected by HIV. The other key element of the NOH model is the idea of capacitating the community through the development of ADPs as local structures and as mechanism for community empowerment.

To assess the perceptions of staff and stakeholders in this regard, two questions were asked, one on the effectiveness of the role of home visitors and one on the program's emphasis on the development of the ADPs as implementing tools in the NOH. See tables 4.4 and 4.5.

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.
On both counts the staff gave a better rating than the stakeholders on the two approaches. Apparently they have relative confidence in the approaches and see it as the obvious thing to do. Stakeholders in Khauhelo and Kodumela and staff in Thaba Nchu were less certain (see significant variations in table 4.4).

Table 25: Did strategy employed by the NOH program working with and strengthening the Home Visitors really work?

Stakeholders		Staff	
Yes, very much so	56.0	Yes, very much so	63.5
Yes, to an extent	31.0	Yes, to an extent	33.8
No, it's not clear	4.0	No, it's not clear	2.7
Uncertain	9.0	Total	100.0
Total	100.0		
			
Significant variations: **Khauhelo:** 25% uncertain **Kodumela:** 14.3% uncertain and 10.7% No, it's not clear = 25.0%		**Significant variations:** **Thaba Nchu:** 26.7% Very much so and 73.3% Yes, to an extent	

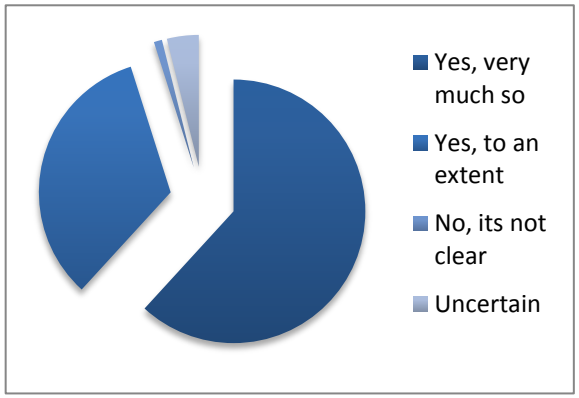
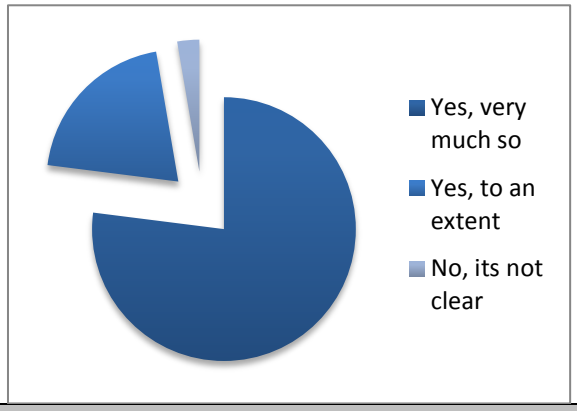
The rating of the home visitors and perceptions about their purpose and function emerging from the stakeholder workshops contained the following (summarised):

- 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 impact 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 school work, encourage school attendance which result in improved school performance and an improved pass rate at schools.
- The fact that OVCs 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.

Not much introspection on ADP as a system of delivery was found in the qualitative data. A question on this however confirms it as an unquestioned approach. More than 90% of both stakeholders and staff confirmed it. See Table 4.5

Table 26: Did the strategy of World Vision to strengthen the capacity of the ADP really work?

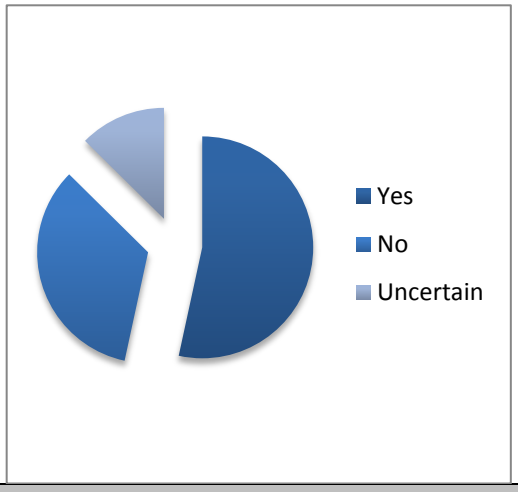
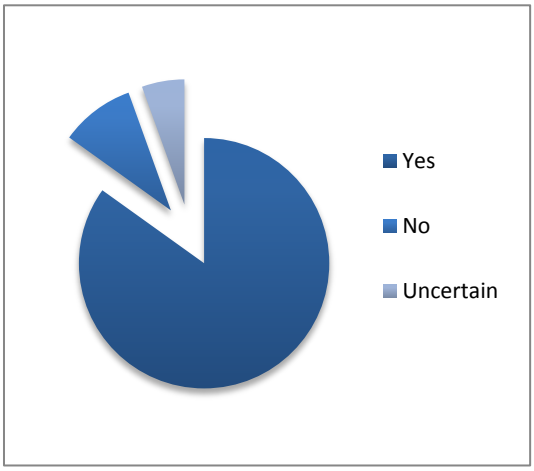
Stakeholders		Staff	
Yes, very much so	61.8	Yes, very much so	77.0
Yes, to an extent	33.3	Yes, to an extent	20.3
No, it’s not clear	1.0	No, it’s not clear	2.7
Uncertain	3.9	Total	100.0
Total	100.0		
			

Other programs providing services (including those who link with NOH)

Other organisations or services also 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. Two questions were thus asked: if any other programs

other than the NOH program focusing on wellbeing of OVC exist and how well the other programs are doing.

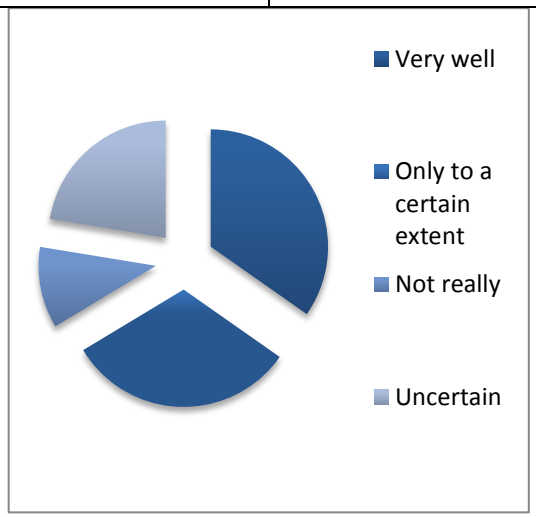
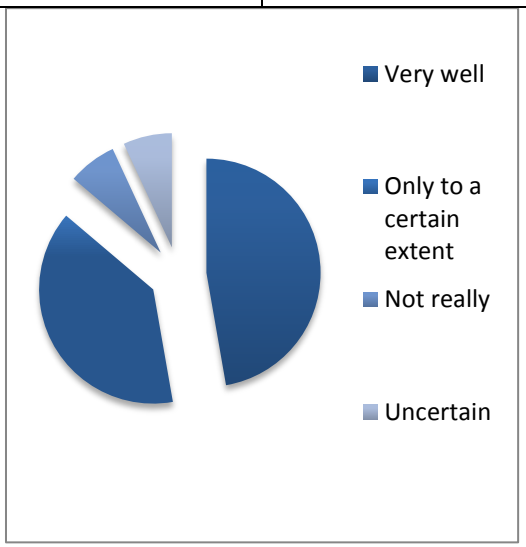
Table 27: Any other programs than the NOH program in your area that focus on wellbeing of OVC

Stakeholders		Staff	
Yes	53.4	Yes	84.9
No	34.0	No	9.6
Uncertain	12.6	Uncertain	5.5
Total	100.0	Total	100.0
			

The staff is probably better informed about other role players with whom they interact, among other, through the Community Care Coalition and Channels of hope. The knowledge about other service providers is indicated in Table 4.6. Across the different ADPs a large number of role players are mentioned, including CBOs, FBOs, government services, clinics, schools, etc.

The assessment of the contribution of these other programs, see Table 4.7, is more certain with la lower percentage of the staff indicating “not really” and “uncertain”. It is difficult, based on the information to say if these organisations will be able to continue delivery, or at the current level, without the inputs from the current ADPs.

Table 28: How well the other programs fare (are doing) in improving the wellbeing of OVC

Stakeholders		Staff	
Very well	34.7	Very well	47.2
Only to a certain extent	31.6	Only to a certain extent	38.9
Not really	11.2	Not really	6.9
Uncertain	22.4	Uncertain	6.9
Total	100.0	Total	100.0
			

Stakeholder workshop comments on community mobilization (summarised):

- Community mobilization takes place mainly by means of community meetings where the services of WV are promoted, through dissemination of information and assisting community-based organizations to access funding from government and other sources and acquiring legal documents.
- 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 communities are assisted with infrastructure projects such as shelter, water, sanitation, toilets, crèches, schools, etc. In Mpofu stakeholders stated that "people regard WV as the provider of almost everything, including services that should be rendered by government". They stated that the community is not yet independent and that they rely heavily on WV support on every aspect of life.

- The problem however remains that not all children in need of care are reached and supported despite the fact that OVC support services have grown.
- Poverty issues and poor health seem 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 becomes critical and is seen as 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 (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.

Table 29: Stakeholder response: Will the ADP/World Vision be able to continue with services to OVC after the expiry of the Pepfar funding?									
			ADP						Total
			Khauhelo	ThabaNchu	Kodumela	Thusalushaka	Umzimbuvu	Mpofu	
Will the ADP/World Vision be able to continue with services to OVC after the expiry of the Pepfar funding?	Very well	Count	6	5	13	23	2	4	53
		% within ADP	40.0%	45.5%	46.4%	**88.5%**	25.0%	33.3%	53.0%
	Only to a certain extent/ Only in certain aspects	Count	2	2	1	3	3	4	15
		% within ADP	13.3%	18.2%	3.6%	11.5%	**37.5%**	33.3%	15.0%
	Not really	Count	3	3	11	0	**3**	3	23
		% within ADP	20.0%	27.3%	39.3%	.0%	**37.5%**	25.0%	23.0%
	Uncertain	Count	4	1	3	0	0	1	9
		% within ADP	26.7%	9.1%	10.7%	.0%	.0%	8.3%	9.0%
Total		Count	15	11	28	26	8	12	100
		% within ADP	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0 %

Table 30: Staff response: Will the ADP/World Vision be able to continue with services to OVC after the expiry of the Pepfar funding?									
			ADP						Total
			Khauhelo	ThabaNchu	Kodumela	Thusalushaka	Umzimbuvu	Mpofu	
Will the ADP/World Vision be able to continue with services to OVC after the expiry of the Pepfar funding?	Very well	Count	3	5	3	4	13	5	33
		% within ADP	50.0%	41.7%	42.9%	44.4%	43.3%	**71.4%**	46.5%
	Only to a certain extent/ Only in certain aspects	Count	3	4	4	4	8	2	25
		% within ADP	50.0%	33.3%	57.1%	44.4%	**26.7%**	28.6%	35.2%
	Not really	Count	0	3	0	1	7	0	11
		% within ADP	.0%	25.0%	.0%	11.1%	**23.3%**	.0%	15.5%
	Uncertain	Count	0	0	0	0	2	0	2
		% within ADP	.0%	.0%	.0%	.0%	6.7%	.0%	2.8%
Total		Count	6	12	7	9	30	7	71
		% within ADP	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0 %