## Raising an AIDS-free generation:

# EVALUATION OF THE GLOBAL FUND ORPHANS & VULNERABLE CHILDREN PROGRAMME

By Creative Consulting & Development Works for NACOSA and NRASD

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# Raising an AIDS-free generation: Evaluation of the Global Fund Orphans & Vulnerable Children Programme

By Lauren Baerecke et al, Creative Consulting & Development Works for NACOSA and NRASD, monitored by the Department for Social Development.

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## PARTNERSHIP IN ACTION

As principal recipient for the Global Fund to Fight AIDS, Tuberculosis and Malaria, NACOSA worked with partners to build the capacity of community organisations, scale up prevention programmes for the most at-risk populations, increase the coverage and uptake of HIV counseling and testing, increase access to services for people living with HIV and strengthen support for orphaned and vulnerable children.

This report is an evaluation of a component of Phase II of NACOSA's Global Fund grant (2013-2016).

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# ACRONYMS

| | |
|---|---|
| AAHT | Anglican AIDS and Healthcare Trust |
| AIDS | Acquired Immunodeficiency Syndrome |
| ARV | Antiretroviral Therapy |
| CASE | Community Agency for Social Enquiry |
| CBO | Community Based Organisation |
| CBIMS | Community Based Intervention Monitoring System |
| CC&DW | Creative Consulting and Development Works |
| CCM | Country Coordinating Mechanism |
| CDDC | Cape Development and Dialogue Centre |
| CSG | Child Support Grant |
| CYCW | Child and Youth Care Worker |
| DoH | Department of Health |
| DSD | Department of Social Development |
| EPWP | Expanded Public Works Programme |
| FAMSA | Family and Marriage Society of South Africa |
| FBO | Faith Based Organisation |
| FGD | Focus Group Discussion |
| HCBC | Home Community Based Care |
| HTC | HIV Counselling and Testing |
| HTS | HIV Testing Services |
| HIV | Human Immunodeficiency Virus |
| HSRC | Human Sciences Research Council |
| KI | Key Informant |
| KMDR | Kerklike Maatskaplike Dienste Raad/Council for Church Social Services |
| KZN | KwaZulu-Natal |
| NACCA | National Action Committee for Children Affected by AIDS |
| NACCW | National Association of Child Care Workers |
| NACOSA | Networking HIV, AIDS Community of South Africa |
| NGO | Non-Governmental Organisation |
| NPO | Non-Profit Organisation |
| NRASD | National Religious Association for Social Development |
| NSP | National Strategic Plan |
| MCSA | Methodist Church of Southern Africa |
| M&E | Monitoring and Evaluation |
| OVC | Orphans and Vulnerable Children |
| PMTCT | Prevention of Mother to Child Transmission |
| PR | Principal Recipient |
| PSS | Psychosocial Support |
| RSQA | Rapid Services Quality Assessment |
| SACBC | South African Catholic Bishops Conference |
| SANAC | South African National AIDS Council |
| SAPS | South African Police Service |
| SAQA | South African Qualifications Authority |
| SOP | Standard Operating Procedure |
| SR | Sub-Recipient |
| SSR | Sub-Sub Recipient |
| TAC | Technical advisory committee |
| TB | Tuberculosis |
| USAID | United States Agency for International Development |

# EXECUTIVE SUMMARY

## Introduction

Creative Consulting and Development Works (CC&DW) was commissioned by the National Religious Association for Social Development (NRASD) and Networking HIV, AIDS Community of South Africa (NACOSA) to conduct an outcome evaluation of the Global Fund Orphans and Vulnerable Children (OVC) Programme. As principal recipients of the Global Fund Phase II Grant, which ran from 1 October 2013 to 31 March 2016, NRASD and NACOSA were responsible for ensuring that grant objectives were met. While NACOSA and NRASD were responsible for monitoring and evaluating the achievement of grant objectives, a special agreement of the Global Fund Phase II Grant is that independent process and outcome evaluations of the OVC Programme be completed. A previous survey and process evaluation was conducted in 2015 and the current evaluation sought to both build on the data collected during this previous evaluation while collecting additional outcomes-focused data.

## Objectives

The purpose of this evaluation was to assess the functioning of the Global Fund Phase II Grant OVC Programme as a whole, including all Phase II activities of the programme grant. In assessing the functioning of the programme, the evaluation had three key objectives:

1. To review the OVC programme's achievements,
2. To assess the effectiveness (outcomes) and efficiency of the OVC programme, and
3. To review the OVC programme's exit and sustainability strategies.

## Background

The Global Fund OVC Programme specifically aimed to work towards the achievement of one of the goals of the Global Fund Phase II Grant - that is, to reduce the number of new HIV infections by at least 50% using combination prevention approaches. Compared to Phase I, Phase II of the Global Fund OVC programme shifted towards the achievement of the programme outcome of raising an AIDS free generation through primary and secondary HIV prevention. Thus, the Phase II OVC programme focused on the provision of HIV prevention information and HIV Testing Services (HTS).

The OVC Programme was implemented through the NRASD and NACOSA, the latter including the National Association of Child Care Workers (NACCW) and Childline South Africa, using four approaches to OVC care:

1. Home Community Based Care Support Programme (HCBC) implemented by NRASD.
2. Community Systems Strengthening Programme implemented by NACOSA.
3. Isibindi Model, implemented by DSD and other partners with mentoring and technical support by the NACCW[1].
4. A specialised child protection programme implemented by Childline South Africa[2].

[1]Although not included in the main body of the report, the NACCW Isibindi model supported by the Global Fund Phase II Grant through NACOSA is included in the evaluation as a case study.
[2] Although not included in the main body of the report, the NACCW Isibindi model supported by the Global Fund Phase II Grant through NACOSA is included in the evaluation as a case study.

For the purposes of the OVC programme, NRASD sub-granted to five partners (four religious and one non-religious). These SRs were the Anglican AIDS and Healthcare Trust (AAHT), Council for Church Social Services (KMDR), the Methodist Church of Southern Africa (MCSA), the Southern Africa Catholic Bishops' Conference AIDS Office (SACBC) and the Starfish Greathearts Foundation (SGF). The five SRs then worked with 47 Community Based Organisations (or sub-sub recipients/SSRs) who delivered services to OVC.

As a PR for the Global Fund Phase II Grant OVC Programme, NACOSA was a direct grant manager to 29 CBOs (or SRs, 26 of which are included in the current evaluation) and channelled and managed small grants funding to these organisations.

# Method

Three evaluation approaches or designs were used to address the evaluation objectives and questions, namely:

## Process evaluation

A process evaluation drew on existing programme monitoring data from NACOSA and NRASD to identify programme achievements in terms of the output and process indicators. Qualitative data from CBO managers and care workers was used to identify the factors that affected the delivery of these services and activities.

## Quasi-experimental research design

A quasi-experimental research design utilised an Intervention Group (CBOs running the Global Fund OVC Programme through NACOSA or NRASD) and Comparison Group (CBOs running an OVC programme funded by the Department of Social Development) design to compare outcome performance measures between the two groups at the end of the programme. In addition, data was compared between Time 1 (utilising data from a previous process evaluation) and Time 2 (the current end-of-programme outcome survey) so as to identify broad changes at intervention sites from the midpoint of the programme to the endpoint.

In order to examine programme effectiveness or outcomes at both the household and organisational level, a survey was conducted with NACOSA SRs, NRASD SSRs and DSD comparison sites. There was no sampling of intervention sites and all SRs and SSRs who were implementing the OVC Programme at the time of the evaluation were included in the evaluation – a total of 26 NACOSA SRs and 47 NRASD SSRs. Including 16 DSD comparison sites which were based on the sites visited during the previous process evaluation, a total of 89 CBOs were visited during the evaluation.

Three different groups were interviewed at each site:

1. CBO managers: A total of 85 telephonic interviews with CBO directors, programme managers or coordinators were conducted utilising closed and open-ended questions.
2. OVC care workers: During 2-day site visits, a survey with two care workers per organisation conducted using mobile survey technology. A total of 178 predominantly female care workers were included in the final sample, 82% (146) working under the Global Fund OVC Programme and 18% (32) working at DSD comparison sites.
3. OVC beneficiaries: During the site visit, a survey utilising mobile technology was conducted with eight OVC (where an OVC was aged 10 years or older, the OVC was surveyed directly) or OVC caregivers (where an OVC was younger than 10 year the caregiver of the child was surveyed) at each site. A total of 685 participants were included in the final OVC sample (82% / 561 for Global Fund and 18% / 124 for DSD); roughly three quarters of these (75%) were OVC aged 10 years and older. The sample was predominantly rural and had either the parents or grandparents as primary caregivers.

Every effort was made to sample the same participants that participated in the previous evaluation however, due to a number of mitigating factors less than half of the OVC sample comprised repeat participants while slightly more than half (58%) of the care workers participating were repeat participants.

## Case studies

In order to supplement the above, ten case studies were constructed to highlight particular findings that emerged from the quasi-experimental survey and manager interviews. The case studies drew on programme documents, monitoring data, key informant interviews and focus groups with care workers at a number of CBOs, as well as qualitative data from the manager interviews conducted as part of the broader evaluation process. The case studies explored the following topics:

1. Case Study on the Childline Residential Therapeutic Support Programme
2. NACCW in the Global Fund Phase II Grant: Case Study on the Lwandile and Libode Isibindi Safe Parks
3. Community Systems Strengthening under the Global Fund OVC Programme
4. Child and Youth Care Worker Training in the Global Fund Phase II Grant
5. Material and Nutritional Support in the Global Fund Phase II Grant OVC Programme
6. Quality of Life in the Global Fund Phase II Grant OVC Programme
7. Sustainability in the Global Fund Phase II Grant: A Case Study on the NACOSA OVC Programme
8. Sustainability in the Global Fund Phase II Grant: A Case Study on the NRASD OVC Programme
9. Creating an AIDS-Free Generation: Case Study on HTS in the NRASD Model of the Global Fund Phase II Grant OVC Programme
10. Creating and AIDS-Free Generation: Case Study on HTS in the NACOSA Model of the Global Fund Phase II Grant OVC Programme

# Findings

The findings were presented according to the three evaluation objectives.

## Achievements

One of the key programmatic output indicators of the programme was **the number of OVC whose household received free basic external support in caring for the child**. Despite some implementation challenges reported by SRs, SSRs and care workers, both PRs successfully reached and exceeded their programme targets in terms of the number of OVC households receiving free basic support in caring for the child through the Phase II Grant:

- NRASD SSRs met and exceeded their targets, reaching a total of 12 331 OVC against a target of 8 384 in Quarter 10 of the grant.
- NACOSA SRs reached a total of 10 163 against a target of 10 200 in Quarter 10 of the grant but it is estimated that they reached over 14 000 households across the whole grant term.

Overall, across both programmes, targets were met and exceeded in terms of the second key programmatic output indicator - number of OVC 'knowing their status' (i.e. **having an HIV test and receiving the result**). While testing was slow to be implemented in the initial stages of the grant, both NRASD and NACOSA surpassed their targets on this indicator by the end of Quarter 10:

- A total of 8110 tests were conducted by NRASD, against a target of 5040.
- A total of 10 642 tests were conducted by NACOSA against a target of 10 600. This included 2 202 successful referrals and 8 440 HTS conducted directly by SRs.

Knowing one's status is an important first step in the prevention of HIV through increasing HIV knowledge and awareness and contributing towards behaviour change. Although a large number of OVC were tested as part of the Phase II Grant, the positivity rates for HIV (2%) and TB (<1%) reported by NRASD SSRs were low.

While the NACOSA and NRASD programmes differed in terms of the nature of material and nutritional support provided, both NACOSA and NRASD exceeded their targets in terms of **material support** provided to OVC over the duration of the grant. As part of the **nutritional support**, emergency nutritional support in the form of food parcels to OVC deemed malnourished was provided to 3 220 OVC by NACOSA whereas NRASD provided a more substantial nutritional component including food parcels and/or cooked meals to their programme and serviced 8 720 with nutritional support.

As part of their community systems strengthening approach, 452 **child care forum** meetings and 3100 **circles of support** were achieved by NACOSA SSRs over the duration of the grant period, surpassing the target on the latter although not the former.

These patterns in service delivery can be understood due to a number of challenges experienced by SRs and SSRs:

- Initial community resistance to HTS, particularly amongst OVC caregivers
- Large distances and poor transport for care workers to travel
- Strained relationships with other stakeholders
- Local dynamics or contexts which prevented efficient delivery of services to OVC

However, it seems that despite these initial challenges which slowed service delivery and the reaching of targets early in the grant term, SRs and SSRs were able to overcome these in the latter part of the grant term with nearly all performance framework output targets being exceeded. Nearly all other targets were also met and/or exceeded.

## Effectiveness

Based on the survey findings, the Global Fund Phase II Grant was successful in ensuring OVC in the programme were **tested for HIV**:

- 62% of OVC from NRASD SSRs reported knowing their status and 71% of OVC from NACOSA SRs reported knowing their status compared to only 36% of OVC from the DSD programme.
- OVC in the Global Fund Programme were 4 times more likely to be tested for HIV than OVC in the DSD Programme.
- OVC in the Global Fund Programme were 4.3 times more likely to be tested for HIV at the end of the programme compared to mid-programme.

Although the **HIV prevention knowledge** of OVC and caregivers in the Global Fund programme was high; however, except for one area of knowledge, Global Fund participants did not have significantly better HIV prevention knowledge when compared to DSD participants. However, the HIV prevention knowledge of OVC in the Global Fund programme improved significantly from mid- to end-of-programme:

- Global Fund OVC and caregivers were 1.5 times more likely to get all HIV prevention/knowledge questions correct at the end of the programme compared to earlier in the programme

The improved HIV prevention knowledge of OVC did not appear to have translated into behaviour change; while engagement in risky behaviours was generally low overall there were no significant differences between OVC aged 10 years and older in the Global Fund OVC Programme compared to OVC in the DSD Programme in terms of substance use or having had sex. There was no change in these behaviours from mid-programme to end-of-programme.

More than 98% of OVC across all programmes were **enrolled in school**. While a quarter (21,4%) of OVC in the Global Fund programme reported missing school in the last 3 months, this was predominantly due to illness and suggested that attendance at school was generally good. Significantly, OVC who had been receiving services for more than 1 year but less than 2 years were 6.4 times more likely to report good or very good school performance. This suggests a positive effect for homework support and other support services provided to OVC through the programme. In addition, OVC and caregivers appeared to be satisfied with the progress of

the child in his/her last school exams; two thirds (66,3%) of OVC/caregivers reported that they were happy with their school performance and did 'good' or 'very good' in their last exams although there were no significant differences in perceived school performance between mid- and end-of-programme.

Levels of **hunger** among OVC households was generally low - 79% of OVC or caregivers in the Global Fund Programme reported having little to no hunger in the household. Although slightly more OVC and caregivers in the DSD Programme reported moderate hunger than Global Fund households (25,8% vs. 19,8%), there were no statistically significant differences. This suggests that households were receiving the necessary nutritional support to prevent moderate or severe hunger.

The **uptake of services** amongst OVC households was high, although not significantly different between Global Fund and DSD households:

- 90% of OVC households in the Global Fund Programme reported receiving a social grant, and
- 72% had accessed health services in the last 6 months.

The **organisational capacity** of NACOSA SRs and NRASD SSRs was built in a number of ways through the OVC Programme:

- Thirty-nine out of 46 NRASD SSRs and 17 out of 26 NACOSA SRs reported that coordination and networking of their organisation in the community had improved.
- Nineteen out of 26 NACOSA SRs identified that the grant had strengthened the capacity of the organisation. Forty out of 47 NRASD SSRs noted strengthened organisational capacity as an achievement of the grant.
- The strengthened capacity of the child and youth care workers was identified by 22 out of 26 NACOSA SRs and 41 out of 47 NRASD SSRs as an achievement of the grant.

In exploring the capacity built, managers reported that:

- Having stronger linkages with other stakeholders, particularly schools and clinics,
- A stronger presence and visibility in the community, with more community awareness of the organisation and its services,
- Improved quality and scope of services provided to better meet the needs of the vulnerable households in their respective communities.
- Improved reporting and recording capacity, including knowledge and use of the CBIMS system.

## Exit and sustainability

With the close out of the Phase II Grant on 31 March 2016, sustainability was a key theme that was explored through manager and care worker interviews. Firstly, at the **organisational level**, the results raised concerns for the 14 SRs and SSRs that reported that the Global Fund OVC Phase II Grant was 100% of their funding income and who will be most at risk following close out. However, a number of promising findings and sustainability strategies of organisations emerged:

- Most SRs and SSRs have multiple funding streams including having more than one funder, fundraising and income generating activities and in-kind support. Having a smaller proportion of funding from a single source will contribute towards sustainability.
- 41 SRs and SSRs reporting receiving no in-kind support, a valuable source of support that can help to buffer the effects of a lack of donor funding.
- However, more than a third of SRs and SSRs are exploring various fundraising options and a number of innovative practices were identified including applying for other funding to replace the loss of the Global Fund Phase II Grant, fundraising and income generating projects and shifting of programme focus or activities.

That 57 SRs and SSRs reported having applied for but not secured funding is indicative of the tough funding climate in South Africa. Local businesses and donors are also stretched by the number of NPOs requesting support.

Nevertheless, organisations were thinking about and planning for the impact of the end of the grant term on staff, service delivery and beneficiaries. Organisations expected to face the most significant changes or challenges with regards to staff retention, the number or frequency services provided to OVC and the scope of services they were able to provide.

Those services that are low-cost and well developed in the organisation and community structures are more likely to be sustainable post close-out including referral mechanisms and linkages to support, child care forums and psychosocial support to OVC. The delivery of material and nutritional support will be most severely impacted by grant closure unless SRs and SSRs are able to link to other service providers or secure sponsorship or funding.

Secondly, at the **household level**, it emerged that a key weakness of SR and SSR programme implementation with regard to sustainability was that OVC were kept in the programme on a continuous basis. Children had predominantly been exited from the programme due to reaching the age of 18 and/or moving away from the area served by the SR or SSR. Few organisations reported a defined exit strategy for children whose needs have been met or situation stabilised according to their care plan. However, organisations predominantly plan to exit children using referral to other NPOs, referral to government services and linkages to income generating projects.

# Lessons and recommendations

SRs and SSRs were able to overcome challenges and programme targets for HTS testing were met and exceeded by both PRs by the end of the grant term. The Global Fund OVC Phase II Grant was particularly effective in achieving the uptake of HTS amongst OVC and their households. Significantly more OVC in the Global Fund Programme know their status compared to those in the DSD Programme. In addition, significantly more knew their status by the end of the programme compared to early in programme implementation. This suggests that the programme model is an effective strategy to increase HIV testing amongst children, including younger children (< 10 years).

Through the education of communities on HIV prevention and the importance of knowing one's status, the programme has paved the way for the recognition of the importance of testing in communities across South Africa. The training provided to care workers as well as the focus on HIV education allowed SRs and SSRs to build trust and acceptance of the importance of HTS amongst community members. In addition, testing is a first step towards increasing HIV knowledge and behaviour change to prevent or reduce risk of infection and improve other outcomes, limiting HIV testing to adolescents in future programming will be an effective strategy.

OVC and caregivers in the Global Fund OVC Programme performed well on most outcomes. Nearly all were enrolled in school and few missed school other than for illness; the uptake of grants and access to healthcare amongst OVC households was also high; few reported going hungry; and engagement in high risk behaviours, such as substance use, was generally low. In addition, social support for OVC in the Global Fund programme is high.

Organisational capacity building and the strengthening of networks and partnerships in communities was a success of the grant for SRs and SRRs. The visibility of SRs and SRRs in their communities has improved and this has resulted in improved service provision to OVC households. These are also likely to result in sustained referral networks and linkages for support for OVC despite the end of the grant term. Capacity building under the Global Fund Phase II Grant was a significant enabler for the sustainability of organisations and the services that were provided as part of the OVC programme. In particular, a programme focus on non-financial activities and services that are effective while not costly to provide, means that such services will be more easily sustainable post close-out.

In the tough funding climate in South Africa, particularly for CBOs in the Children's Sector, organisations should be encouraged to explore multiple funding streams/diversified funding. Those organisations with only one or two funding streams should work towards building multiple smaller funding streams to buffer the effects of the loss of a single funder. Organisations should also explore in-kind support as a resource in times when donor funding is scarce. Lessons can be learned from some SRs and SSRs in terms of innovative and effective fundraising and funding strategies being used. In particular, organisations should continue to build capacity at the individual household and community level through, for example, income generating activities. At the organisational level, income generating activities can also help to raise funds for the sustainability of the organisation. In addition, an organisation that is able to adapt to the broader policy environment has a greater chance of getting resources, which is critical to their survival. Capacity building at the organisational level as part of the support offered by NACOSA and NRASD through the Grant enabled some organisations to adapt their strategy in this regard.

Two key limitations of the evaluation were that it was:

- Unable to utilise a true control group or baseline assessment. In order to more clearly identify programme outcomes, it is recommended that future programmes execute a baseline before programme implementation and/or use a control group that received either no or a significantly different programme.
- Not possible to comment on the sustainability of the programme outcomes for OVC households. In order to identify whether the programme had a sustained impact, it would be necessary to conduct a post-test (for example 6 months after a child has exited the programme).

# 1. INTRODUCTION

Creative Consulting and Development Works (CC&DW) has been commissioned by the National Religious Association for Social Development (NRASD) and Networking HIV, AIDS Community of South Africa (NACOSA) to conduct an outcome evaluation of the Global Fund Orphans and Vulnerable Children (OVC) programme. As principal recipients of the Global Fund Phase II Grant, which ran from 1 October 2013 to 31 March 2016, NRASD and NACOSA were responsible for ensuring that grant objectives were met. While NACOSA and NRASD were responsible for monitoring and evaluating the achievement of grant objectives, a special agreement of the Global Fund Phase II Grant is that independent process and outcome evaluations of the OVC Programme be completed. A previous survey and process evaluation was conducted in August – February 2015 by another evaluation consultancy (Community Agency for Social Enquiry; CASE) and the current evaluation sought to both build on the data collected during this previous evaluation while collecting additional outcomes-focused data.

## 1.1 Purpose and objectives of the evaluation

The purpose of this evaluation was **to assess the functioning of the Global Fund Phase II Grant OVC Programme as a whole**, including all Phase II activities of the programme grant. In assessing the functioning of the programme, the evaluation had three key objectives, which are briefly outlined and discussed below.

### 1.1.1 Objective one: To review the OVC programme's achievements

This objective refers to assessment of the **outputs** of the programme from routine monitoring of output and process indicators. This included, but was not be limited to

- Number of OVC aged 0 -17 years whose households received free basic external support in caring for the child, and
- Number and percentage of OVC that received an HIV test and know their result.

Objective one also speaks to additional activities included under the Phase II Grant, such as number of circles of support held, number of child care forums conducted, and emergency nutrition and material support provided. It also refers to the activities conducted in terms of organisational capacity-building and mentoring, such as number of child and youth care workers (CYCW) trained.

Based on the findings of the previous evaluation, a number of recommendations were made. Although the timeframe between the completion of the process evaluation and the current evaluation has been short (< one year), in reviewing the programme's achievements, the evaluation aimed to explore to what extent the recommendations have been addressed by the principal recipients (PRs), sub-receipts (SRs) and sub-sub recipients (SSRs).

### 1.1.2 Objective two: To assess the effectiveness (outcomes) and efficiency of the OVC programme

In assessing the **effectiveness** of the OVC programme, the evaluation aimed to assess the operationally defined programme outcomes at the organisational and household/OVC level.

At the organisational level, the evaluation aimed to assess organisational and CYCW capacity according to the following criteria:

- organisational mechanisms/systems in place to identify and prioritise services to OVCs who are most in need of support;

- organisational mechanisms/systems in place that ensure that OVCs in their programme received a package of support that is consistent with their needs;
- referral pathways that ensure linkages to services;
- OVC programme that demonstrates a strong HIV prevention (primary and secondary) strategy that appropriately addresses the risks and vulnerabilities of OVC;
- high quality HIV testing services (HTS);
- an OVC programme that demonstrates that it responds to the adherence needs of children who have tested HIV-positive; and
- accurate and robust recording and reporting systems.

At the household/OVC level, the evaluation aimed to assess a number of outcome indicators, including:

- child well-being,
- retention in school,
- nutritional status,
- HTS service uptake,
- HIV knowledge, and
- uptake of additional support services.

Assessing **efficiency** speaks to assessing the cost-effectiveness of the programme by comparing inputs (costs and human resources) to outputs. An ex-post efficiency analysis is conducted after a programme has been implemented and its impact evaluated, with the goal of assessing whether the costs of the programme are justified in relation to the effects of the programme in order to make decisions to expand or continue funding. As the Global Fund Phase II Grant OVC Programme ceased in March 2016, a full cost-benefit or cost-effectiveness analysis is beyond the scope of the evaluation. However, the evaluation aimed to reflect on measures that contributed towards efficiency and inefficiency and whether outputs were achieved on time.

### 1.1.3 Objective three: To review the OVC programme's exit and sustainability strategies

Acknowledging that the OVC Programme Phase II Grant was coming to an end on 31 March 2016 and, after the cessation of the grant, SRs and SSRs would no longer receive Global Fund funding through the respective PRs, the evaluation aimed to assess sustainability strategies both at the household and at the organisational level. Specifically, objective three had two sub-objectives:

#### 1.1.3.1 To explore whether the OVC services offered by the SRs can have a sustained positive impact on vulnerable households

This sub-objective aimed to describe how SRs and SSRs contributed towards sustaining an improved quality of life for OVCs and their households to ensure that households have long-term and sustained mechanisms that enable guardians to continue to support children. The evaluation reflects on the outcomes highlighted in objective two above and the sustainability efforts of the SRs and SSRs to build capacity at the household level.

It must be noted that while the objective refers to sustained positive impact, sustained impact is difficult to determine in such a short timeframe. Typically, sustained or long-term positive impact is explored through a post-test or follow-up that takes place some time after the completion of the intervention or programme. As the current evaluation was conducted at the end of the programme and/or while programme activities were still being implemented, it was not feasible to comment definitively on the sustained positive impact of the services. However, the evaluation attempted to describe how SRs and SSRs have contributed towards sustaining an impact on the households that had gone through the programme and the likelihood that the

programme will be effective. For example, it explored how the SRs and SSRs have worked with households to ensure the household 'exit' the programme appropriately if (a) necessary support/services have been rendered or (b) the household is referred to another service provider.

#### 1.1.3.2 To explore whether the sustainability strategies of OVC SRs and SSRs will ensure that they are able to continue rendering services at the end of Phase II

With the discontinuation of the Phase II grant, this end of project evaluation came at a critical time in terms of determining whether and how organisations had thought about and planned for exit from the grant. Therefore, this sub-objective aimed to explore if and/or how sustainability had been ensured in target communities by SRs and SSRs in terms of being able to continue service delivery to households. This included exploring what capacity had been developed through the programme, how SRs and SSRs had been assisted by PRs to ensure sustainability, alternate or new sources of funding, and employee retention post-March 2016.

## 1.2 Evaluation questions

Table 1 on the following page describes the evaluation framework adopted and contains the specific research questions addressed by the evaluation. The questions were developed by the evaluation team in consultation with the technical advisory committee (TAC), based on the evaluation questions included in the original terms of reference for the evaluation.

**Table 1. Evaluation questions according to key objectives and sources of data**

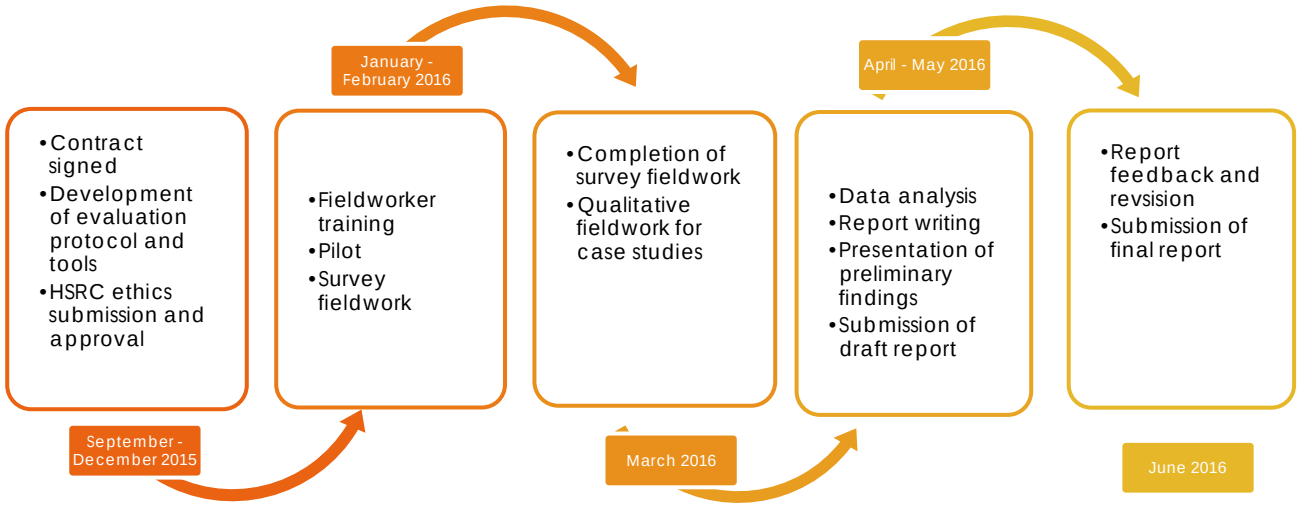
| Objective | Evaluation Questions | Source of Data |
|---|---|---|
| **Achievements** | • What outputs and activities have been delivered and to what extent?<br>• If programme outputs and activities have not been achieved, why not?<br>• What is the quality of the services implemented?<br>• What factors influenced programme delivery? | Programme monitoring data<br>Key informant interviews<br>SR/SSR interviews |
| **Effectiveness, outcome and efficiency** | • To what extent have the intended outputs and activities of the programme been consistent with the needs of OVCs and their primary caregivers?<br>• What are the gaps in services?<br>• What improvements could be made in terms of service delivery?<br>• What best practices can be documented with regard to service delivery and implementation?<br>• To what extent have the grant resources been utilised for the delivery of activities?<br>• Did the programme use the least costly, appropriate resources possible in order to achieve the desired results?<br>• Were outputs achieved on time and within budget?<br>• What factors contributed towards inefficiencies or wasting of resources?<br>• What factors contributed towards efficient programme operation? | Financial records<br>Monitoring data<br>SR/SSR and CYCW interviews<br>Key informant interviews |
| | • What has been the impact of the HTS programme on SRs, OVCs and their caregivers?<br>• What is the current status of OVC in terms of psychosocial well-being, nutritional status and schooling?<br>• What is the level of knowledge and awareness of OVC around HIV/AIDS?<br>• What is the uptake of HTS services?<br>• What is the uptake of social grants, healthcare and child protection services amongst OVC and their households? What are the barriers to access?<br>• What is the current status of OVC caregivers in their ability to meet basic needs?<br>• What systems are in place to ensure linkages to existing support services?<br>• What are the incidence/new infection rates reported by organisations?<br>• In what ways has the grant improved the capacity of organisations to respond to the needs of OVC?<br>• What systems are in place to identify and prioritise OVCs who are most in need of support?<br>• What is the capacity of organisations and CYCW to accurately record and report on their activities? | SR/SSR and CYCW interviews<br>OVC and caregiver survey |

| Objective | Evaluation Questions | Source of Data |
|---|---|---|
| **Exit and sustainability** | • How are programmes ensuring sustainable impact for OVCs who exit the programme?<br>• How sustainable are the outcomes of the programme likely to be, especially at household level?<br>• What sustainability plans do OVC organisations have in place to ensure the programme is sustainable beyond the term of the grant?<br>• What is the likelihood that the sustainability strategies of SRs will ensure they are able to continue rendering services to households beyond the term of the grant?<br>• What are the challenges facing SRs with regards to sustaining services? What are examples of best practice?<br>• How well do the PR's programmes link to the DSD's plan for sustainability, i.e. beyond existing external funding sources? | SR and SSR interviews<br>Key informant interviews |

## 1.3 Evaluation timeline

The evaluation followed the stages outlined in Figure 1 below.

**Figure 1. Overview of evaluation timeline according to key milestones and deliverables**



# 2. THE CONTEXT OF OVC IN SOUTH AFRICA

South Africa remains one of the most unequal countries in the world, and income inequality, as measured by the Gini coefficient, has been increasing since 1993. As a result of increasing inequality, the life chances of millions of children continue to be thwarted. Compared to a child growing up in the wealthiest household, a child in the poorest home in South Africa is 17 times more likely to be hungry, 25 times less likely to be covered by medical schemes and three times less likely to complete secondary education [1].

South Africa has more than 18 million children under the age of 18 years (more than a third of the total population) [2]. A large proportion of South African children are classified as orphans and vulnerable children (OVC). Vulnerable children, according to the national Department of Social Development (DSD)[3], are defined as children whose survival, care, protection or development may be compromised due to a particular condition, situation or circumstance, which prevents the fulfilment of his or her rights[3]. Some children are made particularly vulnerable through circumstances such as HIV infection (acquired at birth or through unprotected sex); living in a household with sick or elderly caregivers; being abandoned, abused or neglected; living in a household caring for many children; experiencing bereavement; or undergoing frequent mobility.

The HIV/AIDS pandemic in particular has resulted in a growing number of orphans and vulnerable children in South Africa. There were approximately 3.85 million orphans in South Africa in 2011, including maternal orphans (a child whose biological mother has died but whose father is alive), paternal orphans (a child whose biological father has died but whose mother is alive) and double orphans (a child whose biological mother and father have died) [4]. The number of double orphans increased from 350 000 in 2002 to 950 000 in 2011, likely due to increased mortality associated with the HIV/AIDS pandemic. The largest proportion of orphans, however, are paternal orphans, who represent sixty percent of all orphans in South Africa or 17 percent of all of children in South Africa)[4].

The death of one or both parents has been shown to impact negatively on child outcomes, including educational outcomes [5], and it places children at risk of living in households with poorer financial resources [6] and food insecurity [7]. Research has shown that orphans are more likely to go hungry and not eat before school as well as not be supervised while playing, which may place them at risk for exposure to violence. Orphanhood is said to place an increased burden on non-parent caregivers, which places orphans at a greater risk of abuse from caregivers; however, they are also at risk of abuse from others outside the household [7,8]. Whereas orphans have traditionally been absorbed by the extended family, there is now concern that the extended family network needs support in being able to cope [5, 9].

Along with parental mortality and orphanhood, children living in HIV-affected households or in households with adult(s) with chronic illnesses may also be particularly vulnerable to abuse and poverty [10,11]. The extent of the HIV/AIDS epidemic in South Africa has led to widespread concern over the impact this is having on the lives of children throughout the country. The findings that poverty, caregiver mental health, and family dysfunction mediate the relationship between household chronic illness and poor child outcomes also suggest that poverty alleviation efforts and social and emotional support for caregivers of children living in households with chronic illnesses such as HIV/AIDS may help to protect OVC [8].

It has also been observed that by the end of the twelve-year schooling period, South Africa loses half of every cohort that enters the school system due to drop-out[12]. Along this route, significant human potential is hindered and the life chances of young people are harmed. This contributes to rising unemployment figures, particularly for young people. According to the 2011 Census, the national unemployment rate was 40% whereas the unemployment rate for youth aged 20 – 24 was 59% and 42% for youth aged 25 – 29 [2].

[3] The DSD definition of OVC is fairly broad. It is important to acknowledge that vulnerability is not a fixed state (like orphanhood), so a child can be vulnerable for a time and then not vulnerable or vice versa.

In addition, data from the National Strategic Plan on HIV, Sexually Transmitted Infections (STI's) and TB 2012-2016 shows that 39% of 15-19 year old girls have been pregnant at least once and 49% of adolescent mothers are pregnant again in the subsequent 24 months [13]. It also reveals that one in five pregnant adolescents is HIV-positive. The South African National HIV Survey in 2012 found that the HIV prevalence rate of 0 – 14 year olds was 2.4%[4] - with this being slightly higher for females (2.4%) than for males (2.3%) [14]. However, in the 15 – 19 year old age group this gap increased significantly. While the prevalence rate was 3.2% overall for this age group, when broken down by sex it was 5.6% for females and 0.7% for males. This is the start of an increasing female HIV prevalence rate; females have a significantly higher HIV prevalence than males across all ages (14.4% vs. 9.9%) [14].

Research suggests that OVC have an elevated risk of HIV infection. A meta-analysis of HIV testing data reports that orphaned children had significantly greater odds of HIV infection as well as higher levels of sexual risk behaviour than non-orphans [15]. This is supported by the South African National HIV Survey, which reported that orphans in the survey were 3.5 times more likely than non-orphans to be HIV positive, with double orphans[5] being 6.9 times more likely than non-orphans to be HIV positive [14]. This difference in HIV prevalence between orphans and non-orphans was particularly significant in the younger age group (0 – 14 years) but was not significant in the older age groups (15 – 18 years). This disparity in HIV prevalence rates for OVC suggests the need for interventions to address this.

[4]These proportions corresponded to an estimated number of 369 000 children aged 0 – 14 years living with HIV with 45.1% of these on ARTs.

[5]Double orphans refer to children who have lost both parents (mother and father) whereas single orphans refer to children who have lost one parent (either mother or father).

# 3. DSD POLICY FRAMEWORK AND NATIONAL PLAN OF ACTION ON OVC

In response to the vulnerability of OVC, the South African government has developed and implemented a series of laws, policies, strategic plans and programmes in order to appropriately address the needs of OVCs and strengthen the capacity of families and communities to care for OVCs [16]. The national Department of Social Development (DSD) published the policy framework for Orphans and other Vulnerable Children affected by HIV/AIDS (OCVAHA) in 2006. It emphasises the importance of developing comprehensive and integrated strategic responses for orphans and other vulnerable children at programmatic level. Its six key strategies are:

- strengthen and support the capacity of families to protect and care for children;
- mobilise and strengthen community-based responses for the care, support and protection of orphans and other children made vulnerable by HIV and AIDS;
- ensure that legislation, policy, strategies and programmes are in place to protect the most vulnerable children; assure access for orphans and children made vulnerable by HIV and AIDS to essential services;
- raise awareness and advocate for the creation of a supportive environment for orphans and children made vulnerable by HIV and AIDS; and
- engage the civil society sector and the business community in playing an active role to support the plight of orphans and children made vulnerable by HIV and AIDS.

The National Strategic Plan (NSP) on HIV, STIs and TB 2012 – 2016 identifies 'mitigating the impact of HIV and TB on orphans, vulnerable children and youth' as Sub-Objective 1.4. The NSP aims to reduce the impact of HIV on OVC by ensuring access to vital social services, such as education. For example, with regard to schooling, the NSP target for 2016 is to achieve 100% school attendance among both orphans and non-orphans aged 10-14 years. The NSP states the following:

> ***The numbers of orphans and children made vulnerable by HIV has increased over the years. The Department of Social Development has been leading activities to protect the rights of orphans, vulnerable children and youth and to reduce their vulnerability and the impact of HIV and TB. There is a need to scale up these interventions and strengthen initiatives at community level to protect the rights of orphans and, in particular, child and youth-headed households. Mental health services must also be part of the package of services provided to support orphans and vulnerable children (pg.36).***

The South African government's response to children and households affected by HIV/AIDS is rights-based in terms of its social protection system, with a large number of households receiving the child support grant, foster care and disability grants and increasing access to education, health care and child protection services [4,16]. In addition to the education, health care and child protections services provided by government, civil society organisations play a significant role helping to fill gaps in government services [16].

Against this background, the Networking HIV/AIDS Community of South Africa (NACOSA) and the National Religious Association for Social Development (NRASD) manage and oversee a comprehensive package of prevention, care and support services appropriate for OVC implemented by affiliated civil society organisations in carefully selected districts in all provinces of South Africa.

# 4. FUNDING LANDSCAPE IN SOUTH AFRICA

In South Africa, as stated above, services for OVC and for children and families affected by HIV/AIDS are provided both by the South African government and by civil society organisations, who sometimes work directly with Government to help implement national programmes and other times provide alternate or supplementary services, with support from a variety of private and public donors.

Since the early 2000s, South African government spending has increasingly been dedicated to social payments for the poor, part of a broader "developmental" approach to poverty alleviation. To strengthen programmes for young people and assert their rights, between 2005 and 2007, the South African government passed a new Children's Act and Children's Amendment Act. Such new laws were intended to give effect to the constitutional rights of children in South Africa to appropriate care, services, and protection and to provide for and regulate far-reaching social services for children and families, including the provision of child support and foster care grants. Over time, these grants have become widely accepted and accessed, in part because many civil society organisations have come to see helping people to access grants as one of their service delivery strategies [18]. In confronting the effects of HIV/AIDS on young people and families, the service provision sector has relied heavily on the assistance provided by the child support and foster care grant to enable "family-based" support for children affected by HIV/AIDS. The strategy reflected the fact that many orphans and apparently vulnerable children in South Africa are not in fact "in need of care," as one study put it [18], because most were taken into some form of family care arrangement [19].

For most young people in South Africa, foster care grants were not needed so much because they were without care, but because they were simply "in need of cash" [18]. However, as the HIV epidemic expanded the foster care system has not been able to keep up with the rapidly expanding numbers of children in need of support. By April 2012, according to the Children's Institute, the foster care system, designed to provide support for 50,000 children, was providing 544,000 grants, with hundreds of thousands of applications still awaiting review [20].

In response to these debates, some researchers and civil society organisations have taken a broader approach, lobbying for the creation of a new social assistance grant, a "kinship grant," which could solve the challenges posed by the rising number of orphans and other children affected by HIV/AIDS by creating a comprehensive, sustainable national system to support extended kin-based care for young people in need [21].

One of the reasons for an increased emphasis on the need to create sustainable national systems to provide support for orphans and vulnerable children has been the continued shifts in the funding climate for OVC programmes from external donors. Starting in the early 2000's, bilateral and international organisations and private donors began to offer funding support for programmes intended to address the expanding effects of the HIV epidemic on children and families in South Africa. The US President's Emergency Plan for AIDS Relief (PEPFAR), launched in 2003, was particularly notable among these. Its $15 billion programme aimed within 5 years to support treatment for two million people living with HIV/AIDS; prevent seven million new HIV infections; and support care for ten million people infected with and affected by the disease, including two million "orphans and vulnerable children," living in 15 target countries (including South Africa). In 2005, the United States (US) Congress passed an additional law, the Assistance for Orphans and Other Vulnerable Children in Developing Countries Act, which called for increased attention and funding for programmes for "orphans and vulnerable children affected by HIV/AIDS", mandating that at least 10% of PEPFAR funds be disbursed to OVC programmes, and created an additional set of oversight and reporting requirements for these programme [22].

Through its massive financial investment—the "largest commitment ever by any nation for an international health initiative dedicated to a single disease" [22] – and its strictly regulated approach, PEPFAR has played a major role in shaping an expanding form of development and philanthropic aid structured around a global public health initiative [24]. In the new approach to "global health", health programmes and development funds have shifted into the control of donor nations and private industries, thus creating a series of "vertical", technical interventions framed by, as Brown describes, "the new international political economy structured around neoliberal approaches to economics, trade, and politics" [25]. The Global Fund, founded in 2002 as a

partnership between governments, civil society and the private sector, has similarly focused on investing in targeted interventions in countries affected by HIV/AIDS. As of 2008, the Global Fund had helped provide antiretroviral drugs (ARVs) to two million people, TB drugs to 4.6 million people, and 70 million insecticide-treated nets to prevent malaria [26].

In 2008, after a prolonged series of debates, the US Congress, reauthorised PEPFAR with $48 billion budgeted over the next five years "to support HIV/AIDS treatment for 2.5 million people, prevent more than twelve million new HIV infections, and care for more than twelve million people living with HIV, including five million orphans and vulnerable children" [26]. While the expanded funding was welcome, the entry of PEPFAR II (as the second five years of PEPFAR programming has been called) in 2009 coincided with major shifts in the global economic climate, and thus the funding climate around HIV/AIDS and global health. After flattening in 2009, donor government funding for HIV/AIDS fell by 10% between 2009 and 2010, the first decline in more than a decade [27]. Similarly, growth in global health funding overall fell to 4% in 2010, and in 2011 and 2012 appeared to have stopped completely [28]. In this new climate of fiscal austerity, a series of reforms were implemented with the aim of shifting PEPFAR programming and other HIV/AIDS initiatives away from "emergency" response and toward a more "sustainable" model framed around collaboration with recipient governments and evidence-based programming [29].

In 2012, the US Secretary of State Hillary Clinton announced that South Africa was to become the first country to "nationalise" its PEPFAR programme, as funds would be scaled back and "responsibility" handed over to the South African government [30]. This is reflective of a larger shift in the structure of funding for HIV/AIDS programmes. Between 2006 and 2012, low-income and middle-income countries have doubled their domestically sourced financing for AIDS programmes from about $5 billion to $10 billion, such that domestic spending now exceeds international disbursements [31] In South Africa, according to Treasury estimates, about 80.7% of the total R29.39 billion budgeted for HIV/AIDS in the fiscal year 2015-16 comes from the government with 19.3% from donors [32]. Despite the large amount of HIV/AIDS funding coming from the South African government, funding support from PEPFAR, the Global Fund, and other external donors has been essential to the provision of services for many civil society organisations.

Another reason for this shift in funding strategies was an increasing body of evidence suggesting that OVC interventions in the first years of PEPFAR, Global Fund and other programmes seemed to have had little measurable effect on the young people they were intended to serve [33]. To address these concerns, emphasis began to shift from a focus on efficient, inexpensive forms of service provision to an interest in interventions that could be shown to have *measurable* impacts [29]. Thus, funding was refocused away from more broad-based care and support programmes to rather focus on targeted goals linked to a broader global agenda of prevention and treatment aimed at ensuring an AIDS-Free generation [34]. This has meant the ending of funding support for certain kinds of programmes, including the defunding of a number of organisations focused on care and service provision for OVC. This evaluation report reflects this current funding reality, in which a great deal of Global Fund and other funding support for OVC programmes in South Africa has or is about to come to an end. Many of the individuals interviewed for this evaluation spoke of the challenges of this moment of change. The question of sustainability of services in the context of this change is a key focus of the report.

# 5. THE GLOBAL FUND OVC PROGRAMME

The key stakeholders in the Global Fund OVC Programme are (a) Global Fund, (b) NRASD, (c) NACOSA, and (d) the national organisations, provincial non-governmental organisations (NGOs) and community-based organisations (CBOs) which deliver services to OVCs. These stakeholders are discussed in more detail below.

## 5.1 Global Fund's Phase II Grant

Established in 2002, the Global Fund to Fight AIDS, Tuberculosis and Malaria is an international funding institution that contributes to the vision of a world free of HIV, TB and malaria through partnership with governments, civil society, communities, the private sector, faith-based organisations and other funders. South Africa is one of the recipients of Global Fund aid. As part of this aid from October 2013 – 31 March 2016, the Global Fund funded six principal recipients (PRs) through the Global Fund Phase II Grant. NACOSA and NRASD were two of these PRs.

In order to receive funds from the Global Fund, a country needs to have a Country Coordinating Mechanism (CCM); in South Africa, this is led by the South African National AIDS Council (SANAC) with representatives from government, the private sector and civil society. The OVC Programme is a subsection of the overall SANAC CCM and both NACOSA and NRASD contribute to the OVC Programme.

## 5.2 Global Fund OVC Programme

The Global Fund Phase II Grant had three broad goals:

1. To reduce the incidence of TB by 50%;
2. To reduce new HIV infections by at least 50% using combination prevention approaches; and
3. To initiate at least 80% of eligible patients on ART, with 70% alive on treatment five years after initiation.

The Global Fund OVC Programme specifically aimed to work towards the achievement of Goal 2 above - that is, to reduce the number of new HIV infections by at least 50% using combination prevention approaches. Phase I of the Global Fund OVC programme[6] aimed to meet this goal through the provision of general welfare services to OVC. Phase II of the GF OVC programme shifted towards the achievement of the programme outcome of **raising an AIDS free generation** through primary and secondary HIV prevention. As encompassed in the NSP on HIV, STIs and TB 2012 – 2016, primary prevention refers to attempts to reduce the incidence rate of HIV through various specific interventions [34]. This includes, for example, risk-reduction interventions targeting young women who test negative to help them avoid contracting HIV [35]. Secondary prevention refers to attempts to reduce or alleviate the prevalence, severity and adverse health and psychological consequences of the disease through early detection and treatment – "to mitigate impact and to break the cycle of ongoing vulnerability and infection" [34; 35]. This includes, for example, the provision of appropriate treatment, care and support to HIV-positive mothers, their infants and family. Knowing one's status is key to reducing HIV transmission to partners and others. While primary prevention efforts aim to protect uninfected persons against the disease, secondary prevention efforts are also a critical HIV prevention and care service at the community level [36].

Thus, the Phase II OVC programme focused on the provision of HIV prevention information and HIV testing services (HTS)[7]. This was an important new component to the programme that also aimed to provide organisations with information on the HIV status of their beneficiaries, which would in turn shape their future programming.

[6]Phase I was implemented from October 2010 – September 2013 for NACOSA and from 1 April 2011 – 30 September 2013 for NRASD.
[7]During the evaluation process the new National HIV Testing Services Policy and Guidelines were released [37]. These guidelines revised the existing HIV counselling and testing (HCT) guidelines and embraced the full range of services that should be provided together with HIV testing in using the phrase "HIV testing services" (HTS). This is the phrase used in this document although during the grant period "HCT" was used.

The OVC programme objectives, output indicators and output targets are shown in Table 2 below. This provides the overall output targets for the Phase II OVC Grant and is broken down further for NACOSA into output targets for the 29 smaller provincial SRs and larger national SRs. This also includes targets in terms of the organisations running the USAID OVC programme. As noted in the introduction in section 1 above, it is the 26 SRs that are included in the main evaluation report whereas the large national SRs (National Association of Child Care Workers and Childline South Africa) are addressed in case studies that are attached as an appendix to the current report.

### Table 2. OVC programme objectives, output indicators and output targets

| Objective | Output Indicator | Output Target | |
|---|---|---|---|
| | | NRASD | NACOSA |
| To provide a comprehensive package of prevention, care and support services to OVC by March 2016 | Number of OVC aged 0 – 17 years whose household received free basic external support in caring for the child[a] | 8 384 | 51 280[c] |
| To ensure 60% to 80% of the OVC reached in the programme are tested for HIV by March 2016 | Number and percentage of OVCs that received an HIV test and know their results[b] | 60% (5 040) | 80% (41 120)[d] |

*Note.* [a]Noncumulative over the grant period. [b]Cumulative over the grant period. [c]This figure is broken down into 10 200 for provincial SRs, 28 720 for NACCW, 12 360 for USAID OVC CSS and 0 for Childline South Africa. [d]This figure is broken down into 10 600 for provincial SRs, 22 976 for NACCW, 0 for Childline and, 7542 for USAID.

As recipients of this grant, NACOSA and NRASD managed the grant and ensured that grant objectives were met. Neither the Global Fund nor the PRs were the direct implementers of the OVC Programme; a sub-granting relationship existed whereby the grant was disbursed to a number of implementing partners (national organisations, NGOs and CBOs) who were part of the service delivery team (see Figure 2). These sub-recipients (SRs) and sub sub-recipients (SSRs) directly implemented the OVC Programme and delivered services to OVC.

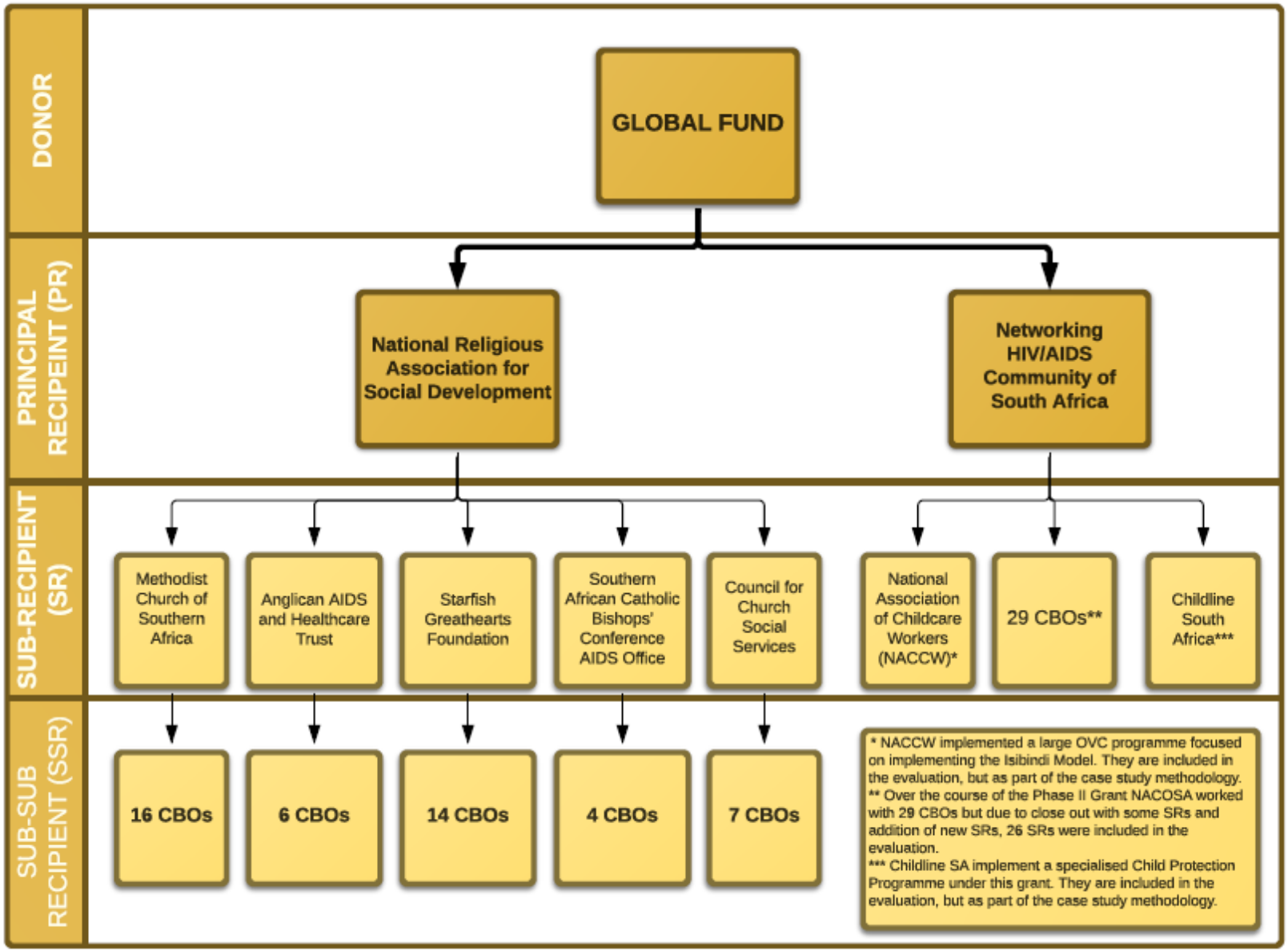
The Global Fund Phase II OVC Programme was implemented through the NRASD and NACOSA, the latter including NACCW and Childline South Africa[8], using four approaches to OVC care:

1. Home Community Based Care Support Programme (HCBC) implemented by NRASD.
2. Community Systems Strengthening Programme implemented by NACOSA.
3. Isibindi Model, implemented by DSD and other partners with mentoring and technical support by the National Association of Child Care Workers (NACCW). Although not included in the main body of the report, the NACCW Isibindi model supported by the Global Fund Phase II Grant through NACOSA is included in the evaluation as a case study (see Appendix D).
4. A specialised child protection programme implemented by Childline South Africa. Although not included in the main body of the report, the Child protection programme supported by the Global Fund Phase II Grant through NACOSA is included in the evaluation as a case study (see Appendix D).

The Global Fund OVC Programme involved a number of different services or activities. These were implemented slightly differently by NACOSA and NRASD and their respective programme models are described in more detail below. The services provided differ from the programme run at DSD-funded sites which were used in the comparison group, particularly around their focus on HIV testing services.

[8]The NACCW and Childline models (models 3 and 4 listed) were only included in the qualitative case study component of the evaluation and not the quantitative survey.

**Figure 2. Illustration of the structure of the Global Fund OVC Programme sub-granting relationship**



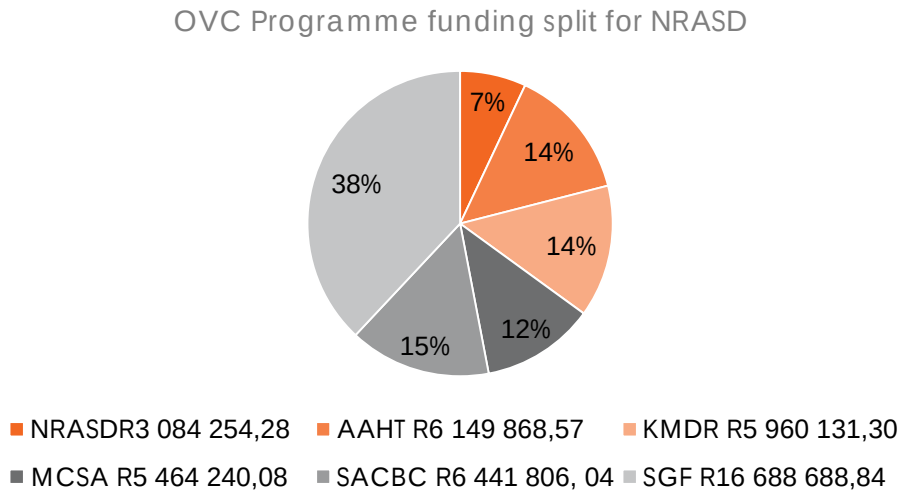
### 5.2.1 NRASD Home and Community Based Care model

NRASD represents a network of different faith, welfare, and development networks and acts as a facilitator in the social development work of the religious sector in South Africa. The basic approach of NRASD is to strengthen the capacity and programmes of existing networks to enable them to play an even bigger role in this field.

#### 5.2.1.1 NRASD sub-granting relationships and scope

As a PR for the GF Phase II grant, NRASD was a grant manager for 10 national sub-recipient (SR) civil society organisations (seven religious and three non-religious). For the purposes of the OVC programme, NRASD sub-granted to five partners (four religious and one non-religious). These SRs were the Anglican AIDS and Healthcare Trust (AAHT), Council for Church Social Services (KMDR), the Methodist Church of Southern Africa (MCSA), the Southern Africa Catholic Bishops' Conference AIDS Office (SACBC) and the Starfish Greathearts Foundation (SGF). The five SRs then worked with 47 CBO SSRs who delivered services to OVC (see Figure 2). NRASD managed a grant worth R43 788 989.11 which was split between the 5 SRs based on the number of SSRs each worked with (see Figure 3). The actual spend was only slightly less than the programme budget of R45 858 903.37.

**Figure 3. Breakdown of actual spend for NRASD SRs**




In addition to this SR and SSR relationship, NRASD had a support structure in place at the provincial and district level, whereby provincial and district offices[9] supported CBOs in terms of implementation quality and capacity, as well as monitoring and evaluation support.

For the Global Fund Phase II grant, NRASD worked in the inland provinces, namely Free State, Gauteng, Limpopo, Mpumalanga, and North West Province.

#### 5.2.1.2 NRASD activities and outputs

The NRASD model provided a comprehensive package of prevention, care and support services appropriate for OVC according to government norms and standards through providing:

- Support for caregivers
- Minimal nutrition
- Basic material support
- HTS

[9]Each provincial office consists of a provincial officer, nurse and social worker, with CYCW and CBIMS M&E support officers at the district level.

It provided needs-based training and mentoring for OVC care workers and their supervisors through caregiver training and training of CYCW.

Lastly, it provided organisational capacity-building and mentoring to NGO's and CBO's to provide a sustainable national HIV and TB response through support in the following areas:

- CBO Management Budget
- CBO Overhead Budget
- Monthly Mentoring
- Routine monitoring and evaluation (M&E)
- Community Based Intervention Monitoring System (CBIMS)

## 5.2.2 NACOSA Community Systems Strengthening Model

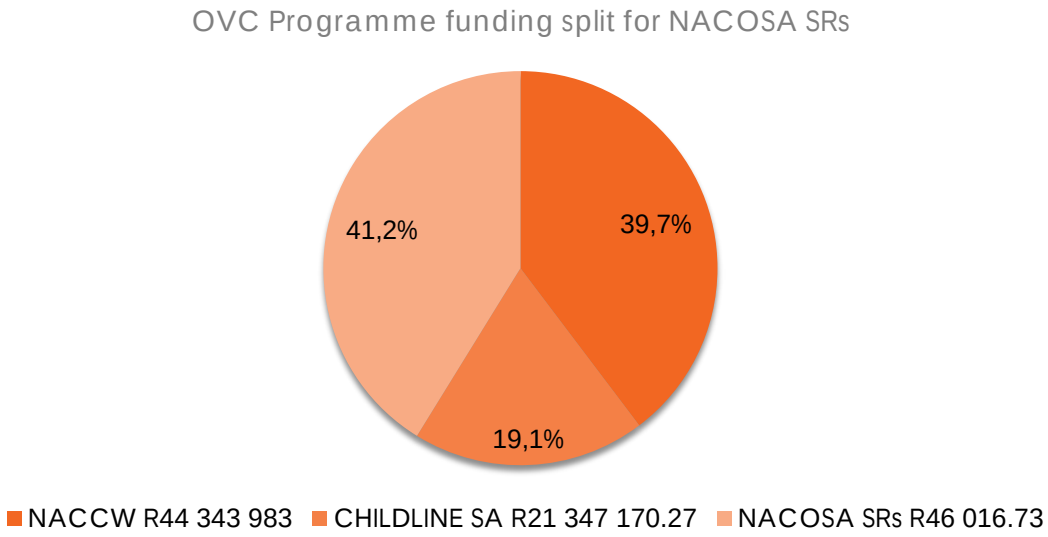
NACOSA is a national civil society networking organisation with more than 1 200 members - mainly CBOs but also non-profit organisations (NPOs) and individuals. Based in Cape Town, NACOSA works to build healthy communities through a model of capacity development, networking and promoting dialogue to turn the tide of HIV and TB.

### 5.2.2.1 NACOSA sub-granting relationships and scope

As a PR for the Global Fund Phase II Grant OVC Programme, NACOSA was a direct grant manager to 29 CBOs and channelled and managed small grants funding to these organisations. Due to close out with some CBOS during the grant term and the joining of new CBOs to the programme, as of September 2015 when the evaluation commenced there were 26 provincial CBOs under NACOSA's grant. These 26 were included in the current evaluation. NACOSA also worked with two large national SRs, the National Association for Child Care Workers (NACCW) and Childline South Africa, who implemented specific models or programmes under this grant that differed from the services provided by the 29 CBOs.

NACOSA managed a grant of R111 707 617. This was split between the three main SRs – NACCW, Childline SA and the 29 smaller provincial SRs (see Figure 4).

**Figure 4. Breakdown of NACOSA's budget for the Phase II Grant OVC Programme**




For the GF Phase II grant, NACOSA worked in the coastal provinces, namely the Eastern Cape, Western Cape, Northern Cape, and KwaZulu-Natal (KZN).

NACOSA offered a model of community systems strengthening that built capacity at community and household level and strengthened community responses. The model worked at the levels of the individual (OVC and household) and the community, and included participation in different community structures (War Rooms, Child Care Forums) and AIDS Councils (district, provincial, national and international).

At household level the OVC and caregivers were supported by trained child and youth care workers (CYCW) to directly support OVC. At the community level, Circles of Support and Child Care Forums (CCFs) were organised and supported. These also contributed towards ensuring appropriate referral to other NGOs that linked the OVC to specialised community resources.

#### 5.2.2.2 NACOSA activities and outputs

Components of the model included:

- Enabling environments, community networks, linkages and partnership
  - Facilitating 6-session circles of support with caregivers to up-skill households in caring for OVC
  - Monthly child care forums to coordinate provision of effective child care services in communities
- Resources and capacity building:
  - Training for child and youth care workers
  - Organisational development training for SRs including CBIMS, risk management and procurement & supply management
- Packages of care to OVC and households through OVC care organisations:
  - Psychosocial support
  - Child protection support
  - Access to social grants
  - Education support (including material support in the form of school uniforms) and ensuring school attendance
  - Emergency nutrition support
  - HIV counselling and testing
  - Referrals and linkage to ART
  - HIV and AIDS related palliative care services
  - Treatment adherence support

### 5.2.3 Intended Outputs

These services or activities were intended to lead to a number of outputs, including:

- OVC and households were assessed and care plans implemented
- OVC received psycho-psychosocial support
- OVC in need received material support and homework supervision
- Malnourished or chronically ill OVC received emergency nutrition
- HIV prevention information, including HIV testing, was provided to OVC
- Multi-sectorial child care forums established and meetings were held regularly
- Child care forums developed and implemented action plans
- Increased knowledge and skills of CYCWs
- Primary caregivers received support and capacity building in caring for their children

### 5.2.4 Intended Outcomes

Through the activities and outputs listed above, the Global Fund OVC programme had a number of intended outcomes including:

- Improved psychological wellbeing of OVC
- Improved retention in school
- OVC linked to food programme
- Improved nutritional status of OVC
- OVC know their HIV status
- Increased HIV prevention knowledge
- HIV positive children are linked to treatment and support
- Access to social grants, health care and child protection services
- Improved linkages for OVC and households to support services
- Community system respond to needs of OVC
- Improved capacity of organisations and CYCW in responding to needs of OVC
- Households and communities are empowered to improve their capacity to:
    - Protect their children
    - Improve psychological well-being of families and children
    - Improve communication in families

### 5.2.5 Impact

Ultimately, the programme aimed to have the long-term impact of:

- Reducing vulnerability of OVC to HIV,
- Reducing AIDS-related mortality, and
- Improving the well-being of OVC and their families.

# 6. EVALUATION METHOD

This section of the report presents the evaluation approach taken by the evaluation team and lays out the key evaluation activities, sampling method, final samples and ethical considerations that were adhered to throughout the evaluation. Specifically, it explains the three evaluation designs the evaluation team used to address the evaluation objectives and questions:

1. Process evaluation
2. Quasi-experimental outcome evaluation
3. Case studies

In addition, this section of the report describes the three keys pieces of data collection that were undertaken:

1. Survey with OVC/caregivers, care workers and managers
2. Collection of secondary data and programme documents
3. Qualitative interviews and focus groups

## 6.1 Design

As noted above, three evaluation approaches or designs were used to address the evaluation objectives and questions, namely Process evaluation, Quasi-experimental research design and Case studies. These are described below.

### 6.1.1 Process evaluation

In order to address the evaluation objectives regarding efficiency and programme achievements and the evaluation questions regarding outputs, the evaluation confirmed these programme outputs through a process evaluation. A process evaluation assesses the fidelity and effectiveness of a programme's implementation, particularly whether it has been implemented as intended, how efficiently programme resources have been used and to benchmark programme successes. The process evaluation component drew on existing project monitoring data that was reported quarterly to SANAC's CCM and every six months to Global Fund.

### 6.1.2 Outcome evaluation: Cross-sectional quasi-experimental design

In addition to the process evaluation element, the evaluation adopted a quasi-experimental research design to explore the short-term to intermediate changes that occurred as a result of the programme. It utilised an Intervention Group (NACOSA and NRASD sites) and Comparison Group (DSD sites) design. A full experimental design was not possible as participants were not randomly assigned to either an intervention or experimental group and no baseline assessment prior to programme exposure had been conducted.

#### 6.1.2.1 Time series design: Comparing Time 1 to Time 2

The evaluation also attempted to compare data at Time 1 (utilising data from the previous evaluation) with data at Time 2 (the current end-of-programme outcome survey) so as to identify broad changes at intervention sites from the midpoint of the programme to the endpoint.

Services were assessed quarter-to-quarter, 6 month-to-6 month, year-to-year as well as overall. It is important to note that a true Repeated Measures design was not possible as the longitudinal data could not be matched at a case level. This limitation, and its impact, is detailed in the limitation section.

#### 6.1.2.2 Cross-sectional design: Comparing intervention and comparison sites

Outcome performance measures were measured cross-sectionally and comparisons were drawn between the Intervention Group and Comparison Group at Time 2 (the current end-of-programme outcome survey). There were a number of limitations to this comparison which are discussed in more detail in the limitations section of this report. However, it is important to highlight that the Comparison group used was not a true control group, if a control group is understood as a cohort not receiving or exposed to any elements or conditions of the intervention being investigated. Furthermore, the main adjustment in the GF Phase II grant from the Phase I grant was the focus of HTS and HIV awareness which were not components of DSD services to OVC. DSD implements social protection and support programmes aimed at eradicating poverty through supporting civil society organisations with grants. DSD's OVC programme focuses on welfare services, psychosocial support, and capacity building.

A further limitation was the assumption in quasi-experimental design that both Intervention and Comparison groups were equally exposed to extraneous factors and that these nuisance effects therefore cancelled out. However, it is not possible to quantify exposure to unrelated intervention programmes and exposure may have differed between the two groups.

### 6.1.3 Case studies

A total of 10 qualitative case studies were used to highlight particular findings that emerged from the quasi-experimental survey discussed above. These are discussed in more detail in section Case study interviews and focus groups below.

## 6.2 Survey

At the community level, a survey was conducted with NACOSA SRs, NRASD SSRs and DSD comparison sites. This evaluation activity provided data for the quasi-experimental component of the evaluation.

### 6.2.1 Sampling of sites

There was no sampling of intervention sites as all SRs and SSRs who received the programme were included in the evaluation, as per the previous process evaluation. The ratio of intervention to comparison sites was 4:1 such that there were 73 intervention sites to 18 comparison sites. The 18 comparison sites were purposefully selected with 2 per province. They were chosen from sites that were deemed comparable according to key criteria including (a) geographic location and profile (e.g. urban vs. rural), (b) community profile, (c) HIV prevalence rate, and (d) organisational typology during the previous evaluation. However, as described in more detail below, 2 comparison sites were excluded from the final sample bringing the ratio of intervention to comparison sites to 5:1.

This sampling of sites allowed comparison at the national level using indicators such as organisational structure, beneficiary profiles, and community/situational analysis to guide comparisons. Although 8 sites had dropped off from the programme since the previous process evaluation, 8 new sites were added bringing the total number of intervention sites to 73 (see Table 3).

**Table 3. Number of intervention and comparison sites broken down by province (target)**

| Province | Intervention sites | | Comparison sites | Total |
|---|---|---|---|---|
| | Number of sites in previous process evaluation | New sites added in current evaluation | | |
| **Eastern Cape** | 8 | 0 | 2 | **9** |
| **Free State** | 8 | 2 | 2 | **12** |
| **Gauteng** | 2 | 2 | 2 | **6** |
| **KZN** | 11 | 0 | 2 | **13** |
| **Limpopo** | 11 | 1 | 2 | **13** |
| **Mpumalanga** | 15 | 1 | 2 | **18** |
| **North West** | 3 | 2 | 2 | **7** |
| **Northern Cape** | 3 | 0 | 2 | **5** |
| **Western Cape** | 4 | 0 | 2 | **6** |
| **Total** | **65** | **8** | **16** | **91** |

### 6.2.2 Sampling of participants per site

Figure 5 below outlines the sampling and data collection techniques per NGO or CBO. As evident in the diagram, a range of the cadres of OVC programme staff were included in the evaluation. Beneficiaries were surveyed according to age:

- Where an OVC was aged 10 years or older, the OVC was surveyed directly, or
- Where an OVC was younger than 10 year, the primary caregiver of the child was surveyed.

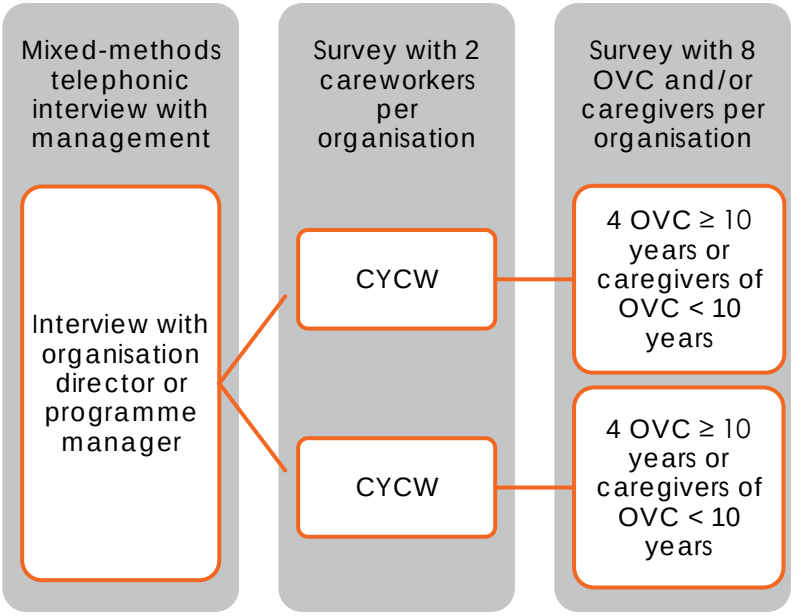
Every effort was made to sample the **same participants who had participated in the previous evaluation**; however, little identifying information had been gathered during the previous evaluation and the information that had been gathered[10] was not readily available to the current evaluation team. Therefore, the evaluation team had to rely on programme staff recollection of participant names.

The evaluation team put a sampling procedure in place to deal with instances where previous participants could not be identified or had left the programme. This attempted to follow the same sampling procedure as in the previous evaluation (two care workers randomly chosen and four OVC/caregivers per care worker randomly selected):

- Where the same care worker was not available or had left the programme, the care worker from the same organisation that had taken over his/her caseload was sampled.
- Where it was not possible to locate or identify previous OVC/caregiver participants[11], new participants were randomly selected from the children in the care worker's caseload.
- In some cases, convenience sampling was used when an OVC/caregiver could not be located on the day of the site visit or refused participation.

[10] This refers to consent forms.
[11] For example, some OVC/caregivers had moved away from the area or exited the programme due to reaching the age of 18 years. In addition, some organisations could not recollect the names of previous OVC/caregiver participants, particularly where care workers had left the organisation.

Figure 5. Overview of sampling per organisation




## 6.2.3 Final sample

Table 4 below provides an overview of the sample for the survey component of the evaluation. The reasons for two fewer organisations participating in the evaluation than the initial target is due to two DSD organisations that could not be identified or located (one each in the Eastern Cape and Limpopo). Table 27 in Appendix A presents the details of sites included in the final survey sample according to PR, district and sub-district.

In addition, two further DSD organisations refused participation in the telephonic manager interview. Excluding these two DSD sites, missing child or caregiver surveys are due to OVC or caregiver refusal or that the child could not be located despite multiple follow-up attempts. The fieldwork team were unable to conduct four care worker surveys, which are accounted for by the two missing DSD organisations.

Table 4. Overview of final survey sampling

| | Target | Completed | Missing |
|---|---|---|---|
| **Organisations participating** | 91 | 89 | 2 |
| **Manager interviews** | 91 | 87 | 4 |
| **OVC / caregiver survey** | 728 | 685 | 43 |
| **Care worker survey** | 182 | 178 | 4 |
| **TOTAL** | 1001 | 950 | 51 |

The profile of organisations included in the final sample are presented in Table 5 below. Not all organisations were registered NPOs and the largest number of other organisations defined their organisation as an HCBC or drop-in centre. Organisations did not only work with OVC but also provided services more broadly in the community for all people infected and affected by HIV. Many also provided services for other vulnerable groups, such as people with disabilities and older persons.

Table 5. Profile of participating organisations

| Characteristic | Global Fund (n = 73) | DSD (n = 14) |
|---|---|---|
| | n | n |
| Organisation type | | |
| NPO | 52 | 13 |
| HCBC | 47 | 9 |
| Drop-in centre | 27 | 6 |
| Prevention and awareness | 12 | 10 |
| Faith-based | 14 | 3 |
| Target groups | | |
| People living with HIV/AIDS | 58 | 10 |
| Youth infected and affected by HIV/AIDS | 45 | 12 |
| Children infected and affected by HIV/AIDS | 65 | 14 |
| People with disabilities | 32 | 8 |
| Older persons | 37 | 7 |
| Other vulnerable households | 19 | 4 |

### 6.2.3.1 Organisation managers

A total of 85 interviews were conducted as part of the interactions with the management of organisations[12]. The profile of staff interviewed are outlined in Table 6 below. The majority of interviews were conducted with programme or project managers, OVC or project coordinators and organisation directors. 'Other senior staff members' interviewed included financial administrators and board members. Only 32 of the staff members interviewed had been interviewed as part of the previous evaluation. The predominant reasons for this were:

- Nine organisations did not participate in the previous evaluation as they had not yet joined the Global Fund OVC Programme,
- The staff member had left the organisation, or
- Nobody in a management position had been interviewed at the organisation.

Table 6. Participants in the management interviews

| Characteristic | Global Fund (*n* = 71) | DSD (*n* = 14) |
|---|---|---|
| | *n* | *n* |
| **Sex** | | |
| Female | 56 | 14 |
| Male | 15 | 0 |
| **Position in organisation** | | |
| Programme or project manager | 43 | 9 |
| Director | 14 | 1 |
| Coordinator | 8 | 0 |
| Other senior staff member | 6 | 4 |
| **Length of time at organisation** | | |
| > 5 years | 44 | 7 |
| 2 - 5 years | 13 | 2 |
| 1 - 2 years | 4 | 1 |
| < 1 year | 3 | 3 |
| Missing | 7 | 1 |
| **Home language** | | |
| Sesotho | 15 | 2 |
| Zulu | 12 | 4 |
| Xhosa | 11 | 2 |
| Afrikaans | 7 | 1 |

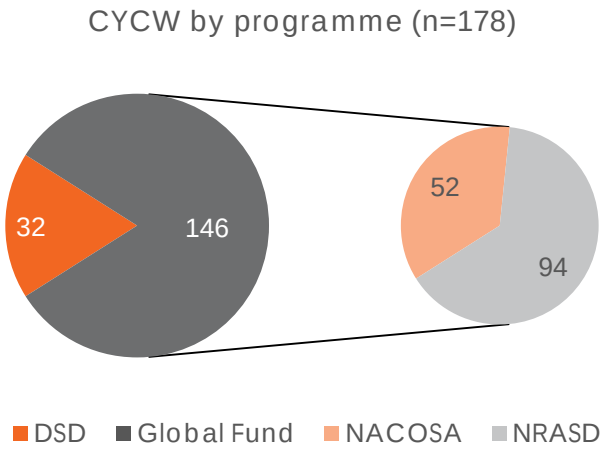
[12] A slightly lower number of interviews were conducted than the 73 organisations visited due to one participant acting as the coordinator for three NRASD SSRs. Only one interview was conducted with this individual, although the coordinator was able to speak to all three organisations.

| Characteristic | Global Fund (*n* = 71) | DSD (*n* = 14) |
|---|---|---|
| | *n* | *n* |
| Xitsonga | 7 | 0 |
| English | 5 | 0 |
| SeTswana | 5 | 3 |
| isiSwati | 3 | 1 |
| Sepedi | 3 | 1 |
| Ndebele | 2 | 0 |
| Other | 1 | 0 |
| **Interviewed in previous evaluation** | | |
| No | 37 | 9 |
| Yes | 32 | 5 |
| Don't know | 2 | 0 |

### 6.2.3.2 Child and Youth Care Workers

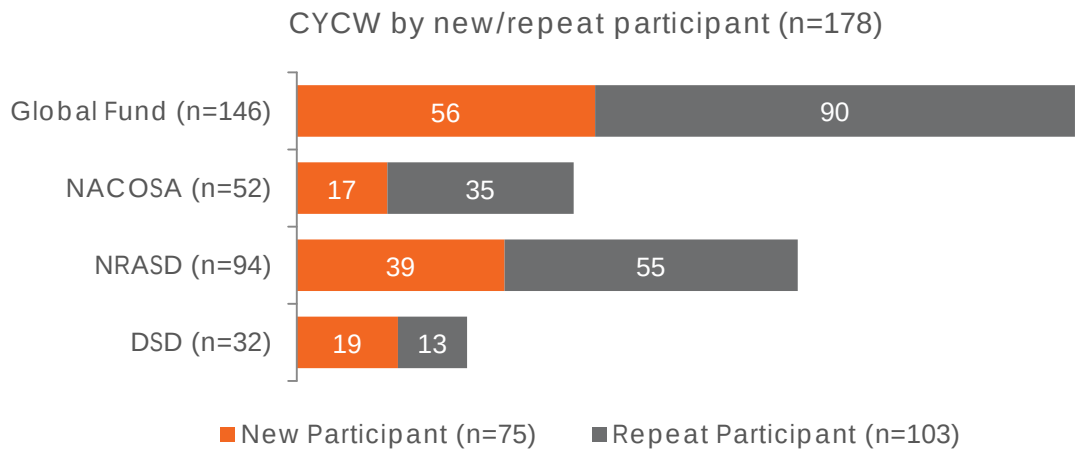
A total of 178 CYCW were included in the final sample. Figure 6 below presents the breakdown of participants according to OVC Programme. With regard to NRASD affiliation 32 were from MCSA SSRs, 28 from Starfish SSRs, 14 from KMDS SSRs, 12 care workers were from AAHT SSRs and 8 from SACBC SRs. Due to the number of SSRs under MCSA and Starfish, the majority of CYCW were affiliated with these two SRs.

**Figure 6. Chart depicting number of care workers by OVC programme**




Just over half (57,9%; n=103) of CYCW across the whole sample were repeat participants. Figure 7 presents the number of CYCW from each programme that were new or repeat participants.

**Figure 7. Number of new and repeat participants in the final care worker sample**



Descriptive statistics for the care worker sample are presented in Table 7. Most care workers were female, aged between 25 and 49 years, had been with the organisation for less than three years and had been an OVC care worker for less than three years.

**Table 7. Socio-demographic characteristics of final care worker sample**

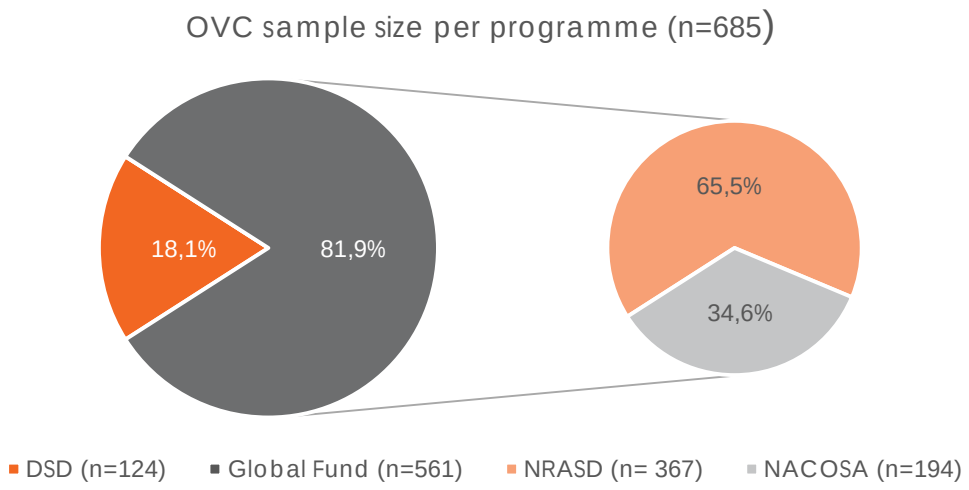
| Characteristic | Global Fund (n=146) | NACOSA (n=52) | NRASD (n=94) | DSD (n=32) |
|---|---|---|---|---|
| | n | n | n | n |
| **Gender** | | | | |
| Female | 138 | 51 | 87 | 30 |
| Male | 8 | 1 | 7 | 2 |
| **Age** | | | | |
| 18-24 years | 15 | 4 | 11 | 8 |
| 25-34 years | 67 | 23 | 44 | 9 |
| 35-49 years | 51 | 20 | 31 | 10 |
| 50-59 years | 12 | 5 | 7 | 5 |
| 60+ years | 1 | 0 | 1 | 0 |
| **Province** | | | | |
| North-West | 5 | 0 | 5 | 4 |
| Limpopo | 18 | 0 | 18 | 2 |
| Gauteng | 4 | 0 | 4 | 3 |
| Mpumalanga | 22 | 0 | 22 | 4 |
| Free State | 20 | 0 | 20 | 4 |
| Kwazulu-Natal | 12 | 12 | 0 | 4 |
| Eastern Cape | 16 | 16 | 0 | 2 |
| Western Cape | 2 | 2 | 0 | 4 |
| Northern Cape | 6 | 6 | 0 | 4 |
| **Time at organisation** | | | | |
| Up to 1 year | 12 | 4 | 8 | 7 |
| More than 1 and up to 3 years | 52 | 14 | 38 | 12 |
| More than 3 and up to 5 years | 28 | 10 | 18 | 2 |
| More than 5 and up to 10 years | 39 | 17 | 22 | 3 |
| More than 10 years | 15 | 5 | 10 | 8 |
| **Time as OVC care worker** | | | | |
| Up to 1 year | 12 | 3 | 9 | 7 |
| More than 1 and up to 3 years | 76 | 23 | 53 | 13 |
| More than 3 and up to 5 years | 26 | 12 | 14 | 2 |
| More than 5 and up to 10 years | 25 | 11 | 14 | 4 |
| More than 10 years | 7 | 3 | 4 | 6 |

### 6.2.3.3 Children and caregivers

A total of 685 participants were included in the final OVC sample. Figure 8 below presents the breakdown of participants according to OVC Programme (Global Fund vs. DSD and NACOSA vs. NRASD). Almost 82% of the OVC sample consisted of Global Fund participants and of that, 65.5% were NRASD participants. With regard to NRASD SR affiliation:

- 34,3% (n=126) were from MCSA SSRs,
- 30% (n=110) were from Starfish SSRs,
- 15% (n=55) were from KMDR SSRs,
- 12,3% (n=45) were from AAHT SSRs, and
- 8,4% (n=31) were from SACBC SSRs.

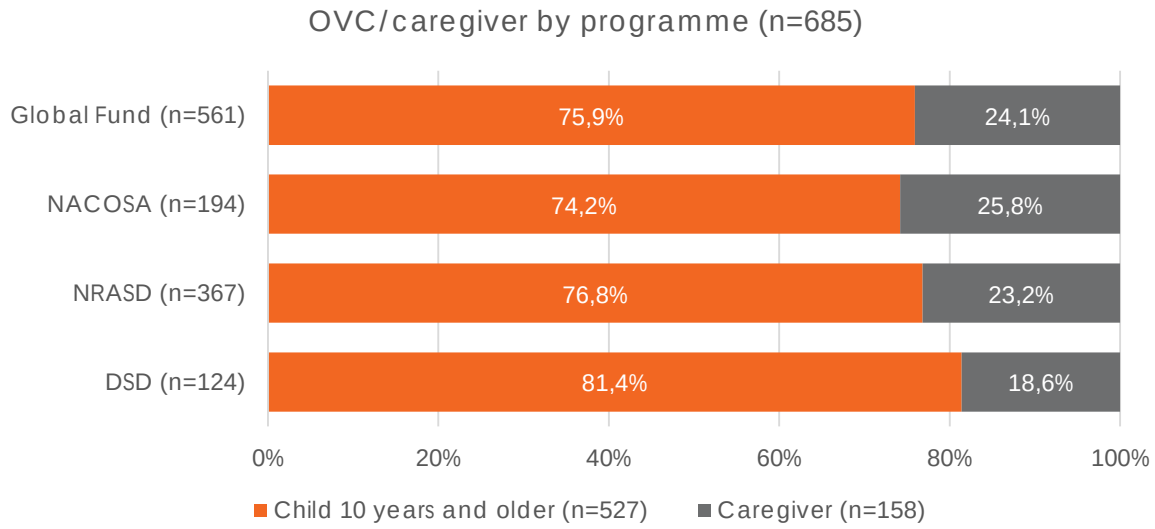
**Figure 8. Pie chart depicting proportion of total sample per OVC programme**




Roughly three quarters (n=527) of the final OVC sample were children aged 10 years and older (see Figure 9). Only a quarter (n=158) were the caregivers of children aged younger than 10 years. Of the 158 caregivers surveyed, 143 caregivers provided their age. The age of caregivers ranged from 18 to 72 years, with a mean age of 41 years. The majority fell within the age bracket of 35 – 49 years (n=61 out of 143 caregivers).

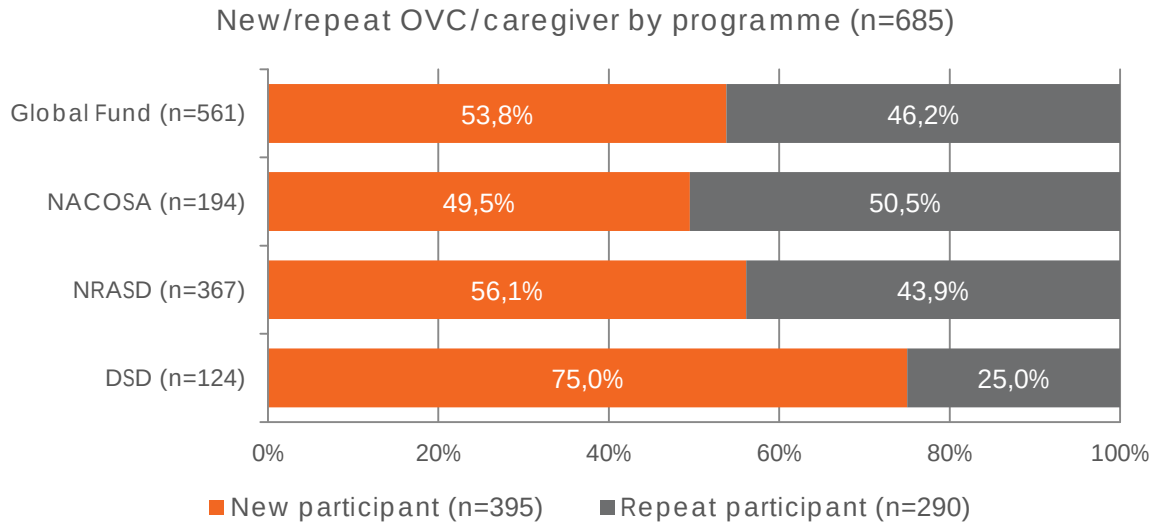
Across all programmes, the majority of OVC caregivers surveyed were the mother or father of the child (55,1%; n=87), followed by grandparents (32,3%; n=51) and aunts or uncles (9,5%; n=15). Only 3 (1,9%) were the older sibling of the OVC and 2 (1,2%) identified themselves as the legal guardian or foster parent. See Figure 43 and Figure 44 in Appendix A for a detailed breakdown of the age and relationship of the caregivers per programme.

**Figure 9. Proportion of final OVC sample comprised of children 10 years and older vs. caregiver of children younger than 10 years**




Although every effort was made to track down previous participants, less than half of OVC participants had taken part in the previous evaluation. Furthermore, just a quarter of DSD participants had taken part before (see Figure 10).

**Figure 10. Proportion of OVC sample participating in the previous evaluation vs. p**




Socio-demographic characteristics of the final OVC sample are presented in Table 8. This includes children aged 10 years and older who were surveyed directly as well as the details of the children aged younger than 10 years, which were obtained via the primary caregiver or guardian. Figures have been disaggregated by Global Fund, NACOSA, NRASD and DSD. The majority of the sample was female, aged between 10 and 15 years, lived in rural areas (i.e. villages, farming areas and the countryside), were part of the OVC programme for more than 3 years and reported having enough money for food but not basics such as clothing.

## Table 8. Socio-demographic characteristics of final OVC sample

| Characteristic | Global Fund (n = 561) | | | DSD (n = 124) |
|---|---|---|---|---|
| | Total | NACOSA | NRASD | |
| | % (*n*) | % (*n*) | % (*n*) | % (*n*) |
| **Sex** | | | | |
| Male | 57.0% (320) | 60.8% (118) | 55.0% (202) | 48.4% (60) |
| Female | 43.0% (241) | 39.2% (76) | 45.0% (165) | 51.6% (64) |
| **Age** | | | | |
| Less than 6 years | 7.7% (43) | 9.8% (19) | 6.5% (24) | 4.0% (5) |
| 6 - 9 years | 16.2% (91) | 15.5% (30) | 16.6% (61) | 13.7% (17) |
| 10 – 12 years | 30.5% (171) | 29.4% (57) | 31.1% (114) | 37.9% (47) |
| 13 - 15 years | 32.1% (180) | 35.6% (69) | 30.3% (111) | 25.8% (32) |
| 16 years and older | 13.6% (76) | 9.8% (19) | 15.5% (57) | 18.6% (23) |
| **Grade** | | | | |
| ECD | 0.4% (2) | 0.5% (1) | 0.3% (1) | 0.8% (1) |
| Grade 0 – 2 | 12.8% (71) | 13.6% (26) | 12.4% (45) | 10.6% (13) |
| Grade 3 – 5 | 22.8% (127) | 20.9% (40) | 23.9% (87) | 30.1% (37) |
| Grade 6 – 7 | 26.1% (145) | 30.4% (58) | 23.9% (87) | 22.8% (28) |
| Grade 8 – 9 | 23.2% (129) | 23.6% (45) | 23.1% (84) | 19.5% (24) |
| Grade 10 – 11 | 11.7% (65) | 7.9% (15) | 13.7% (50) | 13.8% (17) |
| Grade 12 | 1.1% (6) | 1.6% (3) | 0.8% (3) | 1.6% (2) |
| Not enrolled in school or ECD | 2.0%(11) | 1.6% (3) | 1.9% (7) | 0.8% (1) |
| **Province** | | | | |
| North West | 9.6% (54) | 27.8% (54) | - | 6.5% (8) |
| Limpopo | 14.1% (79) | - | 21.5% (79) | 12.9% (16) |
| Gauteng | 7.1% (40) | - | 10.9% (40) | 11.3% (14) |
| Mpumalanga | 15.7% (88) | 45.4% (88) | - | 11.3% (14) |
| Free State | 16.9% (95) | - | 25.9% (95) | 6.5% (8) |
| KwaZulu-Natal | 22.5% (126) | - | 34.3% (126) | 12.9% (16) |
| Eastern Cape | 4.8% (27) | - | 7.4% (27) | 12.9% (16) |
| Western Cape | 4.1% (23) | 11.9% (23) | - | 12.9% (16) |
| Northern Cape | 5.2% (29) | 15.0% (29) | - | 12.9% (16) |
| **Location** | | | | |
| Rural: Villages, farming area, countryside | 66.3% (372) | 73.7% (143) | 62.4% (229) | 61.3% (76) |
| Urban: Towns and cities, including peri-urban townships | 33.7% (189) | 26.3% (51) | 37.6% (138) | 38.7% (48) |

| Characteristic | Global Fund (n = 561) | | | DSD (n = 124) |
|---|---|---|---|---|
| | Total | NACOSA | NRASD | |
| | % (*n*) | % (*n*) | % (*n*) | % (*n*) |
| **Years in the programme** | | | | |
| Less than 6 months | 3.6% (20) | 4.1% (8) | 3.3% (12) | 9.7% (12) |
| More than 6 months but less than 1 year | 14.4% (81) | 11.9% (23) | 15.8% (58) | 12.1% (15) |
| More than 1 year but less than 2 years | 19.4% (109) | 21.1% (41) | 18.5% (68) | 16.1% (20) |
| Less than 3 years | 19.8% (111) | 19.1% (37) | 20.2% (74) | 17.7% (22) |
| More than 3 years | 38.5% (216) | 39.7% (77) | 37.9% (139) | 40.3% (50) |
| Don't know | 4.3% (24) | 4.1% (8) | 4.4% (16) | 4.0% (5) |
| **Socio-economic status** | 30.7% (172) | 24.7% (48) | 33.8% (124) | 35.5% (44) |
| Not enough money for food | 48.7% (273) | 45.9% (89) | 50.1% (184) | 37.9% (47) |
| Enough money for food but not other basic items | 17.3% (97) | 24.2% (47) | 13.6% (50) | 24.2% (30) |
| Enough money for food, clothing but short of other things | | | | |
| Have the most important things but few luxury goods | 3.4% (19) | 5.2% (10) | 2.5% (9) | 2.4% (3) |
| **Primary caregiver** | | | | |
| Mother or father | 57.8% (78) | 60.0% (30) | 56.5% (48) | 42.9% (9) |
| Grandmother or grandfather | 31.9% (43) | 26.0% (13) | 35.3% (30) | 38.1% (8) |
| Aunt or uncle | 8.2% (11) | 10.0% (5) | 7.1% (6) | 19.1% (4) |
| Older sibling | 2.2% (3) | 4.0% (2) | 1.2% (1) | - |

## 6.2.4 Data collection

### 6.2.4.1 Fieldwork team

The fieldwork team consisted of:

- CC&DW researchers who acted as fieldwork coordinators and conducted the telephonic interviews with CBO managers. Fieldwork coordinators ensured that all field logistics were supported while the lead evaluator ensured the planning and management of data flow, processes, structures and resource (including staff) were monitored and well supported.
- The core research team was supported by a team of social auxiliary workers and social workers from Khulisa Social Solutions[13] as well as a fieldworker from Family and Marriage Society of South Africa (FAMSA) in Limpopo and independent social workers in the Free State. This team of 20 fieldworkers conducted the site visits and surveys with OVC/caregivers and CYCW.

### 6.2.4.2 Fieldworker training

A two-day intensive training session was held at the NACOSA training venue in Century City, Cape Town. The training included:

- An introduction and overview of the Global Fund OVC Programme and the evaluation
- Interviewing skills and ethical considerations in conducting research with minors
- Understanding consent
- Review of the questionnaires
- Introduction to Mobenzi mobile data capture technology
- Participant-interviewer role plays
- Logistics and planning

The fieldworker training brought together a diverse fieldwork team from across the country. Feedback on the training session indicated that all fieldworkers found that the training met their needs (with all fieldworkers rating the training as either good or excellent overall) and developed their research and interviewing skills, particularly around using mobile technology to conduct interviews.

### 6.2.4.3 Tools

See below (Table 9) for a list of the data collection tools, which are included as appendices to the current document. The data collection tools incorporated the MEASURE Survey Tools for OVC Programmes[14] and the tools used in the previous evaluation. In addition to the tools in Table 99, a number of consent forms were used including:

- Consent form programme staff and key informants (see Appendix B),
- Consent form for care workers (see Appendix B),
- Consent form for adult caregivers of OVC (see Appendix B), and
- Consent form for OVC aged 10 – 17 years (see Appendix B).

[13] Khulisa works with the public, private and NGO stakeholders to deliver best practice evidence-based programmes and interventions addressing poverty and unemployment, early childhood development, crime, violence and community upliftment. Khulisa has branches in Gauteng, Northwest, Mpumalanga, KZN and Western Cape.

[14] http://www.cpc.unc.edu/measure/our-work/ovc/ovc-program-evaluation-tool-kit

Table 9. key groups of evaluation participants and methods of enquiry

| Participant group | Method of data collection | Type of data collected | Instrument |
|---|---|---|---|
| **OVC (10 – 17 years)** | Face-to-face structured survey conducted using mobile technology | Quantitative | Appendix B: Beneficiary survey (10-17) |
| **Caregivers of OVC (0 – 9 years)** | Face-to-face structured survey conducted using mobile technology | Quantitative | Appendix B: Beneficiary survey (0-9) |
| **CYCWs** | Face-to-face structured survey conducted using mobile technology | Quantitative | Appendix B: Care worker survey |
| **SR and SSR managers** | Telephonic interview utilising open- and close-ended questions | Quantitative and qualitative | Appendix B: Organisation interview |

The three surveys (OVC aged 10 – 17 years, caregivers of OVC aged 0 – 9 years and care workers) were conducted using Mobenzi[15] - a mobile technology used to capture survey data. Mobenzi technology handles the skip logic, validation, synchronisation and complex repeat rules automatically in the background. All survey data was therefore captured via mobile phones using the Mobenzi system. Due to potential connectivity issues in rural areas, fieldworkers were also equipped with a limited number of pen and paper scripts.

### 6.2.4.4 Pilot study

The evaluation tools were piloted at three organisations, including organisations participating in both the Global Fund OVC Programme and comparison organisations funded by DSD. The pilots were conducted as half-day site visits to each organisation by the CC&DW research team. The piloting of the paper-based tools with care workers, children aged 10 – 17 and caregivers of children aged 0 – 9 years resulted in some minor changes or corrections being made but the pilot visits were otherwise deemed successful and the tools were captured into mobile surveys.

### 6.2.4.5 Procedure

The data collection for each site proceeded as follows:

- An initial email and follow-up telephone call was made to the programme manager from each site to (a) initiate contact, (b) set a time to conduct the management interview, (c) plan for fieldwork site visits, and (d) enquire about identification of previous participants.
- CC&DW researchers conducted the telephonic interview with the programme manager for each site prior to the fieldwork visits.
- Fieldwork visits took one of two formats; either (a) a team of two fieldworkers conducted a one-day site visit or (b) a single fieldworker conducted a two-day site visit.
- Fieldworkers surveyed the care workers at the organisation's premises. OVC and caregivers were either surveyed at the organisation's premises or, where participants were not able to travel to the site, the fieldworkers conducted home visits.
- Fieldworkers sought informed consent from the OVC/caregiver or care worker for his/her participation. Informed consent was documented before fieldworkers administered the respective surveys on their allocated mobile phones.

[15] http://www.mobenzi.com/researcher/Features/Mobile-Application

## 6.2.5 Data analysis

### 6.2.5.1 Quantitative data analysis

Quantitative data from the primary and secondary data collection were analysed using Microsoft Excel 2010, Base SAS 6.1 and SAS Enterprise Miner 14.1. The SAS code can be provided on request should the results need to be audited, or should researchers wish to replicate the methodology and statistical approach in future.

To identify potential data capturing errors, outliers, missing values and to assess general data integrity, means, standard deviations, range and quantiles were calculated for continuous variables. Frequencies and cross-tabulations were calculated for categorical variables. Continuous variables were then categorised based on logic for descriptive statistics and by volume for multivariate statistical analyses. Descriptive statistics such as frequencies and percentages were then calculated and charted.

For the **cross-sectional analysis**, chi-square analyses were performed to 1) identify statistically significant bivariate associations between outcome measures and socio-demographic variables, and 2) identify statistically significant bivariate associations between outcome measures and group membership (i.e. Intervention and Comparison groups). Logistic regression models for each outcome variable were then performed. Socio-demographic variables that exhibited statistically significant bivariate associations were included as predictor variables in the logistic regression models. This was done in order to partial out mediating effects on outcome variables that would negatively influence comparisons between the Intervention and Comparisons groups. The following variables were included here:

- OVC tested for HIV
- OVC has birth certificate or ID
- HIV prevention knowledge
- Risk behaviours of OVC aged 10 and older
- Uptake of healthcare and social grants
- Perceived ability of caregiver to meet the needs of OVC
- Social support

While it was originally suggested that modelling be done separately for children and caregivers, and for new and repeat participants, we decided to include these variables as predictor variables and perform a single analysis for each outcome variable. This would allow us to statistically control for any effects without losing information about interactions that would otherwise be missed.

For the **longitudinal analysis**, logistic regression models for each outcome variable were performed in order to identify statistically significant differences in outcomes between Phase I and Phase II. Only participants who participated in both Phase I and Phase II were included in the analysis. The following outcome variables were examined here:

- OVC perceived performance in last school exam
- Missed school in last 3 months
- Birth certificate or ID
- OVC tested for HIV
- Risk behaviours

A Repeated Measures approach is required in order to handle measurement correlations and regression assumption violations that typically arise when the same participants are interviewed over time. However, as data could not be matched at case level this approach could not be performed. The inability the match at case level also prevented us from identifying and controlling for possible confounding socio-demographic variables. The lack of the appropriate statistical approach is a material limitation of the analysis and results should be interpreted with caution.

#### 6.2.5.2 Qualitative data analysis

Open-ended questions were analysed using ATLAS.ti, a qualitative data analysis software. ATLAS.ti is one of the most powerful tools for qualitative research and allows for the management, coding, analysis and graphic visualization of large volumes of unstructured data. Qualitative data was analysed using thematic analysis principles, identifying and recording key themes. Data was coded according to well conceptualised and operationalised code categories identified through inductive and deductive methods.

#### 6.2.5.3 Triangulation of findings

During data analysis, triangulation between various sources (e.g., key stakeholders, SRs and SRRs, and beneficiaries) and types (qualitative and quantitative) have been used. Qualitative findings were compared with quantitative findings in response to the evaluation objectives so as to ensure valid and reliable findings and recommendations. The research team, led by the lead evaluator, triangulated data and findings from the evaluation methods and consolidated the findings into the required research report.

## 6.3 Secondary data

Three key pieces of secondary data were used for the evaluation.

### 6.3.1 Monitoring data

The evaluation team relied on the monitoring data that is routinely reported by NACOSA SRs and NRASD SSRs to the respective PRs. This data is then checked and consolidated, before being sent to SANAC and Global Fund.

### 6.3.2 Previous evaluation data

Three datasets from the previous evaluation team were used in the current evaluation:

- Care worker survey
- Beneficiary survey (10 – 17 years)
- Beneficiary survey (Guardian of OVC 0 – 9 years)

These datasets were consolidated and cleaned by the current evaluation team. Only organisations which were visited as part of the current evaluation were included.

### 6.3.3 Programme documents

In addition to the monitoring data and previous evaluation datasets, the PRs shared various programme documents with the evaluation team. These were used to provide programme descriptions and outlines of activities and processes. These are outlined in more detail in Table 1010 below.

## 6.4 Case study interviews and focus groups

Ten case studies were constructed to highlight specific aspects of the programme. The case study topics were selected in discussion with the TAC and drew on preliminary findings from the survey data, including qualitative data from the management interviews. Of the ten case studies, five each were allocated to NACOSA and NRASD respectively. The final case studies and data collected are outlined in Table 10.

Primary data collection in terms of key informant interviews and focus groups/interviews for the case studies were conducted by CC&DW researchers. In-depth interviews and focus groups were transcribed and fieldwork notes were analysed for these purposes, with data organised around key questions or main indicators. The primary data was supplemented with information gathered from existing programme documents and reports provided by the respective PRs. In addition, in some instances the case studies incorporated data gathered during the survey component of the evaluation, as well as monitoring data, in order to paint a comprehensive picture of the particular case study topic.

**Table 10. Final case study topics and data collection**

| Topic and PR allocation | Site(s) | Primary data collection: Interviews and focus groups | Additional data and programme documents |
|---|---|---|---|
| 1. **NACCW Isibindi (NACOSA)** | • Isibindi Lwandile (EC)<br>• Isibindi Libode (EC) | • Focus group with care workers at both sites<br>• Interview with Director of implementing partner (Catholic Development Centre)<br>• Interview with NACCW Mentor<br>• Interview with NACCW Mentor Supervisor<br>• KI interview with NACCW Deputy Director and National Isibindi Administrator | • NACCW Annual Report 2014/2015<br>• Background to Isibindi Lwandile and Libode (document provided by NACCW) |
| 2. **Childline South Africa Child Protection Programme (NACOSA)** | - | • KI interview with Childline SA National Executive Director and Global Fund Programme Manager<br>• Interview with Childline SA National Therapeutic Manager<br>• Interview with M&E officer<br>• Interview with two Childline SA Case Trackers<br>• Focus group discussion with therapists from the residential therapeutic programme | • Childline SA Quarterly Report Oct – Dec 2015<br>• Mpumalanga case tracking M&E report<br>• OVC Programme quarter 8 report<br>• Childline SA Final Report to NACOSA<br>• Childline SA and NACOSA websites |
| 3. **An HIV/AIDS Free Generation (NACOSA)** | - | - | • Qualitative data from SR management interviews<br>• Survey data |
| 4. **Community Systems Strengthening (NACOSA)** | • Khayelisha Care (KZN) | • KI interview with NACOSA National OVC Manager<br>• Interview with director of Khayelisha Care<br>• Focus group with care workers | • Child Care Forum Manual<br>• Circles of Support Learner Guide<br>• Circles of Support: Resource Pack for Care Workers<br>• Circles of Support Summary of Implementation |
| 5. **Sustainability (NACOSA)** | • Kgatelopele Social Development Forum (NC)<br>• Umvoti AIDS Centre (KZN) | • KI interview with NACOSA Deputy Programme Director<br>• Interview with director at both sites | • Sustainability of the OVC Programme (report produced by NACOSA for Global Fund) |
| 6. **Child and Youth Care Worker Training (NACOSA & NRASD)** | • Simondium Rural Development Forum (NACOSA, WC)<br>• Motheong wa Tumelo (NRASD - AAHT, NW) | • Focus group with care workers at both sites<br>• Individual interview with care worker at Simondium Rural Development Forum | • HTS Training Report<br>• CYCW Overview (April 2016)<br>• NACOSA HTS Training Manual |

| Topic and PR allocation | Site(s) | Primary data collection: Interviews and focus groups | Additional data and programme documents |
|---|---|---|---|
| 7. **An HIV/AIDS Free Generation (NRASD)** | - | - | • NRASD proposal to Global Fund<br>• Qualitative data from SR management interviews<br>• Survey data |
| 8. **Material Support (NRASD)** | • Etelangpele (KMDR, GP) | • Focus group with care workers<br>• Home visit to two beneficiary families<br>• KI interview with NRASD Programme Manager | • Background and programme description of material supported as part of the programme, cross-cutting data from manager interviews |
| 9. **Sustainability (NRASD)** | • Valoyi Traditional Authority Trust (Starfish, LP)<br>• St Lukes (AAHT, LP) | • Interview with director at both sites<br>• Focus group with care workers at both sites<br>• KI interview with NRASD Programme Officer<br>• KI interview with Starfish Programme Manager<br>• KI interview with AAHT Executive Director | • Overview of sustainability efforts provided to Global Fund by NRASD<br>• |
| 10. **Quality of Life (NRASD)** | • Ahanang Parish Based Care (SACBC, GP) | • Focus group with care workers<br>• Home visit to two beneficiary family | - |

## 6.5 Ethical considerations

The beneficiaries who participated in the evaluation included minor children who are classified as a vulnerable group[16]. In addition, the areas addressed by the questionnaires (e.g. HIV and risk behaviours) were seen to be of a sensitive nature. As such, although the research posed minimal risk to respondents, potential emotional, psychological, social, legal, and/or physical harm to the evaluation participants was minimized through special consent and confidentiality procedures. CC&DW employed the below methods to ensure the evaluation and fieldwork teams followed key ethical procedures.

### 6.5.1 Submission for Ethical Approval

CC&DW applied to the Human Sciences Research Council (HSRC) Research Ethics Committee (REC) for professional ethical approval. The application was submitted to the HSRC on 6 November 2015 for the REC sitting on 18 November 2015. With minor revisions to the evaluation protocol and consent forms required, ethical approval was received on 17 December 2016. The official letter noting the successful application was received on 28 January 2016.

### 6.5.2 Informed consent

In following standard consent procedures, all participants were required to sign a consent form giving informed consent to participate before the survey/interview was conducted. The consent process provided participants with detailed information on the purpose and procedures of the evaluation, what the information provided would be used for and how it would be used. In acknowledging the rights of research participants, it was made clear the participation was voluntary and that participants could withdraw at any time or refuse to answer any question. Participants were given a copy of the form, which contained contact details of appropriate services and sources of help (DSD local office, the relevant NGO operating in their area, toll-free child protection hotline and the details of the research team).

Specifically, the following consent forms were used:

1. Informed consent from all adult participants aged 18 years or older, including OVC guardians/caregivers, CYCW, programme staff and key informants;
2. For participants aged 10 – 17 years, guardians/caregivers completed informed consent for the child under their care to participate in the research; and
3. Informed consent was also be required from participants aged 10 – 17 years whose guardians/caregivers had consented to their participation.

### 6.5.3 Confidentiality

Confidentiality of all participants was ensured. Participants over the age of 18 years were interviewed in private and participants under the age of 18 years were interviewed within plain sight, but out of earshot, of their guardians/caregivers or other adults. All participants were assigned a study identity number to ensure names or other identifying information were not included in the report.

### 6.5.4 Dealing with participant distress and reporting of abuse

Fieldworkers were advised during training of the possible and conditional breach of confidentiality. In such cases, the broad procedure to be followed in outlined below.

- In cases where the child was experiencing distress relating to the interview process or in an emergency, the social worker or social auxiliary worker was to work with existing organisational facilities to provide support and referral.

[16] A number of factors may increase the vulnerability of participants to harm, including their age, their status as orphans and vulnerable children, and issues around child protection and safety. As such, it was expected that issues around the death of a parent, trauma and loss, HIV-related stigma, other forms of discrimination, and abuse could have been disclosed during the research.

- In cases of abuse and neglect, the relevant authorities for the protection and safety of children as per the Children's Act were to be notified as well as the social worker and social auxiliary workers' training.
- All incidents were to be submitted in a report format to the lead evaluator.

However, no such incidents were reported during fieldwork. In addition, all participants were provided with the contact details of relevant services to contact for assistance with particular issues and details of the lead researcher and project manager to contact for concerns regarding the research.

### 6.5.5 Fieldworker sensitisation and training

Surveys with CYCW, OVC and their caregivers were conducted by trained social workers and social auxiliary workers. This ensured that risk or harm to research participants was minimised as they were able to draw on their experience in working with children and other vulnerable groups and their knowledge of child protection issues. Social worker and social auxiliary workers were trained to ask questions in a sensitive and objective manner through role play. Standardised procedures on how to deal with questions that had the potential to illicit distress were also covered during training. In addition, they were trained to debrief participants at the end of the survey/interview and participants were given an opportunity to ask any questions. These methods were used to ensure quality assurance in terms of gathering sensitive data from the evaluation participants, while still maintaining data quality.

### 6.5.6 Benefit and compensation

Participants were not given any compensation for their participation. They were made aware of this during recruitment.

# 7. CHALLENGES AND LIMITATIONS OF THE STUDY

Some challenges were experienced during the evaluation process, notably during the data collection period. In addition, an account is given below of the limitations of the research methodology and data in answering the evaluation questions.

## 7.1 Pre-fieldwork challenges

A number of logistical challenges were encountered during the fieldwork planning phase of the evaluation.

### 7.1.1 Challenges in identifying previous participants

The lack of access to names of those care workers and OVC/caregivers who participated in the previous evaluation resulted in additional logistical demands on the research team and communication with organisations. In order to identify these participants, after initial telephonic communication with each organisation, CC&DW sent a follow up email requesting the names and details of those care workers and OVC/caregiver who had participated in the previous research to be supplied on a form.

However, the return of participants' names was slow with the bulk of forms only returned from late January or during the data collection phase of the evaluation. This contributed to slowing the progress of the fieldwork as site visits could not take place until participants had been identified.

In addition, some organisations struggled to identify the previous participants and some had since left the organisation. In these cases, replacement participants had to be randomly assigned.

### 7.1.2 Challenges in identifying and scheduling DSD sites

Significant challenges were faced in contacting and scheduling with DSD Comparison sites. The organisation names provided by the previous evaluation team were not accompanied by contact numbers or names and CC&DW had difficulty in locating these organisations online. In one instance, multiple organisation existed with the same name and it was difficult to identify which one had participated in the evaluation if nobody there remembered participating in the 2014 process evaluation. In addition, contact numbers were outdated or were no longer functioning, Organisations could not be located on the DSD NPO database, or organisations contacted had no recollection of participating in the previous research or reported not being funded by DSD.

Despite multiple attempts to obtain clarity from the previous evaluation team on the DSD sites included in the previous evaluation and contact numbers or alternate HCBC sites funded by DSD from the relevant provincial DSD offices, 2 out of 18 DSD sites could not be visited. This included one site in the Eastern Cape and one site in Limpopo. Also, in two cases replacement DSD organisations were successfully identified (one in Mpumalanga and one in Northern Cape).

### 7.1.3 Challenges in initiating contact

Some of the organisation contact details provided had changed (e.g., people change cell phone numbers regularly), which slowed the process of contacting sites. In addition, CC&DW received approval to contact the DSD sites on 22 December 2015 when many organisations had already closed for the holiday. The lack of contact details or information about these sites meant that contact with DSD organisation was only able to begin in mid-January 2015 when organisations re-opened after the holidays.

In general, the coinciding of the fieldwork planning period with the approaching holiday period meant it was difficult to initiate contact with and make requests of organisation for several reasons. For example, staff were busy with end of year reporting requirements or were on leave. However, significant strides were made with regard to contacting organisations and arranging the logistics for site visits in the new year (January 2016).

## 7.2 Fieldwork challenges

### 7.2.1 Logistical challenges

Fieldworkers encountered a number of transport challenges associated with fieldwork in remote areas:

- Poor public transport links in certain areas and delays when using public transport;
- Poor roads which resulted in damage to vehicles and delays in visits, as well as locating appropriate transport where roads where not accessible to standard vehicles; and
- Difficulty in locating remote and rural sites and obtaining clear and accurate directions to such difficult-to-find sites.

### 7.2.2 Follow ups

Every attempt was made to identify the care workers, children and their caregivers prior to the fieldworkers' visit to the site and ensure those staff and beneficiaries were available on the day(s) of the scheduled visit. However a number of factors resulted in care workers and beneficiaries not being available when fieldworkers visited. This included

- Care workers attending training,
- Beneficiaries having to attend to other responsibilities, such as attending the clinic, work, school trips etc.,
- Children not being able to be located by care workers and/or their guardians,
- Distance or transport challenges resulting in beneficiaries not being able to reach the organisation's premises or fieldworkers not being able to reach the beneficiaries in their homes, and
- Poor communication resulting in care workers or beneficiaries not being aware of the visit.

In such instances, fieldworkers were instructed to try to reach the participant by a number of means. For example, if the participant was scheduled to be interviewed at the organisations premises, to attempt to reach the participant at their home or after school. If they were unable to reach the participant they followed one of two solutions:

- Return to the site on an alternate day to conduct the interview, or
- If it was not possible to return to the site on an alternate day, then to replace the participant with an alternate participant based on availability (convenience sampling) and ability to obtain consent from the parent or guardian.

In some instances, the above solutions were not feasible; however, a maximum of two interviews were missed per site. There were only two instances where more than two interviews were missed.

### 7.2.3 Burden on organisations

Reports from fieldworkers and organisation managers seemed to indicate that the site visits were a significant burden on organisations in terms of arranging the necessary logistics to ensure fieldworkers were able to survey the care workers and beneficiaries identified. Care workers had to accompany fieldworkers to children's homes, which were often located a significant distance from the organisation's premises.

This burden seemed particularly pronounced for DSD organisations and few organisations reported receiving notification from their provincial office that they had been selected to participate. Recommendations include that payment or incentives be provided to sites that are not part of the Global Fund grant, so as to incentivise participation and compensate for travel and time.

## 7.3 Data limitations

### 7.3.1 Inability to infer causality

One of the clear limitations of the proposed research methodology is that it does not allow inferences to be made regarding causality (i.e. that outcomes measured are a result of the GF OVC programme). This is due to a number of factors including that (a) there is no true baseline and post-programme evaluation and (b) there is no true control group. As such, extraneous variables that could also be exerting an effect were not controlled for as would be the case in a true experimental design. The previous survey that was conducted as part of a process evaluation took place between August 2014 and February 2015, midway through the Phase II grant, which began in October 2013 and will close at the end of March 2016. The Comparison Group (DSD sites) used in the evaluation have been exposed to a programme, although this may be different from the NACOSA and NRASD models in terms of the latter focusing on HTS services. That participants were not randomly assigned and that there are some elements of similarity (e.g. in psychosocial support) between the models, means this cannot be interpreted as a true control group.

### 7.3.2 Lack of consistency between evaluation tools

In addition, the survey instruments were changed and expanded from the previous survey. While every attempt was made to include the same questions as those on the previous survey tools, the previous tools were limited in two key ways. Firstly, the previous tools did not assess programme outcomes comprehensively and included measures of only a small number of the programme outcomes. Secondly, the wording of the previous survey questions was not tailored to the evaluation participants and was changed by the current evaluation team. This means that comparisons between Time 1 and Time 2 were limited in terms of where similar domains were covered or in instances where questions have been retained. However, certain domains have been consistently measured, which facilitated comparisons; this included HIV knowledge and behaviour, for example.

### 7.3.3 Lack of identifying information

Due to a lack of identifying information in the dataset available from the previous survey/process evaluation, responses on the current outcome survey could not be linked to those given by the same individuals in the previous survey. This meant that it was not possible to establish changes at an individual level. Identifying information was stored separately and no identifying information beyond the organisational level (e.g., the SR or SSR from which the participant received services) was made available to the current evaluation team. Therefore, broad comparisons were drawn in terms of overall group characteristics.

Therefore, it must be noted that although survey results between Time 1 and Time 2 were compared in the current evaluation, these did not compare outcomes *before* participants were exposed to the programme to outcomes *after* exposure. Instead they may be useful in terms of reporting on shorter term outcome indicators from mid-programme to end-of-programme. This means that pre-post comparisons were not possible that could have given a true assessment of programme effects.

### 7.3.4 Mitigation strategies

To mitigate these limitations in assessing programme effectiveness and establishing differences on outcome indicators between the NACOSA and NRASD models against the comparison (DSD) model, the research team sought to utilise the same intervention and comparison groups that were used in the previous process evaluation survey. Again, a limitation must be noted, that in order to prevent confounding the sample, only participants who had taken part in the previous evaluation were included in the final sample. In addition, group characteristics were statistically compared to assess group equivalence as these differences account for differences witnessed between groups.

# 8. EVALUATION FINDINGS: ACHIEVEMENTS

This section of the report details the achievements of the Global Fund OVC Programme based on the monitoring data provided by NACOSA and NRASD, as well as the OVC organisation management interviews and care worker surveys. It details the services delivered for the output indicators in section Outputs and activitiesand explores the factors that affected service delivery from the perspective of managers and care workers in section Factors influencing programme delivery and quality. The output indicators are presented across the 10 quarters of the grant period. The dates corresponding with each quarter are presented in Table 11.

### Table 11. Dates corresponding with the ten quarters of the Phase II Grant

| | | | |
|---|---|---|---|
| Quarter 1 | 10/2013 – 12/2013 | Quarter 6 | 01/2015 – 03/2015 |
| Quarter 2 | 01/2014 – 03/2014 | Quarter 7 | 04/2015 – 06/2015 |
| Quarter 3 | 04/2014 – 06/2014 | Quarter 8 | 07/2015 – 09/2015 |
| Quarter 4 | 07/2014 – 09/2014 | Quarter 9 | 10/2015 – 12/2015 |
| Quarter 5 | 10/2014 – 12/2014 | Quarter 10 | 01/2016 – 03/2016 |

The key findings from this section are summarised below and detailed in the sections Outputs and activities and Factors influencing programme delivery and quality that follow.

## KEY FINDINGS ON PROGRAMME OUPUTS AND ACHIEVEMENTS

### PROGRAMMATIC PERFORMANCE INDICATORS

- NRASD SSRs met and exceeded their targets in terms of the number of OVC households provided with free basic external support in caring for the child, reaching a total of 12 331 OVC against a target of 8 384 in Quarter 10 of the grant.
- NACOSA SRs reached a total of 10 163 against a target of 10 200 in terms of the number of OVC households provided with free basic external support in caring for the child in Quarter 10 of the grant.
- Overall, across both programmes, targets were met and exceeded in terms of the number of OVC 'knowing their status' (i.e. having an HIV test and receiving the result). While testing was slow to be implemented in the initial stages of the grant, both NRASD and NACOSA surpassed their targets on this indicator by the end of Quarter 10.
- A total of 8110 tests were conducted by NRASD, against a target of 5040.
- A total of 10 642 tests were conducted by NACOSA against a target of 10 600. This included 2 202 successful referrals and 8 440 HTS conducted directly by SRs.
- Although a large number of OVC were tested as part of the Phase II Grant, the positivity rates for HIV (2%) and TB (<1%) reported by NRASD SSRs were low. This suggests that high risk OVC were not being targeted through programme services. However, it is also suggests that the programme itself could act as a protective factor for OVC through increasing, for example, school attendance and HIV prevention knowledge and thereby acting as a possible protection factor for HIV infections amongst OVC.
- Knowing one's status is an important first step in the prevention of HIV through increasing HIV knowledge and awareness and contributing towards behaviour change.

### ADDITIONAL OUTPUT INDICATORS

- While the NACOSA and NRASD programmes differed in terms of the nature of material and nutritional support provided:
  - Both NACOSA and NRASD exceeded their targets in terms of material support provided to OVC over the duration of the grant.

- As part of the nutritional support, emergency nutritional support was provided to 3 220 OVC by NACOSA whereas NRASD provided a more substantial nutritional component to their programme and serviced 8 720 with nutritional support

- 452 child care forum meetings and 3100 circles of support were achieved by NACOSA SSRs over the duration of the grant period, surpassing the target on the latter although not the former. Circles of Support were fairly slow to implement in the initial stages of the grant but quarterly targets were met towards the end of the grant. Due to the nature of Child Care Forum activities and stakeholder involvement, it was not practical to attempt to 'catch up' targets from quarter to quarter.

**FACTORS INFLUENCING PROGRAMME DELIVERY**

- These patterns in service delivery can be understood due to a number of challenges experienced by SRs and SSRs:
  - Initial community resistance to HTS, particularly amongst OVC caregivers
  - Large distances and poor transport for care workers to travel
  - Strained relationships with other stakeholders
  - Local dynamics or contexts which prevented efficient delivery of services to OVC
- However, it seems that despite these initial challenges which slowed service delivery and the reaching of targets early in the grant term, SRs and SSRs were able to overcome these in the latter part of the grant term with nearly all performance framework output targets being exceeded. Nearly all other targets were also met and/or exceeded.

# 8.1 Outputs and activities

## 8.1.1 NACOSA SR outputs and activities

The following outputs and activities were tracked by NACOSA over time from Quarter 1 (Q1) to Quarter 10 (Q10):

1. **Number of OVCs receiving an HIV test and knowing the result** (including OVC tested for HIV and OVCs referred for an HIV test)
2. **Number of OVCs receiving services**
3. Number of meals provided
4. Number of OVCs receiving emergency nutritional support
5. Number of OVCs receiving material support
6. Number of child care forums
7. Number of circles of support

The output indicators 1 to 3 are the key programmatic performance indicators; with indicators 1 and 2 being combined to identify the number of OVC receiving an HIV test and knowing the result. However, indicators 4 to 7 were also tracked during the grant in order to assist the PR in managing the grant and SR performance. For each of the 10 quarters of the programme, the Figures that follow plot the target numbers against the actual numbers. Both count per quarter and cumulative counts across quarters have been included in the figures (the left vertical axis provides the cumulative figures while the right vertical axis provides the count per quarter where relevant).

### 8.1.1.1 HTS

Two of the three programmatic performance indicators for NACOSA tracked the number of OVC tested for HIV. This included both HTS conducted directly by SRs and successful referrals for HTS. Together, the numbers tested directly and numbers referred meant that NACOSA provincial SRs met and exceed their target of 10 600 OVC 'knowing their status' with **a total number of 10 642 OVC 'knowing their status'** as a result of the Global Fund OVC Programme.

Although direct testing was preferable, SRs were also able to opt to refer OVC to the clinic or another HTS providers. Regarding the **number of OVC tested for HIV and received their test results**, NACOSA organisations surpassed their overall target of 7 933 by conducting a total 8 440 HTS sessions. While target numbers were not met from quarter 1 through to quarter 6, HTS activities accelerated from quarter 7 until the end of the programme, exceeding programme targets (see Figure 11a).

According to Figure 11b, more OVC were tested directly by the SRs than were referred to other service providers for testing. This seems to indicate in that NACOSA SRs did not meet their overall target for 'number of OVC referred for an HIV test and know the result' (see Figure 9b); however, in light of HIV testing targets being met overall, it in fact indicates that **more SRs had the capacity to conduct HTS internally and this limited the need for referrals**. A total of 2 202 successful referrals for HTS were achieved.

### 8.1.1.2 OVC reached

The third programmatic performance indicator tracked the number of OVC receiving services through the programme per quarter. Apart from quarter 1, NACOSA organisations either met or exceeded their target with regard to the **number of OVC reached/receiving services** (see Figure 11c). Number of services is non-cumulative over time and so no cumulative distributions have been included - this is because largely the same children were reached with services each quarter. NACOSA agreed with Global Fund to report on the number of OVC reached within the reporting quarter (i.e. does not refer to the number of unique OVC reached over the full grant). In referring to the most recent reporting period Quarter 10, NACOSA provincial SRs had a target of 10 200 for this indicator and achieved a total of 10 163 – this is reflected in quarter 10 in Figure 11c.

This is slightly lower than the number being tested for HIV due to the fact that it does not include the number of unique OVC reached over the full grant. In fact, over 14 000 OVC were reached across quarters 1 to 8 alone. As some SRs moved over the USAID grant in quarters 9 and 10, the reach in the last 2 quarters of the grant is slightly lower.

### 8.1.1.3 Nutritional and material support

NACOSA placed less focus on SRs meeting targets in terms of nutritional support provided during the Phase II OVC Grant. Instead, SRs were encouraged to provide needs-based nutritional support based on a formal nutritional assessment conducted at the clinic. The aim in anticipation of the end of the grant term, was to reduce dependence on the grant to provide food to beneficiaries. It is therefore important to keep this in mind when interpreting these output indicators:

- Regarding the **number of meals provided**, NACOSA SRs did not meet their targets overall from quarters 1 through 6. While surpassing their target for quarter 10, a total of 165 292 meals were provided compared to the target of 183 150 meals (see Figure 11d).
- The actual **number of OVC provided with emergency nutritional support was 3 220** (see Figure 12a). Apart from quarter 9, NACOSA organisations achieved slightly below their quarterly targets for the number of OVC receiving emergency nutritional support.

According to Figure 12b, NACOSA organisations provided a total number of **11 677 OVC with material support** over the full grant period. This number exceeded their overall target of 10 350. Quarter-per-quarter numbers were staggered as while activity was planned for the start of the school year, due to several reasons some of the SRs only distributed the school uniforms in the following quarter.

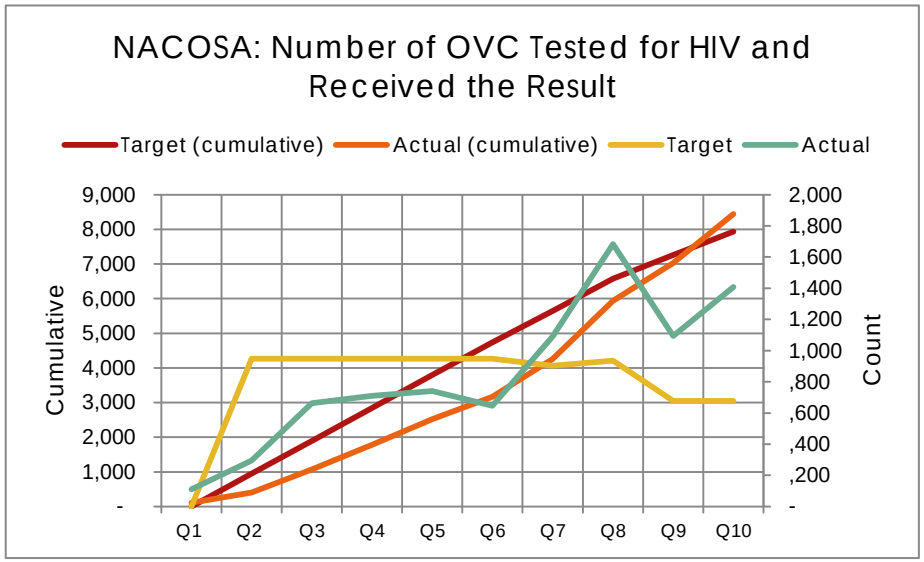
### 8.1.1.4 Community systems strengthening activities

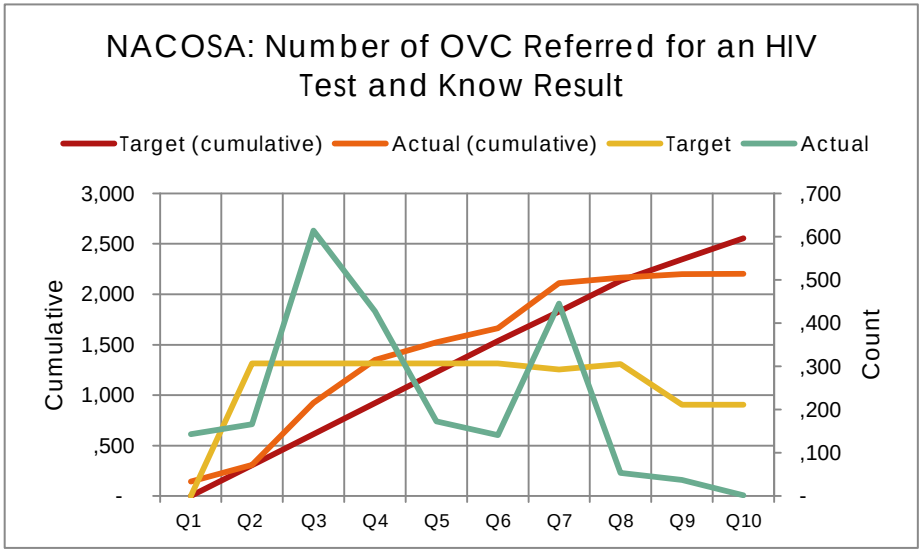
Two key activities that were part of NACOSA's community systems strengthening approach were tracked across the grant term, namely Child Care Forums (CCFs) and Circles of Support. According to Figure 12c, NACOSA organisations met their number of CCF targets for quarters 8 and 10. However, they did not reach the overall target of 528 CCFs by the end of the programme. In total, **452 CCFs were achieved across the duration of the grant**. This slight under achievement in terms of the number of forum meetings care workers participated in can be explained by the nature of CCF activities and stakeholder involvement. As an existing community structure facilitated by care workers[17], it was not practical to attempt to 'catch up' meetings from quarter to quarter as this would mean forum meetings would be held simply to meet targets rather than being need or demand based.

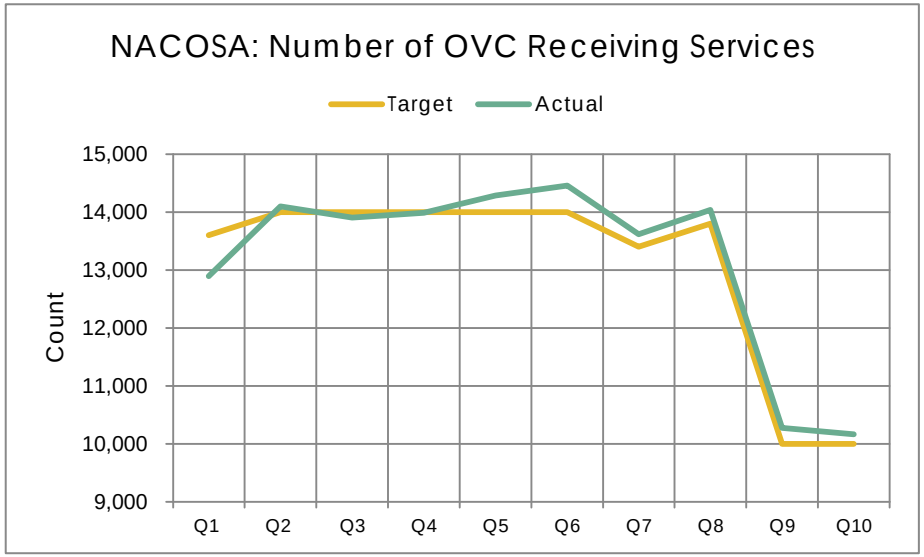
Circles of Support were implemented in alternate quarters (i.e. targets set for Q3, Q5, Q7 and Q9). In looking at the actual and cumulative outputs for this indicator, it is evident that SRs managed to catch up underperformance in the quarters where targets were set in the following quarters. NACOSA exceeded their overall target of 2 622 circles of support by the end of the programme. In total, **3 100 circles of support were achieved** (see Figure 12d).

[17]For a more detailed discussion on the role of CCFs in NACOSA's community systems strengthening approach see the case study on this topic in Appendix D.

**Figure 11a-d. Clockwise from top left: (11a) Target vs. actual number of OVC tested directly and receiving results, (9b) Number of OVC successfully referred for HTS, (9c) Number of OVC reached through programme services and (9d) Number of meals provided for NACOSA SRs Q1-Q10**



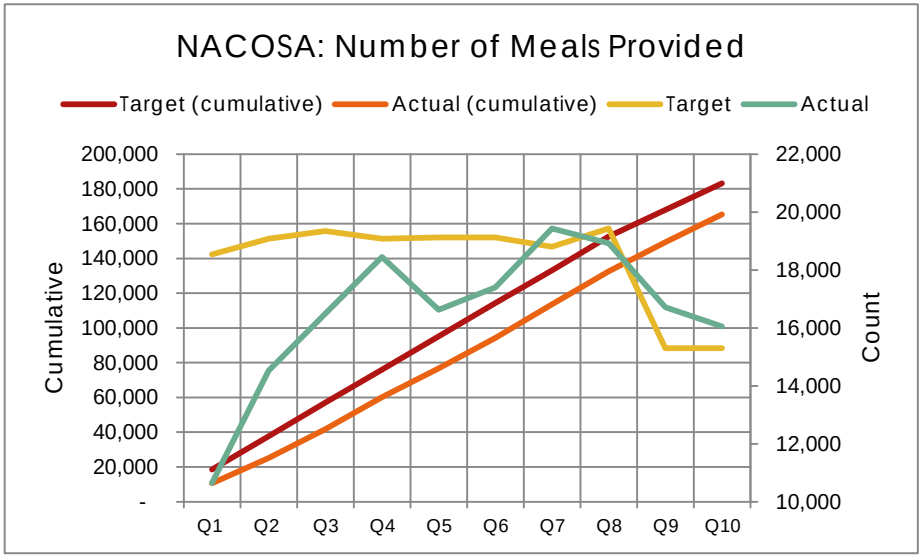
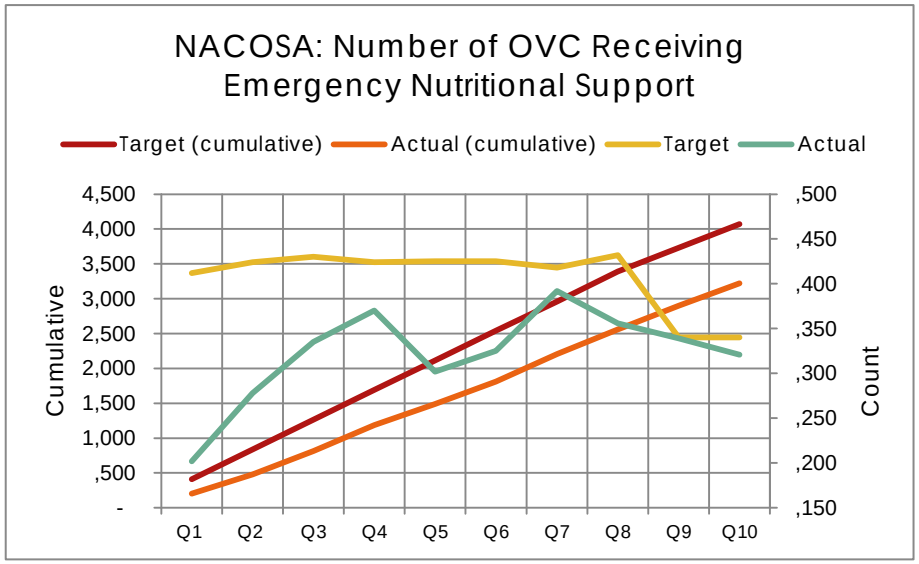
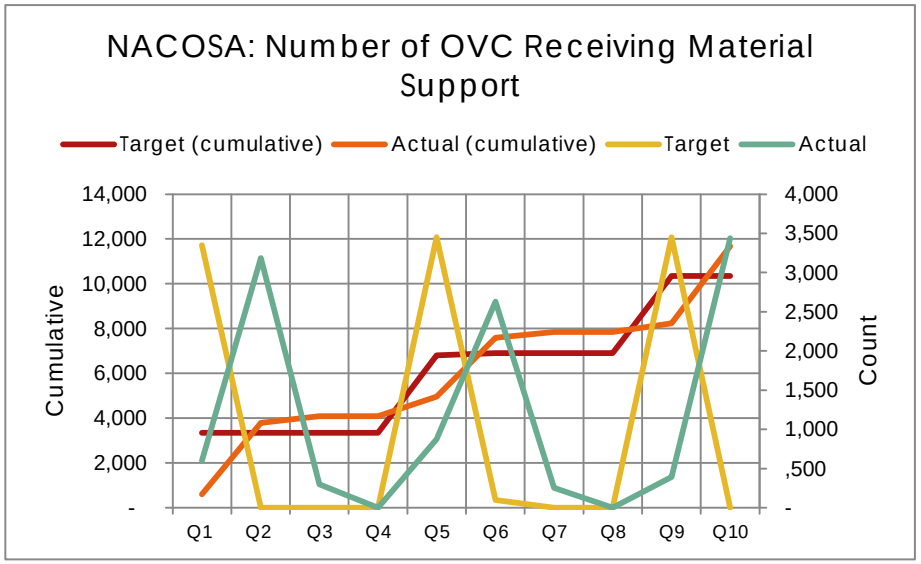
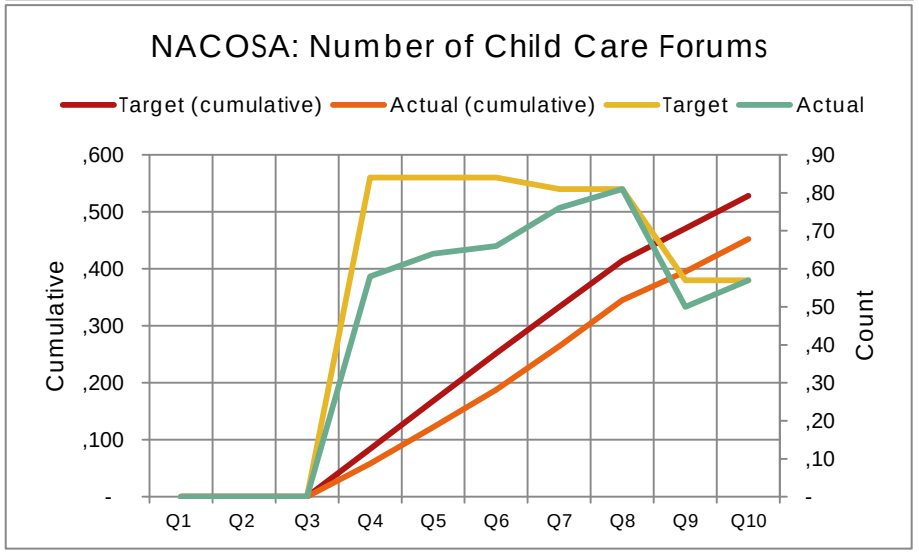
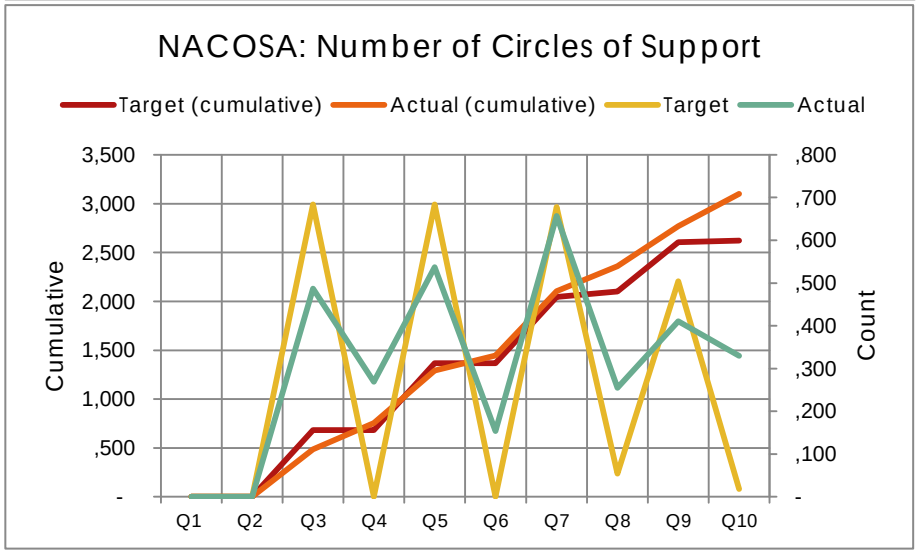



**Figure 12a-d. Clockwise from top left: Target vs. Acutal (9e) Number of OVC receiving emergency nutritional support, (9f) number of OVC receiving material suport, (9g) number of CCFs held and (9h) number of circles of support for NACOSA Srs Q1-Q10**



### 8.1.2 NRASD SSR outputs and activities

The following outputs and activities were tracked by NRASD over time:

1. Number of OVC tested for HIV and know their results
2. Number of OVC that were tested positive for HIV
3. Number of OVC screened for TB
4. Number of OVC screened as potentially positive for TB
5. Number of OVC aged 0-17 years whose households received free basic external support in caring for the child
6. Number of OVC who received nutritional support
7. Number of OVC that received material support
8. Number of caregivers/peer educators supported
9. Number of uniforms provided to care workers
10. Number of CBOs/Branches supported in the programme
11. Number of CBO/Branch reports expected: financial, M&E and programmatic reports to the national level
12. Number of CBO/Branch reports submitted timeously, complete and accurate: financial M&E and programmatic reports to the national level

Indicators 1 and 5 above were the two key programmatic performance indicators tracked and reported by NRASD across the grant term. The Figures that follow plot target numbers against actual numbers across all 10 quarters of the programme for these two key programmatic performance indicators as well as the additional internal PR generated management indicators used by NRASD. It is important to consider these additional indicators which reflect SR and SSR performance on important activities and services. Both count per quarter and cumulative counts across quarters have been included in the Figures.

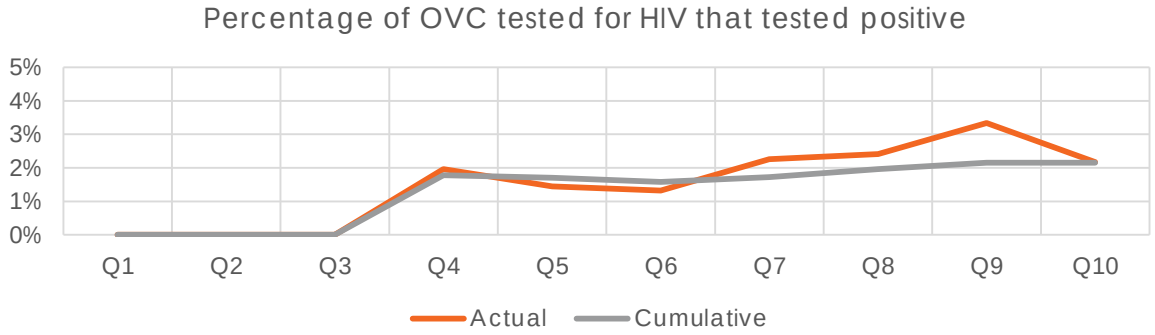
#### 8.1.2.1 HTS and TB screening

As a key programmatic performance indicator, NRASD organisations surpassed their quarterly target numbers of OVC receiving an HIV test and knowing the result across the entire period of the programme. As a result, their overall actual number of **8 110 HTS tests conducted far exceeded their total target number of 5 040** (see Figure 15a). HTS took off fairly slowly in the first three quarters of the grant but a large number of OVC were tested (> 1000) in quarter 4, 8 and 10. In testing 8 110 children compared to the 12 331 reached through the programme (see Figure 16a), NRASD achieved a rate of 66% in terms of the number of children in the programme tested.

NRASD also tracked the number of OVC testing positive for HIV through the monitoring data collected from SSRs. The highest number of children tested positive in quarters 8 (n=46), corresponding with when the highest number of HIV tests were conducted. An overall number of **175 OVC tested HIV positive throughout the duration of the grant** (see Figure 15b). However, out of the 8 110 tests conducted, this reflects a positivity rate of only 2% (see Figure 13). While comparative HIV positivity data is not available for NACOSA SRs to paint an accurate picture of positivity rates across the entire programme, this finding suggests two things:

- High-risk OVC were not being targeted through by the programme.
- The programme itself acted as a protective factor for OVC through increasing, for example, school attendance and HIV prevention knowledge and thereby acting as a possible protection factor for HIV infections amongst OVC.

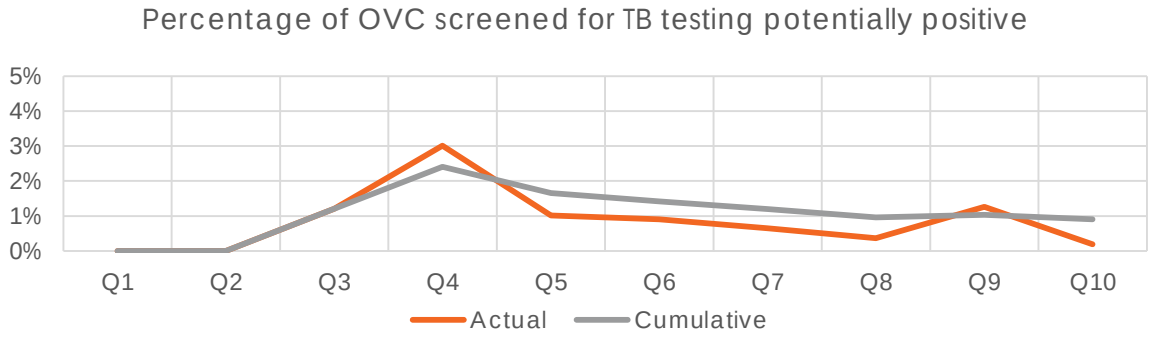
**Figure 13. Percentage of OVC that received an HIV test that then tested positive for HIV**




In addition to HIV testing, NRASD SSRs also reported to their respective SRs and ultimately to NRASD on TB screenings and the results. According to Figure 15c, NRASD organisations **far exceeded their target of 5 040 OVC screened for TB by achieving an overall number of 26 686 screenings**. Apart from quarter 2, quarterly targets were all surpassed, with the screenings steadily increasing from 909 in quarter 1 to 4 155 in quarter 10 (and peaking at 5 706 screenings conducted in quarter 9).

An overall number of **241 OVC tested potentially positive for TB**. As with HIV positivity data, quarterly performance seems to indicate the largest number of OVC screened potentially positive at quarters 4 and 9, corresponding with when the largest numbers of screenings took place (see Figure 15d); however, this still reflects a low potential positivity rate of < 1% (see Figure 14 below).

**Figure 14. Percentage of OVC that were screened for TB that screened as potentially positive**




### 8.1.2.2 OVC reached

With regard to the second key programmatic performance indicator, NRASD organisations **far exceeded their overall target of 8 384 OVC households receiving support.** As Figure 16a displays, a total number of 12 331 OVC households were provided with free external support in caring for the child over the duration of the Phase II Grant by NRASD SRs and SSRs. The overall target number was surpassed despite not meeting their targets for the first 3 quarters of the grant.

### 8.1.2.3 Nutritional and material support

NRASD organisations exceeded their overall target of 2 934 OVC who received **material support** by achieving a total number of 5 528 on this output indicator. Their success was driven by strong performance in the latter half of the programme (see Figure 14b).

According to Figure 14c, NRASD organisations **exceeded their overall target of 2 960 OVC receiving nutritional support** by providing nutritional support to a total of 8 072 OVC. The overall target was reached at quarter 8; 2 quarters before the end of the programme. Their success was largely driven by very good performance at quarter 5 and quarters 7 to 10.

The provision of material and nutritional support was a more substantial component of the NRASD model. In order to explore this further, not only in terms of output but also in terms of the benefit and impact of material and nutritional support on beneficiary households, **a case study is included in Appendix D**.

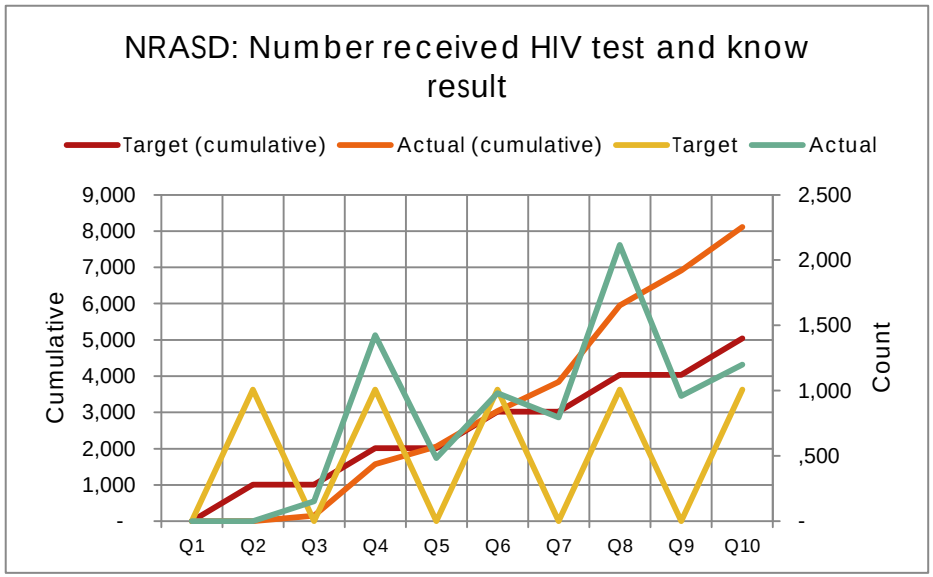
#### 8.1.2.4 Care worker and CBO support

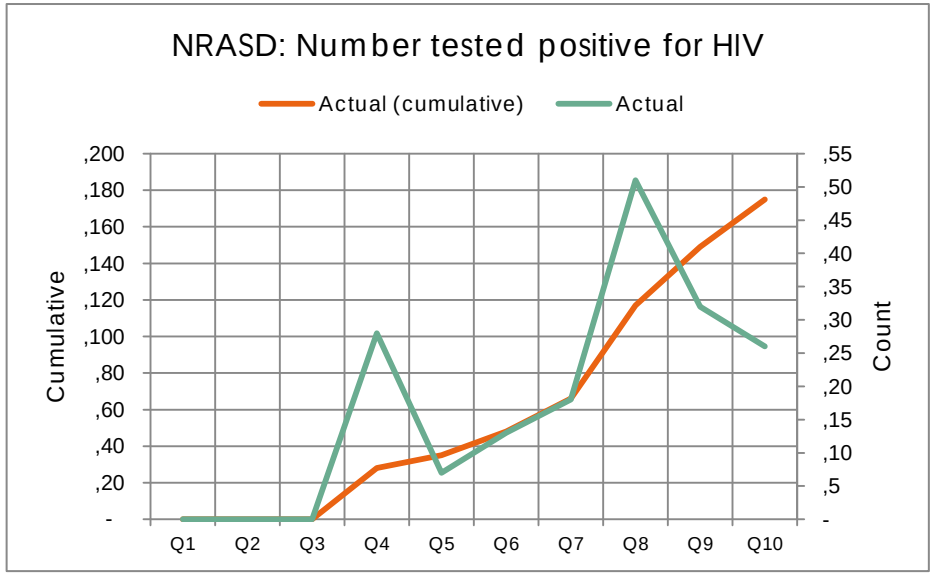
A total of **296 care workers were supported** for the duration of the Grant (see Figure 14d). This number exceeded the target of 262 that was set. The actual **number of uniforms provided over the programme period was 511** which was below the target of 786 (see Figure 17a).

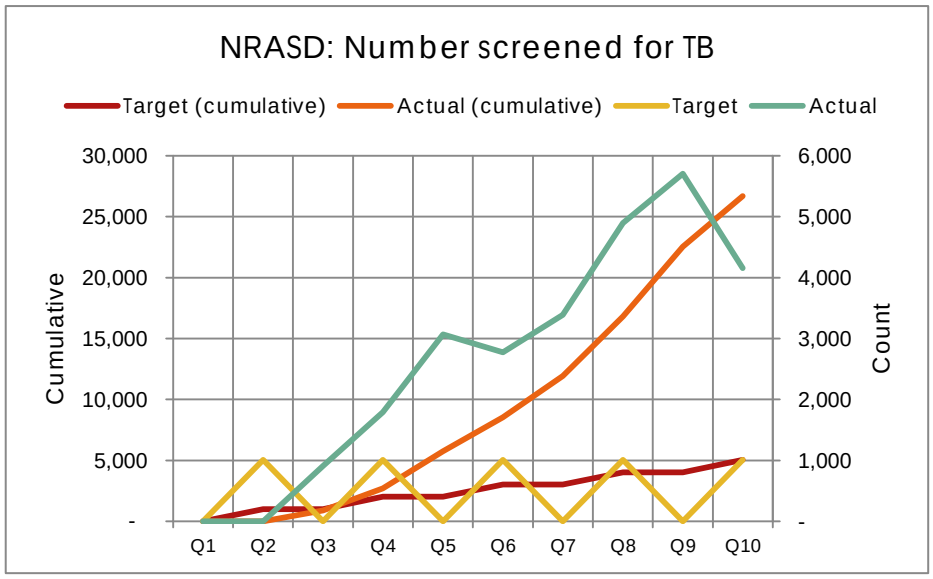
Regarding the number of CBOs supported in the programme, NRASD achieved a total of **61 CBOs supported by the end of the programme** (see Figure 17b).

There were no target numbers of CBO/Branch reports expected and submitted timeously. In total, NRASD achieved a total number of **371 reports submitted on time and complete against an expected number of 448** financial, M&E and programmatic reports to the national level (see Figure 17c). The remaining reports were received after the monthly cut off time, but in time to be included in quarterly reports.

**Figure 15a-d. Clockwise from top left: Target vs. actual OVC (15a) tested for HIV and know the result, (15b) testing positive for HIV, (15c) screened for TB, and (15d) screened potentially positive for TB for NRASD SSRs Q1-Q10**



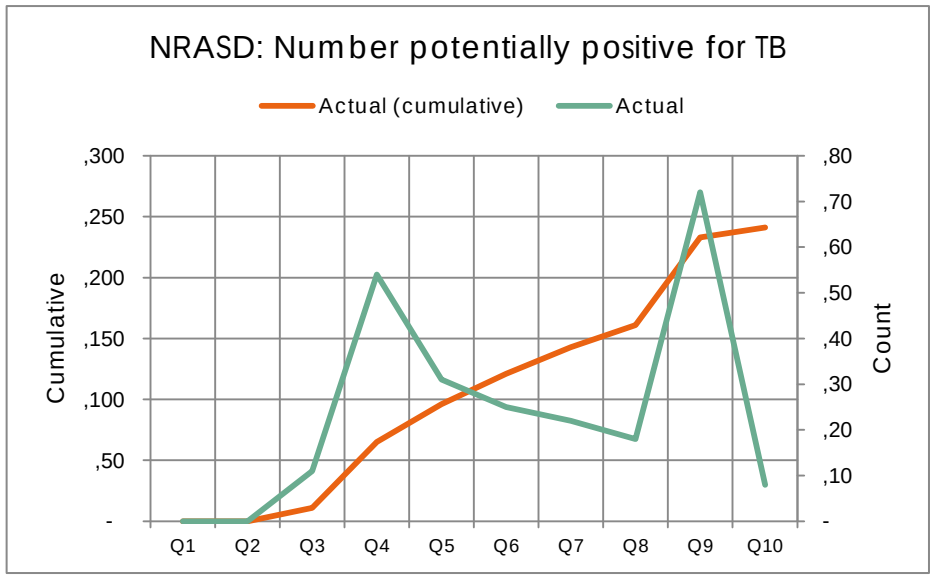
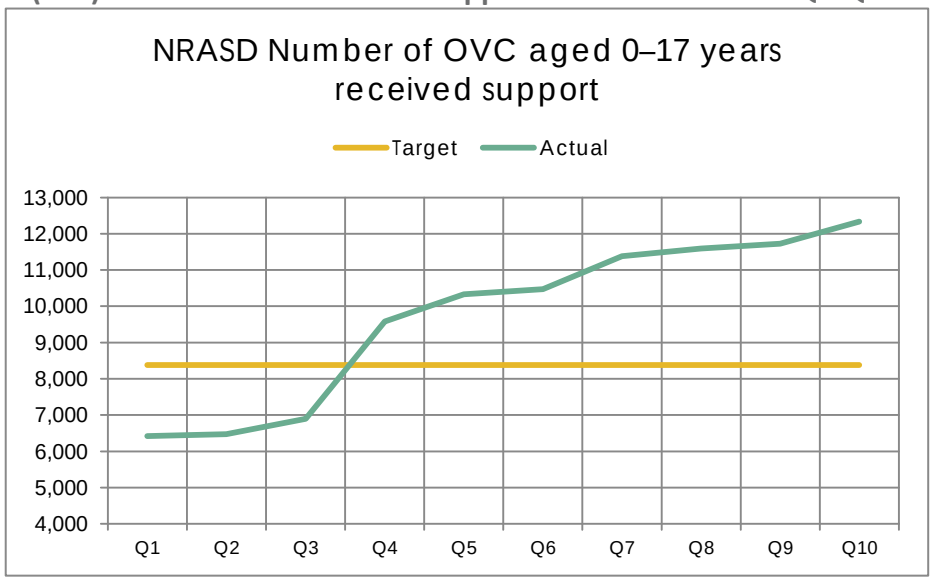
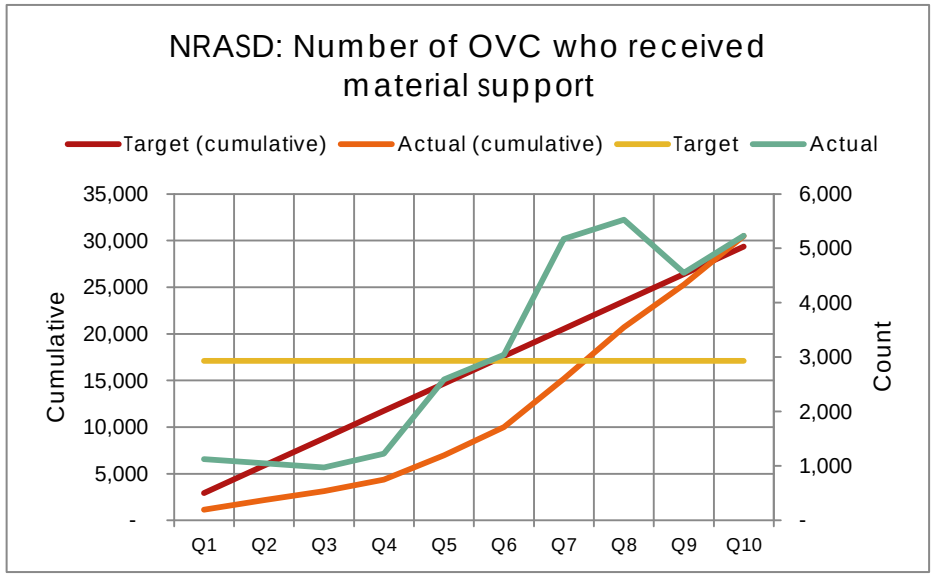
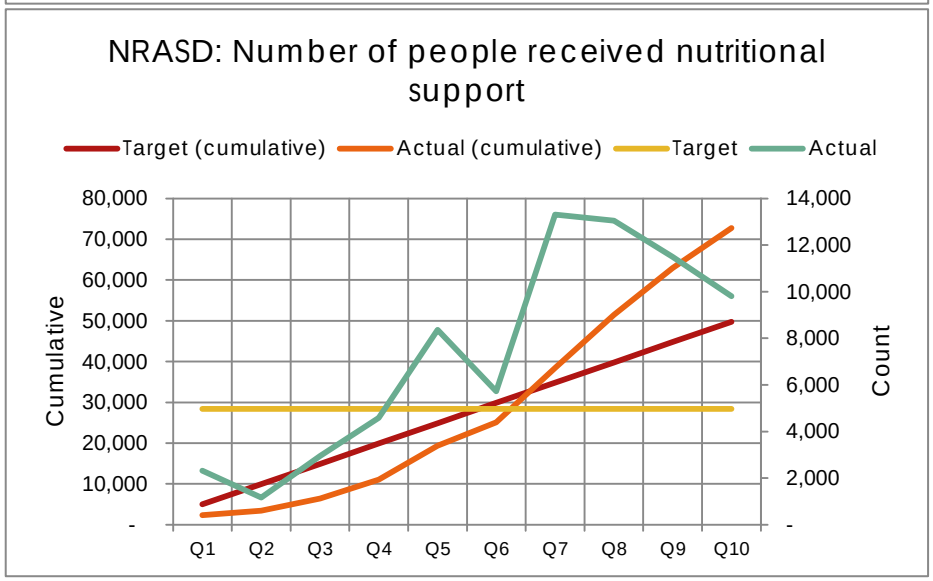



**Figure 16a-d. Clockwise from top left: Target vs. actual (16a) number of OVC receiving support services, (16b) material support, (16c) nutritional support and (16d) number of care workers supported for NRASD SSRs Q1-Q10**



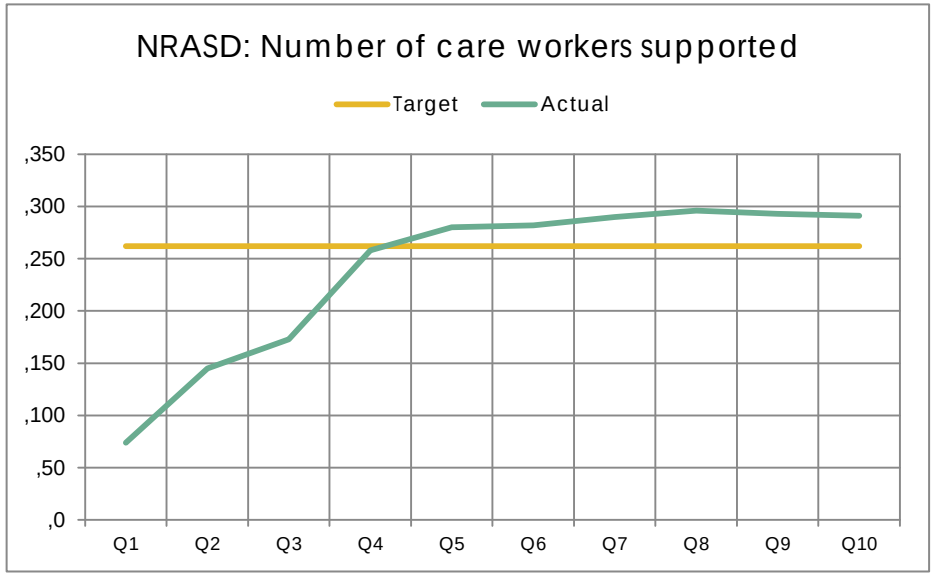
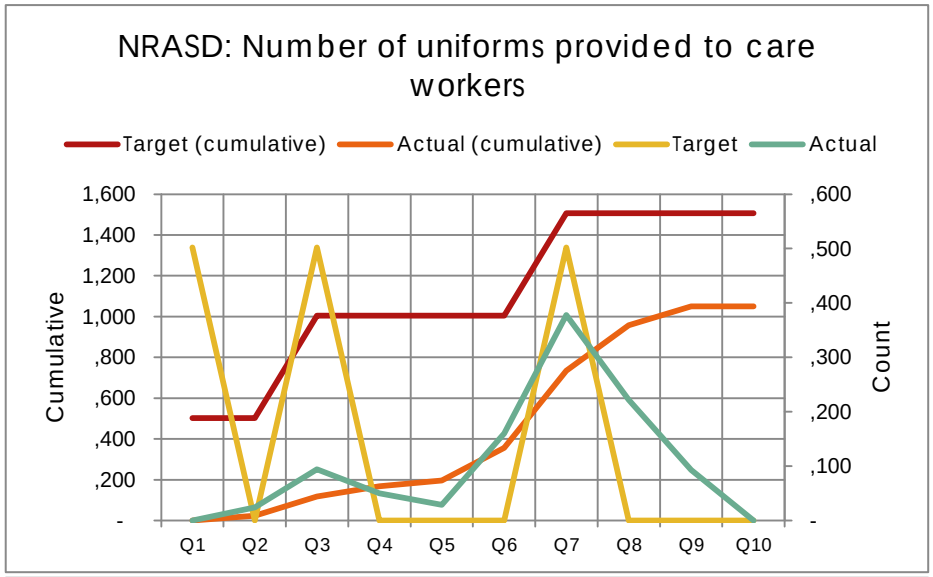
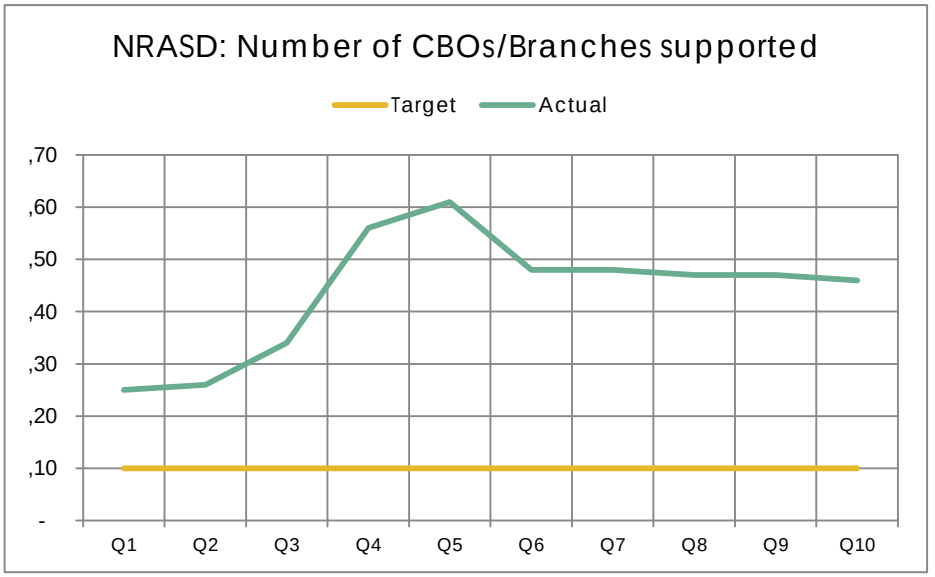
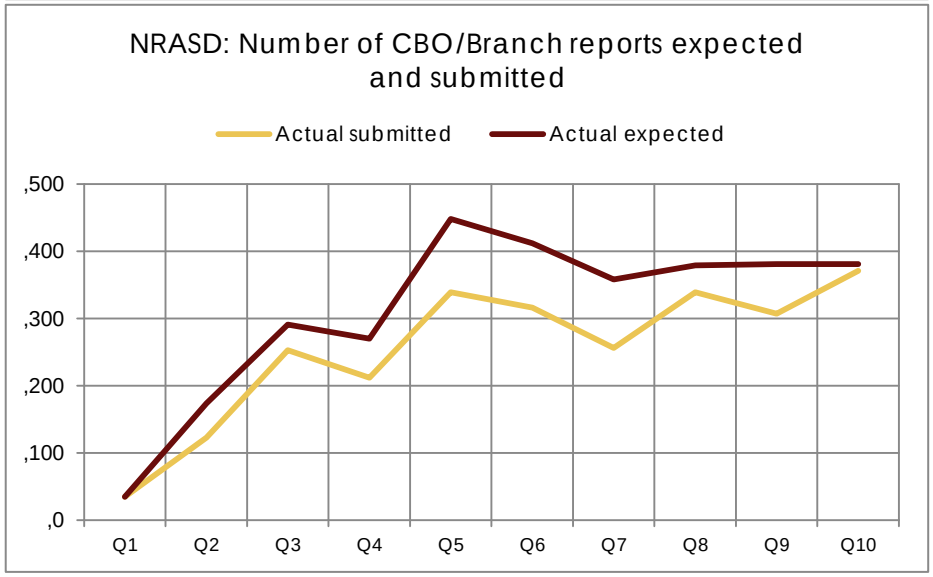



**Figure 17a-d. Clockwise from top left: (17a) Target vs. actual number of uniforms provided to care workers, (17b) number of CBOs supported, (17c) number of CBO reports expected and submitted on time for NRASD SSRs**



## 8.2 Factors influencing programme delivery and quality

In order to identify factors that may have influenced the meeting of targets and quality of the services and activities (outputs) listed above, both managers and care workers were asked to identify general service delivery challenges as well as specific challenges around the delivery of HTS. These are discussed below. Although speaking directly to evaluation questions regarding why programme outputs had or had not been achieved and the quality of services implemented, these responses also speak to factors that may have influenced programme effectiveness and efficiency.

Managers were asked to identify both challenges in service delivery as well as things that worked well. 22 out of 24 NACOSA SRs and 35 out of 45 NRASD SRs identified challenges that influenced the delivery of programme activities and services, both in terms of meeting targets and in the quality of services that could be implemented. Some of the responses given are discussed in more detail below and linked to the challenges noted by care workers. Care workers were also asked to identify whether they experienced challenges in delivering the programme services; 76,7 % of care workers (112 out of 146 care workers) said that they had experiences challenges in running programme services and activities[18]. Those care workers who reported experiencing service delivery challenges, were asked to identify them. Their responses to this open-ended question were coded and are presented in Table 12.

### 8.2.1 Distance

Distance and a lack of transport was a further factor identified by managers and care workers as affecting their ability to provide programme activities and services. For example, one organisation in the Free State reported that they relied on volunteers to transport children to and from the organisation when certain activities were held there, however this was inconsistent and meant that children could not always attend.

A significant aspect of care workers daily role was to visit OVC in their homes. The large areas care workers served and **long distances they travelled to conduct home visits** were time consuming and meant that they sometimes struggled to meet their targets. This also posed safety concerns:

> ***"Walking of long distances daily to access children is time consuming and when it rains carers can't work in the community and are office bound…that negatively impacts on their targets…safety and security is also becoming a concern." Director, NACOSA SR, Western Cape***

In addition, when children lived far from the organisation, it meant that they could not always attend services provided at the centre.

### 8.2.2 Demand and supply of material support

**Demand did not always meet supply**, according to managers. The demand for services in the community was great, but SRs and SSRs could not serve all those that they identified as needing their support. This was linked to material and nutritional support, for which SRs and SSRs felt there were more people in need in the community than they were able to support. They struggled with identifying only the most needy to provide material support, food parcels or cooked meals. Organisations found it difficult to only provide support to some children and not others:

> ***"When a child reaches a certain age they would no longer be eligible for nutrition according to Global Fund rules but for us as staff we would know that this child comes from a troubled and poor background and needs the nutrition...we would feel the guilt of refusing a child nutrition because of the rules and requirements." Programme manager, NACOSA SR, KZN***

[18] This refers to general service delivery challenges, not HCT which is discussed below.

They struggled particularly with the changes implemented from Phase I to Phase II of the Grant, which saw a **decrease in the amount and nature of material and nutritional support** provided in an effort to decrease beneficiary dependency. None the less, they managed to find ways to cope with only limited material and nutritional support, such as working with families around budgeting, linking them with income generating projects and teaching them the skills to start food gardens and grow their own food:

***"It was hard to accept when the nutritional programme budget was cut…there were families who were not yet ready to take care of themselves according to nutrition…but we review[ed] our strategies and found other ways to assist families so that they are not dependent on the organisation." Director, NACOSA SR, Eastern Cape***

Care workers also reported challenges with **demands for material support** in their communities. Beneficiaries demanded material support in order for the care workers to work with the child or family. This, together with the inability to provide material support to other needy children in the community, placed an emotional demand on care workers. They struggled to explain to beneficiary families that material support was only provided for a short period of time or that the family did not qualify for food parcels.

### 8.2.3 Local dynamics

SRs and SSRs that struggled with the change in material support noted that the programme did not necessarily consider the reality of different communities on the ground where the programme was being implemented. Some SRs and SSRs expressed that as the grant was implemented 'top down' the specific realities on the ground in their communities were not considered:

***"It's obvious we must not make them too dependent on us but it also depends on the type of area that you are living in." Programme Manager, NRASD SSR, Gauteng***

***"The targets were overwhelming and unrealistic to our specific communities. Each organisation knows their capabilities and how to be most impactful." Director, NACOSA SR, Western Cape***

Different dynamics on the ground meant that organisations had **to adapt services to the local context**. One example is highlighted in the quote that follows:

***"We used to give them a food parcel when the programme started but we couldn't monitor that the parcel was being used properly. In a small town like us, liquor is a problem… the carers complained that some of the community members were selling food for beer... The carer will make a point that every day at the feeding point when food is prepared for community members, those children also get food. Even if they don't eat the whole plate at least we know they have eaten something." Project manager, NACOSA SR, Northern Cape***

OVC organisations identified a number of factors that contributed towards **inefficiencies in reporting**. Local context played a role here too, particularly in rural areas:

***"They wanted a quotation before they could pay for the material, but the problem is that the nearest town is far for us in order to go and get a service provider to get the quotation. But we negotiated with the funder in order to make the process friendlier to us in rural areas." Programme coordinator, NRASD SSR, Limpopo***

Various other aspects of the local dynamic meant that the programme could not always deliver the programme services as intended, such as ensuring households had access to documentation and social grants. Care workers reported that the provision of services was slowed by a lack of documentation. This was particularly tough if the **households they served came from outside South Africa** and resulted in not being able to link the household to services such as clinics and schools:

***"Despite the campaigns with the schools and Home Affairs very few have managed to get their birth certificates. We are right next to Lesotho so you will find the mother is from Lesotho …the children end up not having IDs and they cannot be admitted at the schools. This is our biggest challenge." Programme manager, NRASD SSR, Free State***

### 8.2.4 Relationships with other stakeholders

Some organisations reported strained relationships between the organisations and other stakeholders, such as DSD. Despite cases being referred to the relevant department, they did not always receive the follow-up support and care that they expected:

> ***"It discourages [you] because you've identified that there is a way for this child to be taken care of but these people that you think that they're supposed to be doing something they just say there's nothing we can do about it." Programme manager, NRASD SSR, Mpumalanga***

However, this appeared to also be due to a lack of understanding of the capacity of other stakeholders. One manager, for example, identified a specific case where a child needed to be placed in protective care but due to a lack of space in a place of safety, the child was placed back into an abusive household.

Care workers reported **struggling to obtain parental support and cooperation** which affected participation and delivery of services to the children and households. Care workers felt that parents were not committed to their children's participation in the programme or their development or progress, particularly with regard to school work. Some managers noted their concerns that this was due to a **sense of dependency** in the community:

> ***"[They] are too dependent on the organisation and therefore are not complimenting the work being done…they don't want to use the skills given to better their own lives they expect the organisation to do it for them forever." Coordinator, NACOSA SR, KZN***

> ***"They want everything to be done by us. They don't want to meet us halfway." Programme manager, NRASD SSR, Mpumalanga***

Some also reported that caregivers were reluctant to allow children to participate in activities due to commitments at home and in some cases were reluctant to share documents or other information the care workers needed to perform certain aspects of their work.

**Table 12. General service delivery challenges reported by care workers**

| Challenge | No. reporting challenges | | Examples |
|---|---|---|---|
| | NACOSA (n= 47) | NRASD (n= 65) | |
| Lack of cooperation from parents | 14 | 20 | "Several parents refuse to allow children to come to the organisation for activities especially on weekends" **NACOSA SR, KZN**<br>"Clients and their guardians don't honour their appointments" **NRASD SSR, NW**<br>"Parents not committing to their children's education or progress" **NRASD SSR, Limpopo**<br>"Parents were reluctant to give information and documents when needed. Some were not welcoming us into their homes" **NRASD SSR, Limpopo** |
| Demand for material support | 15 | 16 | "I was chased away because they said the food parcels are not enough. People want food parcels consecutively, they fight and some people swear at me" **NRASD SSR, Limpopo**<br>"When I do home visits, peoples close their doors if I come empty handed" **NACOSA SR, KZN**<br>"They don't understand that it is for a period of 3 months, they always want more and don't understand that they do not qualify for food parcels" **NRASD SSR, MP**<br>"People that aren't in the programme wanted uniforms as well and it was heart-breaking not being able to help them" **NACOSA SR** |
| Distance and transport | 9 | 9 | "[It's] challenging to walk to houses. I can't walk alone" **NACOSA SR, WC**<br>"Families are far apart and we have high number of children [to visit]" **NRASD SSR, MP**<br>"Some children stay far away from the centre and they can't always make it" **NRASD SSR, MP** |
| Lack of documentation | 3 | 8 | "Some children do not get documents because their parents whereabouts are unknown" **NACOSA SR, KZN**<br>"It get [sic] difficult when the child does not have a birth certificate" **NACOSA SR, Eastern Cape** |
| Fatigue/boredom | 1 | 2 | "Children lose interest in the programme so you must think out of the box" **NACOSA SR, WC** |
| Lack of trust | 2 | 2 | "Parents don't trust us with their children" **NRASD SRR, Limpopo** |
| Scheduling | 0 | 2 | "Children come back home very late meaning they can't benefit from home visits" **NRASD SSR, MP** |

### 8.2.5 Challenges in HTS

In reference to challenges experienced rolling out HTS in their communities, **69,7% of care workers (44 out of 52 NACOSA and 57 out of 94 NRASD CYCW) reported experiencing challenges in delivering or referring for HTS services**. Of these, 80% said at the time of the evaluation they were still experiencing some of these challenges (31 NACOSA and 49 NRASD CYCW). See Figure 45 and Figure 46 in Appendix A for a detailed breakdown. A larger proportion of NACOSA care workers reported challenges with HTS compared to NRASD. This is likely due to the larger number of NACOSA SRs that conducted HTS internally rather than referring for HTS. Whilst NACOSA provided a 10-day accredited HTS training course for care workers to ensure SRs had the in-house capacity to conduct HIV tests, this is a more challenging approach than referring OVC and others to clinic or another service provider.

The most frequent response regarding challenges in delivering HTS services revolved around **resistance and refusal to testing in the community**. Care workers reported that caregivers refused for children to be tested (n=16 NACOSA and n=15 NRASD):

> ***"Parents are not always happy to assist with consent to test the children." Care worker, NRASD SSR, Mpumalanga***

> ***"Some parents refuse to have their children tested, they do not come at the day of testing." Care worker, NACOSA SR, Eastern Cape***

Furthermore, **caregivers refused to be tested** themselves (n=5 NACOSA and n=4 NRASD), even if they consented to their children being tested:

> ***"Parents want to know the status of their child but they don't want to test themselves." Care worker, NACOSA SR, Eastern Cape***

Care workers also reported that **children were reluctant to be tested** (n=5 NACOSA and n=7 NASD):

> ***"Children being anxious about their status and refuse to get tested." Care worker, NRASD SSR, Mpumalanga***

Related to reluctance and refusal to test was a fear around **stigma and confidentiality**, which was a further challenge identified by care workers in delivering HTS services (n=11 NACOSA and n=9 NRASD). This was particularly a concern in the case of testing at clinics. Although it appears that there was also distrust of the care workers themselves around this issue:

> ***"Parents are complaining about clinic there is no confidentiality." Care worker, NACOSA SR, Eastern Cape***

> ***"Parents think that as workers we are saying they have HIV or their child does have and they get angry." Care worker, NRASD SSR, North West***

These factors contributed towards **reluctance amongst caregivers to disclose** their HIV status or that of their children, to their children, partner or the care worker (n=9 NACOSA and n=12 NRASD care workers) as well as a general reluctance for people to talk about HIV in the community (n=2 NACOSA and n=5 NRASD care workers):

> ***"Children are not aware about the treatment they taking because their guardian does not tell them the truth." Care Worker, NACOSA SR, KZN***

> ***"People don't want to hear anything about HIV and they think when the care worker talks it's like she says they do have [it]." Care worker, NRASD SSR, North West***

A further challenge noted by care workers was **adherence and a lack of supervision with regard to ARTs** (n=5 NACOSA and n=5 NRASD care workers):

> ***"Most of the children stay with guardian who drink alcohol so the child ended up defaulting." Care Worker, NACOSA SR, KZN***

*"Some tested positive but don't want to start treatment." Care worker, NRASD SSR, Mpumalanga*

Despite these challenges, both NACOSA and NRASD were able to exceed the targets in terms of the number of OVC tested and receiving their results. This suggests that these barriers were overcome by the end of the grant term as the quotes below depict. Through educating caregivers around HIV prevention and the importance of getting tested, SRs and SSRs witnessed a shift in their communities**. Initial resistance and refusal was replaced by acceptance and uptake of HTS**, even an eagerness for testing:

*"It was a tough task to change their mind-sets…but now it's easier. People can come to us and say they want to test or tell us that they are positive. People didn't want to open the doors for us but after the talks and the meetings, they understood." Manager, NRASD SR, Gauteng*

*"The children are now cooperative. Nowadays they are cooperate [sic] even if we invite them for TB screening, they respond. Normally, they were not." Director, NRASD SSR, Limpopo*

*"Since the beginning of the internal testing and educational sessions…the beneficiaries are more eager to get tested and know their status. Even the parents want to get tested." Coordinator, NRASD SSR, North West*

# 9. EVALUATION FINDINGS: EFFECTIVENESS AND EFFICIENCY

This section of the report presents the findings on the quasi-experimental component of the evaluation, focusing on the outcomes:

- OVC know their HIV status;
- Increased HIV prevention knowledge;
- Wellbeing of OVC in terms of risk behaviours, improved nutritional status, retention in school, access to social grants and healthcare, well-being and support in families; and
- Improved capacity of organisations and care workers.

For each of these areas, the report presents descriptive statistics to identify how OVC/caregivers, care workers and/or SRs/SSRs are performing on these outcomes. Results are presented split by Global Fund (NRASD and NACOSA merged) and DSD. The Global Fund results are further broken down by NACOSA and NRASD so that the performance of OVC/caregivers, care workers and/or SRs/SSRs can be identified separately for each of the PRs. This section also describes the results of the cross-sectional (comparison between Global Fund and DSD and longitudinal analyses (comparison between Global Fund from Time 1 to Time 2).

The key findings from this section are summarised below and detailed in the sections HTS and HIV prevention knowledge, OVC well-being and Organisational capacity building that follow.

## KEY FINDINGS ON PROGRAMME OUTCOMES

### HTS

- The Global Fund Phase II Grant was successful in ensuring OVC in the programme were tested for HIV:
  - 62% of OVC from NRASD SSRs reported knowing their status and 71% of OVC from NACOSA SRs reported knowing their status compared to only 36% of OVC from the DSD programme.
  - OVC in the Global Fund Programme were 4 times more likely to be tested for HIV than OVC in the DSD Programme.
  - OVC in the Global Fund Programme were 4.3 times more likely to be tested for HIV at the end of the programme compared to mid-programme.

### HIV PREVENTION KNOWLEDGE

- The HIV prevention knowledge of OVC and caregivers in the Global Fund programme was high; however, except for one area of knowledge, Global Fund participants did not have significantly better HIV prevention knowledge when compared to DSD participants:
  - Global Fund OVC participants were 1.5 times more likely to correctly answer that HIV can be transmitted from mother to baby during birth than DSD participants.
- The lack of a significant finding despite the focus of the Global Fund Phase II Grant on HTS and HIV prevention knowledge may be due to external sources of HIV knowledge, such as through school curriculum, radio and campaigns in the community (e.g. World AIDS Day).
- The HIV prevention knowledge of OVC in the Global Fund programme improved significantly from mid- to end-of-programme:
  - Participants were 1.5 times more likely to get all HIV prevention/knowledge questions correct at the end of the programme compared to earlier in the programme,
  - Most significantly, they were 2.5 times more likely to know that a healthy looking person can have HIV.

**RISK BEHAVIOUR**

- The improved HIV prevention knowledge of OVC does not appear to have translated into behaviour change; while engagement in risky behaviours was generally low overall there were no significant differences between OVC aged 10 years and older in the Global Fund OVC Programme compared to OVC in the DSD Programme in terms of substance use or having had sex. There was no change in these behaviours from mid-programme to end-of-programme.

**SCHOOLING**

- School enrolment was high - more than 98% of OVC across all programmes were enrolled in school.
- While a quarter (21,4%) of OVC in the Global Fund programme reported missing school in the last 3 months, this was predominantly due to illness.
- Significantly, OVC who had been receiving services for more than 1 year but less than 2 years were 6.4 times more likely to report good or very good school performance. This suggests a positive effect for homework support and other support services provided to OVC through the programme.
- OVC and caregivers appeared to be satisfied with the progress of the child in his/her last school exams; two thirds (66,3%) of OVC/caregivers reported that they were happy with their school performance and did 'good' or 'very good' in their last exams.
- There were no significant differences in perceived school performance between mid- and end-of-programme.

**HOUSEHOLD HUNGER**

- 79% of OVC or caregivers in the Global Fund Programme reported having little to no hunger in the household. Although slightly more OVC and caregivers in the DSD Programme reported moderate hunger than Global Fund households (25,8% vs. 19,8%), there were no statistically significant differences.

**UPTAKE OF SERVICES**

- The uptake of social grants was high amongst all OVC households; 90% of OVC households in the Global Fund Programme reported receiving a social grant.
- Households were not significantly more likely to be receiving a social grant at the end of the programme compared to mid-programme and households in the Global Fund OVC Programme were not significantly more likely to receive a social grant than those in the DSD Programme. This is likely due to a programmatic focus on such services by both programmes.
- Uptake and access to healthcare was high amongst Global Fund OVC and caregivers; 72% had accessed health services in the last 6 months.

**ORGANISATIONAL CAPACITY BUILDING**

- Thirty-nine out of 46 NRASD SSRs and 17 out of 26 NACOSA SRs reported that coordination and networking of their organisation in the community had improved.
- Nineteen out of 26 NACOSA SRs identified that the grant had strengthened the capacity of the organisation, with 4 seeing this as the key or biggest achievement of the grant. Forty out of 47 NRASD SSRs noted strengthened organisational capacity as an achievement of the grant.
- The strengthened capacity of the child and youth care workers was identified by 22 out of 26 NACOSA SRs and 41 out of 47 NRASD SSRs as an achievement of the grant.
- Managers reported:
    - having stronger linkages with other stakeholders, particularly schools and clinics,
    - a stronger presence and visibility in the community, with more community awareness of the organisation and its services,

- improved quality and scope of services provided to better meet the needs of the vulnerable households in their respective communities.

- The reporting and recording capacity of SRs and SSRs has improved and are using (30 out of 73) or starting to use (14 out of 73) the CBIMS system

# 9.1 HTS and HIV prevention knowledge

## 9.1.1 Knowing your status

### 9.1.1.1 Uptake of HTS amongst OVC in the Global Fund OVC Programme

A key intended outcome of the Global Fund OVC Programme was that **OVC knew their HIV status**. The Figures below present the proportion of OVC tested for HIV as reported by caregivers and OVC (see Figure 18), the proportion of OVC tested for HIV and received the result as reported by caregivers and OVC (i.e., proportion knowing their HIV status see Figure 19) and the proportion of OVC who know their status who shared the result with their caregiver (Figure 20). The latter shows only the Global Fund OVC as the DSD sample tested (n=52) was too small. Of the 52 that reportedly know their results, 44 said the results had been shared with the caregiver.

**Figure 18. Proportion of OVC having been tested for HIV, by programme.**

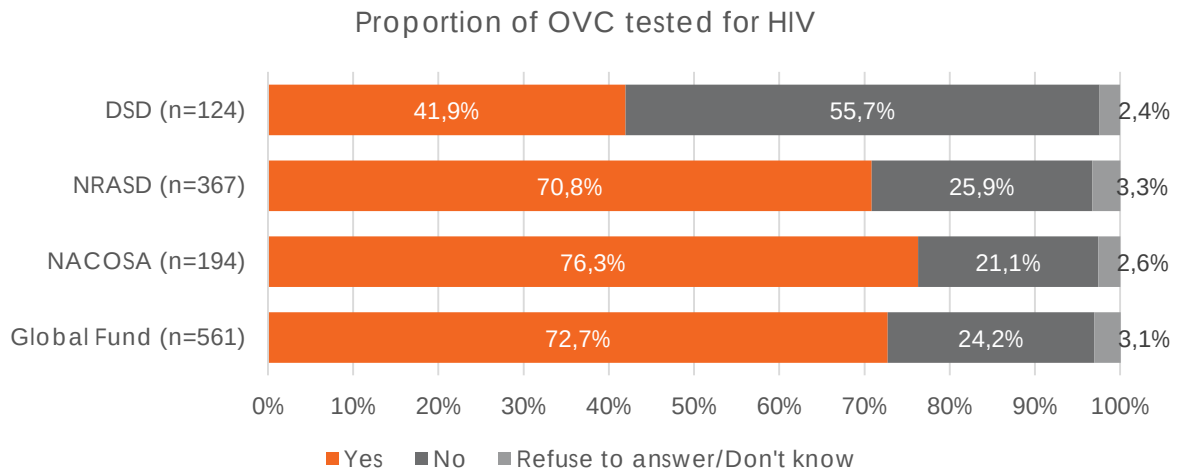



**Figure 19. Proportion of OVC tested for HIV and received the result the last time they were tested (i.e. 'know their status') by programme**

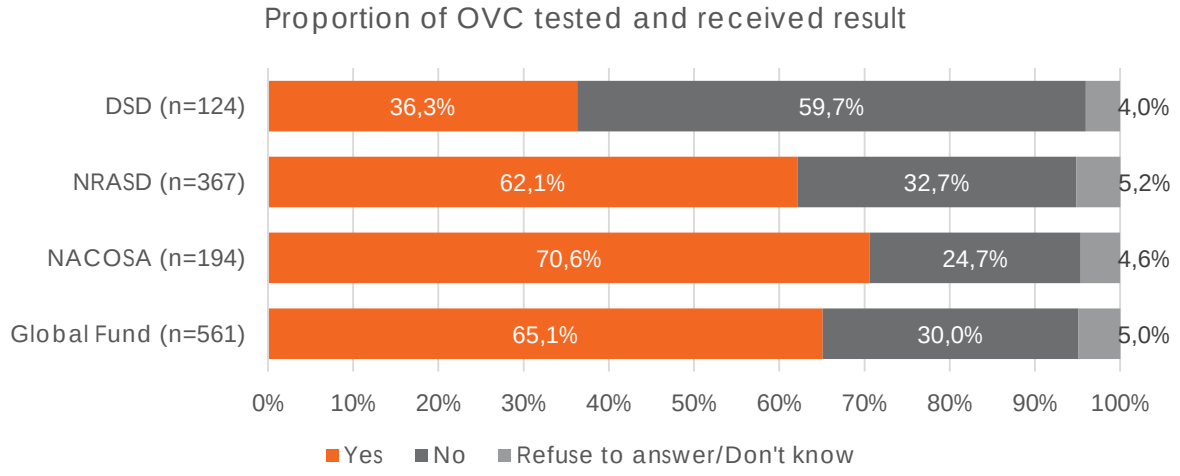
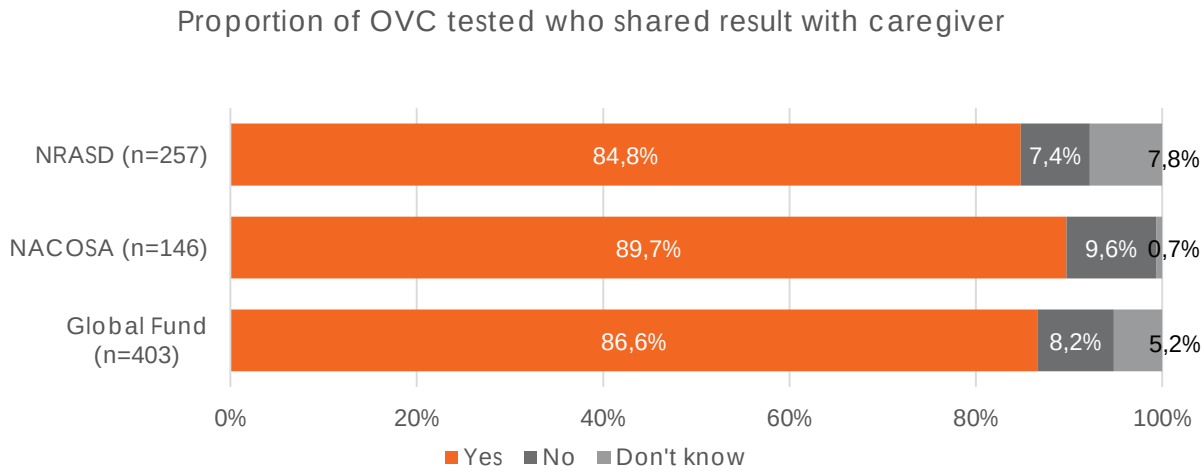


**Figure 20. Proportion of OVC tested and received the result, who shared the result with their caregiver, by programme**




While the above Figures provide proportion of the OVC tested, it is likely that guardians could either not be aware of OVC having been tested or be more likely to report in the affirmative due to social desirability bias. Therefore, the results for OVC aged 10 years and older and caregivers of children younger than 10 years were analysed separately. Due to varying sample sizes, the results are presented as follows:

- Figure 21 presents the proportion of OVC 10 years and older who reported having had an HIV test and/or receiving the result the last time they were tested.
- Figure 22 presents the proportion of OVC aged younger than 10 years in the Global Fund OVC Programme who were reported by their caregiver to have had an HIV test and received the result the last time they were tested.
- Due to small sample sizes in the NACOSA, NRASD and DSD sub-samples, Table 13 presents the count (n) for the number of OVC aged younger than 10 years who were reported by their primary caregiver to have had an HIV test, received the result, shared the result with their caregiver and, if they had not been tested, would want to be tested.

**Figure 21. Proportion of OVC 10 years and older reporting having had an HIV test and receiving the result, by programme**

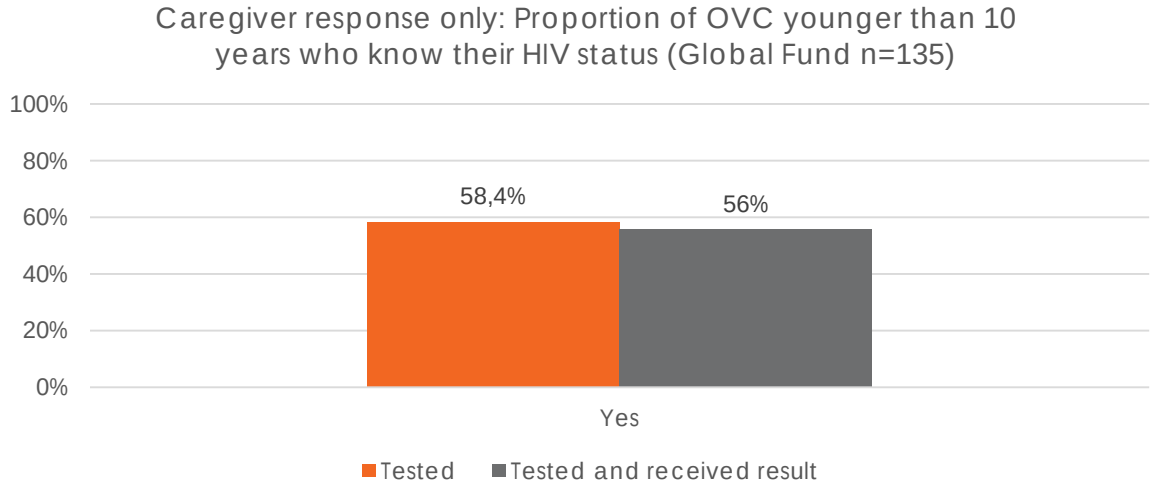


**Figure 22.Proportion of caregivers of OVC younger than 10 years who report the child has had an HIV test and received the result**

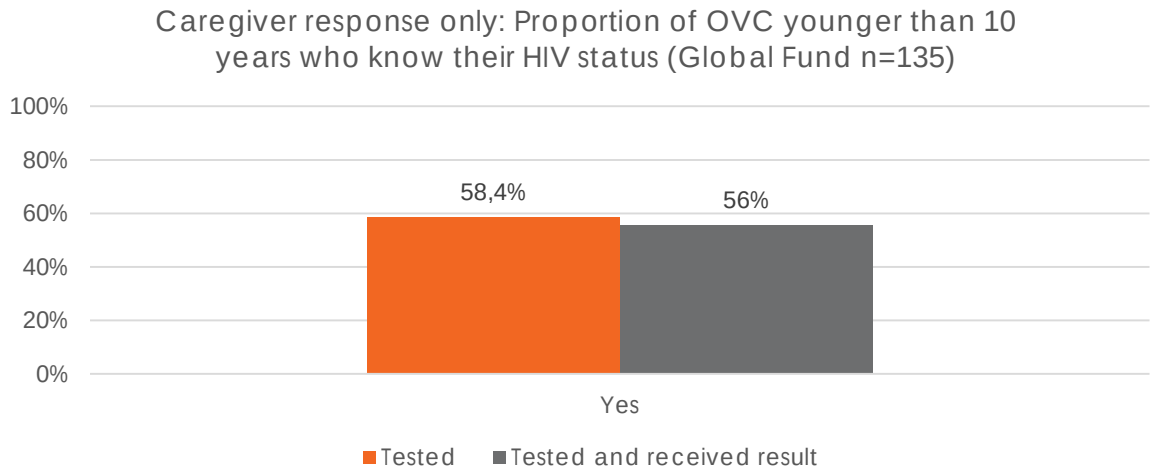



**Table 13. Caregiver report of uptake of HTS amongst OVC younger than 10 years**

| | NACOSA (n = 50) | NRASD (n=85) | DSD (n=23) |
|---|---|---|---|
| **Child tested for HIV** | | | |
| Yes | 45 | 63 | 14 |
| No | 3 | 16 | 8 |
| Don't know | 2 | 6 | 1 |
| **Child received the HIV test results** | | | |
| Yes | 43 | 60 | 14 |
| No | 2 | 3 | 0 |
| Don't know | 0 | 0 | 0 |
| **HIV test results shared with caregiver** | | | |
| Yes | 43 | 58 | 14 |
| No | 0 | 1 | 0 |
| Don't know | 0 | 1 | 0 |

Cross-sectional multivariate modelling revealed that, with all other variables held constant, **Global Fund OVC participants were 4 times more likely to be tested for HIV than DSD participants**. While there were unfortunately too few DSD participants to perform modelling for the remaining HTS uptake characteristics, bivariate analyses revealed that guardians were significantly more likely to report that a child had received their HIV test results than children (95.9% versus 90.2% respectively). Furthermore, guardians were significantly more likely to report that a child had shared their test results than children (99.1% versus 88.5% respectively).

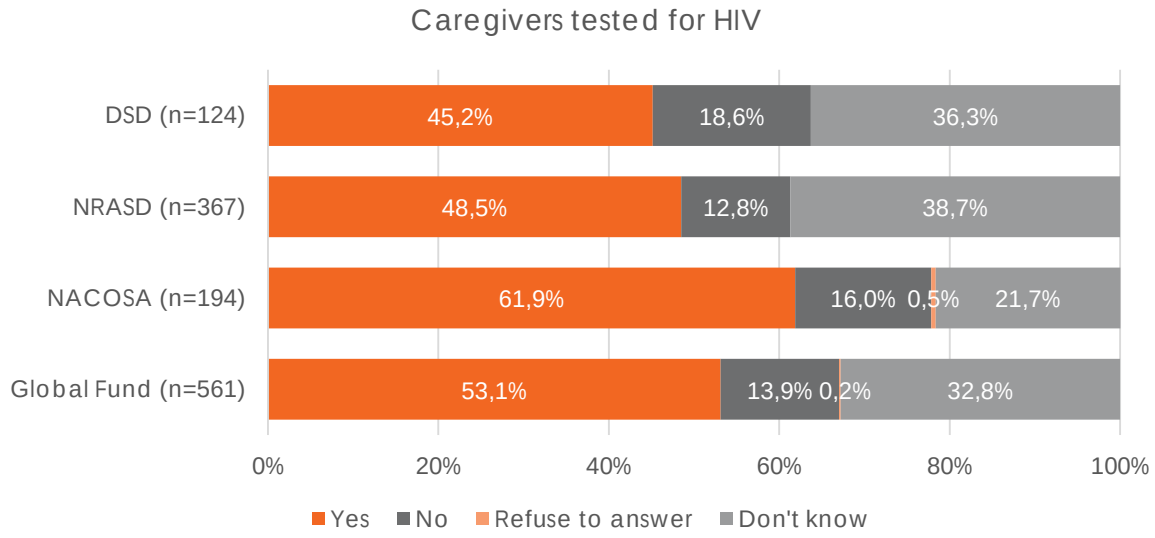
Longitudinal multivariate modelling revealed that, compared to the previous evaluation, at the current evaluation **OVC participants were 4.3 times more likely to be tested for HIV**. There were no other significant differences between the previous and current evaluation in terms of HTS uptake. This is an important finding as knowing one's status is the first step towards behaviour change to reduce or prevent infection an increase HIV awareness and prevention knowledge.

Only 6.2% (n=33) of OVC ≥ 10 years in the current evaluation reported taking ARV medication. Of those on ARVs, 33.3% (n=11) indicated that there has been a time in the past 3 days when he/she skipped or missed taking his/her ARVs. 10.7% (n=17) of OVC ≤ 9 years in the current evaluation were reported by their caregiver to be taking ARV medication. Of those on ARVs, 11.7% (n=2) indicated that there has been a time in the past 3 days when he/she skipped or missed taking his/her ARVs.

### 9.1.1.2 Uptake of HTS by caregivers

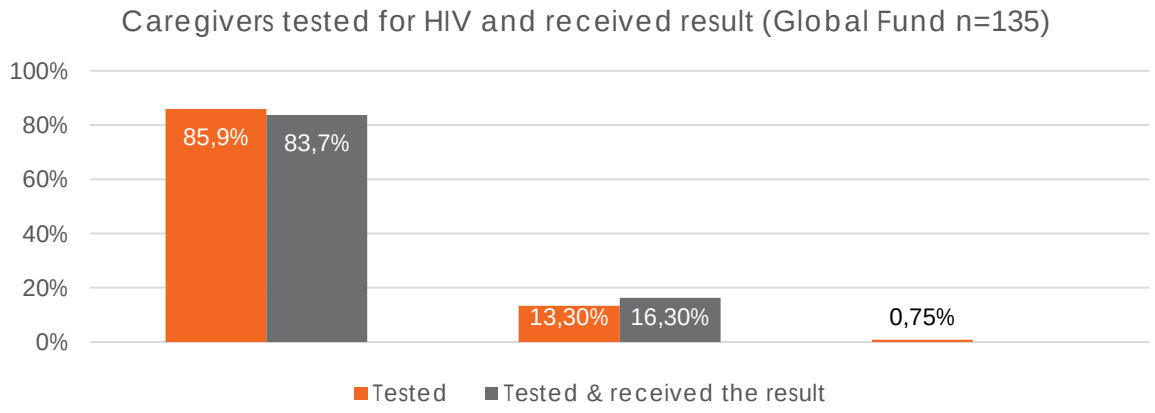
The survey also explored the uptake of HTS amongst **OVC caregivers.** The results are presented in the graphs below.

**Figure 23. Proportion of caregivers having had an HIV test (caregiver self-report and child report of caregivers uptake of HTS).**




The figure above presents the responses from both children and caregivers themselves and are skewed by the large number of OVC who were not aware of their caregiver's uptake of HTS. Hence Figure 24 displays the % for caregivers of children aged 10 years and older in the Global Fund programme only and the remaining figures are presented in Table 14 (only n is reported).

**Figure 24. Proportion of caregivers of OVC aged 10 years and older that have been tested and received the result**



If broken down per programme for caregivers only, the sample sizes are too small to display as a proportion in the table below.

**Table 14. Number of caregivers of OVC aged 10 years and older that have been tested and received the result, by programme**

| | NACOSA (n=50) | NRASD (n=85) | DSD (n=23) |
|---|---|---|---|
| **Caregiver tested for HIV** | | | |
| Yes | 47 | 69 | 20 |
| No | 3 | 15 | 3 |
| Don't know | 0 | 1 | 0 |
| **Caregiver received the HIV test results** | | | |
| Yes | 45 | 68 | 20 |
| No | 2 | 1 | 0 |

Of those caregivers who had not been tested (n=21), only a small number said that they would not want to be tested (n=4):

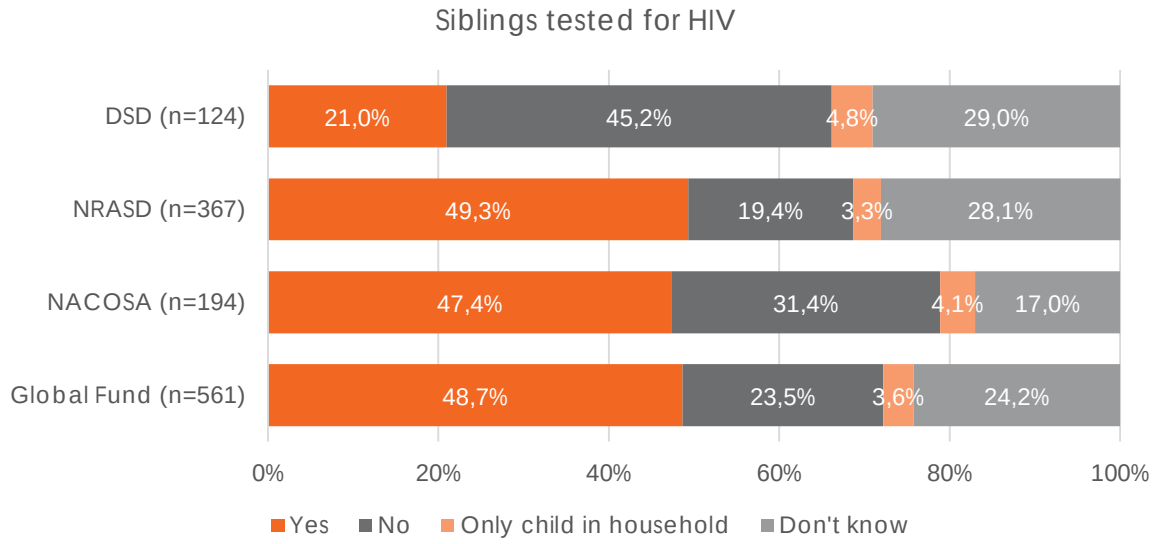
- 3 out of 3 caregivers from NACOSA SRs who had not been tested said they wanted to be tested
- 13 out of 16 caregivers from NRASD SSRs who had not been tested said they wanted to be tested
- 1 out of 3 caregivers from DSD funded organisations who had not been tested said they wanted to be tested

A total of 24.6% (n=39) of OVC caregivers in the current evaluation reported taking ARV medication. Of those on ARVs, 17.9% (n=7) indicated that there had been a time in the past 3 days when he/she skipped or missed taking his/her ARVs. 18.6% (n=98) of OVC children 10 years and older reported that their caregiver was taking ARV medication. Of those on ARVs, 25.5% (n=25) indicated that there has been a time in the past 3 days when their caregiver skipped or missed taking his/her ARVs.

### 9.1.1.3 Uptake of HTS by siblings

The survey asked OVC and their caregivers whether the child's siblings had been tested for HIV.

**Figure 25. Proportion of OVC and caregivers reporting that siblings have been tested for HIV**

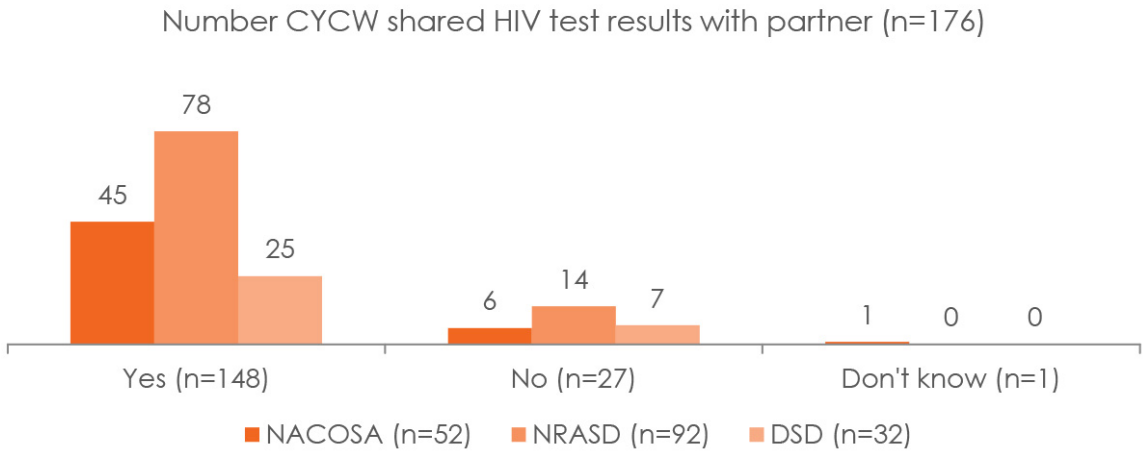


A total of 8.6% (n=59) of caregivers/OVC reported that the child's sibling/s were taking ARV medication. Of those, 11.8% (n=7) indicated that there has been a time in the past 3 days when the sibling(s) skipped or missed taking their ARVs.

### 9.1.2 Uptake of HTS by care workers

**All care workers across all OVC programmes reported having been tested for HIV[19] with only one care worker from the NRASD programme reporting not having received the result** the last time they were tested. Furthermore, most care workers from NACOSA SRs and NRASD SSRs (85,4%; 123 out of 144 CYCW) had shared the results of their tests with their partners. Figure 26 presents the breakdown per programme.

**Figure 26. Number of care workers tested for HIV and receiving the result reporting sharing this result with their partner, per programme**




### 9.1.3 HIV prevention knowledge

The HIV knowledge of OVC and caregivers was assessed through eight statements which respondents were asked to identify as true or false:

- People can reduce their chances of getting HIV by having just one sex partner who has no other sex partners.
- People can reduce their chances of getting HIV by using a condom every time they have sex.
- People can get HIV from mosquito bites.
- A healthy - looking person can have HIV.
- People can get HIV by sharing food with someone who has HIV.
- HIV can be transmitted from a mother to her baby during pregnancy.
- HIV can be transmitted from a mother to her baby during birth.
- HIV can be transmitted from a mother to her baby during breast feeding.

A total knowledge score was calculated by recoding 'True' as 1 and 'False' as 0 for each of the 8 questions. Where the correct answer was 'False', the coding was reversed. The scores for each participants were then summed to derive a total score out of 8.

[19]There was one care worker from the NRASD programme that refused to answer this question.

### 9.1.3.1 HIV knowledge of OVC and caregivers

The HIV knowledge results for OVC aged 10 years and older and caregivers of OVC aged younger than 10 years are presented according to total score in Figure 27 and Table 16 and per question in Table 15 and Table 16 respectively.

**Figure 27. Proportion of OVC aged 10 years and older getting all HIV prevention/knowledge questions correct**

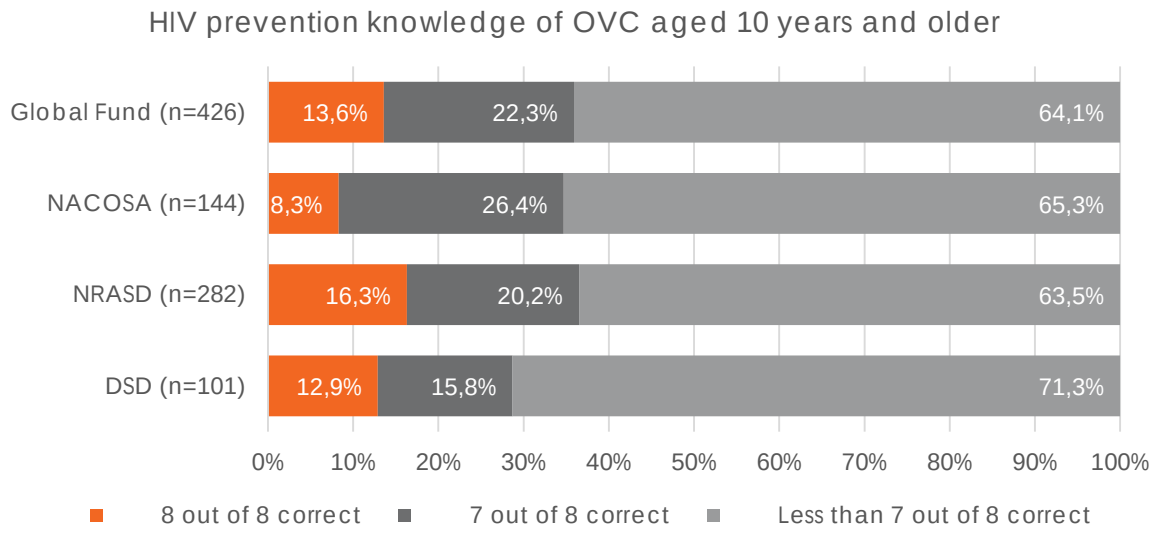



**Table 15. Proportion of OVC aged 10 years and older answering each HIV knowledge/prevention question correctly**

| Statement | Global Fund (n=426) | | NACOSA (n=144) | | NRASD (n=282) | | DSD (n=101) | |
|---|---|---|---|---|---|---|---|---|
| | % | n | % | n | % | n | % | n |
| Using a condom every time | 85.9% | 366 | 84.7% | 122 | 86.5% | 244 | 86.1% | 87 |
| Having just one sex partner | 78.9% | 336 | 73.6% | 106 | 81.6% | 230 | 72.3% | 73 |
| Get HIV by sharing food | 75.1% | 320 | 75.7% | 109 | 74.8% | 211 | 63.4% | 64 |
| HIV from mother to baby during pregnancy | 70.9% | 302 | 72.9% | 105 | 69.9% | 197 | 68.3% | 69 |
| HIV from mother to baby during breastfeeding | 67.8% | 289 | 69.4% | 100 | 67.0% | 189 | 72.3% | 73 |
| Healthy looking person can have HIV | 66.7% | 284 | 60.4% | 87 | 69.9% | 197 | 66.3% | 67 |
| HIV from mosquito bites | 63.4% | 270 | 59.7% | 86 | 65.2% | 184 | 64.4% | 65 |
| HIV from mother to baby during birth | 65.3% | 278 | 68.1% | 98 | 63.8% | 180 | 55.4% | 56 |

**Table 16. Proportion and number of caregivers of OVC aged younger than 10 years getting all HIV prevention/knowledge questions correct**

| | Global Fund (n=135) % | NACOSA (n=50) n | NRASD (n=85) n | DSD (n=23) n |
|---|---|---|---|---|
| 8 out of 8 correct | 14,1% | 5 | 14 | 10 |
| 7 out of 8 correct | 40,7% | 17 | 38 | 8 |
| Less than 7 out of 8 correct | 45,2% | 28 | 33 | 5 |

**Table 17. Proportion of caregivers of OVC aged younger than 10 years answering each HIV knowledge/prevention statement correctly**

| Statement | Global Fund (n=135) | | NACOSA (n=50) | NRASD (n=85) | DSD (n=23) |
|---|---|---|---|---|---|
| | % | n | n | n | n |
| Using a condom every time | 95.6% | 129 | 49 | 80 | 23 |
| Having just one sex partner | 89.6% | 121 | 44 | 77 | 22 |
| Get HIV by sharing food | 88.9% | 120 | 41 | 79 | 20 |
| Healthy looking person can have HIV | 85.2% | 115 | 38 | 77 | 21 |
| HIV from mother to baby during birth | 82.2% | 111 | 45 | 66 | 22 |
| HIV from mother to baby during breastfeeding | 74.1% | 100 | 38 | 62 | 22 |
| HIV from mother to baby during pregnancy | 69.6% | 94 | 30 | 64 | 22 |
| HIV from mosquito bites | 56.3% | 76 | 29 | 47 | 14 |

Cross-sectional multivariate modelling revealed that, with all other variables held constant, **Global Fund OVC participants were 1.5 times more likely to correctly answer that HIV can be transmitted from mother to baby during birth than DSD participants.** There were no other significant differences between Global Fund and DSD. In terms of socio-demographic variables, urban OVC were 2.4 times more likely than rural OVC to correctly answer that a healthy looking person can have HIV. Finally, OVC aged 10-12 years were 2 times more likely to receive a low total knowledge score than OVC aged 15 years and older.

Longitudinal multivariate modelling revealed that, compared to the previous evaluation, at the time of the current evaluation participants were:

- **1.5 times more likely to get all HIV prevention/knowledge questions correct**
- 1.5 times more likely to answer correctly that having just one sex partner can lower one's risk of HIV infection,
- 1.5 times more likely to correctly answer that using a condom every time can lower one's risk of HIV infection,
- 2 times more likely to correctly answer that one can't contract HIV from mosquitos,
- 1.8 times more likely to answer correctly that one can't get HIV by sharing food, and
- 2.5 times more likely to correctly that a healthy looking person can have HIV.

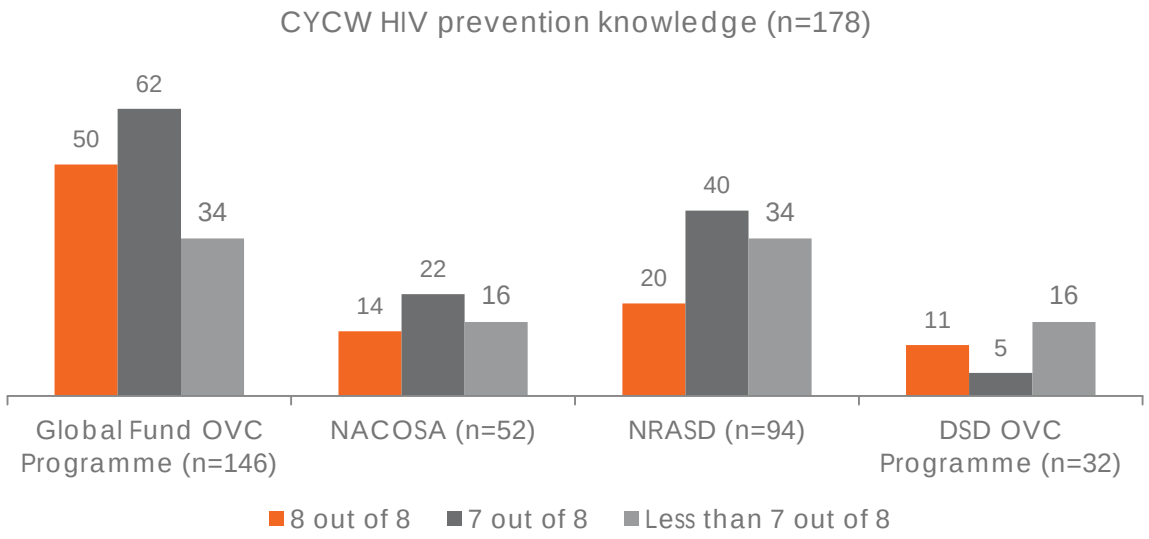
### 9.1.3.2 HIV knowledge and awareness of care workers

The HIV knowledge of care workers was also assessed, using the same questions asked of OVC and caregivers. Figure 28 presents the breakdown per programme of care workers answering all the statements correctly, only getting one wrong or getting more than one wrong. As evident in the Figure, **34,2% of Global Fund care workers answered 8 out of 8 questions correctly,** 42,5% answered 7 out 8 questions correctly and 23,3% answered more than question incorrectly. The same number of DSD care workers got either more than one

statement wrong or all correct/ only one wrong (16 vs. 16 DSD care workers). However, this was reversed across both Global Fund programmes; a larger number of care workers answered all or 7 of the 8 statements correctly than the number who got more than one wrong at NACOSA SRs (36 vs. 16 care workers) and NRASD SSRs (60 vs. 34 care workers). This seems to indicate **stronger HIV prevention knowledge of NACOSA and NRASD care workers** than those in the DSD programme.

Although only slightly more than a third of Global Fund care workers knew 100% of the HIV prevention/knowledge statements, looking at the breakdown per statement (see Table 18 which displays the proportion and number answering each of the statements correctly) it can be seen that this is predominantly due to the care workers not knowing that **HIV can be transferred from a mother to her baby during pregnancy. Nearly a third (31,5%) of Global Fund care workers answered this question incorrectly**. All care workers in the Global Fund Programme knew that people can reduce their chances of getting HIV by using a condom every time they have sex. Other than the 79,5% of Global Fund care workers who knew that HIV could not be transmitted via a mosquito bite, more than 89% of care workers answered the remaining statements correctly.

### Figure 28. Number of care workers getting HIV prevention/knowledge questions correct




### Table 18. Proportion and number of care workers answering each HIV knowledge/prevention statement correctly

| | Global Fund (n=146) | | NACOSA (n=52) | NRASD (n=94) | DSD (n=32) |
|---|---|---|---|---|---|
| | % | n | n | n | n |
| Using a condom every time | 100% | 146 | 52 | 94 | 30 |
| Get HIV by sharing food | 94.5% | 138 | 49 | 89 | 30 |
| HIV from mother to baby during breastfeeding | 91.1% | 133 | 45 | 88 | 22 |
| HIV from mother to baby during birth | 90.4% | 132 | 48 | 84 | 25 |
| Having just one sex partner | 88.4% | 129 | 44 | 85 | 29 |
| Healthy looking person can have HIV | 88.4% | 129 | 42 | 87 | 30 |
| HIV from mosquito bites | 79.5% | 116 | 46 | 70 | 23 |
| HIV from mother to baby during pregnancy | 68.5% | 100 | 34 | 66 | 24 |

### 9.1.4 Towards an HIV Free Generation: Case Studies

Two case studies further explored the HTS and HIV prevention knowledge components of both NACOSA and NRASD's models respectively (see Appendix D). These case studies present a more detailed description of the services provided by SRs and SSRs as part of the programme and the successes and challenges around implementation.

## 9.2 OVC well-being

### 9.2.1 Risk behaviours

It was important to explore whether the knowledge and support OVC obtained through the programme translated into behaviour change. OVC aged 10 – 17 years were asked to respond to a number of questions regarding high-risk behaviours, including whether they had ever been sexually active or had used alcohol, cigarettes or drugs in the last 3 months. The proportion of OVC reporting these behaviours are presented below (see Table 19).

Drinking alcohol was the most frequently reported substance use by OVC, with **nearly a fifth of OVC in the Global Fund and DSD programmes reporting having drunk alcohol in the last 3 months**. As evident in the table, slightly fewer OVC in the Global Fund programme (9,4%) reported having smoked cigarettes than those OVC in the DSD programme (11,9%). Other substance use behaviours were reported by only a small proportion of OVC aged 10 years and older. When rounded off there was no difference in the proportion of OVC who reported having drunk alcohol in the last 3 months (19% across all OVC programmes) or smoked dagga (1% across all OVC programmes). Reported use of drugs other than dagga in the last three months was very low across all programmes, with only three OVC from the Global Fund programme reporting this behaviour.

While there were no significant effects for having smoked cigarettes, bivariate analyses revealed that older children and children in higher grades were significantly more likely to report having smoked cigarettes than younger children in lower grades. After controlling for the effects of these demographic variables, **there were no significant differences between OVC aged 10 years and older in the Global Fund OVC Programme compared to OVC in the DSD Programme on any of these substance use behaviours**. Multivariate modelling revealed that overall girls were 2.8 times less likely to report having drunk alcohol than boys, and children in grades 3 to 9 were 3 times less likely to report having drunk alcohol than children in grades 10 to 12.

Compared to the previous evaluation, participants at the time of the current evaluation were 2.8 times more likely to report having drank alcohol and 3 times more likely to report having smoked cigarettes. It is likely that the increase in risk behaviour is associated with the increase in age of the participants over the period of the grant (older children are more likely to drink alcohol and smoke cigarettes than younger children). Unfortunately there were too few observations to calculate odds ratios for other risk behaviours.

**Table 19. Risk behaviours reported by OVC aged 10 years and older, by programme**

| Risk Behaviour | Global Fund (n=426) | | NACOSA (n=144) | | NRASD (n=282) | | DSD (n=101) | |
|---|---|---|---|---|---|---|---|---|
| | % | n | % | n | % | n | % | n |
| Had sex | 9.4% | 40 | 10.4% | 15 | 8.9% | 25 | 11.9% | 12 |
| Drank alcohol | 19.0% | 81 | 18.8% | 27 | 19.2% | 54 | 18.8% | 19 |
| Smoked cigarettes | 4.5% | 19 | 6.3% | 9 | 3.6% | 10 | 7.9% | 8 |
| Smoked dagga | 0.9% | 4 | 0.7% | 1 | 1.1% | 3 | 0.9% | 1 |
| Took drugs | 0.7% | 3 | 0.7% | 1 | 0.7% | 2 | 0.0% | 0 |

In total, **9,9% (52 out of the total of 527 OVC aged 10 years and older) in the total sample reported having had sex**. Of these, 32 reported having used a condom the last time (61.5%) and 5 reported having ever fallen pregnant or making someone pregnant (10%). When looking at these numbers per programme:

- Of the 15 NACOSA participants who reported having had sex, 7 reported having used a condom and 1 reported having fallen pregnant.
- Of the 25 NRASD participants who reported having had sex, 17 reported having used a condom and 3 reported having fallen pregnant.
- Of the 12 DSD participants who reported having had sex, 8 reported having used a condom and 1 reported having fallen pregnant.

Multivariate modelling revealed that children aged 10-12 years were 3.6 times less likely to report having had sex than children aged 16 years and older, and children in grades 6 to 9 were 3 times less likely to report having had sex than children in grades 10 to 12.

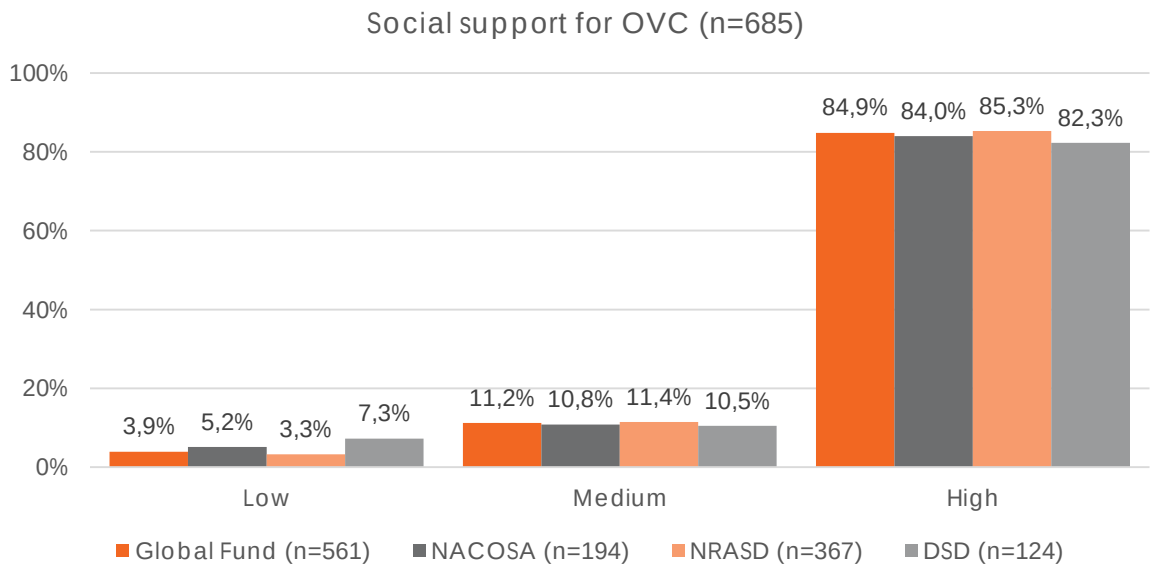
### 9.2.2 Social support

The support OVC received at home was assessed using a series of questions:

- Do you have someone to help you with your daily activities and chores?
- Do you have someone to speak to about any personal problems you may be having?
- Do you have someone to show you love and affection?
- Do you have someone to do enjoyable things with?

The questions were recoded so that 'Yes' was coded as 1 and 'No' was coded as 0. Values then then summed for each participants. A total less than or equal to 2 was categorised as 'Low' social support, 3 was classified as 'Medium' social support and 4 as 'High' social support. According to Figure 29 **the majority of OVC and caregivers (≥ 84%) reported that the OVC had a high level of social support**.

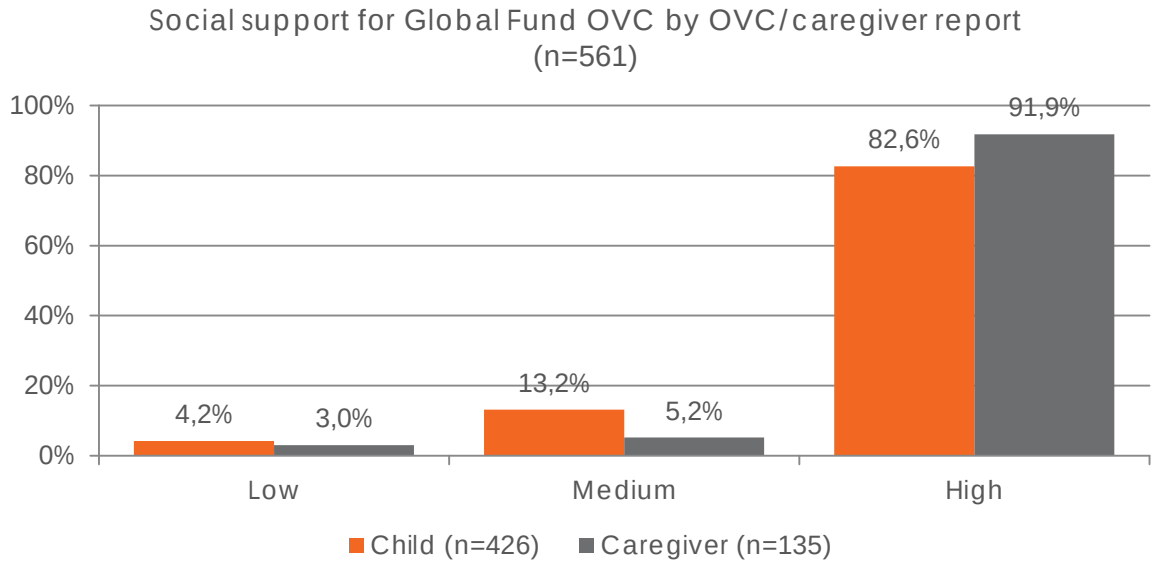
**Figure 29. Proportion of OVC aged 10 years and older and caregivers of OVC younger than 10 years reporting low, medium and high social support for the child**




Bivariate analyses revealed that older children reported significantly lower levels of social support than younger children. After controlling for this variable (age of child) **there were no significant differences between the Global Fund and OVC sample in terms of reported social support available to the OVC**.

The finding that **older children reported significantly lower levels of social support than younger children** could due to the split between OVC aged 10 years and older and caregivers of OVC aged younger than 10 years. Unfortunately, there were too few low and medium social support participants to allow for disaggregation by children and caregivers other than for the Global Fund Programme. This was done to investigate whether it was more likely that caregivers would report high levels of support provided to the child due to, for example, social desirability. Figure 30 presents the social support findings for the Global Sample only, split by OVC 10 years and older and caregivers of OVC younger than 10 years. The results show that **a larger proportion of caregivers of younger OVC in the Global Fund Programme reported that the child had high social support (91,9%) compared to the proportion of older OVC who reported that they themselves had high social support (82,6%)**. A bivariate analysis showed that the difference in proportions was statistically significant. The result suggests that either (a) younger OVC have higher levels of social support than older OVC or (b) caregivers were more likely to report better levels of social support being provided to the child.

**Figure 30. Proportion of OVC/caregivers in the Global Fund OVC Programme reporting low, medium and high social support for the OVC**




Longitudinal multivariate modelling showed that there were **no significant differences in social support between the previous and current evaluations**. The null result might be the result of low statistical power given that so few participants reported 'Low' levels of social support.

## 9.2.3 Education and schooling

### 9.2.3.1 School enrolment and attendance

At the time of the current evaluation, more than 98% of OVC across all programmes were enrolled in school (see Figure 31 below). In addition, few reported missing school during the last 3 months. For those OVC who had reported missing school in the past 3 months across all OVC programmes (22,2%), the predominant reason was that they were too sick to attend school (see Figure 32 below). Five children were too young to attend school and 2 were reportedly attending an ECD programme.

A total of 28.1% of DSD participants reported having missed school during the last 3 months compared to 21.4% of Global Fund participants; however, further investigation revealed this difference was not statistically significant.

**Figure 31. OVC school enrolment by OVC programme**

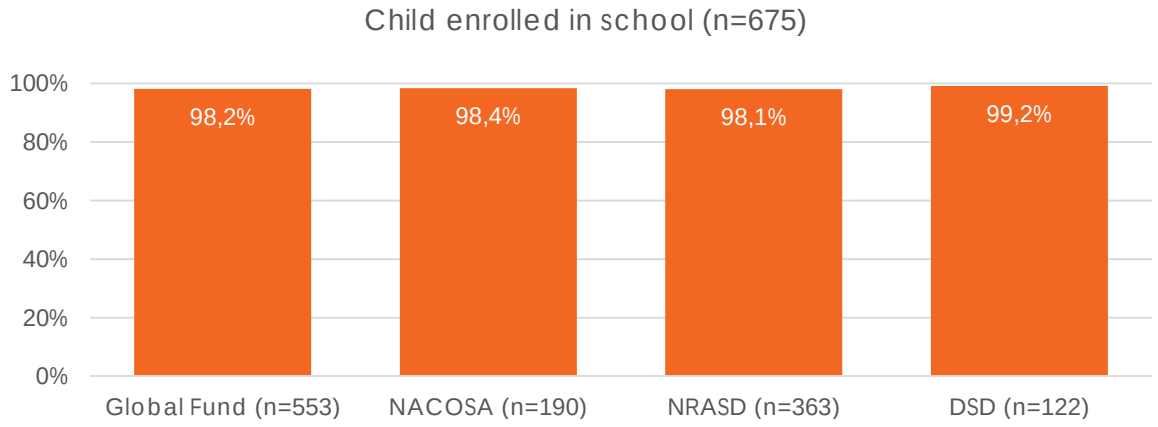
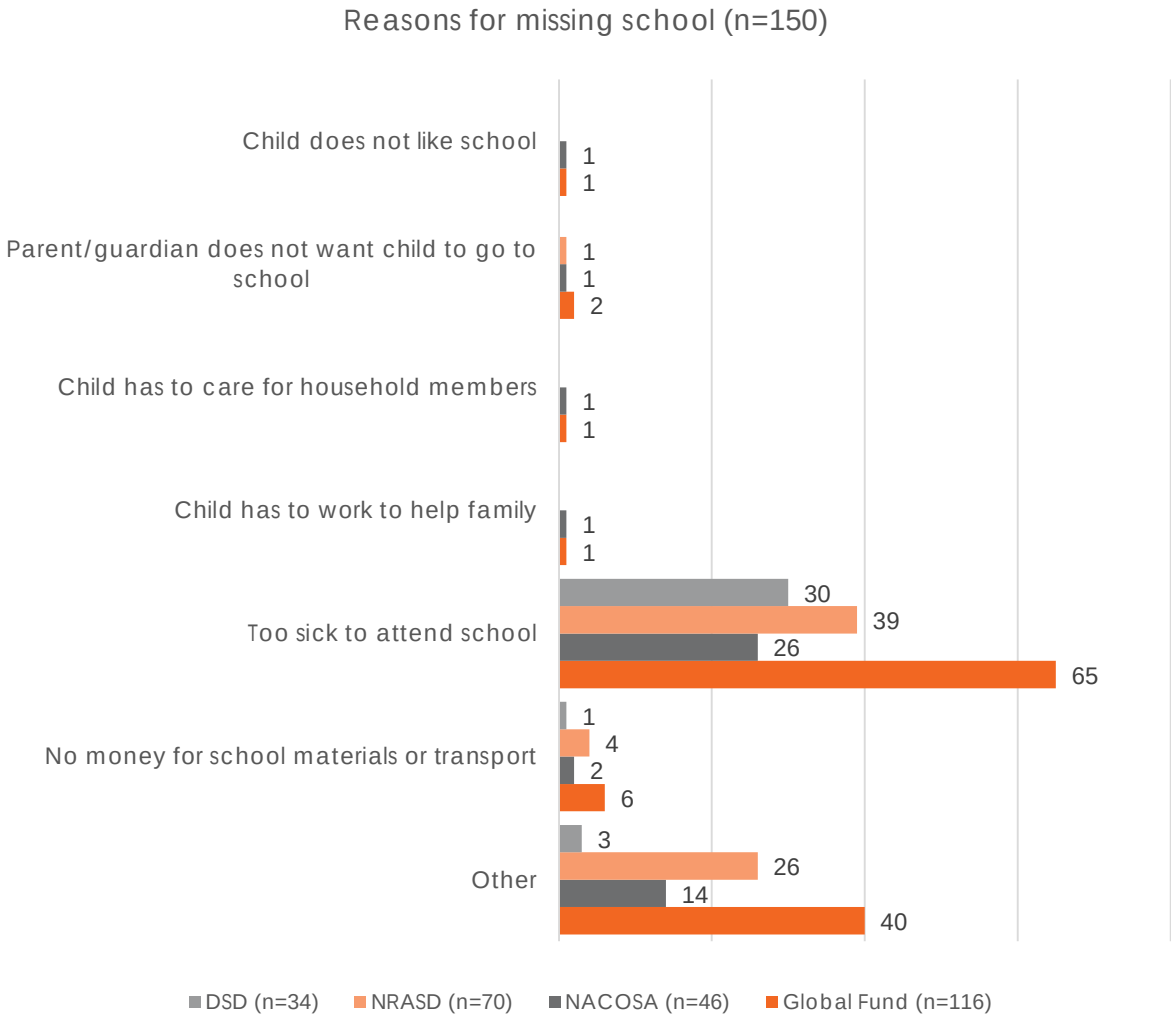



**Figure 32. Most frequently reported reasons children missed school in the last 3 months as reported by OVC and caregivers (count)**



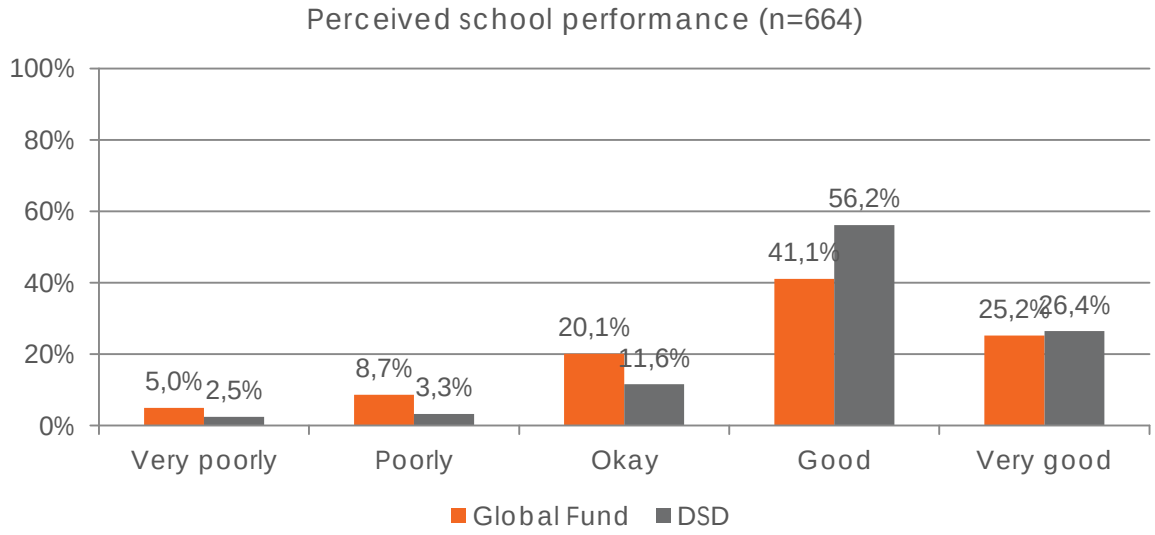
### 9.2.3.2 Perceived performance at school

Although not an accurate measure of a child's performance at school, OVC were asked to rate how they felt they did in their last school exams. The figure below presents the proportion of OVC overall and for each programme perceiving that they did very poorly, poorly, okay, good or very good. Similarly, caregivers were asked to rate how the child younger than 10 years performed.

Across both programmes, **the majority of OVC/caregivers reported that they were happy with their school performance and did 'good' or 'very good' in their last exams (66,3% of OVC in the Global Fund programme and 83,3% of OVC in the DSD sample)**. While bivariate analyses revealed that the difference in perceived school performance between Global Fund OVC and DSD OVC was statistically significant, when entered into a multivariate model the difference became non-significant. The null finding is a result of other variables explaining most of the variance between OVC groups:

- Girls were 3 times more likely than boys to report 'Good' or 'Very good' school performance, and
- **OVC who had been receiving services for more than 1 year but less than 2 years were 6.4 times more likely to report 'Good' or 'Very good' school performance** than those who had received less than 6 months of service.

**Figure 33. Perceived school performance by OVC programme**




Regarding Global Fund OVC specifically:

- 9,1% of NACOSA OVC and 16,0% of NRASD OVC reported 'Poor' or 'Very poor' school performance
- 25,7% of NACOSA OVC and 17,1% of NRASD OVC reported 'Okay' performance at school
- 46,5% of NACOSA OVC and 38,2% of NRASD OVC reported 'Good' performance at schools
- 18.7% of NACOSA OVC and 28.7% of NRASD OVC reported 'Very good' performance at school
- Amongst Global Fund OVC, caregivers of children aged 6-9 years were significantly more likely to report 'Good' or 'Very good' school performance than children aged 16 years and older.
- Finally, girls were significantly more likely to report 'Very good' school performance than boys.

Longitudinal multivariate modelling showed that there were **no significant differences in perceived school performance between the previous and current evaluations**. As mentioned, the effects of confounding variables could not be partialled out and so any true effect may be masked.

### 9.2.4 Nutritional status of household

As a proxy for the nutritional status of the household, household hunger was assessed. The following four questions constituted the Household Hunger Scale (HHS):

1. Had to eat a smaller meal
2. Had to skip a meal
3. Had to go to sleep hungry
4. Had to go the whole day and night without eating

For each question OVC/caregivers were asked to whether this happened rarely (1 or 2 times in the past 4 weeks), sometimes (3 to 10 times in the past 4 weeks) or often (more than 10 times in the past 4 weeks)

A coding procedure[20] was used to assign each question a value of 0, 1, or 2 based on whether the child had experienced this and whether this was frequent of not. The responses were then summed for each household to derive a total score out of 8. Total HHS scores between 0 and 2 were classified as “little to no hunger in household”, scores between 3 and 5 were classified as "moderate hunger in household" and scores between 6 and 8 were classified as “severe hunger in household”.

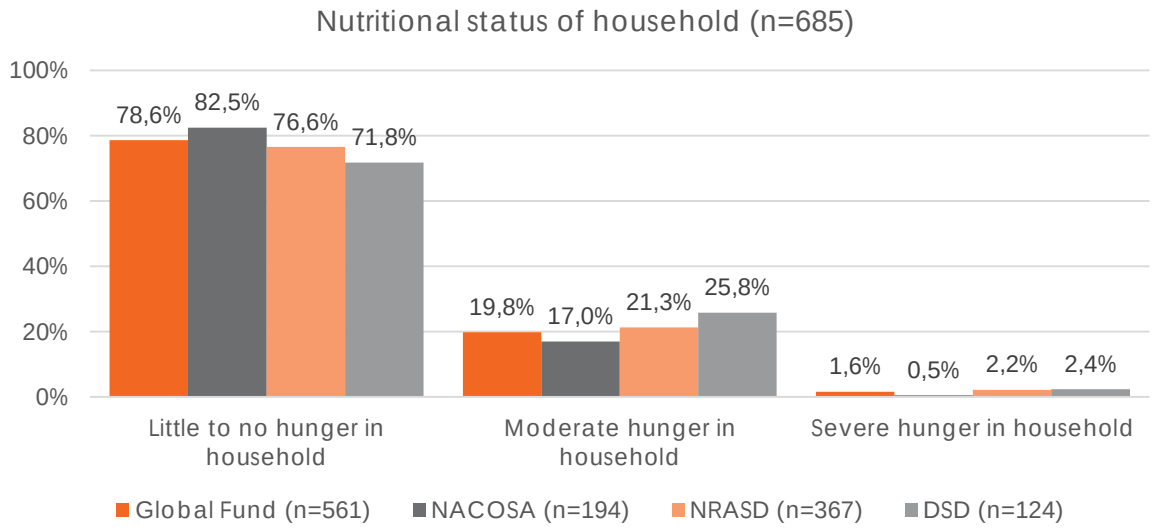
According to Figure 34, the majority of OVC reported having **little to no hunger in the household**. Although the graph below seems to show that DSD households reported more moderate hunger than Global Fund households, there were **no statistically significant differences** between children and caregivers or between Global Fund and DSD OVC programmes.

The finding of little to no hunger in Global Fund households sits in disparity with the findings reported by care workers and managers during their individual interviews. Here, they noted that the nutritional and material support provided was less than the needs of beneficiary OVC households and other needy families in the community (see section 8.2.2). They also reported struggling to select households to receive this support. NACOSA SRs in particular mentioned difficulties around the decrease in material and nutritional support they were able to provide to OVC with the shift from Phase I to Phase II of the Grant.

The findings on the nutritional status of households therefore seems to suggest that OVC households basic nutritional needs are being met, either through the programme directly or other means. That few households report severe hunger (<2% of Global Fund OVC and caregivers surveyed) in particular indicate that few households are in need of emergency nutritional support or, if they are, they are receiving this through the programme or other sources.

[20] The first step was to recode occurrence question (“yes” remained 1 while “no” was recoded from 2 to 0). The responses to each frequency question from the three frequency categories (“rarely,” “sometimes,” “often”) were recoded into two frequency categories (“rarely or sometimes” and “often”). For each of the new variables created, a frequency response of “rarely” remained 1 while a frequency response of “sometimes” (originally coded as 2) was coded as 1 and a frequency response of “often” (originally coded as “3”) was coded as “2”. Next, a code of 0 was assigned for households that replied “No” to each corresponding occurrence question.

**Figure 34. Proportion of OVC experiencing little to no, moderate or severe hunger according to the household hunger scale**




## 9.2.5 Service uptake

### 9.2.5.1 Social grants

The uptake of social grants was high amongst all OVC households. According to Figure 35, **almost 90% of OVC were receiving a social grant**. Of those receiving a social grant, 80% were receiving a child care grant (see Figure 36).

Multivariate modelling revealed that rural OVC participants were 1.7 times more likely to report having received a social grant than urban OVC participants. There were no other statistically bivariate or multivariate differences in terms of receiving a social grant, including

- No significant difference between Global Fund and DSD households, and
- No significant difference between Global Fund households at the time of the previous evaluation compared to the current evaluation.

**Figure 35. Proportion of OVC and caregivers reporting that their household receives a social grant**

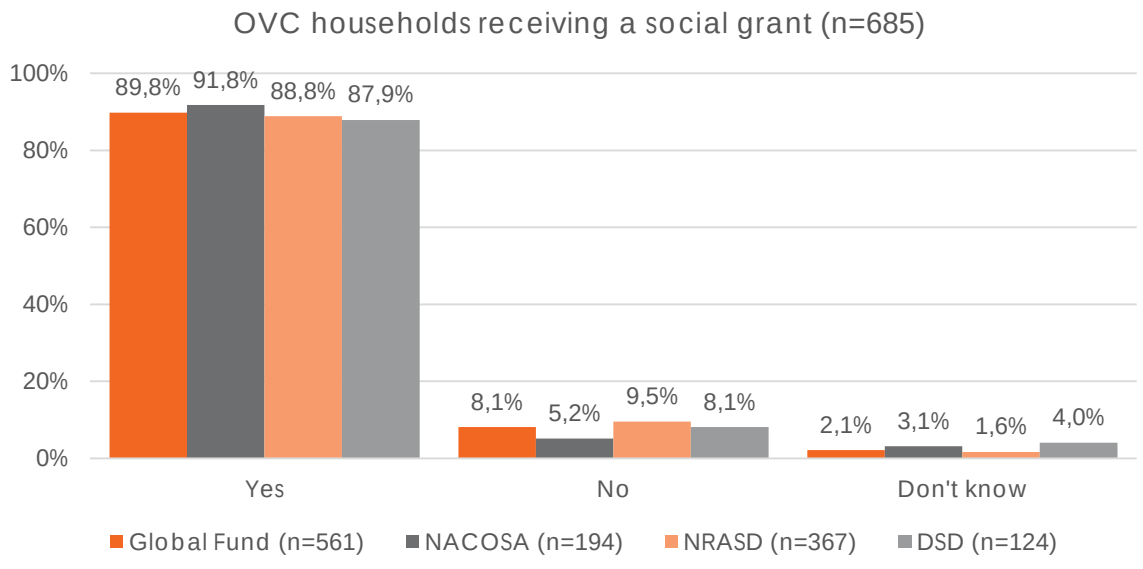
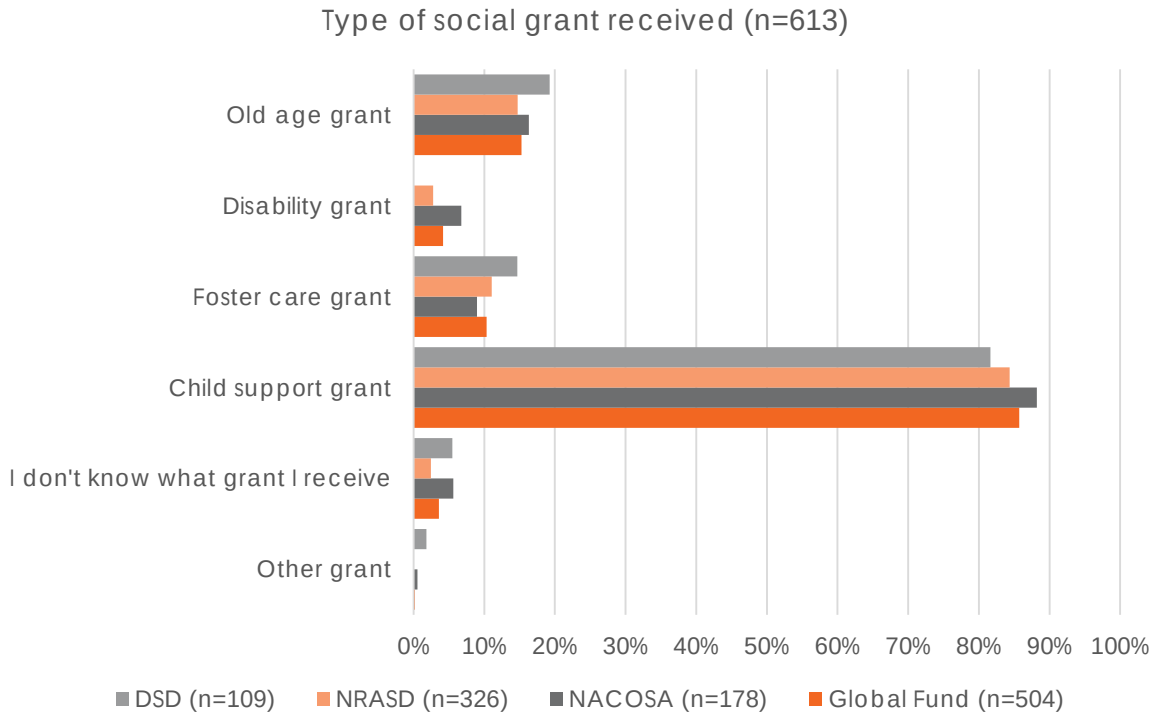


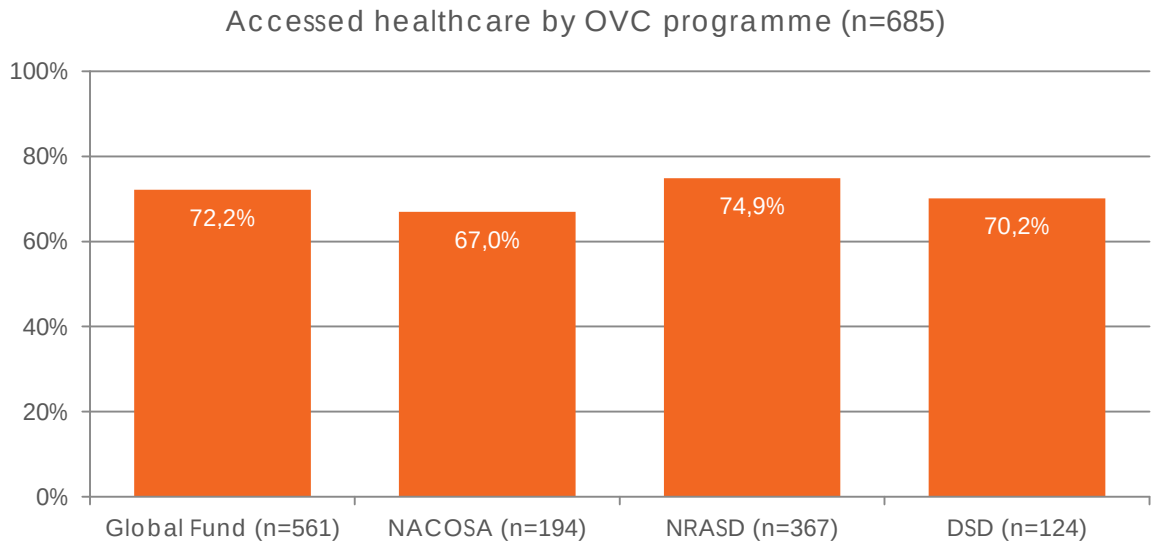
**Figure 36. Type of social grant received by OVC household, by programme.**




### 9.2.5.2 Healthcare

Access and uptake of health services were also assessed in the survey. According to Figure 37, the majority OVC and/or caregivers (nearly three quarters of Global Fund beneficiaries) reported receiving healthcare services in the last 6 months.

**Figure 37. Proportion of OVC and caregivers reporting uptake of health services in the last 6 months**



While the above graph represents both OVC and caregivers, this question was broken down to look at whether OVC had accessed healthcare versus whether caregivers had. In the Global Fund programme specifically, slightly more OVC caregivers reported accessing healthcare services in the last 6 months than OVC children (73,4% vs. 71,4%) although the difference was not statistically significant.

Bivariate analysis revealed that, compared to Gauteng:

- OVC from Mpumalanga were 3.6 times less likely to report accessing healthcare, and
- OVC from Limpopo were 4.6 times more likely to report accessing healthcare (50%; see Figure 52 in Appendix A).

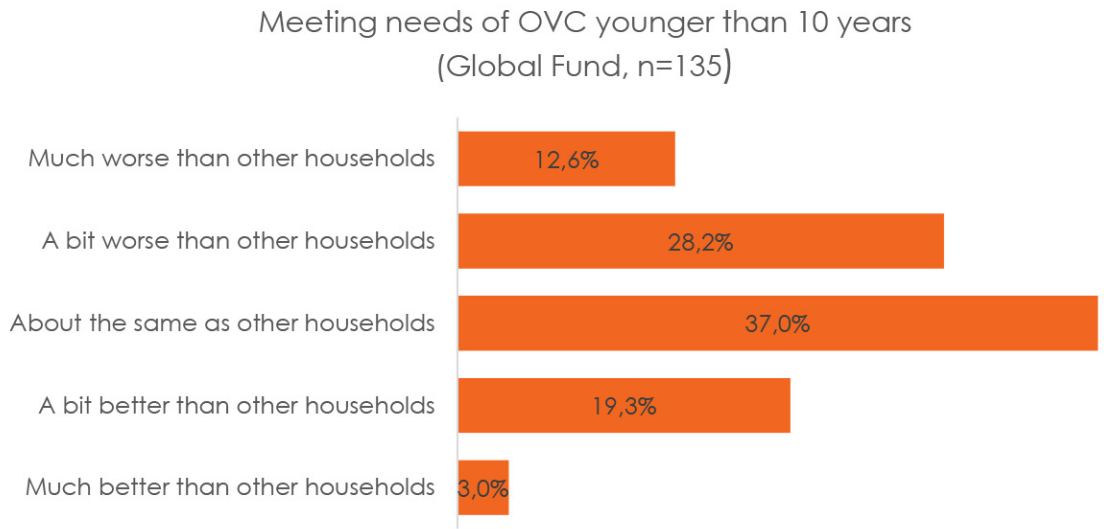
Compared to OVC who had been in the OVC programme for less than 6 months:

- Those who had been in the programme for more than 6 months but less than 1 year were 5.8 times more likely to report having accessed healthcare, and
- Those who had been in the programme for more than 2 years were 3 times more likely to report accessing healthcare (see Figure 53 in Appendix A).

### 9.2.6 Caregivers meeting needs of OVC

Caregivers' perceptions were assessed in terms of their ability to meet the needs of OVC in their household compared to other households in the community. These findings reflect whether caregivers in the Global Fund programme felt they were better able to meet the needs of OVC in their care than were other households. As displayed in Figure 38 **most caregivers of OVC aged younger than 10 years in the Global Fund programme reported that they provided 'about the same as other households' with regards to meeting the needs of children in their care**.

**Figure 38. Perceived ability of caregivers to meet the needs of OVC aged younger than 10 years in the Global Fund OVC programme**



When broken down per programme for NACOSA, NRASD and DSD, the sample sizes were small and therefore the counts are reported in Table 20 below.

**Table 20. Perceived ability of caregivers to meet the needs of OVC aged younger than 10 years in the, by programme (number)**

| Meeting needs of child in care | NACOSA | NRASD | DSD |
|---|---|---|---|
| Much better than other households | 2 | 2 | 0 |
| A bit better than other households | 15 | 11 | 2 |
| About the same as other households | 18 | 32 | 11 |
| A bit worse than other households | 11 | 27 | 7 |
| Much worse than other households | 4 | 13 | 3 |
| Total | 50 | 85 | 23 |

While there were **no statistically significant differences between OVC programmes**, bivariate analyses revealed that older male caregivers were significantly more likely to report that they were performing 'better than other households' than younger, female OVCs. However, the age and gender effects became non-significant when entered into a multivariate model that included the effects of other variables.

### 9.2.7 Quality of Life: Case study

The quality of life (QoL) of OVC in the programme was the focus of a case study for this evaluation. The case study explored the impact of the programme on the QoL of beneficiaries from the experience of an NRASD SSR and beneficiary household. It is included as an appendix to the current report (see Appendix D).

## 9.3 Organisational capacity building

One of the objectives of the programme was to build the capacity of organisations at various levels, including:

- Recording and reporting systems,
- Referral pathways and linkages to support,
- Mechanisms to identify and prioritise services to OVC most at risk, and
- Capacity to respond to the needs of OVC.

A key mechanism through which organisational capacity was built via the Global Fund OVC Grant was through the training provided to organisational staff, at both a management and implementation level - the latter referring to the training of CYCW. This section therefore explores the training provided to management and care workers, whether the respective staff members felt training was sufficient, and what training gaps were identified. It also reports on the recording and reporting systems of organisations, as well as examining how managers reported in terms of how the grant had strengthened the capacity of their respective organisation.

### 9.3.1 Coordination and networking

**Thirty-nine out of 46 NRASD SSRs and 17 out of 26 NACOSA SRs reported that coordination and networking of their organisation in the community had improved** as a result of the Global Fund OVC Programme, with 3 NACOSA SRs noting coordination and networking as the biggest or key achievement of the programme.

NACOSA and NRASD SSRs have **a variety of working relationships and partnerships** with local and community stakeholders, such as the police, churches, the local clinic, government departments, the local municipality, other organisations and ward councillors. Strong networking structures with clinics and other service providers were firmly established. Organisations attributed the increase in the number of relationships and partnerships with relevant stakeholders to the Global Fund Grant:

*"Our network with other stakeholders has increased because of Global Fund programme, we now network with other organisations and different departments at child care forums where we share information and ideas." Programme Manager, NACOSA SR, KZN*

*"The kind of relationships we had before with other NGOs, stakeholders and government were not that much concrete. But now we build those relations." Director, NACOSA SR, Eastern Cape*

*"We have relevant stakeholders like your traditional leaders, your traditional practitioners, your nurses, your retired lawyers, somebody who works in the municipality. We are also part of the local AIDS forum." Director, NACOSA SR, Eastern Cape*

Managers provided a number of explanations and examples of how the coordinating and networking ability of the organisation had improved. Organisations generally used child care forums, war rooms and events to network with other community stakeholders. One NACOSA SR manager described how they **used the child care forum to establish and foster coordination** between the organisation, other organisations and relevant stakeholders:

*"Before we formed the forum, we invited all of the departments in that area community, like SAPS. DSD, child referral, home affairs. We've got all those departments." Coordinator, NACOSA SR, KZN*

The improvement of coordination and networking has contributed to the **visibility and presence of SRs and SSRs** in their relevant communities. Managers reported that their increased activity and involvement with other stakeholders had increased community awareness about the services provided by the organisation, as well as fostering a sense of trust amongst community members:

*"We are identifiable in the community and people are starting now to trust in us." Programme Manager, NRASD SSR, Mpumalanga*

In addition to greater visibility, managers explained how improved coordination and networking enabled **more efficient provision of services**. This was achieved through improved coordination that enabled organisations to directly address the needs of OVC, often through direct referrals to relevant stakeholders, as well as enabling care workers greater access to OVC. Managers also identified that care workers were able to provide improved services to more OVC because community members and school teachers were able to alert child and youth care workers about OVC who appeared to need assistance. This included, for example, OVC who were not attending school and OVC who were performing poorly at school.

*"We have partnerships with other local NGOs in terms of referrals, local municipality, health district, DSD and the community as well." Director, NRASD SSR, North West*

*"The carers are able to go to the school to check on their children. Also, the principal will often make referrals and ask the carers to make home visits to check in on children who are vulnerable or are not going to school regularly." Team Leader, NRASD SSR, Free State*

Organisations reported working closely with numerous stakeholders to ensure that children received the services that they needed. This ranged and included, for example, working with local businesses to ensure that children who lived in homes without a proper floor received a paved floor:

*"In houses where we find maybe children stay there with no floor, just the ground. We will go to the person who sells bricks and cement and request their help to build a floor….or we will request a bed from other community members." Project manager, NACOSA SR, Northern Cape*

Managers noted that strong referral pathways and relationships developed through programme activities would contribute towards the **continuation of such support networks for OVC despite the end of the grant term**. Improved coordination, networking and visibility bodes well for the sustainability of organisations. It gives organisations greater reach in terms of securing further financial, material and training support and improving service provision to beneficiaries:

*"We received an invitation from FDP, it's an organisation that does education, they are funded by PEPFAR and USAID to conduct some training. We've been invited to participate in one of their workshops or training as part of HIV/AIDS training, Like an introduction to HIV/AIDS, having counselling, adherence, TB screening and all of that. So now we are known. If ever we haven't been known, they will have picked us up." Programme Manager, NACOSA SR, KZN*

#### 9.3.1.1 Community systems strengthening case study

Through NACOSA's community systems strengthening (CSS) approach, coordination and networking was a particular programme focus, with activities such as Circles of Support and Child Care Forums. A case study further describes the CSS model and how circles of support, child care forums and war rooms were successfully implemented at a NACOSA SR in KZN (see Appendix D).

### 9.3.2 Organisational capacity building

Nineteen out of 26 NACOSA SRs identified that the grant had strengthened capacity of the organisation, with 4 seeing as the key or biggest achievement of the grant. Forty out of 47 NRASD SSRs noted strengthened organisation capacity as an achievement of the grant; however only 1 NRASD SSR noted strengthened organisational capacity as a key achievement or impact area of the grant.

In explaining the ways in which organisational capacity was built, managers mentioned how resources and training received as part of the grant **improved the quality and reach/scope of services** provided to the community:

*"We have used that knowledge to improve our services and we can see that our beneficiaries are happy, we have become more professional." Manager, NRASD SSR, Mpumalanga*

This, in turn, improved the **visibility and reputation of organisations**, further capacitating organisations. One SR managers gave an example of OVC who were coming to the organisation to ask for assistance because they had seen the assistance the organisation had provided to others:

*"We have improved so much and we have been known now by all… the kids are bring their friends, their neighbours, their family, sibling to come for help." Programme Manager, NRASD SSR, Free State*

*"Throughout the community we have been praised by parents and many people know that our organisation is the best. Some of the services we are providing makes more and more people come to us to get help because social workers and government services take a lot to reach the people in our community." Programme Manager, NACOSA SR, Mpumalanga*

Importantly, capacity building extended beyond the ability to provide a package of services to OVC. Management and organisational systems were strengthened in a way that **equips organisations with good sustainability strategies**:

*"They focused us to look ahead with regards to the government departments that we really need to work with and this has aligned us, focused us and equipped us to work along the same lines as to where government is going. This to us has been the main gain because as a small organisations you can easily get stuck in your own visions." Director, NACOSA SR, KZN*

### 9.3.3 Capacity building of child and youth care workers

The strengthened capacity of the child and youth care workers was identified by 22 out of 26 NACOSA SRs and 41 out of 47 NRASD SSRs as an achievement of the grant, with 2 NRASD SSRs noting strengthened child and youth care worker capacity as the key achievement.

Most of the managers attributed the strengthened capacity of child and youth care workers to the training received as part of the grant. This had **improved not only the knowledge and skills of care workers but also resulted in better care for OVC**.

*"Before joining the grant the care workers did not have enough information and knowledge about how to care for the children. Those that have been trained as CYCW know how to counsel and speak to the children, and provide proper information to the children and their families. They know how to track the child's progress." Programme Manager, NRASD SSR, Mpumalanga*

Managers also attributed the strengthened capacity of child and youth care workers to **improving community awareness and the reputation of the organisation** in terms of their provision of resources and services. This further contributed towards strengthening relationships with community members and other stakeholders such as school teachers and ward councillors.

*"Now we can say we have trained child and youth care workers that delivers the quality services to our beneficiaries. They are not just rendering services, they also have the knowledge about those services and their benefits." Director, NACOSA SR, Eastern Cape*

For a number of SRs and SSRs, the training received by child and youth care workers provided them with skills that would benefit the organisation after the end of the grant term (i.e. speaking to sustainability):

*"Quite a few of them, through the programme, they have been trained in early childhood development, HTS, and various other things. It has upskilled them and given them opportunities they would never have had before. It has put them in a much better position to respond to the need on the ground. That's been a very sustainable input that will benefit the organisation and the staff themselves for a long time into the future." Programme Manager, NACOSA SR, KZN*

*"Because they are able to go the extra mile even if we don't have resources they are able to know wherever they can get the assistance, they are working closely with the schools, the community at large, the churches in our area." Manager, NRASD SSR, North West*

#### 9.3.3.1 CYCW training: Case study

The training of child and youth care workers was a significant component of the programme – essential to both capacity building and the delivery of quality services. CYCW training was explored through a case study that is attached as an Appendix to the current report (see Appendix D).

### 9.3.4 Reporting and recording systems

A number of organisations identified that they had learnt new skills in terms of how to record and report on their activities. Some, reported that they had been equipped from having no monitoring or reporting capacity to implementing systems that could be used beyond the end of the grant term:

*"Before we joined Global Fund we had no files for the OVCs, we had no filing system. However, since we joined Global Fund all that has changed because every child has his/her own file that we use to record information." Project Manager, NACOSA SR, KZN*

Furthermore, organisations that only recorded information on hard copies now have electronic versions of their information and understand the importance of backing up information. The new reporting template given to organisations was described as comprehensive, making reporting writing easier, and central to helping the organisation develop a system for monitoring and reporting on their activities.

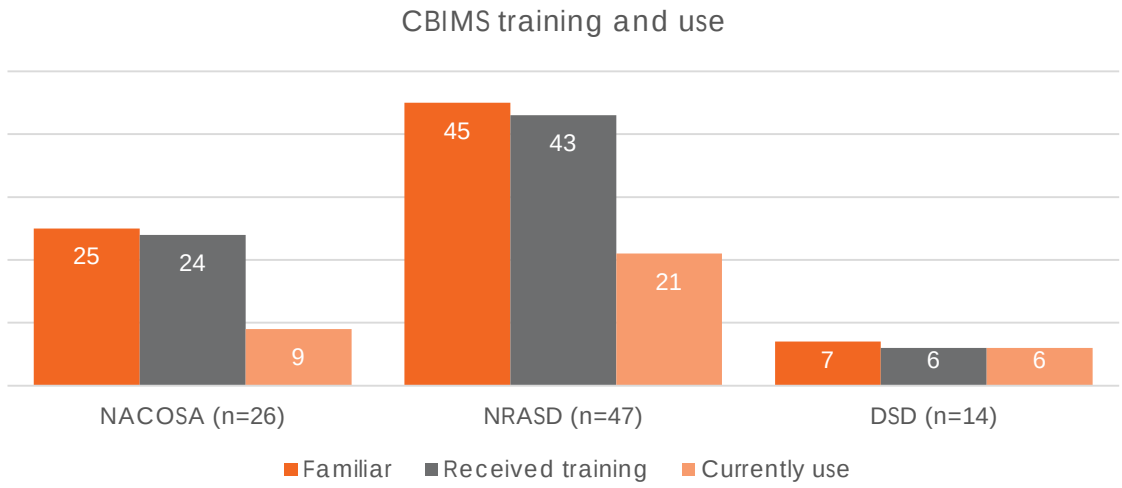
The significance of an evidence-based approach was expressed by managers, who stressed the importance of monitoring and verification of information contained in reports. This approach has been strengthened by an ability to generate statistics, which has improved organisational monitoring and reporting standards. Some managers said the systems required for recording and reporting improved their services, enabling them to keep track of which beneficiaries had received services and improving referral follow ups. Two organisations are currently using the system they used under the Global Fund programme to report to other funders. Despite the end of the grant term, others hoped to continue with recording similar information (albeit scaled down) in order to show to other potential funders:

*We need to continue [with monitoring our activities and financial reporting] because that will assist us with fundraising." Project Manager, NRASD SSR, Mpumalanga*

### 9.3.4.1 CBIMS

CBIMS is a new Community-Based Intervention Monitoring System that is being implemented by the DSD at CBOs. As part of the Global Fund OVC Programme, NACOSA and NRASD (the latter through their SRs) provided training and in some cases refresher training to organisations. Training on CBIMS is linked to sustainability in terms of organisations being able to follow DSD reporting requirements and strengthens their potential for obtaining DSD funding. CBIMS is not only an important reporting requirement that organisations will likely have to use in the future but is also a good practice in terms of being able to demonstrate their services and impact. The number or organisation managers reporting they have heard of/are familiar with the system, staff members who have been trained on CBIMS and/or are currently using CBIMS are presented in Figure 39.

**Figure 39. Number of organisations reporting being familiar with, having received training and currently using the CBIMS system**




As evident in the Figure above, most organisations in both NACOSA and NRASD programmes (70 out of 73) were familiar with and had received training (67 out of 73) on how to use the CBIMS system. Only half of DSD organisations, however, reported the same. Although most NACOSA SRs and NRASD SRs had been trained, less than half (30 out of 73) were using the system at the time of the evaluation. Some of the explanations as to why the system wasn't being utilised and when the organisation planned to start using it included:

- Did not know (n=26)
- Planned to start using it within the 3 months following the time of the interview (n=14)

However, others reported waiting for online registration, password or laptop issues to be resolved or for their district DSD office to start using the system:

***"Our organisation has been trained on CBIMS but you find that the DSD and their members has not been trained…if the organisation knows more than the department…you're being [seen as] a threat." Director, NACOSA SR, Eastern Cape***

Only three organisations provided responses that seemed to indicate that did not plan to use the system at all.

## 9.3.5 Training gaps

Twenty out of 26 NACOSA SRs and 29 out of 47 NRASD SSRs said the training they received was sufficient, from a management perspective. Of those that identified that the training they received was not sufficient for them to be able to perform their role and responsibilities, the **training needs** identified most frequently were:

- Financial management (n=6 NRASD SSRs and n=2 NACOSA SRs)
- Project management (n=5 NRASD SSRs and n=2 NACOSA SRs)

- Programme services: A number of managers (n=6 NRASD SSRs and n=3 NACOSA SRs) identified that programmatic training was needed (e.g., how to run child care forums) for all staff, including management.

***"When they started circles of support they trained the caregivers but they never trained the managers. So the managers had to get information through the caregivers …So the circles of support programme was quite a rocky road because we as managers were never informed about what the whole idea was about." Director, NACOSA SR, KZN***

Managers also identified a number of trainings that would have been helpful for the organisation more broadly, including HTS (n=4 NRASD SSRs), counselling skills (n=3 NRASD SSRs), and more care workers to receive the CYCW training (n=3 NRASD SSRs).

Of those care workers who identified that the training they received was not sufficient for them to be able to perform their role and responsibilities, the **training needs** that they identified most frequently were:

- HTS and/or TB screening (n= 11 NRASD and n=3 NACOSA care workers)
- Child and youth care worker training (n=11 NRASD care workers). This focused mainly around completion of CYCW training.
- Child care and how to work with and counsel vulnerable and delinquent children (n=4 NRASD and n=1 NACOSA care workers)
- Support groups, child care forums and circles of support (n=3 NRASD care workers)
- Social work skills (n=2 NRASD care workers)

Other needs identified included facilitation (n=1 NRASD and n=1 NACOSA care worker), debriefing skills (n=1 NRASD care worker), how to work with the parents of OVC (n=1 NACOSA care worker) and first aid and safety training (n=1 NRASD care worker).

# 10. EVALUATION FINDINGS: EXIT AND SUSTAINABILITY

The evaluation team were aware that the fieldwork was being conducted during a sensitive and difficult time for many SRs and SSRs who were preparing for the imminent close out of the grant in the midst of a tough current funding environment for NPOs in South Africa. However, sustainability was a key theme that was explored through manager and care worker interviews in a number of ways and this section of the report presents these findings.

Sustainability refers not only to whether the benefits of an activity will continue after donor funding has been withdrawn (i.e., estimating future performance) but speaks to financial sustainability of an implementing organisation[16]. The issue of sustainability was therefore explored on two levels:

- **Sustainability at the organisation level** through examining the sustainability strategies of SRs and SSRs and the likelihood of programme services continuing beyond the term of the grant.
- **Sustainability at the household level** through examining the exit of children from the programme.

The key findings from this section are summarised below and detailed in the sections Sustainability strategies of OVC organisations, Sustainability challenges and Sustainability of services that follow.

## KEY FINDINGS ON EXIT AND SUSTAINABILITY

### ORGANISATIONAL SUSTAINABILITY

- Three quarters of SRs and SSRs felt somewhat to well prepared for the end of the grant term.
- 14 SRs and SSRs reported that the Global Fund OVC Phase II Grant was 100% of their funding income. These organisations will be most at risk following close out.
- Most SRs and SSRs have multiple funding streams including having more than one funder, fundraising and income generating activities and in-kind support. Having a smaller proportion of funding from a single source will contribute towards sustainability.
- 41 SRs and SSRs reporting receiving no in-kind support, a valuable source of support that can help to buffer the effects of a lack of donor funding.
- However, more than a third of SRs and SSRs are exploring various fundraising options and a number of innovative practices are identified.
- SRs and SSRs have implemented a number of sustainability strategies to cope with the end of the grant term, with 67 applying for other funding to replace the loss of the Global Fund Phase II Grant.
- The most common funding opportunities being followed are through National Lottery, Department of Social Development, Department of Health and USAID.
- That 57 SRs and SSRs reported having applied for but not secured funding is indicative of the tough funding climate in South Africa. Local businesses and donors are also stretched by the number of NPOs requesting support.

### SUSTAINABILITY OF SERVICES

- Organisations were thinking about and planning for the impact of the end of the grant term on staff, service delivery and beneficiaries:
  - 56 out of 73 SRs and SSRs expect to face staff retention challenges after close out;

- 45 out of 73 expect to cut back on number or frequency of services; and
- 30 out of 73 to cut back on scope or service reach in the community.

- Those services that are low-cost and well developed in the organisation and community structures are more likely to be sustainable post close-out including:
  - Referral mechanisms and linkages to support: 68 out of 73 SRs and SSRs expect to continue acting as a referral mechanism for OVC households.
  - Child care forums: 53 out of 73 SRs and SSRs expect that these will continue despite grant close-out.
  - Psychosocial support to OVC: 61 out of 73 SRs and SSRs expect to be able to continue providing psychosocial support to OVC.
- 27 SRs and SSRs expect to be able to continue with the provision of material support to OVC and 30 expect to be able to continue with the provision of nutritional support in the same or more limited capacity. The delivery of material and nutritional support will be most severely impacted by grant closure unless SRs and SSRs are able to link to other service providers or secure sponsorship or funding.

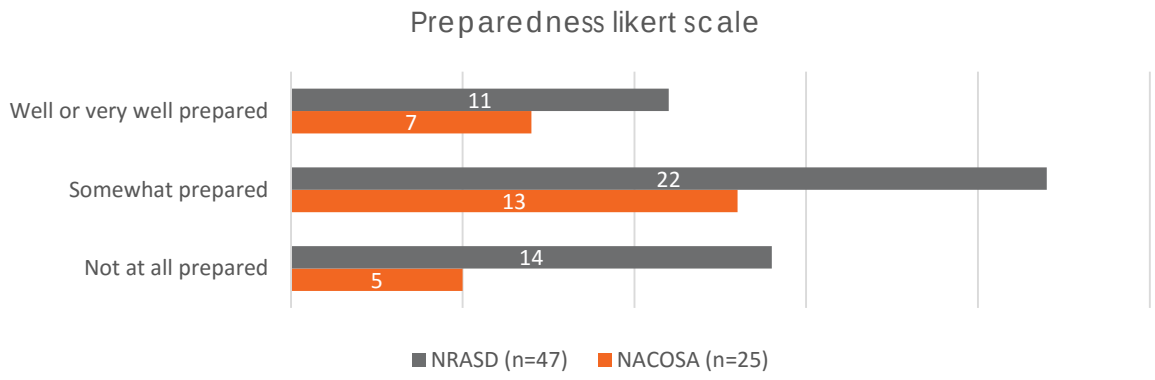
**HOUSEHOLD LEVEL**

- Children have predominantly been exited from the programme due to reaching the age of 18 and/or moving away from the area served by the SR or SSR. Few organisations reported a defined exit strategy for children whose needs have been met or situation stabilised according to their care plan. A key weakness of SR and SSR programme implementation with regard to sustainability was that OVC were kept in the programme on a continuous basis.
- Exit strategies and plans are in place, including referral to other NPOs (39 out of 73 SRs and SSRs), referral to government services (27 out of 73 SRs and SSRs) and linkages to income generating projects.

### 10.1.1 Sustainability strategies of OVC organisations

Figure 40 below presents the **perceived level of preparedness** reported by NACOSA SRs and NRASD SSRs. As evident in the table, just less than a quarter of organisations reported feeling *not at all prepared* for the close-out of the grant (19 out of 72 organisations[21]) with the remaining three quarters feeling either prepared/*well prepared* (18 out of 72 organisations) or *somewhat prepared* (35 out of 72 organisations). This is likely due to early notification that allowed SR and SSR management to put measures in place to plan for sustainability or close-out; or, at least, allowing time to mentally accept and prepare for close-out.

**Figure 40. Number of organisations reporting feeling well prepared, somewhat prepared or not at all prepared for beyond the term of the grant**




21One organisations did not respond to this question.

### 10.1.1.1 Current funding of SRs and SSRs

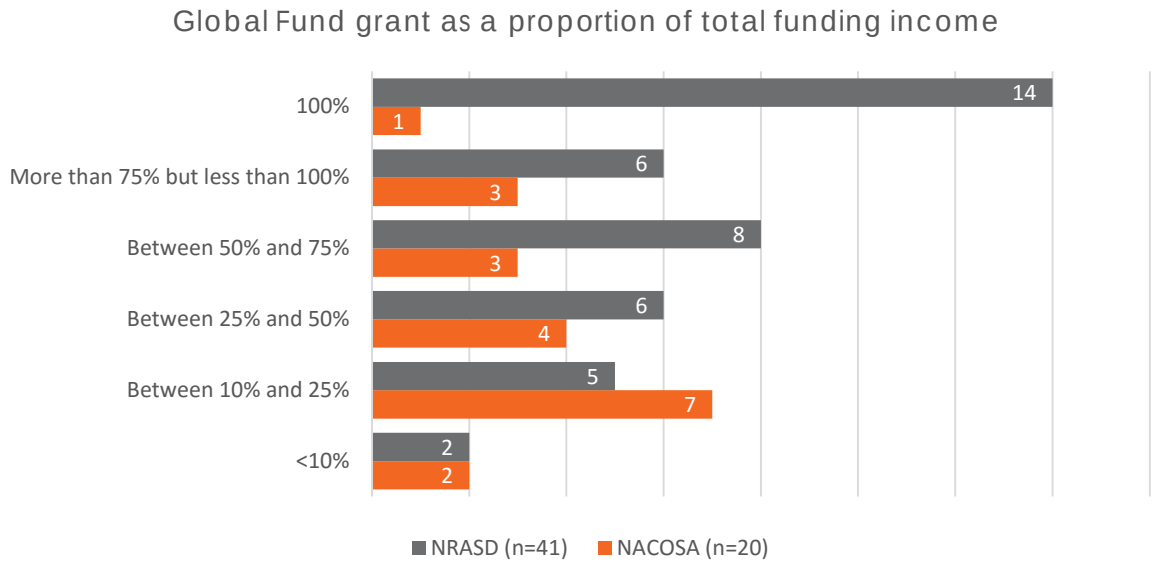
If sustainability is understood as not only relating to the sustainability of the OVC programme but to the future of the organisation and staff members, then it is important to consider the following factors:

- The proportion of an organisation's funding that is made up of a single funder (e.g., Global Fund OVC Programme funding), and
- The number of programmes/sources of funding received by an organisation.

These are important indicators of sustainability as additional programmes and sources of funding can help to absorb the impact of the end of one grant and support beneficiaries who have been a part of that programme.

Figure 41 below presents the number of organisations reporting the Global Fund OVC Phase II Grant as a proportion of their total funding income. Out of the 61 responding organisations[22], the Global Fund OVC Grant was 50% or less of the total funding income for more than a third (26 out of 61 organisations). Eleven out of the 61 organisations reported that the Global Fund OVC Grant was between 50% and 75% of their total funding; 9 reported that the Global Fund OVC Grant was more than 75% but less than 100% of their total funding while 15 organisations reported that the Global Fund OVC Grant was the entirety of their organisation's funding income. The latter group are those that are likely to be most severely impacted by the close out of the grant if applications to alternate funders are not secured or other sustainability mechanisms employed.

**Figure 41. Global Fund OVC Grant as an estimated proportion of total funding of recipient organisations**




The number of funders funding the responding organisations are presented in Table 21. Corresponding with the number of organisations reporting that Global Fund was 100% of their funding income, 15 organisations reported that they had no other funders at the time of the interview. Of these 15, 13 were NRASD SSRs that fell under church SRs (9 were MCSA SSRs, 2 were AAHT SSRs and 2 were KMDR SSRs). Typically, church/religious SRs support weaker CBOS often in even more under-resourced rural settings than non-religious SRs (i.e. Starfish). The higher number of single donor sites that were NRASD SSRs speak to the church being their only funder or source of income. Non-religious SRs and NACOSA typically support larger and stronger CBOs which are more likely to then have multiple donors. The only single donor NACOSA SR was a KZN-based CBO which had experienced recent internal management challenges.

22 Only 61 out of the total sample of 73 SRs and SSRs were able to provide the necessary information to answer this question.

Other than those single donor SR and SRR sites, the number of other funders ranged from one to more than five, with the largest proportion of organisations (just under a third or 31 out of 69 responding organisations) reporting only one or two additional funders. These additional sources of funding income for other programmes and activities will be important to absorb the impact of the loss of the Global Fund OVC Grant.

However, organisations are not only supported financially but also with in-kind support (i.e. non-cash contributions). In-kind contributions are an important resource for NPOs particularly in times when donor funding is scarce. Nine organisations did not respond to this question; however, 41 out of the 64 responding organisations reported that they were not currently receiving regular in-kind contributions (see Table 22). It is also likely, however, that the person interviewed was not aware of all in-kind support received by the organisation.

**Table 21. Number of organisations reporting current additional funders (excluding Global Fund).**

| Number of Other Funders | Number of organisations | | |
|---|---|---|---|
| | NACOSA | NRASD | Total |
| **0** | 1 | 14 | **15** |
| **1** | 3 | 11 | **14** |
| **2** | 5 | 12 | **17** |
| **3** | 3 | 3 | **6** |
| **4** | 6 | 1 | **7** |
| **≥ 5** | 7 | 3 | **10** |
| **Missing** | 1 | 3 | **4** |
| **Total** | **26** | **47** | **73** |

**Table 22. Number of organisations reporting current in-kind support (excluding Global Fund)**

| Number of sources of in-kind support | Number of organisations | | |
|---|---|---|---|
| | NACOSA | NRASD | Total |
| **0** | 11 | 30 | **41** |
| **1** | 4 | 8 | **12** |
| **2** | 3 | 4 | **7** |
| **3** | 2 | 2 | **4** |
| **Missing** | 6 | 3 | **9** |
| **Total** | **26** | **47** | **73** |

### 10.1.1.2 Applications for funding

One key sustainability strategy employed by NACOSA SRs and NRASD SSRs is other funding. Whether the organisation had put a **strategy in place to secure additional funding or income** was also a mechanism influencing an organisation's perceived level of preparedness for the end of the grant. Only 4 out of 71[23] organisations reported having put no financial plan in place following the end of the Global Fund OVC Grant. The sustainability plans of OVC organisations post-March 2016 varied widely. Of the remaining 67 organisations that had taken steps to secure additional funding or income, the number of organisations that have applied for but not secured funding (57 out of 67 organisations), applied for and secured funding (12 out of 67 organisations) and/or are exploring fundraising options (27 out of 67 organisations), are displayed per programme in Figure 42. This is further broken down per province and displayed in Table 23.

23 2 organisations did not respond to this question.

**Figure 42. Plans to secure additional support beyond the terms of the grant**

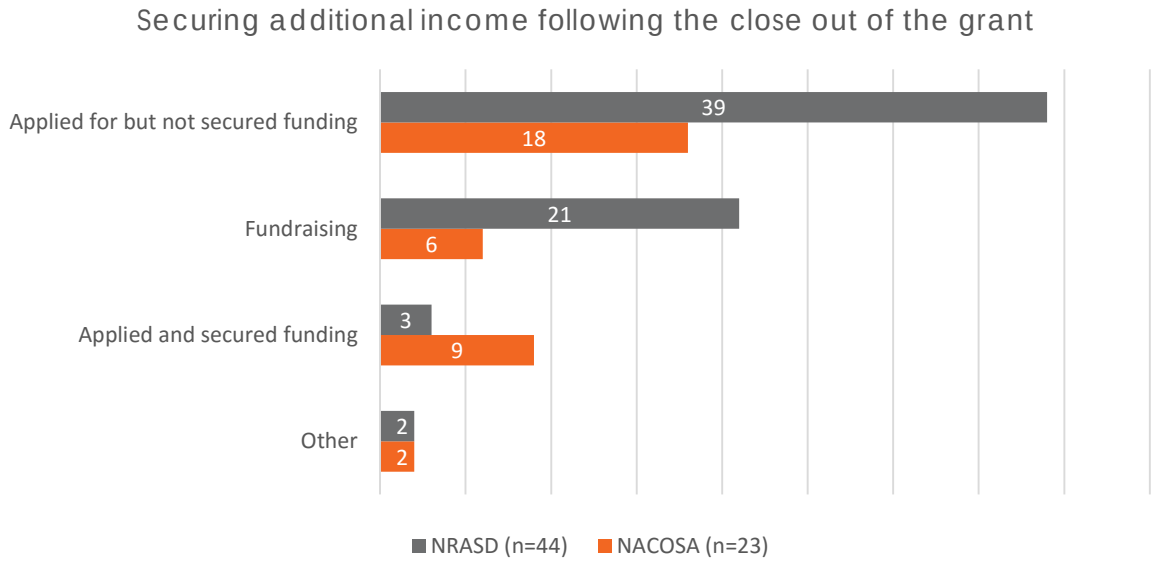



**Table 23. Securing of funding and fundraising beyond the terms of the grant**

| Province | None | Applied not secured | Applied and secured | Fundraising | Other |
|---|---|---|---|---|---|
| **Mpumalanga** | 2 | 11 | 2 | 6 | 1 |
| **KwaZulu-Natal** | 1 | 7 | 4 | 1 | 0 |
| **Free State** | 0 | 10 | 1 | 5 | 0 |
| **Limpopo** | 1 | 10 | 0 | 5 | 0 |
| **Eastern Cape** | 0 | 7 | 2 | 2 | 1 |
| **Gauteng** | 0 | 4 | 0 | 2 | 0 |
| **North West** | 0 | 4 | 0 | 3 | 1 |
| **Western Cape** | 0 | 2 | 2 | 2 | 1 |
| **Northern Cape** | 0 | 2 | 1 | 1 | 0 |
| **Total** | **4** | **57** | **12** | **27** | **4** |

SRs and SSRs were asked to report on where they had applied for funding and the responses are presented in Table 24 below. The most frequent **funders applied to** included National Lottery (44 organisations), Departments of Social Development (20 organisations), USAID (9 organisations) and Department of Health (6 organisations). A myriad of other funders were mentioned, however less than 5 SRs and/or SSRs reported applying to these bodies (see Table 24). Research has found that the biggest determinant of an NGO's survival is whether an NGO receives foreign funding[16]; however, a smaller number of NACOSA and NRASD reported applying to international funders. The largest proportion of those who did (8 out of 20) were NACOSA SRs that had switched over to USAID funding.

That SRs and SSRs are relying on funding from National Lottery is concerning. National Lottery faces huge backlogs and a significant gap between demand and supply which means that SRs and SSRs could wait years before receiving a decision. Funding from National Lottery should be seen a 'bonus' but not relied upon as a stable funding source.

Table 24. Funders applied to or secured by NACOSA SRs and NRASD SSRs

| Province | NACOSA (n=25) | NRASD (n=47) | Name / source |
|---|---|---|---|
| **Government entities or institutions** | 16 | 30 | National Lottery, Eskom, Rand Water, Transnet, Telkom |
| **Government departments** | 12 | 17 | Departments of Labour, Health, Social Development, Arts & Culture, Public Works (EPWP) |
| **International foundations** | 13 | 7 | Bill & Melinda Gates, USAID, US Embassy, FHI360, PACF, XOVA, Other |
| **Local foundations & private sector** | 9 | 16 | ApexHi Charitable Trust, DG Murray Trust, Alexander Forbes, Volkswagen SA, FNB, AngloGold Ashanti, Old Mutual, Discovery, Anglo American, SASOL, Engen, Nedbank, various local mines |
| **Individual donors** | 3 | 10 | Online donations, support from Board members, donations from local community, churches and small businesses |
| **Fundraising** | 5 | 9 | Income generating activities (e.g. sale of second hand clothing and goods), food gardens |

#### 10.1.1.3 Other sustainability strategies and best practices

Besides seeking other funding, SRs and SSRs reported explored a number of other sustainability strategies. Organisations are utilising different methods of **fundraising and income generating** in order to offset the end of the Global Fund OVC Grant. A number of SR and SSR managers identified such methods as an important and effective strategy. This included beading and sewing projects and the growing and selling of produce:

> ***We market our fresh produce from our garden to the local supermarkets to generate income. We believe that the vegetables that we plant will be able to provide include to allow us to continue with support for at least one more year." Director, NRASD SSR, Limpopo***

> ***"There are a lot of mines in the area and we fundraise from the local mines. This is one thing that has worked well for us. We think if we can have R20 000 a month we would be able to keep the programme running." Director, NACOSA SR, Northern Cape***

One organisation identified the importance of such income generating projects in order for organisations to become self-sustaining and demonstrate their fundraising capabilities to potential funders:

> ***"We are making plans to start first with income generating for our care workers. They will do sewing and make clothes. We have the skill here and we want to become self-sustaining through this. This is income for the women [care workers] but also that people must see we do something of our own…it's about doing stuff for ourselves." Director, NACOSA SR, Western Cape***

In addition, such income generating activities were also used to build capacity at the individual or household level. These did not only raise funds for the organisations but also for beneficiaries involved. This is discussed again in section 10.1.4 that follows.

As mentioned above, eight NACOSA SRs have been successfully **shifted to USAID funding** prior to the close-out of the Global Fund OVC Grant. These organisations spoke to the support provided by NACOSA in negotiating with USAID on their behalf and contracting them under NACOSA's USAID programme and the benefits of the focus on HTS provided by the Global Fund grant in helping them to secure this funding.

A number of organisations reported **shifting their programme focus** to areas they saw as more sustainable, for example to early childhood development (ECD), working with HIV positive adolescents or adopting a more medical approach focusing on HIV and TB.

Even organisation for which the end of the grant term would represent a significant or total loss of their funding budget, innovate sustainability strategies had been explored. Some of the practices identified included:

- A NACOSA SR in the Eastern Cape has moved towards digital fundraising in order to secure individual donors from overseas. Using a case study approach, they are securing assistance/**funding for individual OVC** instead of overall funding for the organisation. Although not an easy process, they are hoping they will start to see success with this strategy.
- Another NACOSA SR in the Eastern Cape is exploring providing **paid HTS** through the unions at factories in the communities in which they work. They will not charge individuals coming to test at the centre, but they are exploring opportunities for being paid by factories to provide HTS on a larger scale to workers.
- A number of managers had applied to the **Expanded Public Works Programme (EPWP)** through the Department of Public Works in order to register and secure a stipend for their care workers. Although the stipend is small, the work is part-time and care workers would be able to continue delivering services to OVC.

### 10.1.2 Sustainability challenges

Although a number of best practices are identified above, organisations also reported challenges with regards to sustainability, particularly around securing additional funding. They noted the difficult funding climate at the moment and the **lack of available funding for NPOs running OVC services**:

> ***"We are well aware that funding is coming to an end and that OVC programmes are no longer funded or very few fund them. OVC programmes in general are not in favour at the moment." Director, NACOSA SR, KZN***

While a large proportion of organisation had applied for different funding opportunities, few had secured funding. Managers noted the challenge with the **poor response rate** to funding applications:

> ***"They just don't come back to us." Director, NRASD SSR, Limpopo***

Particularly those organisations who had not secured additional funding, voiced their concerns:

> ***"We don't know what we will do. We are at a loss." Programme Manager, NRASD SR, Mpumalanga***

Although organisations reported exploring options such as fundraising and income generation, these were also challenging. In the context of poor communities, community members are unable to purchase the goods they produce and there is demand from large numbers of NPOs on small numbers of local businesses which usually support these types of activities.

SRs and SSRs identified how key dedicated and skilled fundraisers are for organisational sustainability and funding, as they struggled to put together the necessary information for a strong funding application. However, some did not have the budget to employ staff with such skills:

> ***"I think as a project we need a fundraiser, who can explain what we need and make it black and white…the problem lies…we are not having anything to pay a fundraiser." Programme Manager, NRASD SR, Gauteng***

### 10.1.3 Sustainability of services

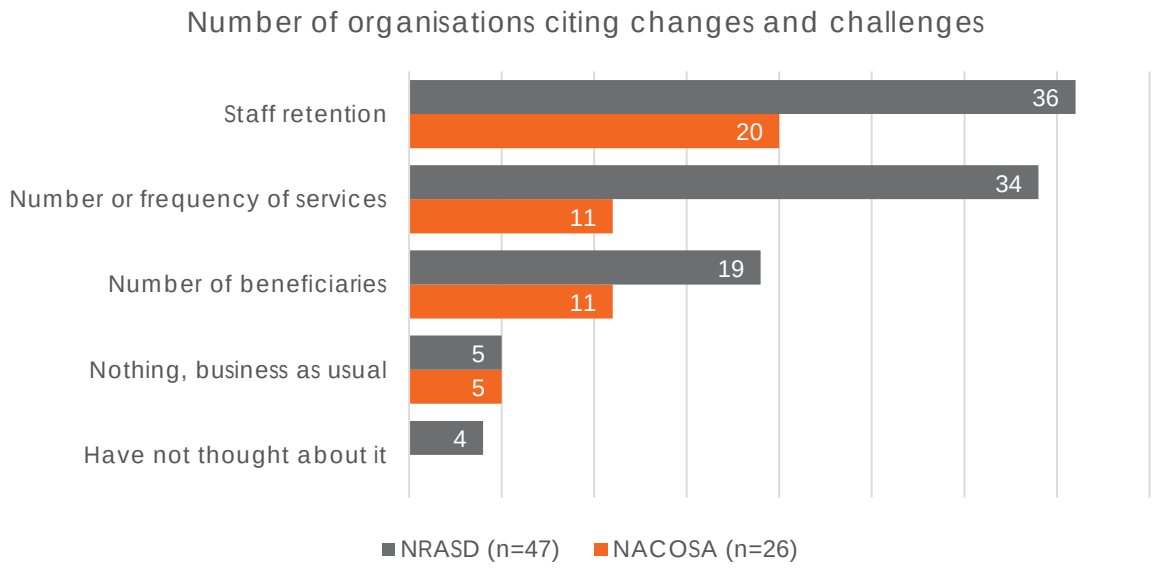
Organisations identified the changes or challenges they expected after the close out of the grant (see Figure 43). The largest number of organisations (56 out of 73) identified **staff retention** as a challenge, foreseeing that they will not be able to pay staff salaries and/or staff would leave:

> ***"We have discussed it, they don't want to continue with the services [because the organisation cannot afford to pay them anything." Project Manager, NRASD SSR, North West***

*"After March 27 staff members will be without a job and those are mostly breadwinners in their homes so it is going to be very bad for a lot of people." Director, NACOSA SR, Northern Cape*

The second most frequently identified challenge was having to **cut back on the number or frequency of services** offered (45 out of 73 organisations). Organisations also identified that the scope of services would change after the close out of the grant and they would have to **cut back on the number of beneficiaries** served (30 out of 73 organisations). A smaller number of organisations (10 out of 73 organisations) identified that nothing would change and it would be 'business as usual'. Only 4 managers indicated that they had not thought about these changes or challenges.

**Figure 43. Challenges or changes organisations will face beyond the term of the grant**




### 10.1.3.1 Staff retention beyond the term of the grant

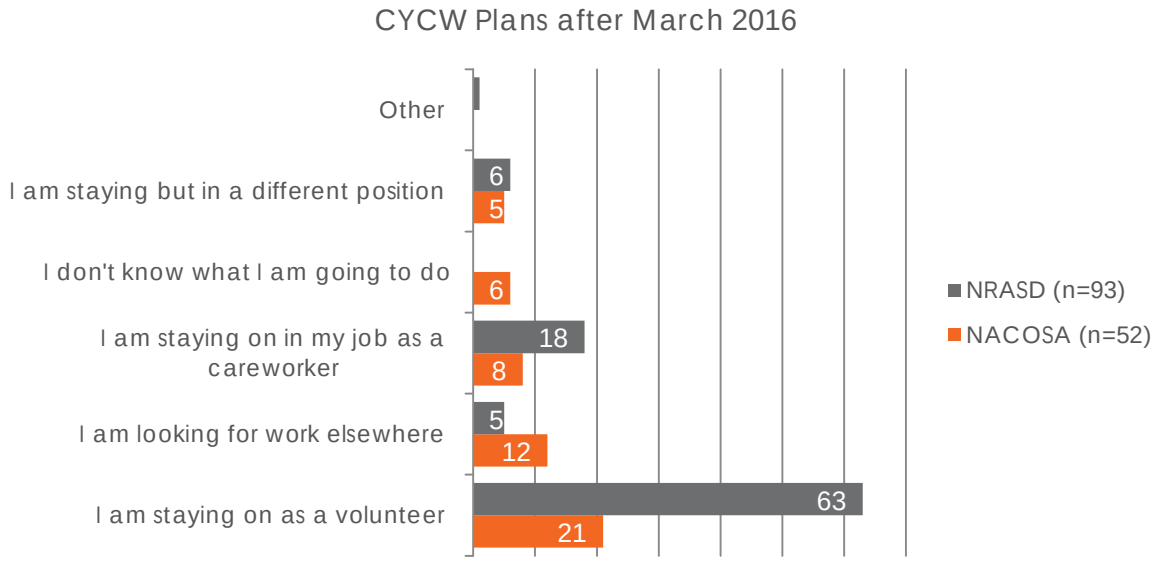
Care workers are key to the delivery of the programme services. They were asked two questions regarding sustainability post March 2016:

1. Whether they were aware that the Global Fund OVC Programme was coming to an end, and
2. What their plans were, if any, for after close-out.

**Nearly all (96,6%) of care workers indicated that they were aware that the grant was coming to an end** (51 out of 52 NACOSA care workers and 89 out of 93 NRASD care workers) . Therefore, only a very small number (5 across both programmes) were not aware.

However, although managers noted concerns that care workers would not stay on at the organisation due to the loss of their monthly stipend, this did not appear to be a key concern amongst the care workers themselves (see Figure 44 for the number of care workers per programme intending to stay in their position as a care worker). The largest number of care workers from both NACOSA SRs and NRASD SSRs reported that they were staying on in a volunteer capacity, with **57,9% of the total sample across both programmes (84 out of 145) indicating their intention to continue their work unpaid**. Only 11,7% (17 out of 145) indicated that they would be looking for work elsewhere while **25,5% (37 out of 145) indicated that they would be staying on at the organisation in a paid position** either in their current position as an OVC care worker (17,9%; 26 out of 145) or in another programme or position at the organisation (7,6%; 11 out of 145).

**Figure 44. Care workers' activities beyond the terms of the grant**




The finding that more than three quarters (82,5%) of care workers intended to stay with the organisation in either a paid or volunteer capacity seems to contradict the concerns noted by managers. However, management may also foresee that although care workers express an intention to stay on in a volunteer capacity that this is not feasible in the long-term. Care workers may leave once no longer receiving a stipend for their work and faced with the reality of having to put food on the table for their families.

Some managers acknowledged that services would continue in the interim for a short period of time as care workers had volunteered to stay on at the organisation while the organisation tried to secure funding but that they expected care workers might find a paid job:

***"We will try our level best to continue with some of the services… however we don't know for how long because the care workers might find a job where they get paid and then leave because they also have families to take care of." OVC Coordinator, NRASD SSR, Limpopo***

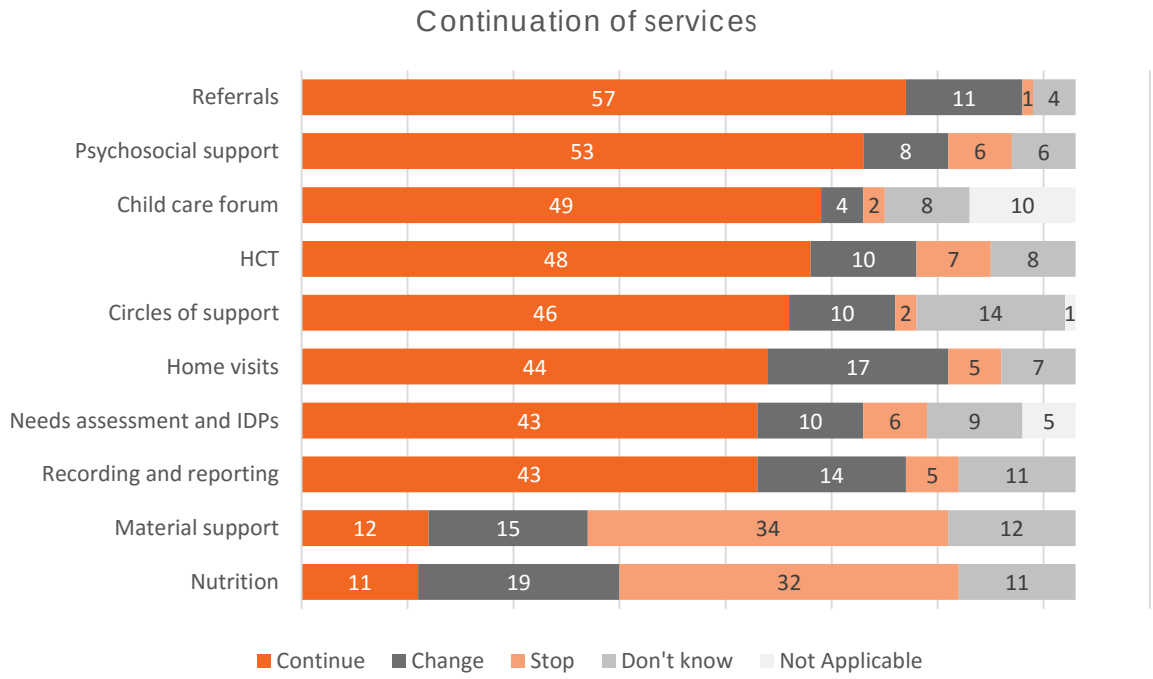
Others indicated that care workers had started at the organisation in a volunteer position and/or their loyalty and dedication to their work and community meant the discontinuation of the stipend would not pose an immediate challenge to service delivery:

***"Of my 20 care workers, 18 are willing to continue even without the stipend…they are very motivated to continue. They are not going to be formally under us and they're each going to do as they can because they also have families who need to eat…but…most of them had other income or they're either married and their husbands bring in money or they get a grant for orphans that live with them. They will really feel it but you can't change their hearts. They will still be doing what they were doing before [our organisation] and NACOSA came, which is wonderful." Director, NACOSA SR, KZN.***

### 10.1.3.2 Rendering services beyond the term of the grant

It is expected that the close out of the grant will have an impact on service delivery. Organisation managers were asked to comment on whether the organisation were likely to be able to continue with the key activities or services of the Global Fund OVC Programme, whether these would stop altogether or continue but change in nature or scope (e.g. take place less frequently, or on a smaller scale). The results are presented in Figure 45 below. As evident from that graph, organisations were **least likely to see material support and nutritional support as sustainable**. The **referral of beneficiaries, the provision of psychosocial support, child care forums, HTS and Circles of Support were identified as more easily sustainable services** that the organisation would be able to continue rendering beyond the term of the grant.

**Figure 45. Perceived sustainability of OVC programme activities beyond the term of the grant**




The NACOSA OVC programme in particular has taken a shift away from the provision of material and nutritional support (which are more expensive to provide) towards the provision of services that are low cost and aimed at building and strengthening community systems, and are therefore more sustainable. The findings reported in Figure 45 confirm that many of these activities are likely to continue in some format beyond the term of the grant. Managers noted that the relationships developed with other stakeholders would allow **activities such as circles of support, referrals and HTS to continue**. These services (particularly the child care forum meetings and circles of support) were well developed and managers anticipated they would carry on regardless of the end of the grant term.

***"It's not easy [to find funding to keep the OVC programme activities going]. We are also trying to establish or strengthen what we have already been doing, like the child care forums, so it does not become only our responsibility to provide services to OVC but that it becomes a community issue…so we are focusing in terms of how the community itself can take responsibility of the children in the community." Director, NACOSA SR, Eastern Cape***

Where organisations would be unable to continue with the provision of HTS themselves (i.e. provided internally) due to a lack of staff or test kits, they identified that they would continue to **make referrals to clinic and other service providers.**

However, there were also concerns that without the provision of material motivations, children and families would be less likely to want to test:

***"People will ask 'What are we going to get?' so we usually have blankets and the children that we have for testing for the day will be getting blankets…some people get motivated by the fact that there's something that we're going to get." Project Manager, NRASD SSR, Mpumalanga***

**Services which require money/funding, such as material and nutritional support, are not likely to continue** unless organisations have secured additional funding which covers the provision of these items:

***"If we can find a funder to support this project, we will change the way we do it and will only consider those children who are in dire need." Director, NRASD SSR, Limpopo***

However, some have managed to identify other service providers to which they can refer OVC for nutritional support (e.g. to DSD) or have secured sponsorship from local businesses or donors:

*"The school uniform we will still manage to do, with sponsorship from the church." NRASD SSR, Mpumalanga*

Due to concerns regarding care workers staying on managers felt that activities such as home visitation and psychosocial support would take place on a smaller scale or in a different format. For example, one NACOSA SR in the Eastern Cape identified that they planned to scale down from 11 communities to 3 communities, offering the same programme activities to a smaller pool of beneficiaries through volunteerism while staff looked for other employment opportunities.

While support groups, circles of support and CCFs would continue, managers were concerned that **attendance would drop** as they would not have the funding to provide refreshments:

*"I don't think we will be able to continue conducting support groups without any refreshments…they will not attend." Coordinator, NRASD SSR, Limpopo*

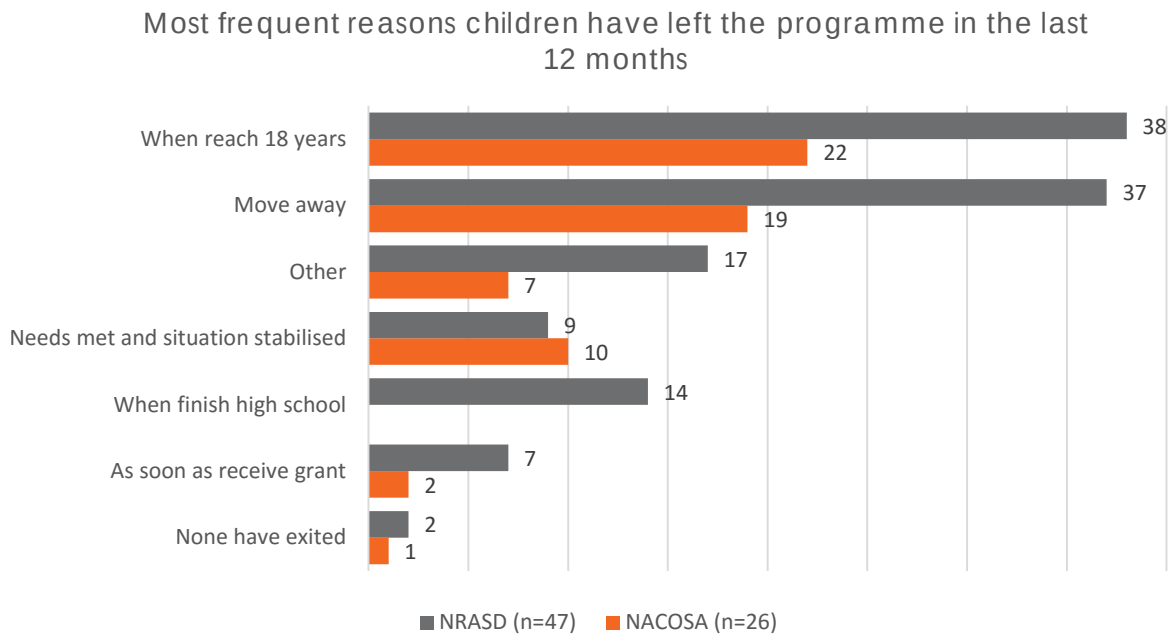
They would continue to be a referral network as even if they couldn't visit children at homes, the organisation was known in the community and people would come to the office to ask for assistance.

### 10.1.4 Exit strategies for OVC

As evident in the above findings on sustainability at the organisational level, a large proportion of organisations are planning on continuing service delivery to OVC to some degree. SRs and SSRs implemented a number of sustainability strategies to ensure that the programme would not stop altogether on 31 March 2016. This means that **many children will not need to be immediately exited from the programme** but will continue to receive support in some capacity from the SRs and SSRs.

However, the exit of OVC from the programme is a key mechanism that ensures sustainability at the household level and contributes towards sustained programme outcomes. The most frequent reasons managers from both NACOSA SRs and NRASD SSRs provided that children exited the Global Fund OVC programme in the last 12 months are highlighted in Figure 46 below.

**Figure 46. Reasons children have exited from the programme as reported by managers**



The most common reasons were that **children reached the age of 18 years** and were therefore no longer considered as a child (60 out of 73 organisations), as well as **children moving away** from the area (56 out of 73 organisations):

***"We have only had one child that has been exited from the programme last year…because he reached the age of 18. None of the other OVC were exited." Coordinator, NRASD SSR, Limpopo***

A total of 24 out of the 73 organisations listed other reasons for programme beneficiaries exiting the programme. The most popular reasons included that:

- Beneficiaries dropped out of the programme due to a lack of interest,
- Falling pregnant,
- Death of the beneficiary, and
- The beneficiary is being helped by a different organisation

Few organisations reported having a defined strategy to exit children from the programme unless they reached the age of 18 years and were no longer eligible to be in the programme or moved away. Only 19 of the 73 SRs and SSRs had exited children due to their needs having been met and the household situation stabilised according to their care plan:

***"The main reason that children leave…is when their needs have been met, then we discharge them because we are trying to serve as many children as possible and spread the services." Director, NACOSA SR, Eastern Cape***

This suggests a weakness in the implementation of the programme amongst SRs and SSRs. Instead of discharging children from the programme once stabilised and attending school as intended through the NACOSA and NRASD models, OVC stayed in the programme for an extended period of time. SRs and SSRs struggled to implement this effectively due to the perceived high levels of need amongst OVC households and therefore need for continuous support.

However, **the majority of SRs and SSRs provided some form of support or referral to the household before exit** to try to ensure they could function independently or link them to other services if still in need of care (see Table 25). Most commonly, this included referral to another NPO or government services - partner organisations and departments were informed about children who were leaving the programme. In addition, SRs and SSRs reporting providing support that would allow households to function independently, including linking them to food gardens and income generating activities. Other organisations reported still supporting an OVC in some capacity even though they were exited from the Global Fund OVC Programme on paper:

***We don't have an exit strategy. We haven't taken any of the OVC off the programme yet. If the child is still at school, even if they have reached 18 and they still need assistance then the centre will continue to support the child where they can. When they move away, we usually only find out after the child has already left." Coordinator, NRASD SSR, Limpopo***

Income-generating activities are an important exit strategy for OVC households and helps to ensure the sustainability of support to OVCs whether they are exited from a continuing programme or a programme closes due to the end of a particular grant. Linking households to income generating activities builds longer-term sustainability and self-sufficiency through providing households with an additional income stream. This included beading and sewing projects, as well as food gardens where the food grown was sold at markets or to other families in the community. This is discussed previously in section 10.1.1 in identifying the sustainability strategies of SRs and SSRs.

Only 5 out of 26 NACOSA SRs and 12 out of 47 NRASD SSRs identified that they provided **no activities or linkages to services for OVC exiting** the programme:

***"We don't have an exit procedure as we haven't encountered a situation where children had to be exited." Coordinator, NRASD SSR, Limpopo***

*"We communicate with their caregivers and inform them [about exiting the child] and we tell them that we hope they have a wonderful time…we give them enough time to prepare for the exit but there is no other special process." Programme Manager, NACOSA SR, KZN*

**Table 25. Activities or linkages provided when exiting children from the programme**

| Activity | NACOSA (n=26) | NRASD (n=47) | Total |
|---|---|---|---|
| **Refer to another NPO or service provider** | 10 | 29 | 39 |
| **Refer to government services** | 4 | 23 | 27 |
| **Food garden** | 6 | 18 | 24 |
| **Link to income generating project** | 8 | 12 | 20 |
| **Ensure access to social grant** | 5 | 15 | 20 |
| **None** | 5 | 12 | 17 |
| **Succession planning** | 4 | 12 | 16 |
| **Other** | 8 | 6 | 14 |

These findings poses a challenge to sustainable programme and programme outcomes in three ways:

- At the household level, the exit of children only when they reach 18 years or move away, contributes towards creating long term dependence. When beneficiaries receive sustained support without thought for an exit strategy once the critical needs of the child have been met, services can be saturated very quickly.
- This history of co-dependence and lack of regular graduation or exit (i.e. turnover) from the programme may mean that it will be more difficult to exit children due to closure of the programme.
- Although 30 out of the 73 SRs and SSRs reported that they expected to cut back the scope of services after close-out (i.e. provide services to fewer beneficiaries; see section Sustainability of services), few reported a defined strategy for exiting those they would no longer be able to work with.

### 10.1.5 Case studies on sustainability

In order to explore the issue of sustainability in more depth, two case studies were constructed - one each for NACOSA and NRASD respectively. These are attached in Appendix D.

# 11. LESSONS LEARNT AND RECOMMENDATIONS

## 11.1 Programme acheivements

- The implementation of HTS was a challenging process for SRs and SSRs. At many sites it was met with resistance at a community and organisational level. This was particularly due to the focus on testing children and in rural communities where stigma around HIV is high. Nevertheless, SRs and SSRs were able to overcome these challenges and programme targets for HTS testing were met and exceeded by both PRs by the end of the grant term. Programme design and setting of targets should, however, take into consideration slow initial uptake of HTS due to such barriers and accommodate increasing targets per quarter.
- Through the education of communities on HIV prevention and the importance of knowing one's status, the programme has paved the way for the recognition of the importance of testing in communities across South Africa. The training provided to care workers as well as the focus on HIV education allowed SRs and SSRs to build trust and acceptance of the importance of HTS amongst community members.
- The small proportion of OVC in the programme testing positive for HIV suggest a number of things including that (a) although successful in achieving high rates of HIV testing amongst OVC, OVC at a high risk of HIV were not targeted by the programme or (b) the programme itself was a successful protective factor for HIV infections amongst OVC. Perhaps limiting HIV testing to adolescents in future programming will be an effective strategy in this regard. In addition, testing is a first step towards increasing HIV knowledge and behaviour change to prevent or reduce risk of infection and improve other outcomes.
- Despite some implementation challenges reported by SRs, SSRs and care workers, both PRs successfully reached and exceeded their programme targets in terms of the number of OVC households receiving free basic support in caring for the child through the Phase II Grant.

## 11.2 Programme effectiveness

- OVC and caregivers in the Global Fund OVC Programme performed well on most outcomes. Nearly all were enrolled in school and few missed school other than for illness; the uptake of grants and access to healthcare amongst OVC households was also high; few reported going hungry; and engagement in high risk behaviours, such as substance use, was generally low. In addition, social support for OVC in the Global Fund programme is high.
- The Global Fund OVC Phase II Grant was particularly effective in achieving the uptake of HTS amongst OVC and their households. Significantly more OVC in the Global Fund Programme know their status compared to those in the DSD Programme. In addition, significantly more knew their status by the end of the programme compared to early in programme implementation. This suggests that the programme model is an effective strategy to increase HIV testing amongst children, including younger children (< 10 years).
- Organisational capacity building and the strengthening of networks and partnerships in communities was a success of the grant for SRs and SRRs. The visibility of SRs and SRRs in their communities has improved and this has resulted in improved service provision to OVC households. These are also likely to result in sustained referral networks and linkages for support for OVC despite the end of the grant term.
- A limitation of this evaluation was that it was unable to utilise a true control group or baseline assessment. In order to more clearly identify programme outcomes, it is recommended that future programmes execute a baseline before programme implementation and/or use a control group that received either no or a significantly different programme.

## 11.3 Enablers and barriers for sustainability

- In the tough funding climate in South Africa, particularly for CBOs in the Children's Sector, organisations should be encouraged to explore multiple funding streams/diversified funding. Those organisations with only one or two funding streams should work towards building multiple smaller funding streams to buffer the effects of the loss of a single funder.
- Organisations should also explore in-kind support as a resource in times when donor funding is scarce. Lessons can be learned from some SRs and SSRs in terms of innovative and effective fundraising and funding strategies being used.
- In particular, organisations should continue to build capacity at the individual household and community level through, for example, income generating activities. Through adding an additional revenue stream for the family, such activities help individual households and communities to support their OVC themselves, whether programme services may come or go. At the organisational level, income generating activities can also help to raise funds for the sustainability of the organisation. This is particularly effective in the longer term to cope with shifts in funding priorities and enable organisations to become self-sufficient.
- An alternate suggestion is for donors to consider a savings or investment fund, where a portion of the larger grant acts as bridging finance for implementing organisations when the grant term ends.
- In addition, an organisation that is able to adapt to the broader policy environment has a greater chance of getting resources, which is critical to their survival. Capacity building at the organisational level as part of the support offered by NACOSA and NRASD through the Grant enabled some organisations to adapt their strategy in this regard.
- Capacity building under the Global Fund Phase II Grant was a significant enabler for the sustainability of organisations and the services that were provided as part of the OVC programme.
- In particular, a programme focus on non-financial activities and services that are effective while not costly to provide, means that such services will be more easily sustainable post close-out.
- SRs and SRRs struggled to implement the exit of OVC from the programme based on need and as a result OVCs were not regularly discharged from the programme. SRs and SSRs seemed to maintain continuous service provision rather than the provision of short-term support to reduce dependency, despite PR attempts.
- A limitation of this evaluation is that it was not possible to comment on the sustainability of the programme outcomes for OVC households. In order to identify whether the programme had a sustained impact, it would be necessary to conduct a post-test (for example 6 months after a child has exited the programme).

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# APPENDIX A: ADDITIONAL TABLES AND GRAPHS

**Table 26. Comparison of previous survey and process evaluation to the current outcome evaluation**

| Evaluation activity/ component | Previous survey and process evaluation | Current outcome evaluation |
|---|---|---|
| **Qualitative data** | Focus groups conducted with OVC aged 16 – 21 in 4 provinces | Case study component (qualitative interviews and focus groups with organisation staff) |
| **Key informant interviews** | Interviews with PR, SR and SSR programme managers (not all were interviewed) | Interviews with PR and SR representatives |
| **Survey** | Focus on process and output indicators with limited outcome indicators | Focus on outcome indicators with limited process and output indicators |
| | Survey with OVC aged 10 -17 utilising mobile technology | Survey with OVC aged 10 -17 utilising mobile technology |
| | Survey with caregivers of OVC aged 0 - 9 utilising mobile technology | Survey with caregivers of OVC aged 0 – 9 utilising mobile technology |
| | Survey with CYCW utilising mobile technology | Survey with CYCW utilising mobile technology |
| | Survey with SR and SSR managers utilising mobile technology | Mixed-methods quantitative and qualitative telephonic interview with SR and SSR managers |
| **Monitoring data** | Was not included in the evaluation | Monitoring data from Q1 to Q10 analysed to identify programme outputs |
| **Financials** | Was not included in the evaluation | Limited financial information included |

Table 27. Details of sites included in the final survey sample according to district and sub-district

| Site | SR/SSR | Province | District | Sub-district | CBO | Previous Evaluation |
|---|---|---|---|---|---|---|
| NRASD SSRs | | | | | | |
| 1. | AAHT | Free State | Lejweleputswa | Masilonyana | Thusang Community Health Workers | X |
| 2. | AAHT | Free State | Thabo Mofutsanyana | Dihlabeng | Thusanang community development | X |
| 3. | MCSA | Free State | Thabo Mofutsanyana | Dihlabeng | Reabarata Re teng | ✓ |
| 4. | MCSA | Free State | Thabo Mofutsanyana | Dihlabeng | People of Hope | ✓ |
| 5. | MCSA | Free State | Thabo Mofutsanyana | Setsoto | Bonang Bacha Health Care | ✓ |
| 6. | MCSA | Free State | Lejweleputswa | Virginia | Santa Anti TB | ✓ |
| 7. | STARFISH | Free State | Thabo Mofutsanyana | Dihlabeng | Bana Bahlokong | ✓ |
| 8. | STARFISH | Free State | Thabo Mofutsanyana | Dihlabeng | Dihlabeng Development Initiative | ✓ |
| 9. | STARFISH | Free State | Thabo Mofutsanyana | Dihlabeng | Golden Gate Hospice | ✓ |
| 10. | STARFISH | Free State | Lejweleputswa | Matjhabeng | Goldenfields Hospice | ✓ |
| 11. | KMDR | Gauteng | Sedibeng | Emfuleni | Etelangpele Drop in Centre | X |
| 12. | MCSA | Gauteng | Sedibeng | Lesedi | Indawo yo sizo | ✓ |
| 13. | SACBC | Gauteng | Sedibeng | Emfuleni | Ahanang Parish Based care organisation Diocese of JHB | ✓ |
| 14. | STARFISH | Gauteng | Sedibeng | Emfuleni | Thy Kingdom | X |
| 15. | AAHT | Limpopo | Sekhukhune | Makhuduthamaga | Rwadishanang (Jane Furse) | ✓ |
| 16. | AAHT | Limpopo | Mopani | Ba-Phalaborwa | Livhuwani (Phalaborwa) | ✓ |
| 17. | AAHT | Limpopo | Mopani | Ba-Phalaborwa | St Lukes (Phalaborwa) | ✓ |
| 18. | KMDR | Limpopo | Sekhukhune | Greater Tubatse | Amogelang Day care | ✓ |
| 19. | KMDR | Limpopo | Mopani | Greater Giyani | Mapayeni Drop in Centre | X |
| 20. | KMDR | Limpopo | Mopani | Greater Letaba | URC Kgapane | ✓ |
| 21. | KMDR | Limpopo | Mopani | Ba-Phalaborwa | Tumelong | ✓ |
| 22. | MCSA | Limpopo | Sekhukhune | Elias Motswaledi | Santa Kgapamadi | ✓ |
| 23. | MCSA | Limpopo | Sekhukhune | Paardeplaas | Womtech | ✓ |
| 24. | MCSA | Limpopo | Sekhukhune | Elias Motswaledi | Sekhukhune Women Against HIV/AIDS | ✓ |
| 25. | STARFISH | Limpopo | Mopani | Greater Letaba Municipality | Ntshuxekani | ✓ |
| 26. | STARFISH | Limpopo | Mopani | Greater Tzaneen | Valoyi Traditional authority Trust | ✓ |

| Site | SR/SSR | Province | District | Sub-district | CBO | Previous Evaluation |
|---|---|---|---|---|---|---|
| 27. | KMDR | Mpumalanga | Ehlanzeni | Bushbuckridge | CMR Mpumalanga | ✓ |
| 28. | MCSA | Mpumalanga | Gert Sibande | Dipaleseng | CCM Damoyi Care Centre | ✓ |
| 29. | MCSA | Mpumalanga | Gert Sibande | Mkhondo | Empilweni Multipurpose | ✓ |
| 30. | MCSA | Mpumalanga | Gert Sibande | Pixley ka seme | Siyakhula | ✓ |
| 31. | MCSA | Mpumalanga | Gert Sibande | Lekwa | Tholimpilo Multipurpose | ✓ |
| 32. | MCSA | Mpumalanga | Ehlanzeni | Greater Nelspruit | Makhundu | ✓ |
| 33. | MCSA | Mpumalanga | Ehlanzeni | Greater Nelspruit | Mashadza House/Special care | ✓ |
| 34. | MCSA | Mpumalanga | Ehlanzeni | Greater Nelspruit | Uthando Care Center | X |
| 35. | SACBC | Mpumalanga | Gert Sibande | Victor Khanye | Ekuthuleni | ✓ |
| 36. | SACBC | Mpumalanga | Ehlanzeni | Mbombela | Tiyimiseleni | ✓ |
| 37. | SACBC | Mpumalanga | Ehlanzeni | Bushbuckridge | Vezokuhle HBC | ✓ |
| 38. | STARFISH | Mpumalanga | Ehlanzeni | Mbombela | Masoyi HBC | ✓ |
| 39. | STARFISH | Mpumalanga | Ehlanzeni | Hazyview | Eco Plan | ✓ |
| 40. | STARFISH | Mpumalanga | Ehlanzeni | Hazyview | Swa Vana | ✓ |
| 41. | STARFISH | Mpumalanga | Ehlanzeni | White River | Phaphamani Home based Care | ✓ |
| 42. | STARFISH | Mpumalanga | Ehlanzeni | Malelane | Thembalethu | ✓ |
| 43. | AAHT | North West | Dr Kenneth Kaunda | City of Matlosana | Motheong wa Tumelo | ✓ |
| 44. | KMDR | North West | Dr Kenneth Kaunda | Tlokwe | Ikgageng | ✓ |
| 45. | MCSA | North West | Dr Kenneth Kaunda | Tlokwe | Tsogella Bokamoso | X |
| 46. | STARFISH | North West | Dr Kenneth Kaunda | Dertig | Leseding Caregivers | ✓ |
| 47. | STARFISH | North West | Dr Kenneth Kaunda | | Reach Out | X |
| **NACOSA SRs** | | | | | | |
| 48. | | Eastern Cape | Cacadu | | Isipho Trust | ✓ |
| 49. | | Eastern Cape | O R Tambo | King Sabata Dalyindebo | Faith and Hope | ✓ |
| 50. | | Eastern Cape | O R Tambo | Mhlontlo | Siyakhanyisa HIV/AIDS Support Group | ✓ |
| 51. | | Eastern Cape | O R Tambo | Nyandeni | Sizanenguqu CHBC | ✓ |
| 52. | | Eastern Cape | NM Bay Metro | Port Elizabeth | Mfesane | ✓ |
| 53. | | Eastern Cape | NM Bay Metro | Joe Slovo | Sophakama | ✓ |

| Site | SR/SSR | Province | District | Sub-district | CBO | Previous Evaluation |
|---|---|---|---|---|---|---|
| 54. | | Eastern Cape | Buffalo City | East London | Sophumelela Clinic | ✓ |
| 55. | | Eastern Cape | Buffalo City | East London | Never Give Up Support Group | ✓ |
| 56. | | Western Cape | Cape Winelands | Drakenstein | Simondium Rural Development Forum | ✓ |
| 57. | | Western Cape | City of Cape Town | Southern | Yabonga | ✓ |
| 58. | | Western Cape | Eden | Mossel Bay | Heart to Heart | X |
| 59. | | Western Cape | Eden | Knysna | Masithandane | ✓ |
| 60. | | Northern Cape | Pixley ka Seme | Siyancuma | Hospice Moeder Theresa | ✓ |
| 61. | | Northern Cape | ZF Macau (Siyanda) | Kgatelopele | Kgatelopele Social Development Forum | ✓ |
| 62. | | Northern Cape | ZF Macau (Siyanda) | Khara!Hais | Noord Kaap Vigs Forum | ✓ |
| 63. | | Kwa-Zulu Natal | eThekwini MM | eThekwini MM | Hillcrest Aids Trust | ✓ |
| 64. | | Kwa-Zulu Natal | eThekwini MM | | Masilenze Izwi Lenkosi Upliftment Initiative (MILUVE) | ✓ |
| 65. | | Kwa-Zulu Natal | Umgungundlovu | Umngeni | Ethembeni HIV/AIDS Ministry | ✓ |
| 66. | | Kwa-Zulu Natal | Umgungundlovu | Umngeni | Masibumbane HIV/Aids Mission of The Hilton Methodist Church | ✓ |
| 67. | | Kwa-Zulu Natal | Umgungundlovu | Msunduzi | Youth for Christ | ✓ |
| 68. | | Kwa-Zulu Natal | Uthukela District | Emnambithi | Mpilonhle Project | ✓ |
| 69. | | Kwa-Zulu Natal | Uthukela District | Imbabazane | Thembalethu Care | ✓ |
| 70. | | Kwa-Zulu Natal | Sisonke District | Umzimkhulu | Sinomhawu Aids Project - Malenge | ✓ |
| 71. | | Kwa-Zulu Natal | uMzinyathi District | Msinga | Khayelisha Care | ✓ |
| 72. | | Kwa-Zulu Natal | uMzinyathi District | Umvoti | Umvoti Aids Centre | ✓ |
| 73. | | Kwa-Zulu Natal | uMzinyathi District | Msinga | Philanjalo | ✓ |
| **Comparison Sites (DSD)** | | | | | | |
| 74. | | Eastern Cape | | | Coping Centre for People living with HIV/AIDS | ✓ |
| 75. | | Free State | | | Senekal Child Care Forum | ✓ |
| 76. | | Free State | | | Petsana Child Care Forum | ✓ |
| 77. | | Gauteng | | | Ikageng | ✓ |
| 78. | | Gauteng | | | Muslim Aids Programme | ✓ |
| 79. | | KZN | | | Maskey Health Services | ✓ |

| Site | SR/SSR | Province | District | Sub-district | CBO | Previous Evaluation |
|---|---|---|---|---|---|---|
| 80. | | KZN | | | Vukani Community Project | ✓ |
| 81. | | Limpopo | | | Tafelkop Lesedi Drop In Centre | ✓ |
| 82. | | Mpumalanga | | | Kutlwano Multi-Purpose Centre | ✓ |
| 83. | | Mpumalanga | | | Sizanani | X |
| 84. | | Northern Cape | | | Protiro | ✓ |
| 85. | | Northern Cape | | | Longlands HBC | X |
| 86. | | North West | | | Maboloka HIV/AIDS Awareness Organisation | ✓ |
| 87. | | North West | | | God is Able | ✓ |
| 88. | | Western Cape | | | Yizani Sakhe | ✓ |
| 89. | | Western Cape | | | Kwakhanya | ✓ |

**Figure 47. Proportion of NRASD OVC sample from the five SRs.**

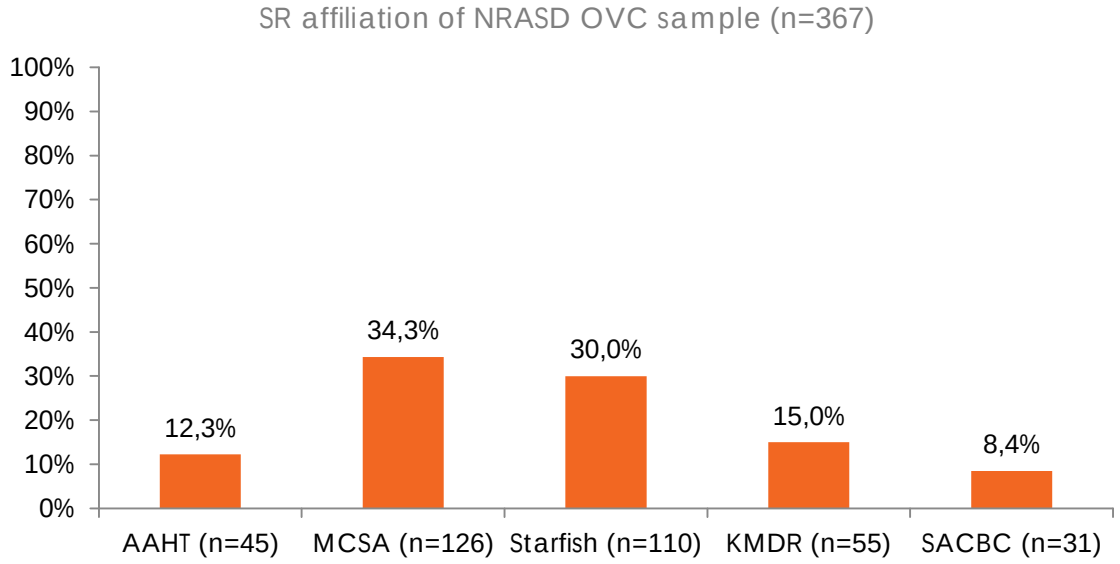



**Figure 48. Breakdown of age of caregivers of OVC younger than 10 years surveyed per programme**

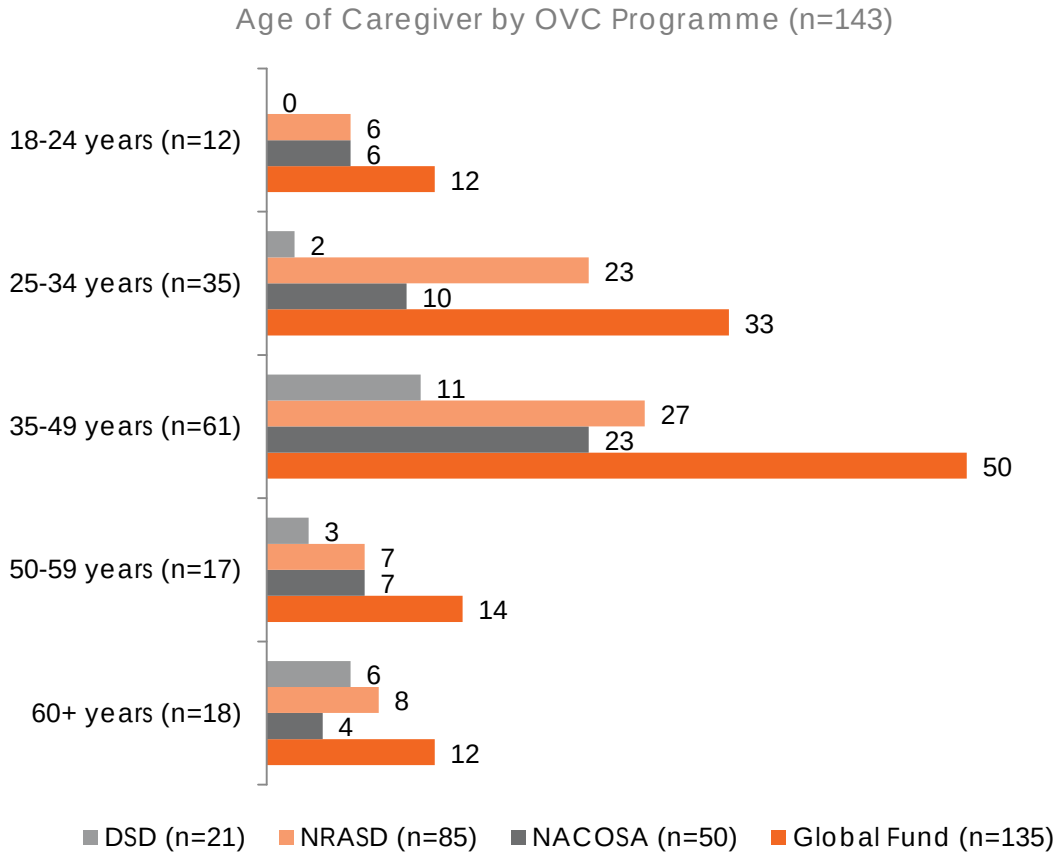


**Figure 49. Nature of relationship of caregiver to OVC aged younger than 10 years**

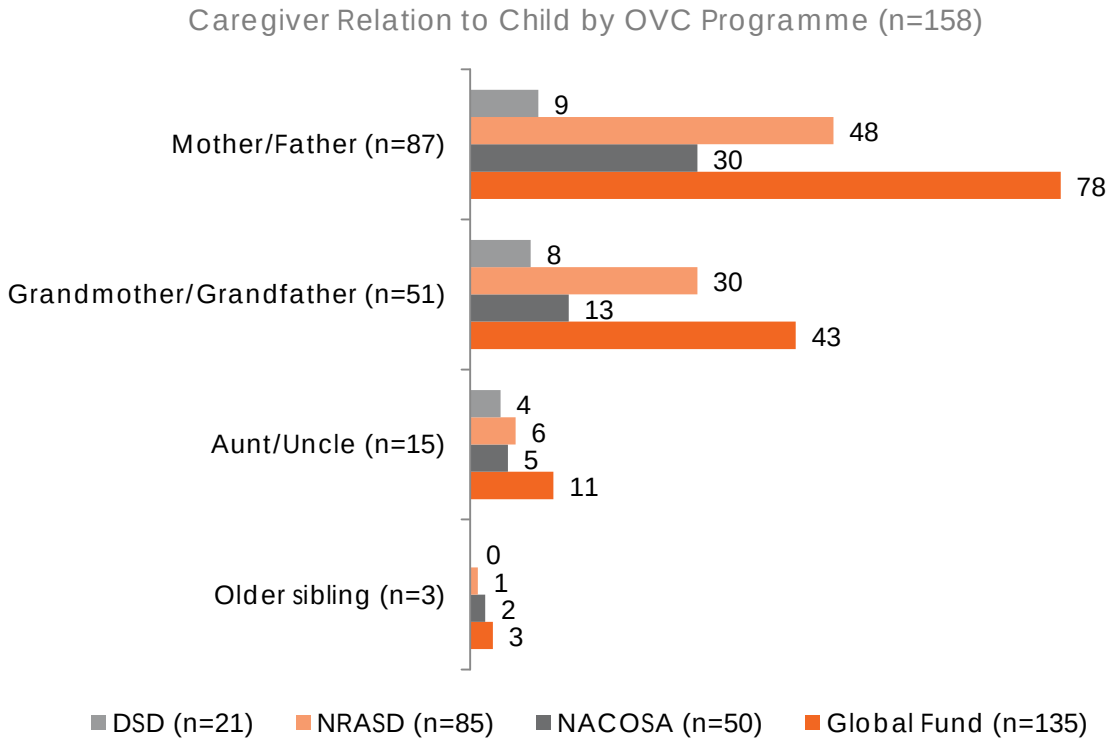



**Figure 50. NACOSA CYCW experiencing challenges in delivering HTS services to OVC.**

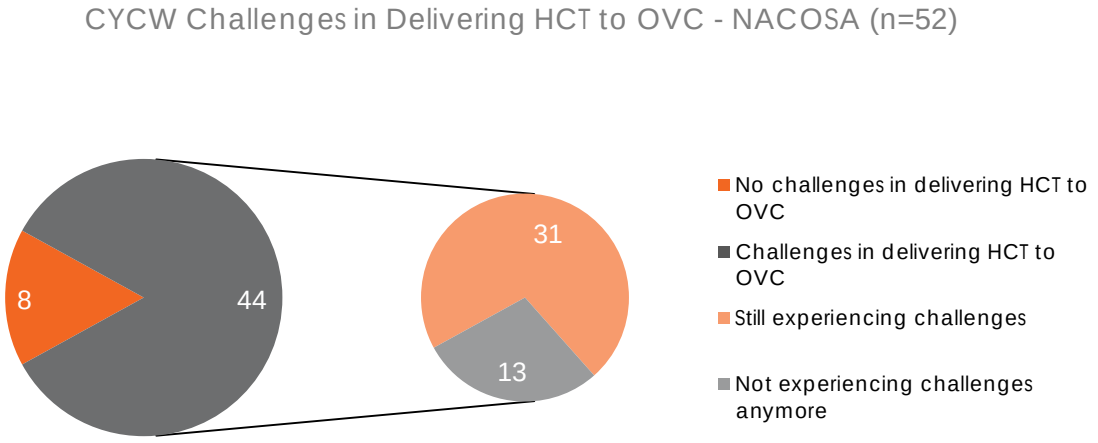
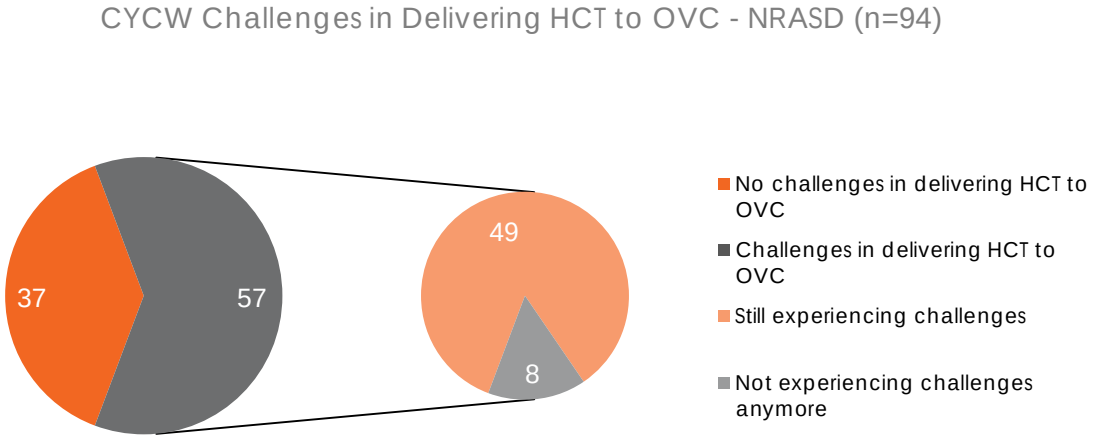


**Figure 51. NRASD CYCW experiencing challenges in delivering HTS services to OVC.**



## Table 28. HTS uptake by OVC

| Characteristic | Global Fund (n=561) | | NACOSA (n=194) | | NRASD (n=367) | | DSD (n=124) | |
|---|---|---|---|---|---|---|---|---|
| | Child | Caregiver | Child | Caregiver | Child | Caregiver | Child | Caregiver |
| | (n) | (n) | (n) | (n) | (n) | (n) | (n) | (n) |
| **Child tested for HIV** | | | | | | | | |
| Yes | 300 | 108 | 103 | 45 | 197 | 63 | 38 | 14 |
| No | 117 | 19 | 38 | 3 | 79 | 16 | 61 | 8 |
| Refuse to answer | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 |
| Don't know | 8 | 8 | 2 | 2 | 6 | 6 | 2 | 1 |
| **Child received the HIV test results** | | | | | | | | |
| Yes | 262 | 103 | 94 | 43 | 168 | 60 | 31 | 14 |
| No | 27 | 5 | 5 | 2 | 22 | 3 | 5 | 0 |
| Don't know | 11 | 0 | 4 | 0 | 7 | 0 | 2 | 0 |
| **HIV test results shared with caregiver** | | | | | | | | |
| Yes | 248 | 101 | 88 | 43 | 160 | 58 | 30 | 14 |
| No | 32 | 1 | 14 | 0 | 18 | 1 | 4 | 0 |
| Don't know | 20 | 1 | 1 | 0 | 19 | 1 | 4 | 0 |
| **Haven't been tested but want to be tested** | | | | | | | | |
| Yes | 91 | 73 | 32 | 38 | 59 | 35 | 48 | 7 |
| No | 25 | 15 | 8 | 0 | 17 | 15 | 12 | 1 |
| Don't know | 10 | 20 | 1 | 7 | 9 | 13 | 3 | 6 |

## Table 29. HTS uptake by caregivers

| Characteristic | Global Fund (n=561) | | NACOSA (n=194) | | NRASD (n=367) | | DSD (n=124) | |
|---|---|---|---|---|---|---|---|---|
| | Child | Caregiver | Child | Caregiver | Child | Caregiver | Child | Caregiver |
| | (n) | (n) | (n) | (n) | (n) | (n) | (n) | (n) |
| **Caregiver tested for HIV** | | | | | | | | |
| Yes | 182 | 116 | 73 | 47 | 109 | 69 | 36 | 20 |
| No | 60 | 18 | 28 | 3 | 32 | 15 | 20 | 3 |
| Refuse to answer | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 |
| Don't know | 183 | 1 | 42 | 0 | 141 | 1 | 45 | 0 |
| **Caregiver received the HIV test results** | | | | | | | | |
| Yes | N/A | 113 | N/A | 45 | N/A | 68 | N/A | 20 |
| No | N/A | 3 | N/A | 2 | N/A | 1 | N/A | 0 |
| **Haven't been tested but want to be tested** | | | | | | | | |
| Yes | N/A | 16 | N/A | 3 | N/A | 13 | N/A | 1 |
| No | N/A | 3 | N/A | 0 | N/A | 3 | N/A | 2 |

## Table 30. HTS uptake by siblings

| Characteristic | Global Fund (n=561) | | NACOSA (n=194) | | NRASD (n=367) | | DSD (n=124) | |
|---|---|---|---|---|---|---|---|---|
| | Child | Guardian | Child | Guardian | Child | Guardian | Child | Guardian |
| | (n) | (n) | (n) | (n) | (n) | (n) | (n) | (n) |
| **Siblings tested for HIV** | | | | | | | | |
| Yes | 183 | 90 | 58 | 34 | 125 | 56 | 19 | 7 |
| No | 102 | 30 | 47 | 14 | 55 | 16 | 44 | 12 |
| Only child in household | 13 | 7 | 7 | 1 | 6 | 6 | 5 | 1 |
| Don't know | 128 | 8 | 32 | 1 | 96 | 7 | 33 | 3 |
| **Siblings taking ARVs** | | | | | | | | |
| Yes | 34 | 16 | 15 | 6 | 19 | 10 | 7 | 2 |
| No | 141 | 73 | 42 | 27 | 99 | 46 | 11 | 5 |
| Don't know | 8 | 1 | 1 | 1 | 7 | 0 | 1 | 0 |
| **Siblings missed taking ARVs** | | | | | | | | |
| Yes | 6 | 1 | 4 | 0 | 2 | 1 | 0 | 0 |
| No | 22 | 14 | 10 | 5 | 12 | 9 | 5 | 1 |
| Don't know | 6 | 1 | 1 | 1 | 5 | 0 | 2 | 1 |

## Table 31. HIV knowledge and awareness for OVC caregivers by OVC programme

| Statement | Total (n=158) | | Global Fund (n=135) | | NACOSA (n=50) | | NRASD (n=85) | | DSD (n=23) | |
|---|---|---|---|---|---|---|---|---|---|---|
| | % | n | % | n | % | n | % | n | % | n |
| **Using a condom every time** | 96.2% | 152 | 95.6% | 129 | 98.0% | 49 | 94.1% | 80 | 100.0 % | 23 |
| **Having just one sex partner** | 90.5% | 143 | 89.6% | 121 | 88.0% | 44 | 90.6% | 77 | 95.7% | 22 |
| **Get HIV by sharing food** | 88.6% | 140 | 88.9% | 120 | 82.0% | 41 | 92.9% | 79 | 87.0% | 20 |
| **Healthy looking person can have HIV** | 86.1% | 136 | 85.2% | 115 | 76.0% | 38 | 90.6% | 77 | 91.3% | 21 |
| **HIV from mother to baby during birth** | 84.2% | 133 | 82.2% | 111 | 90.0% | 45 | 77.6% | 66 | 95.7% | 22 |
| **HIV from mother to baby during breastfeeding** | 77.2% | 122 | 74.1% | 100 | 76.0% | 38 | 72.9% | 62 | 95.7% | 22 |
| **HIV from mother to baby during pregnancy** | 73.4% | 116 | 69.6% | 94 | 60.0% | 30 | 75.3% | 64 | 95.7% | 22 |
| **HIV from mosquito bites** | 57.0% | 90 | 56.3% | 76 | 58.0% | 29 | 55.3% | 47 | 60.9% | 14 |
| **Total knowledge** | | | | | | | | | | |
| 8 out of 8 correct | 18.4% | 29 | 14.1% | 19 | 10.0% | 5 | 16.5% | 14 | 43.5% | 10 |
| 7 out of 8 correct | 39.9% | 63 | 40.7% | 55 | 34.0% | 17 | 44.7% | 38 | 34.8% | 8 |
| Less than 7 out of 8 correct | 41.8% | 66 | 45.2% | 61 | 56.0% | 28 | 38.8% | 33 | 21.7% | 5 |

## Table 32. HIV knowledge and awareness for OVC children 10 years and older by OVC programme

| Statement | Total (n=527) | | Global Fund (n=426) | | NACOSA (n=144) | | NRASD (n=282) | | DSD (n=101) | |
|---|---|---|---|---|---|---|---|---|---|---|
| | % | n | % | n | % | n | % | n | % | n |
| **Using a condom every time** | 86.0% | 453 | 85.9% | 366 | 84.7% | 122 | 86.5% | 244 | 86.1% | 87 |
| **Having just one sex partner** | 77.6% | 409 | 78.9% | 336 | 73.6% | 106 | 81.6% | 230 | 72.3% | 73 |
| **Get HIV by sharing food** | 72.9% | 384 | 75.1% | 320 | 75.7% | 109 | 74.8% | 211 | 63.4% | 64 |
| **HIV from mother to baby during pregnancy** | 70.4% | 371 | 70.9% | 302 | 72.9% | 105 | 69.9% | 197 | 68.3% | 69 |
| **HIV from mother to baby during breastfeeding** | 68.7% | 362 | 67.8% | 289 | 69.4% | 100 | 67.0% | 189 | 72.3% | 73 |
| **Healthy looking person can have HIV** | 66.6% | 351 | 66.7% | 284 | 60.4% | 87 | 69.9% | 197 | 66.3% | 67 |
| **HIV from mosquito bites** | 63.6% | 335 | 63.4% | 270 | 59.7% | 86 | 65.2% | 184 | 64.4% | 65 |
| **HIV from mother to baby during birth** | 63.4% | 334 | 65.3% | 278 | 68.1% | 98 | 63.8% | 180 | 55.4% | 56 |
| **Total knowledge** | | | | | | | | | | |
| 8 out of 8 correct | 13.5% | 71 | 13.6% | 58 | 8.3% | 12 | 16.3% | 46 | 12.9% | 13 |
| 7 out of 8 correct | 21.1% | 111 | 22.3% | 95 | 26.4% | 38 | 20.2% | 57 | 15.8% | 16 |
| Less than 7 out of 8 correct | 65.5% | 345 | 64.1% | 273 | 65.3% | 94 | 63.5% | 179 | 71.3% | 72 |

## Table 33. HIV knowledge and awareness of care workers by OVC programme

| Statement | Total (n=178) | | Global Fund (n=146) | | NACOSA (n=50) | | NRASD (n=96) | | DSD (n=32) | |
|---|---|---|---|---|---|---|---|---|---|---|
| | % | n | % | n | % | n | % | n | % | n |
| **Using a condom every time** | 98.9% | 176 | 100.0% | 146 | 100.0% | 50 | 100.0% | 96 | 93.8% | 30 |
| **Get HIV by sharing food** | 94.4% | 168 | 94.5% | 138 | 94.0% | 47 | 94.8% | 91 | 93.8% | 30 |
| **Healthy looking person can have HIV** | 89.3% | 159 | 88.4% | 129 | 80.0% | 40 | 92.7% | 89 | 93.8% | 30 |
| **Having just one sex partner** | 88.8% | 158 | 88.4% | 129 | 84.0% | 42 | 90.6% | 87 | 90.6% | 29 |
| **HIV from mother to baby during birth** | 88.2% | 157 | 90.4% | 132 | 92.0% | 46 | 89.6% | 86 | 78.1% | 25 |
| **HIV from mother to baby during breastfeeding** | 87.1% | 155 | 91.1% | 133 | 88.0% | 44 | 92.7% | 89 | 68.8% | 22 |
| **HIV from mosquito bites** | 78.1% | 139 | 79.5% | 116 | 88.0% | 44 | 75.0% | 72 | 71.9% | 23 |
| **HIV from mother to baby during pregnancy** | 69.7% | 124 | 68.5% | 100 | 66.0% | 33 | 69.8% | 67 | 75.0% | 24 |
| **Total knowledge** | | | | | | | | | | |
| 8 out of 8 correct | 34.3% | 61 | 34.2% | 50 | 30.0% | 15 | 36.5% | 35 | 34.4% | 11 |
| 7 out of 8 correct | 37.6% | 67 | 42.5% | 62 | 44.0% | 22 | 41.7% | 40 | 15.6% | 5 |
| Less than 7 out of 8 correct | 28.1% | 50 | 23.3% | 34 | 26.0% | 13 | 21.9% | 21 | 50.0% | 16 |

**Figure 52. Proportion of OVC and caregivers across all programmes that report receiving healthcare in the last 6 months, by province**

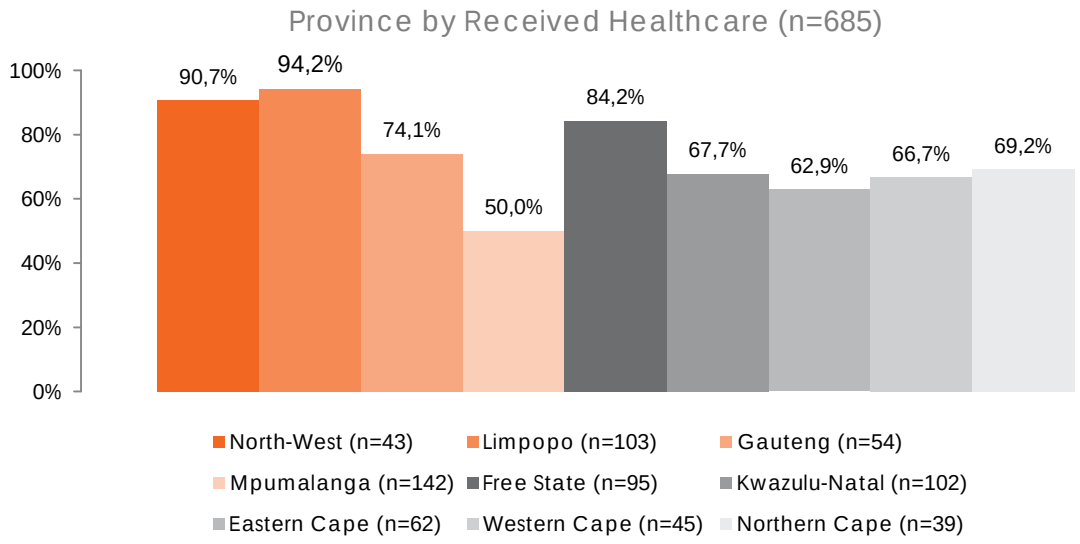
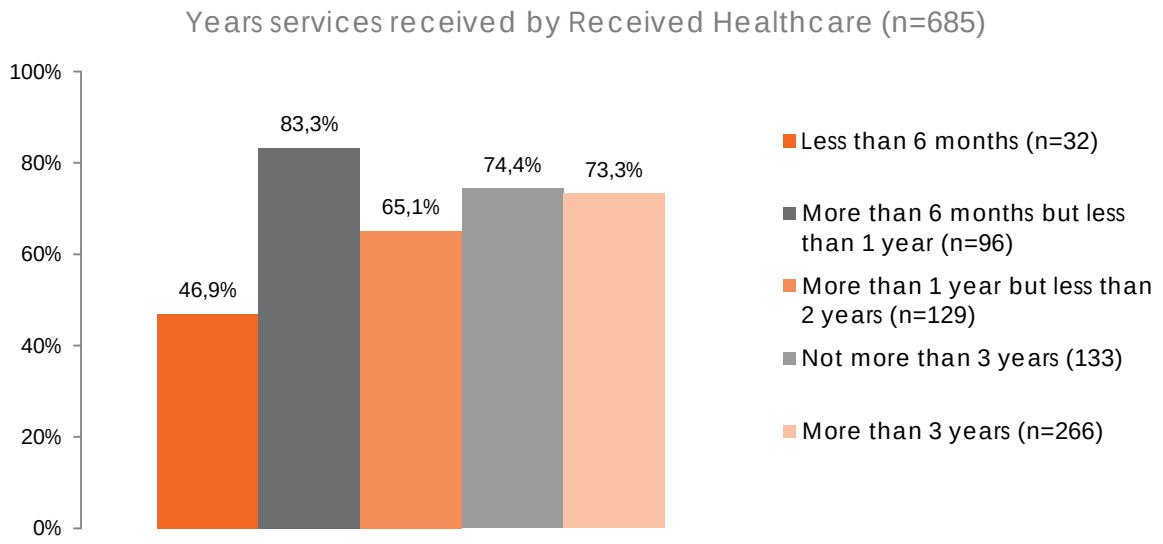



**Figure 53. Proportion of OVC and caregivers across all programmes that report receiving helathcare in the last 6 months, by time in OVC programme**



# APPENDIX B: CONSENT FORMS AND TOOLS

*[Included as an attachment to the report]*

# APPENDIX C: CASE STUDIES

*[Included as an attachment to the current report]*

# APPENDIX D: TERMINOLOGY

**Beneficiaries:** Community members who receive a service.

**Capacity building:** The creation of an enabling environment through skills transfer and the training and empowering of individuals and institutions. Capacity building is a conceptual approach to development that focuses on understanding the obstacles that inhibit people, governments, international organisations and non-governmental organisations from realising their developmental goals while enhancing the abilities that will allow them to achieve measurable and sustainable results.

**Caregiver:** A legal guardian, someone who is chosen to be a guardian either in a will or by a court, or a natural guardian (the biological parents) (Resource pack for care workers: NACOSA).

**Child:** Any person under the age of 18 years.

**Child and youth care worker:** A person who works in the life space of children and adolescents with both normal and special development needs to promote and facilitate optimum development through the planned use of everyday life events and programs to facilitate their ability to function effectively within different contexts (NRASD M&E Plan Report, 2013).

**Child-headed households:** Refers to a household where the parent, guardian or caregiver of the household is terminally ill, has died or abandoned the children in the household, or where no adult family member is available to care for the children in the household, or where a child over the age of 16 years has assumed the role of caregiver in respect of those children (Children's Act, No. 38 of 2005, as amended).

**Child care forum:** A collective of capacitated community members who identify orphans and other vulnerable children and their families and ensure their access to essential services (Revised Child Care Forum Guidelines, 2010).

**Chronic conditions:** A human health condition or disease that is persistent or otherwise long-lasting in its effects. The term chronic is usually applied when the course of the disease lasts for more than three months. Common chronic diseases include arthritis, asthma, cancer, COPD, diabetes and HIV/AIDS and requires comprehensive and coordinated long-term health care.

**Circles of support:** A group of committed men and women who are in a relationship with a person who is isolated and vulnerable by reason of disability, age, living arrangement, limited opportunities, or society's perception (PLAN Institute 2009).

**Community:** Refers to all people living in a specific place, such as a group of people found within a particular geographic area who see themselves as belonging to that place and relate to one another in some respect (Learning about Community Development, 2006).

**Essential services:** Core services to enhance growth and development of the child, including OVC, linked to the

children's Right Charter and the South African constitution.

**Exit strategy:** A planned approach to terminating a situation in a way that will maximize benefit and/or minimize damage.

**Faith-based organisations:** An organisation based on a particular religious ideology, has religiously oriented mission statements and often draws its activists (leaders, staff, volunteers) from a particular religious group.

**HIV Testing Services:** The full range of services that should be provided with HIV testing. These services include counselling; linkage to appropriate HIV prevention, treatment and care services and other clinical and support services; and coordination with laboratory services to support quality assurance and the delivery of correct results (National HIV Testing Services: Policy and Guildines 2015).

**Home and community-based care and support programme**: The provision of comprehensive and quality health and social services in the home and community to promote, restore and maintain a person's optimum level of comfort, social functioning and health.

**Individual Development Plan (IDP):** A document completed by a case worker i.e. Community Caregiver or Social worker for the plan of self-development of a client through carefully thought interventions over a period of time. This plan is then reviewed to see how many goals are fulfilled, what the new goals are and plans any changes in the life of a client. The IDP is developed and discussed with the client or the family's client (NRASD Standard Operating Procedure report).

**Material support:** The provision of support to needy children, directly to them or through their families in the form of basic needs such as blankets, clothes - including school uniforms, food parcels, building materials etc. (NRASD Standard Operating Procedure report).

**Memory work:** A deliberate process of engaging with the past and the present by setting up a safe space that offers the opportunity to assist people with the preparation for loss, bereavement and future. It opens opportunities for communication with the family, breaking the culture of silence relating to death and dying.

**Non-profit organisation (NPO):** A trust, company or other association of persons established for a public purpose and of which its income and property are not distributable to its members or office bearers except as reasonable compensation for services rendered. Nongovernmental organisations (NGOs) and community based organisations (CBOs) are collectively known as non-profit organisations (NPOs).

**Nutritional support:** The support given to people who are at risk of malnourishment. The aim is to offer them the privilege to maintain age-appropriate growth and good health.

**Orphan:** A child who has no surviving parents to care for him or her. Literature identifies two types of orphans, a 'single orphan' where one parent is deceased and a 'double orphan' where both parents are deceased (Children's Act).

**Orphans and Vulnerable Children (OVC):** A child, under the age of 18, whose survival, care, protection or development may be compromised due to a particular condition, situation or circumstance that prevents the fulfilment of his or her rights.

**Outcomes:** Overall outcomes are the state of the target population or the social conditions that the OVC programme expected to have changed in terms of issues described in situation analyses undertaken at the start during the period of implementation. Programme outcomes are the impacts or changes in the observed characteristics of the target population or social conditions, although not necessarily as a result of the programme.

**Outcome evaluation:** Outcome evaluations assess the effectiveness of a program in producing change. Outcome evaluations focus on difficult questions that ask what happened to program participants and how much of a difference the program made for them.

**Outputs:** Tangible results of the programme activities, such as funding or training provided.

**OVC carer:** The person who provides OVC in the community with support through their home and school concentrating on psycho-social, food and material support, school attendance and aid in dealing with acceptance of loss and grief for those infected and affected by illness.

**Primary caregiver:** Any person caring for a child other than a parent or guardian e.g. foster parent, temporal safety parent, a person at the head of a child and youth care centre, head of a child-headed family etc. (NRASD Standard Operating Procedure report).

**Psychosocial support:** Psychosocial refers to the dynamic relationship between psychological and social effects, where the one continually interacts with and influences the other. Psychosocial support services provide support and counselling to restore the normal functioning of individuals and families by enhancing their mental, social, spiritual and emotional wellbeing (Mainstreaming Psychosocial Care and Support into Home Based Care Programmes—REPSSI, 2009)

**Referral:** The process of directing a person to an additional source of help or information. In-referrals are received from somewhere else such as a social worker or a clinic. Out-referrals are from, for example, care worker to a social worker, clinic or some other agency. Ideally organisations should have a list of referral centres so that in the event of them needing to make a referral, they can give names, addresses and telephone numbers to beneficiaries and make follow-up.

**Service providers:** Organisations rendering OVC services.

**Sustainability:** The continued effectiveness of a programme or project over the medium- to long-term (Reducing 'Human Cost' of Caring—South African Red Cross Society, 2007).

**Vulnerable groups:** Vulnerable groups are groups in the community that are at risk of not having their needs met due to inadequate or inaccessible resources and, as a result, are susceptible to deprivation or relative deprivation (New Dictionary of Social Work, 1995).

NETWORKING HIV/AIDS COMMUNITY OF SOUTH AFRICA – NACOSA

3rd Floor, East Tower | Century Boulevard | Century City | Cape Town

t. 021 552 0804 | f. 021 552 7742 | e. info@nacosa.org.za

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