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**AN OUTCOME EVALUATION OF PSYCHOSOCIAL SERVICES  
PROVIDED TO ORPHANS AND VULNERABLE CHILDREN IN THE  
WESTERN CAPE**

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## Table of Contents

List of Acronyms and Abbreviations .....	4
List of Tables.....	4
<b>Executive Summary .....</b>	<b>5</b>
<b>Chapter 1: Background and Rationale for the Evaluation .....</b>	<b>8</b>
1.1 Policy and Legislative Environment .....	8
1.2 The Location of OVC Services within DSD .....	9
1.2.1 The Service delivery context.....	9
1.3 Introduction to the Concept of Orphans and Vulnerable Children .....	10
1.3.1 Defining Orphanhood .....	10
1.3.2 Defining Vulnerability .....	11
1.4 Defining Psychosocial Support Services.....	13
1.5 Measuring Psychosocial Wellbeing.....	16
<b>Chapter 2: Description of the Psychosocial Support Programme Intervention .....</b>	<b>17</b>
2.1 The Implementing Organisations .....	17
2.2 Programme Aims .....	18
2.3 Target Population .....	18
2.4 Programme Delivery and Activities .....	19
2.5 Training of Programme Facilitators .....	21
<b>Chapter 3: Evaluation Plan and Methodology .....</b>	<b>21</b>
3.1 Evaluation Aims and Objectives .....	21
3.2 Evaluation Design .....	21
3.3 Data Collection and Research Sample .....	22
3.3.1 Access points .....	22
3.3.2 Population and sample selection .....	23
3.4 Instrument Design .....	24
3.5 Data Analysis.....	24
3.6 Ethical Considerations .....	25
3.7 Methodological Limitations.....	25
<b>Chapter 4: Findings and Discussion .....</b>	<b>26</b>
4.1 Stories of Significant Change.....	26

4.2 Programme Outcomes.....	27
4.3 Programme Implementation and Process Factors.....	31
4.3.1 Enabling and inhibiting factors for implementation.....	31
<b>Chapter 5: Recommendations .....</b>	<b>37</b>
Conclusion.....	40
<b>References .....</b>	<b>41</b>
<b>Report Annexes.....</b>	<b>43</b>
Annexure I: Participant Consent and Information Sheet.....	43
Annexure II: Facilitator Interview Schedule.....	45
Annexure III: Semi-Structured Interview Guide for beneficiaries.....	48
Annexure IV: Interview Schedule for Parents/Caregivers of OVC.....	52

## List of Acronyms and Abbreviations

<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>CBO</b>	Community-Based Organisation
<b>CHH</b>	Child-Headed Households
<b>DSD</b>	Department of Social Development
<b>ECD</b>	Early Childhood Development
<b>HIV</b>	Human Immunodeficiency Virus
<b>MRC</b>	Medical Research Council
<b>NPA</b>	National Plan of Action
<b>OVC</b>	Orphan and Vulnerable Children
<b>PSS</b>	Psychosocial Support Services
<b>SDRs</b>	Service Delivery Regions
<b>SSI</b>	Semi-Structured Interviews
<b>STIs</b>	Sexually Transmitted Infections
<b>TPAs</b>	Transfer Payment Agreements

## List of Tables

<b>Table 1:</b> Organisations funded by DSD to provide psychosocial support services to OVC..	10
<b>Table 2:</b> Key programmes of CBOs sampled for the evaluation .....	17
<b>Table 3:</b> Programme structure - session topics and objectives .....	20
<b>Table 4:</b> Sample of organisations selected per service delivery region .....	22
<b>Table 5:</b> Sample size selection and data collection technique .....	24

## Executive Summary

DSD is the lead sectorial department that responds to issues affecting OVCs. As such, the Children and Families Directorate within the department funds a number of CBOs who are tasked with implementing the psychosocial support programme for OVC. The target population for the programme are orphaned and vulnerable children or bereaved children between the ages of 7-18 years, who have suffered grief and loss. The programme runs for 10 weeks and is implemented with a group of 10 children on a weekly basis for approximately 1-2hours. The facilitators have received training from an organisation called Khululeka, on running loss and grief support groups. The CBOs are using the Khululeka Khu Kit manual as a guide to assist the facilitators in running these support groups.

### Key Aspects of the Evaluation Approach and Methodology

The evaluation was conducted to assess the outcomes of the PSS programme and its effectiveness in meeting the needs of OVC in the province. The evaluation also looked at how the programme improved the wellbeing of OVC, specifically focussing on those who attended the programme in 2011-2012 to ensure that these children would be 18 or older at the time of the research. Nine organisations were selected across Social Development's Service Delivery Regions in the Western Cape, in consultation with the Children and Families Directorate. The evaluation was conducted using a qualitative approach, drawing on SSIs with OVCs who attended the programme as well as their parent(s)/caregiver(s), and facilitators from the implementing organisation.

### Principle Findings, Conclusions and Recommendations

The main findings of the evaluation were:

#### Programme outcomes

1. **Improved confidence and self-esteem** in beneficiaries who participated in the PSS programme.
2. **Improved emotional coping and acceptance of losses** as OVC reported that the programme has helped them to deal with their losses and to work through the grieving process. Facilitators reported that the children tend to be happier through participation in the programme.
3. Facilitators reported that many of the children are very angry and violent when they start the programme, as they have difficulty coping with their loss and grief. By participating in the programme they are **able to use appropriate coping mechanisms and have improved social relations with their peers.**

4. **The support group provides a support structure in the lives of these OVCs** who often have not had the opportunity or platform to speak about their losses or their grief.
5. **Association with positive peer groups** as all of the male beneficiaries reported that the programme either helped them stay away from gangsterism and drugs. Or the programme resulted in them disassociating with peer groups where gangsterism and drugs were involved.
6. **Improved relationships with parents and caregivers** as some of the beneficiaries reported that their relationship with their parent/caregiver was strained before attending the programme, but improved as a result of attending the programme.
7. **Improvement in school results and attendance** was reported by the beneficiaries and the facilitators. Facilitators received feedback from the schools about the improvement in school performance of those children who attended the programme. Beneficiaries reported that they were more focussed at school and more motivated to complete their schooling.

#### Programme factors affecting implementation

1. All of the facilitators found that **there are too many activities that need to be completed in each session**, as a result the allocated 1-2 hours for the session is often not enough.
2. Both the facilitators and the children felt that **the duration of the programme is too short and the 10 week period needs to be extended**. Facilitators felt this was especially needed in cases of complicated grief where the child needs more assistance and where not much change has been seen.
3. Facilitators often **experience difficulty with adapting the content and some of the activities in the manual for younger children**, as the children often struggle to understand what is happening in the support group.
4. It seems as though there is **not enough parental/caregiver involvement in the programme** as almost all of the parents/caregivers interviewed were not quite sure or aware of what is done in the programme, and only two of the beneficiaries mentioned that they spoke to their parents about the programme.

**Recommendation 1:** Regular follow-ups should be done by DSD regarding the training needs of facilitators as there are some facilitators running psychosocial support groups who have not had the opportunity to attend the psychosocial support training.

**Recommendation 2:** Refresher training should be provided as some of the facilitators have been with the organisation for a long period of time. There is also a need for training in basic counselling skills and first aid training as the facilitators are working with children.

**Recommendation 3:** The current programme manual needs to be adapted so that it is more age appropriate for younger children. Alternatively, technical guidance should be provided or further facilitator training on working with younger children and presenting information in an age appropriate manner.

**Recommendation 4:** Caregiver/parental involvement in the programme needs to be incorporated as well. This could be done by home visits where an information sheet describing the programme or outline of the programme could be provided.

**Recommendation 5:** Intervention efforts should also be targeted at parents/caregivers, as the psychological wellbeing of the child is dependent on and affected by the wellbeing of their guardian. Currently, these organisations are only able to run adult support groups once a month due to financial and funding restraints.

## Chapter 1: Background and Rationale for the Evaluation

The Department of Social Development (DSD) has been identified as the lead sectorial department to respond to issues affecting orphans and other vulnerable children (OVC)<sup>1</sup>. Accordingly, the DSD's Children and Families Directorate in the Western Cape funds a number of organisations commissioned with the task of providing psychosocial support services (PSS) to OVC who are experiencing loss and grief, as well as support services that enable them to function fully in society.

This research project was conducted in response to a request from the Children and Families Directorate to conduct an evaluation, reviewing the effectiveness of these PSS services in meeting the needs of OVC in the province. The findings of this evaluation will be used to assess the extent to which the PSS programme is making a difference and the results the programme has achieved in 2011-2012. The evaluation will focus on these years so as to ensure that children would be 18 or older at the time of the research. This age category would reduce problems with consent to participate for minors. The results of the evaluation will also be used to improve the PSS programme for future implementation.

### 1.1 Policy and Legislative Environment

Many children are living in poverty-stricken AIDS-affected communities, or with a chronically ill parent, in a household that is taking care of orphans due to AIDS, or who are affected by AIDS in other ways<sup>2</sup>. In response to this crisis a National Plan of Action (NPA) was developed in support of orphans and children made vulnerable by AIDS and other circumstances. The strategic goals of the NPA to children affected by HIV and AIDS are:

- Strategy 1: Strengthen and support the capacity of families to protect and care for OVC.
- Strategy 2: Mobilise and strengthen community-based responses for the care, support and protection of OVC.
- Strategy 3: Ensure that legislation, policy, strategies and programmes are in place to protect the most vulnerable children.
- Strategy 4: Ensure access of OVC to essential services.
- Strategy 5: Raise awareness and advocate for the creation of a supportive environment for OVC.
- Strategy 6: Strengthen mechanisms to drive and support the implementation of the NPA.

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<sup>1</sup> National Action Plan for Orphans and Other Children Made Vulnerable by HIV and AIDS South Africa (2009-2012)

<sup>2</sup> Campbell, Moroni & Webb (2008)



However, the major difficulty of the NPA is that it does not provide an operational definition of a vulnerable child. South Africa does however have a number of policies to address the situation of vulnerable children. These include<sup>3</sup>:

1. Integrated Management of Childhood Diseases
2. National Integrated Plan for Children Infected and Affected by HIV/AIDS
3. National Strategic Framework for HIV/AIDS and STIs 2000-2005
4. Guidelines for the Management of HIV Infected children 2005
5. Policy Framework for Orphans and Other Children Made Vulnerable by HIV and AIDS 2005
6. The Children's Act

These policies all address the situation of vulnerable children. While the following policies specifically address the situation of children affected by HIV/AIDS<sup>4</sup>:

7. Education White Paper
8. Integrated Plan for Early Childhood Development (ECD) in South Africa 2005-2010

The Integrated plan for ECD in South Africa 2005-2010 specifically highlights the provision of services to children (0-6years) in families and communities affected by HIV/AIDS. The Children's Act only makes reference to child-headed households and not to orphans or vulnerable children<sup>5</sup>. Also, it seems as though psychosocial health is currently not a policy priority, as no policy guidelines are provided for psychosocial programming within these policies.

As such, it appears as though there are still gaps in the Policies that need to be addressed in order to sufficiently address the plight of OVC.

## **1.2 The Location of OVC Services within DSD**

### **1.2.1 The Service delivery context**

In the 2014-2015 financial year, 38 organisations were receiving funding from DSD to provide PSS services. As indicated in the Transfer Payment Agreements (TPAs) with these organisations, PSS services typically include interventions such as individual and group therapy. The number of organisations providing PSS services is spread across Social Development's Service Delivery Regions (SDRs) as shown in Table 1.

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<sup>3</sup> Dawes, Bray & van der Merwe (2007b)

<sup>4</sup> Dawes, Bray & van der Merwe (2007b)

<sup>5</sup> Dawes, Bray & van der Merwe (2007b)

**Table 1: Organisations funded by DSD to provide psychosocial support services to OVC<sup>6</sup>**

SDR:	West Coast Region	Metro North	Metro South	Metro East	Winelands Overberg Region	Eden Karoo Region	Across SDR Boundary	Total number of DSD funded organisations
<b>Number of DSD funded organisations</b>	3	7	8	6	5	8	1	<b>38</b>

## 1.3 Introduction to the Concept of Orphans and Vulnerable Children

### 1.3.1 Defining Orphanhood

Orphans refer to children under the age of 18 whose parents - either father or mother, or both, have died and consequently have no surviving parent to care for him or her. Orphans are defined in three mutually exclusive categories<sup>7</sup>:

- A maternal orphan is a child whose mother has died but whose father is still alive.
- A paternal orphan is a child whose father has died but whose mother is alive.
- A double orphan is a child whose mother and father have both died.

The definition of orphanhood does however not reflect the importance of multiple caregiving arrangements, extended family, abandonment and wider familial losses due to HIV/AIDS in South Africa<sup>8</sup>.

#### 1.3.1.1 The proportion of orphans living in South Africa

In 2012, there were approximately 3.54 million orphans in South Africa. This includes children without a living biological mother, father or both parents, and is equivalent to 19% of all children in South Africa. Since 2002, the total number of orphans has increased by 19% with 560,000 more orphaned children in 2012 than in 2002. The vast majority (around 60%) of all orphans in South Africa are paternal orphans with living mothers<sup>9</sup>.

Provincially, the lowest number of orphaned children lives in the Western Cape. According to the South African Child Gauge, in 2014, 24,000 children in the province were maternal orphans. A further 115,000 were paternal orphans, and 24,000 children are double orphans<sup>10</sup>.

<sup>6</sup> As of the 2014-2015 financial year

<sup>7</sup> Campbell, Moroni & Webb (2008); National Action Plan for Orphans and Other Children Made Vulnerable by HIV and AIDS South Africa (2009-2012)

<sup>8</sup> Cluver & Gardner (2007)

<sup>9</sup> Matthews, Jamieson, Lake & Smith (2014)

<sup>10</sup> Matthews, Jamieson, Lake & Smith (2014)

### 1.3.2 Defining Vulnerability

The vulnerable child can be defined as being under 18 years of age and at high risk of lacking adequate care and protection. Vulnerability also refers to a child whose survival, care, protection or development may be compromised due to the particular condition, situation or circumstance which prevents the fulfilment of his or her rights<sup>11</sup>. Vulnerable children can be defined as<sup>12</sup>:

- A child made vulnerable by HIV/AIDS.
- A child who has a chronically ill parent - regardless of whether the parent lives in the same household as the child.
- The child who lives in a household where in the past 12 months at least one adult died and was sick for three of the 12 months before s/he died.
- A child living in a household where there is at least one adult who was seriously ill for at least three months in the past 12 months.
- Very poor children.
- Children experiencing malnourishment.
- Children who live outside of family care such as an institution, or children who live on the streets.
- Children with learning or mental disabilities.
- Trafficked children.
- Abused, neglected and abandoned children.

#### 1.3.2.1 Children made vulnerable by HIV/AIDS<sup>13</sup>

Children made vulnerable by HIV/AIDs include:

- Children rendered vulnerable by the epidemic, but who are not orphans e.g. those living with ill caregivers.
- Children who are themselves infected with HIV/AIDS.
- Children excluded from school because of stigma or inability to afford school fees because of loss of income due to HIV/AIDS infection in the household<sup>14</sup>.

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<sup>11</sup> Save the Children UK (2006); Campbell, Moroni & Webb (2008)

<sup>12</sup> Campbell, Moroni & Webb (2008); Dawes, Bray & van der Merwe (2007); Save the Children UK (2006)

<sup>13</sup> Dawes, Bray & van der Merwe (2007a); Byline et al. (n.d)

<sup>14</sup> Dawes, Bray & van der Merwe (2007a); Byline et al. (n.d)

## **The impact of HIV/AIDS on children**

The HIV/AIDS pandemic has disrupted family, community and social structures, and has led to a marked increase in the number of OVC. It was found that children orphaned due to AIDS and those living with HIV-positive caregivers experience more psychological distress than children who have parents, or children who are orphaned due to other causes, or children living with caregivers who have other chronic illnesses<sup>15</sup>.

Children are often made extremely vulnerable through circumstances such as HIV when parents die as a result of AIDS. Other relatives, particularly grandmothers and older siblings, often take on the role of caregivers of children. In some situations children themselves become heads of households, taking care of younger family members<sup>16</sup>.

### **1.3.2.2 Social vulnerability due to child-headed households**

Child-headed households (CHH) are defined as those under the care and supervision of a person below 18 years of age. It also includes households headed by children with adults who are either very old or too sick to be responsible for the household. CHH are further defined as households where the child has assumed the role of primary caregiver in respect of a child or children in the household, in terms of providing food, clothing and psychosocial support<sup>17</sup>.

When a parent dies, older children may be expected to take up paid employment and care for younger siblings<sup>18</sup>. However, children in CHH tend to be more vulnerable as they may encounter challenges such as failure to access social services, inability to generate resources, and unresolved grief<sup>19</sup>.

Traditionally orphans were absorbed by members of the extended family, but at times this safety net does not work as well and many children are left to fend for themselves. According to the Children's Act, CHH should be supported by an adult mentor who will act in the children and young people's best interest. Therefore CHH may be recognised legally as a placement option for orphaned children, with suitable support from a 'supervisory adult' who may arrange assistance - including access to financial grants on behalf of the child or children<sup>20</sup>.

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<sup>15</sup> Save the Children UK (2006)

<sup>16</sup> Save the Children UK (2006)

<sup>17</sup> Mturi (2012)

<sup>18</sup> Byline et al (n.d); Cluver, Gardner & Operario (2009)

<sup>19</sup> Mturi (2012)

<sup>20</sup> Mturi (2012)

### **1.3.2.3 Vulnerability due to other causes:**

Significant numbers of children are likely to be orphaned or made vulnerable by other causes that are not AIDS-related, such as motor vehicle accidents; or they may live in households with carers who are ill but who do not have HIV/AIDS<sup>21</sup>. A mortality profile for the Western Cape was developed by the MRC in 2012. According to this report, the top four leading causes of death in the Western Cape are heart disease, followed by HIV/AIDS, cerebrovascular disease, and interpersonal violence<sup>22</sup>.

In the South African context the majority of children are rendered vulnerable by poverty and its associated challenges to child development and outcomes. Most children, particularly in poor communities, are also affected by domestic and community violence. Thus, poverty and violence are the two key features of vulnerability<sup>23</sup>.

There are also multi-risk communities in which the impact of high levels of poverty and living in a community with high HIV prevalence are combined. These multi-risk communities present the greatest threats and challenges to children's well-being, as their outcomes are most likely to be detrimentally affected where there are multiple risks to development and functioning. Additionally, cumulatively and over time these multiple risks will undermine children's well-being<sup>24</sup>.

## **1.4 Defining Psychosocial Support Services**

The family institution, in which parents play essential leadership roles, caters for the emotional, spiritual and material needs of children<sup>25</sup>. Thus the loss of one's parent/s makes a child vulnerable to psychological distress. It is known that the experience of bereavement can be severely emotional for young children and can affect the psychological and physical development of a child<sup>26</sup>

Young children are the most vulnerable over the long-term as their bodies, brains, social relations and self-confidence develop rapidly during early childhood. Any interruptions and delays in young children's developmental potential are difficult to recover in later years, especially when children continue to live under difficult conditions<sup>27</sup>.

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<sup>21</sup> Dawes, Bray & van der Merwe (2007a)

<sup>22</sup> Groenewald et al (2015)

<sup>23</sup> Dawes, Bray & van der Merwe (2007a)

<sup>24</sup> Dawes, Bray & van der Merwe (2007a)

<sup>25</sup> Onuoha & Munaka (2010)

<sup>26</sup> Byline et al (n.d)

<sup>27</sup> Byline et al (n.d)

It has however been observed that many programmes for orphans and vulnerable children focus on the material needs of children, and less upon the non-material needs such as psychosocial support and protection<sup>28</sup>. Psychosocial support describes a continuum of care and support and aims at ensuring the social, emotional and psychological wellbeing of individuals, their families and communities. The provision of psychosocial support services may be preventative or curative in nature<sup>29</sup>.

Psychosocial support may include a range of actions such as<sup>30</sup>:

- Love and affirmation.
- Ensuring that the child's basic rights are realized (for example protection, nutrition, development, health care, and participation).
- Listening and responding to the child in order to assist him or her to cope in times of difficulties such as coping with loss or exposure to frightening experiences.
- Ensuring that the child is well connected socially to others.
- Strengthening the life-skills of the child.

Psychosocial support helps vulnerable children and their caregivers to cope with the mental and emotional challenges related to the death of their parents or loved ones. When a psychosocial intervention is successful, it brings back control and confidence in the lives of those affected. This results in increased social, physical and psychological well-being. Psychosocial interventions also bring positive change for children regarding their skills and knowledge, emotional and social wellbeing. The extent and quality of the psychosocial services being provided therefore needs to be monitored and evaluated systematically, as this will provide a contextual understanding of the situation of OVC and will contribute to better policies and programme development<sup>31</sup>.

#### **1.4.1 Risk and protective factors for children's psychosocial wellbeing**

Children orphaned by HIV/AIDS experience heightened psychological distress compared to other children and are more likely to experience psychological problems such as depression, peer problems, post-traumatic stress and conduct problems. HIV/AIDS coupled with other stressors such as poverty, single parenthood and high levels of exposure to violence can be additional stressors on children's psychological wellbeing<sup>32</sup>.

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<sup>28</sup> Onuoha & Munaka (2010)

<sup>29</sup> Department of Social Development; Onuoha & Munaka (2010)

<sup>30</sup> Department of Social Development

<sup>31</sup> Dawes, Bray & van der Merwe (2007b)

<sup>32</sup> Cluver, Gardner & Operario (2009)

The literature reviewed has identified both risk and protective factors related to the psychological health of orphans and vulnerable children. Psychological risk factors refer to variables that increase the likelihood of psychological difficulties for the child. Protective factors are variables which improve outcomes despite environmental hazards<sup>33</sup>. Literature reviewed has identified the following common risk and protective factors<sup>34</sup>:

Risk Factors <sup>35</sup>	Protective Factors <sup>36</sup>
<ul style="list-style-type: none"> <li>❖ Poverty (<i>i.e. lack of food, unemployment, household overcrowding, concerns around clothes i.e. lack of school shoes and uniforms</i>)</li> <li>❖ Caregiver illness e.g. witnessing and caring for a parent dying of AIDS</li> <li>❖ Multiple bereavement</li> <li>❖ Affordability of school fees</li> <li>❖ Domestic and community violence</li> <li>❖ Alcohol abuse</li> <li>❖ Lack of medical care</li> </ul>	<ul style="list-style-type: none"> <li>❖ Food security</li> <li>❖ Access to school and educational assistance</li> <li>❖ Having boundaries and discipline</li> <li>❖ Services such as social workers</li> <li>❖ Access to social welfare grants</li> <li>❖ Employment in the household</li> <li>❖ Supportive friends and socialising with friends also seen as a source of comfort</li> </ul>

#### **1.4.2 The importance of psychosocial support services for caregivers of OVC**

Caregivers of OVC are themselves vulnerable in terms of poverty, burden of care and mental health problems, especially depression<sup>37</sup>. Extended families are often already stretched by existing loads of caregiving, poverty and other social problems. Relatives who accept orphans are often elderly and/or poor, and therefore in need of support themselves. Caregivers may also experience stress from the psychological needs of OVC, and their health and wellbeing may be overlooked<sup>38</sup>. As caregivers often face their own challenges, it is difficult to provide adequate support to OVC without also supporting their caregivers<sup>39</sup>. Thus, there is a need to enhance the psychosocial

<sup>33</sup> Kasese-Hara, Nduna, Ndebele & Pillay (2012)

<sup>34</sup> Cluver, Gardner & Operario (2009); Kasese-Hara, Nduna, Ndebele & Pillay (2012)

<sup>35</sup> Cluver & Gardner (2007); Cluver, Gardner & Operario (2009)

<sup>36</sup> Cluver & Gardner (2007); Cluver, Gardner & Operario (2009)

<sup>37</sup> Kasese-Hara, Nduna, Ndebele & Pillay (2012)

<sup>38</sup> Kasese-Hara, Nduna, Ndebele & Pillay (2012)

<sup>39</sup> Thurman, Jarobi & Rice (2012)

wellbeing and caring capacity of OVC guardians. By attending to the needs of caregivers a more nurturing environment can be fostered for children's development<sup>40</sup>.

It was found that caregivers' membership in a support group has an effect on their psychological wellbeing, which in turn has an effect on the treatment and psychological wellbeing of children under their care. The effects of support group membership include better family functioning, lower perceptions of the child as a burden and therefore more positive feelings towards the children in their care, and children with caregivers in support groups have fewer behavioural problems<sup>41</sup>.

This highlights the importance of providing support to caregivers as the quality of care of vulnerable children hinges on interventions that address the psychosocial challenges experienced by their caregivers. As guardians' circumstances and experiences have implications for the welfare of OVC, any efforts aimed at improving the life of OVC must acknowledge their guardians<sup>42</sup>.

### 1.5 Measuring Psychosocial Wellbeing

Psychological wellbeing is a multifaceted construct and various definitions and multiple measures have been proposed. The most commonly used themes for measuring psychosocial wellbeing include a range of the following outcome level indicators:

- School progress or improvement
- HIV medication adherence
- The child engages in cooperative and kind behaviours e.g. considerate of other's feelings
- Emotional symptoms e.g. seems happy
- The child interacts with family and peers
- Peer relationships e.g. interaction with other children as opposed to preference for being alone
- Self-acceptance

Although these indicators do not directly measure psychological wellbeing, they can be used as proxy measures for assessing the wellbeing of orphans and vulnerable children<sup>43</sup>

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<sup>40</sup> Thurman, Jarabi & Rice (2012)

<sup>41</sup> Thurman, Jarabi & Rice (2012)

<sup>42</sup> Kasese-Hara, Nduna, Ndebele & Pillay (2012); Thurman, Jarabi & Rice (2012)

<sup>43</sup> Senefeld et al. (2011); Thurman, Jarabi & Rice (2012); Tsang, Wong & Lo (2012)



## Chapter 2: Description of the Psychosocial Support Programme Intervention

### 2.1 The Implementing Organisations

The psychosocial programme is implemented by Community Based Organisations (CBOs) who are funded by DSD. A sample of nine organisations was selected for this evaluation. These organisations are based across the Social Development Service Delivery Regions, both within and outside of the Metro. DSD funds these organisations for the following programmes:

- **PSS Programme for OVC**
- **Adult Support Groups**

In addition to these programmes these selected organisations are also implementing the following programmes:

**Table 2: Key programmes of CBOs sampled for the evaluation**

	CBO1	CBO2	CBO3	CBO4	CBO5	CBO6	CBO7	CBO8	CBO9
<b>Aftercare programme</b>	X		X	X		X			
<b>Youth programme (access to PCs, assistance with CVs)</b>	X	X			X				X
<b>Loss &amp; Grief Programme at Schools<sup>44</sup></b>			X						
<b>I Protect Me Programme</b>			X						
<b>Lifeskills Programme</b>			X						
<b>Income generating activities (beading &amp; sewing)</b>						X			
<b>Home visits</b>		X	X			X			
<b>Food parcels</b>		X				X			
<b>Food garden</b>					X	X			
<b>Soup Kitchen</b>							X		
<b>Mass Opportunity Development Centres<sup>45</sup></b>	X								
<b>Family Community Motivators<sup>46</sup></b>	X								
<b>Family Support Group<sup>47</sup></b>		X							
<b>Chronic Disease Lifestyle Programme</b>				X					
<b>TB Dots Programme</b>							X		
<b>Lifestyle Modification Programme</b>				X					
<b>Home-based Care</b>				X					
<b>Counsellors Project <sup>48</sup></b>							X		
<b>Elder Programme</b>									X

<sup>44</sup> The loss and grief programme is presented in addition to the PSS OVC programme and are therefore two separate programmes

<sup>45</sup> Feeding scheme programme

<sup>46</sup> Programme that focuses on early development childhood

<sup>47</sup> Programme for parenting skills and fatherhood training

<sup>48</sup> Counsellors are placed at clinics in the 6 different towns

## 2.2 Programme Aims

The PSS programme focuses mainly on assisting children who are struggling with loss and grief, and to help them work through their losses in order to accept them and to become more resilient.

The programme not only deals with loss in death, but also incorporates trauma and other types of losses especially when taking the South African context into consideration and the increasing number of refugees. The programme therefore also deals with other personal losses such as losing your home, family and divorce.

***“The programme mostly deals with loss and grief. We don’t want the children to feel as if the loss was their fault. We want them to make peace with the loss they experienced and be able to move forward.”***

***[PSS support group facilitator]***

The purpose of the psychosocial support group is to help children feel that they belong in a peer group, where others have had similar experiences.

## 2.3 Target Population

The beneficiaries targeted for the PSS programme are orphaned and/or vulnerable children or bereaved children who have suffered grief and loss. The programme is implemented with both primary and high school children between the ages of 7-18 years.

Children are referred to the programme by the different schools the organisation has developed a network with, or by parents, and by other organisations where a relationship has been established. Referrals are also made by door-to-door visits in the community done by the facilitators, attending community meetings to raise awareness of the organisation and its programmes, holding information and awareness raising talks in the waiting area of the community clinic, and through the adult support group and other programmes the organisation is running.

## 2.4 Programme Delivery and Activities

The PSS programme is implemented over a period of three months (i.e. one school quarter). Each support group has 10 members per quarter and some organisations are running one PSS support group while others are running two – each in a different area. A total of 10 sessions are presented with one session occurring each week. Each of the sessions is approximately 1-2hours.

The programme is implemented using the Khululeka Khu Kit<sup>49</sup>, which is a manual designed to assist facilitators working with bereaved children to help them understand grief and loss, and to provide support to these children<sup>50</sup>.

The Khu Kit provides a comprehensive overview of the impact of age and developmental stage on understanding and processing grief, with tips on appropriate helpful resources. It also highlights common causes of premature death in South Africa and how to explain these in an age appropriate way<sup>51</sup>.

The Khu Kit manual is used together with the book 'Someone I love died<sup>52</sup>,' - which contains stories about loss and grief, and pain. This is a storybook for children about children in a grief and loss support group. As children read about other children's losses they learn to open up about their own<sup>53</sup>.

A detailed description of the session topics and objectives for the PSS programme is presented in Table 3.

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<sup>49</sup> The Khu Kit: A resource for people working with bereaved children

<sup>50</sup> [www.khululeka.org](http://www.khululeka.org)

<sup>51</sup> [www.khululeka.org](http://www.khululeka.org)

<sup>52</sup> Someone I love died: A book to help young people deal with death

<sup>53</sup> [www.khululeka.org](http://www.khululeka.org)

**Table 3: Programme structure - session topics and objectives**

Session	Topic	Session Objectives	Activities
<b>Session 1:</b>	Building Trust	<ul style="list-style-type: none"> <li>• Build trust</li> <li>• Getting to know one another</li> <li>• Agree on safety agreements</li> <li>• Identify and clarify expectations</li> </ul>	<ul style="list-style-type: none"> <li>• 1 trust game</li> <li>• 1 team building game</li> <li>• 1 icebreaker</li> <li>• Reading 2 stories from Someone I Love Died</li> </ul>
<b>Session 2:</b>	Context of Each Members Loss	<ul style="list-style-type: none"> <li>• For children to tell their own stories of grief and loss</li> </ul>	<ul style="list-style-type: none"> <li>• 2 activities</li> <li>• 1 icebreaker</li> <li>• 1 trust/team building activity</li> </ul>
<b>Session 3:</b>	Naming the feelings associated with loss	<ul style="list-style-type: none"> <li>• Move from children's stories of grief to how they feel about their stories, and how they feel about what happened to them</li> </ul>	<ul style="list-style-type: none"> <li>• Happy Song of Grief</li> <li>• Whirlpool of grief</li> <li>• Total Truth Process</li> <li>• Feelings wheel</li> </ul>
<b>Session 4:</b>			
<b>Session 5:</b>	Rituals and Traditions	<ul style="list-style-type: none"> <li>• Talking about death and saying goodbye</li> <li>• How different cultures and faiths use rituals and traditions to talk about death and saying goodbye</li> <li>• Help children think about what death is, what does it mean and how they make sense of it for themselves, and what do they believe about death</li> </ul>	<ul style="list-style-type: none"> <li>• Puppet show</li> <li>• Role play/drama</li> <li>• Making a gift for the person lost</li> <li>• Story: Waterbugs &amp; dragonflies</li> <li>• Story from Someone I Love Died</li> </ul>
<b>Session 6:</b>	Now	<ul style="list-style-type: none"> <li>• How children are experiencing their grief and reality at the moment</li> <li>• Remember and honour the person who had passed away</li> <li>• Identify children who are suffering from complicated grief and are in need of referral</li> </ul>	<ul style="list-style-type: none"> <li>• 'Imaginary/real fear' activity</li> <li>• Before and After Picture</li> <li>• Memory box</li> <li>• Freedom birds/letter</li> <li>• Story: Elephant's parting gifts</li> </ul>
<b>Session 7:</b>	Developing internal coping skills	<ul style="list-style-type: none"> <li>• Identify positive and negative coping behaviour and coping mechanisms</li> <li>• What to do and where to go with emotions, feelings and fears</li> <li>• Identify the coping behaviour and mechanisms that have been used up to now, and whether they worked</li> <li>• Identify what could be done differently</li> </ul>	<ul style="list-style-type: none"> <li>• Story from Someone I Love Died</li> <li>• Activities and questions to ask addressing some of the difficult and challenging feelings children might be dealing with in the support group</li> </ul>
<b>Session 8:</b>	External Coping	<ul style="list-style-type: none"> <li>• Identify available external coping resources</li> <li>• Help children some life skills, how to get help and where they could go to get help</li> </ul>	<ul style="list-style-type: none"> <li>• The Trust Bus</li> <li>• Stories from Someone I Love Died</li> </ul>
<b>Session 9:</b>	Looking to the Future	<ul style="list-style-type: none"> <li>• Identify hopes and dreams and help children see a way to move forward through the hurt</li> </ul>	<ul style="list-style-type: none"> <li>• Writing own poems/song/rap to themselves on what they want to see in the future – their goals etc</li> </ul>
<b>Session 10:</b>	Closure	<ul style="list-style-type: none"> <li>• Say goodbye and coping with loss as part of life</li> <li>• Give an overview of the past ten session journey</li> </ul>	<ul style="list-style-type: none"> <li>• Perform or present previous week's poem/song</li> </ul>

## **2.5 Training of Programme Facilitators**

The PSS support group programme is run by a facilitator and co-facilitator. All of the facilitators attend a four day training workshop conducted by an organisation called Khululeka, who are the programme developers. This training workshop is based on the content in the Khu Kit manual.

Through this training the facilitators are able to reflect on their own grief histories and processes. The training also covers the developmental stages and how to relate the concept of death, grief response and the suitable way to provide support in an age appropriate way. The training also equips the facilitators with the tools and knowledge on how to plan and facilitate a grief and loss support group for bereaved children, offering a range of activities and stories to approach particular topics and emotions.

## **Chapter 3: Evaluation Plan and Methodology**

### **3.1 Evaluation Aims and Objectives**

The key aims and objectives of the evaluation were as follows:

1. To explore how the PSS services benefited the lives of OVC and improved their well-being.
2. To provide evidence to inform the ongoing development of interventions for OVC, and to guide programme decisions such as modifying and improving the programme to make it more effective.

It is anticipated that the results of this evaluation will be used to assist in answering some of the most central questions, such as the extent to which the PSS programme is making a difference, the results the programme has achieved in 2011-2012, and how the programme can be improved for future implementation. Focus was placed on the 2011-2012 year as outcomes of the programme would take time to materialize and therefore some time would have to pass before an evaluation of this nature could be conducted.

### **3.2 Evaluation Design**

The evaluation largely drew on qualitative data, involving semi-structured in-depth interviews with OVCs who received PSS services, parents/caregivers of these OVCs, as well as facilitators implementing the programme at the selected organisations. Where required by the operational conditions of the participating organisations, as well as circumstances arising during the fieldwork, the semi-structured interview guides were used for focus group discussions.

### 3.3 Data Collection and Research Sample

#### 3.3.1 Access points

A database of organisations providing PSS services to OVC and who are funded by DSD, was obtained from the Children and Families Directorate within the Department. A total of 38 organisations are being funded<sup>54</sup> by the Department across the Service Delivery Regions for Social Development, within the Western Cape Province. A sample of these organisations was selected for the evaluation in consultation with the Children and Families Directorate, based on the following selection criteria:

1. Organisations are selected from each of the different Social Development Service Delivery Regions for the Western Cape.
2. The organisations are providing PSS/therapeutic services specifically targeting OVC.
3. The organisation has maintained records on the children receiving PSS services

A purposive sampling method was used for the identification of organisations selected to formally participate in the evaluation. The number of organisations selected per Service Delivery Region can be seen below:

**Table 4: Sample of organisations selected per service delivery region**

Service Delivery Region	Organisation
<b>West Coast</b>	CBO1
	CBO2
<b>Metro North</b>	CBO3
<b>Metro South</b>	CBO4
<b>Metro East</b>	CBO5
	CBO6
<b>Winalands Overberg Region</b>	CBO7
<b>Eden Karoo Region</b>	CBO8
<b>Across Service Delivery Region Boundary</b>	CBO9
<b>Total number of CBOs included</b>	<b>9</b>

<sup>54</sup> For the 2014-2015 financial year

### 3.3.2 Population and sample selection

It was envisioned that the key informant participants would be beneficiaries of the programme, who are 18 years of age and older, as gaining informed consent would be easier with these participants. However, it was pre-empted that this would be challenging as the Directorate indicated that many of the children only seek psychosocial support up until the age of 14 years and then drop out of the programme. Additionally, in view of past experience with community based research of this nature, the Research Unit within DSD anticipated situations where participants younger than 18 years could request participation or could be referred by participating organisations who may not have the children's correct ages, or may misinterpret the age criteria for the project.

Also, due to the logistical challenges around tracking past beneficiaries, participants below the age of 18 years but older than 15 years, were not excluded from the evaluation. However, beneficiaries should have attended 75% of the psychosocial sessions. This is in order to ensure that they can provide accurate information of the effects the PSS services had on their lives.

Data was also collected from facilitators at the respective organisations who are implementing the PSS programme, as well as from the parent(s)/primary caregiver(s)<sup>55</sup> of the identified youth where possible. A diverse group of stakeholders were involved in order to capture different perspectives and for triangulation of the data. Table 5 indicates the sample group as well as the number of participants selected.

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<sup>55</sup>As the project is about OVC the assumption is that not all of the children interviewed would have parents. Some of the children might only have one parent whereas others might be living with caregiver/s. Caregiver refers to a family member other than the biological parent/s or anyone else who has taken responsibility for the wellbeing of the child.

**Table 5: Sample size selection and data collection technique for the evaluation**

Data Collection Techniques	Location	Organisation	Participant type	Sample Size
<b>Individual semi-structured interviews</b>	West Coast	CBO1	Beneficiaries	3
			Facilitators	2
			Parents/caregivers	2
		CBO2	Beneficiaries	1
			Facilitators	2
	Metro North	CBO3	Facilitators	1
	Metro South	CBO4	Beneficiaries	3
			Facilitators	2
			Parents/caregivers	2
	Metro East	CBO5	Beneficiaries	4
			Facilitators	3
		CBO6	Beneficiaries	4
			Facilitators	4
	Winelands Overberg Region	CBO7	Beneficiaries	2
			Facilitators	2
			Parents/caregivers	3
	Eden Karoo	CBO8	Beneficiaries	1
Facilitators			3	
Metro East	CBO9	Beneficiaries	3	
		Facilitators	1	
<b>Focus Group Discussions</b>	Metro North	CBO3	Facilitators	4
	Eden Karoo	CBO8	Facilitators	2
Total number of beneficiaries interviewed			21	
Total number of facilitators interviewed			26	
Total number of parents/caregivers interviewed			7	
<b>Total number of participants interviewed</b>			<b>54</b>	

### 3.4 Instrument Design

Semi-structured interview schedules were designed for qualitative data collection with beneficiaries of the programme, their parents/caregivers, and the implementing facilitators of the organisations (see Annexure II, III and IV). These data collection instruments were designed based on the evaluation objectives of the project.

### 3.5 Data Analysis

The qualitative analysis was largely exploratory in nature, and the data collected through the semi-structured interviews were transcribed and analysed thematically. Through this thematic analysis emerging themes were identified. Findings from the qualitative data were then grouped, summarised and analysed in order to address the key evaluation aims and objectives.



## 3.6 Ethical Considerations

Ethical approval for the project was obtained from the Department's Research Ethics Committee prior to the implementation of the research. Informed written consent was also sought from all research participants before participation in the research. Consent was also obtained from participants for the recording of interviews and focus groups (Annexure I: Participant Information and Consent Form). None of the participants' identities have been disclosed, ensuring that their information remains private and confidential.

## 3.7 Methodological Limitations

### 3.7.1 The data collected was predominantly qualitative:

This limited the amount of respondents that could be interviewed. Findings can therefore not be generalized to all stakeholders of the PSS services provided by organisations funded by DSD.

### 3.7.2 The research was retrospective and collected data about past experiences:

Many of the participants attended the psychosocial programme four or five years ago – while they were still in Primary School and very young. Memory recall was therefore often found to be challenging and could have affected how much information could be recalled about the programme as well as the accuracy of the information.

### 3.7.3 No baseline data available:

No pre and post intervention testing was conducted and as this baseline data was not collected it is impossible to make conclusions concerning change in outcomes resulting exclusively from programme exposure.

### 3.7.4 Limitations of the sampling method:

The implementing CBO selected participants to participate in the evaluation and those who were not selected makes it difficult to conclude with certainty that the psychosocial intervention is responsible for the reported outcomes.

## Chapter 4: Findings and Discussion

### 4.1 Stories of Significant Change

Semi-structured interviews were conducted with 21 beneficiaries across the nine sampled organisations. The stories of significant change of three of the beneficiaries are presented here. These stories describe how the programme improved their wellbeing and how their lives benefited through attending these support groups.

#### Story of change 1:

Resilience after traumatic experience

*"I am a lady now because when I got raped I started a new life - to be someone I don't want to be because of that situation and because of what happened to me. It changed me to be someone else and I was trying to be a tomboy so that someone could see me as a man and not as a lady. It helped me to see myself as a lady and to accept what happened to me and to accept who am I and what I do and what I would like and to think of others because I was only thinking of myself. After the programme I was so happy because it changed my life. It made me stronger and it made me emptier because it was so heavy holding all of that stuff"*

#### Story of change 2:

Self-acceptance, association with positive peer groups & improvement in school performance

*"The programme helped me change my behaviour because at that age I was starting to make bad decisions like going to the wrong friends and trying new things like smoking, but after I came here that all changed - my behaviour changed. The programme also helped me to accept myself the way I am. The programme also helped me to stay focused at school. I am doing well now because of the programme. It helped me to be hard working."*

#### Story of change 3:

Positive lifestyle change

*"My life is better off. I do not use drugs like tik and buttons anymore. The programme brought me off those drugs. I did not work that time, but now I have a work and I know more things now due to this organisation."*

Based on these stories of change, it seems as though the loss and grief programme for psychosocial wellbeing is effective at improving school performance, dealing with peer pressure, developing resilience towards traumatic life events, and self-acceptance. According to the literature reviewed, these are all indicators of psychosocial wellbeing.

The experiences of the other programme participants are summarised in the section below. These responses are combined with the programme outcomes as reported by the facilitators as well the parent(s)/caregiver(s) of the children who attended the programme.

## **4.2 Programme Outcomes**

### **4.2.1 Emotional Wellbeing**

#### **(a) Improved confidence and self-esteem**

Facilitators and caregivers described how the children are usually withdrawn when joining the support group, but they have seen how their confidence and self-esteem improves by participating in the programme. Caregivers and facilitators reported how the child becomes more outspoken and is more willing to share and engage not only in the programme, but at home as well. This change could also be related to establishing trust in the facilitator and the group.

#### **(b) Self-acceptance**

Two of the participants spoke about how they gained self-acceptance through attending the programme. One of these participants revealed that she was HIV positive and felt the programme helped her to accept her status and not be concerned about what other people are saying about her. At another site one of the facilitators also referred to self-acceptance being one of the programme outcomes. This facilitator relayed a story about one of the children who was struggling to accept being diagnosed with leukaemia. Through the programme this child was able to deal with and come to accept this condition.

#### **(c) HIV medication adherence**

In one of the sites a facilitator stated that the children also display a sense of emotional wellbeing when it comes to not being ashamed of their HIV status. It has also helped some of the children to adhere to their HIV treatment. One of the programme beneficiaries mentioned how she would not listen to her caregiver about taking her medication, but when she went through the programme she started taking her medication on a regular basis.

#### **(d) Provides a support structure**

For many of these children, the support group is the first opportunity they have to speak about their losses. One of the beneficiaries mentioned how she could speak about things in the support group that she could not speak to her mother about. The programme therefore serves as a platform where the child can speak about and share with children who are facing similar situations. Being in a loss and grief support group with other children provides a sense of comfort and almost all of the beneficiaries felt this gave them the courage to open up in the programme.

***“Having someone to talk to felt like there was someone behind me in everything that was happening to me.”  
[Programme Beneficiary]***

Beneficiaries reported that through the support group they were able to face certain issues in their lives and they were able to share their challenges with others who had similar experiences. This made them feel less alone and made life a bit easier and less stressful.

***“Everyone comes here with problems. I'm feeling free because I have someone I can talk to.”  
[Programme Beneficiary]***

This was also highlighted in the literature where the importance of supportive friends and socialising with friends was raised. This was seen as a sense of comfort and a protective factor related to the psychological health of OVC, which may improve outcomes for the child.

#### **(e) Improved emotional coping and acceptance of losses**

The beneficiaries indicated that the programme has helped them to deal with their losses and working through the grieving process, in order to move forward with their lives. It also assisted many of them to deal with the emotions that come with grief such as sadness, stress and anger. Facilitators found that the children are happier and it seems as though they have overcome their losses through participation in the programme.

***“There was one child, his mother was murdered. He didn't see it, but he saw her lying there in the street. After that he realised it was his father, but the person has never been caught – his father was always fighting with his mother so he was sure it was his father. He was in the programme and he didn't speak to anyone, he didn't even say anything. By the third week he started to get used to us – you could see he feels like he can speak now”  
[Facilitator]***

As reviewed in the literature, HIV medication adherence and emotional symptoms are both proxy measures for psychosocial wellbeing. Also, the intervention seems to be successful as the literature has shown that when a psychosocial intervention is successful it brings back control and confidence in the lives of those affected. Some of the clear programme outcomes for emotional wellbeing seem to be improved confidence and self-esteem, self-acceptance, and emotional coping and acceptance of losses.

#### **4.2.2 Social Wellbeing**

##### **(a) Able to use appropriate coping mechanisms and improved social relations with peers**

Facilitators from two of the organisations described how some children have difficulty coping with their loss and grief, and when they come to the programme many of them are angry and have a negative attitude. Facilitators described how these children have difficulty trusting someone else and when they join the support group they are very violent, just wanting to fight with the other children in the group.

Facilitators however reported that they have seen changes in these children when participating in the programme – their anger is gone and the fighting stops. In these two sites, the facilitators felt the programme equips children with the skills to deal with the emotions of losing someone and to process their grief in more appropriate ways.

The programme has also impacted on the behaviour and coping mechanisms of many of the children, who would often have behaviour problems and be very rebellious as a means of coping with their grief. One of the facilitators from an organisation outside of the Metro described an instance where one of the children had ongoing behaviour problems at school as a result of acting-out:

*“In one of my groups there was a boy whose parents burnt in-front of him. Lucky I was the chair-person of the governing body at the school. Every time he would come for disciplinary hearing so I asked the principle one day if he could give me some background on this child because his in trouble with the school and every time I have to come do a disciplinary hearing with him, something must be wrong. Three weeks after we started there was a big difference in that child at school”*

The facilitators have been able to understand these behaviours and what it means, in order to effectively help children overcome their grief. Through the programme behaviour change can be

seen as many of these children are equipped with the skills to deal with their losses. Facilitators reported how this angry, aggressive, and often violent and rebellious way of responding to grief and communicating their emotional struggles and pain, passes as the child is able to process their grief and adjust to their loss experiences.

These results highlight the importance of strategy 5 in the NPA (i.e. raise awareness of and advocate for the creation of a supportive environment for OVC) in terms of the challenges experienced by OVC where their grief manifests into anger and complicated grief and the importance of education on acting-out behaviour.

### **(b) Association with positive peer groups**

It was interesting to note that across the sites, all of the male beneficiaries spoke about the positive effects of the programme in dealing with peer pressure. Four of the male participants reported that they were friends with the 'wrong crowd' where they were involved with gangsterism, smoking and drugs. Since attending the programme they have realised the negative effects of these types of friendship circles and are able to make better choices.

Four of the other male participants felt that if they had not attended the programme they would probably have been involved in gangsterism and drugs, especially since they come from communities riddled with poverty and crime where gangsterism and drug abuse is rife. It therefore seems as though the programme is successful in dealing with grief responses such as substance abuse to cope, and seeking out rebellious peers or engaging in gang related behaviour.

### **(c) Improved relationships with parent/caregiver**

Closer relationships between the child and the parent or caregiver were found to be another outcome of the programme. Anger towards parents and oppositional behaviour is often a grief response and four of the beneficiaries described how their relationship with their parent/caregiver was strained before coming to the programme. Beneficiaries reported that through the programme, changes such as being more obedient and being more willing to help around the home, contributed to the improvement in their relationship with their parent or caregiver. The caregivers also reported more positive engagement with their children through the programme.

### **4.2.3 Skills and Knowledge**

#### **(a) Knowledge and awareness raising**

Beneficiaries felt the programme provided knowledge and raised awareness around drug addiction, teenage pregnancy, HIV/AIDS, and STI's and the importance of testing. Many of the beneficiaries felt that the programme was beneficial as the knowledge gained prevented engagement in these risky behaviours. It also helped those who were already using substances to stop.

#### **(b) Improvement in school results and attendance**

One of the grief responses for children is a loss of concentration that leads to school and learning problems. Facilitators indicated that they often find that the child's schoolwork and performance is negatively affected by the circumstances that many of them encounter at home on a daily basis.

The facilitators reported that through their relationship with the schools they often receive feedback about the improvement in the children's school results. Furthermore, it was also reported that the rate of truancy has also decreased as the children are more willing to go to school, and don't really get involved with smoking or alcohol and drugs.

The beneficiaries also reported on the impacts of the programme on their school work performance. They felt that they are more focussed at school. Two of the beneficiaries spoke about how they wanted to quit school and drop out, but the programme motivated them to complete their schooling.

## **4.3 Programme Implementation and Process Factors**

### **4.3.1 Enabling and inhibiting factors for implementation**

#### **Enablers to successful implementation**

##### **1. Effectiveness of facilitator training for PSS**

Facilitators found that the psychosocial support training received from Khululeka was effective in equipping them with the knowledge and understanding on how to run support groups with children. Many of the CBOs indicated that they have previously been running psychosocial support groups, but after receiving training they felt more confident in what they were doing and it made working with the children easier. The Khu Kit manual has also offered structure to the psychosocial programme, which was previously lacking for many of the organisations.

Through the training many of the facilitators were able to confront and deal with their own personal losses – even in instances where they thought this has already been resolved. These facilitators felt that one could not successfully implement the OVC programme with children if you have not dealt with your own grief and losses. One of the facilitators felt that the programme would definitely be successful as it helped him deal with his own personal losses.

## **Factors affecting implementation**

### **(a) Programme design factors**

#### 1. Programme duration and time period

The psychosocial programme is a ten week programme as outlined in the facilitator manual, however at least two of the organisations have extended their psychosocial programme to 13 weeks using a template designed by DSD. All of the facilitators felt that there is a lot of content to cover and some of the activities require more time. Therefore the one hour allocated to the programme is not always sufficient.

***“The one hour session is a bit of a rush. We must do an attendance register first, we must do a check in first and then after that we will do an ice-breaker and then we will do the sessions and explain what you want from that. We also need to first do a recap of the previous session and then we will start with the session.”***

***[Facilitator]***

Also, all of the facilitators felt the 10 weeks was not enough and the programme needs to be extended over a longer period of time. The short duration of the programme could impact on its effectiveness as facilitators highlighted that there are often cases where they can see the child still needs more support and assistance beyond the ten weeks - especially where the child has anger and complicated grief. Although referrals are meant to be made where it is recognised that the child needs further help and assistance, many of these CBOs indicated that there are not many organisations in their community that are working with OVC and providing psychosocial support.

Furthermore, facilitators were in agreement that the duration of the programme needs to be extended beyond the ten weeks. Facilitators reported that it often takes about three weeks for the children to ‘warm up to’ and feel comfortable with the facilitators, at this point there is only a few weeks left of the programme. These support groups are the only spaces in which some of these children get to deal with their loss and are able to grieve, as in some cultures parents do not talk to their children about death and children are not allowed to grieve. Even the beneficiaries who attended the programme felt that the ten weeks was too short.



## **2. Adapting the manual for younger children**

The psychosocial programme is implemented with children between the ages of 7-18 years. However, facilitators at two of the organisations found it challenging to run the programme with younger children, especially those who are 7-8 years of age. Facilitators felt that younger children are not able to understand the content and exercises - however they seem to enjoy the games. They also require more time for explanation. The facilitators found that they would explain something in the support group and a few minutes later these younger children would have forgotten what was discussed. It was also indicated that some of the exercises don't always work with the younger child, and facilitators feel unsure of how to navigate around this or how to replace these with more age appropriate exercises. One of the facilitators specifically referred to the stress and trauma relieving physical exercises that are meant to help children physically relieve themselves of their trauma without having to find the words for it, and the difficulty experienced when trying to implement this with younger children.

*“One of the exercises with the soft music some of the younger ones they don't understand that and they trained us with that and we don't know what else there is.”*

Although the training received from Khululeka covered the different stages of childhood and how to deal with each of these stages, facilitators still felt that more facilitation skills training is needed.

There were some beneficiaries who completed the programme when they were very young. These beneficiaries had difficulty recalling what was done in the programme, such as the topics discussed and the activities that were completed. Perhaps this also alludes to the programme content and manual not being age appropriate for the younger child.

### **(b) Process & implementation factors**

#### **1. Long waiting period for facilitator training**

It was reported that the Khululeka facilitator training for psychosocial support is only conducted once a year. At least two of the organisations have facilitators currently running support groups who have not received any training. At these two organisations the facilitators described how this lack of training impacts on the programme, as those facilitators who have completed the training have to then provide the untrained facilitators with on-site training. They find this to be challenging as they felt the facilitator needs to focus their attention on running the support group and not on training new recruits.

## **2. No practical implementation during psychosocial support training**

Facilitators from one of the organisations indicated that not much practical work is done in the training and they therefore found it difficult to do implementation immediately after the training. It was also reported that the training is only done for four days and many of the facilitators felt this needs to be done for a longer period of time, as this was the only psychosocial support training many of the organisations had received.

*“Many of the facilitators sit in the training but you don't get to do it practically, and now you come to your office and you have to get your 10 children or your 15 adults and you can't do it practically.”*

*[Facilitator at implementing organisation]*

It seems as though the four day facilitator training only provides the foundation in terms of theory and practical examples. However, there is still a need for practical mentorship once the support groups are started.

## **3. Facilitators are not equipped with counselling skills and/or training**

Beneficiaries spoke about how good it felt having someone to talk to and to listen to their problems. However, they felt the facilitators are not equipped enough to offer them any sort of counselling – which they thought should be part of the psychosocial support. Facilitators also found this to be a challenging aspect as they have not received any training in counselling children and often this is needed when the child speaks to them about their losses and challenges. Although the facilitators do make referrals to the social workers, they found that they do not really do any counselling, but mainly assess the home situation of the child. Some of the facilitators reported that in these instances they are often not sure what to do.

## **4. Current programme recruitment processes excludes some children**

The implementing organisations are recruiting programme participants through door-to-door home visits in the community, awareness raising at community meetings and in waiting areas of the clinic. Recruitment is also largely done by the schools the organisations have partnered with. There are however children in the community who need the support provided by the psychosocial programme, but they do not attend these specific 'partner' schools. In many of these communities there are high rates of school drop-outs and these children then can't be added to the programme. Facilitators felt this is a gap that the programme is currently not able to address.

## **5. Lack of space to run the programme**

There were only two organisations that didn't mention any specific challenges in terms of space in which to run the psychosocial support group. For the other organisations, space is a big challenge. These organisations do not have their own space in which to run the programme, but rely on other spaces such as the church hall or school premises. While others run their programme in a single container or at the facilitator's home or garage.

***“The support group has to be held in the facilitator's homes. Some of the parents are not happy with this and it creates a problem because they don't always understand why the child is having to go to the facilitator's home.”***  
**[Facilitator]**

One of the CBOs is currently running their programme in the church building as it is the only space available. Facilitators from this organisation reported that there are times when they are informed that the church building won't be available. This is especially challenging in winter when the organisation has to run the programme outside, and it's raining and cold.

There are also organisations that are making use of single containers so space is very constricted. The structure impacts on the programme as children don't attend when it's raining, as one of the facilitators described: “When it's cold the container is cold, and when it's hot the container is hot.”

These challenges negatively impact on the programme as the programme effectiveness is enhanced when the venue is safe, comfortable and big enough for the children to be able to spread out and do activities.

## **6. Not enough caregiver/parental involvement in the psychosocial programme**

Based on responses received from the parents/caregivers it appears as though parental involvement is not really incorporated into the programme. It was however reported that the organisations do make initial contact with the parent/caregiver as they are required to sign a consent form in order for the child to attend the programme. However, parents and caregivers indicated that they do not know much about the programme and don't really know what the children are doing in the programme, as the child does not speak to them about the support group. Also, only two of the beneficiaries mentioned that they have spoken to their parent/caregiver about the programme and the organisation.

Caregiver/parental involvement should be incorporated as the guardian needs to be able to provide support to their children during and after the support group process. The importance of

caregiver/parental involvement is also reflected in the NPA as strategy1: strengthen and support the capacity of families to protect and care for OVC.

The importance of parental/caregiver involvement was reported by two of the organisations. These organisations felt that parental involvement in the programme needs to be included because there are lots of things happening at the child's home, and sometimes the relationship between the child and the parent/caregiver is challenging. These two organisations have incorporated more parental/caregiver involvement by inviting the parent/caregiver to the second session of the programme. This is done so that the parent/caregiver can see and understand what is being done in the programme with the child, especially if they come home emotional.

#### **7. No follow-up after PSS programme concludes**

Facilitators expressed the need for a follow-up intervention at the end of the ten week psychosocial programme. Most of these organisations do not have a youth programme or an afterschool programme, through which the organisation can maintain continual interaction with the child. Some of the facilitators from these organisations indicated that they often 'lose' the child after the 10-week programme and some of the children revert to their old behaviours before joining the programme. One of the facilitators specifically referred to a child who attended the programme, did well, but is now using drugs again. There were facilitators who reported that some of the children who completed the programme are still coming to the organisation even though they have already started a new support group.

#### **8. Delay in processing payments**

Two of the organisations mentioned there are delays in payments being processed by the Department, especially with new TPA's. Often there are delays of up to two months where payments are not made to these organisations. Facilitators reported that they then have to use their own money in order to buy food and other necessities for the children. This also delays the implementation of the programme as some of the organisations cannot run the programme until the payments have been processed. This in-turn impacts on the agreement that the organisation holds with the school, where the programme will be completed at the end of the school quarter in order to commence with a new group of children the next quarter. At the time the evaluation was conducted, one of the organisations indicated that there was already a two week delay in the processing of their payments.

## **9. Facilitator fatigue**

Many of the facilitators indicated that they have been using the current Khu Kit manual since 2011. The facilitators felt they have been implementing the programme with the same material for a long period of time, and therefore the manual needs to be refreshed and updated. They expressed feelings of boredom and demotivation at having to use the same manual for such a long period of time, and felt new information and change is needed in the programme.

## **Chapter 5: Recommendations**

### **1. More frequent facilitator training:**

Facilitators reported that training is only done once a year and needs to be provided more often as new staff join the organisation and then have to wait a while before they are trained. At least two of the organisations indicated they currently have facilitators working on the programme who have not received any training. It was furthermore reported that the organisation often does not know when training will be done.

### **2. Refresher training should be provided as well as additional training:**

Requests for refresher training was made by almost all of the facilitators who reported that they have been with the organisation for a long period of time and feel that there are some things they might have forgotten. Facilitators also felt that the training received was very basic and more advanced training would be beneficial in running the psychosocial programme more effectively. Additional training needs identified was:

- ✓ Basic counselling skills specific to working with children
- ✓ First aid training
- ✓ Capacity building for facilitators

### **3. Assistance with adapting the programme content for younger children:**

Many of the facilitators reported that they find it challenging to implement the programme with younger children. As the maturity levels of children differ according to their age, it is recommended that the current manual be adapted so that it is more age appropriate for the younger child. Technical guidance could also be provided in the manual to assist facilitators with suggestions on how to adapt certain content or activities appropriately. Alternatively, additional facilitator training could be provided for working with younger children, and how to present information in an age appropriate manner.

#### **4. Increase caregiver/parental involvement in the psychosocial programme:**

Based on the findings of the evaluation, it seems as though parental involvement is not really incorporated into the psychosocial programme. Parental involvement could be incorporated through regular communication with the caregivers, and by inviting them to a session of the programme such as the introductory or first session.

Parental involvement could also be incorporated through home visits, which is already being conducted by the CBOs. These home visits are conducted for parents/caregivers to sign the consent form granting the child permission to attend the PSS programme. Perhaps this visit should be used to provide the caregivers with an information sheet describing the programme or an outline of the programme.

#### **5. Intervention efforts should be targeted at parents/caregivers as well:**

Psychosocial support services should be provided to the parents/caregivers of the OVC who are attending the psychosocial programme. According to the literature reviewed, it was found that the psychological wellbeing of the caregiver has an effect on the treatment and psychological wellbeing of the children under their care. Caregivers often face their own challenges, and their circumstances and experiences have implications for the wellbeing of their children. Therefore, interventions should be implemented addressing the psychosocial challenges experienced by these caregivers. This is also important as issues of sustainability comes to the forefront if intervention efforts are only child specific without taking into consideration the situation and needs of the caregiver.

The organisations reported that caregiver interventions are being implemented in the form of adult support groups, but this only occurs once a month. Only one of the organisations reported that they are running adult support groups in the same manner as the PSS programme for OVC (i.e. once a week for 10 weeks). This organisation described the impact of this intervention as follows:

*"When you work with the child and the parent it makes it a successful programme. When you don't only work with the child alone, when you can put the child's parent also in a programme like the adult support group or the parenting skills group – then it makes a successful programme."*

**[Facilitator]**

Perhaps efforts should therefore be directed by DSD towards ensuring that these organisations are equipped and resourced enough to run psychosocial interventions with caregivers more often, as supporting caregivers can translate into benefits for the children under their care.

## **6. Facilitator debriefing:**

Running the psychosocial support programme for OVC can be emotionally draining and facilitators felt that debriefing or some sort of psychosocial support also needs to be provided to them. The facilitators reported that there is a lot of trauma and stress that they need to deal with and at times this does affect them. A space is therefore needed where facilitators can talk about some of the difficulties they encounter as well as the emotional challenges they experience – if they are not coping there is a risk that they may no longer be as effective as a facilitator.

## **7. Follow-up intervention needs to be provided after the PSS programme:**

There seemed to be consensus amongst the organisations sampled for the evaluation regarding the need for a supportive follow-up intervention - especially since the programme runs for such a short period of time. Although there are some organisations that are running a youth programme or afterschool programme, there are other organisations that do not have funding or staff for these types of programmes. They are therefore unable to maintain contact with the OVC. Perhaps funding should be provided for these organisations to conduct home visits following the programme as a means of follow-up. This would assist in maintaining the positive outcomes of the programme.

## **8. Provision of additional funding and resources:**

Facilitators felt funding would help improve the quality of the programme, specifically additional funding for staff and equipment such as balls and toys for the children to work with. Two of the organisations within the Metro mentioned the need for assistance with funding for transport due to gangsterism and turf wars in the area, which specifically affects children who do not live in the immediate vicinity of the organisation.

## **9. Development of M&E tools:**

Currently, the programme only relies on self-report measures which are too subjective and subject to various response biases. As such, there is a need for standard monitoring and evaluation tools to be developed in order to efficiently evaluate the progress and impact of the programme. Some of these tools have already been designed and are included in the Khu Kit manual e.g. questionnaire about the history of the child, and session plan and report.

However, this data was not available for the current evaluation. It is recommended that the implementing organisations submit these completed templates to the Department and that the data is collated so that it can be used for future evaluations of the programme. It would also be

beneficial for pre and post-test measures to be developed, so as to collect data before the programme and comparative data for the same indicators at the end of the programme. Having various sources of data would assist with triangulation and improving the validity of the evaluation results.

## Conclusion

The outcomes of the psychosocial programme have shown the importance of taking care of the emotional and psychosocial needs of orphaned and vulnerable children, and those who suffer bereavement. All of the stakeholders indicated that the programme definitely has a positive impact on the child, as it assists in coping with both the emotional and psychosocial issues affecting them on a daily basis, and contributes towards the positive development of their characters. The evaluation has shown how the programme brings about positive change for children regarding their emotional and social well-being, and skills and knowledge. The evaluation has also highlighted the need to provide psychosocial support to caregivers as many of them often face the overwhelming challenges of raising many children at the same time with limited resources. Many of the organisations included in the evaluation are currently offering adult PSS support groups, but these are limited as it can only be offered once a month due to resource and funding restraints.



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## Report Annexes

### Annexure I: Participant Consent and Information Sheet

#### AN EVALUATION OF PSYCHO-SOCIAL SERVICES PROVIDED TO ORPHANS AND VULNERABLE CHILDREN IN THE WESTERN CAPE

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##### **Information Sheet**

The Children's and Families Directorate within the Department of Social Development has requested that an evaluation be undertaken to assess the effectiveness of the psycho-social support (PSS) services provided to orphans and vulnerable children.

The research team will be conducting interviews with beneficiaries who received psycho-social support services as well as their caregivers. Information will also be gathered from staff members from the implementing organisations who provided these PSS services.

**You have been identified as a participant in the research process. Kindly take note of the following:**

Your consent to participate in this evaluation is voluntary and you have the right to withdraw from the study at any given time. You do not need to ask for permission to withdraw. There are also no consequences for withdrawing from the study or disagreeing to taking part. As a participant you will be asked questions which you may answer to the best of your knowledge.

Your name and identity will not be made public and your private and confidential information will not be divulged, unless you have granted the researcher permission to do so. This means that the information you provide to the researcher will also be handled with care to maintain confidentiality. The researcher will take notes during the interview where necessary, but will also request your permission to voice record the interview in order to validate the data after the interview process.

**Should you have any queries regarding this study, please contact:**

1. Petro Brink  
Deputy Director: Social Research, Department of Social Development  
021 483 4512  
[Petro.Brink@westerncape.gov.za](mailto:Petro.Brink@westerncape.gov.za)
2. Lynn Phillips  
Social Researcher: Department of Social Development  
021 483 3510  
[Lynn.Phillips@westerncape.gov.za](mailto:Lynn.Phillips@westerncape.gov.za)

**If you wish to report any ethical violation that occurred during the course of this research, please contact:**

Mr Gavin Miller  
Director: Directorate Research, Population & Knowledge Management  
Department of Social Development  
021 483 4595/ 4168  
[Gavin.Miller@westerncape.gov.za](mailto:Gavin.Miller@westerncape.gov.za)

**Consent form for participation**

This form implies that a member of the research team has clearly explained: the purpose of the study, voluntary participation and issues of anonymity and confidentiality. If you are in agreement and want to participate in the study, please sign the relevant sections below:

**NB: I have read and understood the conditions involved in taking part in this evaluation as reflected above and hence give my consent.**

I ..... (*print name and surname*) hereby give my consent to participate in the evaluation being conducted to assess the impact of psycho-social services on the wellbeing of orphans and vulnerable children.

Signed: .....

Date: .....

I hereby also grant permission for the interview to be voice recorded:

Signed: .....

Date: .....

## Annexure II: Facilitator Interview Schedule

### Background Information:

1. Could you please tell me more about your organisation and the services it provides to orphans and vulnerable children?

- **when was the organisation started**

2. Can you please tell me more about the psychosocial services you provide to OVC?

- **How often are these services provided?**

3. When did you join the organisation and what is your role in the organisation?

4. Have you received any training from the organisation?

5. How do you understand the term 'orphans and vulnerable children (OVC)'?

### Community Background:

6. What trends are you seeing regarding OVCs in your community? Has there been an increase/decrease?

- **Do you see more orphans or more vulnerable children?**

7. What are some of the reasons why children are orphaned or vulnerable in your community?

## Psychosocial programme:

8. What does the programme hope to achieve?

- **What is the purpose of the psychosocial element of the programme?**

9. Who typically refers OVCs to your organisation?

10. How do you identify and prioritise children who are most in need of support?

11. Does the organisation have the capacity to provide services to all children?

12. Has the programme changed since 2011?

12.1 How has it changed?

- **Has the funding changed?**

12.2 Why has it changed?

13. How in your opinion, do the psychosocial services benefit the children?

- **How has it made a difference in their lives?**

14. What are some of the challenges in providing the programme to the children?

14.1 What are some of the factors affecting your ability to run the programme?

15. What are some of the factors that help make the programme a success?

16. Are there any services the organisation is not able to provide?

**16.1 Are there other NGOs in the area that are able to provide these services?**

**16.2 Are there other NGOs/organisations in the area that also provide the same services as your organisation?**

### **Recommendations for improvement:**

17. Do you think there is anything about the psycho-social support programme that can be improved?

- **If there was one thing about the programme you could change to make it better, what would it be?**

18. Is there anything else you would like to mention before we close the interview?

*Thank the participant for their time*

## Annexure III: Semi-Structured Interview Guide for beneficiaries

### Background Information:

1. What are you doing in your life now? Are you still in school/working/studying/training?

2. Demographic Information:

a. Gender of participant:	
b. Age:	
c. Area of residence:	

3. Who do you live with?

4. Are there any challenges you face at:

4.1 School

- **Are you coping with the work?**
- **Do you enjoy school?**
- **What do you like/not like about it?**
- **Do you have close friends at school?**

4.2 In your community

- **Do you like where you live?**
- **Do you have close friends in the area where you stay?**
- **What do you do to have fun in the community?**

4.3 At home

- **Are you happy at home?**
- **Is your home comfortable?**
- **Do you have enough food?**



## Psychosocial programme:

5. When did you attend the psycho-social support programme (which year)?

6. How long did you attend the programme?

- **1 week, 1 month, 1 year etc.**

7. If you stopped attending these sessions, what were some of the reasons why you no longer came?

- **Did something prevent you from continuing?**

8. How did you find out about the psycho-social support programme?

9. What did you do in the psychosocial programme?

- **What kind of activities did you do?**
- **What kind of topics did you discuss?**

10. What did you think about the psycho-social programme?

- **Did you enjoy it?**
- **What did you like / not like about it?**
- **What were some of the positive and negative things about the programme?**

11. When you think about the things you learnt in the programme, how did you use that in your life? How did the programme change your life?

- **Is your life better or worse? How is it better?**
- **Think about your life before the programme and think about your life after the programme. How has it changed?**
- **How did it feel having someone to talk to?**
- **Do you see things improving in your future?**
- **Do you feel positive about your future? Why?**

12. Were there any other psycho-social support services you received?

*(Please tick all that apply)*

	<input checked="" type="checkbox"/>
Individual counselling	<input type="checkbox"/>
Family counselling	<input type="checkbox"/>
Home visits	<input type="checkbox"/>
School visits	<input type="checkbox"/>
Counselling at the church	<input type="checkbox"/>
Other:	<input type="checkbox"/>

13. Do you know of any other similar NGOs in this area?

13.1 Did you go to any of them?

13.2 Were you referred? What services did you access?

### **Recommendations for improvement:**

14. Do you think there is anything about the psycho-social support programme that can be improved?

- **If there was one thing about the programme you could change to make it better, what would it be?**

15. Is there anything else you would like to mention before we close the interview?

*Thank the participant for their time*

## Annexure IV: Interview Schedule for Parents/Caregivers of OVC

### Background information

1. Are you a caregiver or a parent?
- **Has the child always lived with you?**

2. Has your child attended the psychosocial support group at this organisation?
- *(If no close the interview)*

3. Can you tell me more about the child
- *(the child that has been on the psychosocial programme)?*

4. Who referred the child for psycho-social support services?

Source of referral	X
Friend	
Neighbour	
Colleague	
Church	
Another organisation:	
Other:	

5. How old is the child in your care?

6. Is the child currently in school/studying/working?

7. Do you have any other children in your care?

- **What are the ages of the children?**

8. Have your other children also attended the psychosocial support group?

9. Are there any challenges you face in caring for your child/children?

- **Are there any specific challenges you face regarding their schooling/study/work?**
- **Are there any specific challenges you face at home?**
- **Any specific challenges you face in the community?**

## **The Psychosocial Support Programme**

10. What year did the child attend the psycho-social programme?

11. How long did the child attend the programme?

- **1 week, 1 month or 1 year?**

12. If the child stopped attending, what were some of the reasons why s/he no longer came?

- **Did something prevent them from continuing?**

13. Do you know what kind of topics they discussed at the psycho-social programme?

- **Did the child regularly talk to you about the programme?**
- **Do you have any idea of what kind of topics might have been discussed?**

14. Do you think the child benefited from the programme?

- **How has the programme made a difference in the child's life?**
- **What changes has it made in the life of the child?**
- **Has it made their life better/worse? How?**

15. What other psycho-social support services do you feel should have been provided to the child??

- **Was there any other support the child needed that the organisation was not able to provide?**

16. Did you receive any psycho-social support from the organisation?

*(Please tick all that apply)*

<b>Types of psychosocial support</b>	<b>X</b>
Individual counselling	<input checked="" type="checkbox"/>
Family counselling	<input type="checkbox"/>
Home visits	<input type="checkbox"/>
Attended an adult support group at the organisation	<input type="checkbox"/>
Other:	<input type="checkbox"/>
Counselling at the church	<input type="checkbox"/>

17. Do you know of any other similar NGOs in your community?

17.1 Did you go to any of them?

17.2 What services did you access? Were you referred?

## Recommendations

18. Do you think there is anything about the psycho-social programme that can be improved?

- **Is there anything that can be done to make the programme better?**

19. Is there anything else you would like to mention about the psycho-social programme or the organisation before we close the interview?

*Thank the participant for their time*