ISIBINDI, creating circles of care for orphans and vulnerable children in South Africa: post-programme outcomes

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Abstract

This paper presents the evaluation of post-programme outcomes of the ISIBINDI model, a community-based intervention to promote physical and psychosocial wellbeing of orphans and vulnerable children (OVC) in South Africa. A mixed methods quasi-experimental design was used to investigate the differences between former ISIBINDI participants (18 years and older) and a control group of similar background. ISIBINDI ex-participants at 12 sites (n=427) and a control group of non-participants (n=177) completed a questionnaire which explored level of education and employment, psychosocial wellbeing and HIV-risk behaviour. Focus group discussions were conducted with various stakeholders.

Ex-participants reported higher self-esteem and problem-solving abilities, family support and lower HIV-risk behaviour than the control group. High levels of unemployment especially in rural areas resulted in unemployment of out-of-school OVC which creates new forms of vulnerability. The benefits of the programme may be compromised by the lack of community resources. An effective exit strategy is needed to contribute to financial independence of OVC after exiting the programme.

Key words: Orphans and vulnerable children, community-based intervention, resource-limited community, psychosocial wellbeing, programme evaluation, post programme outcomes

Children affected and orphaned by HIV/AIDS are vulnerable as the illness and death of parents often results in loss of emotional, financial and material support (Nyberg et al., 2012; Richter et al., 2009; Sherr et al., 2014). In Africa, orphans and vulnerable children (OVC) are often cared for in extended families or child-headed households (Schenk et al., 2008) vulnerable to poverty (Chingwenya et al., 2008; Meintjes et al., 2010). Some drop out of school, experience neglect, emotional, physical and sexual abuse and higher HIV-risk compared to unaffected children (Cluver et al., 2007; 2011; Nyberg et al., 2012; Thurman et al., 2006; Watts et al., 2007). OVC experience high levels of psychological distress, including depression and multiple traumas (Cluver & Gardner, 2007; Nyamukapa et al., 2010), mediated by parental disability, poverty and stigma (Cluver et al., 2013). Medicating factors are modifiable through OVC-interventions.

During the past decade various interventions attempted to address the diverse needs of OVC (Setswe & Skinner, 2008). Interventions focused on strengthening families (Richter et al., 2009; Rotheram-Borus et al., 2006), building caregiver capacity (Eloff et al., 2014; Reddy et al., 2009), teacher training (Wood & Goba, 2011), strengthening community infrastructure (Nyberg et al., 2012) and developing community volunteers as mentors (Brown et al., 2007; Schenk, 2009). Despite many OVC-interventions, there are limited evaluations of their effectiveness and no evaluations of post-

programme outcomes (Betancourt et al., 2013; Cluver et al., 2012; King et al., 2009). This paper presents post-programme outcomes of the ISIBINDI-model implemented in South Africa.

Table 1 Components of ISIBINDI programme for OVC (NACCW, 2013).

Core components	Additional components
Services CYCW deliver **Life space work in households** **Create safe and caring communities** **Assess children's developmental needs** **Grief work and emotional support (memory boxes)** **Access government and community services: education, health care, social services, birth registration, access child grants and foster care grants to alleviate poverty** **Provide training and support for caregivers to strengthen families** **Principles underlying services** ❖ **Child rights framework** ❖ **Family preservation** ❖ **Risk management** ❖ **Partnership model between government, CBO, NACCW and donor** ❖ **Inter-sectoral collaboration** ❖ **Network resources**	▪ **Food gardens** ▪ **Income generation projects** ▪ **Safe parks with play equipment** ▪ **Youth life skills development** ▪ **Young men and women's empowerment for employment (bursaries, careers, job opportunities)** ▪ **Child protection programme for abused children** ▪ **Education support programme, help with homework** ▪ **Substance abuse prevention**

ISIBINDI ("*strong heart*") is a multi-site community-based intervention for OVC developed by the National Association of Child Care Workers (NACCW) and funded through PEPFAR and Department of Social Development (DSD). Community-based organisations interested to implement the model recruit community members as child and youth care workers (CYCWs) to serve local families. NACCW provides training, supervision and mentoring to CYCWs (Scott, 2009). The core of the model is home

visits to address the physical, educational and psychosocial needs of OVC younger than 18 years and to strengthen family bonding and community support (Allsopp, 2011; NACCW, 2013). To prepare young people to exit ISIBINDI, life skills training and career guidance are offered. Programme components of ISIBINDI (Table 1) reflect most guidelines for OVC programmes (DSD, 2005; Schenk et al., 2010; UNICEF, 2004; US PEPFAR, 2012) and respond to community needs.

This evaluation aimed to determine how the ISIBINDI-model benefitted former participants' (aged 18 years and older) psychosocial wellbeing, education and employment readiness.

Methods

A quasi-experimental post-intervention assessment was applied to investigate the differences between ISIBINDI ex-participants and a control group. Focus group discussions (FGDs) were conducted with various stakeholders. The research was approved by the Ethics Committee of the Faculty of Humanities, University of Pretoria.

Two-stage stratified cluster sampling was used to recruit ex-participants. A proportional sample of ISIBINDI-sites from each province was selected (KwaZulu-Natal (5), Eastern Cape (4), Mpumalanga (2), Gauteng (1)). Sites with large numbers of participants and implementing multiple programme components were selected. At each of the 12 sites all ex-participants 18 years and older were invited to participate, yielding a convenience sample based on availability.

For each site, a similar neighbouring community where no OVC-intervention was implemented was identified as a control group. Teachers and social workers from these communities recruited OVC 18 years and older using a snowball technique. In total 427 ex-participants (average 35 per site) and 177 control group members (average 14 per site) participated in the survey.

A self-report questionnaire (Shisana et al., 2010) was used to collect data on education, employment, psychosocial wellbeing and HIV-risk. Scales assessing family support (Department of

Education, 2008) and resilience (Mampane, 2010) were included (Table 2). All scales were previously used with South African youth.

Table 2 Psychosocial well-being scales

Variable	Example of question	Number of items	Cronbach alpha
Self-esteem (Shisana et al., 2010) §	"*I feel I am as good of most other people"*	5 items	0.52
Problem solving (Shisana et al., 2010)	"*When solving a problem I try to think of many solutions"*	5 items	0.76
Interpersonal skills (Shisana et al., 2010)	"*I can easily tell when one of my friends is unhappy"*	4 items	0.61
Resilience (Mampane, 2010) §§	"Even if my problems are many, I do not give up trying."	11 items	0.74
Family support §§§	"*My family support and encourage me*"	10 items	0.87
HIV risk compiled from: 1) frequency and amount of alcohol use (scale 1-10) 2) number of sexual partners (scale 1-10) 3) consistent condom use (scale 1-10)	*1) "How many drinks containing alcohol do you have on a typical day?"* *2) "How many sexual partners did you have during the past 12 months?"* *3) "Did you use a condom every time you had sex the past 12 months?"*	3 items	

§ items from the Human Sciences Research Council Household Survey on Youth (Shisana et al., 2010)

§§ items from the Resilience scale of Mampane (2010).

§§§ items from Safe, Caring and Child-friendly Schools Framework (Department of Education, 2008)

Table 3 Characteristics of participants

	Ex-participants (n = 427)	Control (n = 174)
Gender:		
Male	45.4%	48.3%
Female	54.6%	51.7%
Age:		
18 years	32.7%	37.4%
19 years	26.4%	16.1%
20 years	13.9%	11.5%
21 years	12.2%	15.0%
22- 25 years	14.8%	20.0%
Orphaned state:		
Double orphan	37.2%	29.1%
Maternal orphan	21.3%	19.4%
Paternal orphan	18.3%	22.9%
Non-orphan	8.3%	21.7%
Unknown if double orphan §	0.2%	0.6%
Unknown if single orphan §	4.7%	6.3%
Main caregiver while growing up (10-18 years):		
Mother		
Both parents	32.1%	37.4%
Grandparents	10.8%	13.8%
Other family	32.9%	27.6%
Siblings	10.1%	7.5%
Non-relatives	9.8%	9.7%
	4.3%	4.0%
Level of education:		
Grade 9 or less	25.2%	28.9%
Grade 10-11	43.3%	40.5%
Grade 12	24.5%	24.9%
Post school qualification	7.0%	5.7%
Employment:		
Attending school or studying	64.3%	64.5%
Working (formal or informal)	7.4% (out-of-school 20.8%)	4.1% (out-of-school 11.5%)
Unemployed (looking for work)	26.8% (out-of-school 75%)	26.7% (out-of-school 75.4%)
Unemployed (not looking for work)	1.5% (out-of-school 4.1%)	4.7% (out-of-school 13.1%)
Sources of income		
No income	54.5%	71.3%
Formal and informal earnings	7.5%	3.4%
Family support	9.9%	5.7%
Government grants	26.0%	17.8%
Other	2.1%	1.8%

§ Respondents were unsure whether their fathers were dead or alive because they did not know then or did not have contact with them

The questionnaire was translated (and back translated) into applicable vernaculars and pilot tested. Research assistants read the questions in a group setting at each site in the vernacular of participants. Descriptive statistics and comparisons between groups (Chi-square, independent t-tests) were conducted using SPSS version 22.

At each site four FGDs were conducted with ex-participants, their caregivers, CYCWs and community stakeholders to probe stakeholders' opinion of the sustained impact of ISIBINDI. FGDs were transcribed and translated into English for thematic analysis using Atlas-ti.

Results

Participants were 18 to 25 years old. Most ex-participants (76.8%) had lost one or both parents and grew up with grandparents (32.9%), other family (10.1%) or in child-headed households (9.8%). Their level of education was generally low. Although ex-participants and control members were not matched, the groups had similar characteristics (Table 3).

The majority ex-participants (70%) were involved in ISIBINDI for more than a year (some for five years). Most ex-participants were involved in the core programme components (Table 4) and career guidance (66%), job empowerment and life skills training (54%).

Table 4 Exposure to programme components

Project components (n=380)	%
Home visits and family support	89.2
Personal guidance and counselling	86.0
Access to a safe park	80.9
Help with their study programme / tuition/ homework	71.2
Help with further education and training, bursary application, job skills, career guidance	66.7
Participation in life skills training, young men and women's job empowerment programme	53.6
Access to health care and treatment	48.5

Psychosocial wellbeing

Ex-participants reported higher self-esteem (almost significant) and problem-solving abilities than the control group (Table 5). This is illustrated in the qualitative data: *"It really helped me because it gave me guidelines as to how I should carry myself as a lady and as an orphan. I learned that I should never sell myself cheap and I should value myself, make sure that I get an education, as it will open doors for me"* (Ex-participant).

Table 5 Comparison between ISIBINDI ex-participants and control group

		N	Mean	T value	P value (2 tailed)
Self-esteem	Ex-Participants	406	5.01	1.67	.097*
	Control	160	3.82		
Problem solving	Ex-Participants	406	3.97	3.20	.002**
	Control	160	2.26		
Interpersonal skills	Ex-Participants	406	2.95	-.02	.987
	Control	160	2.96		
Resilience	Ex-Participants	406	3.43	.79	.433
	Control	160	3.26		
Family support	Ex-Participants	406	4.62	2.08	0.039**
	Control	160	3.31		
HIV- risk	Ex-Participants	406	12.9	-2.57	.012**
	Control	160	19.7		

*p<0.1; **p<0.05

CYCWs promoted open communication in families to strengthen family relationships. This resulted in ex-participants reporting more family support than the control group (Table 5). A caregiver reported: "*They really made a difference, because my grandchildren were able to talk to them. We were able to sit together and discuss how to deal with the situation at home".*

HIV-risk

Ex-participants reported significantly less HIV-risk behaviour than the control group (Table 5). Specifically, males reported less binge drinking (12.3% vs. 30.6%, $p<0.001$) and females fewer unwanted pregnancies (28.8% vs. 37%, $p<0.1$ almost significant) than the control group.

Education and employment

Ex-participants and control members reported the same level of education (Table 3), despite ISIBINDI's focus on educational assistance. A large percentage of the sample was still in school or studying (64%). Most out-of-school young people were unemployed looking for work (75%). More ex-participants were employed than in the control group (20.8% vs. 11.5%, $p<0.05$). They were financially somewhat advantaged (45.5% vs. 28.7% had some income, $p<0.05$) and more optimistic about their future opportunities than the control group (70.5% vs. 56.3%, $p<0.05$). These differences may be related to ISIBINDI's focus on study support and employment readiness: *"Some sell sweets and some do craftwork back at home to get some money"* (Ex-participant).

Despite initiatives, scarcity of employment and livelihood opportunities particularly in rural areas jeopardises ex-participants: "*There are a lot of children staying at home doing nothing. I just wish she could get a job, because no one is working in the family"* (Caregiver). At age 18 child grants are terminated, leaving many OVC with no income, unless they can find employment. One ex-participant said: "*I am the bread winner. I have no-one else. Even with the little income I get, it is difficult because all my siblings depend on me. I have to do everything in the house with that*." This may precipitate new vulnerabilities, as young people may turn to transactional sex or crime to support themselves and their families: "*Sometimes poverty plays a major role. Girls our age end up with sugar daddies who support them or move in with their boyfriends that destroy their lives"* (Ex-participant). This may be reflected in 5.9% female ex-participants reporting intergenerational sex, 14.5% being victims of partner violence

and 28.8% reporting unwanted pregnancies. The benefits of ISIBINDI may be compromised if participants cannot support themselves financially after formally exiting the programme.

Discussion

This research contributes evidence of the impact of ISIBINDI, a community-based OVC-intervention. ISIBINDI addressed many of the vulnerabilities of OVC and their families (Cluver et al., 2007; 2013; 2014). Ex-participants reported higher self-esteem and problem-solving abilities, more family support and lower HIV-risk than control members. Previous ISIBINDI evaluations also showed more adult support, but no psychological benefits (Thurman et al., 2013; 2014).

Out-of-school OVC were largely unemployed, had low levels of education and could not support themselves and their families financially, leading to new vulnerabilities. To reduce economic vulnerability, OVC-interventions should develop effective exit strategies, by linking OVC to training facilities, career opportunities or local micro-enterprises. In resource-limited areas there should be emphasis on capacity building in local organisations. OVC-interventions should ensure the wellbeing of OVC even after exiting the programme to reduce vulnerability and strengthen communities.

Limitations

A quasi-experimental post-intervention design was used, as no baseline data was available. Therefore, differences cannot be attributed directly to the intervention. Participants were not randomly selected, but through availability. Self-reporting of controversial behaviour should be interpreted with care; patterns of over- and underreporting may influence the quality of the data (Hewett et al., 2003). Some scales (like the self-esteem scale) reflected low reliability.

Conclusion

The evaluation found that the ISIBINDI-model contributes to some positive outcomes that provide a protective barrier for OVC. The evaluation highlighted the importance of looking beyond the age of 18 years to sustain reduced vulnerability.

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