Children and Youth Services Review 62 (2016) 58–64

Contents lists available at ScienceDirect

Children and Youth Services Review

journal homepage: www.elsevier.com/locate/childyouth

Community-based organizations for vulnerable children in South Africa: Reach, psychosocial correlates, and potential mechanisms

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ARTICLE INFO

Article history:
Received 23 November 2015
Received in revised form 18 January 2016
Accepted 19 January 2016
Available online 21 January 2016

Keywords:
Children
Community-based organizations
South Africa
HIV/AIDS

ABSTRACT

Community-based organizations (CBOs) have the potential to provide high quality services for orphaned and vulnerable children in resource-limited settings. However, evidence is lacking as to whether CBOs are reaching those who are most vulnerable, whether attending these organizations is associated with greater psychosocial wellbeing, and how they might work. This study addressed these three questions using cross-sectional data from 1848 South African children aged 9–13. Data were obtained from the Young Carers and Child Community Care studies, which both investigated child wellbeing in South Africa using standardized self-report measures. Children from the Child Community Care study were all CBO attenders, whereas children from Young Carers were not receiving any CBO services, thereby serving as a comparison group. Multivariable regression analyses were used to test whether children attending CBOs were more deprived on socio-demographic variables (e.g., housing), and whether CBO attendance was in turn associated with better psychosocial outcomes (e.g., child depression). Mediation analysis was conducted to test whether more positive home environments mediated the association between CBO attendance and significantly higher psychological wellbeing. Overall, children attending CBOs did show greater vulnerability on most socio-demographic variables. For example, compared to children not attending any CBO, CBO-attending children tended to live in more crowded households (OR 1.22) and have been exposed to more community violence (OR 2.06). Despite their heightened vulnerability, however, children attending CBOs tended to perform better on psychosocial measures: for instance, showing fewer depressive symptoms (B = −0.33) and lower odds of experiencing physical (OR 0.07) or emotional abuse (OR 0.22). Indirect effects of CBO attendance on significantly better child psychological wellbeing (lower depressive symptoms) was observed via lower rates of child abuse (B = −0.07) and domestic conflict/violence (B = −0.03) and higher rates of parental praise (B = −0.03). Null associations were observed between CBO attendance and severe psychopathology (e.g., suicidality). These cross-sectional results provide promising evidence regarding the potential success of CBO reach and impact but also highlight areas for improvement.

1. Introduction

The response to HIV/AIDS in resource-limited settings has included a call for the support of community-based organizations (CBOs) (e.g., Campbell & Mzaidume, 2002). These grassroots, local organizations are well-placed to reach children and families experiencing many day-to-day challenges (Foster, 2007). Yet the evidence-base for the effectiveness of CBOs has been scant (King, De Silva, Stein, & Patel, 2009) and the new environment of 'evidence-based' provision (Sherr & Zoll, 2011) presents significant challenges to CBOs in terms of objective and thorough evaluation (Bee et al., 2014).

In theory, strong community provision is associated with a comprehensive response to community needs and improved psychological adaptation amongst community members. Campbell, Nair, and Maimane (2007) have theorized that communities can be considered to be 'AIDS competent' when community members can access health and social services and work together to reduce HIV stigma, decrease risk behaviour, and support people with HIV/AIDS. In reality, CBOs can take many forms. In many cases in South Africa, CBOs are locally inspired and a reaction to challenges concomitant with HIV/AIDS. In other cases, CBOs are driven by international organizations and donors. Their services may include visits, parenting or early child education, social support, counselling services, financial assistance, and healthcare

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http://dx.doi.org/10.1016/j.childyouth.2016.01.016

provision (Richter et al., 2009). Yet what many of these organizations have in common is the community location, direct local availability, and a focus on child and family provision. Nevertheless, evaluation of CBO input is challenging. Programmes are often small and situated in communities with limited research capacity, which is further compounded by the logistical difficulties of conducting research in vulnerable communities and the resulting high costs (King et al., 2009). Moreover, historically international funding for such evaluative research has been limited. For instance, the first phase of the United States President's Emergency Plan for AIDS Relief (2003–2007) was largely focused on implementing programming as opposed to evaluation (PEPFAR, 2005; Sherr & Zoll, 2011). In addition, CBOs are typically not set up in a systematic way amenable to evaluation and random allocation to services is often seen as unethical.

The first essential step in assessing the effectiveness of CBOs is to identify whether they are reaching the most vulnerable children. In an increasingly resource-constrained environment of funding, targeting has been highlighted as a priority. However, to date, no known studies have examined whether CBOs focused on orphaned and vulnerable children in low- or middle-income countries are actually reaching the children who most need their services. The next essential step is to identify whether CBO attendance is associated with improved psychosocial outcomes. In a systematic review, King et al. (2009) could not identify a single evaluation of a community-based programme to improve psychosocial wellbeing for children affected by HIV/AIDS that met quality standards for inclusion. Other early reviews of community-based interventions found limited evidence and concluded that many of the evaluations that had taken place were not of sufficient scientific rigour (JLICA, 2009; Schenk, 2009). The final step in evaluating CBOs is to determine, where positive outcomes have been found, what mechanisms potentially underlie them. Without considering such mechanisms of change, complex interventions like CBOs remain as 'black boxes', where it is unclear which components were successful and should thus be repeated in future programming (Fraser, Richman, Galinsky, & Day, 2009). One way that has been proposed for how CBOs may positively impact AIDS-affected children is family strengthening (Richter et al., 2009). That is, by creating more positive home environments for children (e.g., supporting better parenting and less family abuse and violence) CBOs may lead to improvements in child outcomes such as mental health. This is hoped to be achieved by CBOs providing social support or parental education, improving service access, and/or alleviating stress.

While more recently there have been evaluation studies of improved quality, many of the community-based interventions being evaluated were set up for research purposes only. In a recent review, only two evaluations were identified that were of existing and ongoing programmes for children affected by HIV/AIDS (Skeen, Tomlinson, Croome, & Sherr, 2014). Mueller, Alie, Jonas, Brown, and Sherr (2011) conducted a post-hoc evaluation of an art therapy programme in South Africa and found that participation in the programme increased self-efficacy amongst 8–18 year-olds as compared to a control group of children who did not attend. Similarly, Thurman, Jarabi, and Rice (2012) used a post-intervention design with a matched control group and found that caregiver social support groups were associated with more prosocial behaviours and less problematic behaviours amongst children of attending caregivers in Kenya. While both these studies suggest promising effects, their scope was limited, with only one community investigated in each and no investigation of programme reach or potential mechanisms of change.

This study was set up to address the inadequate evidence-base on how CBOs work in practice. We had three main objectives in order to better understand CBO provision in South Africa. First, to compare the socio-demographic background of children attending and not attending CBO programming to establish whether CBOs are reaching the most vulnerable children. Second, to identify whether children and families being reached by CBOs have better psychosocial wellbeing compared to those not being reached. Third, to investigate whether family-level factors mediate the association between CBO attendance and improved child psychological outcomes, so as to better understand *how* CBOs may positively affect children and their families.

2. Method

2.1. Participants and procedure

We analysed data obtained from two large studies: one which exclusively recruited CBO attenders (the Child Community Care Study or CCC), and the other, a national random sample (the Young Carers Study or YC) which was utilized to generate a comparison group with no CBO contact at all. These two prospective observational studies were designed in close collaboration and made use of similar measures. Children in CCC were specifically recruited as CBO attenders, whereas those drawn from YC were included based on the fact that they explicitly had no regular access to CBOs or CBO-type services, allowing for analysis of the differences between children attending and not attending CBOs. The focus of this paper is to analyse these cross-sectional data obtained at baseline.

2.1.1. Young carers study

This analysis includes 1402 South African children aged 9–13 years who participated in YC, drawn from the total sample of 6002 children interviewed in 2009–2010. Participants were randomly selected from four urban and rural health districts with over 30% antenatal HIV prevalence in Mpumalanga and the Western Cape. Sampling involved randomly selecting census enumeration areas from the four health districts, visiting every household in the selected areas, and randomly selecting one child from every household with a resident aged 9–17. Refusal rate at baseline was less than 2.5%. Participants completed a 60-min face-to-face interview in the language of their choice. Interviewers were trained and experienced in working with vulnerable children and questionnaires were translated and back-translated in Xhosa, Zulu, Sotho, and Shangaan.

2.1.2. Child community care study

This analysis includes 446 South African children in the age range of 9–13 years from CCC, which had a total sample of 989 children aged 4–13 who were all CBO attenders. The CBOs were recruited by creating a list of all funded programmes from 11 partner organizations. A total of 28 CBOs (24 in South Africa and 4 in Malawi) were randomly selected from the complete list of 588, stratified by funder and geographical region. In this study, only data from South Africa are used. Consecutive children were interviewed from each CBO (approximately 35 children per CBO) from 2011 to 2012 with a refusal rate of less than 1%. Interviews were conducted by trained data collectors using mobile phone technology (Tomlinson et al., 2009). Questionnaires were translated and back-translated into Zulu and Xhosa.

2.1.3. Ethical procedures

YC ethical protocols received approval from the Universities of Oxford, Cape Town, and KwaZulu-Natal and provincial Health and Education Departments. CCC ethical protocols received approval from University College London (reference number 1478/002) and Stellenbosch University (reference number N10/04/112) and the funding agencies supporting the sampled CBOs. In both studies, participating children and their caregivers provided voluntary informed consent and received no incentives apart from refreshments, food, and certificates of participation. Confidentiality was maintained in both studies, except when participants were at risk of significant harm or requested assistance. In such cases, immediate referrals were made to social and health services (YC) or partnering CBOs and/or services (CCC).