LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF
SOCIAL DEVELOPMENT

Final Report

Assessing the effectiveness and impact of funded Department of Social Development Residential Care Facilities. 2022/2023

A caring and Self-reliant society

FOREWORD BY THE MEC

The Department of Social Development (DSD) derives its mandate from Section 27 (1) (c) of the Constitution, which advocates for the right of access to social assistance to those who are unable to support themselves and their dependents. In its quest to respond to this mandate, the Limpopo Department of Social Development provides comprehensive social protection system to vulnerable individuals and households to eradicate poverty and to contribute towards sustainable livelihoods. The Department of Social Development is responsible for the development and administration of the legislation which impacts on social development service provision to its citizens - residential care facilities being one of them.

The department developed the Service Delivery Improvement Plan – a developmental approach espoused by the Integrated Service Delivery (ISD) model, to align itself to the fulfilment of its vision of creating "*a self-reliant and caring society*". The success of developmental social welfare services relies on the smooth running of residential facilities that are tasked with the responsibility to provide social protection services in line with Chapter 11 of the National Development Plan (NDP), the Limpopo Development Plan (LDP), Department's Strategic Plan, Annual Performance Plan (APP), Operational Plan and the budget.

The research was necessitated by a dire need to establish clear empirical evidence to assist the department in its future strategic planning, budgeting, decision-making, and continuous knowledge generation to improve the provision of social welfare services for the benefit of vulnerable children, rural women, unemployed youth, older persons, and persons living with disabilities.

I therefore wish to present the Residential Care Facilities 2022/2023 research report findings and recommendations to be implemented through the developed Service Delivery Improvement Plans.

N. Ndalane

Honourable Nandi Ndalane

09/04/2024

Date

STATEMENT BY THE ACCOUNTING OFFICER

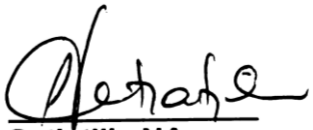
The Social Development Sector provides social protection services and leads government efforts to forge partnerships through which vulnerable individuals, groups and communities become capable and self-reliant participants. The bulk of its services are provided in partnership with civil society which includes nonprofit organisation (NPOs), community-based organisations (CBOs), faith-based organisations (FBOs), traditional councils, municipalities, South African Social Security Agency (SASSA), National Development Agency (NDA), and other government departments. The main targeted groups include children, older persons, persons with disabilities, families, women, victims of crime and gender-based violence, users of substance, youth in conflict with the law, people infected and affected by HIV/AIDS, unemployed and out of school youth, vulnerable and food insecure households.

The Department provides its services through the following programmes: Administration, Social Welfare Services, Children and Families, Restorative Services, Development and Research. Since the establishment of department's residential care facilities there was no evaluation or research conducted on the effectiveness and impact in delivering such services to the beneficiaries These services are classified as the most top priorities of the department in line with section 27 and 28 of the Constitution and White Paper on Social Welfare.

This research project was a major success considering the fact that it was conducted by unemployed graduates who collected and collated data and information from twenty-six (**26**) residential care facilities, and five hundred and twenty-eight (**528**) research participants within DSD funded child and youth care centres (CYCC), disability centres (DC), Old age homes (OAH), secure care centres (SCC), Khuseleka one stop centre (KC) and treatment centre (TC).

It is against this backdrop that the Limpopo Department of Social Development's Research Agenda for 2022/2023 financial year focused on assessing the effectiveness and impact on the residential care facilities that the department is funding. It is hoped that this research's findings and recommendations will go a long way in strengthening interventions to be provided through the residential care facilities.

Signed on behalf of the Limpopo Department of Social Development.



Setlatjile NA
Head of the Department

05/04/2024
Date

ACKNOWLEDGEMENT AND APPRECIATION

The Department of Social Development would like to thank all who participated in this research. Appreciation goes specifically to the research participants from the sampled Child and Youth Care Centres, Disability Centres, Khuseleka One Stop Centre, Secure Care Centres, and the Treatment Centre in the five Districts of Limpopo Province for their participation in this research The Department also wishes to acknowledge the role played by recruited Researchers in conducting field research. Accordingly, the lists of the Researchers and participating Residential Care Facilities are attached as Annexure F – G of this research report.

The Research titled: "*Assessing the effectiveness and impact on the Department of Social Development's funded Residential Care facilities*" was steered by the departmental Research Project Steering Committee (RPSC).

The words of appreciation to the following Research Project Steering Committee members:

- Mr. ME Monyamane (Chairperson), Mr. T Meso (Capricorn District), Mr. AM Shibambu (Mopani District), Dr M Tjale (Waterberg District), Mr. M Makaepea (Sekhukhune District), Ms. P Khomola and Mr. R Musandiwa (Vhembe District), Ms. T Tshivhandekano (Older Persons), Ms. H Moyaha (Children and Families), Mr. TAR Mabilu (Diversity Management), Mr. AM Ledwaba (Persons living with disabilities), Mr. Cholo (Treatment Centre).
- Assistant Provincial Coordinator: Ms. MP Olayemi
- Secretariat and Provincial Research Coordinator: Mr. MJ Moloisi
- Departmental Research Project Overseer: Mr. GN Shikwambani

Finally, word of appreciation goes to Ms. Adel van Der Linde for assistance with the translation of Afrikaans and mediation.

EXECUTIVE SUMMARY

The 2022/2023 Research Agenda for Limpopo Department of Social Development targeted residential care facilities with the objective of assessing the department's effectiveness and impact in the provision of services at these facilities. The study used mixed methods of quantitative and qualitative research approaches for data collection. The unit of analysis was the individual service users, service providers and implementers at these facilities. A total of **528** participants from **26** facilities were reached throughout Limpopo Province. Of the **26** facilities, **13** were child and youth care centres, **07** were old age homes, **02** disability centres, **02** secure care centres, **01** Khuseleka one stop centre, and **01** residential treatment centre. Three (**03**) facilities (i.e., a child and youth care centre, disability centre and old age home) could not be reached due to unforeseen circumstances. The highest participant number (i.e., **263**) reached was from the child and youth care centres and the least number (i.e., **18**) of participants reached was from a treatment centre. Capricorn and Waterberg Districts had the highest facilities reached (i.e., **07**) whereas Sekhukhune had fewer (i.e., **03**) facilities researched.

The findings of this research revealed that whilst beneficiaries at these facilities are well cared for and funds are used for the intended purpose, most participants felt that inadequate funding is the root cause of most of the challenges and affects the quality of care provided within the residential care facilities. The findings further revealed that for most participants - a level of satisfaction among service users at residential care facilities greatly depend on the service provided.

To this effect, the research is recommending the following:

Recommendation 1: Need to conduct market research to inform budget allocations.

Most participants were dissatisfied with recreational activities, medical support, and therapeutic programmers and this could be attributed to the limited budget that most residential care facilities are receiving. The rising inflation (interest) rates resulting in the increase of transportation, food, fuel, and related essentials warrant a review of appropriation of funds to support these facilities.

Recommendation 2: Requisite skills needed to bolster service provision.

Many residential care facilities were observed to be understaffed and lacking certain requisite skills and resources to reinforce effective and efficient provision of services.

Recommendation 3: Need to encourage programme coordinators to participate.

Lastly, whilst voluntary participation is regarded as critical tenets of ethics consideration - the custodians of the selected programmes are equally critical to share information. There is a need to find a balance and thus encourage key informants to participate.

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LIST OF ACRONYMS

CYCC	Child and Youth Care Centre
DC	Disability Centre
DSD	Department of Social Development
ISDM	Integrated Service Delivery Model
NGOs	Non-Government Organisations
NDP	National Development Plan
OAH	Old Age Home
POPIA	The Protection of Personal Information Act (Act 4 of 2013 as enacted on 1 July 2020)
RCFs	Residential Care Facilities
RTC	Residential Treatment Centre
SDIP	Service Delivery Improvement Plan
SCC	Secure Care Centre
SUDEP	Sudden Unexpected Death in Epilepsy
SUDs	Substance Use Disorders

GLOSSARY OF TERMS

Caregiver: Any person who provides care.

Child and Youth Care Centre: A facility that provides residential care to unaccompanied minors and separated children and the care offered includes a therapeutic, development programme or treatment for more than six (6) children outside of their family environment.

Disability Centre: A centre that provides support for people living with disabilities.

Elderly: Individuals 60 years and older, who by reasons of old age, physical, mental disability, or chronic disease are unable to care properly for their person or their own interests (Older Persons Act no 13 of 2006).

Household: One person or a group of people who occupy a common dwelling and who provide themselves jointly with food and other essentials for living.

Khuseleka One Stop Centre: An initiative of the Department of Social Development that provides support services to women and children who are victims of crime and violence under the Victim Empowerment Program

Old Age Home: Residential care facility that provides care for the aged.

Residential Care Facility: A structure used primarily for the purpose of providing accommodation and of providing 24-hour service to service users on a long-term basis.

Secure Care Centre: The physical containment in a safe and healthy environment of children with behavioural and emotional difficulties and/or children in conflict with the law.

Social protection: All initiatives that: (1) provide income (cash) or consumption (food) transfers to the poor; (2) protect the vulnerable against livelihood risks; (3) “Enhance the social status and rights of the excluded and marginalised” (Devereux and Sabates-Wheeler, 2004, p.9).

Treatment Centre: Rehabilitation care centre for substance abusers.

Vulnerability: Refers to the full range of factors that place people at risk of becoming food insecure. The degree of vulnerability for an individual, household or group of persons is determined by their exposure to the risk factors and their ability to cope with or withstand stressful situations.

Vulnerable persons include children, youth, older persons, people with disabilities and service users recovering form substance abuse.

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CHAPTER ONE

GENERAL OVERVIEW OF THE RESEARCH

1.1 Introduction

Residential care refers to long-term care given to persons who stay in a residential facility rather than in their own home or family setting. Others define Residential care facility as a nursing home, home for the aged, adult foster care facility, hospice facility, substance use disorder residential facility, or assisted living facility that does not include independent living facilities (Michigan government, 2021). There are several categories of residential care facilities, depending on the nature of the service required by the residents (service users). These categories include but not limited to; abandoned children, persons with disabilities, persons with mental health problems, persons having learning difficulties, children awaiting trial and in conflict with the law, older persons who are frail aged and in need of care, persons with Alzheimer's disease, dementia or who require additional support residential care facilities.

Many children who need care and protection find themselves placed in child and youth care centres (CYCCs). Children's Act 38 of 2005, maintains that children who are orphaned, abandoned, abused, neglected, or live in the streets can be placed in alternative care. The Act also mandates the Department of Social Development to take care of vulnerable children by placing them in alternative care through the Children's Court - in collaboration with the Department of Justice and Constitutional Development. Placement in CYCCs is a last placement option for children in need of care and protection, after all measures to place them within a family are exhausted. Family includes extended family members or placement in foster care. The children's court determines the best placement option for the child according to the investigation and recommendations of the external social workers' report.

According to Section 150 of the Children's Act 35 of 2005, government is entrusted to take action to protect children who need care and protection, which includes a child who:

- has been abandoned or orphaned and does not have any visible means of support,
- displays behaviour that cannot be controlled by the parent or caregiver,
- lives or works on the streets or begs for a living,
- is addicted to substances that cause dependency and does not have any support to get treatment for his or her addiction,
- has been or is at risk of serious physical or mental harm, or has been abused, neglected, or exploited.

Secure care centre offers programmes designed for the reception, development and secure care of children awaiting trial or sentence. The programme of intervention ensures the appropriate physical, behavioural, and emotional containment of young people while providing an environment, milieu, and programme conducive to their care, safety and healthy development. The concept was created during the transformation process of the child and youth care system. Therefore, with time, secure care as a concept has been used interchangeably – to mean a facility and a programme.

Persons may be placed or taken into care because they have a mental, developmental, or physical disability, often referred to as "special needs." At such facilities often a team of professionals or experts such psychologists, social workers, therapists, and caregivers look after the residents during their stays. For children, conditions, and disabilities such as epilepsy, autism, down syndrome, and cerebral palsy etc. require that children receive residential professional care. In addition, specialized residential can be provided for children with conditions such as anorexia, bulimia, schizophrenia, addiction, or children who are practicing self-harm. Adults may also be placed in these facilities if they have conditions such as amnesia (loss of memory, including information and familiar faces) and disabilities (often a mental disability) such as down syndrome or autism.

Old age homes were introduced as places where the elderly people were sent to live out their remaining days, often as a last resort when families could not care for them. Over time, they have become more like communities, offering a range of services and activities designed to meet the physical, emotional, and social needs of residents. Modern day-old age homes aim to provide a comfortable and safe environment for elderly people, with a focus on improving their quality of life. They also offer several services like medical care, rehabilitation, and recreational activities to enhance the lives of their residents. Other forms of long-term residential care are available for persons or couples unable to take care of their daily needs choosing to live in a retirement apartment complex. Many such long-term residential facilities are designed for elderly persons who do not need 24-hour nursing care but are unable to live independently. Such facilities may be described as assisted residential living facilities, residential care homes, or rest homes providing nutritious meals, housekeeping, laundry service and shelter. Furthermore, and depending on the needs of the resident, the residents are also aided with other services such as personal hygiene, dressing, and walking.

Persons who are addicted to drugs, alcohol and other related substances may be voluntarily or involuntarily admitted to a residential rehabilitation facility for treatment in terms of the Prevention of and Treatment for Substance Abuse Act 70 of 2008. According to Reifs, George, Braude, Dougherty, Daniels, Ghose and Delphin-Rittmon (2014), residential treatment is defined as commonly used direct intervention for individuals with substance use or co-occurring mental and substance use disorders who need structured care. Treatment occurs in nonhospital, licensed residential facilities. Residential treatment aims to help people with substance use disorders and a high level of psychosocial needs become stable in their recovery before engagement in outpatient settings and before return to an unsupervised environment, which may otherwise be detrimental to their recovery process. A study based on eight residential facility system reviews, the level of evidence for residential treatment for substance use disorders (SUD) was rated as moderate. The study concluded that residential treatment for SUD showed value and merits and thus warrants ongoing consideration by policy makers for inclusion for the benefit of public and commercially funded plans (Reifs et al, 2014).

Integrated Service Delivery Model (ISDM) for Developmental Social Services calls for the integration of the services of the department's different programmes, namely Administrative Support Services, Social Welfare Services, Children and Families, Restorative Services and Development and Research. The implementation of this model is essentially a state-driven process engineered by the Department of Social Development, which facilitates the rendering of the services through Non-Profit Organisations, which assume organised roles in the implementation of the broader social protection services in South Africa. To this effect, the Department of Social Development assumes a traditional role and the responsibility to make available the resources needed to fulfil its mandate, by supporting and funding NPOs which render residential care related services to vulnerable children and youth, persons with disabilities, and elder persons. Some of them are from dysfunctional households and child headed households - where some of the children are orphaned and subjected to vulnerability due to poverty, gender-based violence and femicides, amongst other social ills.

Since assuming the role of supporting and funding these facilities, the department has not done an evaluation or conducted research to determine the successes and failures of these facilities. It is against this backdrop that the Provincial Department of Social Development undertook the initiative to conduct a research study to assess the effectiveness and impact on residential care facilities that the department is funding. It is hoped that the study's findings will provide empirical evidence to guide the department's intervention and contribute towards the realisation of the Department's vision – A caring and self-reliant society.

1.2 Background and research rationale

The Department of Social Development is responsible for the development and administration of the legislation which impacts on social development service provision to its citizens - residential care facilities being one of them. To give effect to the developmental approach espoused by the ISDM, the department developed the Service Delivery Improvement Plan (SDIP) to align itself to the fulfilment of its core mandate of creating a self-reliant and caring society. The success of developmental social

welfare services relies on the smooth running of residential facilities that are tasked with the responsibility to provide social protection services in line with Chapter 11 of the National Development Plan (NDP), the Limpopo Development Plan, Department's Strategic Plan, Annual Performance Plans, and the budgets. This research project sought to assess the impact and effectiveness of service provision on the Limpopo provincial Department of Social Development's funded residential facilities.

The Limpopo Department of Social Development has not evaluated or conducted research to determine the successes, failures, lessons learnt and strategies to improve the delivery of services to its targeted beneficiaries since started funding the residential care facilities. Services aligned to the core mandate of the department are expressed in two broad categories that constitute developmental social services, namely, developmental social welfare services and community development. These categories are divided into prevention; early intervention; statutory, residential, and alternative care; and reconstruction and aftercare services. All services are aimed at promoting the optimal functioning and the reintegration of beneficiaries into mainstream society. Department values monitoring, evaluation, and research to assess the effectiveness and impact of service provision in relation to the department's funded residential care facilities. Therefore, the research is aimed at determining the effectiveness and impact so that there is an account of the value for the money spent and other related resources and investments contributed since their (i.e., residential facilities) establishment.

1.3 Purpose of the research

The Limpopo Department of Social Development has conducted a research study aimed at assessing the effectiveness and impact of the department’s funded residential care facilities (RCFs). The research study captured the experiences, opinions, and views of the Service Implementers, Service Providers as well as the Service Users associated with the said facilities. The purpose of the research was to gather information that could be used to better inform the department whether is being effective

and making an impact in the provision of services. If the opposite exists, identify areas of concern, and come up with appropriate interventions that could improve service provision and benefit the Service Users, the NPOs/NGOs and the broader population that is most affected.

Therefore, this research study attempts to assess the effectiveness and impact of the department's funded residential care facilities in the provision of services to the service users. It is hoped the generated information will bring about notable changes to specific strategic interventions and that capacities found to be lacking could be addressed to improve service delivery efforts.

1.4 Aim and objectives.

The aim of the research project is to capture the experiences, opinions and views of the Service Users, Service Providers and Service Implementers of the services at the selected Residential Facilities funded by the department. The outcome of the research will assist the department with future decision making, planning, budgeting, and knowledge sharing. The specific objective of the research project was to: Assess the effectiveness and impact of Limpopo Department of Social Development's funded residential care facilities in the provision of services to targeted beneficiaries by focusing on:

- Child and Youth Care Centres,
- Disability Centres,
- Old Age Homes,
- Secure Care Centres,
- Khuseleka One Stop Centre and
- Treatment Centre.

1.5 Research questions.

This study attempted to answer the following questions:

- What is your understanding of the mandate of the DSD regarding funding of Residential Care Facilities?
- Do you think the budget allocated for this RCF serves the intended purpose?
- What challenges, if any, have you encountered in line with your assigned responsibilities?
- What measures were brough forth to ensure that the mentioned challenges are resolved?
- As a Service Provider/Implementer, are you satisfied with the service put in place to a range of RCFs?
- What do you think could be done to improve service provision at your RCF?

1.6 Scope of the study

In terms of inclusion and exclusion criteria applied, this study targeted residential care facilities funded by the Department of Social Development in the five districts of Limpopo province. The study identified 9 x RCFs in Waterberg, 8 x RCFs in Capricorn, 5 x RCFs in Vhembe, 4 x RFCs in Mopani and 3 x RCFs in Sekhukhune. In terms of the residential care facilities categories, 13 x CYCC, 8 x Old Age Homes, 3 x Disability Centres, 2 x Secure Care Centres, 1 x Khuseleka One Stop Centre and 1 x Treatment Centre were targeted.

Table 1: Research project sites

N0	Name of facility	Type of service	Locality	Municipality
Capricorn District				
01	Association for Persons with Disability (APD)	Provides support for persons with disabilities.	Penina Park	Polokwane
02	Khuseleka Care Centre	One Stop Centre for abused victims.	Sterkloop	Polokwane

03	Martha Hoffmeyer	Residential Centre providing care for the aged.	Polokwane	Polokwane
04	Ngwana House	Child and Youth Care Centre	Fauna Park	Polokwane
05	Polokwane CYCC	Centre to unaccompanied, minors and separated children.	Polokwane	Polokwane
06	Polokwane SCC	Centre for trial awaiting children in conflict with the law.	Sterkloop	Polokwane
07	Sekutupu Old Age Home	Provides care for the aged.	Groothoek	Lepelle-Nkumpi
08	Seshego Treatment Centre	Provides care for substance abusers.	Seshego	Polokwane
Mopani District				
09	Holy Family CYCC	Child and Youth Care Centre	Ofcolaco	Maruleng
10	Iris House CYCC	Child and Youth Care Centre	Giyani Township	Greater Giyani
11	Noah's Ark CYCC	Child and Youth Care Centre	Tzaneen	Greater Tzaneen
12	Shiluvani Life Nkanyisa	Provides support for persons with disabilities.	Shiluvani village	Greater Tzaneen
Sekhukhune District				
13	Epilepsy Care Centre	Provides support for persons with disabilities.	Dennilton	Elias Motsoaledi
14	Loskopvallei Old Age Home	Residential Centre providing care for the aged.	Marble Hall	Ephraim Mogale
15	Tubatse CYCC	Child and Youth Care Centre	Driekop	Tubatse
Vhembe District				
16	Mavambe CYCC	Child and Youth Care Centre	Mavambe village	Collins Chabane
17	Mavambe SCC	Centre for trial awaiting children in conflict with the law.	Mavambe village	Collins Chabane
18	Mtsetweni CYCC	Child and Youth Care Centre	Bungeni	Makhado
19	Ons Tuiste	Residential Centre providing care for the aged.	Makhado	Makhado
20	Takalani Children's Home	Child and Youth Care Centre	Nzhelele	Makhado
21	Thohoyandou CYCC	Child and Youth Care Centre	Thohoyandou	Thulamela
Waterberg District				

22	Abraham Kriel	Child and Youth Care Centre	Modimolle	Modimolle
23	Huis Talje	Child and Youth Care Centre	Belabela	Belabela
24	Huis Tekna	Child and Youth Care Centre	Belabela	Belabela
25	Mantadi CYCC	Child and Youth Care Centre	Mookgophong	Mookgophong
26	Naboom Old Age	Residential Centre providing care for the aged.	Mookgophong	Mookgophong
27	Piet Pot Monument	Residential Centre providing care for the aged.	Mokopane	Mogalakwena
28	Thabang Children's Project	Child and Youth Care Centre	Thabazimbi	Thabazimbi
29	Warmbaths Rusoord	Residential Centre providing care for the aged.	Belabela	Belabela
30	Waterberg Residentia	Residential Centre providing care for the aged.	Modimolle	Modimolle

Each Researcher was provided fifteen (15) structured questionnaires to be administered with the willing participants at the residential care facilities.

1.7 Summary

This chapter has provided the background to the study as well as the purpose for undertaking the study. The questions that need to be answered have been spelt out. Clarity for key concepts that require operational definition has been provided. Chapter 2 will focus on reviewing the literature related to residential care facilities as the central phenomena being researched. The focus is mainly on the facilities funded and supported by the Department of Social in Limpopo province. Chapter 3 deals with the methodology, showing how the study was conducted, profiling tool designed to collect baseline data, sampled population, data collection and the techniques applied in data analysis. Chapter 4 will present the study's findings followed by Chapter 5 which provides a discussion of the study's findings as well as the recommendations.

CHAPTER TWO

LITERATURE REVIEW: RESIDENTIAL CARE FACILITIES

2.1 Introduction

This chapter reviews the literature on residential care facilities. It covers the following areas: (1) Types of residential care facilities, policy, and practice, (2) Child and youth care centres, (3) Disability centres, (4) One stop centre model, (5) Old age homes, (6) Secure care centres, (7) Residential treatment centres, and (8) Legislative requirements for the registration of residential care facilities. The following types of residential care facilities are depicted in the table below:

2.2 Types of residential care facilities

Children's home	Any residence or home maintained for the reception, protection, care and bringing up of more than six children apart from their parents but does not include any school of industries or reform school. Not all children's homes are run by the State. There are children's homes that are maintained and controlled by, for example, the church, welfare organisations or the private sector and were to be registered in terms of section 30 of the Childcare Act 74 of 1983.
Place of safety	Any place established under section 28 [of the Childcare Act] includes any place suitable for the reception of a child, into which the owner, occupier or person in charge thereof is willing to receive a child.
Reform school	A school maintained for the reception, care and training of children sent thereto in terms of the Criminal Procedure Act, 1977 (Act No 51 of 1977)'.
Shelter	Any building or premises maintained or used for the reception, protection, and temporary care of more than six children in especially difficult circumstances. Children in especially difficult circumstances are defined in the Childcare Act 74 of 1983 as 'children in circumstances which deny them their basic human needs, such as children living on the streets and children exposed to armed conflict or violence'
Secure care facility	A facility established under section 28A of the Childcare Act, 1983, and fall under the Department of Social Development.

2.2.1 Child and Youth Care Centres

Child and youth care centres (CYCC) are found in many countries (Smith, Fulcher, and Doran, 2013). According to Smith et al (2013) CYCCs were founded to respond to social problems caused by the process of industrialization and urbanization. As parents move from one place to another searching for educational and job opportunities, children are left to care for their own needs (Adams, 2012). This predicament exposes children to harmful and detrimental circumstances such as alcohol and drug use, sexual abuse, and child labour. Rural-urban migration in South Africa has negatively affected socio-economic development in rural areas. Rural provinces such as Limpopo have been witnessing a huge outflow of people destined for urban areas, predominately to Gauteng and the Western Cape (Mlambo, 2018). In the process, many children are left in the hands of extended families who abuse and neglect them. Some people, out of humanity, dedicated themselves to caring for children who need care and protection by providing food and shelter while their parents are away (Smith et al cited in Malatji & Dube, 2017). Amongst these people are psychologists, social workers, community developers and counsellors. These people were therefore, encouraged to establish family-like settings where neglected children will be cared for, monitored, and groomed, and as a result, CYCCs were established, and a significant number of children were placed in them (Malatji & Dube, 2017).

Table 2: Benefits of staying at Old Age Homes

Child and youth care centres (CYCCs)	Child and youth care centre is a facility for the provision of residential care to more than six children outside the child's family environment in accordance with a residential care programme suited for the children in the facility, but excludes- *(a)* a partial care facility. *(b)* a drop-in centre. *(c)* a boarding school. *(d)* a school hostel or other residential facility attached to a school. *(e)* a prison; or any other establishment which is maintained mainly for the tuition or training of children other than

	an establishment which is maintained for children ordered by a court to receive tuition or training.
Programmes offered at CYCCs.	A child and youth care centre must offer a therapeutic programme designed for the residential care of children outside the family environment, which may include a programme designed for: *(a)* the reception, care, and development of children other than in their family environment. *(b)* the reception, care, and development of children on a shared basis with the parent or other person having parental responsibilities. *(c)* the reception and temporary safe care of children pending their placement. *(d)* early childhood development. *(e)* the reception and temporary safe care of children to protect them from abuse or neglect. *(f)* the reception and temporary safe care of trafficked or commercially sexually exploited children. *(g)* the reception and temporary safe care of children for the purpose of: (i) observing and assessing those children. (ii) providing counselling and other treatment to them, or (iii) assisting them to reintegrate with their families and the community. *(h)* the reception, development and secure care of children awaiting trial or sentence. *(i)* the reception, development, and secure care of children with behavioural, psychological, and emotional difficulties. *(j)* the reception, development, and secure care of children in terms of an order: (i) under the Criminal Procedure Act, 1977 (Act 51 of 1977). (ii) in terms of section 156 (1) (i) placing the child in a child and youth care centre which provides a secure care programme, or (iii) in terms of section 171 transferring a child in alternative care. *(k)* the reception and care of street children.
Services offered at CYCCs	Programmes implemented in the CYCCs are: **1. Developmental programmes** (i) Life skills. (ii) Independent living for children disengaging from the residential care programme. (iii) Victim empowerment. (iv) Family preservation.

	(v) After care. (vi) Promotion of the rights of children, and (vii) Income generating activities. **2. Therapeutic programmes** (i) Developmental assessment. (ii) Psycho-social support. (iii) Individual counselling. (iv) Group counselling. (v) Trauma counselling. (vi) Grieve counselling. (vii) Play therapy. (viii) Family therapy including parenting plans, stress management, conflict resolution, positive communication, positive discipline, and behaviour change, and (ix) Counselling children in child labour, commercial sexual exploitation, and child trafficking. **3. Recreational programmes** (i) Sport (ii) Art (iii) Drama (iv) Dancing (v) Singing, and (vi) Board games.

If a child is believed to be a victim of child labour or is to be living in an abusive environment, a Social Worker must intervene and investigate to establish if the child needs care and protection. After in-depth investigation, if it is established by the Social Worker that the child in question needs care and protection, such a child should be placed in temporary alternative care. Children who are living in unsafe communities, witnessing violence and substance abuse, already experiencing neglect and other forms of abuse need to be helped. Although at times it is too late to prevent harm to children or something has already happened to a child, it is at this point when a different type of intervention becomes crucial. Such vulnerable children may be removed from abusive or unfit environments through government action, or they may be placed in various types of out-of-home to care for them or meet their special needs. In most jurisdictions the child is removed from the home only as a last resort, for their own safety and well-being or the safety of others, since out-of-home care is regarded as very disruptive to the child. They are moved to alternative places usually called residential care facilities (RCFs).

Currently, CYCCs play a significant role internationally as social problems such as child neglect, abuse, and child labour continue to rise. According to Schmid (2006), most CYCCs lack basic resources such as enough space to accommodate all the children who are in need, relevant staff members, as well as vehicles to conduct their day-to-day interventions. In South Africa, the government and private institutions assist CYCCs with funding and donations to ensure that they can provide proper care and protection to the children in need of care and protection. The Limpopo Department of Social Development is committed to support and provide funding to NGOs and NPOs that are assisting government and communities to provide care and protect the rights of vulnerable children.

2.2.2 Disability Centres

Most of the world's population who are labelled as having an intellectual disability live in low- or middle-income countries (LMIC). They are among the most marginalized in every society – at greater risk of poverty, social exclusion, and poor health – and invariably rely on their families to survive as support services are poorly developed or non-existent. This means that the lives of family cares, mothers especially, are also adversely affected. Often the prejudices associated with intellectual disabilities have meant that communities and governments have ignored the needs of these citizens. There have been several developments in South African residential care policy since 1994. The White Paper for Social Welfare which was published in February 1977 contained a section on residential care. The White Paper also indicated that residential facilities would be more multipurpose, more flexible, and less formal. In addition, a residential care facility will generally provide personal care and support such as washing, dressing, and giving medication. Further assistance can be provided in such a way as helping with eating, promoting mobility. There are many different types of benefits in residential care facilities.

Table 2: Services available at the Disability Centres

In the morning	Assistance with walking and preparing for the day. Bathing or showering. Applying lotions. Helping with oral hygiene. Applying makeup and helping with styling their hair. Support with shaving. Dressing
During the day	Assisting to move around the home and the grounds. Assist in the bathroom if need be.

	Assistance during mealtimes. Ensuring residents have the opportunity for social interaction with others. Making sure that residents are well hydrated and taking necessary fluids.
Through the night	Preparing for bed. Repositioning in bed, to stretch and prevent bed sores. Changing continence pads, along with cleaning intimate areas. Changing or maintaining a clean clinical intervention.

Since 2004 Sudden Unexpected Death in Epilepsy (SUDEP) has increased by more than 100% in South Africa. The overall risk of a child having unprovoked seizures is between 1 and 2% of the general population. However, this increases to approximately 6% if a parent has epilepsy. 75% of people with epilepsy will experience their first seizure before the age of 20. Up to 80% of people with epilepsy will be able to control their seizures with medication. 1 in 20 people will have a seizure at some time in their lives. However, this does not mean that they have epilepsy (which requires a specific diagnosis). Slightly more men than women have epilepsy. Residential care facilities are often provided for people that have difficulty living independently, however disabled people and/or epileptic people prefer to live in a residential care facility due to it providing security, social interactions and ongoing support and assistance that is unobtainable at home or elsewhere. People often have the misconception that residential care facilities are a last resort and only need it when they are unwell or completely unable to manage, however there are many residents that simply enjoy the many benefits of the residential care facility.

2.2.3 One Stop Centre model

Globally, the One Stop Centre model is recognised by different names such as “intimate partner violence”, “sexual assault centres”, “crisis centre” or “one stop centre”, and provides multi-sectoral case management for survivors, including health, welfare, counselling, and legal services in one location (Colombini, M Mayhewa, S and Charlotte Wattsa, 2008). According

(Watson and Lopes, 2017) crisis centres are typically located in health facilities, including the emergency departments of hospitals, or as stand-alone facilities near a collaborating hospital, and are usually staffed with specialists 24 hours a day, or can maintain a core group of staff with specialists on call.

The One Stop Centre models in South Africa are community-based centres established as stand-alone, separate facilities in areas which are accessible to the public with all the necessary services provided in the centre. It is an inter-agency unit for victims or survivors of domestic or sexual violence. Such a service was first developed in the largest government-run general hospital in Malaysia (Watson and Lopes, 2017). The victim/survivor is first examined and treated by a doctor and is seen by a counsellor within 24 hours in a separate examination room which protects privacy and confidentiality. If it appears that the victim will be in danger if she returns home, the doctor or counsellor arranges for her to go to an emergency shelter or admits her to the accident and emergency ward for 24 hours. If the patient chooses not to seek shelter, she is encouraged to make a police report at the police unit based in the hospital. In a case involving severe injury, the police see the patient in the ward to record her statement and start investigations (Colombini, M Mayhewa, S and Charlotte Wattsa, 2008).

Equally, South African One Stop Centre models provide accommodation at the centres for a period of six months to the victims and this ensures their safety and recovery under the supervision of professionals, in cases of injuries and psychological trauma. Moreover, the national Victim Empowerment Programme (VEP) has its origins in the Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power, which was adopted by the General Assembly of the United Nations in 1985, to which South Africa is a signatory. The VEP and the roles which are played by providers of VE services are essential components of the concerted strategy of the South African government to demonstrate its commitment to the protection of victims of violence through the ratification of international instruments and the development of appropriate policies, strategies, and legislation (Department of Social Development, 2013).

2.2.3.1 Khuseleka One Stop Centre

The name “Khuseleka” is a Zulu term which means ‘*to protect or to offer a protected environment*”. Khuseleka One Stop Centre was established by the United Nations Office on Drugs and Crime in partnership with the European Union and the Department of Social Development (DSD) with the intention to put the rights and needs of victims at the centre of the crime prevention strategy.

Table 3: Services rendered at the One Stop centres

Shelter	Victims are provided with temporary shelter for a period of six (6) months. The shelter has appropriate accommodation for adults and children, as well as separate sleeping and bathing facilities for men and women.
Social Work Service	Social Workers provide psychosocial services and support to victims - coordinating the therapeutic and counselling services until the victim is released from the shelter.
Health Service	The centre has a clinic in which victims receive primary health services and HIV/AIDS testing, pre-and post-test counselling.
Psychological Support	Victims are referred to psychologists for further counselling.
Police Service	The South African Police Service (SAPS) is arranged to investigate cases of gender-based violence, domestic violence, sexual assault, human trafficking etc.
Skills development programmes	The victims of crime and violence are provided with appropriate education which seeks to empower them, and their children are taken to neighbouring schools. In addition, the victims can acquire meaningful skill which can add value to their lives and immediate use of the skill for earning an income – e.g., skills development programmes such as sewing, gardening, baking, computer literacy training, hairdressing etc. are offered.
Safety and security	There are PSIRA-registered security providers who are trained in guarding RCFs at the shelter.
Nutritious meals	There is free provision of nutritious meals for victims at the shelter.

In Limpopo Province, Khuseleka One Stop Centre is located within the Polokwane Welfare Complex (PWC), formerly known as Polokwane Place of Safety. The UNODC together with the EU ran the organization for a year before handing it over to the Department of Social Development. The Centre was officially launched on the 05th of October 2011 by former Minister Bathabile Dlamini, in line with the department's mandate and scope of service delivery. The services and programmes at the Khuseleka One Stop Centre range from primary (care and protection) to secondary (therapeutic services, restoration, and healing) and tertiary services (skills development and educational programmes). The primary aim of the Centre is to provide temporary shelter and empower victims of domestic violence, human trafficking, hate crime and man-made disasters.

2.2.4 Old Age Homes

De Graaf, Janssen, Roelofs, and Luijkx (2021) defined residential care facility for older persons as facility that provides complex, twenty-four hours, long term care for older adults with mental and or physical impairments. Residential Care Facilities (RCFs) provide a home for frail older adults who are unable to take care of themselves anymore due to their mental or physical impairments (De Graaf et al. 2021:1). According to Brooke (cited by Sun et al. 2021:2), the RCF is a place of residence for older adults from different socioeconomic statuses, educational levels, careers, and cultural backgrounds. Old age home, also known as a nursing home or retirement home is a place where old people can live together and be cared for when they are too weak or ill to care for themselves (Advanced Cambridge Dictionary).

The aging population are people from the ages of 60 years and above. Nonetheless, the theory of stratification classifies aging based on gender as 65 years and above for men and 60 years and above for females. These facilities provide a 24-hour care protection to residents and employees usually includes registered nurses, practical nurses, social workers, nursing assistants and physical therapists among others. On the global scale, it shows that the population of senior citizens is higher and continues

to rise in most countries. Based on the conference held at the International Conference on Population and Development (ICPD), it was recognized that the economic and social impact of population aging is a challenge in most societies (UN, 1994). And despite the challenges faced by this population, they tend to live longer than expected which negatively impact is a distinctive demographic event in the twentieth century and an inevitable demographic consequence (United Nations, 2002).

According to (Mueni, 2022) old age homes in South Africa (SA) provides care to senior citizens since it can be overwhelming for family members to be with them due to work and other responsibilities. Most people prefer to have their aging parents and grandparents stay at nursing homes. Furthermore, most old age homes in SA have modern facilities for the elderly and trained personnel including medical professionals to care for them. The professionals handle all old age complications the resident's experiences such as joint pains, depression, and Alzheimer's related diseases. In South Africa, the growth rate among the elderly (60 years and older) rose from 1,1% for the period 2002–2003 to 3,0% for the period 2019–2020. Vulnerabilities evident in this age group range from the need for social assistance programmes, easy access to cash transfers to food programmes and access to health care.

Furthermore, it is estimated that the population in 2020 was around 59,62 million in South Africa. Around 51,1% (approximately 30,5 million) of the population is female, while 5,43 million people are aged 60 and over (Statistics South Africa, 2020). Old age homes can either be private or government organizations that act as homes for the elderly. They are registered with the Department of Social Development (DSD) and certified as non-profit organizations to provide them with accommodation and medical services. South Africa has about 1150 residential facilities for older persons including retirement villages, frail care facilities, nursing homes and step-down facilities. Those registered with DSD are about 415 and the government manages and subsidizes about eight of them. According to (Bhat, 2021) there are 278 homes around the world for the elderly and 101 old homes specifically for women.

Dubey, Bhasin, Gupta & Sharma (2011), proclaim old age means decline in one's physical and mental ability, the regular giving up of participation within the socio-economic activities, and a transfer in profitable position moving from economic independence to economic dependence upon others for sustenance. It is vital that the state, civil society, and community distinguishes the rights and requirements of the elderly women and make appropriate policies, procedures, laws, rules, legislations and efficient accomplishment of health and safety measures and schemes which are already present thus, these policies will be mandated to protect the human rights of the elderly people. Elder persons are fully protected by the law through the Older Persons Act (OPA).

Table 4: Benefits of staying at Old Age Homes

Safety and security	Safety is the most important benefit of residential care homes and one that sways many decisions. When the elderly and vulnerable can't look after themselves efficiently, quite often they become a hazard to themselves. RCFs are staffed and nurses readily available 24/7. There is always somebody present and ready to look after the service users.
Unity and friendship	Service Users have countless opportunities to socialise not only with people of similar age, but people in the same circumstances as them. There is always an opportunity for Service Users to have human interaction or company.
Rejuvenating the body and soul	As people age or become more vulnerable, it is important to ensure they keep their mind and body invigorated as often as possible.
Daily nutritious meals	Residents are served regular and wholesome meals to ensure they receive daily nutrition they need.
Medical management	Adequate medication management system is in place to ensure medication is monitored accurately and administered appropriately.
Intensive care and supervision	There are many old age homes available that provide specialized services that require more intense care levels (i.e., specific care, palliative care, elderly care, and physical disability).
Conducive living conditions	Living conditions can be more comfortable in Residential Care Facilities because they are regulated and monitored to maintain acceptable living conditions.

2.2.5 Secure Care Centres

The Department of Social Development (2010) defined secure care as a residential facility and programme of intervention which ensures the appropriate physical, behavioural and emotional control of young people who are charged with crimes and who are awaiting trial, division or sentenced. Residential secure care centres are provided for children and young people with significant care and protection needs after it has been determined that other care alternatives within the family or community are deemed inadequate or inappropriate. Therefore, residential secure care centres ought to be a highly specialized environment with an intensive and institutional continuum of services available to children and young people in need of care and protection intervention.

Secure care centres differentiate children who are conflicted with the law, that need to be provided with the programme that will make all the changes about their care and responsibilities for their wrong behaviors as guided by Section 1 of the Children's Amendment Act 41 of 2007 (hereafter Children's Amendment Act). The place ensures that children are prevented from their habit of wrongdoing, this includes restricted movement to ensure that community are safe. The intention was to ensure that there is a “place” where these children are controlled, as well as an “intervention” during their containment.

Table 5: Opportunities provided at Secure Care Centres

Containment	Ensures the appropriate physical, behavioural and emotional containment of offenders.
Safety and security	Provides a conducive environment to the care and safety of offenders while simultaneously ensuring protection of the communities
Personal growth and development	Facility provides educational programmes which enable the offender a focused opportunity for personal growth and development - including academic progress.

2.2.6 Residential Treatment Centres

According to Prevention of and Treatment for Substance Abuse (Act, 2008), ‘’public treatment centre’’ means an inpatient or out-patient treatment centre that is owned and financed by the government or an organ of state and established for the treatment and rehabilitation of service users who abuse or are dependent on substances. Drug and Alcohol Dependency (2019) defined residential treatment as a standard treatment for individuals with severe and complex substance use problems. In the treatment of substance use disorders (SUDs), a common treatment approach used is residential treatment, where patients spend approximately one month engaging in various psychosocial treatments as well learning strategies for the prevention of relapse.

Some authors argue that residential treatment lacks a clear definition of the treatment methods, duration, and standards, highlighting the need for research to further understand effective treatment components (Reif et al., 2014). The opposing outcomes suggest that several confounds might be impacting treatment effectiveness, such as patient factors or program components offered at different treatment centres (Reif et al., 2014). Other studies have misused the label of residential treatment, which has led to confusion between community-based residential treatment and inpatient hospital treatment. It is important for studies to distinguish between these two settings due to the difference in staff and programmes offered in each, with community-based residential treatment typically occurring within a psychosocial framework and inpatient treatment focusing on medical stabilization.

Table 6: Programmes offered at Residential Treatment Centres

Programmes	Substance-specific psychological education,
	Group therapy (including various modalities such as cognitive behavioural therapy), which help in attaining abstinence and other substance related goals,
	Engagement in 12-step groups both inside and outside the treatment centre.

2.3 Legislative requirements for the registration of Residential Care Facilities

The registration of Residential Care Facilities is mandatorily regulated by the DSD and requires for dual registration for most of the RCFs, that is, for the NPO to register with the DSD first as well as the relevant legislation guiding that facility to enable them to access funding (section 193 (3) of the Children's Act) from the DSD for the running of those facilities. For an NPO to be registered, it must comply with the registration requirements as set out in section 12 (2) of the NPO Act (71 of 1997).

2.3.1 Registration of Child and Youth Care Centres

While the Constitution sets out the rights of children in section 28, the Children's Act governs Child and Youth Care Centre (CYCC) in their management and maintenance. For a CYCC to operate, the NPO Act requires it first to register with the national DSD in terms of the NPO Act and register the CYCC with the relevant provincial DSD in terms of the Children's Act (section 197).

The requirements of section 200 (2) entails that an accredited organisation may only operate a CYCC if the centre is:

- Registered with the relevant provincial Department of Social Development.
- Managed and maintained in accordance with the Children's Act.
- Complies with the norms and standards prescribed by the Act for child and youth care centres.
- Complies with the structural, safety, health, and other municipal requirements of the municipality in which the CYCC is situated.

Further requirements upon application entails that:

- Applicant should be a fit and proper person to operate a CYCC,
- Applicant has the necessary skills, funds, and resources available to operate the CYCC,
- Each person employed at, or engaged in the CYCC is a fit and proper person to assist in operating a CYCC, and
- Each person employed at or engaged in the CYCC has the prescribed skills to assist in operating a CYCC.

Proper registration ensures that all children at the centre are registered within the child protection system and receive the necessary court-based and other statutory services they need and are entitled to, thus ensuring the best interest of the children at the centres.

2.3.2 Registration of Disability Centres

The documents which guide disability centres are the Children's Act, the Policy on Social Development Services, White Paper on the Rights of Persons with disabilities, minimum standards on residential facilities, policy on protective workshop. The National Development Plan 2030 requires the Department of Social Development to systematise guidelines, norms, and standards to ensure that they "take into account the needs of children with disabilities in all communities". There has been a reported case of 27 RCFs rendering services for children with disabilities who have been conditionally registered as they are not fully compliant with the Norms and Standards. Protective workshop and residential facilities for persons with disabilities do not have legislative mandate for registration. They only register in terms of NPO Act 71 of 1997.

2.3.3 Registration of Khuseleka One Stop Centre

Khuseleka One Stop centres are founded under the Victim Empowerment Programme to address issues such as domestic violence, rape, human trafficking, and sexual harassment as faced mostly by women and children. The registration for victim support facilities is done through the provincial Head of the Departments (HODs). Model stakeholders includes amongst others, the South African Police Services (SAPS), the Hawks, the National Prosecuting Authority (NPA), South African Social Security Agency (SASSA). Business Against Crime, Civil Society Organisations, and the National Departments of Justice, Correctional Services, and Home Affairs all with different assigned roles to aid with the implementation of the Bill as well as the progressive advancement of the victim support facilities.

2.3.4 Registration of Old Age Homes

The registration process for old age homes also takes the form of dual registration, that is with the registration in terms of the NPO Act as well as in terms of the Older Persons Act (13 of 2006). The framework for ensuring the highest possible standards of care for elderly people in residential care and communities in South Africa has been laid down by the national government and these include the Constitution, the Aged Persons Act (81 of 1967); the Aged Person Amendment Act (100 of 1998); the Domestic Violence Act (116 of 1998); the Older Persons Bill (68 of 2003), the Mental Health Act (17 of 2002) and all these account for regulations and standards, monitoring and inspection, and enforcement.

Literature suggests that the characteristics of the elderly living in RCFs include frailty, cognitive impairment, and communication difficulties (Mandiracioalu & Cam 2006, Gaugler, Leach, Clay & Newcomer 2004). These studies found that the indicators of frailty and dependency among the elderly were significant predicators of staff burnouts and mistreatment of the elderly. In one research done by the Department of Social Development of South Africa (Senior World Chronicle, 2008) to determine the elderly perception on residential care, rural dwelling old people said they did not want to go to nursing homes because it takes away a sense of "pride”.

Services that are rendered by an Old Age Home include but not limited to:

- Care supervision to older persons,
- Rehabilitation services,
- Counselling services,
- Occupational therapy,
- Mobility training, and
- Pain management.

Some of the comprehensive services provided in service centres for older persons according to the (Older Person Service Package 2015/16-2017/18) include:

- Economic empowerment: This is to encourage or help older persons to improve their financial status,
- Active Ageing programmes: Promoting Healthy lifestyle to improve their quality of life,
- Dissemination of information: To keep older persons informed to enable them to do things for themselves and be less dependent on others,
- Education and training (skills development): To assist older persons in acquiring skill that will enhance their quality of life,
- Spiritual, cultural, medical, civic, and social services: The objective is to allow them freedom of association and to participate in activities that give them joy, and
- Regular nutritionally balanced meals: To respond to the nutritional needs of older people to prevent illnesses and premature onset of frailty.

The Minister of DSD is retained with the powers of formulating standards and regulations in RCFs, but it remains the responsibility of the authorities of each RCF to ensure that the services are of high quality and appropriate to the individual needs of each resident.

2.3.5 Registration of Secure Care Centres

The registration of secure care centres takes a similar form to that of CYCCs. The Childcare Act, 1983 which provides for the establishment of children's courts and the appointment of commissioners of child welfare, for the protection and welfare of certain children, for the adoption of children and for the establishment of certain institutions for the reception of children and for the treatment of children after such reception, was amended in 1996 to provide for legal representation for children and for the registration of shelters. The 1998 amendment provided for the rights of certain natural fathers where the adoption of their children born out of wedlock has been proposed and for certain notice to be given. The 1999 amendment provided for the establishment of secure care facilities and for the prohibition against the commercial sexual exploitation of children.

All the residential facilities under secure care government and non-government should be recognized and maintained based on the national regulation, minimum standards, and practice guidelines which are created by international instruments and international accepted child and youth care. They should provide them with the programmes that will measure the crime that child is involved in. The programmes should have an age limit based on the degree of danger which young children pose to peers. The secure care centres should ensure that they have tight security, for the protection of the child and the workers. The facilities are dealing with dangerous children who are involved in different crime scenes, it is important to provide high security and minimum-security units.

2.3.6 Registration of Residential Treatment Centre

The residential treatment centre is registered in terms of the NPO Act and operates in accordance with the Prevention and Treatment of Substance Abuse Act (70 of 2008). Registration can be issued in full for a period of five (5) years or conditional for a period of 12 months subject to the implementation of the provided conditions. The services rendered at the centre are expected to be of quality as they comprise of a multi-disciplinary team of professionals and are provided within the spirit of the protection of human rights and dignity. The DSD provides subsidised treatment which can be accessed through any social worker in the Social Development offices.

2.4 Summary

In this chapter analyses of the following aspects formed part of the review of the related literature: Forms of residential care facilities, policy and practice, child and youth care centres, disability centres, one stop centre model, old age homes, secure care centres, residential treatment centres, and Legislative requirements for the registration of residential care facilities. The next chapter will discuss the methods used to assess effectiveness and impact of Department of Social Development funded residential care facilities in Limpopo province.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter presents selected research designs and plans for this study. Several methodological choices are briefly explained, in terms of what was utilised and the applied strategy. These include aspects such as nature of the study, research design, target population, data collection and analysis, as well as ethical considerations.

3.2 Research design

The 5W-H research design was used as an analytical throughout the research.

Table 7: The 5W-H research design

5W-H	Description
Why	Why are we doing this research?
What	What do we do?
Where	Where is the research going to be conducted?
Who	Who is the target population?
When	When is the project envisaged to be completed?
How	How is the research going to be implemented?

3.3 Research methodology

The study applied a mixed method utilizing both qualitative and quantitative research approaches for data collection. The interview approach was adopted, and although at the beginning the interview questions were structured, they became less structured towards the tail end of the research tool. Semi-structured interviews give the research participants more room to answer in terms of their views, experiences and what is important to them (Miles & Huberman, 1994; Strauss & Corbin, 1998). The qualitative interviews were deemed appropriate to solicit research participant's thoughts and lived experiences of residing and working at the respective facilities.

The unit of analysis was the individual service users, service providers and implementers of the residential care facilities. The research participants were drawn from twenty-six (**26**) residential care facilities (i.e., **13** x CYCC, **2** x Disability Centres, **7** x Old Age Homes, **2** x Secure Care Centres, **1** x Khuseleka One Stop centre and **1** x Residential Treatment Centre). Each Researcher was assigned one residential care facility to interview at least 10 x willing Service Users and 10 x willing Service Providers/Implementers. It means each researcher had a target of twenty (**20**) willing participants to interview in the categories: Service Providers (e.g., Facility Managers, Care Givers, Social worker, Food handler, Board member etc.), Service Users, Support staff (e.g., cleaners, gardeners, plumbers, etc.).

3.4 Data collection

3.4.1 Baseline data collection technique

A Profiling Tool was designed to collect baseline data at the various residential care facilities (i.e., Child and youth care centres, disability centres, old age homes, secure care centres, Khuseleka One Stop centre, and residential treatment centre). The specific details of profiling tool guided the Researchers to:

- Populating the geographic location of the facility (e.g., from district, local municipality, ward number, community/village/town, street name, stand no etc).
- Populating facility information (e.g., name of the facility, when established, bed capacity, number of service users at its establishment, current number of service users etc).
- Disaggregating data according to demographic characteristics e.g., gender, age, disability, etc.
- Establishing the management of the facility (management, board members etc.)
- Establish the registration status of the facility.
- Documenting the type of services rendered (e.g., core/primary, secondary and tertiary services etc).
- Establishing sources of funding and any other fund-raising activities (e.g., donation in kind, developmental income generation activities etc.).

The Profiling tool is attached as Annexure A1.

3.4.2 Field data collection procedure

The Research Project Steering Committee (RPSC) met on 22 August 2023 to review the draft research tool and made inputs that warranted the draft research tool to be amended. The research tool was piloted at Mantadi Child and Youth Care Centre (Waterberg District), Mtsetweni Child and Youth Care Centre (Vhembe District) and Martha Hoffmeyr Old Age Home (Capricorn District). Some questions were later refined after receiving further input from the RPSC to make them readable and to eliminate ambiguity in accordance with the pilot-test results. The research tool was subsequently approved on 15 October 2022 to pave way for field interviews. The research tools were then printed and distributed to the Researchers across the province to embark on data collection process. The research tool was administered by the Researchers who also facilitated the participation of willing participants through signed consent forms.

3.4.3 The research Instruments.

Two structured data collection tools were developed – one for Service Users and the other for Service Providers and Implementers.

3.4.3.1 Service Users

The first section of the research tool had seven questions which sought to solicit the demographic data of the participants. The study used both categorical variables, such as - home language, gender, race, marital status, location of the centre, and continuous variables, such as – age and education level. This section was important to comprehend the backgrounds of the research participants.

The second section had five questions meant to solicit information on the part of the Service Users to tick the appropriate boxes (quantitative) such as type of residential care facility, how long at the facility, ever been re-admitted, any financial support if any, satisfied with the services provided at the facility, and indicating the level of satisfaction/dissatisfaction pertaining to provision of services at facility.

Third and last section had two qualitative questions where the Service Users were offered to elaborate on a) how they were impacted by the services received during your stay in the facility and b) what could be done to improve service provision at the facility.

3.4.3.2 Service Providers and Service Implementers

The first section of the research tool had the first seven questions like the Service Users tool and the eighth on current employment status to solicit the demographic data of the participants. The second section had five open-ended questions.

The interview questions under this section were as follows:

a) *What is your understanding of the mandate of the DSD regarding funding of Residential Care Facilities? Probe*
b) *Do you think the budget allocated for this residential care facility serves the intended purpose? Probe*
c) *What challenges, if any, have you encountered in line with your assigned responsibilities? Probe*
d) *What measures were brought forth to ensure that the mentioned challenges were resolved? Please elaborate.*
e) *Are you satisfied with the services put in place to a range of Residential Care Facilities? Please elaborate.*

3.4.3.3 General closing question

The last question on the research tool was meant to give the research participant to say anything related to the research that might had not been covered by selected research questions.

a) Is there any additional information that you would like to share?

3.5 Data analysis

The collected data was analysed thematically. Ryan and Bernard (2003) argue that if thematic classification is missing, researchers will not be able to describe, explain and compare information gathered during a research process. The collected data was manually analysed to identify themes and make sense of the data. According to Braun and Clarke (2018), thematic analysis entails spotting themes or patterns within qualitative data. To this effect, a theme describes and classifies the probable

interpretations or observations of phenomena selected in the data (Braun & Clarke, 2019). The study only used the data of the research participants who completed the interviews.

3.6 Ethical considerations

The research instrument was administered by the Researchers after obtaining approval from the Research Project Steering Committee overseeing the research project. The ethical considerations such as the right of privacy, confidentiality, anonymity including respecting the rights of the research participants as enshrined in Section 27 (1a-c) and section 28 (1a-f) of the Constitution Act no. 108 of 1996. In line the Protection of Person Information Act (POPIA) and the ethical conduct of research, the study followed the following ethical protocols and considerations namely:

3.6.1 Informed consent

The participants were informed about the purpose of conducting the research, significance of their participation, and that their consent to participate was important. Christensen, Johnson, and Turner (2015) define “informed consent” as telling the participants about all aspects of the study that might influence their willingness to agree to participate.

Researchers requested the assistance of Caregivers in instances where the Service Users were under the age of 18 before participation in the research project. This complies with Section 31 of the Children’s Act (Act 38 of 2005) which states that a person holding parental responsibilities and rights in respect of a child takes any major decision that will affect the child’s circumstances and wellbeing, that person must give due consideration to any views and wishes expressed by the child, bearing in mind the child’s age, maturity, and stage of development. The Facility Managers or *“persons responsible for the day-to-day management of a residential facility*” can give Assent Consent after satisfying themselves that there is no harm for service users

to participate in the research. According to the Children's Act 38 of 2005, a caregiver is defined as "*any person other than a parent or guardian, who factually cares for a child*" and includes:

- A foster parent,
- A person who cares for a child with the implied or express consent of a parent or guardian,
- A person who cares for a child whilst the child is in temporary safe care,
- A person at the head of a child and youth care centre where the child was placed,
- The person at the head of a shelter,
- A child and youth care worker who cares for a child who is without proper family care, and,
- The child at the head of a child-headed household.

This research project included the Child and youth care and disabilities centres where in some instances the research participants (Service Users) were either minors or had disability related challenges, and the Caregivers were requested to assist.

3.6.2 Voluntary Participation

The norm of "voluntary participation" in social research means persons selected to answer questions can choose to participate and not be forced (Babbie, 2013). At all material times, researchers should apprise participants of their right to refuse to participate or withdraw from research. The participants in this study were told that participation was voluntary, and that their agreeing to participate will be evidenced through their signatures on the informed consent form. Additionally, the selected participants were told that there was no remuneration, including time inconvenience and expenses for being part of the research study.

3.6.3 Anonymity

Anonymity is one of ethical guidelines laid down to protect participants' information. The study did not use participant names, but rather used participant numbers to eliminate the risk of identifying their personal details. Bell (2014) defines anonymity as a research protocol in which both the investigator and the reader will not be able to identify the participants based on their responses.

3.6.4 Confidentiality

The research participants were assured that the information provided will be treated strictly as confidential. Confidentiality as one of the ethical principles is important in research to avoid violations from occurring and to outline duty of the investigator (Christensen, Johnson, & Turner, 2015). Confidentiality is an obligation on the part of the investigator that any use of the information obtained from the participants is protected to safeguard their dignity and autonomy (Bos, 2020).

3.7 Summary

This chapter presented insights into the methodology applied. The focus was mainly on the approaches and methods utilized to derive the achievement of stated aims and objectives of the study. Key methodological aspects including study design, target population, data collection and analysis as well as the research ethics that were fully explained. Chapter four will provide the findings of the research.

CHAPTER FOUR

RESEARCH FINDINGS

4.1 Introduction

The chapter presents the results based on the data collected from Thirteen **(13)** child and youth care centres, Seven (**07**) old age homes, Two (**02)** disability centres, Two (**02)** secure care centres, One (**01**) Kkuseleka one stop centre, and One (**01**) residential treatment centre. The participants were interviewed from mixed methods of qualitative and quantitative research.

Table 8: Number of residential care facilities per district reached.

District	CYCC	DC	KOSC	OAH	SCC	STC	Total
Capricorn	02	-	01	2	01	01	**07**
Mopani	03	01	-	-	-	-	**04**
Sekhukhune	01	01	-	01	-	-	**03**
Vhembe	03	-	-	01	01	-	**05**
Waterberg	04	-	-	3	-	-	**07**
Total	**13**	**02**	**01**	**07**	**02**	**01**	**26**

Capricorn District and Waterberg District had the highest facilities reached (i.e., **07**) whereas Sekhukhune had fewer facilities researched (i.e., **03**) as shown by Table 9, and Fig 1 respectively.

A total of **528** participants from **26** facilities were reached throughout Limpopo Province. The highest participant number (i.e., **263**) reached was from CYCCs and the least number (i.e., **18**) of participants reached was from Seshego Treatment Centre as depicted by Table 10 and Fig 2 respectively.

Figure 1: Number of Residential Care Facilities reached per district.

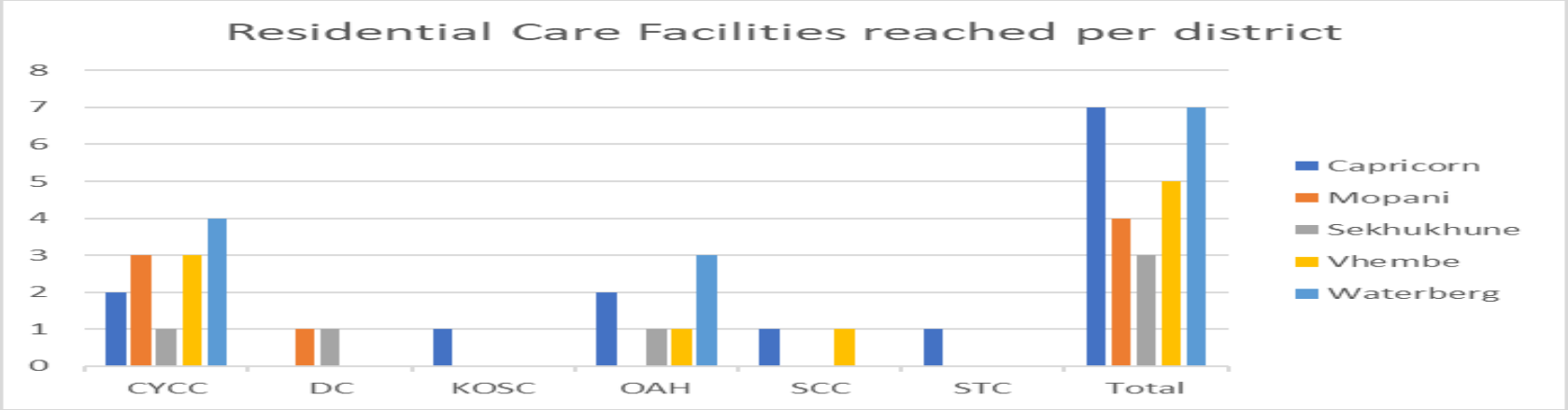
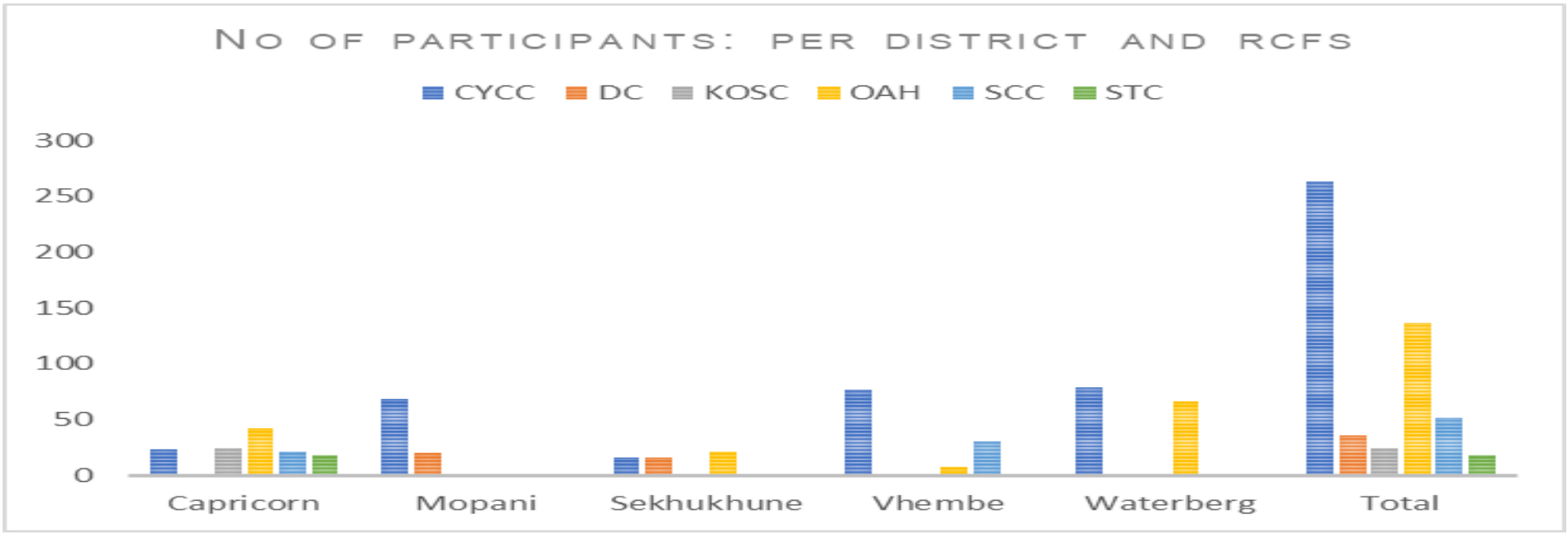


Table 9: Number of research participants per district and category of residential care facilities reached.

District	Types of Residential Care Facilities						
	CYCC	DC	KOSC	OAH	SCC	STC	Total
Capricorn	23	-	24	42	21	18	**128**
Mopani	68	20	-	-	-	-	**88**
Sekhukhune	16	16	-	21	-	-	**53**
Vhembe	77	-	-	7	30	-	**114**
Waterberg	79	-	-	66	-	-	**145**
Total	**263**	**36**	**24**	**136**	**51**	**18**	**528**

Figure 2: Number of research participants per district and category of residential care facilities reached.



4.2 Demographic characteristics of research participants

Most participants were females (**381**) and many of them were in the CYCCs (**206**). The Seshego Treatment Centre (STC) recorded the least number of female participants (**05**) overall evidenced by Table 11 and Fig 3 below.

Table 10: Distribution of Respondents by gender and residential care facilities

Gender	CYCC	DC	K-OSC	OAH	SCC	STC	Total
Female	206	20	18	112	20	5	**381**
Male	57	16	6	24	31	13	**147**
Total	**263**	**36**	**24**	**136**	**51**	**18**	**528**

Figure 3: **Distribution of Respondents by gender and residential care facilities**

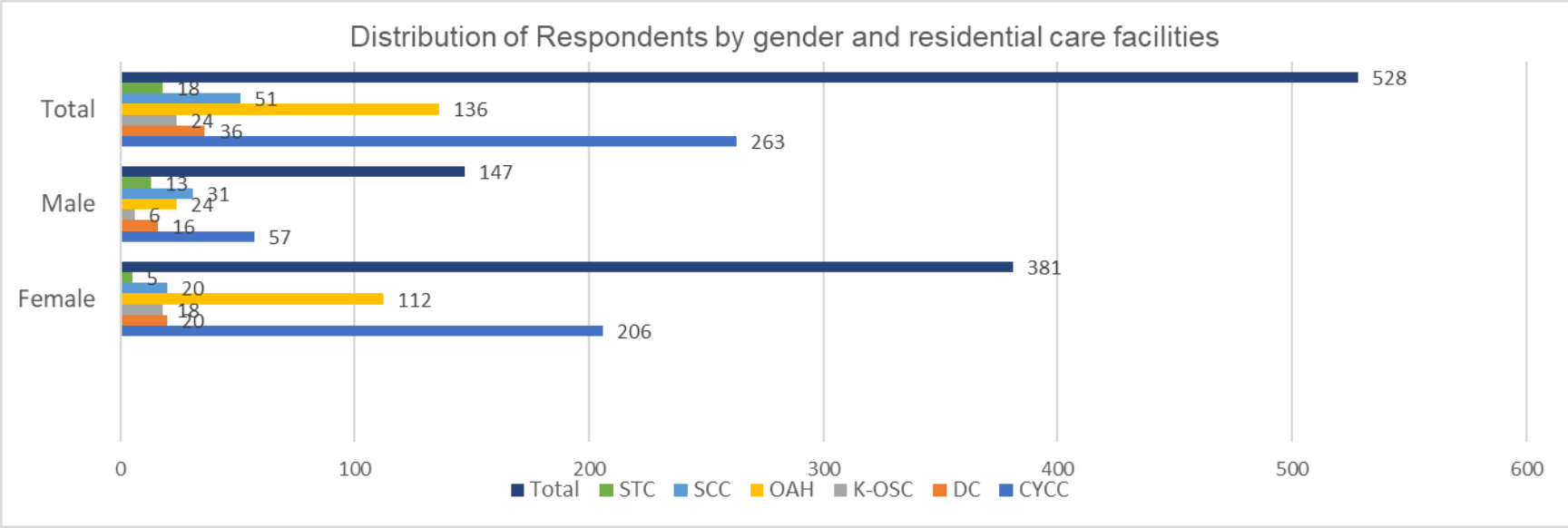


Table 12 and Fig 4 below show that most participants (i.e., **211**) were in the category of age range between 36-59 years, followed by <18 years (i.e., **131**) and 18-35 years (i.e., **105**) respectively.

Table 11: Distribution of Respondents by age and residential care facilities

Age Category	CYCC		DC		K-OSC		OAH		SCC		STC		Total	
	F	M	F	M	F	M	F	M	F	M	F	M	**F**	**M**
<18	83	33	0	0	1	0	0	0	7	7	0	0	**91**	**40**
18-35	36	9	5	2	8	4	8	2	7	15	1	8	**65**	**40**
36-59	84	13	13	9	9	2	51	6	6	9	4	5	**167**	**44**
60+	3	2	2	5	0	0	53	16	0	0	0	0	**58**	**23**
Total	**206**	**57**	**20**	**16**	**18**	**6**	**112**	**24**	**20**	**31**	**5**	**13**	**381**	**147**

Figure 4: Distribution of responses by age and residential care facilities

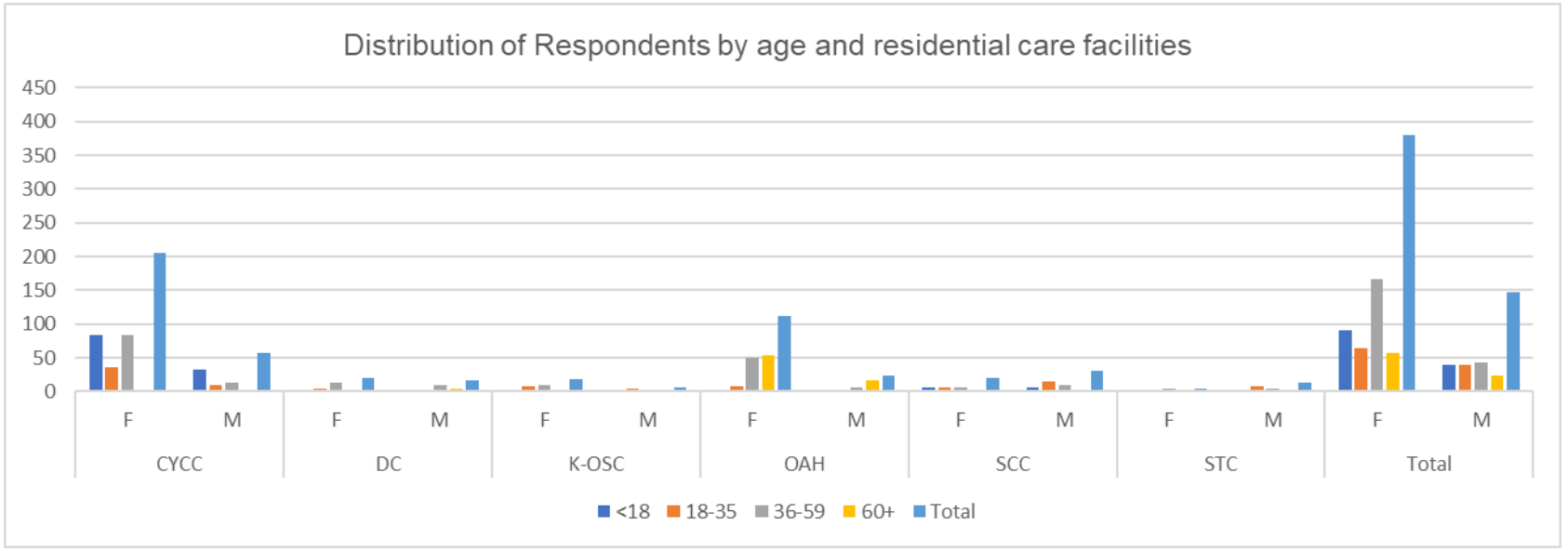
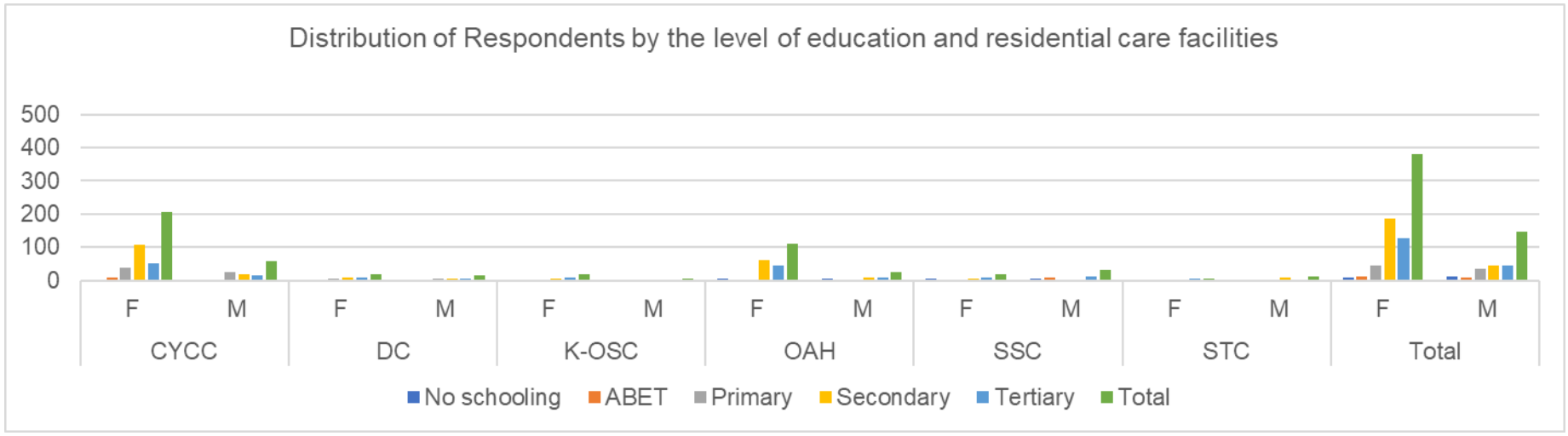


Table 13 and Fig 5 reveal the level of education for most participants to be at the secondary level (**233**), followed by tertiary (**170**) and primary (**82**) levels respectively.

Table 12: Distribution of Respondents by the level of education and residential care facilities

Education Category	CYCC		DC		K-OSC		OAH		SSC		STC		Total	
	F	M	F	M	F	M	F	M	F	M	F	M	**F**	**M**
No schooling	1	0	0	3	0	0	4	4	5	4	0	0	**10**	**11**
ABET	8	0	0	0	2	0	2	0	0	9	0	1	**12**	**10**
Primary	38	25	5	4	2	0	1	3	0	3	0	1	**46**	**36**
Secondary	108	18	8	5	5	3	60	10	5	2	1	8	**187**	**46**
Tertiary	51	14	7	4	9	3	45	7	10	13	4	3	**126**	**44**
Total	**206**	**57**	**20**	**16**	**18**	**6**	**112**	**24**	**20**	**31**	**5**	**13**	**381**	**147**

Figure 5: Distribution of responses by level of education and residential care facilities.

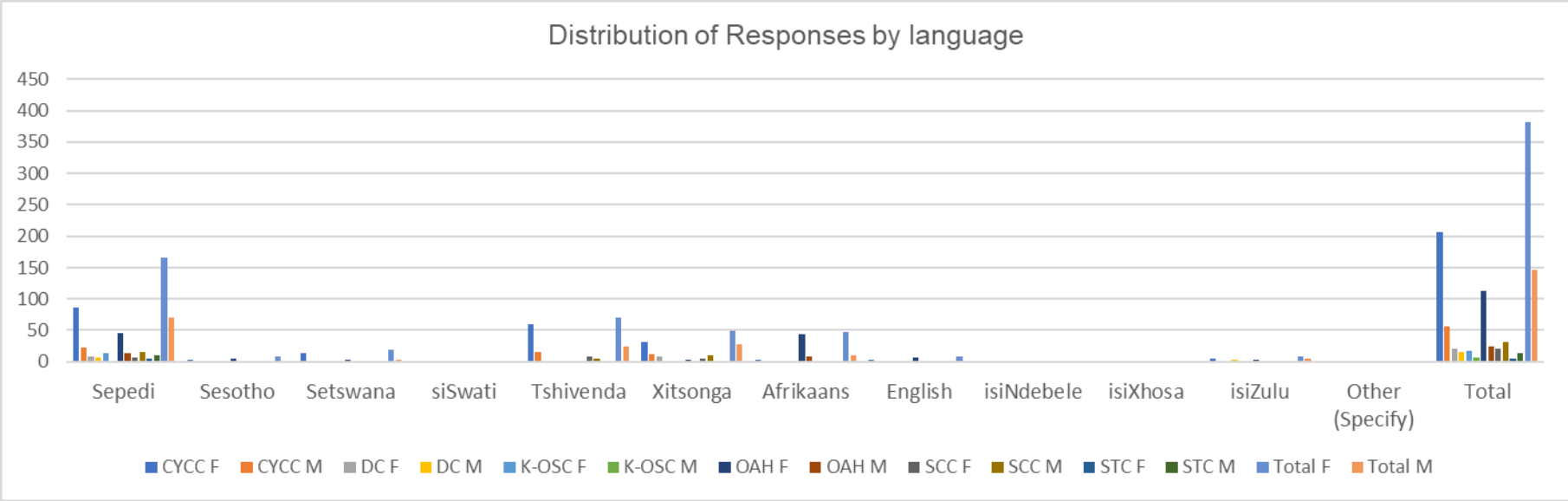


Sepedi (**236**) is the most spoken language followed by Tshivenda (**96**), Xitsonga (**76**) and Afrikaans (**58**). The least spoken language with one (**1**) research participant was isiXhosa as shown by Table 14 and Fig 6 below.

Table 13: Distribution of Respondents by language and residential care facilities

language	CYCC		DC		K-OSC		OAH		SCC		STC		Total	
Category	F	M	F	M	F	M	F	M	F	M	F	M	F	M
Sepedi	87	23	8	7	14	2	46	13	6	15	4	11	**165**	**71**
Sesotho	3	1	0	0	0	0	5	0	0	0	0	0	**8**	**1**
Setswana	14	2	1	0	1	0	3	0	0	1	0	0	**19**	**3**
siSwati	0	0	1	0	0	0	0	0	0	0	0	0	**1**	**0**
Tshivenda	59	15	0	1	1	1	2	1	9	4	0	2	**71**	**24**
Xitsonga	31	12	8	2	1	2	3	1	5	11	1	0	**49**	**28**
Afrikaans	3	0	0	2	1	0	44	8	0	0	0	0	**48**	**10**
English	3	0	0	0	0	0	6	1	0	0	0	0	**9**	**1**
isiNdebele	0	1	0	1	0	0	0	0	0	0	0	0	**0**	**2**
isiXhosa	1	0	0	0	0	0	0	0	0	0	0	0	**1**	**0**
isiZulu	4	2	2	3	0	0	3	0	0	0	0	0	**9**	**5**
Other (Specify)	1	1	0	0	0	1	0	0	0	0	0	0	**1**	**2**
Total	**206**	**57**	**20**	**16**	**18**	**6**	**112**	**24**	**20**	**31**	**5**	**13**	**381**	**147**

Figure 6: Distribution of Responses by language.

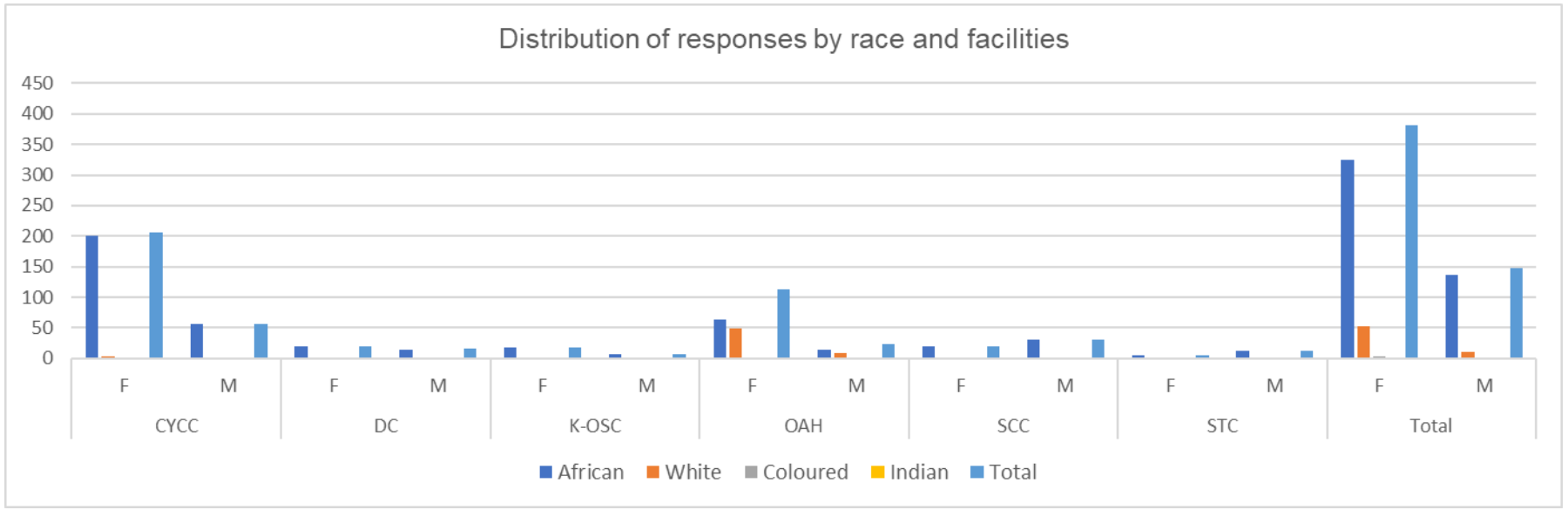


In terms of race, Africans were by far in the majority (**461**), followed by Whites (**63**) and Coloured (**4**). None of the participant was Indian as shown on Table 15 and Fig 7 below.

Table 14: Distribution of Respondents by race and residential care facilities

Race category	CYCC		DC		K-OSC		OAH		SCC		STC		Total	
	F	M	F	M	F	M	F	M	F	M	F	M	**F**	**M**
African	200	57	20	14	17	6	63	15	20	31	5	13	**325**	**136**
White	4	0	0	2	0	0	48	9	0	0	0	0	**52**	**11**
Coloured	2	0	0	0	1	0	1	0	0	0	0	0	**4**	**0**
Indian	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**
Total	**206**	**57**	**20**	**16**	**18**	**6**	**112**	**24**	**20**	**31**	**5**	**13**	**381**	**147**

Figure 7: Distribution of responses by race and facilities.

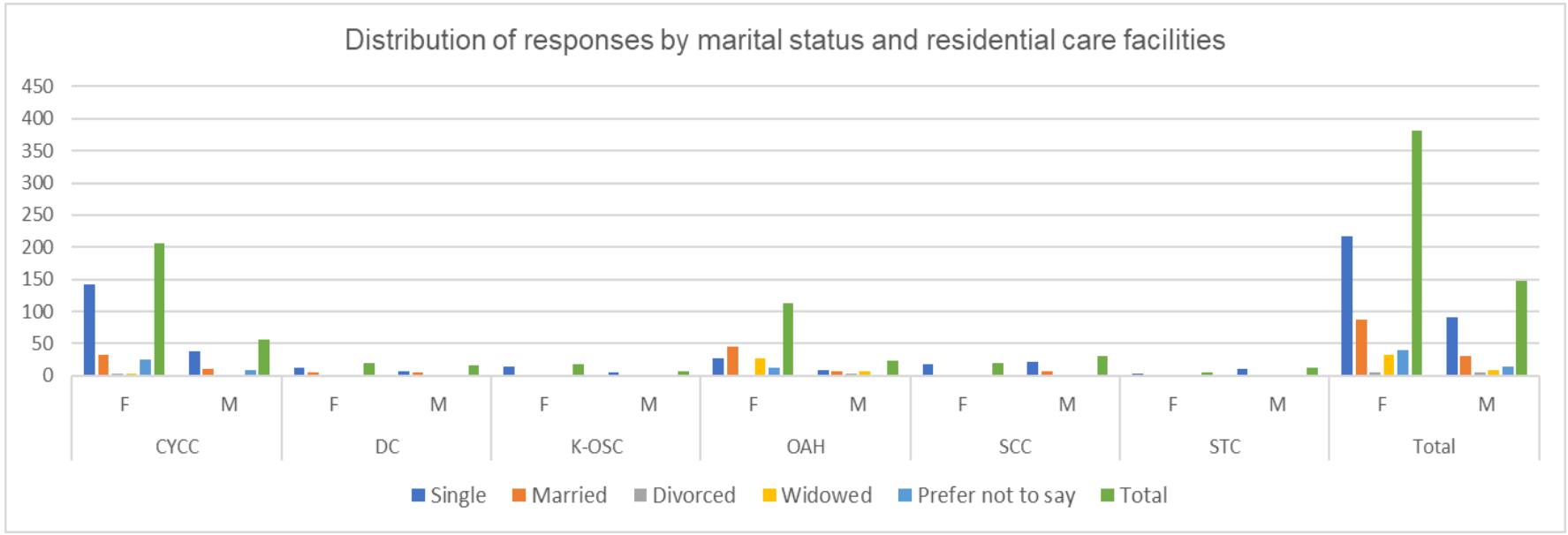


Most participants were single (**305**), followed by those that are married (**118**), and those who preferred not to say (**54**).

Table 15: Distribution of Respondents by marital status and residential care facilities

Marital status	CYCC		DC		K-OSC		OAH		SCC		STC		Total	
	F	M	F	M	F	M	F	M	F	M	F	M	**F**	**M**
Single	142	38	12	7	15	5	27	8	17	22	3	10	**216**	**90**
Married	32	10	5	5	2	1	45	6	2	7	1	1	**87**	**30**
Divorced	3	0	0	2	1	0	1	3	0	0	0	0	**5**	**5**
Widowed	4	0	2	2	0	0	26	6	1	0	0	0	**33**	**8**
Prefer not to say	25	9	1	0	0	0	13	1	0	2	1	2	**40**	**14**
Total	**206**	**57**	**20**	**16**	**18**	**6**	**112**	**24**	**20**	**31**	**5**	**13**	**381**	**147**

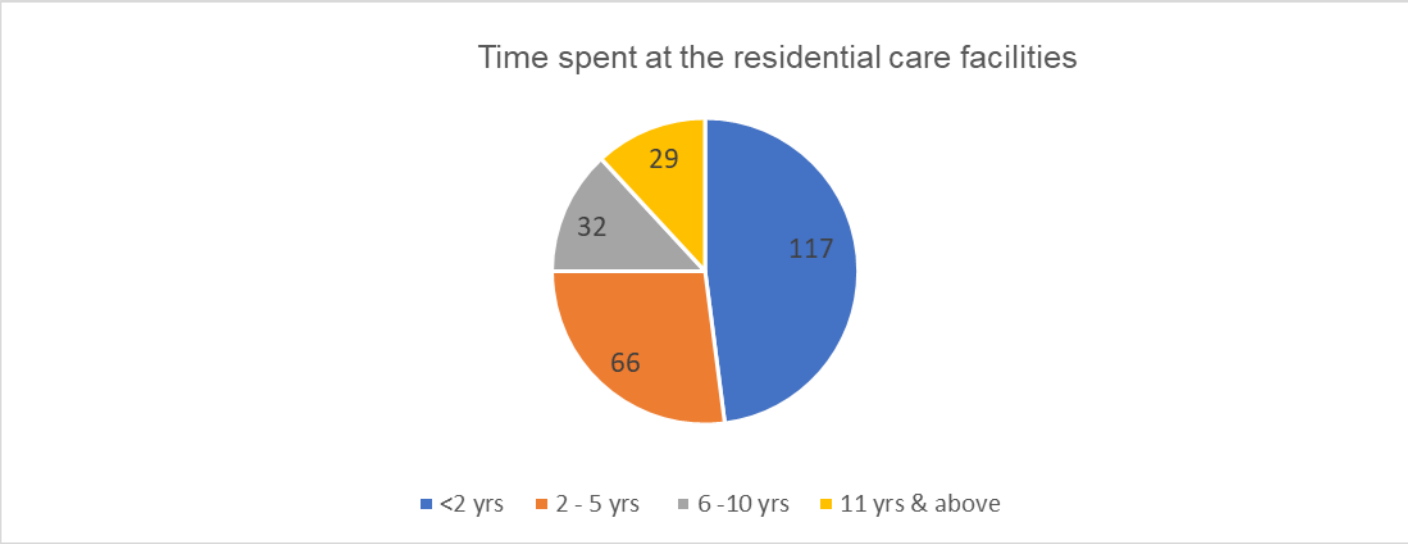
Figure 8: Distribution of responses by marital status and residential care facilities.



4.3 Service Users

A quantitative research questionnaire was administered to the service users and their responses are presented below.

Figure 9: Time spent at the residential care facilities.



The service users were asked about the amount of time they have been at the facilities and 117(48%) of them were found to have stayed at the facilities for less than two (2) years and the other 66 (27%) stayed between 2-5 years. The longest time spent at the facilities was 11 years and above. The figure above presents the amount of time participants have spent at the facilities ranging from <2 years and 11 years and above.

Figure 10: Satisfaction with service provision at the residential care facilities.

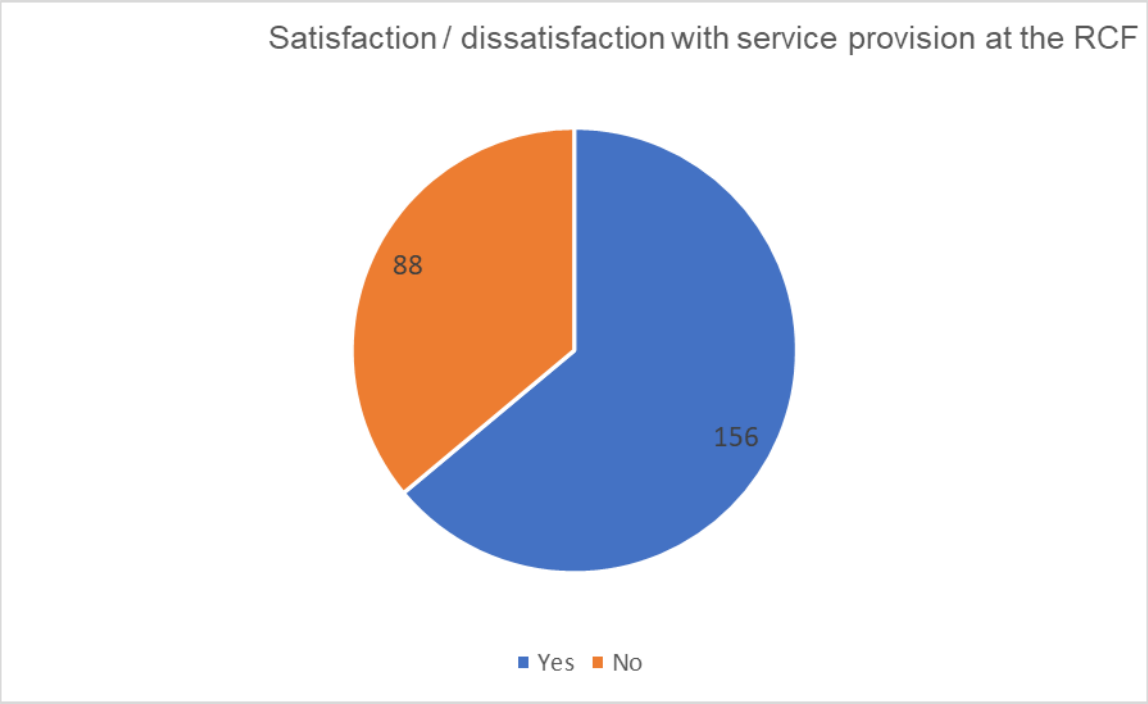
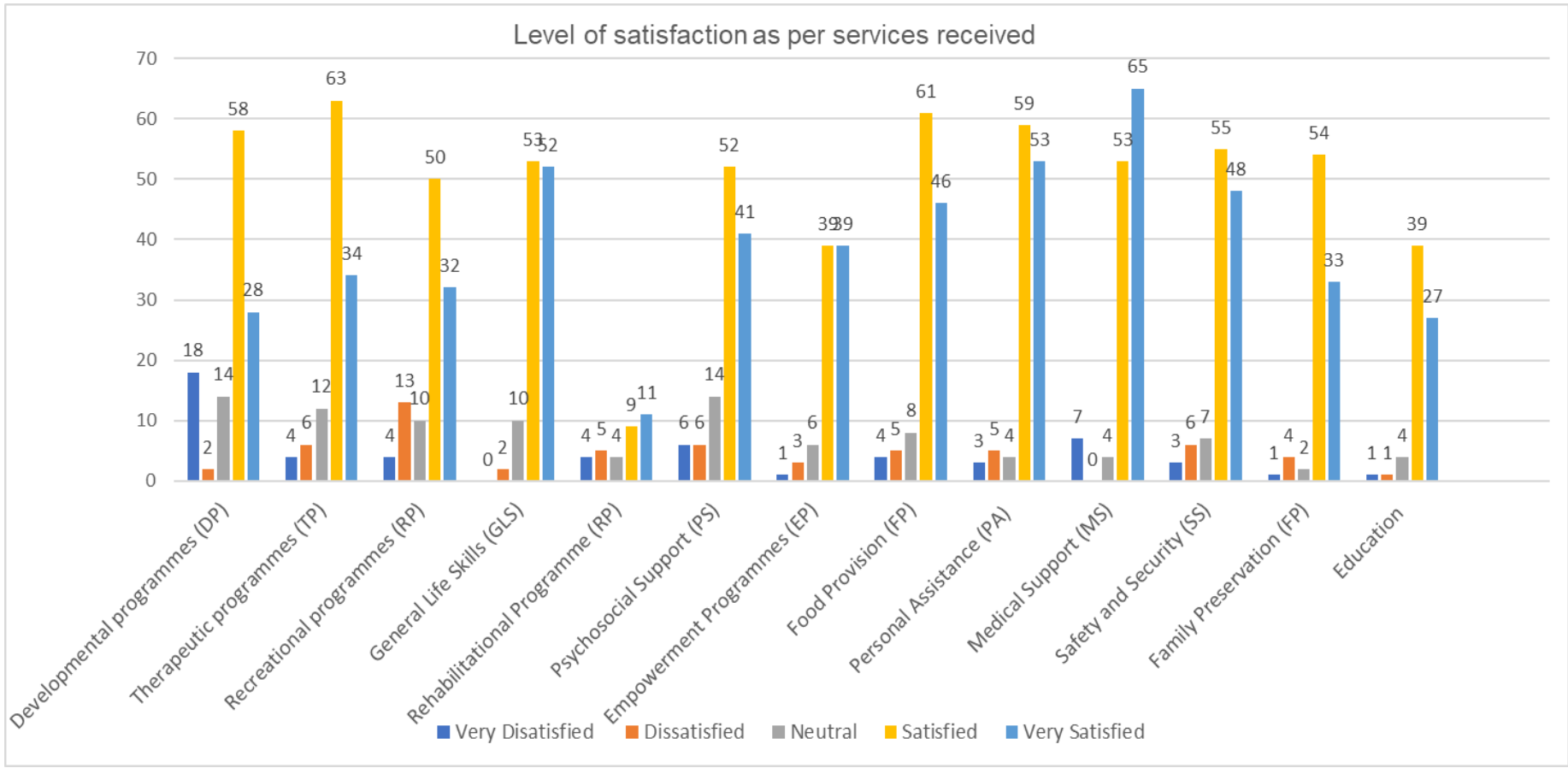


Figure 10 shows that 156 (64%) of the Service Users responded that they were satisfied with the service provision at their respective residential care facilities. Contrary, 88 (36%) expressed dissatisfaction with the service provision at their residential care facilities.

Figure 11: **Level of satisfaction or dissatisfaction per type of service received at the residential care facilities.**



Medical support received the highest very satisfied rating of 65 responses, Therapeutic and Food provision programmes received responses above 60. Of concern is the responses under Developmental and Recreational programmes where twenty-four (24) Service Users expressed very dissatisfied (14) and dissatisfied (10) respectively in Fig 11 above.

Figure 12: Impact

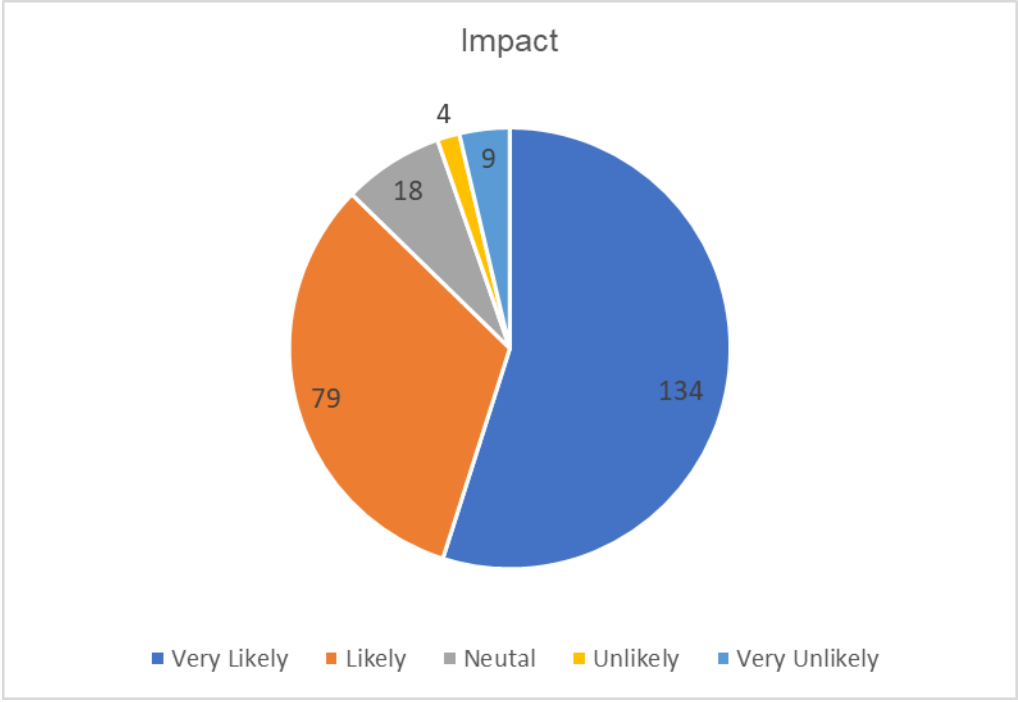
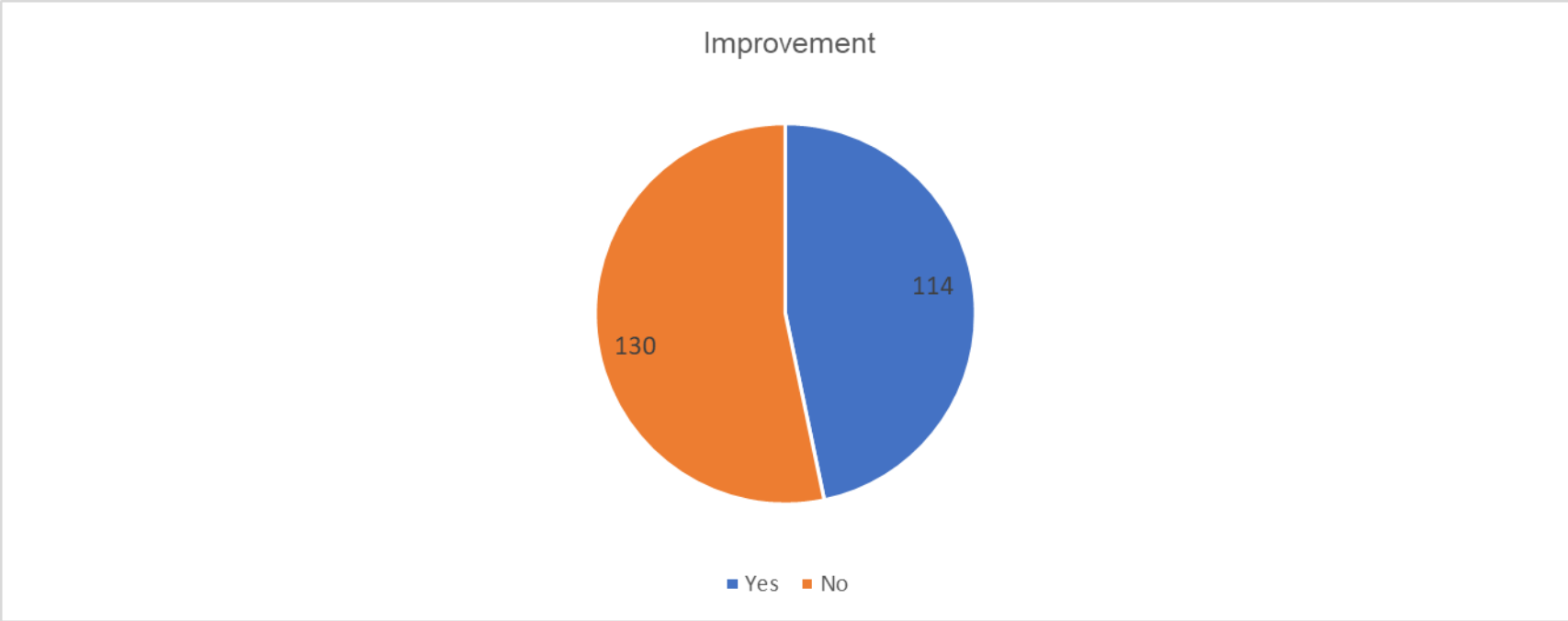


Figure 12 reveals the responses of the Service Users on how likely or unlikely they have been impacted from residing at the residential care facilities. Most of them (**55%**) indicated that they were very likely impacted, **32 %** said likely, **7%** were neutral, **2%** were unlikely and **4%** said they were very unlikely impacted by their stay at the residential care facilities.

Figure 13: **Need for improvement.**



Most Service Users (**53%**) responded that they are happy with the current status quo whereas **47%** of them felt that there is room for improvement of services provided at the residential care facilities as depicted by Fig 13 above.

4.4 Service Providers

Most qualitative questions or open-ended questions were designed for Service Providers as some of the Service Users were either minors or some had a disability. Below are some of the responses from the Service Providers.

4.4.1 Understanding the Department of Social Development's mandate.

Most participants demonstrated a fair knowledge of the Department of Social Development's mandate. The majority mentioned the department's objective on residential care facilities as taking care of the children and provide them with basic needs, as well as bringing change to them and ensuring that the children are placed in a safe environment. Below are some of the extracts:

> ***"****DSD fund us so we can be able to have sources and for development of the children…..because the children come from different places, the funding helps them to have resources according to their individual needs." (***P2, Female, 36-59, Sekhukhune District**).
>
> *"The DSD sponsors the RCF and oversees its financial provision in order to ensure that the children's needs are met, and the facility is operational"* (**Participant 6, Female, 36-59, Waterberg District**).
>
> *"Basically, with regard to funding means the DSD need to be able to cater for the needs of those children within the facility, so that they are not exposed to the very similar situation that they were within their families"* (**P4, Female, 36-59, Vhembe District**).
>
> "*DSD and Life Nkanyisa have an agreement that both parties must make sure that Life Nkanyisa do good service to the facility*" (**P1, Female, 35-59, Mopani District**).
>
> *"I think the mandate of DSD regarding this funding is to help NPOs supported by the government because they help fill the gap that is there in governmental institutions addressing social problems. So, the mandate of the DSD in funding institutions is willing to assist with addressing the issues within the community"* (**P8, Female, 18-35, Capricorn District**).

4.4.2 Budget allocation

When asked about the budget, participants responded that the budget allocated to the residential care facilities serves the intended purpose, but that it was insufficient to properly maintain the service users. For instance, disabled children are expensive to maintain, and they sometimes run out of necessities such as nappies. Below are some the responses to the budget:

> *"I do not know about the financial situation, and while I cannot comment on the budget, I believe that it serves the intended purpose, but it does not cover all needs"* (**P1, Female, 18-35, Waterberg District**).

> "*It is lacking in many areas. For example, other children have uniforms for each sport (t-shirts). When going out to meet with other CYCCs, they feel excluded. Thus, when they meet up with them for activities, it's as if they aren't catered for adequately or are neglected, which is unfortunate"* (**P4, Female, 36-59, Mopani District**).

> *"No, the budget that we get is not enough, everything is always under budget, because there are many children in the Centre and the budget does not meet their basic needs. Same as us volunteers, we get a stipend, we work on weekends, and we don't claim. If the department can allow us to claim on weekends and public holidays and buy clothes for the children. The children only get clothes in December, sometimes their school uniform is oversized, and we don't have a sewing machine, and that reflects badly." (***P1, Female, 36-59, Sekhukhune District).**

> *"Sometimes the institution will go three months without water. Think about ablution, think about the kitchen staff and then children who are housed within the institution and who must go outside to fetch water - which is wrong"* (**P7, Female, 36-59, Vhembe District**).

> *"I checked the financial statements for the past 11 years, and it was never increased. So, I would say we are very thankful for receiving it but, if we look at the inflation that is coming up, and the annual income, everything got an annual increase, so therefore, the subsidy is not sufficient. We need extra funds as well."* (**P24, Female, 36-59, Capricorn District)**.

4.4.3 Challenges encountered in line with aligned responsibilities.

Most participants (i.e., Service Providers) stated that their assigned responsibilities are not difficult, and they do not encounter challenges. However, there are participants who also highlighted their challenges. Hereunder are some of the extracts:

> *"We receive subsidy late; a lot of challenges are also from social workers. Social workers placing children are not effective with placements, no clear communication, psychological services are not offered to the kids and family members" (***P1, Female, 18-35, Waterberg District**).
>
> *"There is a lack of resources, stationery, because it is one of the things that we do not buy on our own - we rely on the district. The district must buy for us, but with the rest I am able to manage. We are also behind with infrastructure. Our children don't have toys and footballs. Basically, if our budget can be improved, we will have everything we need" (***P8, Male, 18-35, Sekhukhune District).**
>
> *"We also have challenge when it comes to menu of children, ... but here there is secondary poverty where you find that kids are eating rice with eggs only, no tomatoes, no onions, no soup and all they are eating is very dry* (**P8, Female, 36-59, Vhembe District**).
>
> ***"****Late delivery of food due to shortage of staff, lack of water and sometimes due to no electricity. The service provider takes too long to deliver the food****"*** **(P8, Male, 36-59, Capricorn District).**
>
> "*Sometimes we lack certain resources such as food for the patients, it requires the staff to go buy the items delaying the work that they have do on time*" (**P4, Female, 36-59, Mopani District**).

4.4.4 Measures brought forth to address the identified challenges.

The participants expressed that measures have been brought forth to address the challenges experienced, however, the challenges are still ongoing. Two themes emerged:

4.4.4.1 Sharing of resources with other facilities

With administrative resources, the participants stated that they have partnered with other DSD clusters to share available resources amongst themselves. One respondent said:

> *"Yes, we tried to resolve it, we met with other clusters, like Praktiseer, they try to share with us, the little that we get we share with other clusters and so far, this has been working." (***P8, Male, 18-35, Sekhukhune District).**

4.4.4.2 Processes and procedures

Other participants expressed that the lack of some of the resources was due to the process that they must follow when they need basic resources, thus, they had arranged to plan annually so that their proposed need to have some resources can be approved by the department. However, there seem to be solution as evidenced by the extracts below:

> *"We have tried to communicate with the department about the issue of budget and they said we must plan annually and give them a list of the things we are going to need but they are still delay us."* (**P2, Female, 36-59, Sekhukhune District**).

> *"The annual plan budget and operational plan are designed but with no value because nobody is following them hence the same challenges are still existing"* (**P16, Female, 36-59, Capricorn District**).

> *"The challenge with the budget is that we are allocated the budget but at the end of the day we are unable to utilize it. Because it takes time to get an order……we are just ordering from them* (Polokwane Head Office). *Ever since we purchased some brooders in January 2022, we have not received it till today"* (**P4, Male, 18-35, Vhembe District**).

> *"Meetings were held to get challenges to be resolved, however the challenges were not resolved. Communication is also a disaster, as we do not receive communication properly. DSD needs to improve communication with the RCFs" (***P1, Female, 18-35, Waterberg District***).*

4.4.5 Satisfaction with the service provision

Most of the participants expressed dissatisfaction with the services and treatment. Hereunder are some of the extracts:

> *“I am not satisfied. No one is satisfied because older people can be racist, they call us kaffir.”* (**P7, Female, 36-59, Waterberg District**).

> “*No, I am not satisfied because this is home for the patients, more has to be done, all is still in progress*” (**P7, Female, 36-59, Mopani District**).

> *"No, I am not satisfied with the services because programmes are not running correctly. Because of a lack of tools, programs such as arts and crafts are no longer available”* (**P19, Male, 36-59, Capricorn District**).

> ***“****Our needs are not always satisfied, sometimes you are able to manage, sometimes you are not, it is just a matter of prioritization, the necessities come first, overall, everything is working fine.”* **(P8, Male, 18-35, Sekhukhune District**).

> *“No, not everything is happening as expected because there is a high shortfall of resources - starting from the care that children are receiving. As a supervisor of the kitchen service there is a lack of food, the diet being eaten is not balanced because sometimes we don’t have enough stock for food”* (**P5, Female, 18-35, Vhembe District**).

Figure 14: **Satisfaction with the provision of services.**

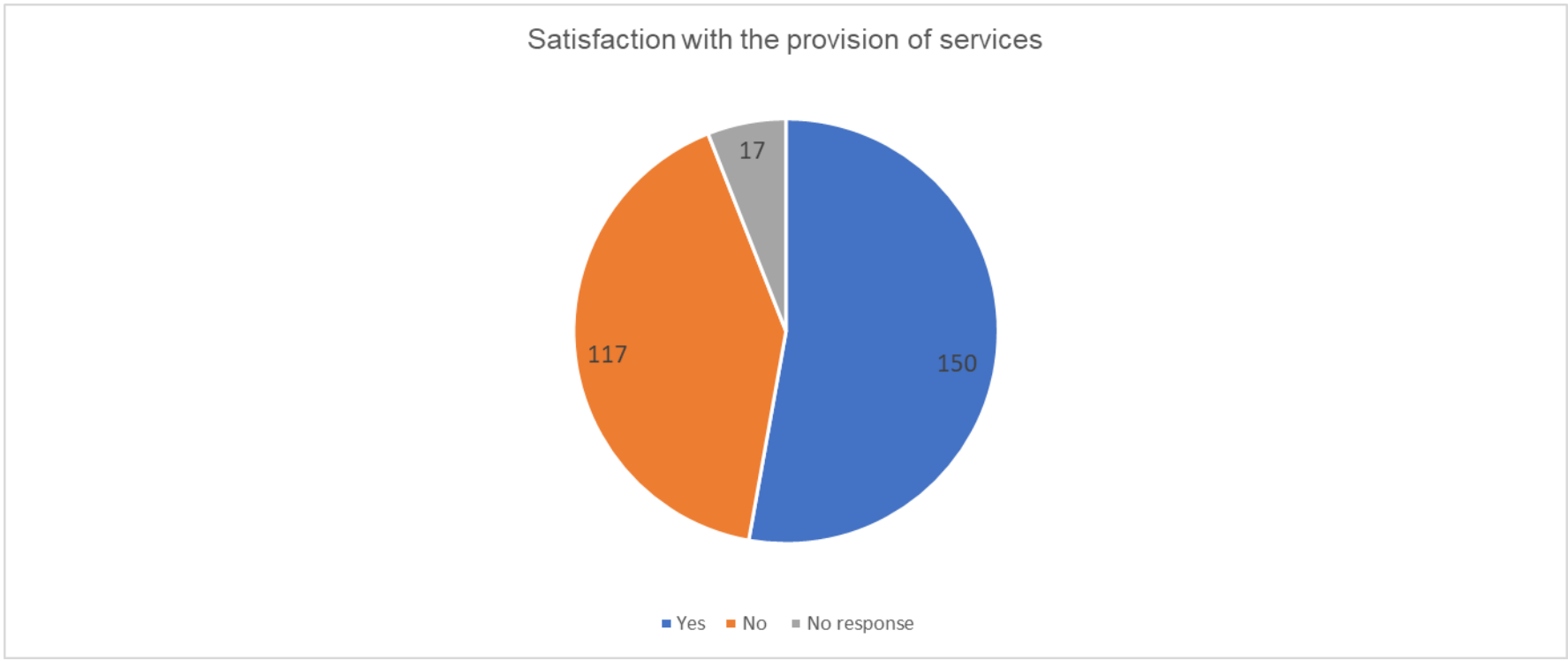


Figure 14 shows that 150 (**53%**) of the Service Providers indicated that they were satisfied with the provision of services, 117 (**41%**) indicated that they were not satisfied with the provision of services and 17 (**6%**) did not want to respond.

4.4.6 Additional information

To further allow the participants to express themselves, they were asked to share any information they thought was important for the researcher to know. The following responses were articulated:

4.4.6.1 Need for additional staff.

Most participants cited the need for additional staff such professional nurses as most facilities accommodate children with chronic illnesses. Below are some of the extracts:

> *"We need to have our own professional nurse here at the Centre because we always have children with chronic. We don't have to go to the hospital, because sometimes when you get to the hospital, they don't give you permission to bypass people in the queues." (***P2, Female, 36-59, Sekhukhune District).**

> *"Under staffing is a major challenge and we are expected to supervise many children and it is impossible to keep them in one place. We are struggling and if an incident happens you will have to account"* (**P14, Male, 36-59, Capricorn District**).

> *'When we talk about funding we talk of money, so once you hear the word budget and money, you must also hear the word Financial Officer. So, in the institution where I am placed since its establishment there is no Financial Officer - meaning there is no one responsible to account for money"* (**P7, Female, 36-59, Vhembe District**).

> "*I work in the kitchen, there is a lot of work, and no assistance is offered in the kitchen, I cannot even go on lunch freely as I have to cut it short due to the amount of work that I have*" (**Participant 6, Female, 36-59, Waterberg District**).

"*Patient's resources are not sufficient and there is lack of staff meaning that patients are not catered for*" (**Participant 7, Female, 36-59, Mopani District**).

4.4.6.2 Improvement of services and related activities

Most participants are of the view that it would be helpful for the residential care facilities to implement outreach programs with the aim of educating the community about the facilities. Hereunder are some of the extracts:

"*Most people are clueless, if social workers can have awareness campaigns and educate the community about the Centre, because it seems people think that the Centre is for people outside of the area." (***Participant 8, Male, 18-35, Sekhukhune District).**

"*I would like to see more shades outside so that, we can sit with our families when they come to pay us a visit*" (**Participant 10, Male, 36-59, Mopani District**).

"**Working in a rural area without danger allowance, we have monkeys, and it is problematic"** (**Participant 8, Male, 36-59, Capricorn District**).

"*I think that the department should come and witness the challenges we face here, as the local office is quiet about them, the late payment of subsidy affects our salaries and derails our plans, as we get late payments"* (**Participant 3, Female, 36-59, Waterberg District**).

"*We really struggle in terms of studying because we do not have library*" (**Participant 12, Male, 18-35, Vhembe District**).

4.5 Summary

The findings of the research were presented based on the data collected from the research participants. In summary, the chapter presents the findings based on the data collected from thirteen Child and Youth Care Centres, seven old age homes, two secure care centres, two disability centres, one Khuseleka one stop centre, and one Treatment centre. In total, **528** participants from **26** residential care facilities were reached in the five districts of Limpopo Province, with the highest targets reached recorded at the CYCCs and the least number coming from Seshego Treatment Centre.

In some of the residential care centres that accommodated minors, disabled persons, frail, and elder persons as service users - most of them could not be interviewed given their challenging physical and intellectual conditions. In liew of that, service providers were asked to assist to circumnavigate some of these barriers to at least reach a few cases and obtain their inputs though under challenging circumstances. The findings have shown that residential care facilities are reliant on governments' funding not only for partial care but also for a variety of services such transport, medication, infrastructure, water, and electricity amongst other things. With respect to service providers, many of them complained about stagnant wages, unpaid overtime, work overload due to shortage of staff, lack of bonuses and appreciation by management. On the one hand, Facility managers complained about payment of subsidies that derail their plans because of getting late payments. The next chapter discusses the research findings linked to the research questions.

CHAPTER FIVE

DISCUSSION OF FINDINGS

5.1 Introduction

This chapter discusses the findings based on the data collected from funded Department of Social Development residential care facilities. Residential Care Facilities have positively impacted on the lives of many people across the world. This study sought to assess the effectiveness and impact of selected residential care facilities funded by the Limpopo Department of Social Development. The study aimed to capture the experiences and perceptions of Service Users as well as Service Providers at these facilities to gather scientific evidence to assist the department with future interventions and approaches. Although the department makes efforts to ensure that residential care facilities operate effectively, the findings also indicate room for improvement in service provision.

5.2 Discussion of the key research findings

5.2.1 Mandate of the Department of Social Development in funding residential care facilities

The findings show that most participants had a fair knowledge of the Department of Social Development's mandate. The majority mentioned the department's objective on residential care facilities as taking care of the children and provide them with basic needs, as well as bringing change to them and ensuring that the service users are placed in a safe environment. The Department of Social Development is responsible for ensuring the well-being of vulnerable groups, such as the children, the elderly and people living with disabilities. Therefore, service providers must understand the mandate of DSD to provide adequate care to the residents, and these suggest that there is still work to be done in educating the minority about the mandate of DSD.

The lack of understanding of the mandate by some may indicate a gap in training and communication between the DSD and service providers. Even though a sizable number of people were able to answer the question, the findings revealed a gap and a need for service providers to be able to know and comprehend the mandates of the DSD better. Closing the knowledge gap on the DSD mandates will ensure that service providers contribute better to assisting the department to have a more meaningful impact because once the providers have a better understanding of the DSD mandates and its operation, it becomes simple for the department to function effectively and actively so.

5.2.2 Budget allocation

Finances and budgets are critical components of a well-functioning department. So far, the DSD's funding in an endeavour to create an effective and impact on these facilities is commendable because the financial support (i.e., funding provided) seemed to have served the intended purposes. The findings revealed that the funds are being used as intended, because the beneficiaries are never without necessities and are well cared for. While beneficiaries at facilities are well cared for and funds are properly used, service providers noted that their income was a bit of a problem because they mostly earned less than the recommended minimum wage. As a result, they requested raises and acceptable minimum wage.

The findings also observed that inadequate funding is the root of most of the challenges and it affects the quality of care provided within the residential care facilities. This resonates with the study by Shi and Singh (2015), which highlights that funding can make it difficult for facilities to maintain adequate staffing levels and provide necessary services to residents. It is very alarming that the management of one of the residential care facilities is selling donations as reported by 63% of their service providers. Some facilities have been funded by the Department of Social Development before 1994 and the department continues to fund the facilities. Some did not disclose other funders during the profiling, and it was uncovered during interviews from service providers that they are also funded by other funders such as the National Lottery Commission (NLC) and get constant donations from other retail outlets such as Checkers. With some charging R6000 for each resident (Service user) every month plus

subsidies and donations, this then raises a question of whether the government should continue funding these types of facilities which have been funded for many decades but cannot seem to stand or operate on their own. This is because the department has a limited budget, it continues to fund facilities which were previously funded leaving little or no chance of emerging NPOs to be funded.

5.2.3 Challenges encountered by Service Providers in discharging their responsibilities.

Most service providers stated that they face no difficulties in carrying out their assigned responsibilities. Those who highlighted challenges, on the other hand, alluded to the management's attempt to address the challenges that service providers face. Furthermore, service providers in management requested the Department of Social Development intervene with respect the challenges of case workers and the placement of beneficiaries once they have reached the age of eligibility to go to a proper care facility that is within their age range (i.e., that fulfils the needs of people of that age group). Participants who encountered difficulties requested that the department speedily addresses these issues as they affect smooth operation and effectiveness of the RCF.

Deaths within residential care facilities, especially old age homes and child and youth care centres (which cater infants) are very common because the service users for these categories are the most vulnerable. However, it raises a great concern when the mortality rate grows rapidly as one participant at one of the residential facilities who had been at the facility for just 5 months - had already experienced 9 deaths which raises the question about the quality of care given to these individuals.

5.2.4 Satisfaction with respect to service provision

Studies show that recreational programmes have a positive impact on health and wellbeing as well as academic performance, not only in children but also in adults (Ferkel, Razon, Judge & True, 2017). The findings suggest a level of satisfaction among Service Users at residential care facilities greatly depending on the service offered. Medical support, Therapeutical, and Food provision programmes were the services that most service users indicated they received, and most participants were satisfied with these services. Nonetheless, the Service Users equally emphasized their dissatisfaction with their Developmental and Recreational programmes, some of them could not even remember the last time they participated in recreational programmes. One of the Service Providers also indicated that the Centre did not have resources for recreational programmes, not even a soccer ball. The Service Provider suggested that an improved budget would enable the Centre to provide the Service Users with the necessary resources for recreational activities.

Empowerment and Education programmes were offered to a smaller number of service users, and the positive responses were below expectations. These programmes are critical, may need to be evaluated and be improved to meet the needs of the Service Users. The likelihood of the impact of the service-on-Service Users is encouraging, which indicated that the services provided had a positive impact on the lives of most of the Service Users. However, the percentage of service users citing a need for service improvement (47%) cannot be overlooked suggesting that there is still room for improvement in the services offered by most residential care facilities.

5.3 Summary

The findings of this study are presented and discussed under this chapter. The chapter interprets the meaning of the findings based on the data collected from the six categories of residential care facilities funded by the Department of Social Development in Limpopo province. The argument in the chapter is that whilst beneficiaries at facilities are well cared for and funds are used for the intended purpose, most participants felt that inadequate funding is the root cause of most of the challenges and affects the quality of care provided within the residential care facilities. The findings revealed that for most participants - a level of satisfaction among service users at residential care facilities greatly depend on the service provided. The next chapter presents the conclusion and suggests recommendations for future decision-making, planning, and knowledge-sharing.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

The purpose of the research was to gather information that could be used to better inform the department whether is being effective and making impact in the provision of services. If the opposite exists, identify areas of concern, and come up with appropriate interventions that could improve service provision and benefit the Service Users, the NPOs/NGOs and the broader population that is most affected. The results show that most participants had a fair knowledge of the Department of Social Development's mandate. The majority mentioned the department's objective on residential care facilities as taking care of the children and provide them with basic needs, as well as bringing change to them and ensuring that the service users are placed in a safe environment. This chapter concludes the overall findings of the study, and these include summary of findings, limitations as well as recommendations to the research findings.

6.2 Recommendations to bolster the department’s service provision efforts.

6.2.1 Need to conduct market research to inform budget allocations.

Most participants were dissatisfied with medical support, recreational activities, and therapeutic programmers and this could be attributed to the limited budget that most residential care facilities are receiving. The rising inflation (interest) rates resulting in the increase of transportation, food, fuel, and related essentials warrant a review of appropriation of funds to support these facilities.

6.2.2 Requisite skills needed to bolster service provision.

Many residential care facilities were observed to be understaffed and lacking certain requisite skills and resources to strengthen effective and efficient provision of services. Additionally, limited human resources reportedly affected effective service provision in most of the facilities. For instance, one participant in one of the selected child and youth care centre (CYCC) suggested the need for every CYCCs to have a resident and full-time nurse as a mitigation strategy to avert transporting sick service users every time they fell sick – given their vulnerabilities.

6.2.3 Careful selection of convenient spaces to obtain information.

During the interviews, some researchers observed that the participants, specifically the non-management staff, were not comfortable in the area provided for the interviews because anyone had access to it. It is recommended any attempts to gather data and related information must consider a conducive and less intimidating space when engaging in studies of this nature in the future to avoid any hindrances or withholding of information.

Table 17: Summary of the key research findings

Research questions	Key findings	Recommendations
What is your understanding of the mandate of the DSD regarding funding of Residential Care Facilities?	Most participants had a fair knowledge of the Department's mandate - including taking care of the service users, providing them with basic needs, and ensuring that they are placed in a safe environment.	The department must continue funding these facilities thus fulfilling its mandate to provide social protection to all its key beneficiaries (i.e., children, elderly and people living disabilities etc.).
Do you think the budget allocated for this residential care facility serves the intended purpose?	The findings revealed that the funds are being used as intended. However, the findings also revealed that inadequate funding is the root cause of most of the challenges.	The department must conduct market research to guide the allocation of budgets to fund the NGOs / NPOs to render effective and efficient residential care services.
What challenges, if any, have you encountered in line with your assigned responsibilities, and what measures were brought forth to resolve the challenges?	Though most service providers said they face no difficulties in performing their tasks – recruitment of full-time professionals with requisite skills were suggested to intensify service provision at the facilities.	The department must continue to allocate human and financial resources to bolster service provision.
Are you satisfied with the services put in place in a range of Residential Care Facilities?	Medical support, recreational and therapeutic programmers are the services that most participants indicated that they were dissatisfied with.	The department must continue to allocate human and financial resources to bolster service provision.

6.3 Limitations of the study

6.3.1 Language barrier

Since a significant number of research participants were not native English speakers, researchers were pressured to administer the questionnaire in each participant's preferred language. Researchers could collect accurate and pertinent findings that were representative of the participants' experiences by conducting research in each participant's preferred language. However, when there are differences in language, the researcher's capacity to interpret both standard language and disciplinary language used in the questionnaire is critical. As a result, translating the responses participants gave in their native languages during the interview process was time consuming and exhausting.

6.3.2 Participants with disability related challenges

Some participants owing to some degree of incapacity to participate could not be included in the research because the severity of their handicap and inability to communicate verbally. This was a limitation because the researchers were unable to obtain information from some of the participants, who could have shed light on the study.

6.3.3 Research environment.

Participants who were not part of management, did not look comfortable with the place that was allocated for the interviews, this could have made participants to withhold some of the information they wanted to share. Even after stating that the second section of the study must be audio recorded, the management in some facilities did not allow the researcher to record any of the participants even when some participants agreed to being recorded. This made data collection a bit challenging as some researchers had to strictly write out the responses by hand and only took note of what was important. This could have affected the results as the researchers could have missed some important information, while scribbling down the responses.

6.4 Conclusion

Residential care facilities continue to make an impact in the lives of both service users and service providers. They provide a home for the service users and a source of income for the service providers. The findings show that the residential care facilities continue to face challenges even with provision of funding. There are poor recreational and educational programmes which result in poor intellectual and academic development for the service users. The lack of basic resources and inadequate funding renders the residential care facilities ineffective.

REFERENCES

Babbie, E. (2013). *The Practice of Social Research.* (13th ed.). Belmont, CA: Wadsworth.

Bell, K. (2014). *Anonymity in open Education Sociology Dictionary.* (6th ed.). American Psychology Association. Accessed October 03, 2021 from https://sociologydictionary.org/anonymity.

Bless, C., Higson-Smith C., & Sithole, S.L. (2013). *Fundamentals of Social Research Methods*. (5th ed.). Juta & Company (Pty) Ltd.

Children's Act (No. 38 of 2005).

Bos, J. (2020). *Confidentiality in Research Ethics for Students in the Social Science.* Springer Cham. Accessed October 03, 2021 from https://doi./10.1007/978-3-030-48415-6_7.

Braun, V. & Clarke, V. (2019). *Thematic analysis: Handbook of Research Methods in Health Social Sciences.* Hoboken, New Jersey: Springer : 843–860. Doi:10.1007/978-981-10-5251-4_103. ISBN 978-981-10-5250-7.

Braun, V. & Clarke, V. (2018*). Using thematic analysis in counselling and psychotherapy research. A critical reflection*. *Counselling and Psychotherapy Research Journal*, 18(2), 107-110. Accessed September 16, 2021 from https://doi.org/10.1002/capr.12165.

Christensen, L.B., Johnson, R.B., & Turner, L.A. (2015). (12th ed.*). Research methods, design, and analysis.* Pearson.

De Vos, A.S., Strydom, H., Fouché, C.B., & Delport, C.S.L. (2011). (4th ed.). *Research at grass roots for the Social Sciences and human service professionals*. Van Schaik Publishers. South Africa.

Du Plooy-Cilliers, F., Davis, C., & Bezuidenhout, R. (2014). *Research Matters.* Juta & Company Ltd. South Africa.

Institutional Review Board Guidebook (1993). Basic IRB Review: Chapter III. Accessed May 16, 2021 from https://biotech.law.isu.edu/research/fed/ohrb/gb/irb_chapter3.htm.

Maree, J.G. (2012). *First steps in research.* (11th impression). Van Schaik Publishers. South Africa.

Mathipa, E.R., Gumbo, M.T. (2015). Addressing Research Challenges: Making headway for Developing Researchers. Mosala – Masedi Publishers and Booksellers.

Mlambo, V. (2018). An overview of rural-urban migration in South Africa: its causes and implications. Archives of Business Research, 6(4), 63–70. https://doi.org/10.14738/abr.64.4407

Miles, M.B., & Huberman, A.M. (1994). *Qualitative Data Analysis: An Expanded Sourcebook* (2nd ed.). Sage Publications.

Mouton, J. (2019*). How to succeed in your Master's & Doctoral Studies: A South African Guide and Resource Book*. (Twenty fifth impression). Van Schaik Publishers. South Africa.
Reif S, George P, Braude L, Dougherty RH, Daniels AS, Ghose SS, Delphin-Rittmon ME. Residential treatment for individuals with substance use disorders: assessing the evidence. Psychiatr Serv. 2014 Mar 1;65(3):301-12. doi: 10.1176/appi.ps.201300242. PMID: 24445598.)
Ryan, G. & Bernard, H.R. (2003). *Techniques to identify themes: Field Methods*. 15(1):85-109. Doi:10.1177/1525822X02239569.
South Africa Yearbook, 2020.
Statistics South Africa. (2014). General household survey 2014-2019.
Statistics South Africa. (2020). National poverty lines, 2020. P0310.1, Pretoria, South Africa. Available from: http://www.statssa.gov.za/publications/P03101/P031012020.pdf.
Statistics South Africa. (2021). Quarterly Labour Force Survey, quarter 4 2020. P0211, Pretoria, South Africa. Available from: http://www.statssa.gov.za/publications/P0211/P02114thQuarter2020.pdf.
Statistics South Africa. (2022). Quarterly Labour Force Survey, Quarter 4 2021 Media Release. Available from: http://www.statssa.gov.za/publications/P0211/Media%20release%20QLFS%20Q4%202021.pdf.
Strauss, A., & Corbin, J. (1998). *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory*. Thousands Oak, CA: Sage Publications.
The Government of the Republic of South Africa. (2017). The National Food and Nutrition Security Plan 2018-2023: Version 07 November 2017.

Appendix A: Profiling tool for district-based Researchers

RESEARCH PROJECT: ASSESSING THE EFFECTIVENESS AND IMPACT OF THE FUNDED DEPARTMENT OF SOCIAL DEVELOPMENT RESIDENTIAL CARE FACILITIES.

TASK NO. 1: THE BASELINE DATA / INFORMATION ON DSD RESIDENTIAL CARE FACILITIES

PART A: GEOGRAPHICAL LOCATION

District municipality: _____Local municipality: _____Ward: _____ Traditional community: _____

Village / Town / Farm / Informal settlement: _____Street: _____Stand no.: _____

Contact person: _____ Contact no.: _____

Estimated population size of the community: _____Estimated household size within the community: _____

PART B: RESIDENTIAL CARE FACILITY INFORMATION

Name of the facility: _____Year established: _____

Capacity of the facility (Bed capacity): _____

Inception No. of beneficiaries: _____

Current No. of beneficiaries: _____

Disaggregated by demographic characteristics.

Male		Female		Other		Child 0-18	Youth 19-35		Elderly 60+		Disability Yes / No	

No. of staff members: _____

Male		Female		Other		Youth 19-35		Elderly 60+		Disability Yes / No	

Facility Management: _____

Male		Female		Other		Youth 19-35		Elderly 60+		Disability Yes / No	

Government structure (Board members): _____

Number of elected board members: _____Year elected: _____Term of office (years): _____ Date of the last AGM: _____

Male		Female		Other		Youth 19-35		Elderly 60+		Disability Yes / No	

Facility registration status

Year registered as NPO: _____NPO Registration No.: _____ Compliance status (Yes/No): _____

Other Registration status (Yes/No): _____Year registered: _____ Registration no.: _____ Compliance status (Yes/No): _____

Type of service(s) rendered in the facility	List of services	Relevant beneficiaries per service
Primary (Core) services		
Secondary services		
Tertiary services		
Other services		

PART C: FUNDING STATUS

First year funded by DSD		Amount funded	R	Current funding (2022-23) by DSD	R

Other source (s) of funding

Funder		Last year funded		Amount funded	
Funder		Last year funded		Amount funded	
Funder		Last year funded		Amount funded	

Other fund-raising activities

Parents / Guardian contribution	Contribution per beneficiary	R	
Donations in kind per year (List of items)		Donations in cash per year	R
Developmental income generation initiatives (List of activities)		Estimated income per year	R

PART D: CHECK LIST

No	List of attachments (support evidence)	Yes / No	Comments
01			
02			
03			
04			
05			

Researcher: _____ **Date _____**

Verified by: _____ **Date: _____**

Signed-off by: _____ **Date: _____**

Appendix B: Participant information

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF SOCIAL DEVELOPMENT

PARTICIPANTS' LETTER OF INFORMATION

1. Brief Introduction and background

The mission of the Department of Social Development (DSD) is to transform society by building conscious and capable citizens through the provision of Integrated Social Development Services (ISDS). it is obliged to account for its activities, accept responsibilities and to disclose results in transparent manner. In this research study, the DSD through its field researcher(s) requests your participation on the subject matter titled "Assessing the effectiveness and impact of the funded Department of Social Development Residential Care Facilities".

2. Purpose of the study

The purpose of the research project is to capture the experiences, opinions, and views of the Service Users and Implementers/Providers of the services at the selected Residential Care Facilities funded by the department. The outcome of the research will assist the department with further decision making, planning, budgeting, and knowledge sharing.

The specific objective of the Research project is to:

Assess the effectiveness and impact of the Limpopo Department of Social Development's funded residential care facilities in the province of the services to the targeted beneficiaries by focusing on:

- Residential Care Facilities for Older Persons,
- Child and Youth Care Centres,
- Residential Care Facilities for Persons with Disabilities,
- Secure Care Centres,
- Khusela One Stop Centre and
- Substance abuse, Prevention and Rehabilitation Centre.

3. Outline of the procedure:

Researchers will collect data from service users and Service Providers/Implementers through a questionnaire and structured interview guide, respectively. The Department of Social Development (DSD) is legally obliged to protect participants' information as guided by the Standard Operating Procedures (SOPS) for the implementation and compliance with the Protection of Personal Information Act (POPIA) in respect of management of performance information. Hence, all the collected data from participants will be protected as per the Protection of Personal Information Act (POPIA) which gives effect to the constitutional right to privacy (Section 14 of the constitution).

Participants should take note that **Section B** of the interview guide which is directed to the Service Providers/Implementers will require an audio recording.

You will be expected to honestly respond to the questions asked. In case you need more clarity in answering some questions, a Department of Social Development Researcher (s) will be available to further assist you in this regard.

Appendix C: Informed Consent

LIMPOPO
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DEPARTMENT OF SOCIAL DEVELOPMENT

PARTICIPANTS' INFORMED CONSENT

I……voluntarily agree to participate in this research study entitled: "Assessing the effectiveness and impact of the funded Department of Social Development Residential Care Facilities". Agreement to participate in this research is granted, and the participant is also granted the right to withdraw at any time or refuse to answer any question without any consequences of any kind. The purpose and nature of the study was clearly explained to me in writing. There will be no benefit or compensation that will be expected from participating in this research. All information and answers provided for this study will be treated confidentially and the identity of the participant will remain anonymous. I understand that under freedom of information legalization I am entitled to access their information I have provided at any time while it is in storage as specified above. I understand that I am free to contact any of the people involved in the research to seek further clarification and information, and in this case will be the Departmental Provincial Research Coordinator, Mr. MJ Moloisi directly on 0824577120.

Signature of the Research Participant…… Date……

Signature of the Researcher/Interviewer…… Date…….

Appendix D: Research tool – Services Users

LIMPOPO
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RESEARCH QUESTIONNAIRE: SERVICE USERS

Department of Social Development

Research Topic: Assessing the effectiveness and impact of the Limpopo Department of Social Development's funded Residential Care Facilities in the provision of services to the targeted beneficiaries by focusing on: Residential Care Facilities for Older Persons, Child and Youth Care Centres, Residential Care Facilities for Persons with Disabilities, Secure Care Centres, Khusela One Stop Centre, and a Treatment Centre.

Questionnaire No	

Location of the Centre

Name of the Centre	
Physical Address	
Community/Village	
Traditional Council	
Ward Number	
Local Municipality	
District	
Contact Person	
Contact Number	

1. Section A: Demographic Data of the Participant (Please Put an 'X' in the correct answer box)

1.1 Home Language

Sepedi	
Sesotho	
Setswana	
siSwati	
Tshivenda	
Xitsonga	
Afrikaans	
English	
isiNdebele	
isiXhosa	
isiZulu	
Other, please specify:	

1.2 Gender

Male	
Female	
Other, please specify:	

1.3 Age Group

12-17 years	
18-35 years	
36-59 years	
60+ years	

1.4 Nationality

South African	
Other, please Specify:	

1.5 Race

African	
White	
Coloured	
Indian	

1.6 Disability

Y	**N**

1.7 Educational Level

No Schooling	
ABET	
Primary Education	
Secondary Education	
Tertiary Education	

1.8 Marital Status

Single	
Married	
Divorced	
Widowed	
Prefer not to answer	

2. SECTION B: Research Participant (Service User) (Please put an 'X' in the correct answer box)

2.1 Type of Residential Care Facility

Residential Care Facilities for Older Persons	
Child and Youth Care Centre	
Residential Care Facilities for Persons with Disabilities	
Secure Care Centre	
Khuseleka One Stop Centre	
Treatment Centre	

2.2 How long have you been at this Residential Care Facility?

<2 Years	
2-5 Years	
6-10 Years	
11 Years and above	

2.2.1 Have you ever been re-admitted?

Y **N**

2.2.2 If yes, how long have you been in this RCF after re-admission?

<2 Years	
2-5 Years	
6-10 Years	
11 Years and above	

2.3 Are you receiving any form of financial support?

Y **N** **2.3.1 If yes, kindly specify:**

……

……

……

2.4 What kind of services do you receive in this Residential Care Facility? (Put an ‘X’ below)

Developmental Programmes	
Therapeutic Programmes	
Recreational Programmes	
General Life Skills	
Rehabilitation Services	
Psychosocial Support	
Empowerment Programmes	
Food Provision	
Personal Assistance	
Medical Support	
Safety & Security	
Family Preservation	
Education	
Other programmes implemented please specify:	

2.5 Are you satisfied with the above-mentioned services provided at the Residential Care Facility?

Y	N

2.5.1 Please indicate the level of satisfaction/dissatisfaction pertaining to the provision of services in your respective care facility as provided below by an 'x' in the appropriate column of the table. (Put an 'x' on the correct answer)

Services	**Very Dissatisfied**	**Dissatisfied**	**Neutral**	**Satisfied**	**Very Satisfied**
Developmental Programmes					
Therapeutic Programmes					
Recreational Programmes					
General Life Skills					
Rehabilitation Services					
Psychosocial Support					
Empowerment Programmes					
Food Provision					
Personal Assistance					
Medical Support					
Safety & Security					
Family Preservation					
Education					
Other programmes implemented please specify:					

3. Section C: Opinions of the participant regarding provision of services within his/her Residential Care Facility

3.1. How were you impacted by the services received during stay in this Residential Care Facility (Put an 'X' below)

Very Likely	
Likely	
Neutral	
Unlikely	
Very Unlikely	

3.2 In your opinion, do you think there is a need for improvement of service provision at this Residential Care Facility?

Y **N**

3.2.1. If yes, what could be done to improve service provision at your Residential Care Facility?

……
……
……

Thank you for participating in this research study. We hope that the data received will be of assistance towards the advancement of the department's policies and our founding principles of protection of social needs of our citizenry. We further hope that it will strengthen our administrative work in improving our decision making, budgeting, planning and knowledge sharing.

Particulars of the Researcher

Name of the Researcher	
Workstation	
Physical Address	
Contact Number	
Date	

Particulars of the Researcher Coordinator

Name of the Research Coordinator	
Workstation	
Physical Address	
Contact Number	
Date	

Appendix E: Research tool – Services Providers

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF SOCIAL DEVELOPMENT

RESEARCH QUESTIONNAIRE: SERVICE IMPLEMENTERS/PROVIDERS

1. Section A: Demographic Data of the Participant (Please Put an 'X' in the correct answer box)

1.1 Home Language

Sepedi	
Sesotho	
Setswana	
siSwati	
Tshivenda	
Xitsonga	
Afrikaans	
English	
isiNdebele	
isiXhosa	
isiZulu	
Other, please specify:	

1.2 Gender

Male	
Female	
Other, please specify:	

1.3 Age Group

12-17 years	
18-35 years	
36-59 years	
60+ years	

1.4 Nationality

South African	
Other, please Specify:	

1.5 Race

African	
White	
Coloured	
Indian	

1.6 Disability

Y	N

1.7 Educational Level

No Schooling	
ABET	
Primary Education	
Secondary Education	
Tertiary Education	

1.8 Marital Status

Single	
Married	
Divorced	
Widowed	
Prefer not to answer	

1.9 Current employment status

Occupation	
Section	

2. SECTION B: INTERVIEW QUESTIONS

NB: Kindly note that the section below requires recording (voice recording) and must be placed on record.

2.1 What is your understanding of the mandate of DSD regarding funding of Residential Care Facilities? Probe

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……
……

2.2 Do you think the budget allocated for this residential care facility serves the intended purpose? Probe

……
……
……

2.3 What challenges, if any, have you encountered in line with your assigned responsibilities? Probe

……
……
……

2.4 What measures were brought forth to ensure that the mentioned challenges were resolved?

……
……
……

2.5 As a Service Provider/Implementer, are you satisfied with the services put in this RCF?

……

……

……

2.6 Is there any additional information you would like to share?

……

……

……

Thank you for participating in this research study. We hope that the data received will be of assistance towards the advancement of the department's policies and our founding principles of protection of social needs of our citizenry. We further hope that it will strengthen our administrative work in improving our decision making, budgeting, planning and knowledge sharing.

Particulars of the Researcher

Name of the Researcher	
Workstation	
Physical Address	
Contact Number	
Date	

Appendix F: List of Appointed Researchers

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF
SOCIAL DEVELOPMENT

Researcher	Gender	Highest qualification	Research site	Municipality	Interviews conducted
Capricorn District					
Bogale EN	Female	Bachelor of Social Work	Treatment centre	Polokwane	18 Participants
Botabota ME	Female	Post Graduate Diploma: Education	Polokwane SCC	Polokwane	21 Participants
Legwabe P	Female	Bachelor of Arts Honours: Psychology	Sekutupu Old Age	Lepelle-Nkumpi	19 Participants
Moeti KM	Male	Bachelor of Social Work	Polokwane CYCC	Polokwane	15 Participants
Motimele LD	Male	BA Honours: Political Science	Khuseleka One Stop	Polokwane	24 Participants
Mopani District					
Maphosa X	Female	Bachelor of Arts Honours	Irish House CYCC	Greater Giyani	24 Participants
Masia KJ	Male	Bachelor of Social Work	Holy Family CYCC	Maruleng	25 Participants
Mohale M	Male	BA Honours in Political Science	Noah's Ark CYCC	Greater Tzaneen	19 Participants
Mothobuka K	Female	Bachelor of Arts: Psychology	Life Nkanyisa	Greater Tzaneen	20 Participants
Sekhukhune District					
Makofane K	Female	Bachelor of Arts Honours: Psychology	Epilepsy Centre	Elias Motsoaledi	16 Participants
Moropang P	Female	Post Graduate Diploma: Education	Tubatse CYCC	Tubatse	16 Participants

Rahlagane A	Female	Bachelor of Arts Honours: Psychology	Loskop Vallei Old Age	Ephraim Mogale	21 Participants
Vhembe District					
Mabambe VT	Female	Bachelor of Arts: Development Studies	Mavambe SCC	Collins Chabane	30 Participants
Mpathe DM	Female	Bachelor of Arts: Youth in Development	Takalane CYCC	Musina	24 Participants
Mutheiwana S	Female	Bachelor of Arts: Communication	Ons Tuste Old Age	Thulamela	07 Participants
Ndou DS	Male	Bachelor of Arts Honours: Psychology	Mtsetweni CYCC	Thulamela	15 Participants
Nephawe N	Male	Master of Arts in Rural Development	Thohoyandou CYCC	Collins Chabane	38 Participants
Waterberg District					
Chauke JM	Female	Bachelor of Social Work	Mantadi CYCC	Mookgophong	26 Participants
Mabona NL	Female	Bachelor of Arts Honours: Psychology	Warmbad Old Age	BelaBela	25 Participants
Mangena TJ	Female	Bachelor of Social Work	Thabang CYCC	Thabazimbi	16 Participants
Masemola N	Female	BA Behavioral Science	Huis Tekna CYCC	BelaBela	22 Participants
Modiba MD	Female	BA Anthropology & Sociology	Naboom Old Age	Mookgophong	11 Participants
Sekhaulela D	Female	BA Honours: Medical Sociology	Huis Talje CYCC	BelaBela	15 Participants
Sithole DM	Female	BA Honours: Political Science	Piet Pot Monument	Mogalakwena	30 Participants
Provincial Office					
Cgina JD	Male	BA Communication Studies	Media & Communication	Polokwane	Not applicable
Maja T	Female	Bachelor of Law (LLB)	Legal Services	Polokwane	Not applicable
Makweya JK	Male	Bachelor of Information Studies	Info & Technology	Polokwane	Not applicable
Phukubye PE	Female	Master of Social Work	Social Sciences	Polokwane	Not applicable
Shiburi TP	Female	Bachelor of Arts Honours: Psychology	Martha Hoffmeyr	Polokwane	24 Participants
			Ngwana House CYCC	Polokwane	08 Participants

Appendix G: List of Residential Care Facilities

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF
SOCIAL DEVELOPMENT

N0	Name of Centre	Municipality	District	No of participants interviewed
Child and Youth Care Centres				
01	Ngwana House CYCC	Polokwane	Capricorn	08 Participants
02	Polokwane CYCC	Polokwane	Capricorn	15 Participants
03	Holy Family CYCC	Mauleng	Mopani	25 Participants
04	Irish House CYCC	Greater Giyani	Mopani	24 Participants
05	Noah's Ark CYCC	Greater Tzaneen	Mopani	19 Participants
06	Tubatse CYCC	Tubatse-Fetakgomo	Sekhukhune	16 Participants
07	Mtsetweni CYCC	Makhado	Vhembe	15 Participants
08	Takalani CYCC	Makhado	Vhembe	24 Participants
09	Thohoyandou Childrens' Home	Thulamela	Vhembe	38 Participants
10	Huis Talje CYCC	BelaBela	Waterberg	15 Participants
11	Huis Tekna CYCC	BelaBela	Waterberg	22 Participants

12	Mantadi CYCC	Mookgophong	Waterberg	26 Participants
13	Thabang Children's Project	Thabazimbi	Waterberg	16 Participants
Disability Centres				
14	Epilepsy South Africa	Elias Motsoaledi	Sekhukhune	16 Participants
15	Life Nkanyisa	Greater Tzaneen	Mopani	20 Participants
Khuseleka One Stop Centre				
16	Khuseleka One Stop Centre	Polokwane	Capricorn	24 Participants
Old Age Homes				
17	Loskop Vallei Old Age Home	Ephraim Mogale	Sekhukhune	21 Participants
18	Martha Hoffmeyr	Polokwane	Capricorn	24 Participants
19	Naboom Old Age Home	Mookgophong	Waterberg	11 Participants
20	Ons Tuste Old Age Home	Makhado	Vhembe	07 Participants
21	Piet Potgieter Old Age Home	Mogalakwena	Waterberg	30 Participants
22	Sekutupu Old Age Home	Lepelle-Nkumpi	Capricorn	19 Participants
23	Warmbaths Rusoord	BelaBela	Waterberg	25 Participants
Secure Care Centres				
24	Mavambe Secure Care Centre	Collins Chabane	Vhembe	30 Participants
25	Polokwane Secure Care Centre	Polokwane	Capricorn	21 participants
Rehabilitation / Treatment Centre				
26	Seshego Treatment Centre	Polokwane	Capricorn	18 Participants