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University of Cape Town



School of Management Studies

A PROCESS EVALUATION FOR THE HIV/AIDS PROJECT FOR THE MBEKWENI
AREA DEVELOPMENT PROGRAMME

SITHEMBILE DUBE
(DBXSIT004)

A dissertation submitted in partial fulfilment of the requirements for the award of the
Degree of Master of Philosophy in Programme Evaluation

Faculty of Commerce

University of Cape Town

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COMPULSORY DECLARATION:

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works of other people has been attributed, cited and referenced.

Signature:

Date:

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EXECUTIVE SUMMARY

This dissertation is a process evaluation of Mbekweni Area Development Programme (MADP)'s HIV/AIDS project. The MADP is a programme that is implemented by World Vision South Africa. The aim of the process evaluation was to assess whether the HIV/AIDS project was implemented as intended. HIV/AIDS is a global problem, particularly prominent in South Africa. It has negatively affected families and communities resulting in increased social and economic burdens. The HIV/AIDS project at MADP uses prevention and care programmes to mitigate the impact of HIV/AIDS in targeted areas of Mbekweni. In order to achieve this aim, the project uses the following programme activities: home visitation, home-based care, life skills, material support and awareness campaigns.

To conduct the process evaluation, programme records, interviews with three key informants and questionnaires with 35 programme staff were used to assess the programme's implementation. Findings from the evaluation show that the programme activities are largely being implemented as intended by the organisation. The HIV/AIDS project is being delivered to the intended beneficiaries and all the activities are being implemented as intended by the organisation.

However, to improve the effectiveness of the project a structured curriculum is recommended in the implementation of the life skills workshops. Challenges in programme implementation are also noted in the HIV/AIDS awareness campaigns and support groups that are provided by pastors. Training and further support is recommended for pastors who are involved in raising awareness as well as other support activities in the community. Another possible improvement could be greater opportunities for supervision and additional support for the pastors. The findings of the study reiterate the importance of prevention and care programmes in achieving the outcome of reducing the impact of HIV/AIDS in communities.

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GLOSSARY

| | |
|-------------|-------------------------------------|
| ADP | Area Development Programme |
| AIDS | Acquired Immune Deficiency Syndrome |
| CBO | Community Based Organisations |
| CCC | Community Care Coalition |
| HBC | Home-based Care |
| HIV | Human Immunodeficiency Virus |
| MADP | Mbekweni Area Development Programme |
| MDG | Millennium Development Goal |
| NGO | Non-Governmental Organisation |
| OVC | Orphan and Vulnerable Children |
| TB | Tuberculosis |
| STI | Sexually Transmitted Infection |

CHAPTER 1

INTRODUCTION

The programme that is being evaluated is a social programme for vulnerable children and their families that are infected and affected by HIV/AIDS. This chapter provides a description of the Mbekweni Area Development Programme (MADP). Firstly, a description of the MADP, specifically focusing on the HIV/AIDS project, will be provided. This will be followed by the programme theory that the programme is based on. A review of literature to assess the plausibility of the programme theory is provided. The chapter concludes with a discussion of the evaluation questions, which will be asked regarding the implementation of the HIV/AIDS project at Mbekweni.

ABOUT THE ORGANISATION

World Vision is an international organisation that is currently operating in more than 60 countries around the world. World Vision is a Christian, relief, development, advocacy organisation whose purpose is to create lasting change in the lives of children, families and communities living in poverty (World Vision, 2009a). World Vision South Africa has 18 programmes that are operating in South Africa. These are referred to as Area Development Programmes (ADP). MADP which started operating in the year 2000 is one of them. It was the first urban development project that was launched by World Vision South Africa. The issues that MADP focused on were HIV/AIDS, Early Childhood Development, Sponsorship, Program, and Project Management (Mbekweni Area Development Programme [MADP], 2009b).

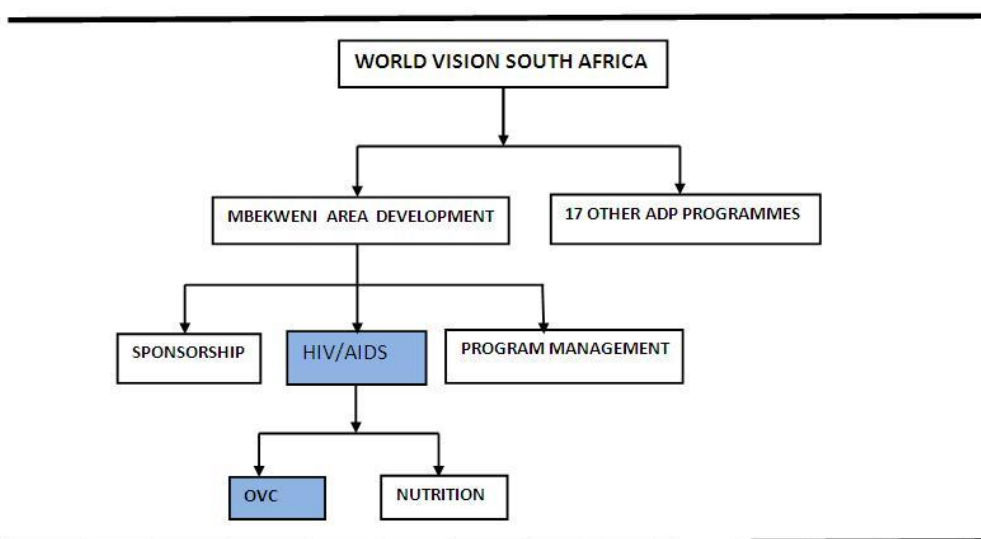
The MADP is located in the Drakenstein local municipality of the Western Cape and serves a population of approximately 50 000 people (MADP, 2009a). The main goal of the MADP is to alleviate poverty and reduce the suffering of the poor people in the targeted area by 2015 (MADP, 2009a). It is important to note that this stated goal is very broad and the MADP must rethink and make a goal that is specific and focused. The MADP is targeting the communities of Mbekweni, Fairyland and the surrounding farm areas (P. Manuels, personal communication, March 17, 2010). The MADP has three specific projects it is currently focusing on: HIV/AIDS, Sponsorship, and Programme Management.

The HIV/AIDS project is funded by World Vision Taiwan (MADP, 2009a). The staff comprises of 10 individuals who co-ordinate and ensure that the projects are implemented (P. Manuels, personal communication, March 17, 2010). The programme works in conjunction with the Drakenstein Municipality which is a major stakeholder.

The process evaluation for the purposes of this dissertation focuses on the HIV/AIDS project. The HIV/AIDS project has two components: orphan and vulnerable children (OVC) project and the nutrition project (P. Manuels personal communication, March 17, 2010). The nutrition aspect of the project has been excluded from this evaluation. The programme activities are described in detail in a later section of this chapter. Figure 1 illustrates the link of MADP to World Vision and shows how the HIV/AIDS project fits into MADP (highlighted in blue).

In 2000, the MADP restructured the services that they provide and this has led to the prioritisation of certain projects due to limited funding (P. Manuels, personal communication, March 17, 2010). Through the redesign, the HIV/AIDS project was identified as a one of the projects that was particularly important due to the continuing negative impact of HIV/AIDS on the people (MADP, 2009a). The main target population of the HIV/AIDS project includes orphans, vulnerable children and families that are infected and affected by HIV/AIDS in the Mbekweni, Fairyland and the surrounding farm areas.

Figure 1. Mbekweni ADP Components



*Figure 1 is based on the information in the MADP's Annual operating plan 2009

BACKGROUND REGARDING THE PROBLEM

HIV/AIDS is a global problem which has had a devastating impact with effects such as death, illness and loss of income. The global impact of HIV/AIDS has been included as one of the priority areas in the Millennium Development Goals (MDG). According to the United Nations, one of the goals in the MDG is for governments in various countries to combat HIV/AIDS, malaria and other diseases (Kusek & Rist, 2004). Table 1 shows the global summary of the AIDS epidemic as reported by UNAIDS in 2010.

Table 1: Global summary of the AIDS epidemic obtained from UNAIDS, December 2009

Table 1

Global summary of the AIDS epidemic obtained from UNAIDS, December 2009

| | | |
|------------------------------------------|----------------------|--------------------------------------------|
| Number of people living with HIV in 2009 | Total | 33.3 million (31.4 million – 35.3 million) |
| | Adults | 30.8 million (29.2 million – 38.6 million) |
| | Women | 15.9 million (14.8 million – 17.2 million) |
| | Children (<15 years) | 2.5 million (1.6 million -3.4 million) |
| People newly infected with HIV in 2009 | Total | 2.6 million (2.3 million– 2.8 million) |
| | Adults | 2.2 million (2.0million - 2.4 million) |
| | Children (<15 years) | 370000 (230 000 – 510 000) |
| AIDS related deaths in 2009 | Total | 1.8 million (1.6 million – 2.1 million) |
| | Adults | 1.6 million (1.4million – 1.8 million) |
| | Children (<15 years) | 260000 (150 000- 360 000) |

*The ranges around the estimates in this table define the boundaries in which the actual numbers lie, based on the best available information.

The regional HIV statistics that are reported by UNAIDS (2010) estimate that in Sub-Saharan Africa 22.5 million people are living with HIV. Walker, Reid and Cornell (2004) suggested that two-thirds of all those living with HIV and AIDS in the world are in Sub-Saharan Africa and that 90% of the people living with HIV/AIDS are in the developing world. A large proportion of people living with HIV in the world are found in Sub-Saharan Africa. World Vision (2009b) reports that:

“An estimated 15 million children under the age of 18 have been orphaned due to AIDS and the number is rising. About 11.6 million of these children live in sub-Saharan Africa. AIDS destabilizes families and entire societies, leaving children

without the care and support necessary to grow up, survive, and thrive. Nearly 33 million people are living with HIV and AIDS, of which 2 million are children under the age of 15” (para. 1).

HIV/AIDS has a negative impact on the social life of those who are infected and affected by HIV/AIDS. According to programme records the Mbekweni area is characterised by the presence of many orphans. The programme records do not give specific numbers or estimates of the orphans in the Mbekweni area. Walker et al., (2004) reported that by 2015 almost 12% of South African children will be orphans as a result of HIV/AIDS. There is a need for interventions in South Africa in order to mitigate the negative impact of HIV/AIDS. Similarly, according to Love Life (2000, p. 11) orphans are “perhaps the most tragic and long term legacy of the HIV/AIDS epidemic”. This suggests that currently one of South Africa’s biggest challenges is caring for the orphans and the impact of HIV/AIDS has left child headed households. In light of this, the HIV/AIDS project identifies orphans and vulnerable children as target populations that should receive the services of the programme due to the devastating impact of HIV/AIDS.

Focusing on South Africa, the government has developed an HIV/AIDS and Sexually Transmitted Infections (STI) strategic plan in an attempt to respond to the devastating impact of the epidemic on the country. The UNAIDS (2008) reports that an estimated 5.7 million people are living with HIV/AIDS in South Africa and an estimated 1.7 million children aged 0-14 are orphans due to AIDS. The HIV, AIDS and STI strategic plan for South Africa (Department of Health, 2007) aims to reduce the impact of HIV/AIDS on individuals, families, communities and society through interventions in four key priority areas: prevention; treatment, care and support; monitoring, research and surveillance; human rights and access to justice.

Walker et al., (2004) reported that HIV/AIDS has had a devastating impact on Southern Africa because of poverty and existing social problems. They suggested that the disease mainly affects poor people in the region because breadwinners are either ill or dying, leaving families with no income due to the illness, resulting in a devastating blow to the family. Access to health facilities and ARV treatment can help mitigate the effects of HIV. Walker et al., (2004) reported that South Africa has a complex social history fraught with conflict and

poverty. They further suggested that South Africa is a classic 'high risk situation' due to the social context and environment of the country.

The Mbekweni area and its surroundings have large informal settlements that are poor (MADP, 2009a) and have a high prevalence of HIV/AIDS. MADP identified the following problems in the Mbekweni area; poverty caused by unemployment, parents lacking interest in supporting their children at school, lack of adequate social services, not enough health facilities for proper treatment, no recreational facilities for the youth, lack of proper housing, overcrowding, Tuberculosis and a lack of acceptance of HIV/AIDS (MADP, 2000; 2002). A closer assessment should be considered to assess whether the problems that are identified were caused by a lack of interest or if there are other reasons influencing the problems such as a lack of resources and education.

The Drakenstein Municipality in the Western Cape noted with special concern that there is a high incidence of TB and HIV/AIDS and this impacts on the social and economic life of families. HIV/AIDS is a critical area for intervention because Mbekweni has the highest rate of infection in the Drakenstein municipality at 11% (MADP, 2009a). There is denial of HIV status and a reluctance to be tested as people prefer not to know their status. Also, if they are infected, they keep it to themselves until it is too late for any intervention (P. Manuels, personal communication, March 17, 2010).

PROGRAMME DESCRIPTION

The MADP HIV/AIDS project provides prevention and care programmes to people that are infected and affected by HIV/AIDS in the targeted areas (MADP, 2009a). MADP trains volunteers to implement the prevention and care programmes. The volunteers follow up with the targeted population through home visits, home-based care, awareness campaigns and support groups for the infected and affected people in order to address stigma (P. Manuels, personal communication, March, 17 2010).

As part of the care programme, the project provides emergency and material support to those that are infected and affected by HIV/AIDS. The main intended outcome of the project is to improve the quality of life and resilience of OVC and their families who are infected or affected by HIV/AIDS.

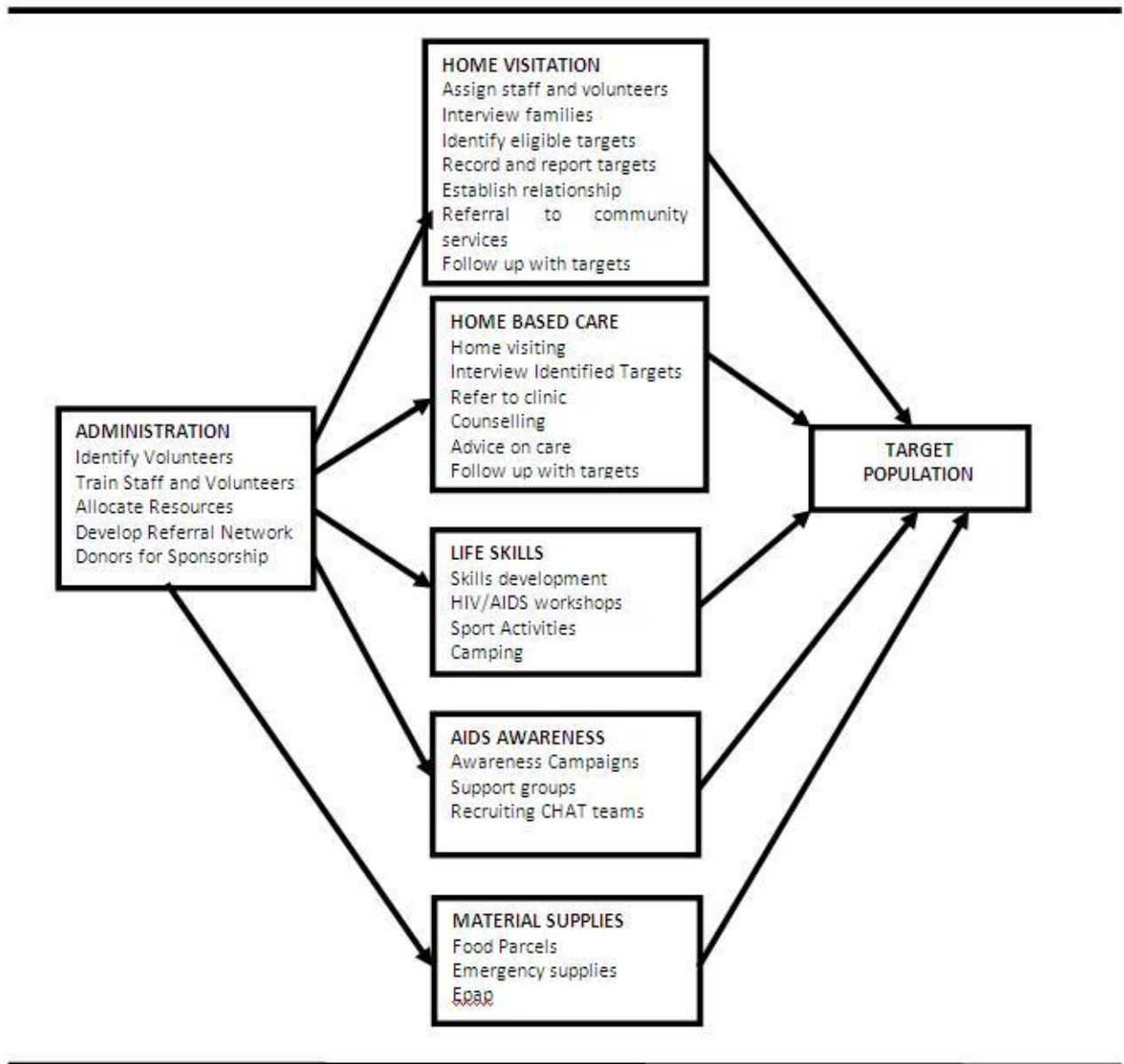
After the mid-term evaluation in 2009 there were objectives that were identified and were included in the redesign of the HIV/AIDS project. It was hoped these would improve care, treatment access and support for people living with HIV/AIDS. The results that were obtained in the mid-term evaluation suggested that the HIV/AIDS project was not being implemented as desired in that it was mainly focused on welfare and handing out material supplies to the target population without intervening in a sustainable manner (I. Maseko, personal communication, March 9, 2010).

The goal of the HIV/AIDS project for the year 2010 was to mitigate the impact of HIV/AIDS on 300 adults and their families in the communities of Mbekweni, Fairyland and general Drakenstein Local Municipality (MADP, 2009a). The MADP partners with the local community leaders from the Drakenstein Municipality, street committees, organisations such as Community Care Coalition, Paarl Hospice, Ikwezi Centre, Government Departments and volunteers from the targeted community in order to achieve the HIV/AIDS goals (MADP, 2009a).

Programme activities.

In order to have a better understanding of the programme Figure 2 show the organisational plan for the HIV/AIDS project which will be followed by a detailed description of the programme's activities below (this organisational plan is based on the MADP's annual report 2009).

Figure 2. Organisational Plan for MADP’s HIV/AIDS project



*Figure 2 is based on the information in the MADP’s Annual operating plan 2009

1. Home Visiting

The HIV/AIDS project has a home visitation programme that is used to achieve the project’s goals. To conduct this activity, home visitors are trained and are allocated areas that they should visit in the target areas of Mbekweni, Fairyland and farm area communities. The home visitors are comprised of eight volunteers who are trained by MADP to conduct home visits, assess families as well as to educate the community regarding HIV/AIDS. The first step that home visitors at MADP make is to establish contact in the community and build relationships with community members.

These home visitors go to all the homes in the targeted communities. The aim for each home visit is to assess and identify orphans, vulnerable children and families that are infected and affected by HIV/AIDS who are in need of the programme's assistance. For instance, the home visitors identify families that have children in the household and investigate if there are any sick family members in the household with HIV/AIDS-related diseases. The home visitor records process notes regarding each family that they have identified in the community as the target population to receive the programme. The notes are taken to the HIV/AIDS project co-ordinator.

During the home visit the home visitors will identify OVC that need to be enrolled in school or are in need of uniforms and medical attention. Home visitors also follow up on OVC and those infected and affected by HIV/AIDS once every month, either at school or at their homes, to offer them support and follow up regarding their coping and further needs.

The HIV/AIDS co-ordinator is responsible for assisting the home visitors to identify how the programme can assist the target population. The HIV/AIDS project co-ordinator often meets home visitors to discuss the families that have been identified as programme beneficiaries. The HIV/AIDS co-ordinator and home visitors make referrals to the families that have received home visits to the services that are appropriate. These referrals are dependent on the needs that have been identified by the home visitors during the home visits. The HIV/AIDS project ensures that families access a medical doctor, social services in order to get a social grant, palliative care, or some of the MADP's internal projects such as sponsorship or establishing a project.

2. Home-based care

The HIV/AIDS project also provides home-based care services to the families that are identified by home visitors as needing support. The HIV/AIDS project co-ordinator identifies the families that need to receive home-based care from the notes that are provided by home visitors regarding every home visit that was conducted. The HIV/AIDS project co-ordinator sends the details of families that need home-based care to the Community Care Coalition (CCC) who have trained home-based carers.

The home-based carers will conduct home visits to the identified families and will attend to the families using their home based care kits that are supplied by MADP. Home-based carers will provide health related advice and counselling on HIV/AIDS related issues. Home-based carers also refer some of the people to the local clinic in certain instances where the families need further medical services.

3. Life Skills

The HIV/AIDS project has life skills workshops that are aimed at the OVC to teach them life skills development. HIV/AIDS education is provided in the workshops to teach prevention strategies with youths and children. The HIV/AIDS education is an effort to bring awareness to the young people about the risks of infection. The HIV/AIDS education is also done in local schools to increase HIV/AIDS awareness among the children.

The project has also established children's clubs as a way of preventing HIV/AIDS and caring for those that are affected by HIV/AIDS. These children's clubs use sporting activities as a way of providing the children with life skills in an effort to prevent the spread of HIV/AIDS.

4. Aids Awareness

The HIV/AIDS project raises awareness for people living with the disease. The aim is to inform or educate people on how to live with HIV/AIDS (MADP, 2009a). The MADP's HIV/AIDS project conducts HIV/AIDS awareness campaigns in the targeted communities through their churches.

The HIV/AIDS awareness campaigns are also implemented by the church pastors through an initiative called Channels of Hope. The pastors teach HIV/AIDS awareness in their congregations by integrating HIV/AIDS in their ministry. As part of raising awareness in the congregations, pastors are responsible for recruiting church leaders and members into volunteering to form groups called congregation hope action teams (CHAT) which intervene and provide support to people living with HIV/AIDS in the community. The pastors are also involved in starting support groups in their congregations for people that are living with HIV/AIDS.

The MADP has trained 30 pastors from different churches to raise HIV/AIDS awareness campaigns in the targeted areas in 2010. The training was conducted in the form of a three-day workshop, which focused on HIV/AIDS education, raising awareness and forming support groups within the churches in the community.

The project is providing AIDS awareness by using volunteers in the interventions that are conducted during the home visitations. Awareness programmes are also conducted among children and youths through the life skills training in MADP's children's clubs.

5. Material Supplies

MADP's HIV/AIDS project also provides material support for the families that are infected and affected by HIV/AIDS. Such families are vulnerable and in need of material or emergency supplies. The HIV/AIDS project provides food parcels, E'pap for those who are sick and school uniforms for children etc.

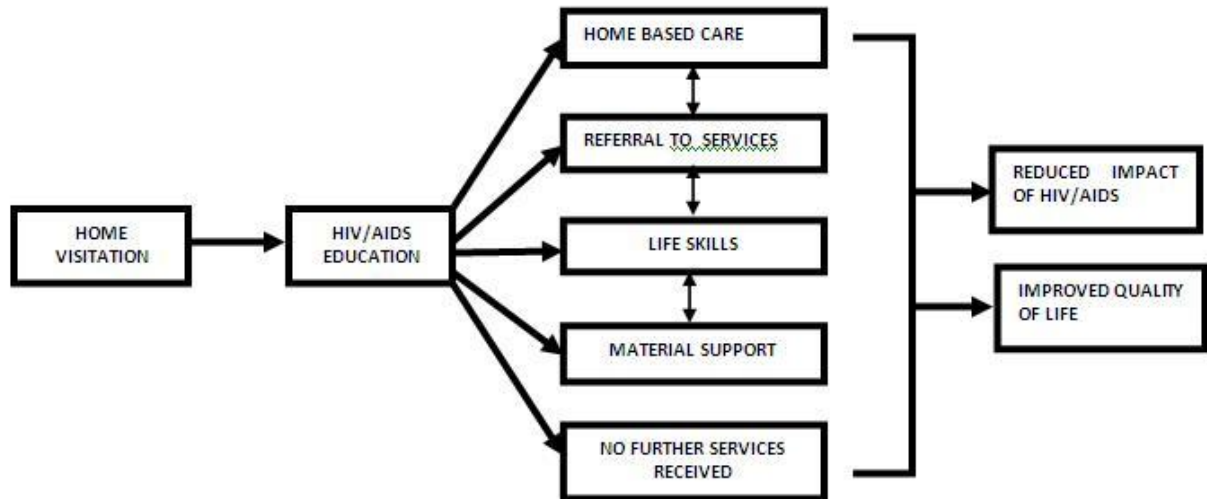
The HIV/AIDS coordinator identifies the material needs of the families that have been assessed by the home visitors. The co-ordinator allocates the amount of materials that the families need and on follow up visits, the home visitors ensure that the families receive the material supplies. These materials may vary depending on each household's needs.

Service utilisation plan

The five activities that are mentioned above are the services that the MADP is rendering to the people who are infected and affected by HIV/AIDS in the targeted areas. According to Rossi, Lipsey and Freeman (2004, p.142) "an explicit service utilisation plan pulls into focus the critical assumptions about how and why the intended recipients of service will actually become engaged with the programme".

The assumptions made by the MADP staff for the HIV/AIDS project are that there is stigma, lack of education and absence of support for people infected and affected by HIV/AIDS. These factors have led to a poor quality of life for the infected and affected people. Figure 3 provides an illustration of how the programme is expected to function.

Figure 3. Service Utilisation Plan for the Mbekweni HIV/AIDS Project



* Figure 3 is based on the information in the MADP's Annual operating plan 2009

Programme implementation

MADP's HIV/AIDS project is being implemented through CCC's home-based carers, eight volunteers and eight development workers who are given the capacity to provide home-based care and counselling for the people living with HIV and AIDS (P. Manuels, personal communication March 17, 2010).

Training is provided to major stakeholders in the community identified by MADP. This includes other organisations, church leadership, women's groups and home visitors. The home-based carers are supplied with home-based kits to use when they go for home visits. Thirty pastors have received training on HIV/AIDS in the Channels of Hope initiative (P. Manuels, personal communication March 17, 2010).

A HIV/AIDS project co-ordinator is involved in the organisation and running of the HIV/AIDS activities. The HIV/AIDS co-ordinator is responsible of the administration of the home visits, home-based care, referrals of programme beneficiaries and material support. An OVC coordinator is responsible for the administration of the HIV/AIDS awareness campaigns and the life skills workshops for children that are beneficiaries in the HIV/AIDS project.

Programme beneficiaries

The projects that are implemented by the ADP targets HIV/AIDS infected adults and their children from the Mbekweni, Fairy Land and farming communities in the Paarl area (MADP, 2009a).

Programme services

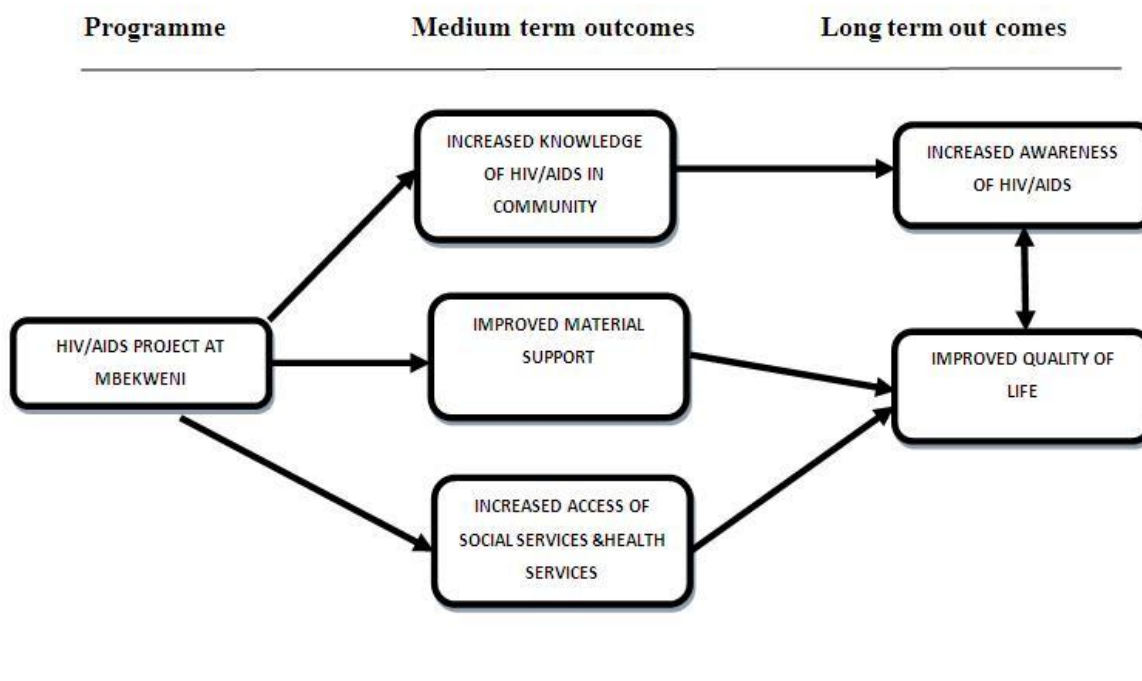
MADP is providing HIV/AIDS prevention and care programmes to the programme's beneficiaries through home visiting, home-based care, life skills, HIV/AIDS awareness campaigns and material supplies.

PROGRAMME THEORY

In order to evaluate the MADP HIV/AIDS programme at the Mbekweni ADP the client's programme impact theory was solicited. The programme impact theory according to Rossi et al., (2004) should describe the cause and effect sequences, in which programme activities are the instigating causes and social benefits are the effects they eventually produce. The Mbekweni ADP uses several activities to reduce the impact of HIV/AIDS on families. Figure 4 describes the HIV/AIDS project's impact theory.

After the implementation of the programme it is expected that the families that access the intervention from the HIV/AIDS project will have increased knowledge on HIV/AIDS. The medium-term goal for the orphan and vulnerable children and their families is that they are empowered and provided with skills to care for themselves, and protect themselves from being infected by HIV/AIDS. The long-term goal is that the families that are living with HIV/AIDS who receive the intervention will have an improved quality of life and the impact of HIV/AIDS will be reduced.

Figure 4. Impact Theory for Mbekweni HIV/AIDS Project



*Figure 4 is based on the information in the MADP’s Annual operating plan 2009

LITERATURE REVIEW

This section provides literature that enhances the client’s understanding of the problems which the targeted beneficiaries of the programme face. This is followed by literature on various interventions that can be used to address some of the problems which people who are infected and affected by HIV/AIDS encounter.

According to Richter and Foster (2005), community-based programmes are one of the most significant ways in which intervention programmes can make a difference in fighting HIV/AIDS. Fitzsimons, Hardy and Tolley (1995) suggested that the impact of AIDS is worst in the parts of the world such as Sub-Saharan Africa where many of the infected people have progressed to illness and then death. HIV/AIDS influences all aspects of life for the infected and affected people. The Mbekweni HIV/AIDS programme mobilises community members to volunteer and become involved in the different initiatives that try to reduce the impact of HIV/AIDS on the community. To ensure that people living with HIV/AIDS and their affected families receive the necessary interventions the MADP aims to understand the problems and

the impact that HIV/AIDS has on these families. The impact of HIV/AIDS on the family life can be assessed through looking at the economic, social and health aspects of the family.

Economic impact of HIV/AIDS on households.

According Holden (2004) the HIV/AIDS epidemic affects households, communities and nations. She discussed that HIV/AIDS's effects are more severe when there is vulnerability. For instance, when there is sickness and death among the economically productive women and men. Mathambo and Gibbs (2009) also supported this view as they reported that HIV/AIDS has devastating consequences that are being seen in families. They noted that these devastating consequences occur when there is prolonged illness and death of family members who are of a working age and this has a huge impact on the family's livelihood and the ability to provide for and protect the family.

Uys and Cameron (2003) suggested that the reality of HIV/AIDS in the family is that children are caring for the sick, end up leaving school earlier, marrying earlier, entering the labour force earlier and are frequently sexually exploited. Payne (2005) noted that families with HIV-infected members experience burdens that include financial limitations, inadequate resources and insufficient support. In Lili et al. (2008) the authors refer to this state as "care-giver burdens".

Love Life (2000) noted that the HIV /AIDS epidemic affects all sectors of society with poor households carrying the burden under the least resources available to cope with the disease. Uys and Cameron (2003), reported that, the link between poverty and AIDS is undisputed, support this view. Their study indicated that malnutrition was associated with poverty and this compromised the immune system for the infected person. Scott, Fulton and Letro (2006) noted that most HIV/AIDS infected children also struggle with malnutrition or a deficiency in nutrition, largely due to poor economic circumstances.

The Mbekweni HIV/AIDS project aims to address the economic impact of HIV/AIDS through the provision of material supplies and emergency food supplies. The infected adults are often infected may be too ill to be employed, leaving the families without food or any income. Regarding nutrition, the MADP's HIV/AIDS project has a supply of nutritious E'pap for children and adults who are ill. E'pap is used to assist the families with a sick family member to ensure that the patient is getting nutritious food.

Social impact of HIV/AIDS on families

Lili et al. (2008) reported that globally, people living with HIV/AIDS have multiple sources of stress. The causes of stress are identified as the “disease itself, financial burdens, stigma and discrimination, pressure of worrying about their families” (p. 431). According to Walker et al. (2004), AIDS is greatly feared. This results in stigma and discrimination against people with the disease. Walker et al. (2004) noted that some community interventions, for example community-based care and support programmes are not successful because stigma is the main barrier to the implementation of the programmes. People infected by HIV/AIDS do not disclose their status because they fear the hostile response from their families and communities. Stigmatised responses to HIV/AIDS in South Africa can be traced back to the government and medical reactions to the disease when it was first diagnosed. Early education campaigns used scare tactics that promoted negative stigma around the disease.

According to programme staff, most of the people living with HIV/AIDS are in denial even when they are very sick with diseases related to HIV/AIDS. (P. Manuels, personal communication, March 17, 2010). Cloete et al. (2010) reported that there is a reluctance to disclose an HIV-positive status due to fear of being rejected and discriminated against by the community. To address the identified issues that are related to stigma, the MADP have implemented programme activities that are targeted at addressing the stigma associated with HIV/AIDS. These include awareness campaigns and support groups within the community of Mbekweni and the surrounding areas. The MADP’s aim is to increase awareness and knowledge of HIV/AIDS and to reduce the stigma in the community.

Another outcome of the HIV/AIDS epidemic is that of orphans and vulnerable children. To minimise this impact on society, MADP’s HIV/AIDS programme has an OVC project in which orphaned and vulnerable children are identified and supported to enroll in school and assisted to access medical services. The caregiver of the orphaned or vulnerable child is referred to social services where they are assisted in applying for the child support grant, (or foster care grant or the care dependency grant), depending on the problem in the family.

Vithayachockitikhun (2006) researched the role of the caregiver in families infected and affected by HIV and highlights some of the issues that may arise in home-based care. In addition, the author reported that most caregiver burdens develop due to the stigma associated with caring for HIV-infected family members. The need for nursing professionals

to be able to identify such issues among caregivers, be able to assist, support them from this stress, and the burdens is also identified as important.

Schenk (2009) reported that children affected by HIV/AIDS in the communities face multiple risks to their health, education and psychosocial wellbeing. Schenk's (2009) research study identifies 21 community-based interventions among OVC that were being implemented in different communities and found that there was value in community interventions in effecting measurable improvements in child and family wellbeing. Furthermore the author recommended that, it is essential for further research and monitoring of the process and outcome data of community based interventions.

The Mbekweni HIV/AIDS programme trains and supports home visitors and home-based carers to conduct visits to people that are living with HIV/AIDS and their families. These visitations provide awareness and advice to the families that are affected by HIV/AIDS. The community volunteers are also trained to intervene and provide support to orphans and their families through referral to the appropriate services, i.e. health and social services. Another outcome of HIV/AIDS which needs to be addressed is the impact of the disease on the health of the infected person and the family.

Health impact of HIV/AIDS on the individual and their families

According to Tompkins (2005), HIV/AIDS affects the nutrition of individuals through out the lifecycle. Clinical AIDS develops into weight loss, micronutrient deficiency, decreased physical capacity and inability to earn enough to be able to provide food leading to food security for the family. Similar notions are raised by Brunner et al. (2001) that one of the significant impacts of HIV/AIDS on the health of infected people is severe weight loss. Scott et al. (2006) reported that inadequate weight or malnutrition is one of the symptoms of HIV in the infected child.

HIV/AIDS has major impacts, not only on the health of the infected individual, but also on the affected family members. Holden (2004) illustrates this well, suggesting that infectious diseases can easily develop and affect the family. For instance Tuberculosis in the HIV-infected person can also put the family at risk.

Fitzsimons et al. (1995) indicated that HIV/AIDS has an impact on health and life expectancy. The number of AIDS cases increases, hence affecting the health system as more patients are increasingly admitted into hospitals. By the time the person dies, the family is impoverished because of the costs in time and money spent caring for and burying them. Campbel, Marston, Richter and Stein (2010) noted that many children who require antiretroviral (ARV) therapy cannot access the necessary treatment. As HIV/AIDS disease progresses, the children may suffer from many symptoms such as pain, diarrhoea, rashes and sores. The Mbekweni HIV/AIDS programme refers the people that are infected by HIV/AIDS to the local clinic and assists them in getting to a doctor in order to receive treatment.

The HIV/AIDS project also provides the E'pap porridge as a nutritious supplement for the people that are sick to negate the impact of the illness on nutrition. The project's beneficiaries are also referred to internal programmes that are run by the MADP. Such programmes as the nutrition project, which will try to mediate food security risks, because the sick are unable to perform their work for food security.

PLAUSIBILITY OF PROGRAMME THEORY

McKerrow (2002) mentioned that in the case of children who are infected or affected by HIV/AIDS, interventions addressing HIV/AIDS should include prevention, care, and support activities which focus on the child and all the household members where the child is living. Blom and Bremridge (2003) suggested that a holistic continuum of HIV prevention and care structures is needed to prevent stigmatisation, discrimination and mitigate the trauma associated with HIV/AIDS. MADP's HIV/AIDS project is intervening in the community through prevention and care programmes that target the infected and affected families by HIV/AIDS.

According to Richter et al. (2008) it is important to use a family strengthening approach in working and supporting children affected by HIV/AIDS to ameliorate the effects of HIV/AIDS on the children. Richter et al. (2008) suggested that a developmental approach to poverty is essential to protect children affected by HIV/AIDS. This study identified access to health and education and income security as basic goals that can reduce the cycle of infection. Pendelbury, Lake and Smith (2009) showed that a majority of children are not able to attend school if they are not able to buy school uniforms and pay school fees. Badcock-Walters

(2002) suggested that AIDS – affected households are often unable to afford school uniforms, school fees, textbooks and other materials. They further suggest that the incidence of HIV infection in the home can be expected to further reduce education.

Ritcher et al. (2008) also recommended that interventions are needed to support distressed families such as home-visiting, protection and the enhancement of children's potential through early child development efforts. In line with this recommendation the MADP's HIV/AIDS project uses a developmental approach to poverty by supporting OVC in attending school and providing food parcels and material support to families.

Foster and Williamson (2000) suggested that, in communities where HIV/AIDS is prevalent, the mechanisms that keep families and households from destitution are comprised of material relief, labour and emotional support by the community. According to Walker et al. (2004) the emotional cost and economic burden of families and communities are vast. As part of the HIV/AIDS project's activities, home visitors and the HIV/AIDS co-ordinator assess the material needs of the targeted families and decide on the supplies that the families receive.

Bebbington and Gatter (1994) reported on the use of volunteers in an HIV social care organisation. They reported that the use of training volunteers in the field of HIV/AIDS plays a major role in communities. The study identified, however that there was a high turnover rate of volunteers, in this field due to poor communication between management staff and volunteers resulting in feelings of being under-valued.

Mashimo et al. (2001) examined the effectiveness of AIDS volunteers in mitigating the stigma towards people living with AIDS in the context of community-based care in Thailand. In the study, a comparison was made between trained volunteers and untrained volunteers in different villages. The comparison was based on the differences in knowledge of HIV/AIDS and attitudes of the villagers. Mashimo et al. (2001) found that there was significantly greater knowledge of HIV/AIDS in the villages that received trained volunteers than the villages without. However, there was no difference in attitude between the villages that received trained volunteers and untrained volunteers.

Smart (2003, p. 181) suggested that “interventions to assist orphans and affected children should be based in and owned by the affected communities themselves”. Smart (2003) found that these members from the community are in the best position to know which households

are severely affected and are able to visit the households more regularly to provide more practical support. The Mbekweni HIV/AIDS programme trains volunteers from the community to visit and follow up on families that are affected by HIV/AIDS. The volunteers are involved in supporting the affected families and are responsible for providing knowledge and awareness of HIV/AIDS in the community.

Mabude et al. (2008) in a study that focused on the use of home-based carers (HBC) in South Africa, showed the importance of the role that trained volunteers played in communities. The study further argues that indeed there is substantial work that has to be done by community-based carers in HBC. However, there is a need to improve the supply of HBC kits and expand the training opportunities for caregivers in the use of these HBC kits.

Uys and Cameron (2003) discussed the importance of home-based care as a method of intervention in HIV/AIDS care in South Africa. The home-based care programmes can provide a comprehensive and holistic coverage of HIV/AIDS issues. Home-based care programmes provide counselling to adults, children, and families infected with or affected by HIV/AIDS. According to Uys and Cameron (2003) reported that ideal home-based care programmes run support groups, do home visits, deal with poverty, teach how one can get infected and provide methods of prevention as well as for the orphan problem. However, it is important to note that the success of home-based care programmes relies on the presence of a supportive family and the availability of resources in the community. The Mbekweni HIV/AIDS programme has home-based carers who follow up on the people that are living with HIV/AIDS and those affected by the disease.

Taylor and Kvalsigin (2008) investigated the impact of HIV/AIDS in communities using in-depth interviews with community members. There are increasing deaths families do not accept that the cause of death is HIV/AIDS and that early childhood development workers trained in the field of HIV/AIDS are essential in communities. In KwaZulu-Natal there was a need for early childhood development workers in communities, to help children in vulnerable households and their families. An increasing number of orphans is due to AIDS related deaths.

The economic impacts of HIV/AIDS on households that are infected and affected by the disease are in need of interventions that include nutritional programmes. Brunner et al. (2001) discuss the impact of a nutritional programme that is established in a HIV/AIDS clinic in a

community. Their research study implemented a nutrition programme for five years with HIV-infected patients who were taking ARV treatment. The nutritional program benefited the participants and appeared to be essential to the provision of this intervention in the community.

Tompkins (2005) studied nutrition interventions in controlling HIV/AIDS. The study discussed the impact of HIV/AIDS on food security and malnutrition in Africa. Tompkins (2005) used scientifically conducted studies to show that specifically focused nutrition interventions can transform, prevent and manage HIV/AIDS, and improve the health of adults and children. Similarly according to Scott et al. (2006) nutrition plays an important role in maintaining the well-being of children infected with HIV/AIDS. Inadequate weight or malnutrition is one of the symptoms of HIV in the infected child. It is recommended that the infected child be placed in foster care or alternatively in a hospice for support care.

Tabi and Vogel (2005) identified nutritional counselling as an intervention that helps and improves the health outcomes of HIV-infected patients in Ghana and certain parts of West Africa. Nutritional counselling does improve the health of HIV-infected patients through the availability of nutritious food, that result in a longer and a better quality of life. Counselling on nutrition and the access to nutritious food improved the health of HIV-infected patients. The Mbekweni HIV/AIDS programme provides home-based care where families receive counselling and health-related advice from the home-based carers.

However, a study by Bowie et al. (2005) on the effect of food supplementation provided by the World Food Programme to patients and their families enrolled predominately in a HIV/AIDS home-based care programme in Bangwe, Malawi gives opposing results. In addition, food supplementation did not improve the survival of the infected but had an effect on their nutritional status. Therefore, Bowie et al. (2005) recommended that the World Food Programme food supplementation needed to be re-assessed. The Mbekweni HIV/AIDS programme provides E'pap as a food supplement to people living with HIV/AIDS in order to improve the nutrition of those that are infected.

Santmyire and Jamison's (2006) study focused on assessing the effectiveness of educational programmes of Pastors of the Assemblies of God in Burkina Faso on HIV/AIDS and mother-to-child transmission. The findings showed that pastors had minimal knowledge regarding HIV/AIDS before the educational programme but after the programme their knowledge

increased. Santmyire and Jamison (2006) reported that at follow-up three months after the intervention the pastors were recommending HIV testing in churches and communities. The HIV/AIDS programme at Mbekweni is aiming to educate members of the church regarding HIV/AIDS and provide support for people living with the disease.

Litefoot et al. (2001) conducted a study to examine how conducting a brief training session on HIV/AIDS prevention with volunteers in church organisations would affect the awareness and teaching of public health of HIV/AIDS messages to others. The study showed that church volunteers who received training showed a higher level of comfort and self-efficacy in delivering HIV/AIDS messages than those who had not received any training. Litefoot et al. (2001) recommended the use of church volunteers for community awareness and HIV prevention messages is an efficient strategy of intervention. The Mbekweni HIV/AIDS programme runs the Channels of Hope intervention through the training of pastors to teach HIV/AIDS awareness and support using the ministry in churches.

McKerrow (2002) mentions that it is important for all workers in existing programmes, as well as in new programmes that are being implemented in with regards to HIV/AIDS, need to receive ongoing training. According to Adams et al. (2007), effective orientation and training are fundamental to the successful implementation of any intervention. The reason being that they communicate the critical first impressions of the intervention and the skills needed to conduct it. MADP's HIV/AIDS project provides training and supervision for the people who render services for the project for example home visitors and development workers. Smart (2003) suggested that supervisory visits can serve to confirm activities and support and identify instances where support is insufficient or absent.

Blom and Bremridge (2003) noted that support groups are a key intervention for people living with HIV/AIDS. Ramlagan, Peltzer, Phaswana-Mafuya and Aquilera (2010) reported that support groups are essential for people living with HIV/AIDS because of victimisation and discrimination when they disclose their status. The pastors were trained in the Channels of Hope workshop to intervene in the community through support groups in their congregations to address issues of stigma related with the disease HIV/AIDS.

An evaluation by Visser (1996) focused on the impact of first aid kits, AIDS and lifestyle education programmes, on secondary school students' behavioural intentions, their knowledge of AIDS as well as attitude towards people with AIDS. The study recommended

that AIDS education should form part of long-term life skills and sex education and that the focus should be on behavioural change. Whiteside and Sunter (2000) reported that children's programmes should be aimed at teaching life skills rather than focusing on HIV/AIDS alone. Visser (1996) recommended that community education and participation are key elements in the effectiveness of AIDS education programmes for adolescent students. Later Visser (2005) recommended that a structured programme is required to provide guidelines and specific content that is needed to address behavioural change in young people. The Mbekweni HIV/AIDS programme is involved in the running of children's clubs and providing life skills training that bring awareness of HIV/AIDS.

This section has provided literature regarding the impact of HIV/AIDS on individuals and families and has also shown some interventions that are being used with families that are infected and affected by HIV/AIDS. An implementation evaluation was done on MADP's HIV/AIDS project and the following section discussed the evaluation questions that were used.

EVALUATION QUESTIONS

This study is a process evaluation to assess how the programme is implemented. An important step in designing an evaluation is to determine the questions that the evaluation seeks to answer (Rossi et al., 2004).

Babbie and Mouton (2001) noted that implementation evaluations serve three functions, including information on the extent of programme delivery, information on the coverage of the programme and information on programme diffusion. In line with Babbie and Mouton (2001) the process evaluation questions in this dissertation were based on coverage, service delivery and organisational support.

In order to perform the process evaluation a set of evaluation questions need to be formulated and these questions will need to provide meaningful information regarding the programme's implementation (Rossi et al. 2004). This evaluation study sets of to answer the following questions:

Coverage

1. Who are the intended beneficiaries of the ADP's HIV/AIDS programme?

2. How are the intended beneficiaries selected for the HIV/AIDS programme?
3. Are the programme activities being delivered to the intended beneficiaries?

Service delivery

4. Home visiting

- a) Are the home visitors visiting the identified communities?
- b) Are home visitors identifying the intended beneficiaries for the programme?
- c) Are home visitors teaching regarding awareness, care, support for people living with HIV/AIDS during the home visits?
- d) Are intended beneficiaries receiving food parcels?

5. Home-based Care

- a) Are home-based carers providing counselling supports to the HIV/AIDS infected people in the community?
- b) Are home-based carers providing referral to other medical services to the intended beneficiaries?

6. Development Workers

- a) Are the orphan and vulnerable children receiving sponsorship?
- b) Are development workers following up on the progress of the intended beneficiaries?
- c) Is the programme implementing life skills workshops for the infected and affected children?

7. Channels of Hope

- a) Are pastors advocating for people infected and affected by HIV/AIDS?
- b) Are pastors raising campaigns in the community regarding the support and care of people living with HIV/AIDS?
- c) Are pastors providing support groups for people living with HIV/AIDS within their congregations?

8. Are the beneficiaries receiving more than one service from the HIV/AIDS project?

Organisational support.

9 Do programme staff receive training on the services that they provide?

10. How often do the programme staff receive additional training and support?

11. Do programme staff receive supervision on the services that they provide?

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CHAPTER 2

METHODOLOGY

This chapter focuses on the materials used for data collection, data providers, and the procedures that the evaluator used to collect the necessary data. The chapter ends with a discussion on how the data was analysed. Babbie and Mouton (2001) identified three main sources of obtaining data for implementation evaluation studies: records, observations and self-reports. This evaluation will use the programme's records as well as qualitative and quantitative data collection methods.

Access and review of programme documents

The data collection process began in March 2010 with a formal meeting with the programme manager. The programme manager gave permission to the evaluator to access programme documentation that is relevant to the implementation evaluation. The programme manager assigned a programme co-ordinator to assist in providing the information. The programme co-ordinator clarified the HIV/AIDS programme's aim, objectives, activities and outcomes. The questionnaires used in the evaluation were developed and informed by programme records.

Other programme records were obtained in July 2010 during interviews with the key informants. These records included lists of programme participants obtained from the database of children that are part of the OVC project and of adults and children that are receiving services from the HIV/AIDS project. An attendance register for the Channels of Hope initiative that pastors are involved with is also provided.

The programme records that were obtained were copied for the evaluator to use and the original documents were returned to the programme staff. Information regarding the programme activities was used to describe the programme and its implementation. Other programme records were summarised and used to answer some of the evaluation questions that show how the programme is implemented.

MEASUREMENT INSTRUMENTS

Programme records

Programme documents are a secondary data source. The programme records that were used were in the form of service documentation. The use of these programme records enabled the researcher to extract comprehensive information about the implementation of the programme (Rossi et al. 2004). The records included:

- Training attendance records
- Database lists of programme beneficiaries of the HIV/AIDS project
- Database lists of programme beneficiaries of the OVC project
- The Annual Operating Plan for the year 2010

The evaluator obtained the programme records from the OVC co-ordinator. The OVC co-ordinator explained the accuracy of the programme records and that they were complete. The use of the programme records strengthened, and answered some of the initial questions regarding the programme's activities and processes. After obtaining these records three individuals were identified as potentially key informants.

The programme records contained information regarding who the beneficiaries of the programme were, information on the implementers of the HIV/AIDS project and the training and services that the MADP was providing. To be able to obtain more detailed information regarding the implementation of the HIV/AIDS project the programme records were used to develop an interview schedule.

Interviews

According to Patton (2002), programme evaluation interviews aim to capture the perspectives of people associated with the programme. The evaluator used interviews with key informants as one of the methods to collect information regarding the implementation of the HIV/AIDS project.

The evaluator conducted three informal discussions with the programme staff in February and March 2010. The first informal discussion was made with the programme manager, and this was the first contact the researcher made with the programme. The following two informal interviews were made with the HIV/AIDS coordinator when the researcher was collecting

some of the programme records. The informal discussions were based on the programme and how MADP was providing the services to the targeted people.

An interview schedule was developed to obtain descriptive detail regarding the implementation of the programme's activities. The interview schedule was administered in face-to-face interviewing with the three selected key informants. The interview schedule started with a focus on the coverage of the programme. Secondly, the interview schedule asked questions regarding the services that the programme is rendering and how the programme staff was implementing these services. Finally, the interview schedule focused on the organisational support that the programme staff is receiving in implementing the programme as planned.

The information obtained in the interviews was used to develop questionnaires for the evaluation. The questionnaires that were developed were for home visitors, home-based carers, development workers and pastors.

Questionnaires

To obtain information regarding the implementation of MADP's HIV/AIDS project, four questionnaires were developed using the information gathered from the interviews. The evaluator developed a separate questionnaire for each of the service providers. The service providers in the HIV/AIDS project included home visitors, home-based carers, development workers and pastors.

The questionnaire had two distinct areas of questions for each service provider: service delivery and organisational support. The first part of the questionnaire explored the knowledge and skill of the programme implementers. Secondly, the questionnaire explored the quality of services rendered to the target population and organisational support to the programme implementers.

Pen and paper questionnaires were developed as a way of addressing some of the evaluation questions. The questionnaire was the dominant data collection tool used in this study. Each questionnaire will be elaborated below.

Home visitors' questionnaire

The home visitor's questionnaire comprised of a 17-items questionnaire that used a 5-point Likert Scale (1-strongly disagree, 2-disagree, 3-neutral, 4-agree and 5-strongly agree). The measure for the quality of the home visitors questionnaire was $\alpha = 0.86$. According to Pallant (2007) the cronbach's coefficient alpha must be greater than 0.7 to show that the questionnaire has good internal consistency and reliability.

Home-based carers' questionnaire

The home-based carers' questionnaire comprised of 10-items that used a 5-point Likert Scale (1-strongly disagree, 2-disagree, 3-neutral, 4-agree and 5-strongly agree). The measure for the quality of the home-based questionnaire was $\alpha = 0.71$. As described above, the measure, which, is over 0.7 demonstrates good internal consistency and reliability.

Development workers' questionnaire

The development workers' questionnaire comprised of a 12-items that used a 5-point Likert Scale (1-strongly disagree, 2-disagree, 3-neutral, 4-agree and 5-strongly agree). The measure for the quality of the home visitors questionnaire was $\alpha = 0.70$. As described above, the measure, which, is over 0.7 demonstrates good internal consistency and reliability.

Pastors' questionnaire

The pastors' questionnaire was a 10-item questionnaire that used a 5-point Likert Scale (1-strongly disagree, 2-disagree, 3-neutral, 4-agree and 5-strongly agree). The measure for the quality of the home visitors questionnaire was $\alpha = 0.87$. As described above, the measure, which, is over 0.7 demonstrates good internal consistency and reliability.

DATA PROVIDERS

Several data providers were targeted in order to obtain the necessary information. Table 2 provides a list of the data providers that were used in conducting this evaluation study. Through out the evaluation report all the service providers (home visitors, pastors, home-based carers and development workers) will be referred to either as service providers, programme implementers or programme staff.

Table 2: Data providers and Data collection methods

Table 2

A Summary of Data Providers and Methods of Data Collection

| Stakeholder | Sample of Data Providers | Method of Data Collection |
|----------------------|---------------------------------|----------------------------------|
| MADP programme staff | 1 X Programme manager | Interview Schedule |
| | 2 X Programme co-ordinators | |
| | 7 X Home visitors | Questionnaire |
| | 7 X Development workers | |
| | 10 X Home based carers | |
| | 11 X Pastors | |

This study initially targeted all programme implementers: n= 57 staff members. The researcher had aimed at collecting data from all data providers, however, this was not possible. Hence, data was only collected from staff members (n=38).

Home visitors

Seven female home visitors volunteered to participate in the study. The seven had children who were registered with the OVC project at MADP. The home visitors reside in the areas that the Mbekweni ADP is operating in. Some of the volunteers did not have any qualifications. The home visitors have received training and workshops related to their interventions in the community, from MADP. Home visitors receive a stipend from MADP for the services that they provide to the programme.

Development workers

The seven development workers who participated in the study were females with matric and are employed full time by the programme. These workers have received various training for the work they do in the community. Development workers are employed by the MADP.

Home-based carers

The 10 home-based carers who participated in the study were all female. The home-based carers have all passed matric. The home-based carers received training for home-based care. Home-based carers receive a stipend from the CCC.

Pastors

The researcher encountered problems collecting data from the targeted 30 pastors who had received training for the Channels of Hope initiative. Some of the pastors were not willing to participate in the research due to problems they had with the programme management. The problems in collecting data from pastors showed that there were problems in the implementation of the Channels of Hope initiative.

Only 11 male pastors agreed to complete the questionnaires. Two out of the 11 pastors were illiterate. These pastors received training from the Mbekweni ADP for the Channels of Hope initiative and receive no stipend for the services they provided the MADP..

Key Informants

According to Patton (2002), key informants are people who are particularly knowledgeable about the inquiry setting. The evaluator selected key informants from the programme staff whose insights were useful in helping the evaluator understand the implementation of the programme.

The programme manager, the co-ordinator for the HIV/AIDS project and the co-ordinator for the OVC project were identified as three key informants for information about the programme's coverage, service delivery and organisational support. The two project co-ordinators and the programme manager are employed by World Vision and receive training from the World Vision Organisation. The interview process was used to obtain information regarding the implementation, training and supervision of the staff of the HIV/AIDS project.

PROCEDURE

Ethical considerations

The process of ethical clearance was obtained from the University of Cape Town's Faculty of Commerce's Ethics Committee to do the research. Permission to gain access to the service providers was requested from the programme manager. The data collection was conducted after the approval by the Commerce's Ethics Committee. The researcher included a cover letter to all data providers that guaranteed them anonymity, confidentiality and voluntary participation in participating in the research.

In order to maintain confidentiality in the results and discussion section, the key informants were not identified by the positions held in the programme. Instead they are referred to as respondents 1, 2 and 3. The evaluator randomly assigned these labels to ensure that the identity of the key informants remained anonymous.

Interviews with the key informants

The data collection process with key informants occurred in July 2010. The key informants were informed that participation was voluntary, confidential and anonymous. The evaluator set up appointments with the three key informants to interview them. The HIV/AIDS co-ordinator was interviewed first and a tape-recorder was used to record the interview process. This was followed by an interview with the OVC co-ordinator on the same day. The OVC co-ordinator expressed discomfort with the use of a tape-recorder, hence the interview was written down as it progressed. The third interview with the programme manager was made on a separate day, after these two interviews due to practical problems of appointment scheduling. The programme manager expressed discomfort with the use of a tape-recorder. This interview was, therefore, also recorded using notes as the interview progressed. The interviews took between an hour and two hours to complete. The information obtained from the interviews was used to develop the questionnaires.

Administering the questionnaires

The evaluator discussed the administering of the questionnaires to the 58 programme implementers with the OVC co-ordinator. The OVC co-ordinator reported that all the programme implementers operate in the community and rarely come into the office with the exception of development workers. The OVC co-ordinator offered to assist in distributing and administering the paper-based questionnaires to the staff of 57 staff that work directly with the target population. This was a recommended route by the programme co-ordinator as some of the staff do not report to the Mbekweni ADP office on a daily basis. It was agreed that for practical reasons the OVC co-ordinator would go out to the programme implementers and administer the questionnaires. The questionnaires were administered between July and August 2010.

Consent forms were utilised to gain informed consent from the volunteers and programme staff. The consent forms contain details about the nature of the evaluation and the contact

details of the programme. The OVC co-ordinator also informed programme staff that they could participate in the study voluntarily and issues of anonymity and confidentiality was also explained to the participants. All questionnaires were administered with a consent form and a cover letter that explained the research.

The questionnaires were administered in the following order; first the home visitors, development workers and home-based carers completed the questionnaires. This was the order in which the OVC co-ordinator reached the programme staff. No problems were encountered in the data collection process of the above-mentioned programme implementers. Administering the pastors' questionnaire proved a challenge, however, as there was resistance in participating and completing the questionnaire. The OVC coordinator reported that the pastors were sceptical about completing the questionnaires and signing the consent forms. The Head Pastor suggested to the OVC co-ordinator that the evaluator explains the research to the pastors during a workshop. The evaluator later attended a workshop that was being held for the pastors by another organisation in the community and explained the research to the pastors who were part of the Channels of Hope initiative. After the presentation, some of the pastors completed the questionnaire. Only 11 pastors agreed to complete the questionnaire from the 30 pastors who attended the Channels of Hope workshop.

DATA ANALYSIS

Programme Records

Content analysis was used on the programme records in order to identify themes. Programme records were used to answer certain evaluation questions. The programme records were assessed and interpreted in the results and discussion section. Patton (2002) reported that interpretation goes beyond the descriptive data. The evaluator used descriptive programme data of programme beneficiaries and the number of workshops that were conducted and interpreted this data.

Interviews

One interview was recorded on a tape-recorder and two interviews were hand written during the data collection period. The evaluator transcribed the two interviews and typed all the three interviews in order to make data analysis easier by having hard copies of all the interviews. The evaluator looked at each question in the interview schedule and analysed the

data given by each respondent and noted similarities and differences by highlighting similarities with the same colour.

Qualitative data that was obtained from the interview process with key informants was analysed according to the strategies described by Huberman and Miles (1998) which includes: noting patterns, themes, clustering and making contrasts of interview responses. The similarities and variations in responses by the respondents were highlighted and analysed.

Thick, rich descriptions that were made by the key informants were used to report the results. Patton (2002, p. 438) reported “thick evaluation descriptions take those who need to use the evaluation findings into the experience and outcomes of the programme”. The information provided from the interviews was quoted and analysed in order to describe clearly how the HIV/AIDS project is implemented by the MADP.

Questionnaires

The questionnaires collected were given a number and checked for any missing data. This was done to ensure that each questionnaire could be identified at a later stage in the evaluation if needed. The quantitative data that was derived from the four questionnaires was subject to descriptive statistics to present the quantitative data in a manageable form. The analysis of questionnaires included the ranges of the item responses.

The evaluator used the evaluation questions in order to analyse the data obtained from the questionnaires. Therefore, item questions were linked with the evaluation questions and the numbers of respondents who agreed, who were neutral and who disagreed with the statement were recorded. The evaluator counted the number of different responses. This analysis method of counting responses was selected because the respondents to the questionnaires were few.

Triangulation

The evaluation study used three data collection methods to conduct the process evaluation. This process is referred to as triangulation. Patton (2002) reported that methods of triangulation often involve comparing and integrating data collected through qualitative and quantitative methods. The evaluation analyses program records, interviews and questionnaires as suggested by Patton (2002) to reduce the bias that comes from using a

single method. Triangulation was used in the evaluation study to enhance the quality and credibility of the process evaluation.

This chapter has provided the tools that were used to conduct the process evaluation. This was followed by a discussion of the data providers and the procedure that was used to collect the data. The chapter ends with a discussion of how the data was analysed. The results and discussion of the data collected are presented in chapter 3.

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CHAPTER 3

RESULTS AND DISCUSSION

This chapter presents the results and a discussion of the process evaluation of the HIV/AIDS project at MADP. The chapter also provides recommendations to MADP (where necessary) to improve the effectiveness of the programme's implementation. According to Babbie and Mouton (2001), an implementation evaluation includes information on the programme's coverage and service delivery. This section provides outcomes of the set evaluation questions, including those related to the programme's coverage, service delivery and organisational support.

Programme records were used in showing the results of the implementation of the programme. These programme records included training attendance records, the Annual Operating Plan, database records of participants from the OVC and records of those infected and affected by HIV/AIDS.

Part of the results that were obtained in this study was from conducting interviews with three key informants. The results from the interviews were obtained from respondent 1, respondent 2 and respondent 3. The evaluator randomly assigned these labels to ensure that the identity of the key informants remained anonymous and that confidentiality is maintained in reporting the results. The interview questions that were used explored questions related to: the coverage of the programme, the service delivery and the organisational support.

Questionnaires were an instrument that was used to obtain some of the results that are discussed in this section. The questionnaires explored the major themes of programme coverage, service delivery and the organisational support.

COVERAGE

The process evaluation focused on addressing the programme's coverage:

1. Who are the intended beneficiaries of the ADP's HIV/AIDS programme?

To obtain data on programme beneficiaries the programme records were used. MADP's Annual Operating Plan (2009) reported that the beneficiaries of the HIV/AIDS project are

HIV/AIDS infected adults and their families who reside in Mbekweni, Fairyland and the surrounding farm areas. Programme records reported that in the year 2010 an estimated 2700 adults and children from the targeted areas had received one or more of the services from the HIV/AIDS project. These services ranged from home visits, food parcels, emergency supplies and life skills. Mathambo and Gibbs (2009) suggested that HIV/AIDS has devastating consequences that is being seen on families. In line with Mathambo and Gibbs' (2009) opinion, the programme beneficiaries for the HIV/AIDS project are families that are infected and affected by HIV/AIDS. These beneficiaries are targeted by the HIV/AIDS project at MADP in order to achieve the project's goal of mitigating the impact of HIV/AIDS on the targeted communities.

According to respondents 1 and 2, the beneficiaries of the MADP are children. These respondents suggested that the programme activities are open to any child. This differs from the beneficiaries that are described in MADP's Annual Report (2009), which suggested that they are orphans and vulnerable children who are infected and affected by HIV/AIDS. This suggests that the programme is not being delivered in the intended manner as it is open to any child. The respondents were asked who the programme beneficiaries are and the following responses were obtained:

Respondent 1: *"...We are taking a sort of broad approach where by we are looking at children that are infected and affected but also we are trying especially with our life skills programme to reach all children..."*

Respondent 2: *"...often these are needy children or who may be living in child headed household or children who may be coming from single headed homes. These are all children from the community and not specifically only HIV/AIDS infected and affected children..."*

Respondent 2: *"...I think it is not fair to exclude other children from the HIV/AIDS project activities because how can you explain to the children that their friends cannot attend the HIV/AIDS project because they are not HIV positive or their family is not infected..."*

In implementing the programme, the programme's staff do not limit the beneficiaries to OVC only. The Mbekweni HIV/AIDS programme is incorporating all children in their interventions, even those who are not affected and infected. This is due to issues around stigma and discrimination surrounding those affected and infected by HIV/AIDS. Cloete et

al. (2010) reported that there is a reluctance to disclose an HIV-positive status due to fear of being rejected and discriminated against by the community. To achieve the outcome of mitigating the impact of HIV/AIDS the MADP is providing services to all children in the community. It is important that the programme is being provided to families that are infected and affected by HIV/AIDS because the HIV/AIDS is affecting not only the infected individual, but it also affects the family as a unit. A family-focused intervention will address the physical, social and economic factors that may affect the household.

Recommendation 1: There is a difference between the targeted beneficiaries in the annual operating plan and targeted beneficiaries that are identified by the programme staff that were interviewed. It is recommended that there is a clarification process where funders, implementers and all documentation is updated on the targeted beneficiaries of the programme.

2. How are the intended beneficiaries selected for the HIV/AIDS programme?

To answer the question about how the intended beneficiaries are selected for the HIV/AIDS programme, programme records were reviewed. The MADP's Annual Operating Plan (2009) suggested that home visitors identify programme beneficiaries during the first visit by taking notes of families with sick people or with orphans and vulnerable children.

When the three key informants were asked how the programme was reaching the intended beneficiaries, two of the key informants suggested that the beneficiaries i.e. adults and children are often referred to the programme by other community-based organisations:

Respondent 3: *"...churches and other non-governmental organisations that help us to identify the target population for the HIV/AIDS project..."*

Respondent 2: *"...targeted population is also reached through networking with other community based organisations..."*

However, respondent 1 gave a different opinion from the other two respondents. Respondent 1 mentioned that home visitors were being used in the identification of beneficiaries. This opinion is in line with the MADP's Annual Operating Plan (2009) which reported that home visitors identify the programme beneficiaries.

Respondent 1: “...if there is a child that is not in our programme and is orphaned or experiencing situations where they are vulnerable like they do not have a place to stay those children are identified by home visitors and become registered.”

The organisation is networking with other community-based organisations in order to identify the target population. This method of networking was not set out in the MADP’s Annual Operating Plan (2009) of the HIV/AIDS project. However, it is being used in conjunction with the planned method of using home visitors to identify the programme beneficiaries

3. Are the programme activities being delivered to the intended beneficiaries?

To determine whether programme activities were being delivered to the intended beneficiaries, interviews and questionnaires were used. One key informant mentioned that the programme activities are being delivered to the intended beneficiaries.

Respondent 3: “The people that are targeted in the HIV/AIDS programme are the infected and affected children, adults and parents in the community who are living with AIDS.”

The question whether home visitors are only visiting families that are infected and affected by HIV/AIDS was asked to home visitors. This was done in order to establish whether programme activities are being delivered to the intended beneficiaries. All the seven home visitors agreed that home visiting is being delivered to the infected and affected families. In order for the programme to achieve its goal of mitigating the impact of HIV/AIDS in the targeted communities of Mbekweni, Fairyland and the surrounding farm areas, the programme activities must be delivered to families that are infected and affected by HIV/AIDS.

SERVICE DELIVERY

The process evaluation focused on the service delivery of all the programme’s activities:

4. Home visiting

4(a) Are the home visitors conducting home visits to the identified communities?

In order to assess whether the programme's activity of home visits was being implemented in the selected communities, interviews with key informants and the home visitors' questionnaire were used. The key informants were asked how they ensured that home visitors are conducting home visits to the identified communities. Two of the key informants suggested that home visitors are visiting the identified communities and they indicated how the organisation ensures that the home visitors are reaching the identified communities.

Respondent 3: *"...our organisation monitors home visitors by requesting for a report on a weekly...also a monitoring form that is signed by the parent after a home visit so basically our home visitors are doing what the organisation requires them to do."*

Respondent 2: *"...Home visitors write notes regarding all the visits that they make and these are given to the HIV/AIDS co-ordinator who goes through them..."*

In order to determine whether home visitors are visiting beneficiaries in the targeted areas six out of seven home visitors who completed the questionnaire, agreed that they are visiting the beneficiaries in the identified areas of Mbekweni, Fairyland and the surrounding farm areas. Only one home visitor took a neutral stance. The results show that the intended beneficiaries from the targeted areas are receiving the service of home visits. Ritcher et al. (2008) recommend that interventions, such as home visiting, for families infected and affected by HIV/AIDS are needed to support distressed families.

The HIV/AIDS project's home visitors are rendering the home visiting service. The service of rendering home visits to the programme beneficiaries results in the programme outcome of having increased support services for beneficiaries that are infected and affected by HIV/AIDS. This is achieved through a referral to access different local services. Home visiting is an essential part of the programme because families that are infected and affected by HIV/AIDS can be supported through advice, counselling and the family's material needs can be identified from visiting the family in their home.

4(b) Are home visitors identifying the intended beneficiaries for the programme?

A question was asked to the key informants to determine whether home visitors are identifying the intended beneficiaries of the programme. One of the key informants mentioned that the home visitors are identifying the programme beneficiaries:

Respondent 1: *“...if there is a child that is not in our programme and is orphaned or experiencing situations where they are vulnerable like they do not have a place to stay those children are identified by home visitors and become registered.”*

Five out of seven home visitors agreed that they are identifying the programme beneficiaries and two out of the seven home visitors. Smart (2003, p. 181) suggested that “interventions to assist orphans and affected children should be based in, owned by, the affected communities themselves”. The home visitors are volunteers from the community who are involved in identifying some of the targeted population. Smart (2003) suggested that these members from the community are in the best position to know which households are severely affected and are able to visit the households more regularly to provide more practical support. The home visitors are comprised of volunteers who reside in the targeted area. This is an advantage because home visitors may already know some people from the community that are infected and affected by HIV/AIDS and who are in need of some of the programme’s services.

4(c) Are home visitors teaching regarding awareness, care, support for people living with HIV/AIDS during the home visits?

Home visitors were asked whether they were teaching HIV/AIDS awareness, care and support during the home visits. Four out of the seven home visitors did not think that they were teaching on HIV/AIDS awareness, care and support. Only two respondents agreed that they were providing awareness, care and support during the home visits conducted. One home visitor remained neutral. The findings show that most of the home visitors were not teaching regarding awareness, care and support during home visits as the mean response was 2.37 (SD 1.51). In literature by McKerrow (2002) it is mentioned that in the case of children who are infected or affected by HIV/AIDS, interventions addressing HIV/AIDS should include prevention, care and support activities which focus on the child and all the household members where the child is living. In future the next focus of the evaluation should look at why home visitors are not teaching regarding prevention, care and support when literature supports these interventions.

The results obtained from the home visitors do not match the findings of other research. Mashimo et al. (2001) reported on the effectiveness of AIDS volunteers in mitigating the stigma of people living with AIDS in the context of community-based care in Thailand. They reported that there was a difference in knowledge between the villages that received trained volunteers and those who received untrained volunteers. In this evaluation study, home visitors have received training on teaching awareness, care and support among people living with HIV/AIDS but they report that they are not using these skills during home visits. For MADP, the results obtained from home visitors regarding teaching, caring and supporting beneficiaries show that the outcome of increasing HIV/AIDS knowledge among programme beneficiaries will not be achieved effectively due to the poor implementation by home visitors. It is important for families that are infected and affected by HIV/AIDS to receive education regarding HIV/AIDS in order to avoid stigma and discrimination of the infected person and also to empower the family to support and care for the people living with HIV/AIDS.

4d) Are intended beneficiaries receiving food parcels and emergency supplies?

In order to address the implementation of material support, programme records, interviews and a question in the home visitors' questionnaire was used to review the support that beneficiaries were receiving from the HIV/AIDS project. Programme records from the HIV/AIDS project show that in the year 2008, 243 families received food parcels. In the year 2009, 178 families received food parcels and in the year 2010, 1933 families received food parcels.

The programme records also showed that in the year 2008 there were no emergency supplies that were provided by the HIV/AIDS project. In the year 2009, five wendy houses were provided for programme beneficiaries as emergency supplies. In the year 2010, 170 families received emergency supplies in the form of building materials, mattresses and blankets. Payne (2005) suggested that HIV-infected/affected families experience burdens (the negative impact of HIV/AIDS) that include financial limitations, inadequate resources and insufficient support. The HIV/AIDS project implements the programme activity of providing material supplies to families in the form of food parcels and emergency supplies to achieve the project's goal of mitigating the impact of HIV/AIDS in the community. Families that are infected and affected by HIV/AIDS may face financial problems especially when a breadwinner is sick. Food parcels and material supplies are important to support the families

coping during the time that the caregiver is sick, with no income and is unable to provide for the family.

A question was asked to determine whether the intended beneficiaries were receiving food parcels and emergency supplies. Two of the three key informants indicated that programme beneficiaries are receiving food parcels and emergency supplies and reported how they keep track of and record this:

Respondent 1: *“We have a budget for our OVC and we can have emergency supplies for child headed households ...we also looking at the living conditions for these households do they have mattresses, do they need blankets, do they need food to eat are they in need of a food parcel so those are the needs that our home visitors go out to identify.”*

Respondent 2: *“...parents participate or benefit from the programme in emergency supplies, food parcels pap, blankets and uniforms the families are asked to sign and write thank-you gratitude notes which are filed as records.”*

A questionnaire was used with home visitors to survey whether the programme beneficiaries were receiving the food supplies. Four out of the seven of the home visitors agreed that programme beneficiaries were receiving food parcels from the programme and three out of the seven home visitors disagreed. The next evaluation must focus on why home visitors suggest that programme beneficiaries are not receiving food parcels. The home visitors were asked whether programme beneficiaries were receiving E’pap. All the home visitors strongly agreed that programme beneficiaries were receiving the E’pap food supplement. Scott et al.’s (2006) study discussed that most HIV/AIDS infected children struggle with malnutrition or a deficiency in nutrition which is exacerbated by their poor economic circumstances. The MADP’s HIV/AIDS project provides food parcels and emergency supplies to support families that are struggling and impacted on negatively by HIV/AIDS.

The implementation of the programme activity of providing beneficiaries with material supplies is aimed at achieving the outcome of increased material support which, in the long term, will result in an improved quality of life for the families that are infected and affected by HIV/AIDS. Families that are infected and affected by HIV/AIDS who face financial problems are not able to afford all the nutritious foods which may aid in improving their poor

health. The provision of a nutrition supplement will help in improving the quality of life for the infected person.

5. Home-based Care

5(a) Are home-based carers providing counselling support to the HIV/AIDS infected people in the community?

Home-based carers were surveyed to assess whether they were providing counselling to the people living with HIV/AIDS. The findings showed most of the home-based carers strongly agreed to providing counselling and support services. Nine of the ten home-based carers agreed to providing counselling services and only one home-based carer disagreed to providing counselling services. Uys and Cameron (2003) discussed the importance of home-based care as a method of intervention in HIV/AIDS care in South Africa. Home-based care programmes can provide a comprehensive and holistic coverage of HIV issues.

The implementation of the programme activity of counselling in home-based care achieves the programmes' long-term outcome of improving the quality of life for the infected and affected people. HIV/AIDS infected people may face psychological stresses caused by stigma and depression due to the illness. It is essential that the people living with HIV/AIDS receive counselling support to reduce the social problems that may arise due to the illness.

5(b) Are home-based carers providing referral to other medical services to the intended beneficiaries?

Home-based carers were surveyed on whether they were providing referrals to other services. Nine of the ten home based carers agreed to providing referrals to programme beneficiaries to the hospital or clinic for further medical services and only one of them disagreed. The access to medical services for families that are infected and affected by HIV/AIDS will increase the opportunity for the project to achieve the long-term outcome of mitigating the impact of HIV/AIDS. Campbel et al. (2010) suggested that many children who require antiretroviral therapy cannot access the necessary treatment. As the disease HIV/AIDS progresses, the children suffer from many symptoms such as pain, diarrhoea, rashes and sores. Fitzsimons et al. (1995) suggested that HIV/AIDS has an impact on health and life expectancy and as the

number of AIDS cases increases, the health system is affected as more patients increasingly get admitted into hospitals.

The MADP's HIV/AIDS project is providing referrals for medical services through home based-care/carers. Home-based care is achieving the project's outcome of improved access to medical services. It is important for people that are living with HIV/AIDS to have access to medical services for the provision of treatment for their health problems.

6. Development Workers

6(a) Are the orphan and vulnerable children receiving material support?

Programme records were used to review whether the OVC were receiving material support. According to the programme documents (including the MADP Annual Operating Plan of 2009) 2500 children are receiving sponsorship from the HIV/AIDS programme. Literature by Schenk (2009) suggested that children affected by HIV/AIDS in their communities face multiple risks in terms of their health, education and psychosocial wellbeing. In line with Schenk (2009) the MADP's HIV/AIDS project addresses the multiple risks that the OVC face through sponsorship. This is done in order to attain the project's goal of mitigating the impact of HIV/AIDS in the community.

In the year 2008 programme records show that 340 OVC received school uniforms. In the year 2009, 75 OVC received school uniforms and in 2010, 429 OVC received school uniforms from the HIV/AIDS project. Research by Pendelbury et al. (2009) showed that a majority of children are not able to attend school if they are not able to buy school uniforms and pay school fees. Badcock-Walters (2002) suggested that AIDS – affected households are often unable to afford school uniforms, school fees, textbooks and other materials. They further suggest that the incidence of HIV infection in the home can be expected to further reduce education.

The HIV/AIDS project aims to improve the quality of life for the families that are infected and affected by HIV/AIDS and the project is achieving this through the services that are provided to children in the form of material support and sponsorship at school. HIV/AIDS has resulted in the presence of many orphans and vulnerable children and it is important that

there are interventions present that support these children such as sponsoring them to have better access to education, food, health and accommodation.

6(b) Are development workers following up on the progress of the intended beneficiaries?

In order to assess whether the programme is being implemented as intended the key informants were asked how the programme ensured that development workers are doing what the programme intends for them to do. Two key informants reported that development workers are following up on the children's progress and they mentioned how the programme keeps record of this:

Respondent 3: *"...Development workers are working according to plan through the Child Monitoring Forms that they submit about each child that they visit. The development workers also report weekly to a community resource officer on every Friday to report on the work that they have done. "*

Respondent 2: *"Development workers have to complete a form regarding every child that they follow up on and this is updated on the system such that every quarter the development worker needs to have completed the forms and if not the system will show and pick up on the number of children that have not been followed up by a development worker in three months."*

In Schenk's (2009) research study, 21 community-based interventions in OVC were identified that are being conducted in different communities. There is value in community interventions in effecting measurable improvements in child and family wellbeing. Schenk (2009) mentions and recommended that it is essential for further research and monitoring of process and outcome data of community-based interventions.

The Mbekweni HIV/AIDS programme is following up on the services that they are rendering in the HIV/AIDS programme. The programme uses follow-up visits on OVC to ensure that the outcome of improving the quality of life for children is achieved. OVC are sometimes left with no income and with the responsibility of caring for their younger siblings. It is important for interventions to support these children and to follow up on their progress.

6(c) Is the programme implementing life skills workshops for the infected and affected children?

The HIV/AIDS project uses life skills as a way of achieving the outcome of improving of the HIV/AIDS knowledge of the children and to empower them with better decision-making skills. To determine whether life skills were being provided to the OVC, programme records and interviews were used. In order to determine if life skills were being provided, programme records from 2008, 2009 and 2010 were used. In 2008, life skills were provided in the form of nine workshops, peer education and camps and 855 OVC participated in these activities.

In the year, 2009 there were 1685 children that participated in the life skills workshops and camps. In the year, 2010 programme records were only available until the month of May, 2010. According to these records, 390 children participated in life skills workshops. The MADP's HIV/AIDS project implemented the life skills workshops in order to achieve their goal of empowering children through educating them with regards to HIV/AIDS in order to improve their quality of life.

To determine whether life skills workshops were being implemented for infected and affected children, interviews also provided some insight. Two key informants reported that life skills workshops are being implemented with the children who are programme beneficiaries:

Respondent 3: *"...sustainable programmes in the community, for instance the life skills project where there was not much being done but at present we are seeing changes in the children's clubs that are being formed in the community."*

Respondent 1: *"For this current year we have had about four of these workshops mobilising children... within our area we currently have six clubs; we are servicing approximately about 250 children on a regular basis about twice or three times in a week..."*

Visser (1996) recommended that AIDS education should form part of long-term life skills and sex education and the focus should be on behavioural change. Visser (1996) further adds that community education and participation are also key elements in the effectiveness of AIDS education programmes for children that are adolescent students. The HIV/AIDS project has life skills workshops that are functioning within the community through children's clubs. Whiteside and Sunter (2000) reported that children's programmes should be aimed at teaching life skills rather than focusing on HIV/AIDS alone. The children's clubs at MADP

aim to achieve the outcome of improving life skills, AIDS education and awareness among the children. Life skills are an essential intervention method because the focus is on empowering young children to make informed decisions that will make them better leaders in the community.

Respondent 1, however, suggested that the children's clubs need to be improved in the quality of their implementation:

Respondent 1: *“My vision for next year is to really have a structured programme running for the children's clubs where by we have some form of curricular that is running. Because currently there is no curricular that is running there is just functioning on areas that they feel comfortable with or areas that they feel need to be addressed as per meetings that they have with the children”.*

Life skills are being implemented in the area effectively through the children's clubs that have been established in the targeted communities, however, respondent 1 suggests a more structured programme for the children's clubs. Visser (2005) recommended that a structured programme is required to provide guidelines and specific content that is needed to address behavioural change in young people.

Recommendation 2: In line with the recommendation by Visser (2005) it is suggested that MADP's HIV/AIDS project may need a more structured curriculum in terms of the life skills activities. A more structured curriculum may help to enhance the programme's effectiveness in changing behaviours of young people.

7. Pastors

Pastors were questioned regarding their role in the implementation of the services in the Channels of Hope Initiative using a questionnaire. Only 11 out of the 30 pastors who participated in the Channels of Hope training participated in the questionnaire. There was a low response rate from the pastors and difficulties were encountered by the evaluator in getting them to become participants in the study. As a result, the evaluator, could not determine, with certainty whether the pastors are implementing the programme as described in the programme description.

One of the pastors, in an informal interview, reported that there were problems between the pastors and the MADP's management such that the pastors were not willing to participate in anything that involved MADP. This affected the participation of the pastors in the evaluation study. The one pastor suggested that the pastors were concerned with the manner that MADP's management was treating them as they had been promised further training and support in the Channels of Hope Initiative to ensure that they are able to intervene effectively in the community. It appeared that the pastors had only received one training workshop in May. Since then there had been no follow-up meetings or support mechanisms that had been suggested by MADP in the first training workshop.

The evaluator attended a conflict resolution training workshop in order to recruit more pastors to participate in the study. There were 30 of the pastors who had received the first Channels of Hope workshop at MADP present. The evaluator arranged with the head pastor to attend the conflict resolution training in order to encourage the pastors' participation in the study. The evaluator explained to pastors that the questionnaire was for educational purposes. Despite this, only 11 pastors volunteered to participate in the study.

7(a) Are pastors advocating for people infected and affected by HIV/AIDS?

In order to assess the nature of the services delivered by pastors, a questionnaire was used. When pastors were asked whether they were advocating for those infected and affected and by HIV/AIDS, seven pastors out of the 11 agreed to advocating for the infected and affected people living with HIV/AIDS. Only two pastors disagreed to doing advocacy work for those infected and affected by HIV/AIDS.

Litefoot et al. (2001) stated that church volunteers who received training showed a higher level of comfort and self-efficacy in delivering HIV/AIDS messages than those who had not received any training. MADP'S HIV/AIDS project aims to achieve the outcome of reducing stigma by improving the support to people that are infected and affected by HIV/AIDS through using the pastors from the community. Pastors are viewed with respect and their opinions are often followed in the Christian community. Pastors are effective in addressing stigmatic views and raising awareness of HIV/AIDS.

7(b) Are pastors raising campaigns in the community regarding support and care of people living with HIV/AIDS?

To determine whether pastors are providing support and care to people living with HIV/AIDS a questionnaire was used to obtain the results. Nine of the 11 pastors surveyed agreed to teaching the community regarding the care and support of people living with HIV/AIDS in the community. Only two pastors remained neutral regarding pastors raising awareness campaigns.

Streak (2002) mentioned that one of the programmes that form part of the National Integrated Plan for Children Infected and Affected by HIV/AIDS is through community outreach/ community mobilisation. It is suggested that the focus is on raising awareness amongst community leaders regarding HIV/AIDS and how the community can access services related to HIV/AIDS. MADP is attempting to achieve the goal of mitigating the impact of HIV/AIDS through the project's activity of awareness campaigns using community leaders.

7(c) Are pastors providing support groups for people living with HIV/AIDS within their congregations?

In order to assess whether pastors were providing support groups a question was asked in the pastors' questionnaire regarding this. When pastors were asked whether they were starting or running support groups for people living with HIV/AIDS, mixed results were obtained. Five pastors reported that they had HIV/AIDS support groups in their churches. Four pastors did not have support groups. Three pastors remained neutral. Literature by Blom and Bremridge (2003) suggested that support groups are a key intervention for people living with HIV/AIDS. Other literature suggests that on-going support helps HIV-positive members to cope with infection and helps both HIV- positive and HIV-negative members, adopt and maintain effective preventative behaviour (UNAIDS 2002). Ramlagan et al. (2010) reported that support groups are essential for people living with HIV/AIDS because they face victimisation and discrimination when they disclose their status. The MADP's HIV/AIDS project attempts to achieve the outcome of improving support for families that are living with HIV and AIDS through providing support groups in the community. Support groups are an important intervention in HIV/AIDS because they provide a safe place for people living with

HIV/AIDS, where they can express themselves and support each other with the challenges that the people with the disease encounter.

8. Are the beneficiaries receiving more than one service from the HIV/AIDS project?

In order to assess whether beneficiaries were receiving more than one service from the HIV/AIDS project, organisational records were used. According to programme records of lists of beneficiaries who are receiving the support of the OVC project and beneficiaries receiving the services from the HIV/AIDS project, some beneficiaries are appearing on both of the lists which illustrates that beneficiaries were receiving more than one service from the various services that are being offered in the HIV/AIDS programme. Blom and Bremridge (2003) suggested that a holistic continuum of HIV prevention and care structures is needed to prevent stigmatisation, discrimination and mitigate the trauma associated with HIV/AIDS. In line with Blom and Bremridge's (2003) suggestion, the programme is supporting programme beneficiaries depending on the nature of their needs such that beneficiaries can receive more than one service. This approach is used to address/fulfil the outcome of mitigating the impact of HIV/AIDS. A holistic approach to dealing with HIV/AIDS is important where people infected and affected by HIV/AIDS receive an intervention that addresses all their needs.

ORGANISATIONAL SUPPORT

The process evaluation finally focused on the organisational support to the service providers:

9. Do programme staff receive training on the services that they provide?

Interviews were used to obtain a description of the organisational support that the programme's staff was provided with. Key informants were asked whether the programme staff received training for the services that they provide. The three key informants reported that the organisation is providing training for the programme staff who implement the HIV/AIDS programme.

Respondent 2: "World Vision is very big on trainings and workshops for its staff and in the three years that I have been employed at World Vision there has been many workshops."

Respondent 3: "World Vision is big on providing training and workshops for the staff and development workers benefit from this."

Respondent 1: *“World Vision works alongside a training organisation by the name of Primecure...Primecure they offer various training be it health, nutrition, counselling skills, various things education on drugs etc to do various things with the people. All the programme staff is part of all this training.”*

Bebbington and Gatter’s (1994) study on volunteers in an HIV social care organisation identified that the use of trained volunteers in the field of HIV/AIDS plays a major role in communities. MADP’s HIV/AIDS programme uses trained volunteers to achieve the outcome of increasing knowledge and support in the communities. Training of service providers is an essential aspect of the improvement of the quality of services that are provided in a programme.

One of the pastors in an informal interview with the evaluator mentioned that there is a concern by the pastors in the administration of the Channels of Hope Initiative with regards to training. The one pastor reported that they have only received one training workshop in May and since this training workshop there was no follow up training or support from the programme because MADP had suggested that there would be follow up trainings. Two of the key informants mentioned that:

Respondent 1: *“...pastors have received one Channels of Hope workshop and not all the churches were covered.”*

Respondent 2: *“Pastors for the Channels of Hope Initiative have received only a two day training earlier in the year... the pastors still need to receive a follow-up training of the initiative and this has not yet been scheduled”*

There is a need for MADP’s HIV/AIDS project to support and motivate the participation of pastors in mitigating the impact of HIV/AIDS in the community. Bebbington and Gatter’s (1994) study identified a high turnover rate of volunteers in the HIV/AIDS field due to poor communication between management staff and volunteers, often resulting in feelings of being under-valued.

10. How often do the programme staff receive additional training and support?

In order to establish the frequency of additional training and support in the HIV/AIDS project, key informants were interviewed. From the results reported by the key informants, it appears that the organisation is providing many training workshops and support services for home visitors and development workers:

Respondent 3: *“Home visitors receive on-going training such that if any stakeholders have training that is related with HIV/AIDS the home visitors attend the training...”*

Respondent 3: *“World Vision is big on providing training and workshops for the staff and development workers benefit from this.”*

However, the concerns regarding the lack of additional training and support for pastors at MADP are noted. In assessing the pastors' questionnaire, when asked whether pastors have received additional training and support for the Channels of Hope Initiative, all of the pastors that participated in the study agreed that they had not received additional training and support from the organisation. McKerrow (2002) mentions that it is important for all workers in existing programmes, as well as in new programmes that are being implemented in with regards to HIV/AIDS, need to receive ongoing training. According to Adams et al., (2007) it is suggested that effective orientation and training are fundamental to the successful implementation of any intervention. The MADP appears to have provided little training for the intervention that is implemented by pastors.

Recommendation 3: For MADP's HIV/AIDS project to be implemented as planned the MADP may need to support and build on the relationship between the programme staff and the pastors. Increased and clearer communication between these two key stakeholders may help to improve the quality of the implementation of the Channels of Hope Initiative. Some authors suggests that it is essential for staff that work in HIV/AIDS-related fields to receive on-going training and continuous support to improve their effectiveness in delivering these interventions (Adams, et. al. 2007; McKerrow, 2002).

11. Do programme staff receive supervision on the services that they provide?

In order to assess whether programme staff are being supervised for the services that they are rendering in the community interviews and questionnaires were reviewed. The three key informants were asked whether programme staff were receiving supervision. It appears that

most of the key informants suggested that there was not much supervision (for pastors) because it is difficult to keep track of the work that the pastors are doing in their congregations and communities. There are no set steps in place to enable for the pastors to receive supervision:

Respondent 3: *“The pastors are not well monitored...”*

Respondent 1: *“It is difficult to try and monitor the pastors in the Channels of Hope Initiative due to its nature...”*

For home visitors and development workers, the findings mentioned earlier show that home visitors and development workers compile reports that are presented to the HIV/AIDS co-ordinator and the OVC co-ordinator as a means for supervision.

Respondent 3: *“The development workers also report weekly to a Community Resource Officer on every Friday to report on the work that they have done. ”*

The findings for the home-based carers show that all 10 of the home-based carers that were surveyed agreed to receiving supervision. Smart (2003) suggested that supervisory visits can serve to confirm activities and support and identify instances where support is insufficient or absent. The MADP provides supervision services to the programme staff to ensure that the programme is being implemented as intended.

Recommendation 4: A possible improvement could be greater opportunities for supervision and additional support for the pastors. The results suggest that the pastors require more guidance and assistance as they attempt to implement the programme. Programme staff could perhaps organise regular feedback sessions where the pastors are given opportunity to discuss implementation problems and challenges and receive advice from programme staff and their peers.

This chapter has presented the results that were obtained from the programme records, interviews and questionnaires. The results were also combined with a discussion and recommendation of the findings. Following this chapter are the limitations to this implementation evaluation.

LIMITATIONS TO THE EVALUATION

This section of the evaluation sets to highlight the limitations of the evaluation. An explanation is provided as to how the evaluator endeavoured to overcome the effects of such limitations.

Firstly, some of the questions in the questionnaires are based on self-report data of how the staff is implementing the programme. The data obtained from these types of self-reports may be biased. There may be a tendency to give socially desirable answers. This is a limitation because using questionnaires where respondents may be giving socially desirable answers to the evaluator. To ensure that this would not have an effect the findings of the evaluation were obtained through triangulation: three methods were used to collect results for the programme evaluation.

Two of the pastors who participated in the study were illiterate. The questionnaires had to be read out to the pastors and because the evaluator is not fluent in Xhosa, an interpreter was used to explain the questions. This is a limitation because the interpreter may have translated the questions in a way that he understood which may necessarily be different from the actual question.

The process evaluation did not obtain information regarding the implementation of the programme from programme beneficiaries. This may be a limitation to the study because the views of people who are benefiting from the programme are not included in the study.

CONCLUSION

This evaluation study has examined the implementation of MADP's HIV/AIDS project. The process evaluation has assessed the manner in which the programme activities of home visitation, home-based care, life skills workshops, material support and HIV/AIDS workshops are implemented to achieve the goal of mitigating the impact of HIV/AIDS in the targeted areas.

The findings from this implementation evaluation demonstrate that the HIV/AIDS project at Mbekweni's ADP is implemented as intended. The process evaluation of MADP's

HIV/AIDS project has highlighted some positive aspects of the implementation. However, it is important for the programme to address the existing challenges. For instance, the lack of providing on-going training for pastors that may compromise the future effectiveness of the programme. Consideration should be given to implementing the proposed recommendations of the evaluation in order to strengthen the intended goal of mitigating the impact of HIV/AIDS in Mbekweni, Fairyland and the surrounding farm areas.

This evaluation provides information to the MADP's management pertaining to the programme's implementation. The evaluation has offered three suggestions on improving the effectiveness of the programme. MADP is also able to use this evaluation as part of an outcome evaluation in the future.

It is essential for social programmes such as the MADP's HIV/AIDS project to be evaluated. Evaluation may help to improve the programme's effectiveness and strengthen accountability to the key stakeholders and public. This evaluation study can help practitioners, administrators and policy makers in adopting strategies that can effectively improve prevention and care programmes for people who are infected and affected by HIV/AIDS.

REFERENCES:

- Adams, J. (2007). *Managing people in organisations: Contemporary theory and practice*. New York, NY: Palgrave Macmillan.
- Babbie, E., & Mouton, J. (2001). *The practice of social research*. New York, NY: Oxford.
- Badcock-Walters, P. (2002). Education. In J. Gow & C. Desmond (Eds.), *Impacts and Interventions: The HIV/AIDS epidemic and the children of South Africa* (pp. 95-110). Durban, South Africa: University of Natal Press.
- Bebbington, A. C., & Gatter, P. N. (1994). Volunteers in an HIV social care organisation. *Aids Care*, 6, 571-586.
- Bloom, S., & Brembridge, C. (2003). Running support groups for people with HIV/AIDS. In L. Uys & S. Cameron (Eds.), *Home-based HIV/AIDS care* (pp. 81-90). Oxford, England: Oxford University Press Southern Africa.
- Brunner, R. L., Larson, T. A., Scott, B. J., Navarro, R. D., Huba G. J., & Melchior, L. A. (2001). Evaluation on the impact and acceptance of a nutrition program in an HIV community clinic. *AIDS Patient Care and STDs*, 15, 533-543.
- Campbel, L., Marston, J., Richter, L., & Stein, A. (2010). Shielding children from suffering. *Human Science Research Council: Review*, 8, 12-14.
- Cloete, A., Strebel, A., Simbayi, L., Wyk, B., Henda, N., & Nqeketo, A. (2010). Challenges faced by people living with HIV/AIDS in Cape Town, South Africa: Issues for group risk reduction interventions. *Aids Research and Treatment*, 1-8. doi: 10.1155/2010/420270
- Department of Health. (2007). *HIV, AIDS and STI strategic plan for South Africa, 2007-2011*. Retrieved November 15, 2010, from <http://www.doh.gov.za/docs/misc/stratplan-f.html>
- Fitzsimons, D., Hardy, V., & Tolley, K. (1995). *The economic and social impact of Aids in Europe*. London, England: Cassell PLC.
- Foster, G., & Williamson, J. (2000). A review of current literature of the impact of HIV/AIDS of children in Sub-Saharan Africa. *Aids*, 14, 275-284.
- Holden, S. (2004). *Mainstreaming HIV/AIDS in development and humanitarian programmes*. Oxford, England: Oxfam.
- Huberman, A. M., & Miles, M. B. (1998). Data management and analysis methods. In N.K. Dezin & Y.S. Lincoln (Eds.), *Collecting and Interpreting Qualitative Materials*. Thousand Oaks, CA: Sage.
- Kusek, J.Z., & Rist, R.C. (2004). *Ten steps to a results-based monitoring and evaluation system*. Washington, DC: World Bank.

- Lili, L., Wu, Z., Wu, S., Jia, M., Liaber E., & Lu, Y. (2008). Impacts of HIV/AIDS stigma on family identity and interactions in China. *Families Systems and Health*, 26, 431-442.
- Litefoot, M., Rotheram-Borus, M. J., Towns, B., Cline, T. R., Webber, D., Murphy, D. A., & Tsai, L. F. (2001). Religious groups as diffusers of HIV antibody testing and prevention messages. *Journal of Community Psychology*, 24, 459-472.
- Love Life. (2000). *The impending catastrophe: A resource book on the emerging HIV/AIDS epidemic in South Africa*. Parklands, South Africa: DGR Writing & Research Beyond Awareness Campaign.
- Mashimo, A., Miura, H., Sakano, S., Hamada, A., Thepthien, B., & Umenai T. (2001). The role of AIDS volunteers in developing community-based care for people with AIDS in Thailand. *Asia-Pacific Journal of Public Health*, 3, 3-8.
- Mabude, Z. A., Beksinska, M. E., Ramkissoon, A., Wood, S., & Folsom, M. (2008). A national survey of home based care kits for palliative HIV/AIDS care in South Africa. *Aids Care*, 20, 931-937.
- Mathambo, V., & Gibbs, A. (2009). Extended family child care in a context of AIDS: Collapse or adaptation. *Aids Care*, 21, 22-27.
- Mbekweni Area Development Programme. (2000). *Participatory rural appraisal*. Paarl, South Africa: Author.
- Mbekweni Area Development Programme. (2002). *Design document*. Paarl, South Africa: Author.
- Mbekweni Area Development Programme. (2009a). *Annual operating plan*. Paarl, South Africa: Author.
- Mbekweni Area Development Programme. (2009b). *Mid-term evaluation*. Paarl, South Africa: Author.
- McKerrow, N. (2002). Treatment of HIV/AIDS and related illness. In J. Gow & C. Desmond (Eds.), *Impacts and Interventions: The HIV/AIDS epidemic and the children of South Africa* (pp. 175-188). Durban, South Africa: University of Natal Press.
- Moloi, G. (2001). Building an urban response to protect HIV/AIDS orphans. In *Aids orphans in Africa: Building and urban response* (pp. 61-65). Johannesburg, South Africa: Centre for Policy Studies.
- Payne, M. (2005). *Modern social work theory* (3rd ed.). Chicago, IL: Lyceum Books.

- Pallant, J. (2007). *SPSS survival manual: A step by step guide to data analysis using SPSS for windows*. Buckingham, England: Open University Press.
- Patton, M.Q. (2002). *Qualitative research and evaluation methods*. London, England: Sage.
- Pendelbury, S., Lake, L., & Smith, S. (2009). *South African Child Gauge*. Cape Town, South Africa: Children's Institute University of Cape Town.
- Ramlagan, S., Peltzer, K., Phaswana-Mafuya, N., & Aquilera, J. F. (2010). Support group needs for people living with HIV and AIDS (PLWHA) in communities around Durban, South Africa. *Journal of Psychology in Africa*, 20, 117-122.
- Richter, L. M., Sherr, L., Adato, M., Belessey, M., Chandan, U., Drimie, S., Haour-Knipe, M., Hosegood, V., Kimou, J., Madhaven, S., Mathambo, V., & Wakweva, A. (2008). Strengthening families to support children affected by HIV/AIDS. *Aids Care*, 21, 3-12.
- Rossi, P.H., Lipsey, M. W., & Freeman, H. E. (2004). *Evaluation: A systematic approach*. London, England: Sage.
- Santmyire, A., & Jamison, M. (2006). Educating African pastors on mother-to-child transmission of HIV/AIDS. *Journal of Nursing Scholarship*, 38, 321-327.
- Schenk, K. D. (2009). Community interventions providing care and support to orphans and vulnerable children: A review in evaluation evidence. *Aids Care*, 21, 918-942.
- Scott, G.B. Fulton, C.M., & Letro, K. (2006). *Supportive care for HIV infected children and their families*. Norwalk, CT: Crown House Publishing Limited.
- Smart, R.(2003). Planing for orphans and HIV/AIDS affected children. In L. Uys & S. Cameron (Eds.), *Home-based HIV/AIDS Care* (pp.174-191). Oxford, South Africa: Oxford University Press Southern Africa.
- Streak, J. (2002). Mitigating the impacts with a focus on government responses. In J. Gow & C. Desmond (Eds). *Impacts and Interventions: The HIV/AIDS epidemic and the children of South Africa* (pp. 147-174). Durban, South Africa: University of Natal Press.

- Tomkins, A.M. (2005). Evidence based nutrition interventions for the control of HIV/AIDS: Paper presented at the 18th International Congress of Nutrition, Durban South Africa, 19-23 September 2005. *Professional Nursing Today*, 9, 8-12.
- Uys, L., & Cameron, S. (2003). *Home-based HIV/AIDS care*. Oxford, South Africa: Oxford University Press Southern Africa.
- UNAIDS. (2002). *Children on the Brink*. Geneva, Switzerland: Author.
- UNAIDS. (2008). *Fact sheet*. Retrieved December 3, 2010, from <http://www.slideshare.net/richard.walls/2008-unaid-report-ssa-stats-summary>
- UNAIDS. (2010). Global report: The global reference book on the AIDS epidemic and response. Retrieved December 3, 2010, from http://www.unaids.org/globalreport/Epi_slides.htm
- Visser, M. (1996). Evaluation of the first AIDS kit, the AIDS and lifestyle education programme for teenagers. *South African Journal of Psychology*, 26, 103-113.
- Visser, M. (2005). Life skills training as a preventive strategy in secondary schools: Evaluation of a large scale implementation process. *Journal of Social Aspects of HIV/AIDS*, 2, 203-216.
- Vithayachockitikhun, N. (2006). Family Care giving of Persons Living with HIV/AIDS in Thailand: Care giver burden an outcome measure. *International Journal Of Nursing Practice*, 12, 123-128.
- Walker, L., Reid, G., & Cornell, M. (2004). *Waiting to happen HIV/AIDS in South Africa*. Colorado, CO: Lynne Rienner Publishers.
- Whiteside, A., & Sunter, C. (2000). *AIDS the challenge for South Africa*. Cape Town, SouthAfrica: Human & Rousseau.
- World Vision. (2009a). *Our work*. Retrieved April 6, 2010, from <http://www.worldvision.org.za/about.php>
- World Vision. (2009b). *HIV and AIDS*. Retrieved December 3, 2010, from <https://www.worldvision.co.za/core-issues/health>

University of Cape Town

Appendix A: Consent Form

CONSENT

I hereby agree to participate in research regarding the HIV/AIDS project at World Vision’s Mbekweni Area Development Programme. I understand that my participation is voluntary. I understand that I can stop at any point and that this decision will not affect me negatively.

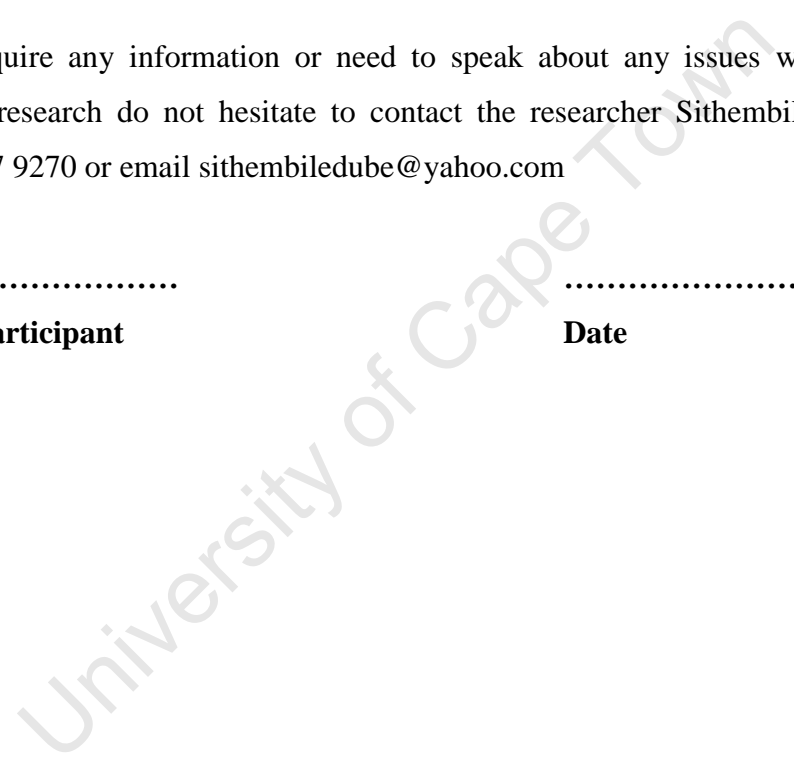
I understand that all information from this interview is confidential and will be used for academic purposes only for the University of Cape Town. My name will not appear in any documentation that report. All the information gathered is secure only the researcher her supervisor will have access to this data.

I understand that this is a research project whose purpose is not to necessarily benefit me personally.

Should you require any information or need to speak about any issues which may arise related to this research do not hesitate to contact the researcher Sithembile Dube on the number 074 327 9270 or email sithembiledube@yahoo.com

.....
Signature of participant

.....
Date



Appendix B: Covering Letter

PROGRAMME EVALUATION MASTERS PROGRAMME

2010 RESEARCH PROJECT

Dear Respondent

You are invited to participate in the Programme Evaluation Masters research project. As part of my Master's programme I am required to conduct an empirical study. I am doing an implementation evaluation of the Mbekweni Area Development Programme's HIV/AIDS project.

Along with this letter is a short questionnaire that should take you about 10 to 15 minutes to complete. There are no risks involved if you participate in this survey. Participation is strictly voluntary and confidential. This survey is anonymous therefore do not put any identifiers on the questionnaire.

Should you require any information or need to speak about any issues which may arise related to this research do not hesitate to contact the researcher Sithembile Dube on the number 074 327 9270 or email sithembiledube@yahoo.com

Instructions:

1. Answer all the questions.
2. Please do not discuss the questions or your answers to this questionnaire with anyone.
3. When you have finished with the questionnaire, please return it to the researcher.

Thank you for your participation.

Appendix C: Home visitors Questionnaire

| Home visitors Questionnaire | | Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|--------------------------|-----------------|----------------|--------------|-----------------------|
| <i>Please show how much you agree with each of the following statements by ticking a number from 1 to 5 (1 = strongly disagree; 5 = strongly agree).</i> | | | | | | |
| 1 | After training I know how to identify people who can become programme beneficiaries. | 1 | 2 | 3 | 4 | 5 |
| 2 | After each home visit that is made I write notes regarding each family that I have visited. | 1 | 2 | 3 | 4 | 5 |
| 3 | All the people that are in need of the HIV/AIDS programme in the community are benefiting from the programme. | 1 | 2 | 3 | 4 | 5 |
| 4 | I visit families that are infected and affected by HIV/AIDS. | 1 | 2 | 3 | 4 | 5 |
| 5 | I visit all the programme beneficiaries once a month. | 1 | 2 | 3 | 4 | 5 |
| 6 | I visit beneficiaries who are only in the identified areas of Mbekweni, Fairy Land and the surrounding farm areas. | 1 | 2 | 3 | 4 | 5 |
| 7 | I teach families about HIV/AIDS during home visits. | 1 | 2 | 3 | 4 | 5 |
| 8 | I teach families and caregivers on how to look after a HIV/AIDS infected family member. | 1 | 2 | 3 | 4 | 5 |
| 9 | I provide support to families that are infected and affected by HIV/AIDS. | 1 | 2 | 3 | 4 | 5 |
| 10 | I take food parcels to HIV/AIDS infected and affected families. | 1 | 2 | 3 | 4 | 5 |
| 11 | The people infected by HIV/AIDS are receiving E'pap from the MADP. | 1 | 2 | 3 | 4 | 5 |
| 12 | I have received home visiting training from the MADP. | 1 | 2 | 3 | 4 | 5 |
| 13 | I have received training on HIV/AIDS. | 1 | 2 | 3 | 4 | 5 |
| 14 | After training I feel comfortable teaching on HIV/AIDS. | 1 | 2 | 3 | 4 | 5 |
| 15 | After training I feel confident to visit families in their homes. | 1 | 2 | 3 | 4 | 5 |
| 16 | I have received additional training and support on working in the field of HIV/AIDS. | 1 | 2 | 3 | 4 | 5 |
| 17 | I receive training and supervision once every month. | 1 | 2 | 3 | 4 | 5 |

Appendix D: Home Based Carers Questionnaire

| Home Based Carers Questionnaire | | Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------|-----------------|----------------|--------------|-----------------------|
| <i>Please show how much you agree with each of the following statements by ticking a number from 1 to 5 (1 = strongly disagree; 5 = strongly agree).</i> | | | | | | |
| 1 | I perform home visits to the identified programme beneficiaries who are infected by HIV/AIDS. | 1 | 2 | 3 | 4 | 5 |
| 2 | I provide counselling and support to the programme beneficiaries that I visit. | 1 | 2 | 3 | 4 | 5 |
| 3 | I teach programme beneficiaries regarding HIV/AIDS. | 1 | 2 | 3 | 4 | 5 |
| 4 | I provide hygiene and advice regarding healthy behaviour to people living with HIV/AIDS. | 1 | 2 | 3 | 4 | 5 |
| 5 | I teach families and caregivers on how to care for the people that are living with HIV/AIDS. | 1 | 2 | 3 | 4 | 5 |
| 6 | I refer sick family members to the clinic or hospital for further medical attention. | 1 | 2 | 3 | 4 | 5 |
| 7 | I have received training on home based care. | 1 | 2 | 3 | 4 | 5 |
| 8 | I have received training on HIV/AIDS. | 1 | 2 | 3 | 4 | 5 |
| 9 | I have received additional training and support on working in the field of HIV/AIDS. | 1 | 2 | 3 | 4 | 5 |
| 10 | I receive supervision often. | 1 | 2 | 3 | 4 | 5 |

Appendix E: Development Workers Questionnaires

| Development Workers Questionnaire | | Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|-----------------|----------------|--------------|-----------------------|
| <i>Please show how much you agree with each of the following statements by ticking a number from 1 to 5 (1 = strongly disagree; 5 = strongly agree).</i> | | | | | | |
| 1 | After training I am able to identify the orphan vulnerable children who can become programme beneficiaries. | 1 | 2 | 3 | 4 | 5 |
| 2 | All orphan and vulnerable children are receiving sponsorship. | 1 | 2 | 3 | 4 | 5 |
| 3 | I follow up on the identified orphan and vulnerable children and ensure that all their needs are met through sponsorship. | 1 | 2 | 3 | 4 | 5 |
| 4 | I keep record of the progress of the orphan and vulnerable children. | 1 | 2 | 3 | 4 | 5 |
| 5 | All the orphan and vulnerable children in the targeted communities are visited by community development workers at least once every month. | 1 | 2 | 3 | 4 | 5 |
| 6 | Orphan and vulnerable children who receive the MADP also receive life skills training workshops. | 1 | 2 | 3 | 4 | 5 |
| 7 | Youths that are part of the orphans and vulnerable children receive training on skills development from the MADP. | 1 | 2 | 3 | 4 | 5 |
| 8 | Orphan and vulnerable children are involved in sporting activities that are hosted and offered by MADP. | 1 | 2 | 3 | 4 | 5 |
| 9 | I am involved in raising awareness of HIV/AIDS in schools and children's clubs. | 1 | 2 | 3 | 4 | 5 |
| 10 | I have received training from the programme on working with the orphan and vulnerable children. | 1 | 2 | 3 | 4 | 5 |
| 11 | I receive support and supervision from the management. | 1 | 2 | 3 | 4 | 5 |
| 12 | I receive additional training workshops to improve service delivery. | 1 | 2 | 3 | 4 | 5 |

Appendix F: Pastors Questionnaire

| Pastors Questionnaire | | Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|--------------------------|-----------------|----------------|--------------|-----------------------|
| <i>Please show how much you agree with each of the following statements by ticking a number from 1 to 5 (1 = strongly disagree; 5 = strongly agree).</i> | | | | | | |
| 1 | I teach regarding HIV/AIDS in the ministry of my congregation. | 1 | 2 | 3 | 4 | 5 |
| 2 | My congregation reaches out to the community through raising awareness of HIV/AIDS in the community. | 1 | 2 | 3 | 4 | 5 |
| 3 | After the channels of hope training I was able to do an assessment of my community and my congregation's needs | 1 | 2 | 3 | 4 | 5 |
| 4 | After training I formed a congregation hope action team (CHAT) that is working towards HIV/AIDS | 1 | 2 | 3 | 4 | 5 |
| 5 | After training I had enough understanding of HIV/AIDS. | 1 | 2 | 3 | 4 | 5 |
| 6 | My congregation has started HIV/AIDS support groups for people living with HIV/AIDS. | 1 | 2 | 3 | 4 | 5 |
| 7 | I teach the congregation and local community issues of support and care for the people who are living with HIV/AIDS. | 1 | 2 | 3 | 4 | 5 |
| 8 | I teach my congregation and community how to prevent of HIV/AIDS. | 1 | 2 | 3 | 4 | 5 |
| 9 | I receive additional training and support from MADP. | 1 | 2 | 3 | 4 | 5 |
| 10 | I am networking with other non governmental organizations in advocating for those infected and affected by HIV/AIDS. | 1 | 2 | 3 | 4 | 5 |

Appendix G: Interview Schedule

Interview Schedule (for project coordinators and programme manager)

Coverage

1. Who are the intended beneficiaries for the HIV/AIDS project?
2. How are the beneficiaries selected from the community to receive the programme's services?
3. Are beneficiaries benefiting one service or multiple services from the programme?
4. How does management ensure that the programme staff is delivering the services as intended by the programme?

Service Delivery

1. What are the criteria for selecting volunteers who participate in implementing the programme.
2. What training does the programme offer to staff members:
 - a) Home visitors
 - b) Home based carers
 - c) Development workers
 - d) Pastors
3. What other organizations are providing similar services to HIV/AIDS programme in the targeted community?

Organisational Support

1. Are programme staff receiving supervision?
2. What additional support and training is given to programme staff?