A Formative Evaluation of the Parent Infant Home Visiting Programme

Sheridan-Lee Percival

(PRCSHE002)

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

2020

Supervisor: Dr Adiilah Boodhoo

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 proposal from the work, or works of other people has been attributed, cited, and referenced.

Signature: Signed by candidate Date: 31 July 2020

University of Cape Town

The copyright of this thesis vests in the author. No quotation from it or information derived from it is to be published without full acknowledgement of the source. The thesis is to be used for private study or non-commercial research purposes only.

Published by the University of Cape Town (UCT) in terms of the non-exclusive license granted to UCT by the author.

University of Cape Town

Acknowledgements

I would like to express my sincere gratitude to my parents, Cecelia and Sebastian Percival, and my partner, Curwin Mentor, for their unwavering support and love throughout this process.

My gratitude also goes to my academic supervisor, Dr Adiilah Boodhoo, for her valuable feedback and encouragement throughout this dissertation.

A special thanks to the Parent-Infant Home Visiting Programme manager, the Parent Centre staff and programme participants as well, for their time given for the purposes of this dissertation.

The UCT Knowledge Co-op facilitated this collaborative project between
The Parent Centre and UCT
See http://www.knowledgeco-op.uct.ac.za or
Contact us at know-op@uct.ac.za / 021 – 650 4415

Table of Contents

Acknowledgements i

Table of Contents ii

List of Tables viii

List of Figures viii

List of Acronyms ix

Chapter one: Introduction 6

Background to the evaluation 6

Programme description 7

Clinic Talks 8

0-5 counselling 8

The Parent-Infant Home Visiting Programme (PIHVP) 8

Structure of the PIHVP's home visits 9

Antenatal home-visits 10

Postnatal home-visits 11

Introduction 12

Discussion and input activities 12

Psychological Assessments 13

Demonstration 14

Conclusion 14

The Client's Programme Theory 17

Programme plausibility 19

Conclusion of the plausibility assessment 25

Evaluation level of the PIHVP 25

Evaluation questions 26

Chapter Two: Methods 27

Methodological Approaches 27

Primary data 27

Secondary data 27

Ethical Considerations 27

Primary data 28

Secondary data 28

Data sources 29

Primary data 29

Secondary data 30

Data collection procedure and analysis 34

Question 1: Did the PIHVP beneficiaries recruited for the first 2019 programme cycle meet the eligibility criteria specified by programme? 39

Data collection procedure 39

Data analysis 39

Question 2: What proportion of participants completed and dropped out of the PIHVP during the first programme cycle of 2019? What are the reasons provided for programme dropout? 39

Data collection procedure 39

Data analysis 39

Question 3: To what extent did the PIHVP meet its targeted number of participants? What are the reasons for over/under coverage? 40

Data collection procedure 40

Data analysis 40

Question 4: Did the participants receive the home-visiting sessions at the duration and frequency prescribed by the programme model? 40

Data collection procedure 40

Data analysis 41

Question 5: Did PIACs complete and conduct all programme activities, developmental screenings and demonstrations as intended? 41

Data collection procedure 41

Data analysis 41

Question 6: How did participants perceive PIACs in terms of the support they provided and their preparation level, knowledge, and reliability? 42

Data collection procedure 42

Data analysis 42

Question 7: To what extent do PIACs implement the skills acquired through their training into their sessions? 42

Data collection procedure 42

Data analysis 43

Question 8: Are the participants satisfied with the service they received? What are the strengths and limitations they identified? 43

Data collection procedure 43

Data analysis 43

Question 9: To what extent did participants engage with the PIACs (around the content) during home-visit sessions? 44

Data collection procedure 44

Data analysis 44

Chapter 3: Results 44

Question 1: Did the PIHVP beneficiaries recruited for the first 2019 programme cycle meet the eligibility criteria specified by programme? 44

Teenage pregnancy 45

Unplanned pregnancy 45

Support from partner 45

Level of risk for postnatal depression 47

Community Violence 48

Poverty 49

Question 2: What proportion of participants completed and dropped out of the PIHVP during the first programme cycle of 2019? What are the reasons provided for programme dropout? 51

Question 3: To what extent did the PIHVP meet its targeted number of participants? What are the reasons for over/under coverage? 53

A. PIHVP not reaching target participant intake 53

B. Reasons for not reaching programme target 54

Question 4: Did the participants receive the home-visiting sessions at the duration and frequency prescribed by the programme model? 56

Frequency of home visits 56

Duration of home visits 58

Amount of home visits 59

Question 5: Did PIACs complete and conduct all programme activities, developmental screenings and demonstrations as intended? 59

Antenatal 60

Postnatal 60

Question 6: How did participants perceive PIACs in terms of the support they provided and their preparation level, knowledge, and reliability? 67

A. PIACs are supportive 67

B. PIACs well prepared for sessions 68

C. PIACs knowledgeable about session topics 69

D. PIACs seen as reliable by participants 69

Question 7: To what extent do PIACs implement the skills acquired through their training into their sessions? 70

Perspective of M&E social worker 70

Perspective of participants 72

Question 8: Are the participants satisfied with the service they received? What are the strengths and limitations they identified? 72

A. Curriculum topics and PIAC counselling seen as programme's strength 73

B. Participants perceptions of programme's impact 74

C. High recommendation of the PIHVP to others 75

Question 9: To what extent did participants engage with the PIACs (around the content) during home-visit sessions? 76

Antenatal sessions 76

Postnatal sessions 76

Chapter 4: Discussion 78

Level of service utilisation 78

Coverage of the intended PIHVP population 78

Low levels of participant retention 79

Low levels participant enrolment 80

Bias among PIHVP participant population 81

Deficiencies in secondary data sources 81

Client Evaluation Forms 81

Parent Infant Information sheets 82

Implementation fidelity 83

Exposure and/or dosage of the PIHVP 83

Quality of programme delivery 84

Adherence to the PIHVP's programme design 84

Participant responsiveness 85

Recommendations 86

General 86

Service Utilisation 87

Fidelity 88
Quality of delivery 89
Limitations 89
Contribution to knowledge 90
References 92
Appendix A: Informed consent form for semi-structured interviews with programme staff 100
Appendix B: Informed consent form for semi-structured interviews with programme participants 102
Appendix C: Interview guide for programme staff interviews 104
Appendix D: Interview guide for programme participant interviews 106
Appendix E: Parent Centre Intellectual Property Agreement 109
Appendix F: The Parent Infant Intake form 113
Appendix G: Client Evaluation Form 117
Appendix H: Parent Infant Information Sheets 118
Appendix I: M&E report 181
Appendix J: DSD Termination Sheet 186
Appendix K: Frequency statistics for evaluation question 1 187
Appendix L: Frequency statistics for evaluation question 2 188
Appendix M: Quotes to support evaluation question 3 189
Appendix N: Client Evaluation form results 191
Appendix O: Frequency statistics for evaluation question 5 192
Appendix P: Quotes to support evaluation question 8 216
Appendix Q: Frequency statistics for evaluation question 9 219
Appendix R: High-level guideline for planning and developing a participatory M&E framework 220

List of Tables

Table 1. Summary of the PIHVP's antenatal component agenda 11
Table 2. Summary of the PIHVP's postnatal component agenda 15
Table 3. Process Evaluation Questions 26
Table 4. Summary of the data collection and analysis procedure 35
Table 5. Contingency table of relationship between participants' pregnancy status, age and marital status.....46
Table 6. Frequencies of first EPDS scores of PIHVP participants 48
Table 7. Frequencies of residential areas in which enrolled PIHVP participants are situated 49
Table 8. Frequencies of employment level for enrolled PIHVP participants 50
Table 9. Frequencies of education levels for enrolled PIHVP participants 50
Table 10. Frequency of enrolled participants who complete the PIHVP 51
Table 11. Contingency table of relationship between participants' pregnancy status, age and marital status 52
Table 12. Frequency of time intervals between antenatal sessions 56
Table 13. Frequency of time intervals for postnatal sessions with 7-day time interval 57
Table 14. Frequency of time intervals for postnatal sessions with 14-day time interval 58
Table 15. Frequency of time intervals for postnatal sessions with 28-day time interval 58
Table 16. Summary of average duration of PIHVP home visit sessions 59
Table 17. Summary of adherence rates for antenatal sessions 61
Table 18. Summary of adherence rates for postnatal sessions 63

List of Figures

Figure 1. The PIHVP's Programme Theory Logic Model.....18

List of Acronyms

BIAB	The Behavioural and Interactive Assessment of the Baby
ECD	Early Childhood Development
EPDS	Edinburgh Postnatal Depression Scale
LMIC	Low and Middle-Income Countries
MOU	Maternity and Obstetric Units
M&E	Monitoring and Evaluation
NPO	Non-Profit Organisation
PIAC	Parent Infant Attachment Counsellor
PIHVP	Parent Infant Home Visiting Programme
PIP	Parent Infant Programme
RCT	Randomised Controlled Trial
RFA-A	Risk Factor Assessment – Adapted
TOC	Theory of Change

Executive Summary

Background

The Parent-Infant Home Visiting Programme (PIVHP) is a home-based parenting programme targeted at new and expectant mothers, characterised as *vulnerable*. Participants are recruited from low-income communities situated on the Cape Flats, in Cape Town, South Africa. The programme consists of antenatal and postnatal sessions, facilitated by trained Parent Infant Attachment Counsellors (PIACs) recruited from target communities. There are two programme cycles per year: one from January to June, and a second one from July to December. The overarching goal of PIHVP is to contribute towards the prevention of child abuse, abandonment, and neglect; and to promote positive infant growth and development.

The programme has to date not been guided by an explicit theory of change (TOC). There was no Monitoring and Evaluation (M&E) system in place, at the time of the evaluation, either. The programme engages in extensive data collection for administrative purposes. This data, however, is not captured nor analysed systematically to monitor progress or measure impact. This formative evaluation aims to capitalise on the existing data.

Evaluation Focus

This evaluation focused on the first 2019 programme cycle. The main objective of this evaluation was to determine the extent to which the PIHVP had been implemented with fidelity. As such, a process evaluation was conducted to address the following evaluation questions:

1. Did the PIHVP beneficiaries recruited for the first 2019 programme cycle meet the eligibility criteria specified by programme?
2. What proportion of participants completed and dropped out of the PIHVP during the first programme cycle of 2019? What are the reasons provided for programme dropout?
3. To what extent did the PIHVP meet its targeted number of participants? What are the reasons for over/under coverage?
4. Did the participants receive the home-visiting sessions at the duration and frequency prescribed by the programme model?

5. Did PIACs complete and conduct all programme activities, developmental screenings and demonstrations as intended?
6. How did participants perceive PIACs in terms of the support they provided and their preparation level, knowledge, and reliability?
7. To what extent do PIACs implement the skills acquired through their training into their sessions?
8. Are the participants satisfied with the service they received? What are the strengths and limitations they identified?
9. To what extent did participants engage with the PIACs (around the content) during home visit sessions?

Methodology

The evaluator first extracted and refined the programme's TOC through structured consultations with the programme manager. The plausibility of the PIHVP's programme theory was then assessed through an extensive literature review. The evaluator then proceeded with the process evaluation. A combination of both primary and secondary data sources was used. Primary data was collected from three PIHVP programme staff members and eleven programme participants, through semi-structured interviews. Secondary data was extracted from existing programme documents, including Client Evaluation forms and PIAC performance monitoring reports. The data collection and analysis procedure of all data sources are extensively detailed in the methods section of this paper.

Key Findings and Conclusions

Based on the literature consulted, the programme theory of the PIHVP was deemed plausible. More specifically, the literature supported the structure, duration, and content of the PIHVP; the type of facilitator utilised by the programme; and their strategies for engaging participants. Findings of the process evaluation indicated that:

- The PIHVP did not use its eligibility criteria as a method for screening participants' suitability for the programme. As a result, enrolled participants only satisfied three of its ten eligibility criteria. Therefore, enrolled participants were not closely aligned with the PIHVP's target population.

- A large portion of participants dropped out of the PIHVP during the evaluation period. Many of these participants indicated they were ‘not available’ to complete the full programme. Based on the ambiguity of this dropout category, it was unclear whether this unavailability was due to factors internal or external to the programme.

- The PIHVP did not reach its intended participant enrolment figures for the first programme cycle of 2019. The evaluation found that this was due to factors both internal and external to the programme

- There were extreme deviations from the intended frequency of home-visit sessions both within the antenatal and postnatal components of the PIHVP, with slight deviations noted from the intended programme duration. These deviations may have affected participants’ time spent on the programme and the amount of exposure to programme content, respectively.

- Inconsistent data capturing during the evaluation period restricted the amount of meaningful data on PIACs adherence to programme activities, and participants’ levels of response to programme content. However, based on the data that could be analysed, there appeared to be ‘high’ levels of adherence to conducting screenings, demonstrations, and the first activity of programme sessions. These adherence levels then appeared to regress to ‘moderate’ and ‘low’ levels across most of the remaining activities. PIACs also appeared to frequently capture superficial and inconsistent notes on participants’ responses to programme activities. A steady frequency of no responses being captured at all, were also noted across both adherence and participant responses.

- Participants perceived PIACs as supportive, well-prepared, reliable, and knowledgeable. The programme’s curriculum topics and counselling from PIACs were considered as its strengths, and the current programme length, as its limitation. Most participants indicated that the programme had an impact on their parenting, and that they would recommend the programme to other parents. However, the possible bias among these results and the non-representative sample used, may have limited the reliability and generalisability of these findings, respectively.

Recommendations

- There is scope for a proper M&E system to be developed for the PIHVP. This would enable data to be collected, and ultimately analysed, in a more systematic manner. A participatory approach is recommended, as it will encourage greater ownership of the M&E system and enhance the M&E capacity and skills of the PIHVP. A high-level guideline for developing this is also provided.

- Continuous upskilling of PIACs facilitation skills particularly focused on their time management and data capturing is recommended, to ensure that all programme content is delivered within the prescribed programme, with comprehensive programme notes.

- Strengthening of the self-administered survey conducted by the programme – the Client Evaluation form. It is recommended that both the form, and its data collection process, be anonymised. Furthermore, it is recommended that the format be restructured to display items categorised by themes; that questions be rephrased to remove ambiguity; and that provision be made for more rating scales.

- Strengthening of the data collection tool used to capture programme session data – the Parent Infant Information sheets. It is recommended that each of these sheets be restructured to reflect the programme activities of their respective sessions, and that quantitative data capturing components be incorporated as well. This will assist in more efficient note taking of key information. Furthermore, it is recommended that sheets be made available in PIACs' home languages, to assist them in capturing more detailed notes.

- It is recommended that eligibility criteria of the PIHVP be used as a screening tool to determine participants' suitability for the programme before enrolment, to ensure sufficient coverage of the intended population.

- Implementation of strategies to increase participant retention rates, such as regular telephonic communication with parents to remind them of upcoming sessions and to confirm scheduled dates and times for these sessions; sending them updates on sessions missed; and following up on why sessions were missed.

- Implementation of strategies to increase participant recruitment figures, such as strengthening relationships with influential organisations and individuals within the community to gain buy-in and support of the PIHVP; hosting PIHVP open-days at community halls; and strengthening the capacity of the programme's door-to-door recruitment strategy.

Chapter one: Introduction

The following chapter provides a background to the evaluation, more specifically the context in which the Parent Centre (implementing organisation) intervenes. This is followed by a comprehensive description of the Parent-Infant Programme (PIP), including the Parent-Infant Home Visiting component (PIHVP), which is the focus of this evaluation. The programme theory (and logic model) is then unpacked, followed by a literature review to test its plausibility. Finally, the level of evaluation, as well as the evaluation questions are detailed.

Background to the evaluation

The prevalence of violence across townships in the Western Cape have reached devastating heights, with communities like Khayelitsha and Nyanga contributing to approximately 42% of the entire province's attempted murder rate (Charles, 2019). This endemic community violence is deeply rooted in the population's low socio-economic standard of living, which is characterised by high levels of poverty, unemployment, and low levels of education. Children and youth are particularly vulnerable to these adverse socioeconomic circumstances. Over the 2017/2018 period, 66 murders and more than 1400 cases of sexual assault on children and youth were reported in the Western Cape. These crimes primarily stemmed from neglect and abuse (Weber & Bowers- Du Toit, 2018). When children are exposed to violence, they become more susceptible to mental health issues (Ward, Artz, Leoschut, Kassanjee & Burton, 2018), they are at greater risk of unwanted pregnancies and HIV infection, and the risk of them becoming perpetrators of crime themselves, is increased (Osofsky, 1999).

Efforts aimed at reducing the effects of violence on children should start with educating and up-skilling their parents and caregivers (Butchart, 2013). This should include providing families with home visitation services; and training on pre- and post-natal care, healthy child development and non-violent discipline (Butchart, 2013). These strategies are the basis of many Early Childhood Development (ECD) programmes. These initiatives typically focus on child health and nutrition, education, and parental support; and have been shown to contribute towards the fight against poverty (Penn, 2008). Furthermore, they encourage holistic infant development by focusing on their physical, intellectual, and emotional needs (McMullen, 2013). Evidence suggests physical development is promoted through healthy and nutritious age-appropriate diets and movement exercises (McMullen, 2013; Germer, 2014); emotional development through high

levels of positive face-to-face interactions and living in a loving environment (Germer, 2014); and intellectual development through reading, singing and playing with your infant (McMullen, 2013; Germer, 2014).

Factors such as poor environmental conditions; inadequate access to resources; limited education; and high levels of maternal depression, stress, family instability and violence within the home contribute heavily to diminished infant development - a prevalent occurrence among the poor in South Africa (Williams et al., 2001; Letourneau, Stewart & Barnfather, 2004). These environments typically do not promote the loving and nurturing environment necessary for children to learn and grow (Richter, 2003).

Programme description

The Parent-Infant Programme (PIP) is a support service offered to new and expectant mothers from low-income communities in Cape Town, which encourages positive parenting and secure parent-infant attachment. The PIP has been implemented by the Parent Centre - a non-profit organization (NPO) situated in Wynberg, Cape Town - for the past 26 years. The Parent Centre offers a host of counselling services and parenting programmes that are aimed at providing parents from low-socioeconomic communities with the necessary knowledge and skills to raise resilient and well-balanced children. The PIP receives funding from both local and international donors, including the Western Cape Association for Infant Mental health, Vital Foundation, National Lottery Distribution Trust Fund, Mutual and Federal community Trust and Rolfe-Nussbaum Foundation.

The PIP's curriculum is largely adopted from the 'First 1000 days' initiative, which advocates for the nutrition and health; care and support; and safety and stimulation of children for the first two years of their lives - believed to be a crucial period for their development. The adopted version of the 'First 1000 days' initiative spans across the PIP's three components – Clinic talks, the Parent-Infant Home Visiting Programme (PIHVP), and 0-5 Counselling. The PIHVP is the focus of this evaluation and will be discussed further in subsequent sections of this paper.

Clinic Talks

Clinic talks are presented once a week in maternity and obstetric units (MOU) in public clinics across the Cape Flats. The main outcome is to provide pregnancy and early parenting education to mothers during the antenatal period. The women who present these clinic talks are known as Parent Infant Attachment Counsellors (PIACs). PIACs are local women who receive specialized training and supervision from the PIP, which enables them to provide both educational talks in clinics and facilitate PIHVP sessions. PIACs do not recruit mothers onto clinic talks independently from MOU's. Expectant mothers often wait long hours at local clinics for their antenatal check-ups. It is during this time that they receive talks from various organizations – the PIP being one of them. Clinic talks are also one of the primary methods for recruiting new and expectant mothers onto the PIHVP.

0-5 counselling

The 0-5 counselling is a specialized service offered to parents during the first five years of their child's life. This one-on-one counselling service is aimed at assisting parents in understanding the complexities of raising their infant or toddler, by exploring alternative ways of managing problems. It also promotes knowledge and awareness of infant mental health. It typically consists of one to six sessions, delivered by a clinical social worker at the PIP's Wynberg office in Cape Town. Additional sessions are made available to parents who require longer term support. Unlike the PIP's clinic talks, the 0-5 counselling service operates independently from the PIHVP, and participants are primarily recruited through PIP portals like the organization's website.

The Parent-Infant Home Visiting Programme (PIHVP)

The PIVHP is a home-visiting programme that provides participants with 20 one-on-one sessions, conducted within the participant's home. It operates within eight communities across the Cape Flats including Hanover Park, Nyanga, Khayelitsha, Philippi, Gugulethu, Mitchell's Plain, Retreat and Imizamo Yethu. These communities are often characterized by high levels of poverty and community violence. The PIHVP is aimed at vulnerable mothers, which the programme defines as women are who characterised by the following traits:

- Pregnant teenagers

- Women who have no support from their partner
- Women who have unplanned/unwanted pregnancies
- Women who have poor relationships with their own mothers
- Women who have a history of depression
- Women who are at high risk for postnatal depression
- Women who experience domestic violence and/or community violence
- Women who live in poverty
- Women who have a history of abuse (physical and/or sexual)
- Women who have been raped

The PIHVP reaches approximately 400 mothers annually. These mothers are recruited through various methods including clinic talks; referrals from health professionals in local MOUs and other non-profit organisations (NPOs) operating within target communities; and door-to-door recruitment. Home visits are conducted by PIACs. As previously mentioned, these local women receive specialized Parent-Infant Intervention training prior to them commencing fieldwork. PIACs also receive weekly supervision by two programme supervisors – one a qualified social worker and the other a psychologist. Since the PIHVP's inception, a new programme manager and two new PIACs were appointed in November 2015. The PIHVP also appointed an M&E social worker in 2019, however, her role was limited to that of PIAC performance monitoring. All PIHVP staff (i.e. PIACs, programme supervisors, M&E social worker) report to the programme manager.

Structure of the PIHVP's home visits

The PIHVP consists of antenatal and postnatal sessions, which collectively span over a period of six months. There are five one-hour antenatal sessions aimed at guiding vulnerable mothers through issues that may influence their pregnancy and prepare them for their labour and birth. The main intended outcome is for mothers to have the best possible pregnancy, labour, and birth experience (Parent Centre Report, 2018). The postnatal component consists of 15 one-hour sessions that are centred on healthy infant development and maternal health. The main intended outcome is to promote secure parent-infant attachment; and develop responsive, attuned, and non-intrusive parenting abilities among participating mothers (Parent Centre Report, 2018). The

overall goal of PIHVP is to contribute towards the prevention of child abuse, abandonment and neglect, and positive infant growth and development (Parent Centre Report, 2018).

Antenatal home-visits

The PIHVP aims to enrol mothers onto the programme before 32 weeks gestational age, as the targeted demographic often lack the information and resources needed for a healthy pregnancy. Sessions are then typically scheduled once a month. However, if mothers are recruited after 32 weeks gestational age, sessions are scheduled bi-weekly to weekly, to ensure expectant mothers receive all the prescribed antenatal sessions prior to their labour and birth.

All antenatal sessions follow a similar agenda. Sessions typically start with PIACs being encouraged to 'tune in' to the mother's current emotional state; that is – acknowledging and reassuring mothers through any concerns raised. This is followed by discussion and input related activities on pregnancy, labour, and birth. Informational handouts are also made available to parents during sessions 1 to 3. Two types of psychological assessments are conducted during session 2, namely the Edinburgh Postnatal Depression Scale (EPDS) and the Risk Factor Assessment – Adapted by the Perinatal Maternal Health Project for Mowbray Maternity Hospital (RFA-A). The EPDS is used to identify signs of postpartum depression, while the RFA-A determines whether parents are predisposed to violent and harmful behaviour toward themselves and their unborn baby. Sessions then typically conclude with PIACs scheduling a date and time for the next home visit. After all sessions, PIACs are required to write a report noting which topics were discussed and any other concerns they may have regarding the mother. Table 1 below provides an overview of the agenda and programme content covered for each antenatal session.

Table 1

Summary of the PIHVP's antenatal component agenda

<table>
<tr><th></th><th>AN1</th><th>AN2</th><th>AN3</th><th>AN4</th><th>AN5</th></tr>
<tr><td rowspan="3">Introduction</td><td>Welcome and introduction to PIHVP</td><td rowspan="3">'Tuning in' to mother's current emotional state</td><td rowspan="3">'Tuning in' to mother's current emotional state</td><td rowspan="3">'Tuning in' to mother's current emotional state</td><td rowspan="3">'Tuning in' to mother's current emotional state</td></tr>
<tr><td>Policies and Procedures of PIHVP</td></tr>
<tr><td>Complete consent form</td></tr>
<tr><td rowspan="5">Discussion and Input</td><td rowspan="5">Mother's health during current pregnancy</td><td>Stages of foetal development</td><td>Infant feeding</td><td>The labour and birth</td><td>Conception</td></tr>
<tr><td>Work of the placenta</td><td>Siblings (of the baby)</td><td>Mother's employment arrangements</td><td>Family planning options</td></tr>
<tr><td>Mother's support structures</td><td>The growing foetus</td><td>The mother's partner/baby's father</td><td>Practical preparations for the birth</td></tr>
<tr><td rowspan="2">State support grants</td><td rowspan="2">Mother's dreams (of her baby)</td><td rowspan="2">Siblings (of the baby)</td><td>Home coming (after birth)</td></tr>
<tr><td>Queries about labour and birth</td></tr>
<tr><td>Psychological assessment administered</td><td>n/a</td><td>EDPS and RFA-A</td><td>n/a</td><td>n/a</td><td>n/a</td></tr>
<tr><td rowspan="2">Informational handout distributed</td><td rowspan="2">'Pregnancy niggles'</td><td rowspan="2">'Development of the foetus'</td><td>'Road to health chart'</td><td rowspan="2">n/a</td><td rowspan="2">n/a</td></tr>
<tr><td>'Preparing older siblings for a new baby'</td></tr>
<tr><td>Conclusion</td><td>Arrangements for next visit</td><td>Arrangements for next visit</td><td>Arrangements for next visit</td><td>Arrangements for next visit</td><td>Arrangements for next visit</td></tr>
</table>

Postnatal home-visits

The scheduling of postnatal sessions is divided into weekly sessions for sessions one to nine, bi-weekly sessions for postnatal sessions 10 to 13; and monthly home visits between

postnatal sessions 14 and 15. The prescribed agenda for all sessions are: introduction; discussion and input; psychological assessments; demonstrations; and conclusion.

Introduction

PIACs commence sessions by 'tuning in' to the mothers' current emotional state by acknowledging and reassuring mothers through any concerns raised. This is followed by 'maternal empowerment', where PIACs recognize and praise positive parenting demonstrated by mothers and facilitate independent problem-solving with them.

Discussion and input activities

These activities are aimed at educating mothers on healthy childhood development and maternal health; with the initial home-visit session primarily centred on the latter. During this session, PIACs begin exploring the mother's feelings and experience of labour and birth; her concerns and anxieties around the baby's behaviour and functioning; and probing whether the mother is experiencing 'the blues' or possible symptoms of postnatal depression. PIACs also start to observe and note the baby's level of social responsiveness and behaviour.

From postnatal session 2 to 14, the infant's feeding, sleeping, crying, and level of consolability is discussed during every session. PIACs essentially gather initial information on this during session 2 to gauge mothers' current knowledge on these issues, and then use this as a basis to track the infant's progress over subsequent sessions. PIACs also continuously check-in on how mothers are coping with these issues as well and assist them when needed. With regards to discussion topics, 'infant feeding' explores various feeding options (i.e. breastfeeding, formula feeding) with mothers and concerns relating to this. 'Infant sleeping' explores the infant's sleeping patterns. Here, PIACs gauge mothers' pre-existing knowledge on this, and further develop it through information on typical infant sleeping patterns, rhythms and behaviours, and techniques to transition babies into a sleeping state. 'Crying and consolability' is centred on understanding the reasons behind an infant's crying and teaching mothers' different strategies for consoling their babies; ranging from minimum intervention (e.g. using her voice alone) to maximum, direct intervention (e.g. holding and rocking her baby).

In addition, ‘infant health’ and ‘family planning’ are also discussed. The former informs mothers on the importance of regular clinic visits, vaccinations and caring for the umbilical cord, while the latter provides mothers with information on various contraception options available. Infant health and family planning are discussed during postnatal session 3 and 4, respectively. The final session is used to review and reflect on mothers’ experience of the entire PIHVP programme, and lessons learned from it.

Psychological Assessments

The Behavioural and Interactive Assessment of the Baby (BIAB) is an informal assessment conducted by PIACs to assess the baby’s individual and interpersonal capacity. The 12 items measured by this assessment are:

- The Six Infant Behavioural States
- Shutting out negative stimulation while asleep
- Uncovering, undressing, and placing in supine
- Ventral suspension
- Crawling
- Defensive movements
- Crying and consolability
- Cuddliness
- Social interactive package
- Imitation, responsiveness, and reciprocity
- Intrusiveness
- Rooting and sucking.

The full assessment is administered during postnatal sessions 2, 5 and 8. Provision is made for the first BIAB assessment to carry over into session 3, if PIACs do not complete it fully in session 2. In session 6, only selected items of the BIAB are completed, namely: the social interactive package; and imitation, responsiveness, and reciprocity. During session 7, PIACs are encouraged to repeat certain items of the assessment again, particularly those focused on infant social responsiveness. In addition to the BIAB, the EPDS is also administered during postnatal session 3.

Demonstration

During postnatal session 4 and 7, PIACs demonstrate full-body infant massage techniques to mothers, which encourage positive parent-infant interaction. The aim is for PIACs to initially demonstrate, and then encourage and allow mothers to do it independently. In postnatal sessions 9 to 15, these demonstrations are expanded to facilitate more social interactions between mother and baby, like face-to-face interactions, verbal and non-verbal reciprocal exchanges, and social games like peek-a-boo. Discussions on the infant's perceived social responsiveness are initiated with parents during session 13; with session 14 focused on encouraging mothers to explore different ways of interacting with their babies, now that they have more motor ability.

Conclusion

Postnatal sessions 1 to 14 conclude with PIACs giving parents the opportunity to voice any concerns they may have, and then scheduling the next home visit. Session 15, however, concludes with parents reviewing and reflecting on their experience of the PIHVP and lessons learned from it.

Table 2 below provides an overview of the postnatal home visit agenda across all sessions.

Table 2

Summary of the PIHVP's postnatal component agenda

	Introduction	Discussion and input	Psychological assessment administered	Demonstration	Conclusion
PN 1	'Tuning in' to mother's current emotional state	The birth	n/a	n/a	Arrangements for next visit
		The 'baby blues'			
		Infant feeding			
	Practice maternal empowerment	Infant health issues			
		Mother's concerns for the baby			
PN 2	'Tuning in' to mother's current emotional state	Infant feeding	Start BIAB	n/a	Arrangements for next visit
		Infant sleeping			
	Practice maternal empowerment	Crying and consolability			
PN 3	'Tuning in' to mother's current emotional state	Infant health	EPDS	n/a	Arrangements for next visit
		Infant feeding			
	Practice maternal empowerment	Crying and consolability	Complete BIAB		
		Infant sleeping			
PN 4	'Tuning in' to mother's current emotional state	Family planning	n/a	Infant massage	Arrangements for next visit
		Infant feeding			
	Practice maternal empowerment	Crying and consolability			
		Infant sleeping			

PN 5	‘Tuning in’ to mother’s current emotional state	Infant feeding	BIAB	n/a	Arrangements for next visit
		Crying and consolability			
	Practice maternal empowerment	Infant sleeping			
PN 6	‘Tuning in’ to mother’s current emotional state	Infant feeding	BIAB – items 9 (social interactive package) and 10 (imitation, responsiveness and reciprocity) only	n/a	Arrangements for next visit
		Infant sleeping			
	Practice maternal empowerment	Crying and consolability			
PN 7	‘Tuning in’ to mother’s current emotional state	Infant feeding	n/a	Infant massage	Arrangements for next visit
		Infant sleeping			
	Practice maternal empowerment	Crying and consolability			
PN 8	‘Tuning in’ to mother’s current emotional state	Infant feeding	BIAB	n/a	Arrangements for next visit
		Infant sleeping			
	Practice maternal empowerment	Crying and consolability			
PN 9 – 15	‘Tuning in’ to mother’s current emotional state	Infant feeding	n/a	Facilitate social interactions between mother and baby	Arrangements for next visit
		Infant sleeping			
	Practice maternal empowerment	Crying and consolability			

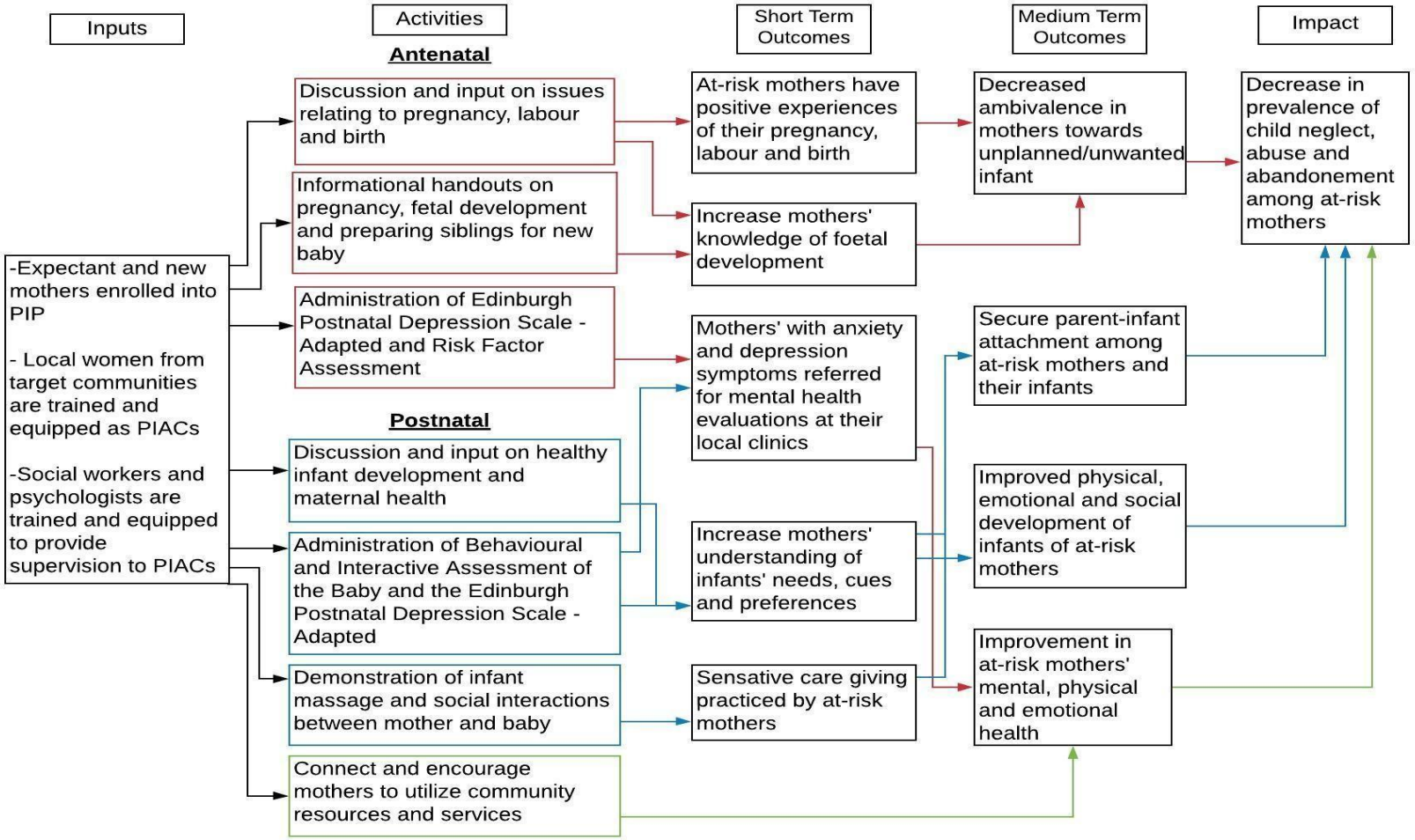
The Client's Programme Theory

Rossi and colleagues (2004) argue that a "programme theory explains why the programme does what it does and provides the rationale for expecting that doing so will achieve the desired results" (2004, p.134). A causal model is often used to illustrate these linkages between a programme's inputs, activities, intended or observed outcomes and impacts (Roger, 2008). Prior to this evaluation, the PIHVP attempted to draft a theory of change (TOC), as a requirement for a funding proposal. However, this diagram did not illustrate any clear casual linkages. Nevertheless, the evaluator used this as a basis to construct a clearer, more standardised TOC as it identified core PIHVP components and their intended results. The TOC was further refined through information obtained from programme documents, and notes captured during consultations with the programme's manager.

The PIHVP provides mothers with parenting information, skills, and support services during and after their pregnancy. This is anticipated to result in the intended short-term outcomes of improved parental knowledge and capabilities, which will lead to mothers exercising more sensitive caregiving with their infants. This should then lead to the medium-term outcomes of improved maternal and child well-being; increased secure parent-infant attachment; and decreased ambivalence towards having an unplanned or unwanted infant. Ultimately, this is believed to result in the intended impact of the PIHVP, which is to decrease the prevalence of child neglect, abuse, and abandonment among at-risk mothers. Figure 1 below illustrates the final TOC of the PIHVP that was formulated by the evaluator.

Figure 1

The PIHVP's Programme Theory Logic Model



Programme plausibility

A programme's theory should be considered plausible before an evaluation is done on it. Pocock (2009) explains this means determining whether a particular intervention can reasonably be expected to produce certain outcomes. For this evaluation, plausibility was tested by reviewing relevant literature on interventions like the PIHVP. There are several underlying causal assumptions made within the programme theory of the PIHVP, namely that:

1. Providing at-risk mothers with antenatal and postnatal parenting information, skills and support focused on improving parent-infant attachment leads to the outcomes specified in the programme theory
2. Home visitors' modelling positive parent-infant interactions is an effective strategy for engaging at-risk mothers
3. Providing 20 programme sessions over a period of six months will improve parent-infant attachment bonds between at-risk mothers and their infants
4. Using trained, local women to conduct home-visiting sessions is an effective strategy to train at-risk mothers on positive parent-infant attachment

The literature review below, judges these assumptions against the relevant literature on parent-infant home-visiting programmes to determine the level of plausibility of the PIHVP.

1. Providing at-risk mothers with antenatal and postnatal parenting information, skills and support focused on improving parent-infant attachment leads to the outcomes specified in the programme theory

An ongoing debate exists within the literature as to whether home-visiting programmes focused on ECD are impactful. There is however, extensive evidence to support these programmes, with findings of reductions in child maltreatment (Peacock, Konrad, Watson, Nickel & Muhajarine, 2013; Casillas, Fauchier, Derkash & Garrido, 2016), injury (Kendrick et al., 2013) and improvement in children's cognitive and socio-emotional development (Peacock et al., 2013; Sama-Miller et al., 2018). Parent-infant home visiting programmes have also been shown to improve maternal health (Sama-Miller et al., 2018) and parenting behaviours and

attitudes (Kendrick et al., 2000; Sama-Miller et al., 2018). Furthermore, systematic reviews by Hahn and colleagues (2003) and Balakrishna, Teixeira, Meyrick, and Hart (2019) found ECD-focused home visiting programmes had the ability to reduce the incidence of child abuse and neglect and promote secure attachment and attunement among mothers and their infants, respectively.

Programmes of this nature have been studied among South African populations as well. A Randomised Control Trial (RCT) by Cooper and colleagues (2009) on an intervention implemented in Khayelitsha, Cape Town found significant improvement in mother-infant relationships and secure infant attachment. This finding was further supported by a mixed methods study conducted by Bain, Dawson, Esterhuizen, Frost and Pininski (2016) that found significant effects on the knowledge of parents regarding their infant's relational needs and mothers' reflective functioning capability.

Longitudinal studies appear to emulate this positive perception of parent-infant attachment programmes' effectiveness. Positive effects were found by Rowe and Fisher (2010) on at-risk mothers susceptible to maternal depression on infant behaviour and maternal psychological functioning, which sustained for 6 months after the programme. These sentiments were shared by Suess and colleagues (2016) whose study found positive effects on secure attachment between young mothers at high-risk for violence and their infants, 12 months post-intervention. These effects, however, were not conclusively sustained through to the 24-month time point. Despite the contrasting findings of its study, Suess and colleagues (2016) confirmed significantly less attachment disorganization among those receiving the parent-infant attachment intervention as opposed to those who were not, at both time points.

Despite its extensive support, several studies have found no impact among parent-infant programmes. An RCT conducted by Pontoppidan, Klest and Sandoy (2016) found no effects on parent health, parent-child relationships, and infant development. Similar results were found in RCT's by Duggan et al. (2004) and Berlin et al. (2017), which showed programmes of this nature had no significant effects on malleable parental risk factors, and infant attachment security or disorganization, respectively. In the same vein, a systematic review conducted by Ijzendoorn, Juffer and Duyvestyn (1995) found that programmes focused on infant attachment security had little to no effect, with a more recent review by Rayce and colleagues (2017) further

finding no significant long-term effects on child behaviour in none of the 16 studies it included in its meta-analysis on interventions focused on parent-infant relationships.

Drawing a conclusion from polarized viewpoints on any topic is challenging. However, considering the available literature, the dominant opinion appeared to be that parent-infant programmes focused on maternal and infant development and secure attachment are indeed effective. Hence, the PIHVP's approach to bringing about its outcomes can be deemed plausible.

2. Home visitors' modelling positive parent-infant interactions is an effective strategy for engaging at-risk mothers.

The PIHVP provides two types of modelling - the demonstration and facilitation of positive parent-infant interaction and infant massage. There is evidence to suggest that modelling positive parent-infant interaction has positive outcomes for both parents and their infant. Trumbull, Rothstein-Fisch and Greenfield (2000) argue that engaging parents through modelling reinforces the parent-infant relationship, resulting in improved child development, parental satisfaction, and programme success. Similar results were found by Peterson, Luze, Eshbaugh, Jeon and Kantz (2007), whose study showed greater parental engagement within home-visiting programme activities when positive parent-infant interactions were modelled. Increased parental engagement is linked to greater parental confidence and competence for promoting their child's development (Peterson et al., 2018). An RCT by Landry, Smith, and Swank (2006) further found that the modelling of positive parent-infant interactions significantly increased maternal warmth and mothers' responsiveness to their child's behaviours. This practice has also been shown to promote positive behaviour among children (Park, 2018).

Although the available evidence affirms the modelling of parent-infant interactions, Whitaker and Cowley (2012) explain that the modelling demonstrated by home visitors should be informed through an iterative process, such as the Parent Advisor model developed by Davis, Day and Bidmead (2002). This framework, based on the theory of personal constructs, argues that positive parent-infant attachment modelling can only be perceived as genuine and helpful to parents when these demonstrations are informed by family-specific issues. In other words, it should be informed by observations made of parent-infant interactions during programme sessions, and not based on the home visitor's personal perceptions of what positive parent-infant

interactions should be (Davis, Day and Bidmead, 2002). The home visitor's constructive comments should then be fed back into the loop, which may inform new points of inquiry, and so on.

In contrast to positive social interactions, the modelling of infant massage has been met with much greater debate within the literature. Although there is evidence to suggest that infant massage has positive effects on outcomes such as increased maternal sensitivity (Kersten-Alvarez et al., 2011), and increased parental perception of stress and decreased depressive symptoms (Bennet, Underdown & Barlow, 2013); Cooke (2015) cautions against the interpretation of these findings. In her meta-analysis, Cooke (2015) found that of the 34 studies reviewed on infant massage in healthy term babies up to six months old, 20 were found to be of poor methodological quality; which included issues such as small sample size and allocation bias. Bennet and colleagues (2013) suggest that infant massage rather be offered as one component among many; as at-risk mothers and their infants are unlikely to benefit from interventions of this nature, in isolation.

There are two components of the PIHVP which align with the findings of the literature. Firstly, the practice of 'tuning in' to mothers and that of maternal empowerment throughout the intervention, speak directly to the iterative process highlighted as an essential component to parent-infant modelling. 'Tuning in' to mothers creates an open line of communication between PIACs and parents, which allows PIACs to tailor demonstrations to the needs of the parent. Maternal empowerment encourages independence, as mothers are given the opportunity to exercise what they have observed, which may inform further inquiry – leading to increased improvement in parenting knowledge and skill. Secondly, infant massage is offered as one of many activities within the programme. Hence, the modelling demonstrated by PIACs during sessions can be deemed as a plausible method for engaging at-risk mothers.

3. Providing 20 programme sessions over a period of six months will improve parent-infant attachment bonds between at-risk mothers and their infants

There is great dispute within current literature as to what number of sessions and length of intervention improves parent-infant attachment. Studies such as that conducted by IJzendoorn, Juffer and Duyvestyn (1995); Bakermans-Kranenburg, van IJzendoorn and Juffer (2003); and

Roy, Schum and Britt (2013) found that parenting interventions with more than 16 sessions to be ineffective. On the other hand, studies such as Guther, Gaziano and Gaziano's (2009) found short-term interventions to promote nurturing parenting attitudes and behaviours. There are also more pragmatic findings, such as that of Britto and colleagues' (2015), who found that shorter-term parenting programs in low and middle-income countries (LMIC) were effective only at parent-level outcomes; whereas longer-term interventions were found to be more effective at improving both parent- and child-level outcomes. This stance on longer-term interventions is further supported by systematic and meta-analytic reviews conducted by Selph, Bougatos, Blazina and Nelson (2013) and Casillas and colleagues (2016) respectively, which found more intense interventions over a longer term to be more effective. Further evidence suggests that parenting interventions conducted within a three to six-month duration produced better effects (Roy, Schum & Britt, 2013).

According to UNICEF (2016) standards for ECD parenting programmes in LMIC, the dose (i.e. frequency, intensity, and duration) of these programmes should be tailored to the circumstances in which they operate and the availability of resources. Furthermore, the report details that programmes aimed at changing parental behaviour should be given in greater dosages than those focused only on creating awareness among parents (UNICEF, 2016). The UNICEF report (2016) further found that programmes yield better results when they have a high frequency, with more sessions at the start of the programme, that later taper off as the programme progresses. These findings are supported by Moran, Ghate and van der Merwe (2004) whose review of international evidence on successful implementation strategies for parenting programmes found that interventions that were longer in duration and intensity were better suited for parents who had multiple needs and faced more complex problems. They further found that given the complex dynamics within low income families, it would be unrealistic to expect a single service intervention (typical of shorter-term programmes) to meet all their needs. Therefore, longer-term parenting interventions like the PIHVP would be more effective as they are more likely to operate at a level of multi-agency, which enables access to other appropriate services to meet a wide range of vulnerable families' needs (Moran, Ghate & van der Merwe, 2004). Hence, the current programme dose of the PIHVP can be assumed to improve attachment bonds between at-risk mothers and their infants.

4. Using trained, local women to conduct home-visiting sessions is an effective strategy to train at-risk mothers on positive parent-infant attachment

Evident in the literature as well, is the variability on who facilitates parent-infant interventions. This ranges from professionals (Olds, Hill, Robinson, Song & Little, 2000) to trained, local women from communities where the programme is conducted (Pocock, 2009; Bain et al., 2016). Parent-infant interventions who utilize professionals typically use healthcare professionals such as nurses, or family support workers (Hickey, McGilloway, Leckey & Stokes, 2018) who possess a graduate degree or diploma. Given their academic knowledge and experience, it is not surprising that programmes led by professionals yield positive effects such as improved maternal understanding of their infant's needs and cues, and decreased maternal stress (Hickey, McGilloway, Leckey & Stokes, 2019). Gilmer and colleagues (2016) argue that the cost of this option is exorbitant, especially in the LMIC context. As a result, there has been a growing tendency to employ the services of local women to deliver parent-infant interventions.

Evidence suggests that the utilization of local women as home visitors is not only cost-effective (Olds et al., 2002), but it increases the level of parental participation; as it is believed more positive relationships are built between parents and home visitors when they share similar racial and cultural backgrounds (Cooper, 2009; Woolfolk & Unger, 2009; Le Roux, 2013). Walkup and colleagues (2009) further found that parents perceived home visitors from their community as more relatable, which consequently lead to positive effects on maternal knowledge and infant behaviour outcomes. However, several aspects need to be in place for this option to be successful. These women have to possess: an adequate level of knowledge and training (Pocock, 2010; Rossiter et al., 2012), the ability to recognize parental risks (Duggan et al., 2004), and the ability to link parents to other community resources (Duggan et al., 2004; Heaman, Chalmers & Woodgate, 2006).

Considering the low income context in which the PIHVP operates; and the proactive steps the programme takes to extensively train and provide regular supervision to its home visitors; it can be assumed that the use of local, trained women is an effective strategy for training at-risk mothers on positive parent-infant attachments.

Conclusion of the plausibility assessment

The abovementioned evidence suggests that the dosage, method of teaching, and type of home-visitor utilised by the PIHVP is largely supported by the literature on home-based parenting programmes. Therefore, the programme theory of the PIHVP can be considered plausible.

Evaluation level of the PIHVP

The scope of the evaluation was determined through informal meetings between the evaluator and the programme manager. Through these engagements, the evaluator was informed that the current processes of the PIHVP were not guided by a proper TOC. Hence, the programme manager had no assurance that the programme was being implemented as intended. Furthermore, with no official M&E system in place, data is currently collected without the intention of it being used to track programme performance and progress over time. Data collection is currently perceived as an administrative task; as it is purely stored upon capturing, and systematised nor analysed in any way. The programme manager further conveyed interest in wanting to know which type of participants the PIHVP works for; what participants' perceptions of the programme were; and whether PIACs were implementing their training during home visit sessions.

It became apparent that many of the issues raised by the programme manager were linked to implementation. The main aim of the evaluation, therefore, was to assist the programme in improving its current operational state. Hence, a formative evaluation approach was adopted. Formative evaluations focus on whether programmes are functioning as intended; with the purpose of shaping programmes to become better (Rossi, Lipsey & Freeman, 2004). Formative evaluations therefore support the understanding of a programme's processes - what works, what does not work, and how things can be improved on (Baxter, Courage & Caine, 2015). To supplement this formative approach, a process evaluation was recommended for the PIHVP. Process evaluations determine how well programmes are operating and the extent to which their services are delivered to the appropriate recipients (Rossi, Lipsey & Freeman, 2004). The PIHVP supported this notion, as they believed a process evaluation would enable them to judge whether the capacity of the programme was able to deliver on its intended outcomes.

Evaluation questions

Given the abovementioned rationale, Table 3 below illustrates the questions for the process evaluation, and their respective sub-categories. 'Service utilization' is focused on programme coverage – determining whether those receiving the programme are indeed its intended beneficiaries. 'Fidelity' determines the commitment and trustworthiness of the intervention and its staff. 'Quality of delivery' examines the level of services provided to participants, and 'participant responsiveness' determines the level of effort participants put into programme sessions and activities.

Table 3

Process Evaluation Questions

Service Utilisation	1. Did the PIHVP beneficiaries recruited for the first 2019 programme cycle meet the eligibility criteria specified by programme?
	2. What proportion of participants completed and dropped out of the PIHVP during the first programme cycle of 2019? What are the reasons provided for programme dropout?
	3. To what extent did the PIHVP meet its targeted number of participants? What are the reasons for over/under coverage?
Fidelity	4. Did the participants receive the home-visiting sessions at the duration and frequency prescribed by the programme model?
	5. Did PIACs complete and conduct all programme activities, developmental screenings and demonstrations as intended?
Quality of delivery	6. How did participants perceive PIACs in terms of the support they provided and their preparation level, knowledge, and reliability?
	7. To what extent do PIACs implement the skills acquired through their training into their sessions?
Participant responsiveness	8. Are the participants satisfied with the service they received? What are the strengths and limitations they identified?
	9. To what extent did participants engage with the PIACs (around the content) during home-visit sessions?

Chapter Two: Methods

This chapter outlines the method adopted for this evaluation. A mixed methods approach was implemented as both qualitative and quantitative data were used to systematically answer the evaluation questions. With the evaluation being informed by both primary and secondary data; the methodological approach, ethical considerations, and data sources for each of these data types are detailed separately. The data collection procedure and analysis followed for each of the nine evaluation questions is then discussed.

Methodological Approaches

Primary data

An exploratory methodological approach investigates problems which have not yet been clearly defined; and generates preliminary research to determine initial theories for solving them (Fowler, 2013). Therefore, this approach does not seek to find conclusive results, but rather lay the groundwork for additional research to be conducted on the identified problem. This approach was suitable for primary data, as it allowed the evaluator to develop preliminary theories through interviews with both PIHVP staff and participants on programme recruitment and participant satisfaction, respectively.

Secondary data

Descriptive research is a non-experimental methodological approach that describes the current condition of a phenomena without attempting to determine how, when, and why it occurred in the first place (McCombes, 2019). This approach was therefore suitable for secondary data, as it enabled the evaluator to identify characteristics, frequencies, and proportions within the PIHVP context (McCombes, 2019). As a result, the descriptive research approach was applicable to all service utilization, service delivery and fidelity evaluation questions.

Ethical Considerations

Ethical clearance was obtained from the Faculty of Commerce Ethics in Research Committee before both primary and secondary data were collected. Different ethical procedures were used for the two data types to maintain the integrity of the evaluation. These procedures are outlined below.

Primary data

Informed consent forms (Appendix A and B) were distributed to all respondents before interviews were conducted, following an explanation of their rights as interviewees and the purpose of the interview. These forms, as well as the interview guides (Appendix C and D) were translated into Afrikaans and isiXhosa. The translated versions were used in interviews where respondents were not conversant in English. Furthermore, all interviews were audio-recorded where written and verbal consent were given.

Names and other personal identifiers were not used during audio-recordings, notes, and transcriptions of the interview process to ensure respondents' anonymity. All data sources generated through interviews were stored in separate locked cabinets in a private room. All electronic data, including original SPSS spreadsheets developed by the evaluator, were stored in a password protected DropBox account. Primary data findings were reported using general descriptions and pseudonyms where required to conceal respondents' identities. Only the evaluator and her supervisor had access to both hardcopy and electronically stored research data. Once the evaluation concluded, all data retrieved for the evaluation were permanently destroyed and erased.

Secondary data

Secondary data was sourced from the PIHVP's hardcopy document archives. Ethical clearance to access these documents was granted through the Parent Centre Intellectual Property Agreement (Appendix E); provided that the data be used for the sole purpose of the evaluation and be returned to the PIHVP once the evaluation concluded.

Before data analysis commenced, all names and personal identifiers were removed from all documentation and replaced with project numbers and/or pseudonyms by the programme manager to maintain their participants' anonymity. The evaluator only assessed components of these documents that were of relevance to the evaluation. Secondary data findings were reported using general descriptions and pseudonyms where required to conceal participants' identities. All documents were stored in a locked cabinet, in a private room, only accessible to the evaluator; and were returned to the programme once the evaluation concluded.

Data sources

This evaluation drew mostly from secondary data, as it focused on a historical programme cycle - January to June 2019. This provided direct evidence of activities completed over this period; which saved on both time and cost, as it would've been logistically and administratively impossible for the evaluator to collect the same amount of data within the same timeframe - as the programme serves hundreds of participants across several communities. The data was also routinely collected by the programme, which provided the evaluator with ample data across a large sample, to analyse. In addition, the secondary data provided information on the programme's service utilisation, fidelity, quality of delivery and participant responsiveness. Burkhardt, MacDonald and Rathemacher (2010) argue that this makes the data 'fit for purpose' and considered 'good enough' for an evaluation. Therefore, the collection of new data was kept to a minimum, and primarily used for triangulating the existing data.

Primary data

Primary data was provided by eleven programme participants and three staff members of the PIHVP.

Participant interviews

Semi-structured face-to-face interviews, instead of a focus groups, were used to collect data from participants as it minimized both the financial and possible emotional burden on them. The intention was for participants to not incur any cost by having the evaluator travel to them and conduct the interviews where they would feel most comfortable - their own homes.

Purposive sampling considered the willingness of at-risk mothers wanting to participate in interviews, the availability of PIACs to act as support and translators for participants during interviews, and data saturation and variability among a homogenous population like the PIHVP's (Guest, Bruce & Johnson, 2006). A sample of twelve interviewees were extracted from the cohort of participants who completed the PIHVP within the evaluation period. This equated to two interviews per community. However, only eleven interviews were conducted, as one respondent declined participation. Key data derived from these interviews were participants' perceptions, and level of satisfaction with the PIHVP.

Programme staff interviews

Purposive sampling ensured that staff selected for interviews were those who could provide direct insight into participant recruitment. Through a meeting with the programme manager, three staff members were identified - the programme manager herself, and two programme supervisors. Semi-structured face-to-face interviews were conducted with the programme supervisors, and a semi-structured telephonic interview with the programme manager. Key data derived from these sources were reasons for enrolment targets not being reached.

Secondary data

A two-stage sampling procedure was followed with secondary data. First, purposive sampling was done at the programme level, to determine which of the PIHVP's available data collection tools provided specific data on programme implementation. This process identified eight data collection tools, namely: Parent Infant Intake form; Client Evaluation form; Parent Infant Information sheets; M&E reports; DSD Termination sheet; Logbooks; Parent Centre Annual Report; and the PIHVP Programme manual. Secondly, sampling was done at the data source level, to ensure the source had sufficient data to answer the evaluation questions. Here, two sampling techniques were identified: purposive sampling, which only considered participant cases that completed the programme; or the entire population's data for the evaluation period. The reasons for incorporating either of these sampling techniques for a particular data source are discussed in the subsequent sections.

Parent Infant Intake form

The Parent Infant Intake form (Appendix F) was developed by the programme director of the PIP and has been in circulation since the programme's inception in 1994. However, parts of the form have been updated since then, to ensure relevant information was captured over time. The form is completed once by PIACs during the first home visit session. It captures participant information pertinent to several of the evaluation questions, including personal and demographic data; whether the current pregnancy was planned; gestational age at first visit; EPDS and RFA-A scores; and the dates when all programme sessions were conducted.

Only 133 participants completed the programme during the evaluation period. Due to this small size, the evaluator consulted the entire population's data for this period, which translated into 133 forms.

Client Evaluation form

The Client Evaluation form (Appendix G) was developed by the first programme manager in the early 2000's. Since her appointment in 2015, the new programme manager had adapted this version into its current format. This is a self-administered questionnaire distributed by PIACs to participants at the end of the programme. It attempts to capture data on participant satisfaction based on these eight questions:

1. Did the programme help you become a better parent?
2. Did the programme help your child develop better?
3. Did you feel supported?
4. Information was helpful and useful
5. Was the PIAC well-prepared?
6. Was the PIAC knowledgeable?
7. Did the PIAC stick to her appointments?
8. Will you recommend the PIHVP to other mothers?

The data source further provides participants with the opportunity to share any additional comments and/or recommendations for the programme. With only 50 of the 133 participants completing the PIHVP, this meant only 50 forms were completed during the evaluation period. Due to its small size, the evaluation considered the entire population's data for this source, which translated into 50 forms.

Parent Infant Information sheets

The Parent Infant Information sheets (Appendix H) were jointly conceptualised by the previous programme manager and the current programme supervisors in 2013. Essentially, these are reports completed by PIACs at the end of every home visit. This document was designed to capture qualitative data on participants' responses to programme activities and developmental screenings conducted during home visits. Additionally, it captures PIAC's observations of the mother and her home environment, and any thoughts and/or concerns of participants.

Purposive sampling was used for this data source, as participants who completed all 20 programme sessions were able to provide the most comprehensive data. With 50 participants having complete the PIHVP during the evaluation period, this translated into 1000 sheets being consulted.

M&E reports

The M&E report (Appendix I) was conceptualised in 2013, alongside the establishment of an official M&E social worker post within the programme. This report was revised in 2019 by the current programme manager and M&E social worker. Essentially, the M&E reports are records of performance observations, which should ideally take place at least twice a month for each PIAC. These observations are conducted by the M&E social worker during actual home visit sessions. PIACs should get a 'planned' visit that is scheduled with their knowledge; and an 'unplanned' visit, where the M&E social worker accompanies them to a home visit without their prior knowledge of it. The reports capture qualitative data on PIAC's strengths and weaknesses, in terms of the quality with which they convey the PIHVP curriculum and the extent to which they implement their training. Given its nature, these reports are therefore considered as an observational log, rather than an official M&E document, despite its name.

The PIHVP started capturing M&E reports in February 2019. This meant for the evaluation period, 80 reports should have been completed (8 PIACs with 10 M&E reports each). However, due to capacity constraints, only 11 M&E reports were completed during this period. Due to this small size, all 11 M&E reports were consulted.

DSD Termination sheet

The DSD Termination sheet (Appendix J) is a Microsoft Excel-based spreadsheet that was developed by a Parent Centre staff member responsible for consolidating the programme's statistics, in 2018. This document was originally drafted as a funding requirement for the Department of Social Development (DSD) to collate all programme cases across a financial year, hence the name. These sheets are categorised by PIAC and details their caseload on a quarterly basis. It also indicates the dates on which their home visits were conducted. Key data derived from this document were the amount and frequency of home visits.

The evaluation period covered two quarters of the year - January to March, and April to June. Therefore, two quarterly DSD termination sheets per PIAC were consulted, totalling 16 sheets. Due to its small size, all 16 sheets were consulted.

Logbooks

Logbooks are handwritten logs completed by PIACs, that details their caseloads for a given programme cycle, the start and end dates of these cases, and reasons why participants drop out of the programme. The idea originated from a programme supervisor who requested all her PIACs she supervised, log their caseload information into one document. This practice was then adopted by all PIACs in 2018. Although this source was primarily used to determine reasons for participant dropout, it was also used as a source to triangulate start and end dates of participant cases. Each of the six communities in which the programme is delivered, have their own designated logbook. Therefore, all six logbooks were examined.

Parent Centre Annual Report

The Parent Centre Annual report has been published annually on the Parent Centre website since 2012. The report is compiled by the Parent Centre's director and details the performance of all its programmes over a financial year, including the PIHVP. Essentially, it provides a brief programme description, the number of participants enrolled onto the programme; the programme outputs achieved; as well as accomplishments and obstacles experienced by programmes within that year.

This source was primarily used to triangulate data on participant recruitment targets for 2019. Only the 2019 annual report was consulted as it covered the period under evaluation.

PIHVP Programme manual

The PIHVP Programme manual is a resource prescribed to all PIACs as it details the programme's antenatal and postnatal curriculum, the agenda of activities and screenings for each home visit, and guidelines on how the programme content should be conveyed to participants. It was originally developed as a demonstration project in 1993 by the programme developers of the PIP, who adapted it from the 'Healthy Families America' programme model. The manual has since been adapted through the doctoral studies of Landman (2009), which is the version currently in circulation. This source ensures PIACs provide all the required information to participants correctly, at the right time during the programme. The evaluator used this source as a

template to determine whether PIACs were completing all prescribed programme activities and screenings, as planned. The version of the manual currently in circulation was consulted for this evaluation.

Data collection procedure and analysis

The following section outlines the measures and procedures followed for each evaluation question. A summary of this is first provided in Table 4 below, with a more detailed outline provided after this.

Table 4

Summary of the data collection and analysis procedure

Evaluation Question	Data sources	Data collection and analysis procedure
1	***Secondary:*** Parent Infant Intake forms	Personal and demographic information were extracted from the secondary data source and analysed using IBM SPSS to determine the frequencies of enrolled participant characteristic categories and their alignment with intended population. A chi-square analysis further determined whether significant relationships were present between selected variables.
2	***Secondary:*** DSD Termination sheets; Parent Infant Intake forms; PIAC logbooks	DSD Termination sheets were manually examined and triangulated with logbook data to verify the start and end dates of participant cases. Logbook data was further used to identify various participant dropout categories. Proportions of participants who completed and dropped out of the PIHVP, as well as the frequencies of identified reasons for dropout were then determined through descriptive statistics using IBM SPSS. A chi-square analysis further determined whether a significant relationship existed between participants' age and their reason for dropout.
3	***Primary:*** Programme staff interviews ***Secondary:*** PIP annual report (2019)	Three semi-structured programme staff interviews were conducted. Their transcripts were analysed by adopting an inductive approach and utilising NVivo. Themes developed from this analysis would be used to determine whether enrolment targets were met, as well as reasons for under/over coverage. Enrolment figures provided were triangulated with data provided in the 2019 annual report.

Evaluation Question	Data sources	Data collection and analysis procedure
4	***Secondary:*** DSD Termination Sheets; PIHVP Programme manual; PIAC logbooks; M&E reports; Client Evaluation forms	DSD Termination sheets were manually examined and triangulated with logbook data verify the start and end dates of participant cases. Time difference (in days) between visits were manually calculated, and then analysed using descriptive statistics to determine the average time (in days) between home visits. Duration of home visits were extracted from M&E reports, and analysed using descriptive statistics to determine the average duration of home visits. Both sets of results were compared to the programme manual to determine the extent to which the programme design was adhered to. Data on the amount of home visits were extracted from question 7 of the Client Evaluation forms. Descriptive statistics then determined the frequency with which PIACs adhered to scheduled appointments.
5	***Secondary:*** M&E reports; Parent Infant Information Sheets; PIHVP Programme manual	All intended programme activities were identified through the programme manual. Data extracted from Parent Infant Information sheets were manually examined, then analysed using descriptive statistics in IBM SPSS to determine the frequency with which these activities were conducted as intended. M&E reports were analysed using NVivo. An inductive approach was used to develop themes that informed to the extent to which PIACs conducted all required activities and screenings.

6	***Primary:*** Participant interviews ***Secondary:*** Client Evaluation forms	Eleven semi-structured participant interviews were conducted. Analysis of these transcripts through NVivo, using an inductive approach, developed themes that informed participants' perceptions on the level of knowledge, preparedness, and support received from PIACs. Descriptive statistics run on data extracted from question 3, 5, 6 and 7 of Client Evaluation forms further determined the frequency with which participants perceived PIACs were supportive, knowledgeable, well-prepared and reliable.
Evaluation Question	**Data sources**	**Data collection and analysis procedure**
7	***Secondary:*** M&E reports; Client Evaluation forms	M&E reports were manually examined and then analysed through NVivo, using an inductive approach. Themes were then developed and informed the extent to which PIACs implemented aspects of their training during home visit sessions. Additionally, descriptive statistics were run on participant responses to questions 4 and 6 of the Client Evaluation forms to determine the extent to which participants perceived PIACs as knowledgeable, and programme information as helpful and useful.
8	***Primary:*** Participant interviews ***Secondary:*** Client Evaluation forms	The same participant interviews conducted in question 7 covered content on participant satisfaction with the PIHVP. Interview transcripts were transcribed through NVivo, using an inductive approach. This analysis developed themes which informed what participants perceived as the programme's strengths and weaknesses, its perceived impact and recommendations for improvement. Additionally, descriptive statistics were run on participant responses to all questions in the Client Evaluation form, which determined the extent to which participants were satisfied with the entire PIHVP.

9	***Primary:*** 3-Point Likert scale ***Secondary:*** Parent Infant Information Sheets	Participants' responses to activities that required discussion with PIACs were identified through the Parent Infant Information sheets, then ranked according to the 3-Point Likert scale; with 1 = no response, 2 = closed-ended response (yes or no), and 3 = open-ended response (yes/ no with explanation). Descriptive statistics then determined proportions of participants who responded using open- and closed-ended answers, and where no response were captured at all.

Question 1: Did the PIHVP beneficiaries recruited for the first 2019 programme cycle meet the eligibility criteria specified by programme?

Data collection procedure

The Parent Infant Case Presentation form was used to obtain demographic and other relevant personal information on enrolled participants for the period of January to June 2019, to determine whether they met the programme's eligibility criteria and matched the profile of its intended beneficiary.

Data analysis

Data extracted from these forms were entered onto an IBM SPSS spreadsheet, which created an electronic database of enrolled participants across the evaluation period. Descriptive statistics was used to determine proportions of different categories across all variables. A chi-square analysis was then run to determine whether selected variables were contingent on one another. This provided a more comprehensive picture of the actual beneficiary of the PIHVP.

Question 2: What proportion of participants completed and dropped out of the PIHVP during the first programme cycle of 2019? What are the reasons provided for programme dropout?

Data collection procedure

The first and second quarter DSD Termination sheets of 2019, Parent Infant Intake sheets, and logbooks were manually examined to determine how many enrolled participants completed, and dropped out, of the PIHVP. DSD Termination sheets provided start and end dates for each participant case, which were cross-referenced with Parent Infant Intake sheets and logbook data. Reasons provided for participant dropout were also determined through logbooks.

Data analysis

The start and end dates, as well as reasons for participant dropout, were all manually entered onto an IBM SPSS spreadsheet. Descriptive statistics was used to determine the proportion of participants who completed and dropped out of the PIHVP, as well as the frequency with which various reasons for dropout were cited. A chi-square analysis was then run to determine whether these reasons for dropout were contingent on participants' ages.

Question 3: To what extent did the PIHVP meet its targeted number of participants? What are the reasons for over/under coverage?

Data collection procedure

Semi-structured interviews with programme staff was used to determine whether the PIHVP had successfully reached its recruitment targets or not; as well as the reasons for this. Potential interviewees were personally approached by the evaluator to determine their willingness to participate. Once this was confirmed, the dates and times of the interviews were scheduled. A reminder was sent via email a week prior to the interview to re-confirm interviewees' participation. Two of the three interviews were conducted face-to-face at the Parent Centre offices in Wynberg, Cape Town, while the other one was conducted telephonically. The 2019 Parent Centre Annual Report was also consulted to cross-reference the participant enrolment figures for the period under evaluation.

Data analysis

Thematic analysis on NVivo was used to transcribe data captured through interview notes and audio-recordings. Codes were then developed using an inductive approach, which allows theories to emerge organically from the raw data as it is analysed (Thomas, 2006). Themes were then developed from these codes, which determined whether the programme reached its enrolment target, and the reasons for this. The Parent Centre Annual Report, on the other hand, was manually examined.

Question 4: Did the participants receive the home-visiting sessions at the duration and frequency prescribed by the programme model?

Data collection procedure

The frequency of visits was determined from the first and second quarter DSD Termination sheets, Parent Infant Intake sheets, logbooks, and programme manual. Start and end dates of participant cases were cross-referenced across all these sources. The duration of visits was determined from M&E reports which provided direct data on actual programme duration. The amount of home visit sessions received was determined through proxy data derived from question 7 of the Client Evaluation form, which indicated participants' perceptions on whether PIACs adhered to their scheduled appointments during the evaluation period.

Data analysis

For frequency, the time difference (in days) between visits were manually calculated and entered onto an IBM SPSS spreadsheet with a row for each participant. Through descriptive statistics, the proportions of antenatal and postnatal sessions that adhered to the intended time intervals prescribed by the programme, were determined. For duration, descriptive statistics was used to determine the average duration of home visits during the evaluation period. For amount of sessions received, participants' responses were entered onto an IBM SPSS spreadsheet, upon which descriptive statistics determined the frequency with which PIACs adhered to scheduled appointments.

Question 5: Did PIACs complete and conduct all programme activities, developmental screenings and demonstrations as intended?

Data collection procedure

Parent Infant Information sheets and the programme manual provided data for this evaluation question. The programme manual was manually examined to determine which programme activities, developmental screenings and demonstrations were planned for each home visit session. Data provided by Parent Infant Information sheets were then compared to this, to determine the extent to which these activities were truly conducted during the evaluation period.

Data analysis

The programme activities, screenings and demonstrations for each home visit detailed in the programme manual were used to create an outline for an IBM SPSS spreadsheet; on which data derived from Parent Infant Information sheets were populated. Activities were deemed 'complete' by the evaluator when information relating to this were made explicitly available in the Parent Infant information sheets. Descriptive statistics then determined the frequency with which all programme activities, screenings and demonstrations were conducted during the evaluation period.

Question 6: How did participants perceive PIACs in terms of the support they provided and their preparation level, knowledge, and reliability?

Data collection procedure

Semi-structured face-to-face interviews with participants were used to determine their perceptions of PIACs. Potential interviewees were contacted by a Parent Centre social worker to determine their willingness to participate. Once this was confirmed, the dates and times of the interviews were scheduled. A telephonic reminder was sent to all interviewees a week prior to the scheduled interview, with 11 out of the 12 participants confirming their participation. All eleven interviews were conducted within participants' homes. In addition, data was extracted from participant responses to question 3, 5, 6 and 7 of the Client Evaluation forms, as it provided further information on whether participants' perceived PIACs as supportive, well prepared, knowledgeable, and reliable.

Data analysis

Thematic analysis on NVivo was used to transcribe data captured through interview notes and audio-recordings. An inductive approach was used to develop codes; through which themes on participants' perceptions of support received, and the PIAC's level of knowledge, preparedness, and reliability, were determined. Related responses from the Client Evaluation forms were manually entered on an IBM SPSS spreadsheet, upon which descriptive statistics determine the frequency with which participants perceived PIACs as supportive, knowledge, well-prepared and reliable.

Question 7: To what extent do PIACs implement the skills acquired through their training into their sessions?

Data collection procedure

M&E reports and Client Evaluation forms were manually examined to determine the extent to which PIACs were implementing their training during home visits. Criteria 7, 8, 11, 12, 14 and 15 of the M&E reports were examined, as these criteria assessed elements of PIAC training directly. In addition, participant responses to questions 4 and 6 of the Client Evaluation form provided data on participants' perception of PIACs level of knowledge and whether the perceived the information provided to them as helpful and useful.

Data analysis

M&E reports were analysed through NVivo. For criteria 7, 8 and 11, word frequency queries were run to determine the number of instances where the M&E social worker noted the level of PIAC knowledge, their communication, and use of clarification and reflection, respectively. This data was cross-referenced with a manual examination to identify if any mentions of these criteria were missed. Texts analysed included the direct wording of the criteria, as well as adjectives related to them. With criteria 12 and 14, thematic analysis with an inductive approach was used. This resulted in themes being developed to determine the extent to which PIACs were able to identify appropriate referral requirements and exercise boundaries, respectively. Finally, criteria 15 was manually examined to determine the frequency and way in which PIACs addressed obstacles during sessions. Responses to the Client Evaluation forms were entered onto an IBM SPSS spreadsheet, upon which descriptive statistics determined the frequency with which participants perceived programme information as helpful and useful, and PIACs knowledgeable.

Question 8: Are the participants satisfied with the service they received? What are the strengths and limitations they identified?

Data collection procedure

Data related to this evaluation question were extracted from the same semi-structured face-to-face participant interviews utilised in evaluation question 6. Therefore, the same procedure for approaching and recruiting interviewees, as well as how and where interviews were conducted, were followed. However, the data examined for this evaluation question related to participants' level of satisfaction with the programme. Responses to all questions in the Client Evaluation form were examined, as all questions were related to participant satisfaction.

Data analysis

Thematic analysis on NVivo was used to transcribe data captured through interview notes and audio-recordings. Codes were then developed using an inductive approach, upon which themes were developed to determine what participants perceived as the programme's strengths and weaknesses, whether they perceived the programme as having an impact on their lives, and whether they would recommend it to other mothers. Responses to the Client Evaluation forms

were entered onto an IBM SPSS spreadsheet, upon which descriptive statistics determined the proportions of participants satisfied with various aspects of the PIHVP.

Question 9: To what extent did participants engage with the PIACs (around the content) during home-visit sessions?

Data collection procedure

Parent Infant Information sheets were examined to determine the actual activities, screenings and demonstrations conducted during the evaluation period. Participant responses to these activities were then ranked according to a 3-Point Likert scale developed by the evaluator where rank code: 1 = no response; 2 = closed-ended response (yes or no); and 3 = open-ended response (yes/ no with explanation).

Data analysis

Programme activities, screenings and demonstrations requiring participant responses were entered onto an IBM SPSS spreadsheet with a row for each participant. Rank codes 1, 2 or 3 were then entered under each activity, screening, or demonstration, dependent on the participant's level of response. Descriptive statistics then determined proportions of participants who responded using open- and closed-ended answers, or where no response was captured.

Chapter 3: Results

This chapter outlines both the quantitative and qualitative results of all ten process evaluation questions. To facilitate the quantitative analysis, the evaluator consolidated all secondary data into an electronic database. The consolidation of data into one single spreadsheet to generate information and knowledge on the PIHVP, had not been done prior to this evaluation.

Question 1: Did the PIHVP beneficiaries recruited for the first 2019 programme cycle meet the eligibility criteria specified by programme?

Parent Infant Intake forms provided data on six of the PIHVP's ten eligibility criteria, namely whether women: were pregnant teenagers; had unplanned pregnancies, were at high risk for postnatal depression; had support from their partners; had experienced community violence; and lived in poverty. The latter three criteria were determined through proxy indicators measured by this data source.

Teenage pregnancy

A 'teenage pregnancy' is as a pregnancy occurring between the ages of 10 and 19 years and is a major contributor to ill-health and poverty among women (World Health Organisation, 2004). Across the evaluation period, only 20.3% of the 133 PIHVP participants were classified as teenage pregnancies. Most participants were older than 20 years; with 52.6% between the ages of 20 to 30 years, and 26.0% between the ages of 31 to 45 years. Table K1 in Appendix K further details the proportion of these age groups, expressed in frequencies.

Unplanned pregnancy

Pregnancies are considered 'unplanned' when a woman does not want to become pregnant at the time she did or did not want to become pregnant at any time in the future (Schwartz et al., 2012). Unintended pregnancies are associated with numerous poor child health and maternal outcomes, regardless of the pregnancy's outcome (Eisenberg & Brown, 1995). It was found that 64.3% (N = 126) of participants had unplanned pregnancies, with remaining 35.7% indicating their pregnancies were planned. Table K2 in Appendix K further details the proportion of planned and unplanned pregnancies, expressed in frequencies.

Support from partner

'Marital status' was used as a proxy to determine 'support from partner'. Marital status categories included single, married, and widowed. 'Single' consisted of two subcategories: 'attached' which indicated the mother is unmarried but in a relationship with the father; and 'unattached' which indicated the mother is unmarried and not in a relationship with the father. Schwartz and colleagues (2012) explain that when expectant and new mothers are not in a relationship with the child's father, they rarely receive any emotional and/or financial support from them. Therefore, the 'single and unattached' subcategory was specifically used as the proxy indicator for this criterion. The results found that only 23.1% of participants (N = 130) were 'single and unattached'. Participants who were 'single and attached' (45.4%) and married (31.5%) were more prevalent during the evaluation period. Table K3 in Appendix K further illustrates these proportions, in frequencies.

Relationship between 'teenage pregnancy', 'unplanned pregnancy' and 'support from partner' categories

A cross tabulation was run to determine whether participants' ages, their level of support, and the planning of their pregnancies, were contingent on another. Table 5 below expresses this relationship in proportions, as it pertains to the entire participant population.

Table 5

Contingency table of relationship between participants' pregnancy status, age, and marital status

Pregnancy status	Marital Status	Age Group			Total
		10 yrs. - 19 yrs.	20 yrs. - 30 yrs.	31 yrs. - 45 yrs.	
		%	%	%	%
Planned	Single and attached	0.0	18.2	4.5	22.7
	Married	0.0	43.2	22.7	65.9
	Single and unattached	4.5	4.5	2.3	11.4
		4.5	65.9	29.5	100.0
Unplanned	Single and attached	18.5	29.6	8.6	56.8
	Married	0.0	4.9	8.6	13.6
	Single and unattached	11.1	12.3	6.2	29.6
		29.6	46.8	23.4	100.0

A Chi-square analysis run on these results further found that planned pregnancies were significantly contingent upon the participants' age and marital status χ^2 (4, n = 44) = 17.11, $p < .05$, Cramer's V = .441, with a moderate effect size. Similarly, unplanned pregnancies were also found to be significantly contingent upon participants' age and marital status χ^2 (4, n = 81) = 13.54, $p < .05$, Cramer's V = .289, with a moderate effect size.

When variable categories are found to be significantly contingent on one another, their standard residuals need to be examined. Standard residuals greater than 1.96 and less than -1.96 are considered significant. The analysis found significantly more planned pregnancies among 10-19-year olds who were single and unattached (Z = 3.7). Similarly, there appeared to be significantly more unplanned pregnancies among 31-45-year married participants (Z = 2.8).

Level of risk for postnatal depression

The PIHVP uses the EPDS to screen participants for signs of postnatal depression. Three screenings are conducted across the programme's postnatal component. The first EPDS score was used to determine whether participants were at high risk for postnatal depression before starting the PIHVP. A score of 10 or more suggests the presence of mild to major depression symptoms, and scores of 13 or higher indicate that a mother most likely has postnatal depression. Results in Table 6 below show that only 14.2% (N = 120) of participants were likely to have postnatal depression, with a further 19.2% showing mild to major signs of depression. The remaining 66.7% were not considered at high risk for postnatal depression prior to starting the PIHVP.

Table 6

Frequencies of first EPDS scores of PIHVP participants (N = 120)*

EPDS score	*n*	%
13 and above	17	14.2
10-12	23	19.2
0-9	80	66.7
Total	120*	100.0

**Note. Missing 13 participant cases*

Community Violence

Community violence is predominantly experienced within areas characterised by high levels of poverty and unemployment. These communal characteristics are prevalent within communities situated on the Cape Flats. Khayelitsha, Nyanga and Hanover Park are among the ten communities on the Cape Flats that accounted for 42% of the Western Cape's entire murder rate (Charles, 2019). Data on experiences of community violence were not directly captured by the programme. Therefore, the areas in which participants lived were used as a proxy indicator, as most of them were notoriously violent.

A descriptive analysis revealed that more than half of the participants were from two communities - Mitchell's Plain and Imizamo Yethu, which accounted for 24.1% and 31.6% of the 133 PIHVP participants, respectively. The wide coverage of these communities was largely due to their area size, and that they had two PIACs operating within each them, as opposed to one. Table 7 below provides further information on the proportion of participants from other communities.

Table 7

Frequencies of residential areas in which enrolled PIHVP participants are situated (N=133)

Residential area	*n*	%
Mitchell's Plain	32	24.1
Khayelitsha	15	11.3
Imizamo Yethu	42	31.6
Hanover Park	16	12.0
Retreat	9	6.8
Nyanga	19	14.3
Total	133	100.0

Poverty

Wagstaff (2002) argues that a strong relationship exists between an individual's socioeconomic status and poverty. Socio-economic status is primarily determined through one's level of education and occupational status. 'Level of education' and 'occupation' were therefore used as proxy indicators to determine whether participants lived in poverty.

A descriptive analysis revealed that most participants were not formerly employed; with 83.1% (N = 130) classifying themselves as unemployed, and a further 7.7% (N = 130) classifying themselves as scholars. Table 8 below provides further information on the proportions of employment levels across all participants.

Table 8

Frequencies of employment level for enrolled PIHVP participants (N=130)*

Employment status	*n*	%
Scholar	10	7.7
Unemployed	108	83.1
Employed	12	9.2
Total	130*	100.0

**Note. Missing 3 participant cases*

In terms of their education, only 32.8% (*N* = 128) of participants had obtained a Matric level education, with a total of 27.3% (N = 128) of participants not reaching Grade 10 – the level at which scholars select more focused subjects in line with their desired career path. Table 9 below provides information on the proportions of education levels across all participants.

Table 9

Frequencies of education levels for enrolled PIHVP participants (N = 128)*

Education level	*n*	%
Grade 12	42	32.8
Grade 11	37	28.9
Grade 10	14	10.9
Grade 9	15	11.7
Grade 8	17	13.3
Below grade 8	3	2.3
Total	128*	100.0

Note. Missing 5 participant cases

The analysis of enrolled participants' characteristics showed that, of the six criteria measured by existing programme data sources, only three were satisfied – two of which were derived from proxy data. This means that the participants of the first 2019 PIHVP programme cycle did not fully meet the eligibility criteria specified by the programme and were therefore not closely aligned with the PIHVP's target population.

Question 2: What proportion of participants completed and dropped out of the PIHVP during the first programme cycle of 2019? What are the reasons provided for programme dropout?

Descriptive analysis showed that of the 133 enrolled participants, only 37.9% completed the full PIHVP, with a staggering 62.1% dropping out of the programme. These proportions are further illustrated in Table 10.

Table 10

Frequency of enrolled participants who complete the PIHVP (N = 132)*

Completed programme?	*n*	%
Yes	50	37.9
No	82	62.1
Total	132*	100.0

**Note. Missing 1 participant case*

Further analysis revealed that 50% of mothers indicated they were 'not available' to complete the full programme. It is the PIHVP's policy to make at least three attempts to contact a participant before they are considered as having 'dropped out' of the programme. Another commonly cited reason was participants moving out of their area. The programme strives to continue home visits with participants if they move within communities where the PIHVP operates. However, the 20.7% identified under this category did not move within PIHVP targeted areas, and their cases were therefore closed. Table L1 in Appendix L provides further information on the frequencies of reasons cited for programme dropout among participants.

A cross tabulation was run between participants' ages and their reasons for dropout to determine whether these variables were contingent on one another. Table 11 below expresses this relationship in proportions, as it relates to all enrolled participants.

Table 11

Contingency table of relationship between participants' pregnancy status, age, and marital status

Reason for dropout	Age Group			
	10 yrs. - 19 yrs. %	20 yrs.- 30 yrs. %	31 yrs.- 45 yrs. %	Total %
Mom cannot be found	0.0	2.4	0.0	2.4
Miscarriage/baby died	2.4	1.3	0.0	3.7
Mom went back to school	6.1	0.0	1.2	7.3
Mom returned to work	2.5	8.5	4.9	15.9
Mom moved out of area	3.7	13.4	3.7	20.7
Mom not available	9.8	20.7	19.5	50.0
	24.5	46.3	29.3	100.0

A Chi-square test then determined whether this relationship was significant. To report on this statistic, the assumption of expected frequencies in cells being more than five, needs to be upheld. This assumption was not met in this cross tabulation, therefore the Fisher's Exact Test (FET) was reported on instead to determine significance. The test found that reasons for programme dropout was significantly contingent upon participants' age, FET (n = 82) = 17.42, p < .05, Cramer's V = .367, with a moderate effect size. The standard residuals indicate significantly more participants within the 10-19-year age group cited 'returning to school' as their reason for dropout, as compared to participants in other age groups (Z = 2.9).

In summary, the results indicated that a large proportion of participants dropped out of the PIHVP during the evaluation period. Of the categories identified, 50% of participants were recorded as 'not available' to complete the programme. Given the ambiguity of this category, it cannot be determined whether participants dropped out due to the programme itself, or factors external to it.

Question 3: To what extent did the PIHVP meet its targeted number of participants? What are the reasons for over/under coverage?

Qualitative analysis results found that: a) the PIHVP did not meet its annual recruitment target for their 2019 annual programme cycle; and that b) the reasons for this were both internal and external to the programme. Quotes which speak directly to these themes are included in this section. Full interview quotes for this evaluation question are provided in Appendix M.

A. PIHVP not reaching target participant intake

All three interviewees agreed that the annual participant recruitment target was 300, with interviewee 2 further explaining the reasoning behind this value:

"We aim for 300 per year… we try to have each counsellor finish 30 moms from April to April…"

(Interviewee 2)

It was discovered that the PIHVP was unable to reach this intended target for the 2019 programme cycle. Statistics provided by two interviewees further highlight this:

"As of end March, the programme only managed to enrol 182 participants…"

(Interviewee 3)

"…the last numbers I got was that we finished 159 per end of this quarter, September."

(Interviewee 2)

Of note here, the enrolment figures embedded in the quotes above relate to different time periods during the 2019 programme cycle. Despite this, it evident that the programme did not

manage to reach its targeted intake. Although, the other interviewee did not have exact figures to report on, she agreed with this.

B. Reasons for not reaching programme target

The interviews revealed several challenges that hindered the programme from reaching its intended recruitment target. These challenges were both internal and external to the programme.

Internal challenges ranged from the PIACs themselves:

"… some of the counsellors find it easier to approach moms than others."

(Interviewee 1)

"They walk to their visits which takes a lot of time…we can't actually expect them to walk for hours forever. So that has impacted on our numbers."

(Interviewee 2)

To the programme's management of PIAC time on training versus conducting actual home visits:

"Training workshops and capacity building of PIACs take away a lot of time from home visits"

(Interviewee 3)

"…this year we suddenly got to have a whole week of trauma training, which obviously benefits them (PIACs) *hugely both work and personally, but then maybe we* (programme management) *don't sit down and actually count that this actually means 40 less visits per day, so its 200 visits lost in a year."*

(Interviewee 2)

Another interviewee felt that PIACs having to recruit their own participants may also be a hindrance to the programme's ability to reach its intended enrolment target:

"…they (PIACs) *actually have to get their own clients… and I'm not sure they feel supported enough by the top* (management) *in getting recruitment pathways easier…we've never really*

managed to have a lasting system where the clinic sisters are on board enough to actually write out the referral and get them to us…"

(Interviewee 2)

In the case of external challenges, community violence was cited as the main reason for not reaching the intended enrolment target:

"…it's hard to work in these communities, and when bullets are flying, we tend to tell our counsellors that safety comes first - don't go to work."

(Interviewee 2)

Furthermore, the implications of working within informal settlements have also been cited as having a negative impact on enrolment figures:

"…often in the informal settlements, finding somebody is very difficult and it often requires the counsellor to have made an arrangement with the new recruit to meet at a certain point so they can show them where they live. And what often happens is they (recruits) *are not where they should be…"*

(Interviewee 1)

"… like Mary, her whole cohort* (of participants) *relocated… and then it* (participant cases) *doesn't count, so that's unfortunate like maybe in the past our numbers looked better because we didn't have that."*

(Interviewee 2)

"…you get people's houses who have burnt down. Then the whole demographic changes of the areas that you (visit)*… I mean Imizamo Yethu for instance, where a whole section is wiped out for one counsellor."*

(Interviewee 3)

In summary, the PIHVP was unable to reach its annual participant enrolment target during the 2019 programme cycle due to external factors, and the programme's own capacity and

management constraints. Based on engagements with programme staff, it appears that increasing the capacity of - and support given to – PIACs, would significantly improve the programme's ability to achieve enrolment target.

Question 4: Did the participants receive the home-visiting sessions at the duration and frequency prescribed by the programme model?

Frequency of home visits

For antenatal sessions, PIHVP's standards indicate that participants enrolled before 32 weeks gestational age, should receive home visits that are scheduled one month apart. Participants enrolled after 32 weeks gestational age, are required to receive weekly home visit sessions. Table 12 below illustrates the frequencies with which antenatal sessions were delivered to participants during the evaluation period.

Table 12

Frequency of time intervals between antenatal sessions (N = 50)

Programme component	Time interval			Total
	<15 days	15 – 31 days	> 30 days	
	%	%	%	%
Antenatal session				
AN1 to AN2	68	14	18	100
AN2 to AN3	60	32	8	100
AN3 to AN4	70	22	8	100
AN4 to AN5	68	26	6	100

The results in Table 12 indicate that antenatal sessions were largely administered to participants within less than 15 days between each home visit session, with the time interval between antenatal session 3 and 4 (70%) experiencing the highest frequency of this. Given that most participants were enrolled onto the programme prior to 32 weeks gestational age, these

results show that the PIHVP was not administering the antenatal component at its intended frequency. Based on the PIHVP's design, participants should spend approximately four months of their pregnancy on the programme. However, with time intervals of 15 days or less, this duration is cut down to half of that – to approximately two months.

The 15 postnatal sessions of the PIHVP are grouped according to the prescribed time intervals between home visits. Postnatal sessions 1 to 9 have a prescribed time interval of seven days, postnatal sessions 10 to 13 have a 14-day time interval, and postnatal sessions 14 to 15 have a time interval of 28 days. Table 13 below outlines the programme's adherence to the seven-day interval grouping. A key finding here is that only 12% (N = 50) of sessions were conducted within the prescribed time interval. The results indicate that most sessions (58%) were conducted between 8 to 12 days.

Table 13

Frequency of time intervals for postnatal sessions with 7-day time interval (N=50)

Time interval	*n*	%
7 days	6	12
8-12 days	29	58
More than 12 days	15	30
Total	50	100

Analysis done on postnatal sessions with a 14-day time interval showed that 34% (N = 50) of these sessions were conducted below the prescribed benchmark, with a further 26% conducted at a time interval frequency above 20 days. Table 14 below provides further frequencies for this time interval group.

Table 14

Frequency of time intervals for postnatal sessions with 14-day time interval (N=50)

Turnaround time	*n*	%
Less than 14 days	17	34
14 days	7	14
15-20 days	13	26
More than 20 days	13	26
Total	50	100

Results in Table 15 below indicate that 72% (*N* = 50) of home visit sessions within the 28-day time interval grouping were conducted well below its prescribed benchmark, with the remaining 28% (*N* = 50) exceeding it. Considering the frequencies across all time interval groupings, it evident that the PIHVP had a low level of adherence to the prescribed frequency with which home visit sessions should be delivered.

Table 15

Frequency of time intervals for postnatal sessions with 28-day time interval (N=50)

Turnaround time	*n*	%
Less than 28 days	36	72
More than 28 days	14	28
Total	50	100

Duration of home visits

Findings showed that on average, unplanned visits lasted for 47 minutes (*SD* = 7.58), whereas planned visits lasted for 50.83 minutes (*SD* = 10.21). Table 16 below further depicts the minimum and maximum duration of home visits

Table 16

Summary of average duration of PIHVP home visit sessions (N = 11)

Variable	*n*	M	SD	Min	Max
Unplanned visits	5	47.00	7.58	40	60
Planned visits	6	50.83	10.21	40	60

The prescribed duration of home visits as per the PIHVP's design is 60 minutes. Based on the abovementioned findings, the maximum deviation from this was therefore 13 minutes. When interpreting this deviation, consideration should be given to the presence of the M&E social worker during these home visit sessions, as this may have contributed to its occurrence.

Amount of home visits

Analysis of the Client Evaluation forms found that all participants (100%) perceived PIACs as adhering to their scheduled home visits (Table N1 in Appendix N). When considering this result, it is important to note that these self-administered forms were completed in the presence of PIACs. The implications of this are results with a high likelihood of social desirability bias. Further discussion on this is provided in evaluation question 6. In the interim, this result should be interpreted with caution.

In summary, the results indicate that participants did not receive the intended frequency and duration of the PIHVP. The reasons for this were not sufficiently documented by the programme. Furthermore, with the possibility of social desirability bias within the Client Evaluation forms, data from an alternative source is required to triangulate these findings before any conclusions on this are made.

Question 5: Did PIACs complete and conduct all programme activities, developmental screenings and demonstrations as intended?

Examination of the Parent Infant Information sheets found that data had been inconsistently captured during the evaluation period. However, this data was still analysed, as no

other alternative data was available on adherence for this period. The evaluator considered this data on the assumed patterns of programme adherence to be a starting point for more rigorous data to be built on. 'Adherence', in this instance, was determined when activities were explicitly mentioned as being completed in the data source.

To highlight the stark contrasts in adherence, the following standards were applied: 'high' levels of adherence were considered as activities completed at a rate of 70% and above, 'moderate' adherence as activities completed at rates of between 40% and 69%, and 'low' levels of adherence as activities completed at a rate of below 40%. There were also instances where no data was captured at all. Table 17 and 18 below provide summaries of the presumed levels of programme adherence for the antenatal and postnatal components of the PIHVP, respectively. The full results of all twenty sessions are reported in Appendix O.

Antenatal

The findings indicate that PIACs were conducting most antenatal sessions at high and moderate adherence rates. Sessions where adherence levels were above 90% focused on topics related to the mother's health (session 1), stages of foetal development (session 2), the growing foetus and mother's dreams about her baby (session 3), and labour and birth (session 4). Low levels of adherence were seen on topics related the state support grant (session 2), the infant's siblings (session 3), mothers' employment arrangements (session 4), and conception and home coming (after the birth) (session 5). Based on the analysis, no data was captured on two activities – one of which addresses mothers' queries about labour and birth (session 5).

Postnatal

Postnatal sessions were adhered to in more varying degrees than antenatal sessions. It appeared that PIACs conducted developmental screenings and demonstrations at high levels, typically above 80%. Instances of high adherence to discussion and input activities were also seen across eight of the fifteen postnatal sessions – which primarily focused on the mother's birth story (session 1) and infant feeding (session 9 – 15). The emphasis on these components, however, jeopardised adherence to most of the second, third and fourth postnatal activities, which primarily focused on topics related to infant feeding, sleeping, and crying and consolability

(sessions 1-15). Based on the analysis, no data was captured for ten activities – two of which addressed the 'baby blues' and the mother's concerns for her baby (session 1).

In summary, programme activities across both components were conducted at varying degrees of adherence, more so for the postnatal component. Generally, screenings, demonstrations and the first activities of home visit sessions had high levels of adherence, while subsequent activities were mostly conducted at low levels of adherence during the evaluation period.

Table 17

Summary of adherence rates for antenatal sessions (N = 50)

Antenatal	**Level of Adherence**	**Programme activities**					
		Activity 1	**Activity 2**	**Activity 3**	**Activity 4**	**Activity 5**	**Screening**
Session 1	**High**	**100%**					
	Moderate		**58%**				
	Low						
	None						
Session 2	**High**	**92%**	**72%**				**88%**
	Moderate			**68%**			
	Low				**10%**		
	None						
Session 3	**High**	**82%**		**100%**	**100%**		
	Moderate						
	Low		**6%**				
	None						
Session 4	**High**	**94%**					
	Moderate			**44%**			
	Low				**2%**		

	None		**0%**				
Session 5	**High**						
	Moderate		**54%**	**68%**			
	Low	**38%**			**14%**		
	None					**0%**	

Key: **None** = 0% | **Low** = < 40% | **Moderate** = 40% - 69% | **High** = 70% - 100%

Table 18

Summary of adherence rates for postnatal sessions (N = 50)

Postnatal	Level of Adherence	Activity 1	Activity 2	Activity 3	Activity 4	Activity 5	Screening	Demonstration
Session 1	**High**	**100%**						
	Moderate							
	Low			**26%**	**24%**			
	None		**0%**			**0%**		
Session 2	**High**						**100%**	
	Moderate							
	Low							
	None	**0%**	**0%**	**0%**				
Session 3	**High**						**90%**	
	Moderate	**64%**						
	Low		**34%**	**26%**	**22%**			
	None							
Session 4	**High**							**94%**
	Moderate							

	Low	4%	26%	18%	8%			
	None							
Session 5	High						96%	
	Moderate							
	Low	6%						
	None		0%	0%				
Session 6	High						90%	
	Moderate							
	Low	38%	30%	20%				
	None							
Session 7	High							84%
	Moderate							
	Low	26%	22%	8%				
	None							
Session 8	High						100%	
	Moderate							
	Low							
	None	0%	0%	0%				

Postnatal	Level of Adherence	Activity 1	Activity 2	Activity 3	Activity 4	Activity 5	Screening	Demonstration
Session 9	High	78%						
	Moderate		54%					
	Low			30%	18%			
	None							
Session 10	High	92%						
	Moderate		42%					
	Low			38%	20%			
	None							
Session 11	High	78%						
	Moderate							
	Low		34%	26%	16%			
	None							
Session 12	High	94%						
	Moderate		50%	42%				
	Low				20%			
	None							

Postnatal	Level of Adherence	Activity 1	Activity 2	Activity 3	Activity 4	Activity 5	Screening	Demonstration
Session 13	**High**	**92%**					**96%**	
	Moderate		**54%**					
	Low			**34%**	**24%**			
	None							
Session 14	**High**	**78%**						
	Moderate		**54%**	**46%**				
	Low				**36%**			
	None							
Session 15	**High**	**84%**						
	Moderate		**58%**					
	Low			**38%**	**28%**			
	None							

Key: **None** = 0% | **Low** = < 40% | **Moderate** = 40% - 69% | **High** = 70% - 100%

Question 6: How did participants perceive PIACs in terms of the support they provided and their preparation level, knowledge, and reliability?

Table N1 in Appendix N outlines participants' responses to all eight questions included in the Client Evaluation form. Analysis of responses to questions 3, 5, 6 and 7 found that all 50 participants (100%) perceived PIACs as well-prepared, knowledgeable, and reliable, with a further 98% considering PIACs as supportive, during the evaluation period.

Burns and colleagues (2008) argue that self-administered questionnaires are best completed by respondents without an interviewer or programme staff member present. As this was not the case when the Client Evaluation forms were administered, it introduced a high likelihood of social desirability bias. This response bias occurs when survey respondents answer questions in a way which they believe will be viewed favourably by others. When reviewing the highly positive results of this source, it is evident that having the PIAC present while completing the evaluation form may have resulted in participants over-reporting 'good' PIAC behaviour. Despite having this useful mechanism in place, the PIHVP's implementation of it had detrimental effects on the value of its data. Therefore, these results were triangulated with participant interviews to validate them.

With the participant interviews, questions were focused on the same four criteria as the Client Evaluation form. The results found that all participants perceived PIACs to be a) supportive; b) well prepared for their sessions; c) knowledgeable about session topics; and d) adherent to their scheduled appointments with them.

A. PIACs are supportive

The theme of PIACs being perceived as supportive by participants emerged a total of 14 times across all eleven participant interviews.

Five of these participants categorised this support as emotional, which emerged eight times across these interviews. The following quotes substantiate this theme:

"…all of these things I never shared with anyone, but I shared it with Mary she's the one who tried to give me strength."*

(Interview 1)

"…she would encourage me a lot. She gave me support. I felt very happy when I was with her."

(Interview 6)

Participants perceiving PIACs as a mother figure emerged as a sub-theme to the category of emotional support. This theme emerged six times across four of the five abovementioned interviews. The quotes below validate this theme:

"She was more like a mother… like a mother's opinion; that's (the) *kind of person she was to me."*

(Interview 10)

"I feel she was more like a friend and a mother the time she was doing (the sessions) *…and she was a nice person…because we talked about many things besides the baby."*

(Interview 5)

Two participants also acknowledged PIACs providing them with social support during their time on the programme. The following quotes extracted from these interviews substantiate this theme:

"Sometimes she used to get me food… I have a small child, no money, no nothing. She used to help me, one day she brought me clothes for my child…"

(Interview 1)

"…I did not have clothes for my baby. I did not have soap. But she brought me stuff from Johnson & Johnson, she brought me clothes for my baby. That's one thing I'm so grateful for, because I was so stressed."

(Interview 8)

B. PIACs well prepared for sessions

PIACs being perceived as prepared for their home visit sessions emerged a total of 13 times across eight interviews. Most of these instances related to home visit sessions being well organised. A quote extracted from one of these interviews validate this theme:

"Every session (was organised), *that's how I saw it, every session because she would explain to me: 'Okay, the next session this is what we* (are going to) *do'; and when it comes to the next session, that's what aunty Diana* brought."*

(Interview 4)

C. PIACs knowledgeable about session topics

The theme of PIACs being perceived as knowledgeable by participants emerged a total of 12 times across all eleven interviews. The knowledge referred to by participants related specifically to the topics discussed during home visit sessions. The selected quotes extracted from these interviews further substantiate this theme:

"Yes, I saw her as someone who knew, who had knowledge of what she came to do. Because she would tell me how to wash the child, how to breastfeed the child, how to hold the child if the child is too small. She seemed to know what she was doing."

(Interview 8)

"Yes (she was knowledgeable)*, because sometimes I also didn't understand certain stuff but then she would start from over just to make me understand more of that situation"*

(Interview 9)

D. PIACs seen as reliable by participants

Furthermore, PIACs perceived as being reliable by participants emerged 13 times across all eleven interviews. This level of reliability related specifically to PIACs adherence to scheduled home visit appointments. The selected quotes extracted from these interviews further substantiate this theme:

"…if she gave me an appointment that she's coming Thursday or Tuesday, she was coming that day unless I tell her not to come. Sometimes for me when I'm not available, we would communicate, and we would shift the appointment."

(Interview 2)

"She knows her time. When she says 9 o clock, it's 9 o clock. And she used to be early (sometimes)*."*

(Interview 1)

The results derived from participant interviews indicate that there were minimal divergent views from the Client Evaluation form data. Therefore, it can be assumed that participants perceived PIACs as supportive, prepared for sessions, knowledgeable about session topics, and reliable during the evaluation period. However, the poor construction and administration of the Client Evaluation form still needs to be reviewed. This will be further examined in the Discussion chapter of this paper.

Question 7: To what extent do PIACs implement the skills acquired through their training into their sessions?

Perspective of M&E social worker

From the M&E reports, criteria 7, 8, 11, 12, 14 and 15 were examined as they speak directly to elements of PIAC training.

Criteria 7: PIAC knowledge of session topic

Analysis of the eleven M&E reports found that the most commonly cited adjectives to describe the level of knowledge PIACs displayed during their sessions were 'vast' which appeared twice, 'good' which appeared three times, and 'adequate' which appeared four times. Further manual examination found that the M&E social worker identified PIACs as knowing programme content "off by heart", twice. One report did not provide any direct comment on the level of knowledge displayed by the PIAC. These findings show that PIACs displayed acceptable levels of PIHVP content knowledge across the evaluation period.

Criteria 8: PIAC communicating clearly, sensitively, and directly

For criteria 8, the results found that 'clear' communication was used four times; 'sensitive' communication was used once; a combination of 'clear and sensitive' communication was used four times; and a combination of 'clear, sensitive, and direct' communication was used twice. 'Direct' communication was never used in isolation during the evaluation period. These

results show that although PIACs largely used a combination of communication techniques when engaging with participants, they do not frequently employ a combination of clear, sensitive, and direct communication during home visit sessions. These findings were confirmed through manual observation of the M&E reports of synonyms relating to clear, sensitive, and direct communication.

Criteria 11: PIAC ability to use clarification and reflection techniques

The results found that PIACs used clarification three times; reflective techniques twice; and a combination of reflective and clarification techniques three times. PIACs did not utilise reflection nor clarification on three occasions. Manual examination of these reports confirmed these findings. This indicates that reflection and clarification techniques were largely applied throughout the evaluation period. However, they were seldomly used simultaneously during home visit sessions.

Criteria 12: PIAC ability to identify appropriate referral requirements

Thematic analysis found that all referrals during the evaluation period were to local clinics; with one referral including a recommendation to see a social worker as well. Referrals to local clinics were largely linked to infant health, with only one related to pregnancy health. Of the infant health referrals: two were linked to infant constipation; one to infant's coughing and proper formula feeding measurements; and one referral not listing any specific reasons. From the reasons listed, it is evident that the referrals made by PIACs were appropriate.

Criteria 14: PIAC ability to exercise boundaries

Thematic analysis found that PIACs largely had the ability to exercise and maintain a professional boundary between themselves and participants. This ability was displayed in various ways, namely: providing information without being prescriptive; using non-judgemental questioning styles; not sharing personal beliefs; and respecting mothers' infant feeding choices (breastfeeding versus bottle feeding). There was one instance of possible transference – where the PIAC was visibly affected by a participant's domestic circumstances. However, it was noted by the M&E social worker that this was not noticed by the client. Therefore, it can be reasonably assumed that PIACs adequately demonstrated the ability to exercise boundaries in their sessions.

Criteria 15: The way PIACs address obstacles which interfere with the session

Manual examination of the eleven M&E reports found that there were only three occasions in which PIACs experienced session hindrances. Of these three, only two reports detailed exactly how PIACs addressed these obstacles. In one case, the baby cried during the session and the PIAC suggested ways to calm her; in the other case, unsolicited advice on remedies for infant constipation was given by the participant's mother, upon which the PIAC politely suggested that breastmilk is one of the best remedies for this. Despite the limited occurrence of obstacles during sessions, it is evident that when they were present, PIACs handled them in a professional manner.

Perspective of participants

The results provided in Table N1 (Appendix N) on questions 4 and 6 of the Client Evaluation form indicate that all 50 participants (100%) perceived the information provided by PIACs as helpful and useful to them as parents; and that PIACs were knowledgeable, respectively. However, as previously concluded by evaluation questions 4 and 6, the results of this data source should be interpreted with caution.

Despite the results indicating that both the participants and M&E social worker believed PIACs implemented their training during home visit sessions, the problematic administration of the Client Evaluation forms means additional data from participants is required to confirm their view on this issue, before any conclusions can be made.

Question 8: Are the participants satisfied with the service they received? What are the strengths and limitations they identified?

Analysis of the Client Evaluation forms indicated that all 50 participants (100%) believed the programme improved their parenting and would recommend the programme to other mothers. All participants (100%) also considered PIACs to be well-prepared, knowledgeable, and as providers of helpful and useful information. Of the 50 participants, 98% believed the PIHVP aided in their child's development and felt supported by PIACs during their time on the programme. These results are further outlined in Table N1 (Appendix N).

Participant interviews were used to triangulate the highly positive results outlined above. The results of these interviews found that: a) participants cited the curriculum topics and

counselling received from PIACs as the programmes strengths, and the programme's duration as its weakness; b) participants believed the programme impacted their (maternal) mental health state and parenting skills; and that c) all participants would recommend the PIHVP to other mothers. Quotes directly related to themes were included in this section. Full interview quotes for this evaluation question are provided in Appendix P.

A. Curriculum topics and PIAC counselling seen as programme's strength

The theme of curriculum topics cited as being the programme's strength emerged 13 times across nine of the eleven interviews. Quotes extracted from some of these interviews substantiate this theme:

"The way I must look after my baby, as in rubbing her out, checking where it's sore…her cries, basically everything about her…everything (all session topics) *helped me."*

(Interview 9)

"How to massage the baby, and how to help the baby when they have stomach cramps and everything else I learnt was very helpful."

(Interview 3)

"The pictures of the foetus and answering the questions that I had of the umbilical cord tangling around the baby's neck and all those things… getting answers to the questions that I had to everything was good."

(Interview 4)

The counselling participants received from PIACs was also viewed as a programme strength, with this theme emerging three times across three interviews. The quotes below validate this theme:

"If I wasn't there (at the MOU) *that day, and Veronica* wasn't there, I wouldn't have gotten the kind of help that Veronica* offered me..."*

(Interview 10)

"… the impact that she (PIAC) *had on me, I believe that she has the same impact on other mothers because it really helped me."*

(Interview 4)

The current length of the programme considered as its shortcoming, emerged five times across five interviews with this slightly branching out to the duration of home visit sessions. This, however, only emerged from one interview. The first three quotes (Interview 3, 7 and 9) addresses the issue of programme length, while the fourth quote (Interview 4) addresses the duration of home visit sessions:

"I would say that the period should be longer, maybe until the baby turns 1 years old? Because when the baby turns 1, there is other stuff and then we also need help."

(Interview 3)

"I told her (PIAC) *she must continue to come after 6 months…like for 1 year at least."*

(Interview 7)

"…some mothers are still in a state of depression, stress or something like that. Maybe you learnt (how to deal with it) *in the programme, but at that moment it just slips your mind. So, I think it should stretch to 1 year for some parents, just to check up on the child and the mother."*

(Interview 9)

"Besides making (the programme) *longer, maybe* (make) *the* (session) *hours a little bit more? Maybe an hour and a half? Because sometimes we get into conversation and then time passes by so quickly."*

(Interview 4)

B. Participants perceptions of programme's impact

Participants perceiving the programme as having an impact on their lives emerged ten times across nine interviews. The sub-theme of the PIHVP impacting participants' parenting skills emerged seven times within six of these interviews. Quotes extracted from some of these interviews validate this theme:

"The programme helped me raise my child, with breastfeeding my child, with everything."

(Interview 6)

"Yes, (the programme) *has changed me, because now I know what to do with my children when I'm raising them. It has changed my parenting."*

(Interview 8)

An additional sub-theme indicated that the PIHVP impacted on the participant's mental health. This, however, only emerged once from one interview. The quote below validates this:

"(The programme) *really had an impact. When this programme was introduced to me, I really opened up, so for me it was just like really a relief just to get all of those things out that was stressing me during the pregnancy."*

(Interview 4)

C. High recommendation of the PIHVP to others

Finally, emerging across all eleven interviews was that participants would, or already have, recommend the programme to other mothers. Quotes extracted from some of these interviews substantiate this theme:

"Yes, I will recommend it (the programme) *to other women. It is helpful and encouraging."*

(Interview 6)

"…even when I'm at the clinic and I see a pregnant woman, I tell her about the programme. I used to have a (Parent Centre) *card that I would give to pregnant woman."*

(Interview 8)

"I always do (recommend the programme)*, every day."*

(Interview 9)

The results derived from participant interviews indicate that there were minimal divergent views from the Client Evaluation form data. Therefore, it can be assumed, to a large

extent, that participants were satisfied with the PIHVP. However, as previously mentioned, there remains a need to review the content and administration of Client Evaluation forms. This will be addressed in the Discussion chapter of this paper.

Question 9: To what extent did participants engage with the PIACs (around the content) during home-visit sessions?

With many of the PIHVP session activities centred on discussion and input between PIACs and participants, the evaluator initially set out to determine the extent to which mothers participated in the PIHVP through the Parent Infant Information sheets. Despite being designed to capture this type of data, poor data capturing during the evaluation period hindered this process. The implications of this, and recommendations to correct it, are discussed later in this paper. Instead, a descriptive analysis was run on how PIACs captured this type of data to determine whether any data capturing patterns could be identified. A summary table of the frequencies of these responses across all 20 home visit sessions are provided in Table Q1 (Appendix Q).

Antenatal sessions

The analysis found that PIACs appeared to capture a high frequency of open-ended communication during session 1 (84%) and session 2 (88%), with a moderate level of this seen during session 4 (52%). Furthermore, a high and moderate frequency where no responses were captured were noted for session 3 (76%) and 5(62%), respectively.

Postnatal sessions

Results indicated that PIACs captured a high frequency of open-ended communication for only four out of the 15 postnatal sessions, with session one being the only session that reflected this across all 50 participant cases (100%). Across the remaining sessions, PIACs captured what appeared to be more closed-ended dialogue between themselves and participants, with high levels of this seen in postnatal session 2 (72%). There was also a steady frequency of no responses captured, particularly across sessions 11 (50%), 12 (42%) and 14 (40%).

In summary, the mixed results indicate that no conclusive patterns could be determined in terms of how communication during programme sessions were captured by PIACs. Further

research into these data capturing patterns are required to determine whether they were random or not.

Chapter 4: Discussion

In this chapter, the findings of the process evaluation are discussed in line with two broad components of programme implementation – service utilisation and programme fidelity. Data deficiencies linked to certain data sources are also discussed. The limitations of the evaluation, and its contribution to knowledge, are then outlined.

Level of service utilisation

Service utilisation concerns the extent to which participants utilise the services of a programme. Its two main focuses are coverage and bias. 'Coverage' concerns the extent to which a programme has reached its intended population, as specified by the programme's design. Rossi and colleagues (2004) argue that not many social programmes can achieve 'full coverage', hence 'bias' becomes an issue. 'Bias' is concerned with whether certain subgroups of a population participate in greater proportions than others.

Coverage of the intended PIHVP population

The PIHVP has eligibility criteria in place to determine whether participants are characterised as 'vulnerable mothers' – who are their intended population. This mechanism was used by the evaluator to determine whether the actual beneficiaries of the programme aligned with its intended population, hence determining its 'coverage'.

Analysis of this process found that it had been unsystematically implemented. Participants were measured against these criteria after they had already been enrolled onto the programme, as this data was collected during the first antenatal session. The analysis further found that only six of the ten eligibility criteria were measured by the programme, with the current data collection tools only able to measure three of these criteria directly. Salkind (2010) explains that incorrectly implementing eligibility criteria has implications on a programme's feasibility and decreases its chances of finding a true association between exposure to the intervention, and outcomes.

The incorrect implementation of the eligibility criteria, in turn, had a direct influence on the type of participant enrolled onto the programme during the evaluation period. Of the six eligibility criteria measured, the actual beneficiaries only satisfied three. The results found that most enrolled mothers lived in poverty, had unplanned pregnancies, and were assumed to have

experienced community violence as they lived in low-income communities with high rates of violent crime. With the large remainder of eligibility criteria not being fulfilled and/or measured, the PIHVP had significant 'under coverage' of its intended population among its actual beneficiaries. According to Stufflebeam and Coryn (2014), the main implication of under coverage is that it may result in incorrect inferences being made about the programme. Bernard and colleagues (2013) further found that programmes who do not reach their intended audience cannot influence them in any way. Analyses run on programmes in this situation are more likely to result in it being wrongfully deemed ineffective, consequently putting the intended population in a position where they may not receive any intervention at all (Holtgrave, 1998). Radey (2018) explains that vulnerable mothers benefit more from parenting programmes than mothers who are not, as it acts as a protective factor against psychological distress and poor parenting practices that are indicative of their weak support systems and socio-economic contexts. Therefore, not receiving a programme such as the PIHVP would be a great loss for these mothers.

Low levels of participant retention

The evaluation further found a high level of participant dropout during the evaluation period. High participant dropout can confound the programme's outcomes (Ozbek, Gencer, Mustan, 2018), its effectiveness, and waste valuable mental health resources (Frairs & Mellor, 2009). Furthermore, it brings into question the feasibility of delivering the programme (Williams, Hoare, Owen & Hutchings, 2019). However, a study by Rostad, Moreland, Valle and Chaffin (2017) found that this is a common occurrence among parenting programmes; with their study showing 50% of parents do not complete full parenting interventions.

Nevertheless, it remains imperative to determine what causes this participant dropout. The results found that half of participants cited 'not (being) available' as their reason of dropping out. Aside from it being the most prevalent, this category is also the most ambiguous, as the programme currently does not document exactly why these participants were 'not available'. This ambiguity compromises the chances of developing specific participant retention strategies for the PIHVP.

Axford, Lehtonen, Kaoukji, Tobin and Berry (2012) suggest that parenting programmes should work as hard at keeping their participants engaged in the programme, as they do recruiting them. Strategies that enable this include regular telephonic communication with

parents to remind them of upcoming sessions, updating them on sessions they have missed, and following up on reasons for missed sessions (Axford et al., 2012). Another retention strategy common among parenting programmes are incentives – either in the form of cash or vouchers. The effectiveness of such incentives, however, has been mixed (Gasden, Ford & Breiner, 2016). Therefore, the evaluator suggests the PIHVP investigate which retention strategies are the most feasible given the context and capacity of both their programme and their intended population.

Low levels participant enrolment

Results of the process evaluation indicated that the PIHVP did not reach its intended participant enrolment target for 2019. Low programme recruitment has implications on the feasibility of delivering parenting programmes, and its sustainability in the long-term (Williams, Hoare, Owen & Hutchings, 2019).

In addition, the results highlighted two issues hindering the PIHVP from attaining their target – their recruitment strategies and community violence. In its design, the PIHVP identified two main recruitment strategies – clinic talks in local MOUs, and referrals from health professionals and other NPOs operating within PIHVP-target communities. The latter has not yielded many recruits over the past few years due to a breakdown in contact between the PIHVP and other organisations, and reluctance from certain health professionals to do referrals as it was perceived as additional work to them. Clinic talks, although more successful than referrals, were not sufficient to reach the PIHVP's enrolment targets either. This prompted a new strategy among PIHVP staff – door-to-door recruitment. Although PIHVP staff saw this as a viable alternative, the prevalence of community violence is a barrier to this strategy. When there is a flare up of gang violence, PIACs are advised to stay at home for their own safety. Community violence therefore not only restricts door-to-door recruitment, but also recruitment through clinic talks, as PIACs are not able to walk to local MOUs to conduct them.

A systematic review by Axford and colleagues (2012) found that one of the best ways to improve programme recruitment rates is by securing endorsement of the programme by influential organisations and people within the community. With this already being an identified recruitment strategy, it is suggested that the PIHVP strengthen their pre-existing relationships with these role players to develop feasible recruitment strategies that benefit all parties. Further

recommendations on increasing participant enrolment are outlined in the recommendations section of this paper.

Bias among PIHVP participant population

Discussions with PIHVP staff members found that the programme had a tendency of enrolling all mothers who showed interest in it. This, in addition to the eligibility criteria not being used as a screening tool, resulted in under coverage bias among the PIHVP participant population. This was evident as there were particular sub-groups participating in greater proportions than others, during the evaluation period. This included mothers between the ages of 20 to 30 years old, who were at low risk for postnatal depression, that were either married or in committed relationships with their child's father, who were unemployed and had unplanned pregnancies. Aside from the latter two characteristics, this sub-group of participants does not embody a 'vulnerable' mother according the programme's criteria. This under coverage bias is problematic, as underrepresentation of the intended population means the findings extrapolated from this sample cannot be generalised across the larger PIHVP population, as this sample may be significantly different from people in the larger, intended population (Lavrakas, 2008).

Deficiencies in secondary data sources

During the evaluation period, the PIHVP were already capturing copious amounts of participant data for administrative purposes. However, the methods utilised to capture this, were problematic. The evaluator found several deficiencies within the programme's data, particularly relating to participants' perceptions of, and responses to, the programme. These data deficiencies were evident in two sources - the Client Evaluation Form and Parent Infant Information Sheets.

Client Evaluation Forms

The evaluator planned to use this source to determine participants' opinions on the amount of sessions they received (*exposure and/or dosage of the programme*), their perceptions of PIACs and the extent to which they implemented their training (*quality of the programme*), and their satisfaction with the programme (*participant responsiveness*). However, the poorly constructed questions and restrictive response options ('yes', 'no', 'sometimes') lead all 50 participants to give extremely positive ratings on all criteria measured. Furthermore, a high

likelihood of social desirability bias was suspected, as these forms were not anonymised in any way and were completed during home visit sessions with PIACs present.

According to Stalkin (2010), when social desirability bias is present in self-report questionnaires, it compromises the validity of its results. Given the programme's large participant population and the geographic areas it covers, this data source is a cost-effective way of obtaining data from a more representative sample, and its data would be easier to analyse, compared to participant interviews (Sinclair, O'Toole, Malawaraarachchi & Leder, 2012). It is therefore recommended that this form and its data collection method be anonymised, as this has been shown to promote greater disclosure of undesirable behaviour (Murdoch et al., 2014). Consequently, the form will produce results of higher quality that will be considered more credible (Kelley, Clark, Brown, Sitzia, 2003).

Parent Infant Information sheets

The evaluator planned to use this data source to determine whether programme session activities were conducted as intended (*adherence to PIHVP's programme design*), and the extent to which participants responded to them (*participant responsiveness*). However, analysis of this source found that most of the notes captured were superficial and lacked detail on participants' responses. The notes were also largely inconsistent, which indicated that there may have been no standardised procedure in place for data capturing. MacKinnon and colleagues (2017) argue that important participant information is lost when programme facilitators do not capture detailed notes on them. This may have compromised the quality of the data, which hindered the evaluator from making any direct inferences from it. It is therefore recommended that PIACs be taught how to capture key issues and information during sessions, which can be elaborated on after the session concludes, so as not to impact too much on facilitation time during sessions (MacKinnon, Dale, Lyons & Cavanagh, 2017).

The results of this data source, however, are still discussed within the implementation fidelity section as this was the only source that provided direct data on adherence and participant responsiveness to programme activities. Given the lack of alternative data, the evaluator considered the results to be a starting point for more rigorous data to be built on.

Implementation fidelity

Implementation fidelity is concerned with the extent to which a programme is being implemented as intended (Carrol et al., 2007). To determine this, four key elements of fidelity were interrogated - adherence to an intervention, exposure or dose, quality of delivery, and participant responsiveness (Carrol et al., 2007). Discussions related to these elements are outlined below.

Exposure and/or dosage of the PIHVP

Programme exposure or dosage concerns the amount of the programme received by participants, at the frequency and duration with which it was designed (Carrol et al., 2007). The results found that most programme participants had not received the intended dosage of the PIHVP during the evaluation period. Antenatal sessions were conducted at frequencies of less than half of the prescribed time interval, which consequently shortened the duration of this programme component. According to Heaman and colleagues (2006) rushing through components of a parenting programme may compromise the delivery quality, and possibly the programme's chances of having long-term effects on its participants. Most of the postnatal sessions, on the other hand, were conducted over the prescribed time intervals. This meant that most participants spent more than the prescribed duration on this component. Although this deviation in programme frequency does not directly impact on the programme's effect on parents and their children (Giannotta, Özdemir & Stattin, 2019), Mytton and colleagues (2014) argue that it does have implications on the programme's viability, as it incurs higher programme costs and losses.

The programme had also deviated from its prescribed session duration. Although this deviation was a minor, analysis of the M&E reports found that more than half noted PIACs did not cover all scheduled session activities. Hence, this deviation should not be disregarded, as it may have had bearing on the amount of programme information participants were receiving, thereby jeopardising programme integrity. Burrel and Tonkin (2020) argue that a violation of programme integrity has implications on programme treatment, as it is likely to become less effective – making it impossible to then determine its true impact.

Quality of programme delivery

Quality of delivery focuses on how programme staff provide content to participants, and the degree of quality to which this was done (Carrol et al., 2007). For this process evaluation, this was primarily determined through the extent to which PIACs implemented their training during home visit sessions.

The results found that PIACs had the ability to do proper referrals, handle obstacles which interfered with their sessions, and exercise boundaries between themselves and participants during sessions. PIACs were also found to possess good levels of knowledge on programme content. Results of criteria which measured more than one characteristic, such as communicating clearly, sensitively, and directly; found more inconsistent results, with PIACs displaying these characteristics either jointly or in isolation. It is unclear whether all characteristics need to be present for the criterion to be satisfied. If not, the evaluator recommends that they be structured as separate criteria so as not to compromise the status of others.

West and colleagues (2018) explain that when home visitors diligently follow their training, it ensures that they are better able to manage their sessions, particularly during unexpected situations. Additionally, when home visit sessions are well managed, it creates an atmosphere that promotes better participant engagement and learning, which ultimately influences the programme's effects on parents (West et al., 2018). It is important to bear in mind, however, that only 11 of the 80 required M&E reports were completed during the evaluation period. As a result, the sample used for this study was not necessarily representative of all home visit sessions. It is therefore recommended that the PIHVP increase its capacity to conduct more performance observations at the prescribed intervals to ascertain the extent to which PIACs are truly implementing their training during sessions.

Adherence to the PIHVP's programme design

Adherence to an intervention determines whether a programme has been delivered as intended (Carrol et al., 2007). The evaluation results revealed mixed levels of adherence across the programme. Firstly, there appeared to be a high level of adherence to completing the first activity of home visit sessions; with the second activity conducted at moderate to low levels of adherence; and many of the activities subsequent to this (i.e. activities 3 to 5) conducted at low

levels of adherence. This indicated a general decline in programme activity adherence across the PIHVP, as it progressed. High levels of adherence were seen across most developmental screenings and demonstrations. However, where these were scheduled, there appeared to be a very low level of adherence to discussion and input activities. Instances where no participant responses were captured by PIACs were also common during the evaluation period. According to Burrel and Tonkin (2020), when a programme does not adhere to its original design, the integrity of that programme is compromised. This has further implications on programme treatment, as it is likely to become less effective – making it impossible to determine the programme's true impact (Burrel & Tonkin, 2020).

Participant responsiveness

Carrol and colleagues (2007) argue that participant responsiveness encompasses the judgements formulated by participants on the relevance and outcomes of an intervention; and the extent to which participants engage and respond to it. This process evaluation attempted to determine this through participants' responses to programme activities and their level of satisfaction with the programme.

Perceived levels of participant responses to PIHVP activities

Results showed that data captured on participant responses to discussion and input activities was largely inconsistent across the evaluation period. PIACs appeared to largely capture notes that lacked in-depth detail on participant responses to programme activities. This appeared indicative of 'closed-ended' communication from participants. In addition, there was also a steady frequency of no responses being captured at all during the evaluation period. Several apparent patterns were observed among the results on participant responses. Firstly, more in-depth notes were captured during sessions that focused on the participants' emotions and experiences, like the first postnatal session where participants share their birth story. Secondly, session notes that lacked detail appeared more commonly in sessions focused on PIAC engagement with infants, particularly where the BIAB was conducted. However, the frequency of no responses across the programme highlights the need to ascertain whether these patterns were coincidental or a true reflection of participants' level of engagement.

Perceived participant satisfaction with the PIHVP

Analysis of participant interviews found that they were largely satisfied with the PIHVP. The majority considered the topics discussed during the programme as its strength and perceived the programme as having an impact on their lives as parents. Furthermore, all participants indicated that they would, or already have, recommended the programme to other mothers. It is important to note, however, that only a small sample of participants were interviewed. Therefore, these results are not necessarily generalisable to the entire PIHVP population (Vasileiou, Barnett, Thorpe & Young, 2018). Moreover, the vulnerability of participants further required a PIP staff member to be present during interviews. Despite the evaluator perceiving participants as being honest during their interviews, it is important to highlight that this may have influenced participants' responses as well.

Recommendations

The purpose of this evaluation was to determine how the PIHVP was functioning in its current state, and then use this knowledge to generate recommendations on how the programme's performance could be improved. The section below highlights the key recommendations for the PIHVP. This has been categorised into general, as well as service utilisation, quality of delivery, and fidelity-related recommendations:

General

- Firstly, the evaluator strongly recommends the PIHVP prioritise putting a proper M&E system in place. Data is currently not analysed nor systematised in any way, and purely stored upon collection. As a result, programme performance and progress cannot be tracked. The evaluator suggests that an M&E system be developed using a participatory approach, as this method encourages active engagement between the evaluator and programme staff. It will also encourage greater ownership of the M&E system and enhance M&E learning, management capacity, and skills among programme staff. A high-level guideline for planning and developing a participatory M&E system, based on the work of Lennie, Tacchi, Koirala, Wilmore and Skuse (2011), is provided in Appendix

R. In some instances, these steps were slightly modified to better suit the context of the PIHVP.

- It is further recommended that the PIHVP restructure and strengthen the Client Evaluation form. Firstly, the evaluator suggests that the form and data collection process be anonymised, as this promotes greater disclosure of undesirable behaviour. This could be done by omitting participants' names from the form and not having PIACs present when it is completed. Instead, participants should be provided with an envelope to submit their evaluation forms in. This sealed envelope should then only be opened by a programme staff member responsible for analysing the data. In addition, the evaluator suggests items on the form be categorised by themes to improve clarity on which programme component feedback is required on. Questions should also be rephrased to remove ambiguity, as this results in questions being interpreted in different ways by different people. Rating scales should also be incorporated, as this captures more of the real variance in participants' responses. Furthermore, the evaluator suggests this form be completed by participants who drop out of the programme as well to gain a much broader understanding of what aspects of the PIHVP are functioning well for participants, and where it can be improved.

Service Utilisation

- It is recommended that the PIHVP revise and/or develop data collection tools that measure all ten of its eligibility criteria as directly as possible. The evaluator further suggests that this eligibility criteria be used as a screening tool to determine participants' suitability for the PIHVP, before they are enrolled onto the programme. This will ensure sufficient coverage of the programme's intended population and that those who are most in need of the PIHVP, receive its services.
- To increase participant retention rates, it is recommended that the PIHVP consider regular telephonic communication with parents to remind them of upcoming sessions, update them on the sessions they have missed, and follow up on reasons for missed sessions. This may mitigate the large dropout rates experienced by the programme and

the loss of programme resources, as PIACs would know ahead of time whether sessions should be rescheduled.

- It is further recommended that the programme consider less ambiguous categories that indicate reasons for programme drop out, particularly the 'not available' category. With this being the most cited reason for participant drop out, it would be helpful for the programme to know exactly whether participants' unavailability was due to factors internal or external to the programme. This may further inform decisions on suitable retention strategies.
- To increase participant recruitment figures, it is recommended that the programme strengthen its relationships with fellow community organisations and develop feasible PIHVP recruitment strategies that accommodate all parties. Aside from direct referrals, this could include PIHVP pamphlets being available and distributed within these organisations and hosting PIHVP open days at community halls. Given the viability of the door-to-door recruitment, the evaluator suggests the programme capacitates this initiative more. A formal schedule for this should be developed, so that the programme's shuttles can be made available to PIACs as a safer and more time-efficient method to navigate through communities.

Fidelity

- There is scope for the current capacity of PIAC performance monitoring to be increased. This will ensure that the observations are being completed at the intended frequency prescribed by the programme's design. Regular performance data will provide the programme with crucial information on the true extent to which PIACs are implementing their training, and the quantity and quality with which they provide the PIHVP to participants.

- The evaluator also suggests the PIHVP consider restructuring and strengthening the Parent Infant Information sheets. It is recommended that the individual sheets be customised to reflect the programme activities of the respective session. Furthermore, the sheets should include more quantitative components so that PIACs can capture session-related information more efficiently. For example, tick-boxes could be included to

indicate which activities were completed, instead of having this information captured qualitatively. The evaluator further suggests that sheets be made available in PIACs' home languages as well. Brackett (2012) explains individuals are more expressive in their home language, both in spoken and written word. This may therefore assist PIACs in capturing more detailed notes.

Quality of delivery

- Finally, it is recommended that the PIHVP continue to upskill the facilitation skills of PIACs, particularly their data capturing and time management skills, as this contributes to programme enhancement. PIAC's session notes are a key source that provides insight into participants' level of progress on the programme, which can be used to inform decisions and improve practices (Cserti, 2019). Therefore, PIACs current skills need to be improved for them to capture notes of high quality, in an efficient and effective manner. Furthermore, strengthening PIACs time management skills ensures that all programme session content is delivered within the prescribed time allocation. To ensure that the acquired skills are adequately maintained, it is suggested that it be monitored by the M&E social worker during her observations. Routine monitoring will ensure that adequate standards are maintained (Görgens & Kusek, 2009), which is likely to result in more accurate data on programme adherence.

Limitations

The following section details the challenges encountered during the evaluation process that may have restricted its ability to fully explore the implementation of the PIHVP. Firstly, given the limited literature available on parenting programmes within South Africa and Africa, the plausibility assessment was largely based on research conducted in America and Europe. However, the evaluator narrowed the scope of international literature to populations like the PIHVP - at-risk mothers from low-income communities. This resulted in more reliable conclusions being drawn from the plausibility assessment.

Another limitation was the principal use of secondary data sources to inform the evaluation. Despite providing valuable insight into the PIHVP's performance over the evaluation period, this data had several issues which may have impacted the evaluation process. Firstly, the unsystematic way in which data is captured and stored by the PIHVP resulted in significant time spent on retrieving relevant, manual data sources; and converting and consolidating them into an electronic format that could be analysed. Secondly, the quality with which data was captured was suboptimal. This compromised the amount of useful participant information that could be extracted from certain data sources. As a result, the evaluation could not gauge the full extent to which programme content was shared with participants, and their engagement with the programme. Furthermore, missing data appeared to be a common occurrence across several programme data sources. By not knowing what these gaps are, the results could not be generalised across the programme. Finally, certain data collection procedures used by the programme introduced a high level of bias, which further compromised data quality. Although the evaluator attempted to triangulate these findings with primary data, it cannot be said with certainty that these results were reflective of the entire PIHVP population, as only a small sample was surveyed.

Finally, there were also limitations to collecting primary data. With the PIHVP targeted at vulnerable mothers from low socio-economic communities, most of the logistics around interviews had to involve PIHVP staff. This included them arranging and being present during interviews. This extensive involvement may have introduced a level of bias both in the type of interviewee that participated, as well as their responses. Furthermore, only eleven participant interviews were conducted. This sample was extracted from the minority of participants who completed the entire PIHVP. Despite these participants being in a better position to provide information on the programme, their views cannot be considered representative of the entire PIHVP participant population, given the programme's large dropout rate. Therefore, these interview findings were not generalisable either.

Contribution to knowledge

This evaluation contributed to the limited literature currently available on home-based parenting programmes in South Africa. It further developed an operational TOC for the PIHVP and showcased the need for fidelity among programmes of this nature, so that it can be

implemented to its full potential. The evaluation also highlighted the importance of capacitating facilitators of parenting programmes, as their skills are pivotal in capturing crucial participant data. Furthermore, it showed that supporting facilitators with programme resources would allow parenting programmes to reach and assist their intended population more efficiently.

This evaluation served as a formative report for the PIHVP. The focus on the programme's implementation provided insight into their current level of performance, and it is hoped that the findings and recommendations will provide the programme with new knowledge and capacity to improve its effectiveness and efficiency. Furthermore, these formative findings will provide a good foundation upon which further research can be developed on.

References

Axford, N., Lehtonen, M., Kaoukji, D., Tobin, K., & Berry, V. (2012). Engaging Parents in Parenting Programmes: Lessons from Research and Practice. *Children and Youth Services Review, 34*, 2061-2071. doi: 10.1016/j.childyouth.2012.06.011

Bain, K., Dawson, N., Esterhuizen, M., Frost, K., & Pininski, D. (2016). 'Abazaliabazamayo' (Parents who Keep on Trying): Mothers' Responses to the Ububele Mother-Baby Home Visiting Programme. Early Child Development and Care, 187 (1), 13-34. doi: 10.1080/03004430.2016.1150271

Bakermans-Kranenburg, M. J., Van IJzendoorn, M. H., Juffer, F. (2003). Less is more: meta-analyses of sensitivity and attachment interventions in early childhood. *Psychological Bulletin, 129* (2), 195215.

Balakrishna, R., Teixeira, M., Meyrick, J., & Hart, R. (2019). A systematic review of the effectiveness of infant massage programmes in improving mother and infant attachment and dyadic attunement. *Community Practitioner, 92* (5), 45-47.

Bennet, C., Underdown, A., Barlow, J. (2013). Massage for Promoting Mental and Physical Health in Typically Developing Infants Under the Age of Six Months, *Cochrane Database of Systematic Reviews*. Retrieved from https://doi.org/10.1002/14651858.CD005038.pub3

Bens, I. (2005). *Facilitating with Ease! Core Skills for Facilitators, Team Leaders and Members, Managers, Consultants and Trainers* (4th ed.). San Francisco, CA: Jossey- Bass.

Berlin, L.J., Marticoccio, T. L., Carmody, K. A., Goodman, W. B., O'Donnell, K., Williams, J., Murphey, R. A., & Dodge, K. A. (2017). Can Typical US Home Visits Affect Infant Attachment? Preliminary Findings from a Randomised Trial of Healthy Families Durham. *Attachment & Human Development, 19* (6), 559-579. doi: 10.1080/14616734.2017.1339359

Brackett, M. H. (2012). *Data Resource Design: Reality Beyond Illusion*. Bradley Beach, NJ: Technics Publications.

Britto, P, R., Ponguta, L. A., Reyes, C., Karnati, R. (2015). *A Systematic Review of Parenting Programmes for Young Children in Low- and Middle-Income Countries*. Early Childhood, UNICEF. Retrieved from http://www.unicef.org/earlychildhood/files/P_Shanker_final__Systematic_Review_of_Parenting_ECD_Dec_15_copy.pdf

Burkhardt, J. M., MacDonald, M. C., & Rathemacher, A. J. (2010). *Teaching Information Literacy: 50 Standards-Based Exercises for College Students* (2nd ed.). Chicago, IL: American Library Association

Burrel, A. & Tonkin, M. (2020). *Property Crime: Criminological and Psychological Perspectives.* London, U.K: Routledge.

Butchart, A. (2013, May 13). *Preventing Violence against Children: What Approaches Work?* Retrieved from https://www.unicef-irc.org/article/977-preventing-violence-against-children-whatapproaches-work.html

Carrol, C., Patterson, M., Wood, S., Booth, B., Rick, J., & Balain, S. (2007). A Conceptual Framework for Implementation Fidelity. *Implementation Science, 2* (40), 1-9. doi: 10.1186/1748-5908-2-40

Casillas, K. L., Fauchier, A., Derkash, B. T., &Garrido, E. F. (2016). Implementation evidence-based home visiting programs aimed at reducing child maltreatment: A Meta-analytic review. *Child Abuse and Neglect, 53*, 64-80. doi: 10.1016/j.chiabu.2015.10.009

Charles, M. (2019, April 12). *Cape Town has SA's highest murder rate*. Retrieved from http://www.iol.co.za/capeargus/news/cape-town-has-sas-highest-murder-rate-21018353

Cooke, A. (2015). Infant Massage: The Practice and Evidence-Base to Support it. British *Medical Journal of Midwifery, 23* (3), 60-125. doi:10/12968/bjom.2015.23.3.166

Cooper, P. J., Landman, M., Tomlinson, M., Molteno, C., Stein, A., McPherson, K., & Murray, L. (2009).Improving the quality of the Mother-Infant Relationship and Infant Attachment in a Socioeconomically Deprived Community in South Africa: A Randomised Controlled Trail. *British Medical Journal, 338*, 974-982.

Cserti, R. (2019, January 28). *Essential Facilitation Skills for an Effective Facilitator*. Retrieved from https://www.sessionlab.com/blog/facilitation-skills/

Davis, H., Day, C., & Bidmead, C. (2002). *Working in Partnership with Parents: The Parent Adviser Model*. London: The Psychological Corporation Limited.

Duggan, A., Fuddy, L., Burrel, L., Higman, S M., McFarlane, E., Windham, A., &Sia, C. (2004). Randomisation Trial of a State-wide Home Visiting Program to Prevent Child Abuse: Impact in Reducing Parental Risk Factors. *Child Abuse & Neglect, 28*, 623-643. doi: 10.1016/j.chiabu.2003.08.008

Eisenberg, L., & Brown, S. S. (1995). *The Best Intentions: Unintended Pregnancy and the Well-being of Children and Families*. Washington, DC: National Academic Press.

Fowler, F. J. (2013). *Survey Research Methods* (5th ed.). Thousand Oaks, CA: Sage

Freedman, V. A. (2000). Implications of Asking "Ambiguous" Difficulty Questions: An Analysis of the Second Wave of the Asset ad Health Dynamics of the Oldest Old Study. *The Journals of Gerontology: Series B, 55* (5), 288-297. doi: 10.1093/genrob/55.5.S288

Friars, P. & Mellor, D. (2009). Drop-out from Parenting Training Programmes: A Retrospective Study. *Journal of Child and Adolescent Mental Health, 21* (1), 29-38. doi: 10.2989/JCAMH.2009.21.1.5.807.

Gasden, V.L., Ford, M., & Breiner, H. (2016). *Parenting Matters: Supporting Parents of Children Ages 0-8*. Washington, DC: The National Academic Press.

Germer, C. (2014, May 27). *Providing for the Infant's Developmental Needs*. Retrieved from http://prezi.com/m/b0bzg9qzkqgc/providing-for-infants-developmental-needs/

Giannotta, F., Özdemir, M., & Stattin, A. (2019). The Implementation Integrity of Parenting Programs: Which Aspects Are Most Important? *Child & Youth Care Forum, 48*, 917-933. doi: 10.1007/s10566-019-09514-8

Gilmer, C., Buchan, J. L., Letourneau, N., Bennet, C. T., Shanker. S. G., Fenwick, A., & Smith-Chant, B. (2016). Parent Education Interventions Design to Support the Transition to Parenthood: A Realist Review. *International Journal of Nursing, 59*, 118-133. doi: 10.1016/j.jinurstu.2016.03.15.

Görgens, M. & Kusek, J. Z. (2009). *Making Monitoring and Evaluation Systems Work: A Capacity Development Toolkit.* Washington, DC: The World Bank.

Guest, G., Bruce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods*, *18*, 59-82. doi:10.1177/1525822X05279903

Guthrie, K. F., Gaziano, C., & Gaziano, E. P. (2009). Toward Better Beginnings: Enhancing Healthy Child Development and Parent-Child Relationships in a High-Risk Population. *Home Health Care Management & Practice*, *21* (2), 99-108.

Hahn, R. A., Bilukha, O. O., Crosby, A., Fullilove, M. T., Liberman, A., Mosciciki, E. K., Snyder, S., Tuma, F., Schofield, A., Corso, P. S., & Briss, P. (2003). First reports evaluating the effectiveness of strategies for preventing violence: early childhood home visitation: Findings from the Task Force on Community Preventative Services. *Centers for Disease Control, 52* (14), 1-9.

Heaman, M., Chalmers, K., &Woodgate, R. (2006). Early Childhood Home Visiting Programme: Factors Contributing to Success. *Journal of Advanced Nursing, 55* (3), 291-300. doi: 10.1111/j.1365-2648.2006.03914.x

Hickey, G., McGalloway, S., Leckey, Y., & Stokes, A. (2018). Parent and Facilitator Experiences of an Intensive Parent and Infant Programme delivered in Routine Community Settings. *Primary Healthcare and Research Development, 20*, 1-12.doi: 10.1017/S146342361900029X

Holtgrave, D. R. (1998). *Handbook of Economic Evaluation of HIV Prevention Programmes*. New York City, NY: Plenum Press.

IJzendoorn, M. H., Juffer, F., Duyvesteyn, M. G. C. (1995). Breaking the intergenerational cycle of insecure attachment: A review of the effects of attachment-based interventions on maternal sensitivity and infant security. *Journal of Child Psychology and Psychiatry, 36* (2), 225-248.

Kelley, K., Clark, B., Brown, V., & Sitzia, J. (2003). Good Practice in the Conduct and Reporting of Survey Research. *International Journal for Quality in Health Care, 15* (3), 261-266. doi: 10.1093/intqhc/mzg031

Kendrick, D., Elkan, R., Hewitt, M., Dewey, M., Blair, M., Robinson, J., Williams, D., & Brummell, K. (2000). Does home visiting improve parenting and the quality of the home environment? A

systematic review and meta-analysis. *Archives of Disease in Childhood*, *82* (6), 443-451. doi: 10.1136/adc.82.6.443

Kendrick, D., Mulvaney, C. A., Ye, L., Stevens, T., Mytton, J. A., & Stewart-Brown, S. (2013). Parenting interventions for the prevention of unintentional injuries in childhood, *Cochrane Database of Systematic Reviews*. Retrieved from https://doi.org/10.1002/14651858.CD006020.pub3

Kersten-Alvarez, L. E., Hosman, C. M. H., Riksen-Walraven, M., Doesum, K. T. M., & Hoefnagels, C. (2011). Which Preventative Interventions Effectively Enhance Depressed Mothers' Sensitivity? A Meta-Analysis. *Infant Mental Health Journal, 32* (3), 362-376. doi:10.1002/imhj.20301.

Kusek, J. Z. & Rist, R. C. (2004). *Ten steps to a results-based monitoring and evaluation system: a handbook for development practitioners*. Washington, DC: World Bank.

Landman, M. (2009). *Inside the Black Box of a Successful Parent-Infant Intervention in a South African Informal Settlement: Mothers' and Counsellors' Accounts of the Process* (Unpublished doctoral dissertation). University of Stellenbosch, Cape Town, South Africa.

Landry, S.H., Smith, K.E., Swank, P. R. (2006). Responsive parenting: Establishing early foundations for social, communication, and independent problem-solving skills. *Developmental Psychology, 42* (4), 627-642. doi: 10.1037/0012-1649.42.4.627

Lavrakas, P. J. (2008). *Encyclopaedia of Survey Research Methods*. Thousand Oaks, CA: Sage Publications.

Lennie, J., Tacchi, J., Koirala, B., Wilmore, M., & Skuse, A. (2011, June 17). *Equal Access Participatory Monitoring and Evaluation toolkit*. Retrieved from https://www.betterevaluation.org/en/toolkits/equal_access_participatory_monitoring

Letourneau, N. L., Stewart, M. J., &Barnfather, A. K. (2004). Adolescent Mothers: Support Needs, Resources, and Support-Education Interventions. *Journal of Adolescent Health, 35,* 509-525. doi: 10.1016/j.jadohealth.2004.01.007

Mackinnon, M. P., Dale, J., Lyons, S. H., & Cavanagh, F. (2017). *Building Capacity: Small Group Facilitation and Note-Taking for Dialogue and Deliberation*. Alberta Climate Dialogue. Available at: https://www.albertaclimatedialogue.ca/cd35-buildingcapacity

Markiewicz, A. (2018, January 10). *Why do programs benefit from developing monitoring and evaluation frameworks?* [Blog post]. Retrieved from http://www.betterevaluation.org/en/blog/how-do-programs-benefit-from-ME-frameworks

McCombes, S. (2019, August 20) *Descriptive research*. Retrieved from https://www.scribbr.com/methodology/descriptive-research/

McMullen, M. (2013). Understanding development of infants and toddlers. In C. Copple, S. Bredekamp, D. Koraleck & K. Charner (Eds.), *Developmentally Appropriate Practice: Focus on Infants and Toddlers* (pp. 23-50). Indiana: NAEYC.

Moran, P., Ghate, D., & van der Merwe, A. (2004). *What Works in Parenting Support? A Review of the International Evidence* (Report No. 547). London, United Kingdom: Policy Research Bureau.

Murdoch, M., Simon, A. B., Polusny, M. A., Bangerter, A. K., Grill, J. P., Noorbaloochi, S., & Partin, M. R. (2014). Impact of Different Privacy Conditions and Incentives on Survey Response Rate, Participant Responsiveness, and Disclosure of Sensitive Information: A Randomised Controlled Trial. *BMC Medical Research Methodology, 14* (90), 236-279. doi: 10.1186/1471-2288-14-90.

Mytton, J., Ingram, J., Manns, S., Stevens, T., Mulvaney, C., Blair, P., Powell, J., Potter, B., Towner, E., Emond, A., Deave, T., Thomas, J., Kendrick, D., & Stewart-Brown, S. (2014). The Feasibility of Using a Parenting Programme for the Prevention of Unintentional Home Injuries in the UnderFives: A Cluster Randomised Controlled Trial. *NHR Journals Library, 18* (3), 123-144.

Olds, D., Hill, P., Robinson, J., Song, N., & Little, C. (2000). Update on Home Visiting for Pregnant Women and Parents of Young Children. *Medical Care, 31*, 155-174.

Organisation for Economic Cooperation and Development (OECD). (2002). Glossary *of Key Terms in Evaluation and Results Based Management*. Retrieved from https://www.oecd.org/dac/evaluation

Osofsky, J. D. (1999). The Impact of Violence on Children. *Domestic Violence and Children, 9* (3), 3349. doi: 10.2307/1602780.

Ozbek, A., Gencer, O., & Mustan, A. T. (2018). Which Parents Dropout from an Evidence-Based Parenting Programme (Triple-P) at CAMHS? Comparison of Programme- Completing and Dropout Parents. *Clinical Child Psychology and Psychiatry, 24* (1), 135-150. doi: 10.1177/1359104518792294.

Park, P. (2018). *Improving Children's Life Chances: Can the Parent Child Home Programme (PCHP) narrow the school readiness gap in the UK? A report from the Deputy Chief Executive, 2018*. London, United Kingdom: Winston Churchill Memorial Trust.

Peacock, S., Konrad, S., Watson, E., Nickel, D &Muhajarine, N. (2013). Effectiveness of home visiting programs on child outcomes: A systematic review. *BMC Public Health, 13* (17), 64-75. doi: 10.1186/1471-2458-13-17

Penn, H. (2008). *Childcare and Early Childhood Development Programmes and Policies: Their relationship too eradicating child poverty* (Report No. 8). Essex, United Kingdom:

Peterson, C. A., Luze, G. J., Eshbaugh, E. M., Jeon, H., &Kantz, K. R. (2007). Enhancing parent-child interactions through home visiting: Promising practice or unfulfilled promise? *Journal of Early Intervention, 29* (2), 119-140.

Pocock, R. (2009). *Evaluating the Training and Supervision of Home Visitors in a Parent-Infant Home Visitation Programme* (Unpublished master's dissertation). University of Cape Town, Cape Town.

Ponto, J. (2015). Understanding and Evaluating Survey Research. *Journal of the Advanced Practitioner in Oncology, 6* (2), 168-171.

Pontoppidan, M., Klest, S.K., & Sandoy, T.M. (2016) The Incredible Years Parents and Babies Program: A Pilot Randomized Controlled Trial. *PLoS ONE, 11*(12), 1-22. doi: 10.1371/journal.pone.0167592

Radey, M. (2018). Informal Support among Low-income Mothers Post Welfare Reform. *Journal of Child and Family Studies, 27* (12), 3782-3805. doi: 10.1007/s10826-018-1223-0.

Rayce, S.B., Rasmussen, I.S., Klest, S. K., Patras, J., & Pontoppidan, M. (2017). Effects of Parenting Interventions for At-Risk Parents with Infants: A Systematic Review and Meta-Analyses. *BMJ Open, 7* (12), 1-20. doi: 10.1136/bmjopen-2016-015707

Richter, L. M. (2003). Poverty, underdevelopment and infant mental health. *Journal of Paediatrics and Child Health, 39*, 243-248.

Rossi, P., Lipsey, M.W., & Freeman, H.E. (2004). *Evaluation. A Systematic Approach* (7thed.). Thousand Oaks, CA: Sage.

Rossiter, C., Fowler, C., McMahon, C., & Kowalenko, N. (2012). Supporting Depressed Mothers at Home: Their Views on an Innovative Relationship-Based intervention. *Contemporary Nurse, 41*(1), 90-100.

Rostad, W. L., Moreland, A. D., Valle, L. A., Chaffin, M. J. (2018). Barriers to Participation in Parenting Programmes: The Relationship between Parenting Stress, Perceived Barriers, and Programme Completion. *Journal of Child and Family Studies, 27* (4), 1264-1274. doi: 10.1007/s10826-017-0963-6.

Rowe, H. J., & Fisher, R. W. (2010). The Contribution of Australian Residential Early Parenting Centres to Comprehensive Mental Health Care for Mothers and Infants: Evidence from a Prospective Study. *International Journal of Mental Health Systems, 4* (6), 1-12. doi: 10.1186/1752-4458-4-6

Roy, R. N., Schumm, W. R., & Britt, S. L. (2013). *Transition into Parenthood*. New York, NY: Springer.

Salkind, N. J. (2010). *Encyclopaedia of Research Design*. Thousand Oaks, CA: Sage Publications.

Sama-Miller, E., Akers, L., Mraz-Esposito, A., Zukiewicz, M., Avellar, S., Paulsell, D., & Del Grosso, P. (2018). Home Visiting Evidence of Effectiveness Review: Executive Summary (Report No. 2018-113). Washington, DC: U.S Department of Health and Human Services.

Selph, S. S., Bougatsos, C., Blazina, I., & Nelson, H. D. (2013). Behavioural Interventions and Counseling to Prevent Child Abuse and Neglect: A systematic review to update the U. S. Preventative Services Task Force Recommendation. *Annals of Internal Medicine, 158* (3), 555693. Sinclair, M., O'Toole. J., Malawaraarachchi, M., & Leder, K. (2012). Comparison of Response Rates and Cost-Effectiveness for a Community-Based Survey: Postal, Internet and Telephone Modes with Generic or Personalised Recruitment Approaches. *BMC Medical Research Methodology, 12* (132), 261-266. doi: 10.1186/1471-2288-12-132

Stufflebeam, D. L. & Coryn, C. L. S. (2014). *Evaluation Theory, Models and Applications* (2nd ed.). San Francisco, CA: Jossey- Bass.

Suess, G.J., Bohlen, U., Carlson, E. A., Spangler, G., & Frumentia, M. M. (2016). Effectiveness of Attachment Based STEEP Intervention in a German High-Risk Sample. *Attachment and Human Development, 18* (5), 443-460. doi: 10.1080/14616734.2016.1165265.

Schwartz, S. R., Rees, H., Mehta, S., Venter, W. D., Taha, T. E., & Black, V. (2012). High Incidence of Unplanned Pregnancy After Antiretroviral Therapy Initiation: Findings from a Prospective Cohort Study in South Africa. *PLoS One, 7* (2), 350-356. doi: 10.1371/journal.pone.0036039

The Parent Centre. (2018). 3-5 years Annual Report. Retrieved from http://theparentcentre.org.za/resources/2018-annual-report

Thomas, D. R. (2006). A General Inductive Approach for Analyzing Qualitative Evaluation Data. *American Journal of Evaluation, 27* (2), 237-246. doi:10.1177/1098214005283748

Trumbull, E., Rothstein-Fisch, C., & Greenfield, P. M. (2000). *Bridging Cultures in our Schools: New Approaches That Work*. San Francisco, CA: WestEd.

UNICEF. (2016). *Standards for ECD parenting programmes in low- and middle-income countries*. Retrieved from https://www.unicef.org/earlychildhood

Vasileiou, K., Barnett, J., Thorpe, S., & Young, T. (2018). Characterising and Justifying Sample Size Sufficiency in Interview-based studies: Systematic Analysis of Qualitative Health Research Over a 15-year Period. *BMC Medical Research Methodology, 18* (148), 132-155. doi: 10.1186/s12874-018-0594-7.

Wagstaff, A. (2002). Poverty and Health Sector Inequalities. *Bulletin of the World Health Organization, 80* (2), 97-105.

Walkup, J. T., Barlow, A., Mullany, B. C., Pan, W., Goklish, N., Hasting, R., Cowboy, B., Fields, P., Baker, E. V., Speakman, K., Ginsburg, G., & Reid, R. (2009). Randomized Control Trial of a paraprofessional-delivered in-home intervention for young reservation-based American Indian mothers. *Journal of the American Academy of Child & Adolescent Psychiatry, 48* (6), 591-601. doi: 10.1097/CHI.0b013e3181a0ab86

Ward, C. L., Artz, L., Leoschut, L., Kassanjee, R., & Burton. (2018). Sexual Violence against Children in South Africa: A Nationally Representative Cross-Sectional Study of Prevalence and Correlates. *The Lancet, 6* (4), 60-82. doi: 10.1016/S2214-109X (18)30060-3.

Weber, S., & Bowers- Du Toit, N. (2018). Sexual Violence against Children and Youth: Exploring the Role of Congregations in Addressing the Protection of young Girls on the Cape Flats. *Theological Studies, 47* (3), 1-8. doi: 10.4102/hts.v74i3.5089 West, A., Gagliardi, L., Gatewood, A., Higman, S., Daniels., J., O'Neill, K., & Duggan, A. (2018). Randomized Trial of a Training Program to Improve Home Visitor Communication Around

Sensitive Topics. *Maternal and Child Health Journal, 22* (1), 70-78. doi:10.1007/s10995-0182531-0

Western Cape premier says more than 10 people murdered every day in May. (2019, June 11). Retrieved from http://www.iol.co.za/capeargus/news/western-cape-premier-says-more-than-10-peoplemurederd-every-day-in-may-25901452

Whitaker, K., & Cowley, S. A. (2012). An Effective Programme is Not Enough: A Review of Factors Associated with Poor Attendance and Engagement with Parenting Support Programmes. *Children & Society, 26* (2), 138-149. doi: 10.1111/j.1099-0860.2010.00333.x

Williams, M. E., Hoare, Z., Owen, D.A., & Hutchings, J. (2019). Feasibility Study of the Enhancing Parenting Skills Programme. *Journal of Child and Family Studies, 29*, 686-698. doi: 10.1007./s10826-019-01581-8.

Williams, T., Samuels, M. L., Mouton, J., Ratele, K., Shabalala, N., Shefer, T., & Strebel, A. (2001). *The Nationwide Audit of ECD Provisioning in South Africa*. Pretoria, South African: Department of Education Directorate.

Woolfolk, T. A., & Unger, D. G. (2009). Relationships Between Low-Income African American Mothers and their Home Visitors: A Parents as Teachers Program. *Family Relations, 58*, 188200.

World Health Organization. (2004). Adolescent Pregnancy: Issues in Adolescent Health and Development. Retrieved from https://www.whqlibdoc.who.int

Appendices

Appendix A: Informed consent form for semi-structured interviews with programme staff

Study Title: A Formative Evaluation of the Parent-Infant Home Visiting Programme

Name of interviewee: _____

Dear Participant,

My name is Sheridan-Lee Percival and I am a master's student enrolled in the MPhil in Programme Evaluation course at the University of Cape Town. I would like to invite you to take part in a face-to-face interview concerning your perceptions of, and level of satisfaction with the Parent-Infant Home Visiting Programme (PIHVP).

This interview will provide valuable insight into determining how well the PIHVP is operating and the extent to which their services are delivered to the appropriate participants. This will greatly contribute to the effective delivery of the PIHVP and the achievement of its intended outcomes. This evaluation of the PIHVP has been approved by the Commerce Faculty Ethics in Research Committee. This interview should take no longer than 20 minutes.

Your participation is entirely voluntary and confidential. This interview will be audio-recorded, and notes will be taken be taken by the interviewer. Any personal identifiers will be omitted from both audio-recordings and interview notes, and pseudonyms will be used to ensure your anonymity is maintained both during the interview and transcription process. Both the audiorecordings and interview notes will be permanently destroyed once transcripts have been generated. You may choose to opt out of the interview process at any stage without penalty. If you have any queries regarding the nature of this evaluation, please feel free to contact Dr Adiilah Boodhoo (dissertation supervisor) on 062 039 1499.

Please indicate your consent to participate below:

By signing this consent form, I confirm that I am willing participant and consent to the session being audio-recorded. I also confirm that I was provided the opportunity to ask any questions.

Participant signature: _____ Date: _____

Student evaluator signature: _____Date: _____

Please direct any concerns and/or complaints caused during the interview process to the MPhil Programme Evaluation course convenor, Associate Professor Sarah Chapman at Sarah.Chapman@uct.ac.za

Appendix B: Informed consent form for semi-structured interviews with programme participants

Study Title: A Formative Evaluation of the Parent-Infant Home Visiting Programme

Name of interviewee: _____

Dear Participant,

My name is Sheridan-Lee Percival and I am a master's student enrolled in the MPhil in Programme Evaluation course at the University of Cape Town. I would like to invite you to take part in a face-to-face interview concerning participant enrolment in the Parent-Infant Home Visiting Programme (PIHVP), given your involvement in the programme.

This interview will provide valuable insight into determining how well the PIHVP is operating and the extent to which their services are delivered to the appropriate participants. This will greatly contribute to the effective delivery of the PIHVP and the achievement of its intended outcomes. This evaluation of the PIHVP has been approved by the Commerce Faculty Ethics in Research Committee. This interview should take no longer than 40 minutes.

Your participation is entirely voluntary and confidential. This interview will be audio-recorded, and notes will be taken be taken by the interviewer. Any personal identifiers will be omitted from both audio-recordings and interview notes, and pseudonyms will be used to ensure your anonymity is maintained both during the interview and transcription process. Both the audiorecordings and interview notes will be permanently destroyed once transcripts have been generated. You may choose to opt out of the interview process at any stage without penalty. If you have any queries regarding the nature of this evaluation, please feel free to contact Dr Adiilah Boodhoo (dissertation supervisor) on 062 039 1499.

Please indicate your consent to participate below:

By signing this consent form, I confirm that I am willing participant and consent to the session being audio-recorded. I also confirm that I was provided the opportunity to ask any questions.

Participant signature: _____ Date: _____

Student evaluator signature: _____Date: _____

Please direct any concerns and/or complaints caused during the interview process to the MPhil Programme Evaluation course convenor, Associate Professor Sarah Chapman at Sarah.Chapman@uct.ac.za

Appendix C: Interview guide for programme staff interviews

Evaluation question 3: To what extent did the PIHVP meet its targeted number of participants? What are the reasons for over/under coverage?

Introduction

Thank you for agreeing to speak with me and share your knowledge on the Parent Infant Home Visiting Programme's (PIHVP) participant recruitment figures. The interview should take between 15-20 minutes to complete. Please note that I am here to hear your thoughts and opinions, and there are no right or wrong answers to the questions. If you wish to decline to answer, you are free to do so. Furthermore, I would like to ensure you that any information shared during this interview will be kept confidential and will not be shared by anyone outside of this study. If you have any questions for me, please feel free to ask me at any time. Before we start the interview, do I have your permission to audio-record this interview? (Start audio recorder if permission granted). Interviewer: "*This is interview (interviewee ID number) on (date) and he/she has granted permission for this interview to be recorded."*

Topic	**Questions**
Number of participants recruited	● What is the target intake of the PIHVP per annum? ● How many participants were successfully enrolled for the most recently completed programme cycle?
Reasons for over/under coverage of enrolment target	● Why did the PIHVP not reach the targeted intake for the most recently completed programme cycle? **OR** ● Why did the programme exceed the targeted intake for the most recently completed programme cycle?

Conclusion	● Do you have any more thoughts or opinions you would like to share regarding this topic?

Appendix D: Interview guide for programme participant interviews

Introduction

Thank you for agreeing to speak with me and share your opinions on the Parent Infant Programme's (PIP). The interview should take between 30- 40 minutes to complete. Please note that I am here to hear your thoughts and opinions, and there are no right or wrong answers to the questions. If you wish to decline to answer, you are free to do so. Furthermore, I would like to ensure you that any information shared during this interview will be kept confidential and will not be shared by anyone outside of this study. If you have any questions for me, please feel free to ask me at any time. Before we start the interview, do I have your permission to audio-record this interview? (Start audio recorder if permission granted). Interviewer: "*This is interview (interviewee ID number) on (date) and he/she has granted permission for this interview to be recorded."*

Evaluation question 6: How did participants perceive PIACs in terms of the support they provided and their preparation level, knowledge, and reliability?

Topic	**Questions**
Level of support received from PIACs	● Was your PIAC able to listen and understand your emotional experiences during your home-visiting sessions? ● Do you think your PIAC was encouraging towards you? ● Would you consider your PIAC to be reliable?
Preparedness of the PIAC during home sessions	● How often were home-visiting sessions well run and organised? ● How often were visual hand-outs made available to you during your home-visiting sessions?
Level of knowledge of PIACs	● In your opinion, would you say that the PIAC knew and understood the topics spoken about

	during your home-visiting sessions? ● As far as you can recall, was there ever an occasion when the PIAC was not able to answer a question you had related to the programme? - If yes, what was the PIAC's response to this situation?
Question 8: Are the participants satisfied with the service they received? What are the strengths and limitations they identified?	
Perceptions of programme's strengths and weaknesses	● What, in your opinion, were the home visitors' strengths? ● What, in your opinion, were the home visitors' shortcomings/weaknesses? ● What aspects of the programme did you find were most beneficial to you as a parent? ● What aspects of the programme did you find were the least beneficial to you as a parent?
Perceptions of programme impact	● Having completed the PIP, to what degree would you say has it impacted your life?
Programme recommendation	● Do you have any suggestions/comments that will help make the programme better? ● Given your experience of the PIP, how likely would you be to recommend it to other pregnant women/ new mothers?

Conclusion	● Do you have any more thoughts or opinions you would like to share regarding this topic?

Appendix E: Parent Centre Intellectual Property Agreement

WORKING AGREEMENT between THE PARENT CENTRE (TPC)

and

UCT MASTER'S DEGREE STUDENT:

_____Sheridan-Lee Percival_____

(Herein referred to as THE STUDENT)

ID NUMBER:

_____9308170064081_____

1. INTRODUCTION

This Working Agreement defines the relationship between THE PARENT CENTRE and THE STUDENT and governs the access to, and use of THE PARENT CENTRE's PARENT INFANT HOME VISITING PROGRAMME (THULA SANA) Intellectual Property, including written Materials; research and related data and analysis; training techniques; and audio/visual presentations (the "Materials") during the period of the research project and thereafter.

2. PURPOSE AND SCOPE

2. The purpose of this agreement is to grant the student use of TPC Intellectual Property for the purposes of the research project.

2.2. The period of engagement shall commence: 3rd July 2019 and end: ____3 July 2020

3. MATERIAL USAGE

3.1. THE STUDENT acknowledges and agrees that the Materials are the sole and exclusive property of TPC and may not be used other than strictly in accordance with the Agreement as described. The ownership of all Materials pertaining to the TPC Parent Infant Home Visiting Programme (Thule Sana) remains vested with The Parent Centre and the Authors.

3.2. THE STUDENT shall not reproduce, copy, alter, amend and/or sell any Materials relating to the TPC Parent Infant Home Visiting Programme (Thula Sana) Programme combine any said material with any other tool without written authorization of The Parent Centre.

3.3. No Materials pertaining to the TPC Teen Parent Infant Home Visiting Programme (Thula Sana) may be used or distributed beyond the purposes stated in this Agreement.

3. 4. TPC Programme and Materials must be explicitly acknowledged any time the Programme is advertised, implemented or used – by reference to "The Parent Centre Parent Infant Home Visiting Programme (Thula Sana)".

4. LEGAL CONSIDERATIONS

4.1. This Working Agreement constitutes the entire Agreement of the parties relating to the subject matter addressed in this Agreement. This Working Agreement supersedes all prior communications, contracts, or agreements between the parties with respect to the subject matter addressed in this Agreement, whether oral or written.

4.2. The contents of this Agreement are legally binding with effect from the date that this Agreement is countersigned by THE STUDENT. This Agreement may not be varied except by a written document signed by or on behalf of each of the parties.

4.3. The Parties agree and confirm that it is the respective intention to cooperate with each other and to exercise good faith necessary to ensure the success of the research engagement.

4.4. THE STUDENT will indemnify and hold TPC harmless from any claims related to its use of the Parent Infant Home Visiting Programme (Thula Sana) Materials.

4.5. Should either party breach any terms of this Agreement, and remain in default for fourteen (14) days after a remedy has been requested, the aggrieved party shall be entitled to terminate its participation in the partnership.

4.6. If there is a dispute regarding the interpretation of any provision of this Agreement, either party may request that such dispute be referred to mediation or arbitration.

4.7. In this event the parties must agree upon a mediator and / or arbitrator and in the case of arbitration, the terms of reference. The cost of mediation or arbitration shall be shared unless otherwise agreed.

SIGNATURES:

For: THE PARENT CENTRE

Signature:

Name: BLANCHE REZANT

Designation: PARENT INFANT PROGRAMME MANAGER

Date: 09/07/19

Place: WYNBERG

THE STUDENT

Signature:

Name: Sheridan-Lee Percival

Designation: MPhil Student

Date: 11/07/19

Place: Kenilworth

Appendix F: The Parent Infant Intake form

Parent Infant Case Presentation Format

Counsellors Name: .....

Area: .....

Identifying Information

Client name	
Physical address	
Age	
Marital status	m/as/su/d/w (circle)
Employment status	
Dependants	
Support system	
Other organizations involve (this includes Health Departments)	

Background Information

.....
.
.....
.
.....
.
.....
.
.....
.
.....
.
.....
.
.....
.
.....

Presenting Problem

.....
.
.....
.
.....
.
.....
.
.....
.
.....
.

.....
.
.....
.
.....
.
.....
.
.....

Intervention made by Parent Infant Attachment worker.

.....
.
.....
.
.....
.
.....
.
.....

How does the problem influence the client:

Physically (health)

.....
.
.....
.
.....
.
.....

Emotionally

.....
.
.....
.
.....
.
.....

Previous Intervention

.....
.
.....
.
.....
.
.....

Planning

.....
.
.....
.
.....
.
.....
.
.....
.
.....

.

.....

.

.....

Appendix G: Client Evaluation Form

Client Evaluation form

It is our aim to better our services and we would appreciate if you could take a few minutes to share your experience with our service

Name: .....

Area: .....

Name of attachment worker.....

Put a tick or a cross in the appropriate box

		Yes	Sometimes	No
1.	Did the program help you to become a better parent?			
2.	Did the program help your child develop better?			
3.	Do you feel you were supported?			
4.	The information was helpful and useful.			
5.	The worker was well prepared for each session?			
6.	Was she knowledgeable about the subject?			
7.	Did she stick to her appointments?			
8.	Will you recommend this program to other pregnant mothers?			

Any Comments or recommendations.

Appendix H: Parent Infant Information Sheets

COUNSELLOR'S NAME: PROJECT NUMBER:

DATE: CLIENT'S NAME:

QUESTIONS FOR DETAILED REPORTS –**ANTENATAL VISIT 1**

1/ WHAT DID YOU OBSERVE ABOUT THE HOUSE AND THE MOTHER IN THIS VISIT?

2/ DID YOU GIVE INFORMATION IN THIS VISIT – IF YES – WHAT?

3/ HOW DID THE MOTHER RESPOND TO THE INFORMATION?

4/WHAT DID MOTHER SAY WHEN YOU ASKED HER IF SHE ENJOYED BEING PREGNANT OR IF PREGNANCY WAS DIFFICULT FOR HER?

5/HOW DID MOTHER RESPOND WHEN YOU TALKED ABOUT HER UNBORN BABY AND WHEN YOU ASKED HER WHAT THOUGHTS SHE HAD ABOUT HER UNBORN BABY/FOETUS?

6/WRITE IN AS MUCH DETAIL AS POSSIBLE WHAT THE MOTHER TALKED ABOUT IN THIS VISIT AND HOW YOU REPLIED?

7/WHAT DO YOU THINK THE MOTHER WAS FEELING IN THIS VISIT?

8/ WHAT WERE YOU THINKING AND FEELING WHEN SHE WAS TALKING TO YOU?

9/ ARE YOU WORRIED ABOUT THE MOTHER OR HER SITUATION? IF YES – WHY? DO YOU NEED TO REFER MOTHER?

SUPERVISOR'S COMMENTS: DATE:

COUNSELLOR'S NAME: PROJECT NUMBER:

DATE: CLIENT'S NAME:

QUESTIONS FOR DETAILED REPORTS –**ANTENATAL VISIT 2**

1/ WHAT DID YOU OBSERVE ABOUT THE HOUSE AND THE MOTHER IN THIS VISIT?

2/ DID YOU GIVE INFORMATION IN THIS VISIT – IF YES – WHAT?

3/ HOW DID THE MOTHER RESPOND TO THE INFORMATION?

4/WHAT DID MOTHER SAY WHEN YOU ASKED HER IF SHE ENJOYED BEING PREGNANT OR IF PREGNANCY WAS DIFFICULT FOR HER?

5/HOW DID MOTHER RESPOND WHEN YOU TALKED ABOUT HER UNBORN BABY AND WHEN YOU ASKED HER WHAT THOUGHTS SHE HAD ABOUT HER UNBORN BABY/FOETUS?

6/WRITE IN AS MUCH DETAIL AS POSSIBLE WHAT THE MOTHER TALKED ABOUT IN THIS VISIT AND HOW YOU REPLIED?

7/WHAT DO YOU THINK THE MOTHER WAS FEELING IN THIS VISIT?

8/ WHAT WERE YOU THINKING AND FEELING WHEN SHE WAS TALKING TO YOU?

9/ ARE YOU WORRIED ABOUT THE MOTHER OR HER SITUATION? IF YES – WHY? DO YOU NEED TO REFER MOTHER?

SUPERVISOR’S COMMENTS: DATE:

COUNSELLOR'S NAME: PROJECT NUMBER:

DATE: CLIENT'S NAME:

QUESTIONS FOR SHORT REPORTS – **ANTENATAL VISIT 3**

1/Did you give the mother information in this visit? If yes, what information?

2/ What was the mother's mood during this visit? (happy, sad, angry etc)

3/What did mother say about her pregnancy in this visit?

4/ Were you worried about the mother or her unborn baby after this visit? If yes – what worried you?---

---

5/Do you need to refer mother?---

6/How did you (counsellor) feel after this visit?

DATE OF NEXT VISIT:----------

SUPERVISOR'S COMMENTS:

COUNSELLOR'S NAME: PROJECT NUMBER:

DATE: CLIENT'S NAME:

QUESTIONS FOR SHORT REPORTS – **ANTENATAL VISIT 4**

1/ Did you give the mother information in this visit? If yes, what information?

2/ What was the mother's mood during this visit? (happy, sad, angry etc)

3/What did mother say about her pregnancy in this visit?

4/ Were you worried about the mother or her unborn baby after this visit? If yes – what worried you?

5/Do you need to refer mother?

6/How did you (counsellor)feel after this visit?

DATE OF NEXT VISIT:----------

SUPERVISOR'S COMMENTS: ----------

COUNSELLOR'S NAME: PROJECT NUMBER:

DATE: CLIENT'S NAME:

QUESTIONS FOR SHORT REPORTS – **ANTENATAL VISIT 5**

1/ Did you give the mother information in this visit? If yes, what information?

2/ What was the mother's mood during this visit? (happy, sad, angry etc)

-3/What did mother say about her pregnancy in this visit?

4/ Were you worried about the mother or her unborn baby after this visit? If yes – what worried you?

5/Do you need to refer mother?

6/How did you (counsellor)feel after this visit?

DATE OF NEXT VISIT:----------

SUPERVISOR'S COMMENTS: ----------

COUNSELLOR'S NAME: PROJECT NUMBER:

DATE: CLIENT'S NAME:

POST-NATAL VISIT 1: THE MOTHER'S BIRTH STORY

HOW IS MOTHER TODAY? ARE YOU WORRIED ABOUT MOTHER?----------

First write the report in the language with which you feel most comfortable. Where required translate it into English. Write down the mother's story in as much detail as you can remember and try to use the mother's words.

Make sure you cover the points below:

*The process of labour, birth and the first few hours after the birth.

*How she felt she managed the process of labour and birth.

*How she felt she was cared for.

*Did she want, and was she allowed a birth attendant?

*What were her feelings and thoughts as she saw her baby for the first time?

*What would have improved the experience for her?

Read through your report carefully. Are there any gaps? Would anyone else reading it understand and make sense of what happened?

PLACE OF BIRTH: **BIRTH STORY:**

POSITIVE/NEGATIVE (CIRCLE)

NATURE OF BIRTH: NVD/C-SECTION (CIRCLE)

BABY'S BIRTHDATE: ---------- **SEX: ----------**

BABY'S BIRTH WEIGHT: (SEE CLINIC CARD) ----------

HEAD CIRCUMFERENCE: ----------

APGAR SCORE: ----------

DATE OF NEXT VISIT:----------

SUPERVISOR'S COMMENT: DATE:----------

BEHAVIOURAL ASSESSMENT

GUIDELINES FOR EVERY BEHAVIOURAL ASSESSMENT

IMPORTANT QUESTIONS COUNSELLORS MUST ASK **THEMSELVES** IN THE 1ST, 2ND AND 3RD ASSESSMENTS TO ASSESS IF THE BABY IS WITHDRAWN OR NOT:

1/ CHECK IF BABY'S FACIAL EXPRESSIONS CHANGE? WITH MOTHER OR OTHERS?

2/ CHECK IF BABY MAKES EYE CONTACT?

3/ HOW ACTIVE IS BABY DURING YOUR VISITS?

4/ DOES BABY SELF-STIMULATE OR ENGAGE WITH THE ENVIRONMENT?

5/ HOW VOCAL IS BABY?

6/ DOES BABY TRY AND ENGAGE WITH PEOPLE IN THE ROOM?

7/WHAT WERE YOUR FEELINGS ABOUT MOTHER/CAREGIVER AND BABY AT THE END OF EACH ASSESSMENT?

ASSESSMENT 1: POSTNATAL VISIT 2

DATE OF ASSESSMENT…….

PROJECT NUMBER…….

NAME OF ASSESSOR…….

MOTHER'S NAME……

MOTHER'S AGE…….

BABY'S NAME…….

BABY'S AGE…….

QUESTIONS

1/ WHO WAS PRESENT IN THE HOME WHEN YOU DID THE ASSESSMENT?

2/ HOW DID THE MOTHER AND FATHER PRESENT THEMSELVES? (EG. WHAT WAS THEIR PHYSICAL APPEARANCE LIKE? WHAT WAS THEIR MOOD LIKE?)

3/ DESCRIBE WHAT TYPE OF HOME AND THE CONDITIONS OF THE HOME.

4/ WHAT WORDS DO THE MOTHER AND FATHER USE TO DESCRIBE THE BABY?

ITEM 1: THE SIX BEHAVIOURAL STATES QUESTION A a/ DESCRIBE THE INFANT'S BEHAVIOUR DURING THIS ITEM:

---

b/ HOW WOULD THIS INFORMATION HELP THE MOTHER AND FATHER WITH THE MANAGEMENT OF THEIR INFANT?

---

c/ DESCRIBE THE MOTHER AND FATHER'S RESPONSE TO WHAT YOU DEMONSTRATED TO THEM AND SHARED WITH THEM DURING THIS ITEM:

---

d/ HOW DID YOU MANGE THIS ITEM? (EG. WHAT WAS EASY? WHAT DID YOU STRUGGLE WITH? WHAT DID YOU ENJOY?)

ITEM 2: SHUTTING OUT NEGATIVE STIMULATION (INTRUSIVE LIGHT AND SOUND) WHILE ASLEEP a/ DESCRIBE THE INFANT'S BEHAVIOUR DURING THIS ITEM:

a/ RESPONSE TO INTRUSIVE LIGHT

---

b/ RESPONSE TO INTRUSIVE SOUND

---

b/ HOW WOULD THIS INFORMATION HELP THE MOTHER AND FATHER WITH THE MANAGEMENT OF THEIR INFANT?

---

c/ DESCRIBE THE MOTHER AND FATHER'S RESPONSE TO WHAT YOU DEMONSTRATED TO THEM AND SHARED WITH THEM DURING THIS ITEM:

---

d/ HOW DID YOU MANAGE THIS ITEM? (EG. WHAT WAS EASY? WHAT DID YOU STRUGGLE WITH? WHAT DID YOU ENJOY?

ITEM 3: UNCOVERIING, UNDRESSING AND PLACING IN SUPINE (LYING ON BACK, FACE UPWARDS) a/ DESCRIBE THE INFANT'S BEHAVIOUR DURING THIS ITEM

---

b/ HOW WOULD THIS IINFORMATION HELP THE MOTHER AND FATHER WITH THE MANAGEMENT OF THEIR INFANT?

---

c/ DESCRIBE THE MOTHER AND FATHER'S RESPONSE TO WHAT YOU DEMONSTRATED TO THEM AND SHARED WITH THEM DURING THIS ITEM

---

d/ HOW DID YOU MANAGE THIS ITEM? (EG. WHAT WAS EASY? WHAT DID YOU STRUGGLE WITH? WHAT DID YOU ENJOY?)

ITEM 4: VENTRAL SUSPENSION a/ DESCRIBE THE

INFANT'S BEHAVIOUR DURING THIS ITEM

---

b/ HOW WOULD THIS INFORMATION HELP THE MOTHER AND FATHER WITH THE MANAGEMENT OF THEIR INFANT?

---

c/ DESCRIBE THE MOTHER AND FATHER'S RESPONSE TO WHAT YOU DEMONSTRATED TO THEM AND SHARED WITH THEM DURING THIS ITEM

---

d/ HOW DID YOU MANAGE THIS ITEM? (EG. WHAT WAS EASY? WHAT DID YOU STRUGGLE WITH? WHAT DID YOU ENJOY?)

ITEM 5: CRAWLING a/ DESCRIBE THE INFANT'S

BEHAVIOUR DURING THIS ITEM

---

b/ HOW WOULD THIS INFORMATION HELP THE MOTHER AND FATHER WITH THE MANAGEMENT OF THEIR INFANT?

---

c/ DESCRIBE THE MOTHER AND FATHER'S RESPONSE TO WHAT YOU DEMONSTRATED TO THEM AND SHARED WITH THEM DURING THIS ITEM

---

d/ HOW DID YOU MANAGE THIS ITEM? (EG. WHAT WAS EASY? WHAT DID YOU STRUGGLE WITH? WHAT DID YOU ENJOY?)

ITEM 6: DEFENSIVE MOVEMENTS (CLOTH OVER FACE) a/

DESCRIBE THE INFANT'S BEHAVIOUR DURING THIS ITEM

---

b/ HOW WOULD THIS INFORMATION HELP THE MOTHER AND FATHER WITH THE MANAGEMENT OF THEIR INFANT?

---

c/ DESCRIBE THE MOTHER AND FATHER'S RESPONSE TO WHAT YOU DEMONSTRATED TO THEM AND SHARED WITH THEM DURING THIS ITEM

---

d/ HOW DID YOU MANAGE THIS ITEM? (EG. WHAT WAS EASY? WHAT DID YOU STRUGGLE WITH? WHAT DID YOU ENJOY?)

ITEM 7: CRYING AND CONSOLABILITY a/ DESCRIBE THE INFANT'S BEHAVIOUR DURING THIS ITEM

---

b/ HOW WOULD THIS INFORMATION HELP THE MOTHER AND FATHER WITH THE MANAGEMENT OF THEIR INFANT?

---

c/ DESCRIBE THE MOTHER AND FATHER'S RESPONSE TO WHAT YOU DEMONSTRATED TO THEM AND SHARED WITH THEM DURING THIS ITEM

---

d/ HOW DID YOU MANAGE THIS ITEM? (EG. WHAT WAS EASY? WHAT DID YOU STRUGGLE WITH? WHAT DID YOU ENJOY?)

ITEM 8: CUDDLINESS a/ DESCRIBE THE INFANT'S

BEHAVIOUR DURING THIS ITEM

---

b/ HOW WOULD THIS INFORMATION HELP THE MOTHER AND FATHER WITH THE MANAGEMENT OF THEIR INFANT?

---

c/DESCRIBE THE MOTHER AND FATHER'S RESPONSE TO WHAT YOU DEMONSTRATED TO THEM AND SHARED WITH THEM DURING THIS ITEM

---

d/ HOW DID YOU MANAGE THIS ITEM? (EG. WHAT WAS EASY? WHAT DID YOU STRUGGLE WITH? WHAT DID YOU ENJOY?)

ITEM 9: SOCIAL INTERACTION PACKAGE (GENTLE RATTLE HEARD BUT NOT SEEN; RATTLE SEEN AND HEARD; FACE AND VOICE SEEN AND HEARD; VOICE HEARD BUT NOT SEEN)

a/ DESCRIBE THE IINFANT'S BEHAVIOUR DURING THIS ITEM

---

b/ HOW WOULD THIS INFORMATION HELP THE MOTHER AND FATHER WITH THE MANAGEMENT OF THEIR INFANT?

---

c/ DESCRIBE THE MOTHER AND FATHER'S RESPONSE TO WHAT YOU DEMONSTRATED TO THEM AND SHARED WITH HER DURING THIS ITEM

---

d/ HOW DID YOU MANAGE THIS ITEM? (EG. WHAT WAS EASY? WHAT DID YOU STRUGGLE WITH? WHAT DID YOU ENJOY?)

ITEM 10: IMITATION, RESPONSIVENESS AND RECIPROCITY a/

DESCRIBE THE INFANT'S BEHAVIOUR DURING THIS ITEM

---

b/ HOW WOULD THIS INFORMATION HELP THE MOTHER AND FATHER WITH THE MANAGEMENT OF THEIR INFANT

---

c/ DESCRIBE THE MOTHER AND FATHER'S RESPONSE TO WHAT YOU DEMONSTRATED TO THEM AND SHARED WITH THEM DURING THIS ITEM

---

d/ HOW DID YOU MANAGE THIS ITEM? (EG. WHAT WAS EASY? WHAT DID YOU STRUGGLE WITH? WHAT DID YOU ENJOY?)

ITEM 11: INTRUSIVENESS a/ DESCRIBE THE MOMENTS

---

b/ DESCRIBE THE INFANT'S BEHAVIOUR

---

c/ HOW DID YOU HANDLE THESE MOMENTS? (WHAT DID YOU SAY AND DO?)

---

d/ DESCRIBE THE MOTHER AND FATHER'S RESPONSE TO WHAT YOU DEMONSTRATED TO THEM AND SHARED WITH THEM DURING THIS ITEM

ITEM 12: ROOTING AND SUCKING a/ DESCRIBE THE

INFANT'S BEHAVIOUR DURING THIS ITEM

---

b/ HOW WOULD THIS INFORMATION HELP THE MOTHER AND FATHER WITH THE MANAGEMENT OF THEIR INFANT?

---

c/ DESCRIBE THE MOTHER AND FATHER'S RESPONSE TO WHAT YOU DEMONSTRATED TO THEM AND SHARED WITH THEM DURING THIS ITEM

---

d/ HOW DID YOU MANAGE THIS ITEM? (EG. WHAT WAS EASY? WHAT DID YOU STRUGGLE WITH? WHAT DID YOU ENJOY?)

CONCLUSION:

1/ HOW DID THE OTHER FAMILY MEMBERS WHO WERE PRESENT RESPOND TO THE ASSESSMENT?----------

---

2/ HOW WERE MOTHER AND BABY DURING THIS VISIT? DO YOU HAVE ANY CONCERNS?----------

---

SUPERVISOR'S COMMENTS: ----------

COUNSELLOR'S NAME: PROJECT NUMBER:

DATE: CLIENT'S NAME:

QUESTIONS FOR DETAILED REPORTS – **POSTNATAL VISIT 3**

1/ WHAT DID YOU OBSERVE ABOUT THE HOUSE AND THE MOTHER IN THIS VISIT?

2/ DID YOU GIVE INFORMATION IN THIS VISIT – IF YES – WHAT?

3/ HOW DID THE MOTHER RESPOND TO THE INFORMATION?

4/WHAT DID MOTHER SAY WHEN YOU ASKED HER IF SHE ENJOYED HER BABY OR IF IT WAS DIFFICULT TO BE WITH HER BABY?

5/ DESCRIBE IN DETAIL THE INTERACTION BETWEEN MOTHER AND BABY IN THIS VISIT

6/ ASK MOTHER – “DO YOU THINK YOUR BABY HAS THEIR OWN THOUGHTS AND FEELINGS? IF YES, WHAT COULD THEY BE?

7/WHAT ELSE DID THE MOTHER SAY TO YOU IN THIS VISIT?

8/ WHAT DO YOU THINK THE MOTHER WAS FEELING IN THIS VISIT?

9/ WHAT WERE YOU THINKING AND FEELING WHILE SHE WAS TALKING TO YOU?

10/ ARE YOU WORRIED ABOUT THE MOTHER OR HER SITUATION? IF YES – WHY? DO YOU NEED TO REFER MOTHER?

DATE OF NEXT VISIT:----------
SUPERVISOR'S COMMENTS: DATE:

NAME: PROJECT NUMBER:

DATE: CLIENT'S NAME:

QUESTIONS FOR SHORT REPORTS – **POST NATAL VISIT 4**

1/ Did you give the mother information in this visit? If yes, what information?

2/ What was the mother's mood during this visit? (happy, sad, angry etc)

3/How was the baby in this visit? And how did mother and baby interact in this visit?

4/Were you worried about the mother or the baby after this visit? If yes – what worried you?

5/Do you need to refer mother?

6/How did you (counsellor)feel after this visit?

DATE OF NEXT VISIT:----------

SUPERVISOR'S COMMENTS: ----------

BEHAVIOURAL ASSESSMENT

GUIDELINES FOR EVERY BEHAVIOURAL ASSESSMENT

IMPORTANT QUESTIONS COUNSELLORS MUST ASK **THEMSELVES** IN THE 1ST, 2ND AND 3RD ASSESSMENTS TO ASSESS IF THE BABY IS WITHDRAWN OR NOT:

1/ CHECK IF BABY'S FACIAL EXPRESSIONS CHANGE? WITH MOTHER OR OTHERS?

2/ CHECK IF BABY MAKES EYE CONTACT?

3/ HOW ACTIVE IS BABY DURING YOUR VISITS?

4/ DOES BABY SELF-STIMULATE OR ENGAGE WITH THE ENVIRONMENT?

5/ HOW VOCAL IS BABY?

6/ DOES BABY TRY AND ENGAGE WITH PEOPLE IN THE ROOM?

7/WHAT WERE YOUR FEELINGS ABOUT MOTHER/CAREGIVER AND BABY AT THE END OF EACH ASSESSMENT?

BEHAVIOURALASSESSMENT 2 – POST NATAL VISIT 5

DATE OF ASSESSMENT…… PROJECT

NUMBER…….

NAME OF ASSESSOR…….

MOTHER'S NAME…… MOTHER'S

AGE…….

BABY'S NAME…….

BABY'S AGE…….

QUESTIONS

1/ WHO WAS PRESENT IN THE HOME WHEN YOU DID THE ASSESSMENT?

2/ HOW DID THE MOTHER AND FATHER PRESENT THEMSELVES? (EG. WHAT WAS THEIR PHYSICAL APPEARANCE LIKE? WHAT WAS THEIR MOOD LIKE?

3/ DESCRIBE WHAT TYPE OF HOME AND THE CONDITIONS OF THE HOME?

4/ WHAT WORDS DO THE MOTHER AND FATHER USE TO DESCRIBE THE BABY?

ITEM 1: THE SIX BEHAVIOURAL STATES a/ DESCRIBE THE INFANT'S BEHAVIOURAL STATE DURING THIS ITEM

ITEM 2: SHUTTING OUT NEGATIVE STIMULATION (INTRUSIVE LIGHT AND SOUND) WHILE ASLEEP a/ DESCRIBE THE INFANT'S BEHAVIOUR DURING THIS ITEM a/RESPONSE TO INTRUSIVE LIGHT

---

b/ RESPONSE TO INTRUSIVE SOUND

ITEM 3: UNCOVERING, UNDRESSING a/ DESCRIBE THE

INFANT'S BEHAVIOUR DURING THIS ITEM

ITEM 4: VENTRAL SUSPENSION a/ DESCRIBE THE

INFANT'S BEHAVIOUR DURING THIS ITEM

ITEM 5: CRAWLING a/ DESCRIBE THE INFANT'S

BEHAVIOUR DURING THIS ITEM

ITEM 6: DEFENSIVE MOVEMENTS a/ DESCRIBE THE

INFANT'S BEHAVIOUR DURING THIS ITEM

ITEM 9: SOCIAL INTERACTION PACKAGE a/ DESCRIBE

THE INFANT'S BEHAVIOUR DURING THIS ITEM

CONCLUSION:

1/ COUNSELLOR MUST ASK MOTHER/CAREGIVER IF SHE WANTS ANYTHING ABOUT THE ASSESSMENT EXPLAINED AGAIN? IF SHE DID, GIVE DETAILS:

2/ DID PARENT/CAREGIVER COMMENT ON THE BABY DURING THE ASSESSMENT? WERE YOU CONCERNED ABOUT THEIR RESPONSE? IF YES, GIVE DETAILS:

3/ IF YOU WERE WORRIED ABOUT THE BABY'S DEVELOPMENT IN THIS ASSESSMENT THEN ASK THE MOTHER IF SHE IS WORRIED ABOUT HER BABY? WRITE DOWN YOUR CONCERN AND HER RESPONSE HERE:

4/ IF YOU THINK THE MOTHER/CAREGIVER IS STRUGGLING WITH CONSOLING OR CONNECTING WITH HER BABY OR IS INTRUSIVE WITH HER BABY OR STRUGGLES TO UNDERSTAND HER BABY'S CRIES – THEN **ITEMS 7 AND 8 AND 12** SHOULD BE REPEATED IN ALL THREE ASSESSMENTS.

5/ HOW WERE MOTHER AND BABY DURING THIS VISIT?DO YOU HAVE ANY CONCERNS?----------

---

SUPERVISOR'S COMMENTS: ----------

COUNSELLOR'S NAME: PROJECT NUMBER:

DATE: CLIENT'S NAME:

QUESTIONS FOR DETAILED REPORTS – **POSTNATAL VISIT 6**

1/ WHAT DID YOU OBSERVE ABOUT THE HOUSE AND THE MOTHER IN THIS VISIT?

2/ DID YOU GIVE INFORMATION IN THIS VISIT – IF YES – WHAT?

3/ HOW DID THE MOTHER RESPOND TO THE INFORMATION?

4/WHAT DID MOTHER SAY WHEN YOU ASKED HER IF SHE ENJOYED HER BABY OR IF IT WAS DIFFICULT TO BE WITH HER BABY?

5/ DESCRIBE IN DETAIL THE INTERACTION BETWEEN MOTHER AND BABY IN THIS VISIT

6/ ASK MOTHER: “DO YOU THINK YOUR BABY HAS THEIR OWN THOUGHTS AND FEELINGS? IF YES, WHAT COULD THEY BE?”

7/WHAT ELSE DID THE MOTHER SAY TO YOU IN THIS VISIT?

8/ WHAT DO YOU THINK THE MOTHER WAS FEELING IN THIS VISIT?

9/ WHAT WERE YOU THINKING AND FEELING WHILE SHE WAS TALKING TO YOU?

10/ ARE YOU WORRIED ABOUT THE MOTHER OR HER SITUATION? IF YES – WHY? DO YOU NEED TO REFER MOTHER?

DATE OF NEXT VISIT:----------
SUPERVISOR'S COMMENTS:

COUNSELLOR'S NAME: PROJECT NUMBER:

DATE: CLIENT'S NAME:

QUESTIONS FOR SHORT REPORTS – **POST NATAL VISIT 7**

1/ Did you give the mother information in this visit? If yes, what information?

2/ What was the mother's mood during this visit?(happy, sad, angry etc)----------

---

3/How was the baby in this visit? And how did mother and baby interact in this visit?

4/ Were you worried about the mother or the baby after this visit? If yes – what worried you?

5/Do you need to refer mother?----------

6/How did you (counsellor)feel after this visit?

DATE OF NEXT VISIT:----------

SUPERVISOR'S COMMENTS::----------

BEHAVIOURAL ASSESSMENT

GUIDELINES FOR EVERY BEHAVIOURAL ASSESSMENT

IMPORTANT QUESTIONS COUNSELLORS MUST ASK **THEMSELVES** IN THE 1ST, 2ND AND 3RD ASSESSMENTS TO ASSESS IF THE BABY IS WITHDRAWN OR NOT:

1/ CHECK IF BABY'S FACIAL EXPRESSIONS CHANGE? WITH MOTHER OR OTHERS?

2/ CHECK IF BABY MAKES EYE CONTACT?

3/ HOW ACTIVE IS BABY DURING YOUR VISITS?

4/ DOES BABY SELF-STIMULATE OR ENGAGE WITH THE ENVIRONMENT?

5/ HOW VOCAL IS BABY?

6/ DOES BABY TRY AND ENGAGE WITH PEOPLE IN THE ROOM?

7/WHAT WERE YOUR FEELINGS ABOUT MOTHER/CAREGIVER AND BABY AT THE END OF EACH ASSESSMENT?

BEHAVIORAL ASSESSMENT 3 – POST NATAL VISIT 8

DATE OF ASSESSMENT…….

PROJECT NUMBER…….

NAME OF ASSESSOR…….

MOTHER'S NAME…….

MOTHER'S AGE…….

BABY'S NAME……

BABY'S AGE……

QUESTIONS

1/ WHO WAS PRESENT IIN THE HOME WHEN YOU DID THE ASSESSMENT?

2/ HOW DID THE MOTHER AND FATHER PRESENT THEMSELVES? (EG. WHAT WAS THEIR PHYSICAL APPEARANCE LIKE? WHAT WAS THEIR MOOD LIKE?)

3/ DESCRIBE WHAT TYPE OF HOME AND THE CONDITIONS OF THE HOME?

4/ WHAT WORDS DO THE MOTHER AND FATHER USE TO DESCRIBE THE BABY?

ITEM 1: THE SIX BEHAVIOURAL STATES a/ DESCRIBE THE INFANT'S BEHAVIOR DURING THIS ITEM

ITEM 2: SHUTTING OUT NEGATIVE STIMULATION (INTRUSIVE LIGHT AND SOUND) WHILE ASLEEP a/ DESCRIBE THE INFANT'S BEHAVIOUR DURING THIS ITEM a/ RESPONSE TO INTRUSIVE LIGHT

---

b/ RESPONSE TO INTRUSIVE SOUND

ITEM 3: UNCOVERING, UNDRESSING a/ DESCRIBE THE INFANT'S BEHAVIOUR DURING THIS ITEM

ITEM 4: VENTRAL SUSPENSION a/ DESCRIBE THE INFANT'S BEHAVIOUR DURING THIS ITEM

ITEM 5: CRAWLING a/ DESCRIBE THE INFANT'S BEHAVIOUR DURING THIS ITEM

ITEM 6: DEFENSIVE MOVEMENTS a/ DESCRIBE THE

INFANT'S BEHAVIOUR DURING THIS ITEM

CONCLUSION:

1/ COUNSELLOR MUST ASK MOTHER/CAREGIVER IF SHE WANTS ANYTHING ABOUT THE ASSESSMENT EXPLAINED AGAIN? IF SHE DID, GIVE DETAILS:

2/ DID PARENT/CAREGIVER COMMENT ON THE BABY DURING THE ASSESSMENT? WERE YOU

CONCERNED ABOUT THEIR RESPONSE? IF YES, GIVE DETAILS:

3/ IF YOU WERE WORRIED ABOUT THE BABY'S DEVELOPMENT IN THIS ASSESSMENT THEN ASK THE MOTHER IF SHE IS WORRIED ABOUT HER BABY? WRITE DOWN YOUR CONCERN AND HER RESPONSE:

4/ IF YOU THINK THE MOTHER /CAREGIVER IS STRUGGLING WITH CONSOLING OR CONNECTING WITH HER BABY OR IS INTRUSIVE WITH HER BABY OR STRUGGLES TO UNDERSTAND HER BABY'S CRIES – THEN **ITEMS 7 AND 8 AND 12** SHOULD BE REPEATED IN ALL THREE ASSESSMENTS.

5/ YOU HAVE COMPLETED ALL THREE ASSESSMENTS - LOOK BACK AT ASSESSMENTS 1, 2, AND 3, AND DECIDE IF YOU HAVE ANY WORRIES ABOUT THE BABY'S DEVELOPMENT? IF YES GIVE DETAILS:

SUPERVISOR'S COMMENTS: ----------

COUNSELLOR'S NAME: PROJECT NUMBER:

DATE: CLIENT'S NAME:

QUESTIONS FOR SHORT REPORTS – **POST NATAL VISIT 9**

1/ Did you give the mother information in this visit? If yes, what information?

2/ What was the mother's mood during this visit? (happy, sad, angry etc)

3/How was the baby in this visit? And how did mother and baby interact in this visit?

4/ Were you worried about the mother or the baby after this visit? If yes – what worried you?

5/Do you need to refer mother?----------

6/How did you (counsellor)feel after this visit?

DATE OF NEXT SESSION: ----------

SUPERVISOR'S COMMENTS:----------

COUNSELLOR'S NAME: PROJECT NUMBER:

DATE: CLIENT'S NAME:

QUESTIONS FOR DETAILED REPORTS – **POSTNATAL VISIT 10**

1/ WHAT DID YOU OBSERVE ABOUT THE HOUSE AND THE MOTHER IN THIS VISIT?

2/ DID YOU GIVE INFORMATION IN THIS VISIT – IF YES – WHAT?

3/ HOW DID THE MOTHER RESPOND TO THE INFORMATION?

4/WHAT DID MOTHER SAY WHEN YOU ASKED HER IF SHE ENJOYED HER BABY OR IF IT WAS DIFFICULT TO BE WITH HER BABY?

5/ DESCRIBE IN DETAIL THE INTERACTION BETWEEN MOTHER AND BABY IN THIS VISIT

6/ ASK MOTHER – “DO YOU THINK YOUR BABY HAS THEIR OWN THOUGHTS AND FEELINGS? IF YES, WHAT COULD THEY BE?”

7/WHAT ELSE DID THE MOTHER SAY TO YOU IN THIS VISIT?

8/ WHAT DO YOU THINK THE MOTHER WAS FEELING IN THIS VISIT?

9/ WHAT WERE YOU THINKING AND FEELING WHILE SHE WAS TALKING TO YOU?

10/ ARE YOU WORRIED ABOUT THE MOTHER OR HER SITUATION? IF YES – WHY? DO YOU NEED TO REFER MOTHER?

DATE OF NEXT SESSION:----------
SUPERVISOR'S COMMENTS:

COUNSELLOR'S NAME: PROJECT NUMBER:

DATE: CLIENT'S NAME:

QUESTIONS FOR SHORT REPORTS – **POST NATAL VISIT 11**

1/ Did you give the mother information in this visit? If yes, what information?

2/ What was the mother's mood during this visit? (happy, sad, angry etc)

3/How was the baby in this visit? And how did mother and baby interact in this visit?

4/ Were you worried about the mother or the baby after this visit? If yes – what worried you?

5/Do you need to refer mother?---

6/How did you (counsellor)feel after this visit?

DATE OF NEXT SESSION:----------

SUPERVISOR'S COMMENTS:----------

COUNSELLOR'S NAME: PROJECT NUMBER:

DATE: CLIENT'S NAME:

QUESTIONS FOR SHORT REPORTS – **POST NATAL VISIT 12**

1/ Did you give the mother information in this visit? If yes, what information?

2/ What was the mother's mood during this visit? (happy, sad, angry etc)

3/How was the baby in this visit? And how did mother and baby interact in this visit?

4/ Were you worried about the mother or the baby after this visit? If yes – what worried you?

5/Do you need to refer mother?---

6/How did you (counsellor)feel after this visit?

DATE OF NEXT SESSION:---

SUPERVISOR'S COMMENTS:----------

COUNSLLOR'S NAME: PROJECT NUMBER:

DATE: CLIENT'S NAME:

QUESTIONS FOR SHORT REPORTS – **POST NATAL VISIT 13**

1/ Did you give the mother information in this visit? If yes, what information?

2/ What was the mother's mood during this visit? (happy, sad, angry etc)

3/How was the baby in this visit? And how did mother and baby interact in this visit?

4/ Were you worried about the mother or the baby after this visit? If yes – what worried you?

5/Do you need to refer mother?---

6/How did you (counsellor)feel after this visit?

DATE OF NEXT SESSION:----------

SUPERVISOR'S COMMENTS: ----------

COUNSELLOR'S NAME: PROJECT NUMBER:

DATE: CLIENT'S NAME:

QUESTIONS FOR SHORT REPORTS – **POST NATAL VISIT 14**

1/ Did you give the mother information in this visit? If yes, what information?

2/ What was the mother's mood during this visit? (happy, sad, angry etc)

3/How was the baby in this visit? And how did mother and baby interact in this visit?

4/ Were you worried about the mother or the baby after this visit? If yes – what worried you?

5/Do you need to refer mother?---

6/How did you (counsellor)feel after this visit?---

DATE OF NEXT SESSION:----------

SUPERVISOR'S COMMENTS:----------

COUNSELLOR'S NAME: PROJECT NUMBER:

DATE: CLIENT'S NAME:

QUESTIONS FOR SHORT REPORTS – **POST NATAL VISIT 15**

1/ Did you give the mother information in this visit? If yes, what information?

2/ What was the mother's mood during this visit? (happy, sad, angry etc)

3/How was the baby in this visit? And how did mother and baby interact in this visit?

4/ Were you worried about the mother or the baby after this visit? If yes – what worried you?

5/Do you need to refer mother?----------

6/How did you (counsellor)feel after this visit?

DATE OF NEXT SESSION:----------

SUPERVISOR'S COMMENTS:----------

Appendix I: M&E report

Parent Infant Intervention program

Monitoring and Evaluation Report

Month: .....

Attachment worker: .....

Total of weekly plans hand in for the period: .....

Area: .....

Supervisor: .....

Client: .....

Case nr: .....

Session: .....

Duration of session: .....

Planned/Unplanned visit (circle)

Date: .....

	Strengths	**Weaknesses/ challenges**
1.**Scheduled visit according to weekly plan**	....	....

	…… ….. …… …… …… ……	……
2**.Punctuality**	…… …… …… …… …… ……	…… …… …… …… …… ……
3.**Introduction of M/E worker** **Introduction of today`s session**	…… …… ……. …… …… …… …… ……	…… …… …… …… …… …… …… ……
4.**Recap of last visit**	…… …… …… …… …… …… …… ……	…… …. …… …… …… …… …… ……

6.**Preparedness for session**	…… …… …… …… …… ……	…… …… …… …… …… ……

7.Knowledge of specific session	…… …… …… …… …… …… …… …… ……	…… …… …… …… …… …… …… …… …… ……
8.Communicates clearly, sensitively and directly	…… …… …… …… …… …… ……	…… …… …… …… …… …… ……
9.The use of handouts or visual material	…… …… …… …… …… …… …… ……	…… …… …… …… …… ….. …… …..

10. Transfer of correct and relevant information	....	....
11.The ability to use		
clarification and reflection	....	....
12.The ability to identify appropriate referral requirements	....	....
13.Referral to other Parent centre programs	....	....

14.The ability to exercise boundaries	....	....
15.How does the worker addresses obstacles that interfere with service delivery	....	....

General comments

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

Any recommendations

.....

.....

.....

.....

.....

.....

.....

.....

Monitoring and Evaluation Social worker: .....

Signature: .....

Date: .....

Appendix J: DSD Termination Sheet

Month: Month: Month:

Total: Total: Total:

Project No.	Client name	Dates	Dates	Dates	Dates	Dates	Dates	Dates	Dates	Dates	Dates
		AN1	AN2	AN3	AN4	AN5	P1	P2	P3	P4	P5
		P6	P7	P8	P9	P10	P11	P12	P13	P14	P15
		AN1	AN2	AN3	AN4	AN5	P1	P2	P3	P4	P5

		P6	P7	P8	P9	P10	P11	P12	P13	P14	P15

Appendix K: Frequency statistics for evaluation question 1

Table K1

Frequencies of participant age groups (N = 131)*

Age group	*n*	%
10 yrs. – 19 yrs.	27	20.3
20 yrs. – 30 yrs.	70	52.6
31 yrs. – 45 yrs.	34	26.0
Total	131*	100.0

**Note. Missing 2 participant cases*

Table K2

Frequencies of enrolled PIHVP participants planning their pregnancy (N=126)*

Pregnancy status	*n*	%
Unplanned	81	64.3
Planned	45	35.7
Total	126*	100.0

**Note. Missing 7 participant cases*

Table K3

Frequencies of PIHVP participants' marital status (N = 130*)

Variable	*n*	%
Single and unattached	30	23.1
Married	41	31.5
Single and attached	59	45.4
Widowed	0	0
Total	130*	100.0

**Note. Missing 3 participant cases*

Appendix L: Frequency statistics for evaluation question 2

Table L1

Frequencies of reasons provided for programme dropout (N = 82)*

Reasons for dropout	*n*	%
Mom cannot be found	2	2.4
Miscarriage/baby died	3	3.7
Mom went back to school	6	7.3
Mom returned to work	13	15.9
Mom moved out of area	17	20.7
Mom not available	41	50.0
Total	82*	100%

**Note. Missing 1 participant case*

Appendix M: Quotes to support evaluation question 3

A. PIHVP not reaching target participant intake

"I think we aim for 300 per finished programmes per year. Uhm, it used to be 400 but it came down when we lost a couple of counsellors. So now we try to have each counsellor finish 30 moms from April to April, which we struggle with."

(Interviewee 2)

"As of end March, the programme only managed to enrol 182 participants…"

(Interviewee 3)

"Well, uhm the numbers are actually lying here somewhere, and it shows that we are actually a bit in trouble. So, the last numbers I got was that we finished 159 per end of this quarter, September."

(Interviewee 2)

B. Reasons for not reaching programme target

"… some of the counsellors find it easier to approach moms than others."

(Interviewee 1)

"You know that they walk to their visits which takes a lot of time, a long time to get from one to the next. Uhm, they are getting older so I'm sure that they're slower. We have one with arthritis, we have you know all these ladies that are getting older and I don't think the Parent Centre… I mean I keep saying: 'what's the plan? 'what are we going to do in the future?' We can't actually expect them to walk for hours forever. So that has impacted on our numbers."

(Interviewee 2)

"Training workshops and capacity building of PIACs take away a lot of time from home visits"

(Interviewee 3)

"Another thing often impacts is uhm that we maybe us as the [inaudible 1 second] that steer this programme haven't made conscious decisions as to how many days we should give of actual work with moms. We uhm, like this year we suddenly got to have a whole week of trauma training, which obviously benefits them (PIACs) hugely both work and personally, but then maybe we don't sit down and actually count that this actually means 40 less visits per day, so its 200 visits lost in a year."

(Interviewee 2)

"Well, when I came on board on this programme, I was quite shocked to realise that they actually have to get their own clients. I thought that's a hell of an ask to actually get your own clients. Do I think its hugely challenging you know these ladies have to have amazing counselling skills and listening skills, and then they also have to have like salesman skills and like group speaking skills? It's quite an ask uhm, and I'm not sure they feel supported enough by the top in getting recruitment pathways easier. I mean we've had stints over the years but we've never really managed to have a lasting system where the clinic sisters are on board enough for them to take the trouble to actually write out the referral and get them to us so that's a lot of finding them yourself, wondering around the area, preferably with a mate so they often they'll ask someone in the team to come out for the day because it's quite difficult to kind of sell yourself all on your own."

(Interviewee 2)

"Well I think that there's lots of reasons, I think uhm one reason is that it's hard to work in these communities, and when bullets are flying, we tend to tell our counsellors that safety comes first don't go to work. They are known in their communities so whenever there are hectic days old clients will call them and say: 'this is not a good day, don't come'. Often, they don't go, sometimes they go home half-way because there's been an incident, or it just feels to tense and hectic. So that obviously impacts."

(Interviewee 2)

"… you see the other thing with the challenges is the attempted visits. Uhm it is difficult because again often in the informal settlements, as you've probably discovered, finding somebody is very difficult and it often requires the counsellor to have made an arrangement with the new recruit to meet at a certain point and so they can show them where they live. And what often happens is they are not where they should be, where they need to show them and then they (PIAC) get very disappointed with that, so look that is an ongoing challenge."

(Interviewee 1)

"… then also what obviously impacts is when people move away, then they just don't count. We get them they want to (do the programme) but then they move. Or they… like Mary*, her whole cohort that you are trying to get hold of have relocated, you know? So they are going from a funny little place in Nyanga and relocating to Kuils River or… and then in the middle you are trying to finish a programme, but you only got to PN7 or PN8 and then it doesn't count, so that's unfortunate like maybe in the past our numbers looked better because we didn't have that."

(Interviewee 2)

"…you get people's houses who have burnt down and things like that. Then the whole demographic changes of the areas that you (visit)… I mean Imizamo Yethu for instance, where a whole section is wiped out for one counsellor and uhm they try and find the mothers and rebuild again, so that's a challenge."

(Interviewee 3)

Appendix N: Client Evaluation form results

Table N1

Frequencies of the level of communication captured by PIACs during PIHVP sessions (N=50)

Programme component	Level of communication captured		Total	Open-ended	
	Closed-ended	No response			
		%	%	%	%
Antenatal					

Session 1	84	2	12	100
Session 2	88	10	2	100
Session 3	12	12	76	100
Session 4	52	6	42	100
Session 5	16	22	62	100
Postnatal				
Session 1	100	0	0	100
Session 2	22	72	6	100
Session 3	80	12	8	100
Session 4	30	38	32	100
Session 5	26	48	26	100
Session 6	66	24	1	100
Session 7	24	46	30	100
Session 8	12	52	36	100
Session 9	24	50	26	100
Session 10	54	26	20	100
Session 11	10	40	50	100
Session 12	20	38	42	100
Session 13	28	50	22	100
Session 14	20	40	40	100
Session 15	28	40	32	100

Appendix O: Frequency statistics for evaluation question 5

Antenatal sessions

Table O1

Frequencies of PIACs completing antenatal session 1 activities (N = 50)

Variable	Response	*n*	%
Activity 1	Yes	50	100
	No	0	0
		50	100
Activity 2	Yes	26	52
	No	24	48
		50	100

Table

O2

Frequencies of PIACs completing antenatal session 2 activities and screenings (N = 50)

Variable	Screening	Response	*n*	%
		Yes	44	88
		No	6	12
			50	100
Activity 1		Yes	46	92
		No	4	8
			50	100
Activity 2		Yes	36	72
		No	14	28
			50	100
Activity 3		Yes	34	68
		No	16	32
			50	100
Activity 4		Yes	5	10
		No	45	90
			50	100

Table

O3

Frequencies of PIACs completing antenatal session 3 activities (N = 50)

Variable	Activity 1	Response	*n*	%
		Yes	41	82
		No	9	18
			50	100
	Activity 2	Yes	3	6
		No	47	94
			50	100
	Activity 3	No	50	100
		Yes	0	0
			50	100

Table

Activity 4	Yes	50	100
	No	0	0
		50	100

O4

Frequencies of PIACs completing antenatal session 4 activities (N = 50)

Variable	Response	*n*	%
Activity 1	Yes	47	94
	No	3	6
		50	100
Activity 2	No	50	100
	Yes	0	0
		50	100

Table

Activity 3	Yes	22	44
	No	28	56
		50	100
Activity 4	Yes	1	2
	No	49	98
		50	100

O5

Frequencies of PIACs completing antenatal session 5 activities (N = 50)

Variable	Activity 1	Response	N	%
		Yes	19	38
		No	31	62
			50	100

Table

Activity 2	Yes	27	54
	No	23	46
		50	100
Activity 3	Yes	34	68
	No	16	32
		50	100
Activity 4	Yes	7	14
	No	34	68
		50	100
Activity 5	No	50	100
	Yes	0	0
		50	100

Postnatal sessions

Table O6

Frequencies of PIACs completing postnatal session 1 activities and screenings (N = 50)

Variable	Response	*n*	%
Activity 1	Yes	50	100
	No	0	0
		50	100
Activity 2	No	50	100
	Yes	0	0
		50	100
Activity 3	Yes	13	26
	No	37	74
		50	100
Activity 4	Yes	10	20
	No	40	80

Table

		50	100
Activity 5	No	50	100
	Yes	0	0
		50	100

O7

Frequencies of PIACs completing postnatal session 2 activities and screenings (N = 50)

Variable	Response	*n*	%
Screening	Yes	50	100
	No	0	0
		50	100
Activity 1	No	50	100
	Yes	0	0
		50	100
Activity 2	No	50	100

Table

	Yes	0	0
		50	100
Activity 3	No	50	100
	Yes	0	0
		50	100

O8

Frequencies of PIACs completing postnatal session 3 activities and screenings (N = 50)

Variable	Response	*n*	%
Screening	Yes	45	90
	No	5	10
		50	100
Activity 1	Yes	42	84
	No	8	16
		50	100

Table

Activity 2	Yes	17	34
	No	33	66
		50	100
Activity 3	Yes	13	26
	No	37	74
		50	100
Activity 4	Yes	11	22
	No	39	78
		50	100

O9

Frequencies of PIACs completing postnatal session 4 activities and demonstrations (N = 50)

Variable	Response	*n*	%
Demonstration	Yes	47	94

Table

	No	3	6
		50	100
Activity 1	Yes	2	4
	No	48	96
		50	100
Activity 2	Yes	13	26
	No	37	74
		50	100
Activity 3	Yes	9	18
	No	41	82
		50	100
Activity 4	Yes	4	8
	No	46	92
		50	100

Table

O10

Frequencies of PIACs completing postnatal session 5 activities and screenings (N = 50)

Variable	Response	*n*	%
Screening	Yes	48	96
	No	2	4
		50	100
Activity 1		3	6
	Yes		
	No	47	94
		50	100
Activity 2		50	100
	No		
	Yes	0	0
		50	100
Activity 3		50	100
	No		

Table

	Yes	0	0
		50	100

O11

Frequencies of PIACs completing postnatal session 6 activities and screenings (N = 50)

Variable	Screening	Response	*n*	%
		Yes	45	90
		No	5	10
			50	100
Activity 1			19	38
	Yes			
	No		31	62
			50	100
Activity 2			15	30
	Yes			
	No		35	70
			50	100

Table

Activity 3		10	20
	Yes		
	No	40	80
		50	100

O12

Frequencies of PIACs completing postnatal session 7 activities and demonstrations (N = 50)

Variable	Response		
		n	%
Demonstration	Yes	42	84
	No	8	16
		50	100
Activity 1	Yes	13	26
	No	37	74
		50	100
Activity 2	Yes	11	22
	No	39	78
		50	100

Table

Activity 3	Yes	4	8
	No	46	92
		50	100

O13

Frequencies of PIACs completing postnatal session 8 activities and screenings (N = 50)

Variable	Response	*n*	%
Screening	Yes	50	100
	No	0	0
		50	100
Activity 1		50	100
	No		
	Yes	0	0
		50	100
Activity 2		50	100
	No		

Table

	Yes	0	0
		50	100
Activity 3		50	100
	No		
	Yes	0	0
		50	100

O14

Frequencies of PIACs completing postnatal session 9 activities (N = 50)

Variable	Response	*n*	%
Activity 1	Yes	39	78
	No	11	22
		50	100
Activity 2	Yes	27	54
	No	23	46
		50	100

Table

Activity 3	Yes	15	30
	No	35	70
		50	100
Activity 4	Yes	9	18
	No	41	82
		50	100

O15

Frequencies of PIACs completing postnatal session 10 activities (N = 50)

Variable	Response	*n*	%
Activity 1	Yes	46	92
	No	4	8
		50	

Table

Activity 2	Yes	21	42
	No	29	58
		50	
Activity 3	Yes	19	38
	No	31	62
		50	
Activity 4	Yes	10	20
	No	40	80
		50	100

O16

Frequencies of PIACs completing postnatal session 11 activities (N = 50)

Variable	Response	*n*	%
Activity 1	Yes	47	94
	No	3	6

Table

		50	100
Activity 2		17	34
	Yes		
	No	33	66
		50	100
Activity 3		13	26
	Yes		
	No	37	74
		50	100
Activity 4		8	16
	Yes		
	No	42	84
		50	100

O17

Frequencies of PIACs completing postnatal session 12 activities (N = 50)

Table

Variable	Response	*n*	%
Activity 1	Yes	47	94
	No	3	6
		50	100
Activity 2	Yes	25	50
	No	25	50
		50	100
Activity 3	Yes	21	42
	No	29	58
		50	100
Activity 4	Yes	10	20
	No	40	80
		50	100

O18

Frequencies of PIACs completing postnatal session 13 activities and screenings (N = 50)

Variable	Response	*n*	%
Screening	Yes	48	96
	No	2	4

Table

		50	100
Activity 1		46	92
	Yes		
	No	4	8
		50	100
Activity 2		27	54
	Yes		
	No	23	46
		50	100
Activity 3		17	34
	Yes		
	No	33	66
		50	100
Activity 4		12	24
	Yes		
	No	38	76
		50	100

Table

O19

Frequencies of PIACs completing postnatal session 14 activities (N = 50)

Variable	Response	*n*	%
Activity 1	Yes	39	78
	No	11	22
		50	100
Activity 2	Yes	27	54
	No	23	46
		50	100
Activity 3	Yes	23	46
	No	27	54
		50	100
Activity 4	Yes	18	36
	No	32	64
		50	100

Table

O20

Frequencies of PIACs completing postnatal session 15 activities (N = 50)

Variable	Response	*n*	%
Activity 1	Yes	42	84
	No	8	16
		50	100
Activity 2	Yes	29	58
	No	21	42
		50	100
Activity 3	Yes	19	38
	No	31	62
		50	100
Activity 4	Yes	14	28
	No	36	72
		50	100

Appendix P: Quotes to support evaluation question 8

A. Curriculum topics and PIAC counselling seen as programme's strength

"The way I must look after my baby, as in rubbing her out, checking where its sore and whatever, her cries basically everything about her (the baby). So, everything in the session it stuck. Like if I find a problem, (the baby) is maybe feverish or she's starting to get feverish, then I would think back: 'Okay, Diana* said this… okay, I've got a pamphlet about that, so wait I'm just going to recall quickly before I rush somewhere'. Then I think about her (the PIAC) and then I'll try (what I learnt), then it works! So basically everything (all session topics) helped me."

(Interview 9)

"How to massage the baby, and how to help the baby when they have stomach cramps and everything else I learnt was very helpful."

(Interview 3)

"The pictures of the foetus [giggles] and answering the questions that I had; of the umbilical cord tangling around the baby's neck and all those things, and uhm… getting answers to the questions that I had to everything was good."

(Interview 4)

Participants considered another strength of the programme to be the counselling they received from PIACs:

"This programme was a really, really big help for me through everything, I couldn't have asked for a better counsellor. If I wasn't there (at the MOU) that day, and Veronica* wasn't there, I wouldn't have gotten the kind of help that Veronica* offered me, so this programme was great, it was wonderful."

(Interview 10)

"I would really, really like to thank the programme, for employing miss Diana* because the impact that she had on me, I believe that she has the same impact on other mothers because it really helped me. I don't know how other mothers feel, but she helped me, so it was actually a great experience for me."

(Interview 4)

Current length of the programme considered a shortcoming, with this slightly branching out to the actual duration of home visit session. The first three quotes (Interview 3, 7 and 9) substantiate the theme of the programme length being a shortcoming of the PIHVP, while the fourth quote (Interview 4) validates the duration of home visit sessions:

"I would say that the period should be longer, maybe until the baby turns 1 years old? Because when the baby turns 1, there is other stuff and then we also need help."

(Interview 3)

"You see, I told her (PIAC) she must continue to come after 6 months…like for 1 year at least."

(Interview 7)

"I think they must make it (the programme) a little longer man. Like not 6 months, a bit more than 6 months. (After) 6 months some mothers are still in a state of depression, stress or something like that. Maybe you learnt (how to deal with it) in the programme, but at that moment it just slips your mind. So, I think it should stretch to 1 year for some parents, just to check up on the child and the mother. I think that would be helpful."

(Interview 9)

"Besides making (the programme), maybe (make) the (session) hours a little bit more? It's mostly about an hour, right? So maybe an hour and a half? Because sometimes we get into conversation and then time passes by so quickly."

(Interview 4)

B. Participants perceptions of programme's impact

"The programme helped me raise my child, with breastfeeding my child, with everything."

(Interview 6)

"Yes, (the programme) has changed me, because now I know what to do with my children when I'm raising them. It has changed my parenting."

(Interview 8)

An additional sub-theme indicated that the PIHVP impacted on the participant's mental health:

"(The programme) really had an impact. When this programme was introduced to me, uhm I really opened up, so for me it was just like really a relief just to get all of those things out that was stressing me during the pregnancy."

(Interview 4)

C. High recommendation of the PIHVP to others

"Yes, I will recommend it (the programme) to other women. It is helpful and encouraging. I can also tell other women that is very helpful."

(Interview 6)

"…even when I'm at the clinic and I see a pregnant woman, I tell her about the programme. I used to have a (Parent Centre) card that I would give to pregnant woman. I would tell them: 'It's not for sick people, it's for everyone that is pregnant'".

(Interview 8)

"I always do (recommend the programme), every day. I even sit with them (other mothers) and say: 'You know what? I had someone that helped me, its Diana*. If you wanna be captured (onto the PIHVP) go to her, go to the clinic – to the MOU, I will describe her face to you."

(Interview 9)

Appendix Q: Frequency statistics for evaluation question 9

Table Q1

Frequencies of the level of communication captured by PIACs during PIHVP sessions (N = 50)

Programme component	Level of communication captured		Total	Open-ended
	Closed-ended	No response		
	%	%	%	%
Antenatal				
Session 1	84	2	12	100
Session 2	88	10	2	100
Session 3	12	12	76	100
Session 4	52	6	42	100
Session 5	16	22	62	100
Postnatal				
Session 1	100	0	0	100
Session 2	22	72	6	100
Session 3	80	12	8	100
Session 4	30	38	32	100
Session 5	26	48	26	100
Session 6	66	24	1	100
Session 7	24	46	30	100
Session 8	12	52	36	100
Session 9	24	50	26	100

Session 10	54	26	20	100
Session 11	10	40	50	100
Session 12	20	38	42	100
Session 13	28	50	22	100
Session 14	20	40	40	100
Session 15	28	40	32	100

Appendix R: High-level guideline for planning and developing a participatory M&E framework

The high-level guidelines to planning and developing an M&E framework using a participatory approach are based on eight essential steps identified by Lennie, Tacchi, Koirala, Wilmore and Skuse (2011). In some instances, these steps were slightly modified to better suit the context of the PIHVP.

Step 1: Identify stakeholders

The programme manager and evaluator should schedule an initial meeting to identify individuals who have high levels of interest and influence on the programme in terms of their roles and responsibilities. In the context of the PIHVP, this would most likely be the programme manager herself, the two programme supervisors, and the two programme social workers – one who conducts PIAC performance monitoring, and the other who counsels families who are part of the PIHVP. However, the evaluator should ensure stakeholders do not only consist of management staff, but also staff who are in direct contact with participants as well. The programme manager and evaluator should reach a consensus on these stakeholders before their participation in the development of the framework is confirmed.

Step 2: Clarify expectations and outcomes from the evaluation

This step focuses on stakeholders' expectations of the M&E process and their informational needs. Different stakeholders often require different information from the M&E framework and differ in their preferred method of collecting this information. To satisfy all stakeholder needs, each of them should be asked: 'what are the key things you want to find out

about the programme?' The evaluator suggests this question be posed via email, as it would be more convenient and economical than setting up a meeting. The evaluator should then formulate stakeholders' answers into a list of research questions, then refine this list to limit repetitive questions. Stakeholders should then be engaged again, preferably through a follow-up email, where the refined list of questions are made available to them, from which they should highlight a final list of research questions that are an immediate priority to them. The research questions indicated as an immediate priority for the programme should then become the evaluation's focus, which should consequently inform the expectations and outcomes of this process.

Step 3: Identify objectives and indicators

Another meeting should then be held with all stakeholders to determine the programme's objectives. The stakeholders should list what they regard as the process and outcome objectives of the programme. Once completed, it is suggested that the evaluator visually project the logic model of the PIHVP and collaboratively with stakeholders, compare how well their listed objectives relate to the model. Through this comparison, key process and outcome objectives of the PIHVP will emerge.

The meeting's focus should then shift to which process and outcome indicators should be included in the M&E framework based on the objectives identified. The evaluator should utilise Kusek and Rist's (2004) "CREAM" criteria to select good performance indicators that are: Clear, Relevant, Economic, Adequate and Monitorable (Kusek & Rist, 2004). First, outcome statements should be drafted for all programme objectives in a Microsoft Word table. Then, potential indicators that are collaboratively determined should be subjected to the "CREAM" criteria. This ought to result in a final list of indicators suitable for the M&E framework. It is suggested that the evaluator develop their own list of suitable indicators as well in case programme staff have difficulty developing their own. These indicators should be subjected to the "CREAM" criteria as well, to determine their suitability for the M&E framework. Priority should be placed on having a manageable number of indicators that could be reviewed regularly and periodically by the programme.

Step 4: Identify key questions

It is suggested that the evaluator host a workshop to introduce and discuss the Development Assistance Committee's (DAC) criteria. Following the DAC criteria ensures evaluation questions are relevant, effective, efficient, impactful and sustainable (OECD, 2002). The DAC criteria, the PIHVP's programme theory and objectives, and the indicators identified in the previous step should be used to formulate evaluation questions for the M&E framework. Stakeholders should be encouraged to draft initial research questions, which are then compared to the DAC criteria. As a result, a comprehensive list of evaluation questions ought to be formulated. This list should then be presented to the stakeholders, upon which key evaluation questions should collaboratively be agreed upon.

Step 5: Determine which methods to use

The workshop should then shift focus to identifying appropriate methods to utilize in order to answer the key evaluation questions. This discussion should provide different stakeholders with the type of information they want when they want it; and assist in answering evaluation questions. In addition, stakeholders should be made aware of a range of appropriate qualitative and quantitative research methods, as well as their associated strengths and limitations. It is suggested that research methods that complement one another, as well as the programme, be encouraged. Furthermore, the PIHVP's capacity to implement certain research methods and how conducive they were to the participants involved should also be considered before a consensus is reached on which methods to utilise for the M&E framework.

Step 6: Consideration of resources and support available

Another meeting should be held with all stakeholders to determine the amount of resources and support required from the programme for its monitoring and evaluation. Discussions should focus on: the amount of time needed to complete the collection, analysis and reporting of data for each evaluation question; the amount of staff, level of expertise and support from programme management to conduct the evaluation research; and the financial capacity of the programme to fund the evaluation. It is recommended that this information be captured on a Microsoft Excel spreadsheet and later visually projected to start discussion on, and confirm, the logistics and costs associated with each evaluation question in terms of the abovementioned

discussion points. The outcome of this discussion should assist in the estimation of the evaluation's scale and scope, as this should be proportionate to the scale of the programme.

Step 7: Develop an implementation strategy

A final meeting should then be held with all stakeholders to schedule all key tasks in the M&E framework. It is suggested that a Gannt chart be developed using Microsoft Excel, which details key evaluation tasks down the first column of the spreadsheet, and the timeframe across the other rows. Collaboratively, realistic time frames should be set for each activity using the Gannt chart, with the evaluator ensuring that tasks are well integrated with one other. Back-up processes for possible implementation issues, such as low data quality, should also be discussed to ensure the M&E framework can remain effective and efficient despite encountering unforeseen issues.

Step 8: Develop learning and improvement strategy

The final meeting's focus should then shift to discussion on the best dissemination strategy for the outcomes of the M&E framework and recommendations to stakeholders. As previously mentioned, the development and implementation of the M&E framework within the PIHVP is to increase their current M&E knowledge and understanding, as such it is encouraged that the process be viewed as an opportunity for continual learning and improvement of the programme. Suggestions include holding quarterly or annual meetings; issuing quarterly or annual reports; or a combination of both. Stakeholders should then suggest their preferred dissemination strategy. This could be done by casting a vote, upon which the majority vote can be chosen as the selected strategy.