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EVALUATING THE TRAINING AND SUPERVISION OF HOME VISITORS IN A
PARENT-INFANT HOME VISITATION PROGRAMME

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A dissertation submitted in partial fulfilment of the requirements for the award of the Degree
of Master of Social Sciences in Organisational Psychology

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COMPULSORY DECLARATION:

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works of other people has been attributed, cited and referenced according to the convention of the APA Publication Manual (6th ed.).

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Date:30/04/2010.....

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Executive summary

The training and supervision of home visitors for the Parent Centre's Parent-Infant Home Visitation Programme (PIHVP) was evaluated. The evaluation aimed to determine whether training and supervision prepared the home visitors to deliver the PIHVP as intended. The following evaluation questions were therefore asked:

1. Do home visitors perceive that pre-service training has given them sufficient knowledge and skills to deliver the service as intended?
2. From the perspective of the recipients, do home visitors apply their knowledge and skills during home visitation?
3. Do programme recipients find the skills and knowledge applied by the home visitors to be useful?
4. From the perspective of the home visitors, does supervision adequately prepare them for home visitation?

In order to answer these evaluation questions, supervision and training questionnaires were administered to 12 home visitors. The supervision questionnaire measured home visitors' views on the extent to which group and individual supervision fulfil their educative, supportive and administrative functions, and the extent to which they felt supervision prepared them for visits. The training questionnaire asked them to rate the extent of their home visiting skills and knowledge a) before training and b) immediately after training. Interviews were also conducted with 27 past programme recipients, during which they were asked a) in which areas their home visitor assisted them, b) which assistance they found most useful and c) if there were any other areas in which they would like to have been assisted.

Results from the training questionnaire suggest that home visitors feel that training adequately prepared them for home visiting. Even when they had knowledge and skills in some areas prior to training, they felt that training significantly contributed to these. Furthermore, many home visitors noted how training has positively affected their own family lives.

The supervision questionnaire results indicated that home visitors felt that both individual and group supervision fulfilled their functions, but that group supervision did so to a greater extent. Some home visitors expressed a desire to have more individual sessions per month.

The recipient interviews confirmed that home visitors apply their training skills and knowledge during visits and further confirmed that they individualise home visits to suit the

needs of recipients. Recipients were most frequently assisted in areas that were highly relevant to pregnant women and new mothers, such as infant massage, breast feeding and nutrition, emotional support and drinking during pregnancy. Highly relevant areas were also perceived by recipients to be the most useful. Four mothers indicated that they wished for the programme to continue for longer, and seven mothers indicated additional areas in which they would have liked to have been assisted.

Two important additional findings were made. Firstly, home visiting information sheets were often incomplete. Secondly, important information related to the vulnerability of recipients is not available; this information is important if programme staff want to know whether the programme is delivered to the intended targets.

Given these findings, the following recommendations can be made:

- 1) To maximise the learning process, those home visitors who have relevant skills and knowledge prior to training should act as peer educators during training.
- 2) Home visitors who desire more individual supervision sessions per month should be offered these if funding allows for it. This will ensure that they will be fully supported and prepared for home visits.
- 3) Since mothers found assistance with areas that are highly relevant to them to be considerably useful, training should focus more on issues that are highly relevant to new mothers and less on issues that are not.
- 4) Home visiting coversheets need to be completed in full by home visitors in order to ensure that the programme is being implemented as intended.
- 5) Comprehensive risk profiles should be compiled for each recipient to ensure that the programme is delivered to the intended targets.

Abstract

An evaluation of the training and supervision of the Parent Centre's Parent-Infant Home Visitation Programme was conducted for the purposes of this dissertation. The evaluation used training and supervision questionnaires administered to 12 home visitors and structured interviews conducted with 27 programme recipients. The evaluation indicated that home visitors perceived that training and supervision adequately prepared them for home visits. Even when home visitors had knowledge and skills in some of the areas prior to training, it was still perceived to significantly contribute to their home visiting skills and knowledge. Some indicated that they desired more individual supervision sessions per month. Interviews with recipients revealed that support in areas that were highly relevant to mothers with young infants were perceived to be the most useful. During the evaluation, it was also discovered that programme records were sometimes missing, incomplete or inadequate. Given these findings, key recommendations for programme implementation are made.

Keywords: programme evaluation, home visiting, home visitor training, home visitor supervision, parent-infant interventions

Chapter One: Introduction

A programme evaluation may focus on programme need, design and theory, implementation, outcomes or cost and efficiency (Rossi, Lipsey, & Freeman, 2004). Research undertaken for this dissertation involved an implementation evaluation of the Parent Infant Home Visitation Programme (PIHVP). The PIHVP consists of pre- and post-natal home visits to mothers who are at risk of forming insecure infant attachment and maltreating their children. This programme is run by the Parent Centre, a Cape-Town based NGO providing various services to parents (www.parenting.org.za). In particular, this evaluation focuses on the training and supervision of home visitors and the perceptions of the programme recipients of the PIHVP. More specifically, the evaluation aims to determine whether the training and supervision process is perceived by home visitors to have adequately prepared them for their role and whether the services provided are perceived as useful by recipients.

Structure of the Dissertation

This dissertation is written up in a form that straddles the demands of a research dissertation and a programme evaluation report (as required for this degree programme). This chapter presents a discussion of home visiting programmes, a detailed description of the Parent Centre's PIHVP, supervision, training and programme theory. The literature around home visiting interventions is reviewed to test the plausibility of the Parent Centre's programme theory. The chapter ends with the evaluation rationale and questions. Chapter Two describes the evaluation methods, in particular the data providers, materials and data analysis. Chapter Three consists of the results and discussion of the evaluation as well as some important additional findings. Chapter Four contains the conclusion, recommendations, a comment on the contribution to the field and the limitations of the evaluation.

The Nature of Home Visiting Programmes

Home visiting programmes vary in their goals, targets, implementation and timing. Overall, PIHVPs aim to prevent and remedy the various problems that vulnerable populations of mothers and young children or infants face. Mothers can be considered as vulnerable to these problems if they are unmarried, younger than 19 years of age and have low income (Overpeck, Brenner, Trumble, Trifiletti, & Berendes, 1998). The ages of the children targeted by these interventions vary, with some interventions targeting infants (Armstrong, Fraser,

Dadds, & Morris, 1999; Olds 2002; Cooper *et al.*, 2002; Cooper *et al.*, 2009) and others targeting children as old as six years (Watanabe, Flores, Fujiwara & Tran, 2005).

Examples of the various goals of these programmes include reducing child maltreatment (Olds, 2002); improving infant nutrition (Walker, Chang, Powell, & Grantham-Mcgregor, 2005); improving mother-child interactions (Armstrong *et al.*, 1999; Cooper *et al.*, 2002; Cooper *et al.*, 2009); improving maternal antenatal health (Olds *et al.*, 2002); reducing maternal depression (Armstrong *et al.*, 1999) decreasing childhood morbidity and mortality due to unintentional injuries (Odendaal, Marais, Munro, & van Niekerk, 2008); improving child cognitive development (Watanabe *et al.*, 2005) and increasing the quality of the home environment (Fraser, Armstrong, Morris, & Dadds, 2000). The implementation of these services may be carried out by nurses (Armstrong *et al.*, 1999; Olds, 2002), paraprofessionals (Cooper *et al.*, 2002; Cooper *et al.*, 2009) or non-professionals (Wasik & Roberts, 1994). Some programmes begin during pregnancy (Olds, 2002; Cooper *et al.*, 2009) while others begin in the post-natal period (Armstrong *et al.*, 1999; Cooper *et al.*, 2002). PIHVPs differ in their length, with some programmes lasting for only six weeks in the immediate postnatal period (Armstrong *et al.*, 1999) and others lasting from pregnancy until the child is two years old (Olds, 2002).

The nature of home visitor training and supervision also varies across PIHVPs. Training can take place before home visitation begins (pre-service training) and once home visitors have begun visitation (in-service training) (Wasik & Roberts, 1994). Some programmes utilise both training types, whilst some utilise only one. The length and intensity of training also varies widely across programmes (Gomby, Culross, & Behrman, 1999). Supervision of home visitors may take place in groups, individually or on-site. The most recent survey of home visitor supervision was conducted by Wasik and Roberts (1994). They found that the frequency of supervision varies widely. Some programmes offer weekly individual or group supervision, whilst others only offer these supervision types every few months. Programmes may offer on-site supervision either on a monthly, bi-monthly or quarterly basis. Wasik and Roberts (1994) concluded that home visitors do not receive adequate supervision and training, as many home visitors received little or no supervision and little ongoing training.

The Need for Parent-Infant Home Visitation Programme in South Africa

The Parent Centre's PIHVP focuses mainly on promoting secure infant attachment and preventing child maltreatment. Programmes such as these are needed in the South

African context, due to the fact that many South African mothers experience stressors that may interact to increase the likelihood of forming insecure infant attachment and maltreating their children (Dawes & Ward, 2008).

Some of the stressors associated with maltreatment are related to maternal youth (Baumrind, 1994; Brown, Cohen, Johnson, & Salzinger, 1998). Teenage pregnancies and hence maternal youth are common in South Africa: in 2003, 11.9% of teenage girls aged 15-19 years had been pregnant in the past or were currently pregnant (Berry & Hall, 2009).

Low income may result also results in stressors associated with child maltreatment (Baumrind, 1994; Brown *et al.*, 1998), and as 38% per cent of South African children live in households where no adult is employed (Hall, 2009), it is clear that South African children are at risk on this criteria. Stressors related to child maltreatment may result from maternal illness (Brown *et al.*, 1998; Walker *et al.*, 2007). This is a relevant concern in South Africa as postnatal depression is common among South African mothers, with one in three mothers being depressed in some South African communities (Cooper *et al.*, 1999). Furthermore, many mothers are physically ill as a result of the high rate of HIV infection among pregnant women; in 2003, an HIV prevalence of 27.9% was found in women receiving antenatal care at nine clinics across South Africa (Makubalo, Netshidzivhani, Mahlasela, & du Plessis, 2003). Maternal isolation may cause stressors associated with child maltreatment (Baumrind, 1994; Brown *et al.*, 1998); this is a concern in South Africa as that 40% of South African children live with their mother only (Meintjies, 2009), which suggests that mothers have little paternal support. It has been found that children who are handicapped are more likely to be maltreated, probably due to the stressors associated with having a handicapped child (Brown *et al.*, 1998). This is a relevant concern in the South African context as the prevalence of Foetal Alcohol Spectrum Disorders (FASD) in the Western Cape is the highest in the world (May *et al.*, 2005). Since children with FASD have been found to have poor cognitive-motor skills and personal-social abilities (Adnams *et al.*, 2001), thus placing them at risk of being maltreated due to being handicapped.

It has been found that children who are maltreated are likely to have an insecure attachment style (Egeland & Sroufe, 1981). It is however not the case that insecure attachment style causes parental maltreatment of their children. Rather, it is likely that other factors such as environmental adversity promote insecure attachment and child maltreatment.

Mothers with postnatal depression tend to have insecure attachment with their infant (Lyons-Ruth, Zoll, Connell, & Grunebaum, 1986; Teti, Gelfand, Messinger, & Isabella, 1995). The aforementioned high rate of postnatal depression is thereby concerning as

insecure attachment has been linked to range of negative outcomes for children including psychopathology (Lewis, Feiring, McGuffog, & Jaskir, 1984; Rosenstien & Horowitz, 1996) and antisocial behaviour (Lyons-Ruth , 1996).

Since many South African mothers are at risk for forming insecure attachment with their infants and perpetrating child maltreatment, it is clear that interventions targeting these mother-infant dyads are needed.

Description of the Parent Centre's PIHVP

The first step in evaluation includes extracting a description of the programme elements (Rossi *et al.*, 2004). The information used to create this programme description was derived from interviews with programme staff, the Parent Centre website (www.parenting.org.za), the home visitor training manual and the 2008 and 2009 Parent Centre Annual Reports.

Aims of the programme.

The Parent Centre's PIHVP's long term goal is to reduce child maltreatment. This is achieved via the short-term goals (supporting and educating mothers who are at risk of perpetrating child abuse and neglect) and the medium term goal (improving mother-infant attachment).

History.

The Parent Centre's PIHVP began to form in 1993 when the Parent Centre was a department in the Cape Town Child Welfare Society. The manager at the time attended a conference on child maltreatment and neglect in Chicago, where she learnt about the Healthy Families America programme. This programme consisted of antenatal and postnatal home visits by nurses to vulnerable pregnant mothers and aimed at reducing child maltreatment. On returning to South Africa, the Parent Centre manager acquired funding to launch a pilot project based on Healthy Families America. The area selected for intervention was Hanover Park, a low-income area in Cape Town. The first home visitors were trained to implement the programme.

In 1995, one of the Hanover Park programme researchers attended the Infant Mental Health Conference at the University of Cape Town. There she recruited several researchers for involvement in researching the programme. Funding was obtained and a pilot programme (called Thula Sana) was implemented in Khayelitsha. The Hanover Park programme and

training were both restructured for the Thula Sana project. Since Thula Sana and the Hanover Park Pilot, the programme has experienced further restructuring and is now rolled out in Imizamo Yethu, Gugulethu, Mitchell's Plain and the Hout Bay Harbour community.

Target population.

The current PIHVP targets vulnerable pregnant women are the target population of the PIHVP. Vulnerable pregnant women are defined by the PIHVP programme manager as women who fall into one or several of the following categories:

- Pregnant teenagers
- Women who have no support from the partner
- Women who have poor relationships with their own mothers
- Women who have a history of depression
- Women who have a high risk of postnatal depression
- Women who experience domestic violence
- Women who live in poverty
- Women who have a history of abuse (physical and sexual)
- Women who have been raped

Resources.

The human and financial resources that are required for the implementation the PIHVP are described below.

The programme manager.

The programme manager has multiple responsibilities, including networking, budgeting, performing presentations, training planning, training home visitors and supervising area supervisors.

Home visitors.

Home visitors deliver the PIHVP to programme recipients. They are members of the community in which the PIHVP is implemented and have formal training in the helping professions.

Trainers.

Trainers are required to prepare home visitors for home visits; these trainers include staff from the Parent Centre as well as trainers who are outsourced for their skills. Such outsourced trainers include practitioners from the Planned Parenthood Association, AIDS Training Information and Counselling Centre (ATICC), as well as private practitioners specialising in infant massage, trauma counselling, grief counselling, birth options and infant nutrition.

Supervisors.

There is a large supervision team available. The home visitors receive weekly supervision from area supervisors. The area supervisors receive weekly or fortnightly supervision from the programme manager; more experienced area supervisors receive fortnightly supervision, while those who are less experienced received weekly supervision. The supervisor of the area supervisors also receives fortnightly supervision.

Financial resources.

The Department of Social Development provides 60% of the salaries for seven out of the fifteen members on the PIHVP team. A current funder is the World Childhood Foundation, who committed to funding the programme until 2012. The cost to deliver the programme is an average of R2060 per client. This budget covers all costs associated with visiting, such as recruitment of clients, home visitor travelling costs, home visitor time spent writing reports, supervision of the home visitors, supervision of the area supervisors, the programme manager's consultation fees, materials required for the home visits, administrative expenses and quarterly home visitor workshops. The total home visiting budget in from April 2008 to March 2009 was R1.03million. Given this budget and the cost per client, it is possible to deliver the programme to 500 clients per year. The programme was delivered to 434 recipients from April 2008 to March 2009.

Programme activities.***Choosing communities for the PIHVP.***

Communities to which the PIHVP is delivered are chosen according to the need for the programme, which is determined in a number of ways. For example, community organisations often refer mothers to the Parent Centre for one of their various other services. If many new mothers from a particular community are referred, the Parent Centre considers

this community to be in need of the PIHVP. Alternatively, community organisations sometimes contact the Parent Centre and request that the PIHVP be implemented in their community. Another way in which communities may be chosen for the PIHVP is with reference to the list of vulnerable communities that has been compiled by the Western Cape Department of Social Development. Once a community has been identified as in need of the PIHVP and if funding allows for possible expansion of the programme, a needs assessment is conducted by the Parent Centre programme staff in collaboration with other service organisations in the area, such as maternity and obstetrics units and the community health clinics.

Recruitment, selection and training of home visitors.

After a community is identified as in need of the PIHVP, positions for trainee home visitors are advertised in the community. Advertisements are placed in community newspapers, libraries, clinics, shopping centres and churches. Additionally, the Parent Centre will approach community organisations and ask whether they recommend anyone for the training. Women who apply for training must reside in the community. This is important as they will have knowledge of the resources in the community and it will also be easier to establish rapport with mothers with a similar background to themselves. They must be fluent in the community language (for easy communication with programme participants) and in English (as most of the training is in English). Applicants must be mothers (biological, adoptive or foster) as this ensures that they have experience in parenting and will also find it easier to empathise with mothers in the programme. They must preferably have a Grade 12 level of education, as the training programme is pitched at a level that assumes an understanding of abstract and potentially difficult concepts. They must also preferably have community work experience.

Once applications have been received, applicants are interviewed to determine their suitability for the training programme. Requirements for acceptance into the training programme are empathic ability, nonjudgmental attitudes, good listening skills and willingness to learn and take initiative. The number of applicants selected for training is dependent on the need for home visitors at the time. In general, twice as many trainees as required will be trained. The decision to train twice as many as needed is based on the assumption that some trainees will drop out or will be deemed as not suitable for home visiting.

The selected home visitors receive pre-service training and in-service training. The former consists of 38 training sessions of four hours each, spanning nine months. In-service training consists of quarterly workshops. Pre-service training modules and their respective sessions are listed in Table 1 below.

Table 1

Pre-service training modules and sessions

Module	Session
1. Overview.	Questionnaires, welcome, introductions, expectations.
2. Experiential awareness building.	My earliest memory, people who shaped my childhood. Life stages and influences. Your mother's pregnancy with you, your pregnancy with your first child.
3. Managing and improving early childhood parenting.	Children's needs and factors that influence their behaviour. Behaviour as communication. The art of listening. More about listening and managing different feelings. Even more about listening to difficult feelings and anger. Building children's self esteem: responding and mediating. Building children's self esteem: relabeling and descriptive praise. Setting limits and being assertive. Discipline and self-control.
4. Client-centred therapy and problem solving with new mothers.	Therapeutic and undermining factors in counselling. Values and their impact on counselling. Managing counter transference. The problem-solving model. Counselling using the problem-solving methods. The therapeutic approach to home visiting and a code of ethics.
5. Behavioural assessment of the infant with the parent.	What is a baby? The role of the home visitor. Elements of assessment. The behavioural assessment practise. The behavioural assessment practise continued.
6. Community practise, infant observation and behavioural assessment.	Behavioural assessment and infant observation. Presentation of behavioural assessment and infant observation.
7. Job shadowing.	Accompany parent-infant community counsellor on visits.
8. Specialised workshops.	Sexuality and family planning. Pregnancy, labour and birth. Postnatal depression. Grief work. Child maltreatment. Breastfeeding and nutrition. HIV and AIDS. Foetal Alcohol Spectrum Disorder. Infant massage.

Note. Module 3 (Managing and improving early childhood parenting) is adapted from Parent Centre Early Childhood Management Programme and World Health Organisation International Child Development Programme.

Each training session includes an icebreaker, feedback on the last session, feedback on homework, brainstorming, input from the trainer, exercises and a summary of what was covered in the training session.

There is an evaluation of trainees midway through pre-service training. This is done in order to identify trainees who are not coping with the programme. Such trainees are counselled out of training. The mid-training evaluation is also an opportunity for trainees to receive feedback on their training performance. At the end of pre-service training there is another evaluation, after which suitable trainees are selected as home visitors for their communities.

Two to three home visitors are assigned to a community, as the responsibility of an entire community is too great for one home visitor and funds are usually not available for the employment of more than three per community.

Recruiting recipients.

Mothers are usually referred to the PIHVP by the maternity unit in their community. The units are given the Parent Centre's list of criteria for detecting vulnerable women (as presented earlier in this dissertation) and accordingly use these criteria for referring women to the programme. A home visitor visits the unit once a week and acquires information about mothers who have been referred. Thereafter she visits these mothers in their homes and invites them to join the programme. Home visitors also provide weekly talks at maternity units during which they inform mothers of the PIHVP. Some mothers ask to be a part of the programme as a result of these talks.

Delivering the programme.

Mothers in the programme receive five antenatal and fifteen postnatal home visits until their child is six months old. Home visitors prepare recipients for the arrival of their babies by passing on the skills and knowledge that they have acquired during training. For example, during the antenatal phase, the birth process and foetal development is explained. During the postnatal phase, the home visitor provides supportive counselling to the mother and imparts further skills and knowledge. There is a particular focus on encouraging sensitive and non-intrusive interaction with their infant. The content of home visiting will vary across recipients, as the home visitors are trained to individualise the programme to suit the needs of the recipient.

One of the functions of home visiting is to screen recipients for depression. This is done via the administration of the Edinburgh Postnatal Depression Scale (EDPS) (Cox, Holden, & Sagovsky, 1987). Home visitors are also required to administer the EPDS during the second antenatal visit, the third postnatal visit and the thirteenth postnatal visit. If the recipient scores higher than 13 on the EPDS, then it is concluded that she may be suffering from postnatal depression and the mother is referred to a community therapist.

Once the recipient's baby is six months old, the home visitor will assess her readiness for termination from the programme. If it is determined that the recipient is not ready for termination and if funding allows for it, then further home visits may be offered.

Supervision of home visitors.

Group supervision takes place once a week for the first three weeks of the month, and individual supervision takes place in the last week of the month. Home visitors from Khayelitsha and Gugulethu attend supervision at the Parent Centre office in the Khayelitsha Community Health Centre, and other home visitors attend supervision at The Parent Centre in Wynberg. Field supervision may take place if it is deemed necessary and if funding allows for it. There are three separate groups for group supervision, each with their own area supervisor: the Gugulethu and Khayelitsha group, the Hanover Park and Mitchell's Plain group, and the Imizamo Yethu and Hout Bay Harbour group. Home visitors receive individual supervision from the same supervisor with whom they have group supervision.

In an interview, the programme manager stated that supervision has three functions: supportive, educative and administrative. Supervision fulfils the supportive function in two ways. Firstly, home visitors are required to hand in home visit reports to their supervisors. The supervisor gives detailed feedback on these reports during individual supervision and general feedback on reports during group supervision. Secondly, case discussions take place, with a focus on cases that are most challenging for the home visitors. Supervision fulfils the education function via the sharing of skills and knowledge by supervisors on relevant topics. The supervisor may make use of role playing to demonstrate these skills. Supervision fulfils the administrative function via the supervisor informing home visitors on workshops and training sessions that they need to attend.

Programme Theory

Programme theory "explains why the programme does what it does and provides the rationale for expecting that doing so will achieve the desired results" (Rossi *et al.*, 2004, p.

134). Before an evaluation of a programme is performed, it needs to be decided whether that programme has a plausible impact theory. In other words, it needs to be determined whether it is plausible to expect that certain outcomes will follow a particular programme. This can be done by reviewing the literature pertinent to that type of programme.

Two programme theories will be outlined in this section. The first is the programme theory of the PIHVP itself. The second is the programme theory of the home visitor training and supervision. These programme theories are based on information derived from interviews with the programme manager.

PIHVP theory.

The Parent Centre's PIHVP provides supportive counselling and parenting skills and knowledge to mothers. The intended short-term outcomes are that maternal well-being and coping will improve and that recipients will apply their newly acquired parenting knowledge and skills. This should result in the medium-term outcome of an increase in secure attachment between mothers and infants. Secure attachment may occur when a parent is readily available, sensitive to a child's needs and lovingly responsive (Bowlby, 1988). This in turn will result in the long-term outcome of reduced child maltreatment. See Figure 1 below for a diagram representing the PIHVP programme theory

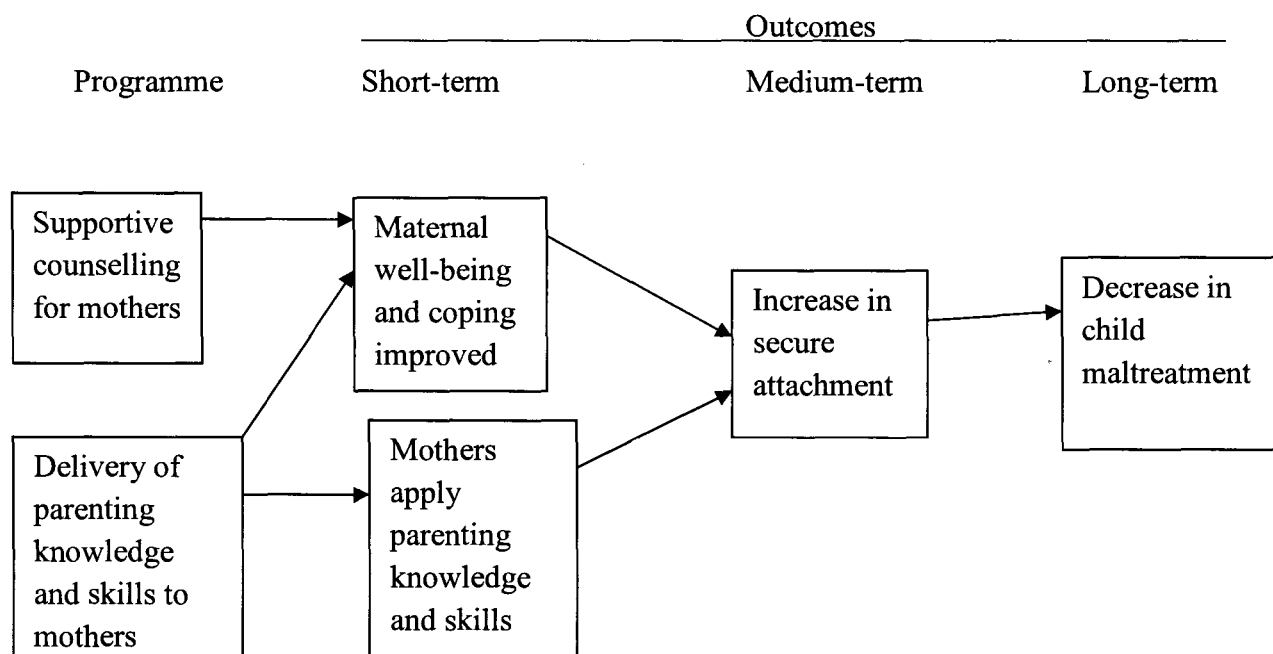


Figure 1. Programme theory of the Parent-Infant Home Visitation Programme.

Literature on the outcomes of home visiting programmes and the links between maternal well-being, attachment and maltreatment need to be reviewed to test the plausibility of the PIHVP programme theory. In addition, the literature and recommendations around the successful implementation of home visiting programmes need to be reviewed to determine whether the implementation of the PIHVP is conducive to beneficial outcomes. This literature is considered next.

Outcomes.

The efficacy of various PIHVPs has been evaluated. It must be noted, however, that many of these evaluations did not utilise randomisation, control groups or long term-follow-ups. The evaluations that have been conducted have indicated that PIHVPs have many potential benefits for mothers and infants. Short- to medium-term outcomes include improved mother-infant interaction (Cooper *et al.*, 2002; Cooper *et al.*, 2009); reductions in postnatal depression (Armstrong *et al.*, 1999); reduced child maltreatment (Huxley & Warner, 1993); improvements in experience of parenting role, reduced childhood injuries, fewer subsequent maternal pregnancies, greater workforce participation and reduced use of public assistance and food stamps (Olds, 2002); reduced smoking by mothers (Olds *et al.*, 2002); improved maternal knowledge of developmental milestones, more realistic expectations for children and less punitive maternal attitudes on childrearing (Field, Widmayer, Stringer & Ignatoff, 1980) and higher full IQ scores for children (Walker *et al.*, 2005). Long-term outcomes for infants and children targeted by these programmes include reduced number of arrests and convictions and reduced substance abuse and promiscuous sexual activity at 15 years of age (Olds *et al.*, 1998).

Given these potential outcomes of home visitation programmes, it is plausible to expect that the Parent Centre's PIHVP, if appropriately implemented, should be followed by an increase in parenting knowledge and skills, improved maternal well-being and coping, improved mother-infant attachment, and a reduction in child maltreatment and neglect.

It is not clear however that if mothers gain parenting knowledge and skills, that they will necessarily apply them to their parenting. Gomby (2007) states that the following approaches are likely to change parenting behaviour in such as way as to protect children from maltreatment:

1. Efforts to strengthen parenting knowledge and capacities should take place in the antenatal period. This will give parents an understanding of how children grow and develop so that their expectations are realistic.

2. Teenage parents, first-time parents, single parents with limited support and parents with substance abuse problems should be targeted.

3. Parents should be provided with emotional support and services to help them cope and develop their strengths.

It is long accepted that a change in knowledge or attitudes is not necessarily followed by a change in behaviour (Ajzen & Fishbein, 1977). However, implementation of the Parent centre's PIHVP involves many of the aforementioned approaches for changing parenting behaviour. In particular, the programme begins in the antenatal period, targets teen parents and unsupported parents, provides them with emotional support and offers services which will help them cope and develop their parenting skills. It is therefore plausible to expect that the programme should change parenting behaviour, thereby decreasing the likelihood of child maltreatment.

Links between maternal mood and style, attachment and maltreatment

The Parent Centre's PIHVP theory expects that the provision of support to mothers will result in improved maternal mood. This is plausible given the literature, which states that mothers who have little social support tend to have a negative mood (Levitt, Weber & Clark, 1986). Mothers with a negative mood or postnatal depression have been found to have insecure attachment with their infants (Levitt *et al.*, 1986; Lyons-Ruth *et al.*, 1986; Teti *et al.*, 1995). It is therefore plausible to expect that an improvement of maternal mood should be followed by improved infant attachment. It has also been found that, when mothers interact insensitively and non-intrusively with their infants, insecure infant attachment tends to result (Isabella, 1993). This further supports the PIHVP theory, as the programme aims to promote sensitive and non-intrusive mother-infant interaction.

As previously mentioned, children who are maltreated are likely to have an insecure attachment style, but the relationship is probably not causal (Egeland & Sroufe, 1981). Rather, it is likely that other factors such as environmental adversity promote insecure attachment and child maltreatment. It is plausible to expect that the PIHVP should be followed by a decrease in maltreatment, as the programme a) encourages secure infant attachment and b) provides recipients will support and skills to cope with the effects of environmental adversity.

Implementation.

Various implementation factors may influence the success of a PIHVP in achieving its outcomes. These include the timing of the intervention, the choice of home visitors and the successful adaptation of programmes to their context.

Timing and length.

It appears that the timing of the programme is more important than programme length for achieving outcomes. A study by Eckenrode *et al.* (2000) utilised two experimental groups: one which received home visits during pregnancy only, and another which received home visits during pregnancy and home visits through to the child's second birthday. A fifteen year follow-up of the intervention found that families who had received visitation during pregnancy and infancy had significantly fewer mother-perpetrated child maltreatment reports than families who received visitation during pregnancy only. Research conducted by Fraser, Armstrong, Morris and Dadds (2000) illustrated that a postnatal-only intervention lasting until the infant was 12 months old did not have a positive impact on parenting stress, parenting competence or the quality of the home environment. However, this programme did significantly decrease risk of child maltreatment for the treatment group between baseline and at seven months. Olds *et al.* (2002), in a 25-year follow-up of a PIHVP that began during pregnancy and continued up to two years of age, found that the intervention was successful in reducing child maltreatment and neglect, reducing subsequent pregnancies, increasing maternal workforce participation and reducing use of social assistance and reducing adolescent arrests, convictions, substance abuse and promiscuous sexual activity. These studies suggest that programmes which start in the antenatal period tend to be more beneficial than those which are shorter or start during the postnatal period. Due to the fact that the Parent Centre's PIHVP begins during pregnancy, the PIHVP programme theory is supported, given the literature demonstrating the benefits of programmes beginning in the antenatal period.

It is recommended that the goals of the programme be taken into consideration when deciding on when a PIHVP should commence. This point is illustrated by Armstrong *et al.* (1999), who found that a PIHVP that lasted for six weeks and only started in the postpartum period resulted in no significant differences between breast feeding practises the intervention and control groups. This was due to the fact that most mothers in the study had ceased breast feeding two weeks before the intervention had even begun. This emphasises the importance of considering the programme goals when deciding on when a programme should commence.

Given the nature of the Parent Centre's PIHVP and its goals (such providing information on appropriate infant and child care) and the fact that the intervention begins during pregnancy, the timing of the programme is well-suited to its goals, thus offering further plausibility to the programme theory.

Selection of home visitors.

There is debate in the literature as to whether professionals or paraprofessionals should be selected as home visitors. In research conducted by Olds *et al.* (2002), programme effects for children whose families were visited by nurses were approximately twice those for those visited by paraprofessionals. However, research conducted by Durlak (1979) concluded that paraprofessional helpers can achieve outcomes that are equal to or even superior to those obtained by professionals. Cooper *et al.* (2002), in a pilot study of the Parent Centre's PIHVP, also found favourable results concerning paraprofessional-delivered PIHVPs. This study found that mothers receiving the intervention had significantly better engagement with their infant at six months post partum than did mother-child pairs in the control group. Children in the intervention group were significantly heavier and taller than those in the control group at six months post partum. However, the intervention had no effect on maternal mood.

Cooper *et al.* (2009) conducted a randomised controlled trial of an programme based on the Parent Centre's PIHVP. The programme was similar to the Parent Centre's PIHVP as paraprofessionals were employed to encourage sensitive and responsive interactions in order to improve infant attachment. They also received weekly supervision. However, the home visitors received four months training (instead of nine) and the programme consisted of 16 visits (instead of 20). The evaluation found that at both six and 12 months postpartum, mothers taking part in the PIHVP were significantly more sensitive and less intrusive in their interactions with their infants, and had significantly higher rates of secure attachment than mothers in the control group. Although the prevalence of maternal depressive disorder was not reduced, the intervention significantly improved maternal mood. This finding offers strong support for the plausibility of the PIHVP programme theory in stating that the intervention can improve maternal mood and infant attachment.

While there is debate around whether professionals should be selected over paraprofessionals, there is little disagreement over the personal qualities that home visitors should possess. Korfmacher, Kitzman and Olds (1998) found that, when mothers perceived home visitors to be empathetic, children were more responsive to their mothers and the care

giving environment was of a higher quality. This finding indicates that it is desirable for home visitors to be empathetic individuals. Wasik and Roberts (1994) also suggest that home visitors should be empathetic. It has also been recommended that home visitors should be parents themselves, have good interpersonal skills, be mature and have good judgement (Olds, 1988; Wasik, Bryant, & Lyons, 1990). In order to be selected for training, the Parent Centre requires that applicants be empathetic, be parents themselves and have good listening skills. This provides further plausibility to the claim that the Parent Centre's PIHVP will have the desired outcomes, as home visitors are selected according to many of the recommendations outlined in the literature.

The need to adapt home visiting programmes for developing countries.

Most of the evidence for home visiting programmes is based on evaluations of programmes that have been implemented in developed countries. These evaluations propose various guidelines for the sound implementation of community based programmes. Tomlinson, Swartz and Landman (2003) summarise these guidelines. These include, inter alia, requirements of random assignment to control and experimental groups, large sample sizes, the use of professional visitors and blind assessment. It is clear, however, that such programmes are not feasible for implementation in South Africa, which faces political, social, cultural and financial difficulties that are not experienced by programme implementers and researchers in developed countries. For example, to employ professionals to deliver PIHVPs in South Africa, it would be difficult if not impossible due to the lack of government funding and shortage of health professionals. It is therefore necessary for such programmes to be implemented by paraprofessionals in South Africa.

Tomlinson *et al.*'s (2003) argument highlights the need to adapt home visiting programmes for implementation in developing countries. Lee, Altschul and Mowbray (2008) propose that programmes need to be adapted to their contexts. In the Planned Adaptation approach, there are four steps for successfully adapting home visiting programmes for different contexts.

1. Examining home visiting programme theory. This implies that intervention must retain the integrity of the mechanisms of change as outlined in the programme theory and as established in the evidence base.

2. Identifying population differences. The social, cultural and economic differences between the original population and the target population must be examined.

3. Adapt programme content. If there are relevant population differences, then the content of the programme needs to be adapted to serve the needs of the target population.

4. Adapt evaluation strategy. The evaluation of the adapted programme needs to be adapted accordingly.

Given the need to adapt home visiting programmes, it has been argued that alongside best *practices*, there should be best *processes* for the planning of the most suitable intervention for a given population (Green, 2001). This means that whilst the implementation of home visiting programmes should attempt to follow the guidelines proposed for best practice, that it is more important that the implementation be planned according to the context in which the programme is delivered.

The Parent Centre's PIHVP appears to be an example of a programme that has been successfully adapted to suit its context. Firstly, the PIHVP theory embodies many of mechanisms of change that are contained in developed world home visiting programme theories. Secondly, the programme content has been adapted to suit the South African population and context. This is evident due to the focus on issues such as HIV and AIDs and FASD during home visitor training. Thirdly, the PIHVP is implemented in a way that takes South Africa's contextual limitations into account. In particular, the programme recognises the shortage of health care providers and government funding in South Africa, and therefore uses paraprofessionals to deliver the programme. The fact that the PIHVP has been adapted in this way provides support to the expectation that the programme will have the intended outcomes, as it ensures that the needs of the programme is adapted to suit the needs of the recipients as well as the inherent limitations in the South African context.

Training and supervision programme theory.

The programme theories for the impact of training and supervision have been combined as these programmes share the long-term outcome of home visitors delivering the programme as intended.

A short-term outcome of home visitor training is that home visitors should acquire home visiting skills and knowledge. This should be followed by two medium-term outcomes: home visitors should apply their skills and knowledge during home visits, and they should apply their skills and knowledge to their own parenting. The application of skills and knowledge should bring about the long-term outcome of the programme being delivered as intended. The application of skills and knowledge to home visitors' own lives should cause home visitors' family lives to improve.

The short-term outcome of the supervision programme is that the home visitors should receive ongoing emotional, educational and administrative support. The medium-term outcome that should follow from this is that the home visitors will be prepared for visits. The intended long-term outcome should be that the programme will be delivered as intended. See Figure 2 below for a diagram representing the training and supervision programme theory.

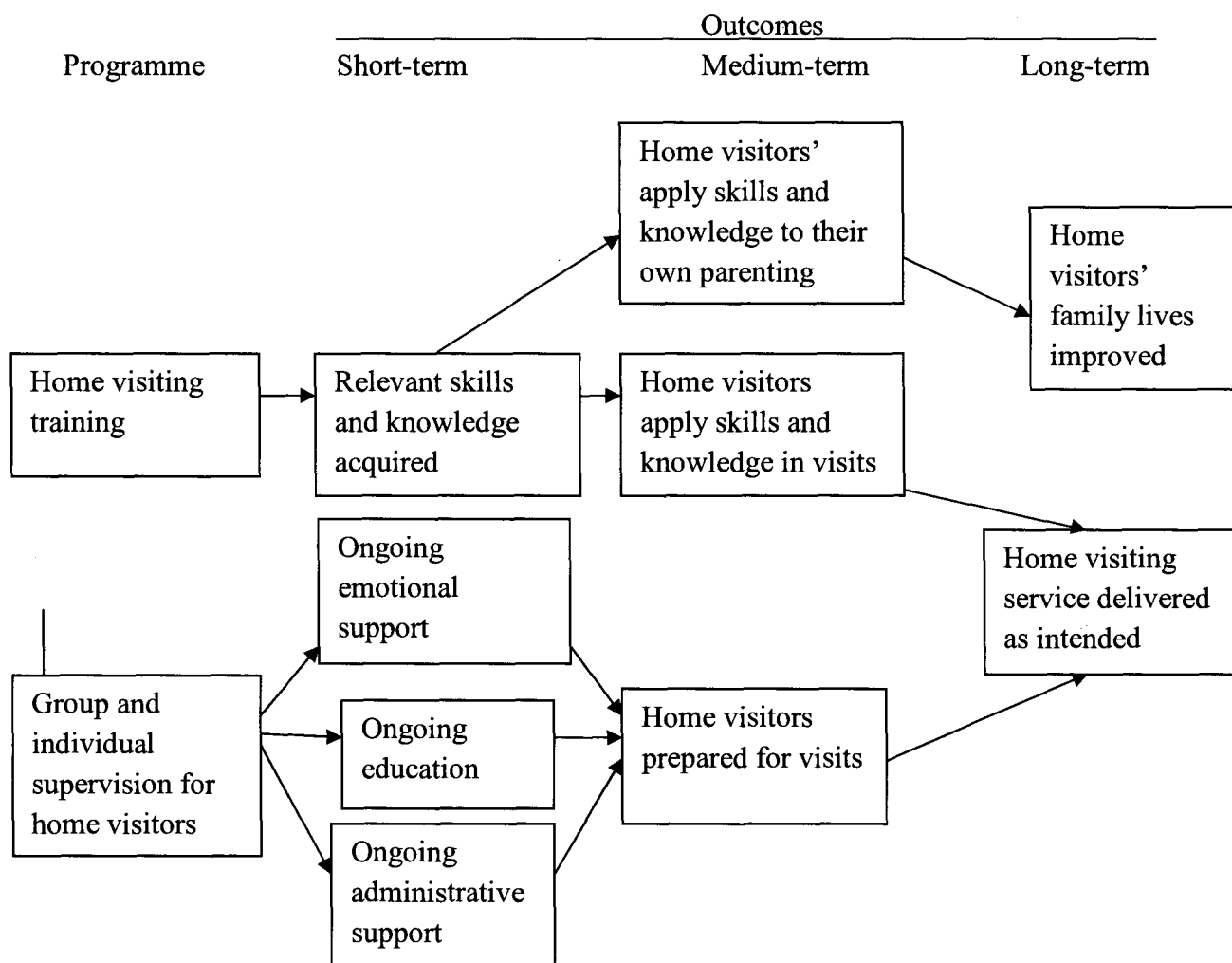


Figure 2. Training and supervision programme theory.

To the knowledge of the evaluator, no evaluations on the training and supervision of home visitors have been published. However, recommendations on the training and supervision that home visitors should receive have been made.

Wasik and Roberts (1994) recommend that home visitors receive extensive pre-service and in-service training to ensure that home visitors are prepared for their jobs and therefore deliver the service as intended. The Parent Centre's PIHVP administers an intensive nine-month pre-training course to home visitors and they are also required to attend regular

workshops once they commence home visits. This offers plausibility to the expectation that home visitors should be prepared to deliver the service as intended.

Wasik *et al.* (1990) outline three training procedures that should maximise the learning process of the trainees. These include role playing, experiential learning (i.e. trying out new learnt behaviours) and peer education. The Parent Centre's home visitor training programme utilises role playing and experiential learning, which offers support for the claim that the training programme should result in home visitors acquiring home visiting skills and knowledge.

Wasik (1993) gives an outline of the basic content that is valuable in a home visiting training programme. Such content includes the history of home visiting, the philosophy of home visiting, knowledge and skills of the helping process, knowledge of families and children, knowledge and skills specific to the programme and knowledge and skills specific to communities. Given the modules and sessions of the PIHVP training programme outlined previously, it is clear that most of these areas are covered during training. This offers further support to the claim that training should result in home visitors acquiring home visiting knowledge and skills.

The assumption that skills learnt in training will be transferred to home visiting is not necessarily justified. Certain conditions need to be met in order for the transfer of training to take place: trainees must actually have learnt skills and knowledge in training, they must desire to apply it to their work, the work environment must support the application of new skills and knowledge to the job, and trainees must have the opportunity to practise the training on the job (Holton, 1996). The PIHVP theory regarding the application of training to visits is therefore only plausible insofar as these conditions are met. The evaluator however has no reason to expect that these conditions are not met. Firstly, it is likely that home visitors do learn skills and knowledge during training, given the nature of the training and the literature reviewed. Secondly, those who apply for training no doubt have an intrinsic motivation to be home visitors. Thirdly, the supervision of home visitors offers support and encouragement to apply what they have learnt in training. Fourthly, during training, home visitors have the opportunity to shadow other home visitors, thus allowing them to practice their skills and knowledge in the field. It is therefore likely that the home visitors will transfer their training skills to home visits.

Supervision is assumed to be particularly important for paraprofessional home visitors as these visitors need close direction and are more likely than professionals to feel overwhelmed (Wasik, 1993). Home visitor supervision may occur individually, in groups, or

on site. Wasik *et al.* (1990) argue that programmes should consider utilising all three supervision types in order to adequately support home visitors. Individual supervision allows for more individual attention on the home visitor, whilst group supervision allows for home visitors to support each other, and on-site supervision allows the supervisor to observe the home visitor and to make suggestions for improvement (Wasik *et al.*, 1990). The Parent Centre's PIHVP utilises three group supervision sessions and one individual supervision session per month, but on-site supervision only occurs if it is deemed necessary and if funding allows for it. Nonetheless, it is plausible to expect that the supervision process will adequately prepare these home visitors for their job, given that they receive weekly supervision in two of the three supervision types recommended by Wasik *et al.* (1990).

Ekstein (1972, as cited in Wasik *et al.*, 1990) recommends that home visitor supervisors should play the role of administrator, teacher and therapist. The Parent Centre's PIHVP supervision programme aims to fulfil three functions: administrative, educative and supportive. It is therefore clear that the supervisor serves the recommended role of administrator, teacher and therapist. This offers further support for the plausibility of the theory that the supervision process adequately prepares home visitors for the visitation process.

Rationale for Evaluation and Evaluation Questions

As can be seen from the literature, the Parent Centre's PIHVP theory and training and supervision theory are plausible. Whilst evaluations of adapted versions of the Parent Centres' PIHVP have been performed (Cooper *et al.*, 2002; Cooper *et al.*, 2009), the training and supervision of home visitors have never been formally evaluated. It is crucial that training and supervision adequately prepare home visitors for their role, otherwise the programme quality will suffer and those who utilise the service will not benefit. The home visitors' preparedness for programme delivery was evaluated for these reasons. Related to the issue of preparedness, is the question as to whether the home visitors apply their knowledge and skills acquired from training when they are in the field.

This evaluation can therefore provide the Parent Centre with an assessment of the home visitors' preparedness to deliver the service from the perspective of the home visitors. The evaluation can also provide the Parent Centre with information on whether participants are receiving the service as intended.

Given this rationale, this evaluation will address the following questions:

Question 1: Do home visitors perceive that pre-service training has given them sufficient knowledge and skills to deliver the service as intended?

Question 2: From the perspective of the recipients, do home visitors apply their knowledge and skills during home visitation?

Question 3: Do programme recipients find the skills and knowledge that are applied by the visitors to be useful?

Question 4: From the perspective of home visitors, does supervision adequately prepare them for home visitation?

Chapter Two: Methods

Data Providers

Data providers consisted of three sets of participants: 12 home visitors (i.e. all of the home visitors) who are employed by the Parent Centre, and 27 programme recipients, who were randomly selected from the list of recipients who completed the programme in 2008, and the programme manager, who provided descriptive data regarding the programme theory, training and supervision activities. Descriptive data on the home visitors is presented in Table 2 and home visitor education levels are displayed in Figure 3 below.

Table 2

Home visitor descriptive data

Variable	Descriptive statistics	N
Age	Mean = 37.5 Range: 32-48	11
Years worked for the Parent Centre	Mean = 2.8 Range: 0.5-6	12

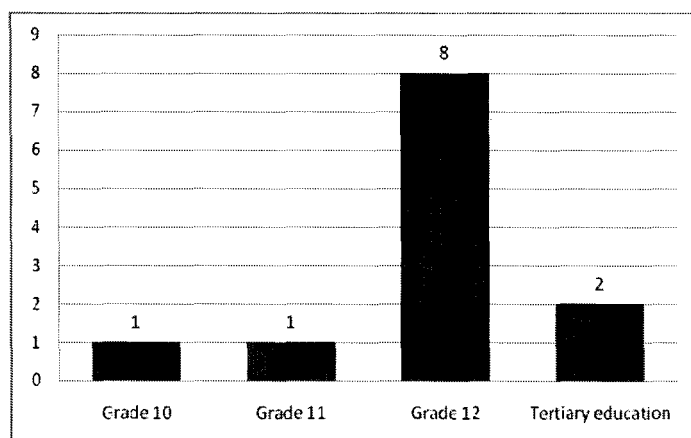


Figure 3. Home visitor education levels.

Descriptive data could only be gathered for 24 out of 27 programme recipients, as three of the recipient files could not be located by the Parent Centre. This data is presented in Table 3, their education levels are displayed in Figure 4, their employment statuses are displayed in Figure 5, their relationship statuses are displayed in Figure 6 and the frequency of planned and unplanned pregnancies are displayed in Figure 7 below.

Table 3

Recipient descriptive data

	Descriptive statistics	n
Age	Mean = 26.75 years Range: 18-38	24
EPDS score at intake	Mean = 9.1 Range = 3-16	21

Note. EPDS scores at intake were not recorded by home visitors for 3 recipients

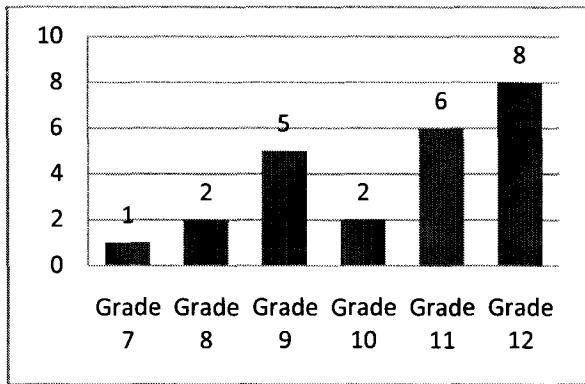


Figure 4. Recipient education levels

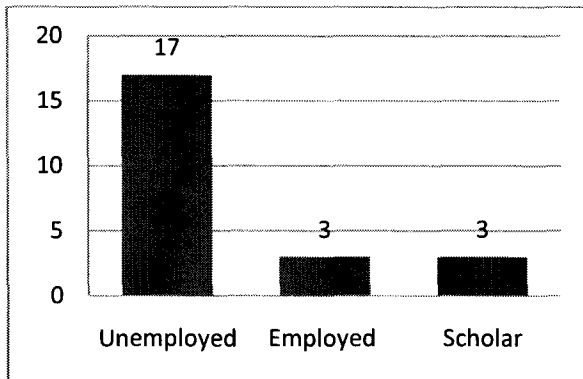


Figure 5. Recipient employment statuses (missing=1).

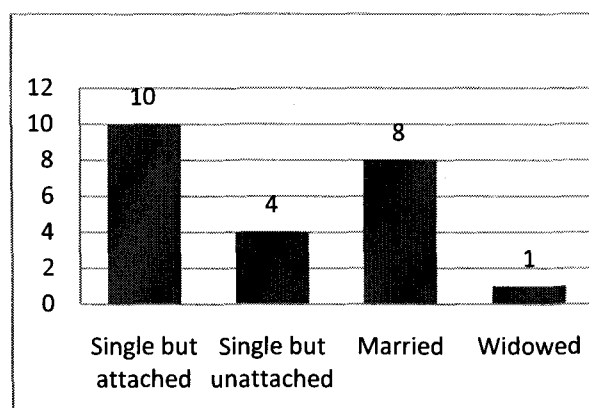


Figure 6. Recipient relationship statuses (missing=1).

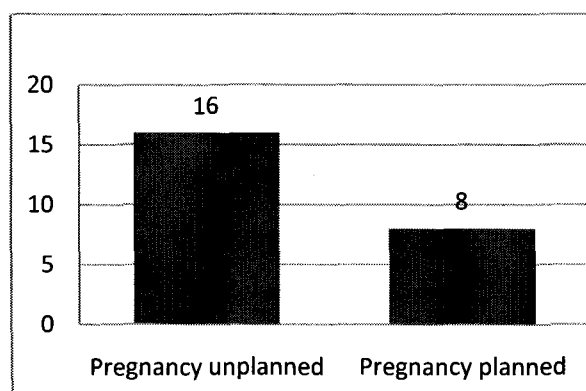


Figure 7. Planned and unplanned pregnancies.

Recipient descriptive data was collected from programme records to gauge the extent to which recipients can be considered “at risk” in relation to the criteria used by the Parent Centre to in order to establish their appropriateness for inclusion in the programme, as well in relation to criteria established in the literature. Information surrounding some of these criteria was not available in the records.

It must be remembered that the risk factors outlined below usually interact with other risk factors and stressors before child maltreatment actually occurs; it is unlikely that they will cause maltreatment in isolation (Dawes & Ward, 2008).

The youngest recipients were 18 years old ($n = 3$). Since maternal youth is a risk factor for child neglect (Brown *et al.*, 1998), this indicates that most recipients were not at risk for perpetrating maltreatment on grounds of their age. The majority of recipients were unemployed ($n = 17$). This places their children at risk of being maltreated as low income is a risk factor associated with child neglect (Brown *et al.*, 1998). The majority of recipients had unplanned pregnancies ($n = 16$), which is a risk factor for child maltreatment when interacting with other stressors (Zuravin, 1991). The average EPDS score at intake was 9.1,

which indicates that overall, recipients were unlikely to be suffering from depression when they began the programme (The Parent Centre consider scores of 13 or higher to indicate postnatal depression). Although two recipients did have EDPS scores higher than 13 at intake, in general, recipients were not at risk of forming insecure attachments with their children or subsequently maltreating them as a consequence of insecure attachment (Lyons-Ruth *et al.*, 1986; Murray, 1992, as cited by Murray & Cooper, 1997). The largest portion of recipients had passed Grade 12 ($n = 8$), and most recipients had at least passed Grade 9 ($n = 21$). Since low maternal education is a risk factor for child maltreatment (when interacting with other factors) (Brown *et al.*, 1998), the majority of recipients were not at risk in this sense. Single parenthood and low paternal involvement are associated with child maltreatment (Brown *et al.*, 1998). However, the majority of recipients had partners ($n = 18$). While isolation does not appear to be a risk factor in this population, this does not necessarily mean that those in relationships would be risk free as child maltreatment may still co-occur within abusive partner relationships.

Overall, recipients were not at risk due to isolation, depression or youth. They were however at risk due to unplanned pregnancies and unemployment.

Materials

Programme records.

These include the records of home visits, which are compiled by the home visitors. At the first visit, the home visitor is required to record descriptive data about the recipient. A copy of the sheet in which this information is entered is available in Appendix A. After each visit, home visitors are required to describe in writing what occurred during the visit. The visitors are also required to administer the Edinburgh Postnatal Depression Scale to recipients during their second antenatal visit, their third postnatal visit and their thirteenth postnatal visit. These completed scales are also intended to be kept as programme records.

Training questionnaire.

An 18-item, 10-point scale training questionnaire was developed by the evaluator based on the content and goals of home visitor training (see Appendix B). This scale required respondents to rate their skills and knowledge related to home visiting. They were asked to retrospectively rate their skills and knowledge before training and immediately after training on a scale of 1 to 10 (1 = Very incompetent and 10 = Very competent). Under each

questionnaire item, a space was provided for comment. See Table 4 below for a list of the competencies in which home visitors were required to rate themselves.

Table 4

Competencies in which home visitors were required to rate themselves

-
1. Helping parents to understand their children's behaviour
 2. Teaching parents to listen to their children
 3. Helping parents to build their children's self esteem
 4. Teaching parents about setting limits for their children
 5. Teaching parents about appropriate discipline
 6. Teaching parents how to use problem-solving techniques
 7. Using problem-solving when counselling parents
 8. Performing a behavioural assessment of an infant and parent
 9. Teaching parents how to massage their infant
 10. Detecting postnatal depression in mothers
 11. Recognising when a child is being abused
 12. Teaching mothers about breast feeding and infant nutrition
 13. Teaching parents about HIV and AIDS
 14. Teaching parents about Foetal Alcohol Spectrum Disorder
-

The training questionnaire was piloted using a 5- point scale, where the respondent had to state whether they agreed with statements such as "After training, I know how to teach mothers listen to their children." When this format was used, the respondent tended to give a response set, as she ticked "5" (strongly agree) for most questions. Three decisions were therefore made. Firstly, it was decided to change the 5-point scaled to a 10-point scale to encourage more response variation (Kaplan & Saccuzzo, 2009). A 10-point scale also has the advantage of not containing a mid-point, thus forcing participants to make a judgement over whether they agree or disagree with the statement presented to them (Kaplan & Saccuzzo, 2009). Secondly, instead of only rating their competencies after training, it was decided that the questionnaire would also ask respondents to retrospectively rate their competencies prior to training. This was done in order to determine whether respondents perceived that training significantly contributed to their competencies. This was important as it is possible that home visitors were already competent in some areas prior to training. Thirdly, instead of using "strongly disagree" and "strongly agree" as scale endpoints, "very incompetent" and "very competent" were chosen. An example of the final question format is available in Figure 8 below.

My competency in teaching parents about *appropriate discipline*:

Before training:	1	2	3	4	5	6	7	8	9	10
After training:	1	2	3	4	5	6	7	8	9	10

Comment:

Figure 8. Example of training questionnaire item format.

As can be seen in Figure 8, a space was provided for comment from the respondent. This was included to allow for respondents to give an explanation for their ratings if they wished to do so.

All Chronbach's alpha scores were compared against the .65 level of acceptable reliability for comparing groups (Tredoux & Durrheim, 2004). An analysis of this questionnaire indicated that the questionnaire was a reliable measure of home visitor perceptions of their skills and knowledge related to home visiting pre- and post-training ($\alpha = .912$).

Supervision questionnaire.

A 12 item, 10-point scale supervision questionnaire was developed by the evaluator based on the content and functions of supervision (see Appendix C). This questionnaire required respondents to indicate the extent to which they agreed with statements on the supportive, educative, and administrative functions of supervision, the extent to which supervision prepared them for their job and the sufficiency of the number of monthly supervisions they received. The scale of 1 to 10 had endpoints of "very strongly disagree" and "very strongly agree". Questions measured perceptions towards group supervision (GS) and individual supervision (IS) separately. The test specification of the supervision questionnaire is available in Table 5 below.

Table 5
Test specification for the supervision questionnaire

		Supervision type	
		Group	Individual
Perceptions	Supportive	2 items	2 items
	Educative	1 item	1 item
	Administrative	1 item	1 item
	Preparedness	1 item	1 item
	Frequency	1 item	1 item

A list of the items to which home visitors were required to respond is presented in Table 6 below.

Table 6
Supervision questionnaire items

1. During individual supervision, I feel emotionally supported.
2. During group supervision, I do not feel emotionally supported.
3. During individual supervision, I do not gain new knowledge and skills.
4. During group supervision, I gain new knowledge and skills.
5. During group supervision, I often don't get a chance to talk about cases that are challenging for me.
6. During individual supervision, I get a chance to talk about cases that are challenging for me.
7. During group supervision, my supervisor informs us on upcoming workshops and events that we can attend.
8. During individual supervision, my supervisor informs me on upcoming workshops and events that I can attend.
9. I have insufficient number of individual supervisions per month.
10. I have sufficient number of group supervisions per month.
11. After group supervision, I feel prepared for the home visits in the week ahead.
12. After individual supervision, I do not feel prepared for the home visits in the week ahead.

As can be seen from the items above, the decision was made to negatively word some items (Items 2,3,5,9 and 12). Including negatively worded items is a good method of preventing and detecting response sets, which occur when respondents unthinkingly tick the same answer choice throughout the questionnaire (Kaplan & Saccuzzo, 2009). The negatively worded items were reverse-scored.

The questionnaire was piloted as a 5-point scale (1 = "strongly disagree" and 5 = "strongly agree"). As with the original training questionnaire, the respondent with whom the supervision questionnaire was piloted gave an acquiescent response set. The response format was therefore changed to a 10-point scale to encourage more varied responses. A comment

area was available below each item to allow respondents to explain their answers if they wished to do so.

Chronbach's alpha was calculated separately for items measuring IS and for items measuring GS to test their reliability. Items used to measure perceptions of IS reliably measured home visitor perceptions of this supervision type ($\alpha = .693$). However, items used to measure perceptions of group supervision were not reliable ($\alpha = .375$). In particular, Item 7 "During group supervision, my supervisor informs us on events and workshops we can attend" (which increased Chronbach's Alpha to .43 when removed) and Item 11 "After group supervision, I feel prepared for the home visits in the week ahead" (which increases Chronbach's Alpha to .411 when removed) were unreliable. When these items were both removed, Chronbach's alpha was however still not acceptable ($\alpha = .48$). The results generated from the GS portion of the questionnaire must therefore be interpreted with caution and must not be considered to be a reliable representation of home visitor perceptions of GS.

Programme recipient interview.

A structured interview was conducted with 27 programme recipients who completed the programme in 2008. A copy of the interview schedule is available in Appendix D. Interview schedules were provided in the home language of the recipient. These interviews were conducted by the home visitors. However, they did not conduct interviews with their own past recipients. Rather, another home visitor from the same area conducted the interview. This was deliberately organised to prevent recipients from give desirable answers to interview questions.

The interview started with interviewers reading out a checklist of possible areas of assistance to recipients. Recipients were asked to indicate in which of these areas their home visitors assisted them. A list of the potential areas is available in Table 7 below.

Table 7

Areas in which recipients may have been assisted

-
1. Problem behaviour in children
 2. Child discipline and punishment
 3. How to communicate with children
 4. Building self esteem in children
 5. Infant massage
 6. Help with worries, anxiety and depression
 7. Breast feeding and nutrition
 8. HIV and AIDS
 9. Drinking during pregnancy
 10. Drugs and alcohol in the family
 11. Violence in the family
 12. How to solve problems
 13. Service referral
 14. Provision of emotional support
-

Interviewers wrote each identified area on an individual card. The recipient was asked to rank the cards from most useful to least useful area of assistance. The interviewer then wrote the order in which the recipients placed the cards in on the backs of the cards, as well as on the interview schedule. The recipients were also asked whether there was anything other than what was included in the list of areas that they were assisted with, and whether there was anything else with which they would have liked to have been assisted. The interviewers recorded these responses on the interview schedules.

Procedure**Ethics.**

Ethical clearance was granted by the University of Cape Town Department of Commerce. Informed consent was given by home visitors and programme recipients before they participated in the evaluation. See Appendices E and F for the home visitor and recipient consent forms. Note that recipients received consent forms written in their home languages.

Administration of home visitor questionnaires.

Supervisors informed the home visitors about the evaluation and asked them to stay for an extra hour after one of their group supervision sessions to complete the questionnaires. The questionnaires were therefore administered to three separate groups: the Gugulethu / Khayelithsa group, the Hanover Park / Mitchell's Plain group, and the Imizamo Yethu / Hout Bay Harbour group. Before questionnaires were administered, the evaluator explained the

aim of the evaluation and asked the home visitors to sign the consent forms. The home visitors were instructed to ask any questions that they may have.

Once the questionnaires were completed, the evaluator asked the home visitors whether they would be interested in assisting with data collection by conducting interviews with programme recipients. It was explained that they would be paid their usual hourly rate when conducting the interviews and that their travelling costs would be covered. Nine of the twelve home visitors were interested and their contact details were gathered in order to arrange a date and time for training.

Home visitor interview training.

The evaluator held a two-hour training session with the home visitors who had expressed an interest in conducting the recipient interviews. During this session, the evaluator role-played how to conduct the structured interview and demonstrated how to capture the interview data on the structured interview form. The group paired up and took turns conducting the interview with each other and some volunteered to role-play interviews in front of the group. The evaluator gave continuous feedback. The home visitors were also trained on the importance of administering consent forms before the interview could begin.

Programme recipient interviews.

The programme manager requested that interviewers perform no more than three interviews each so as not to interrupt their normal visiting schedules. Each interviewer was given a list of six random recipients in their community who had completed the programme in 2008. They were asked to secure an interview with three of the recipients on the list. Even though the interviewers only had to conduct three interviews, they were given the names of six past recipients to account for the probability that some recipients would not be available for interview. Before the interviews commenced, the recipients were required to sign a consent form and it was explained to them that they could end the interview at any time. The interviews were conducted in recipients' home languages. The home visitor captured the relevant interview data on the interview schedule in the recipient's home language and later translated the interview schedules into English for the evaluator's convenience.

Data Analysis

Statistical analyses were performed using SPSS 17.0. Data derived from home visitor training and supervision questionnaires was subject to descriptive analysis, including item

and questionnaire mean scores, as well as the standard deviations and ranges of item responses. The overall pre- and post-training scores were compared to test whether the difference between these scores is significant. Individual item scores for pre-training and post-training were also compared to determine which training modules significantly increased home visitor knowledge and skills. The overall scores for group and individual supervision were compared to determine whether there is a significant difference between home visitor perceptions of these supervision types. The IS item scores were compared to the corresponding group GS item scores to determine whether home visitors perceive a difference between the particular functions of the supervision types. Non-parametric Wilcoxin tests were used for all comparisons as the training and supervision questionnaire data were not normally distributed.

Comments made on the training and supervision questionnaires were analysed according to strategies described by Miles and Huberman (1994). These include noting patterns or themes that emerge across responses to particular items, grouping respondent's responses that have a similar pattern into categories and making contrasts by comparing the responses of respondents of similar backgrounds. Such analysis allowed for an explanation of the ratings chosen by home visitors.

Data derived from the recipient interviews was also subject to descriptive analysis such as frequency distributions and rankings. In particular, the total number of support areas in which recipients were helped, the areas in which they were most frequently helped, and the rankings of the perceived usefulness of these support areas were calculated.

Chapter Three: Results and Discussion

For this dissertation, the results and discussion sections have been combined, as this allowed for commentary on findings as the chapter progresses. The chapter has been organised around the evaluation questions.

Evaluation Question One

In order to answer the question “Do home visitors perceive that pre-service training has given them sufficient knowledge and skills to deliver the service as intended?” home visitors were asked to recall their pre-training and immediate post-training skills and knowledge. They were also given the opportunity to comment on their answers.

Visitor’s overall mean score for pre-training skills and knowledge was 3.4 out of a possible 10, whilst the overall mean score for the post-training skills and knowledge was 9.2 out of 10. A Wilcoxin test revealed that the difference between overall pre- and post-training skills and knowledge is significant ($z = -3.06$; $p = .002$). It is therefore clear that the home visitors perceive that their training had a great effect on their home visiting skills and knowledge. This view is also evident from some of the comments that the home visitors gave when reflecting on their overall training experience:

“After training I felt stronger and well-equipped”

“Before training, I never had a clue about parenting skills, although I was a parent of three, but after the training I was clued up.”

Some home visitors even referred to training as life changing:

“The training made a big change in my life... now I can cope with everything in life.”

Mean pre- and post-training scores for each training area were also calculated in order to determine which training areas contributed significantly to home visitor skills and knowledge. See Tables 8 and 9 below for item means, minimum, maximums and standard deviations for pre- and post-training.

Table 8

Descriptive statistics for pre-training questionnaire items

Item	Min	Max	<i>M</i>	<i>SD</i>
1: Understanding children's behaviour	1	9	4.08	2.75
2: Listening to children	1	10	3.58	3.09
3: Building self esteem	1	9	3.83	2.82
4: Setting limits	1	8	3.33	2.23
5: Appropriate discipline	1	8	3.08	1.93
6: How to use problem solving	1	9	2.92	2.23
7: Using problem solving when counselling	1	10	3.25	2.63
8: Performing behavioural assessment	1	4	1.83	1.2
9: Infant massage	1	7	3.17	2.37
10: Postnatal depression	1	7	2.67	2.06
11: Child maltreatment	1	10	3.67	3.06
12: Breast feeding and nutrition	1	10	5.08	3.48
13: HIV and AIDS	1	9	3.58	2.67
14: Foetal Alcohol Spectrum Disorder	1	10	3.50	3.12

Table 9

Descriptive statistics for post-training questionnaire items

Item	Min	Max	<i>M</i>	<i>SD</i>
1: Understanding children's behaviour	7	10	9.42	.90
2: Listening to children	5	10	9.25	1.49
3: Building self esteem	6	10	9.17	1.267
4: Setting limits	8	10	9.25	.87
5: Appropriate discipline	6	10	8.92	1.24
6: How to use problem solving	7	10	9.00	.95
7: Using problem solving when counselling	5	10	9.00	1.48
8: Performing behavioural assessment	6	10	9.42	1.17
9: Infant massage	7	10	9.50	.91
10: Postnatal depression	5	10	9.25	1.49
11: Child maltreatment	4	10	8.92	1.93
12: Breast feeding and nutrition	8	10	9.75	.62
13: HIV and AIDs	7	10	9.17	1.12
14: Foetal Alcohol Spectrum Disorder	5	10	8.92	1.56

A chart depicting the differences pre- and post skills and knowledge skills for each module is presented in Figure 9 below.

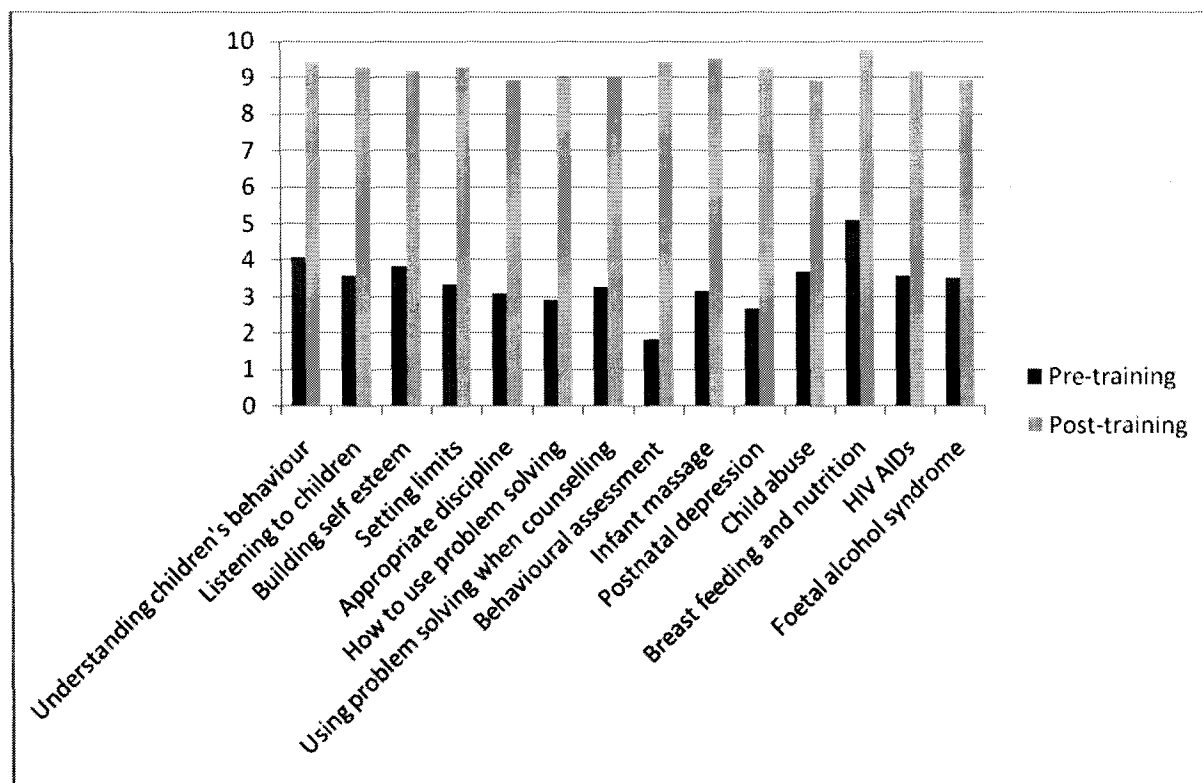


Figure 9. Training item means at pre-test and post-test.

Home visitors perceived some training areas to contribute more to their skills and knowledge than others. For example, some home visitors reported having large amounts of skills and knowledge on breast feeding and nutrition prior to training ($M = 5.08$). This limits the extent to which training is able to contribute to their skills and knowledge in this area. This is supported by the following comments from home visitors illustrate that they already knew a fair amount about breast feeding prior to training:

“I always knew that breast is best but now I know the importance and the bond and trust it build between the mum and her baby”

“Before I knew that breast is good but I did not know how good it is... having all the vitamins the baby needs.”

“I did a lot of research on these topics before I had my own children”

It is also evident that some home visitors were well-informed about breast feeding and nutrition prior to the Parent Centre training as they had practised as breast-feeding counsellors prior to training:

“[I] was a breastfeeding counsellor before I did training at the Parent Centre.”

“[I] was a breastfeed-peer counsellor before this job.”

The area in which home visitors had the least amount of skills and knowledge prior to training is behavioural assessment. This is evident when considering the mean pre-training score for Item 8, which measured behavioural assessment and had the lowest pre-training mean score of all the items ($M = 1.83$). This is also illustrated by the follow comments from home visitors on their training in behavioural assessment:

“I didn’t know anything about it, but now I know that parents need to see a baby not just as baby but as human being that can communicate with her although not through talk”

“After training I know that a child can speak through their expression”

“Before training I did not understand that there was a need for something like behavioural assessment”

“This was a new thing for me and it was exciting. Also, it help to understand more your baby.”

Despite home visitors reporting that they already had skills and knowledge in some of the areas covered in training, there was a significant increase in knowledge and skills from pre- to post-training for every training area ($p < 0.01$ for all). See Table 10 below for the results of the Wilcoxin test results when the ratings from pre- and post-training were compared for each training area.

Table 10

Wilcoxin test results for comparison of pre- and post-training area scores

Pre-post pair	<i>z</i>	<i>P</i>
Understanding children's behaviour	-3.070	.002
Listening to children	-2.944	.003
Building self esteem	-2.944	.003
Setting limits	-3.078	.002
Appropriate discipline	-3.071	.002
How to use problem solving	-2.949	.003
Using problem-solving when counselling	-2.947	.003
Performing behavioural assessment	-3.103	.002
Infant massage	-3.072	.002
Postnatal depression	-3.071	.002
Child maltreatment	-2.952	.003
Breast feeding and nutrition	-2.699	.007
HIV and AIDS	-3.074	.002
Foetal Alcohol Spectrum Disorder	-2.944	.003

The results in the above table indicate that the home visitors perceived a significant increase in their skills and knowledge in all training areas, even for areas in which they had prior skills and knowledge.

These findings indicate that the first evaluation question has been answered in the affirmative. In particular, it appears that training served three purposes for the home visitors. Firstly, they believed that training taught them the knowledge and skills necessary for home visiting. Secondly, where home visitors were already in possession of skills and knowledge in some of the training areas, training was still perceived to significantly contribute to these. Thirdly, training has provided home visitors with a valuable experience for improving their own parenting practices and lives in general.

Evaluation Question Two

In order to answer the question "From the perspective of the recipients, do home visitors apply their knowledge and skills during home visitation?" home visitors conducted structured interviews with past recipients on how useful they found the PIHVP to be. Home visitors did not conduct interviews with their own clients in order to reduce the likelihood of recipients giving desirable (but dishonest) answers to interview questions.

Recipients were first asked to indicate the support areas in which they received help. They were read out a list of potential support areas, which was based on the training that home visitors received. The largest proportion of recipients reported that they received help in nine out of a possible 14 support areas. The minimum number of areas in which recipients

were helped was seven and the maximum was 14 (i.e. all the support areas on the list). A chart depicting the number of areas in which recipients were helped is available in Figure 10 below.

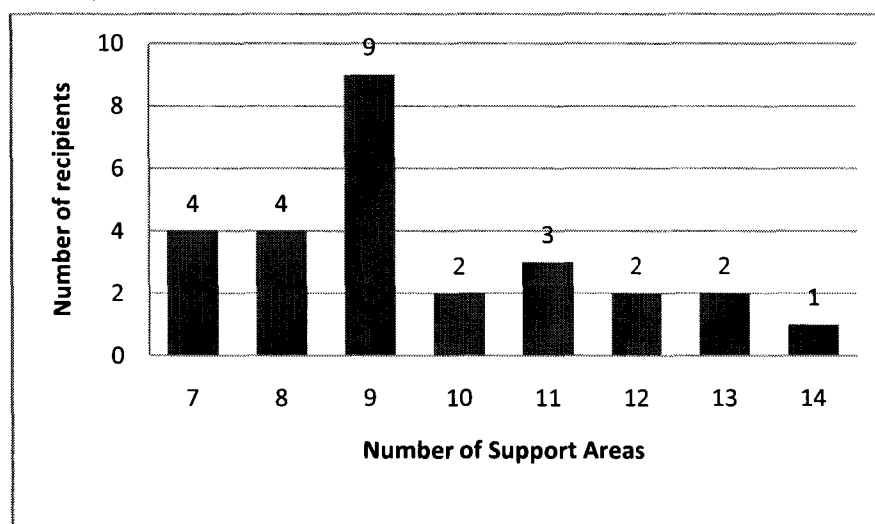


Figure 10. Number of support areas in which recipients were assisted.

This finding suggests that home visitors are applying their training skills and knowledge during home visitation, as all recipients received assistance in at least seven areas in which the home visitors were trained.

The most common support area in which recipients were assisted was infant massage, as 92.6% received help in this area ($n = 25$). The second most common areas in which recipients were helped were breast feeding and nutrition and emotional support (88.9%) ($n = 24$ for both). Drinking during pregnancy and communication with children were the third most common areas with which recipients were helped (77.8%) ($n = 21$ for both). The least common area in which recipients were supported was service referral (33%) ($n = 9$). See Figure 11 below for a chart depicting of the number of recipients who were assisted in each area.

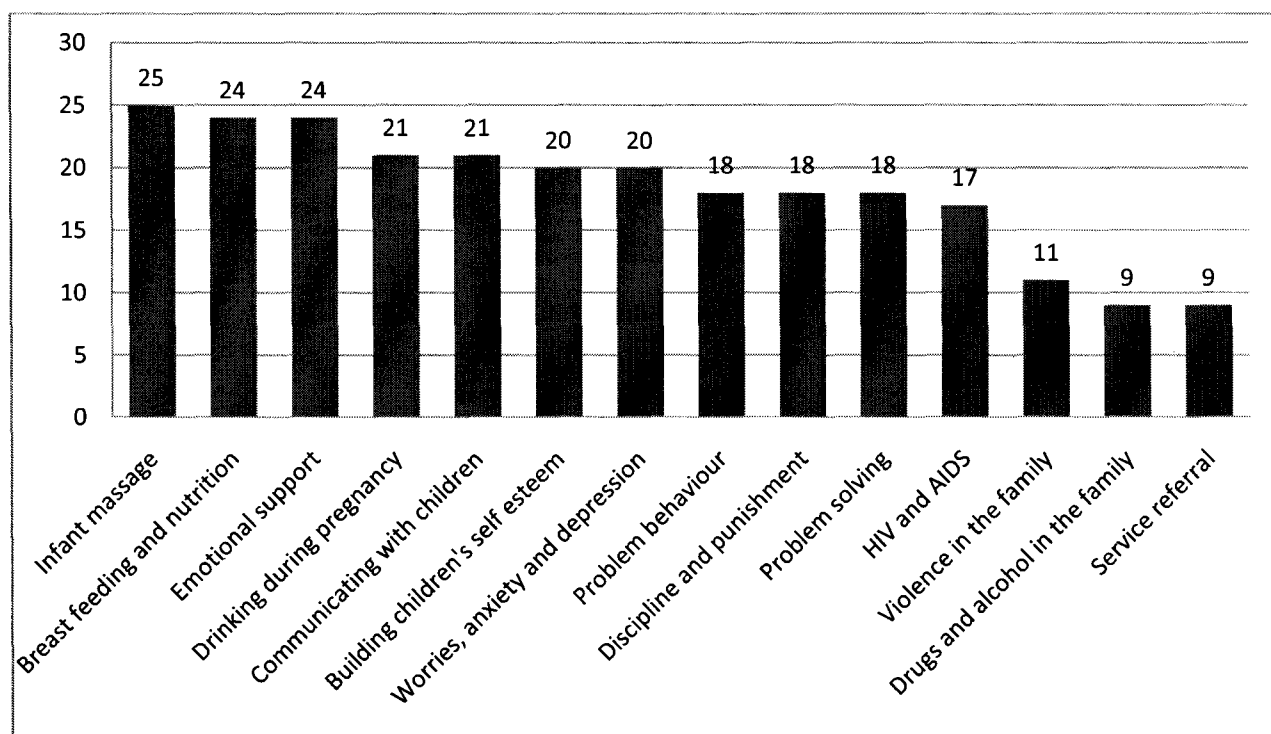


Figure 11. Number of recipients receiving assistance in each area.

The fact that infant massage, breastfeeding and nutrition, the provision of emotional support, drinking during pregnancy and communicating better with children were the most frequent areas in which recipients were assisted is noteworthy. These support areas are all highly relevant to new mothers, with the exception of communicating better with children, which would only be highly relevant to mothers with older children. The relevancy of the areas in which recipients were assisted will be further discussed later in this chapter.

Recipients were also asked if there were any other areas in which they received assistance. Seven of the recipients each identified one such area, which can be grouped into infant-directed and mother-directed assistance. Infant-directed assistance included help with infant diarrhoea, constipation and bathing. Mother-directed assistance included remedies and advice on stretch marks, work-related issues, information about talks at the local clinic and “learning self-love.”

Three of the aforementioned findings suggest that home visitors individualise the service to meet the needs of recipients. Firstly, some recipients identified additional areas in which they were assisted. Secondly, the number of areas in which recipients were helped varied. Thirdly, clients were usually most frequently helped in areas that were highly relevant to them. With regard to the claim that the PIHVP is individualised to serve the needs of recipients, it can therefore be stated that the home visiting service is being delivered as

intended. Furthermore, since home visitors are trained to individualise the service according to the needs of recipients, it can be stated that home visitors apply their training in this way.

The second evaluation question can therefore be answered in the affirmative. As perceived by the programme recipients, home visitors are applying their skills and knowledge to home visitation, as recipients were all assisted in at least seven of the areas covered in training. Furthermore, the service is being delivered as intended with regards to individualisation.

Evaluation Question Three

In order to answer the question “Do programme recipients find the skills and knowledge that are applied by the visitors to be useful?” recipients were asked to rank the areas in which they were assisted from most useful to least useful. The top five most useful areas for each recipient were combined to obtain a frequency distribution of the areas ranked in the top five. These frequencies are presented in Figure 12 below.

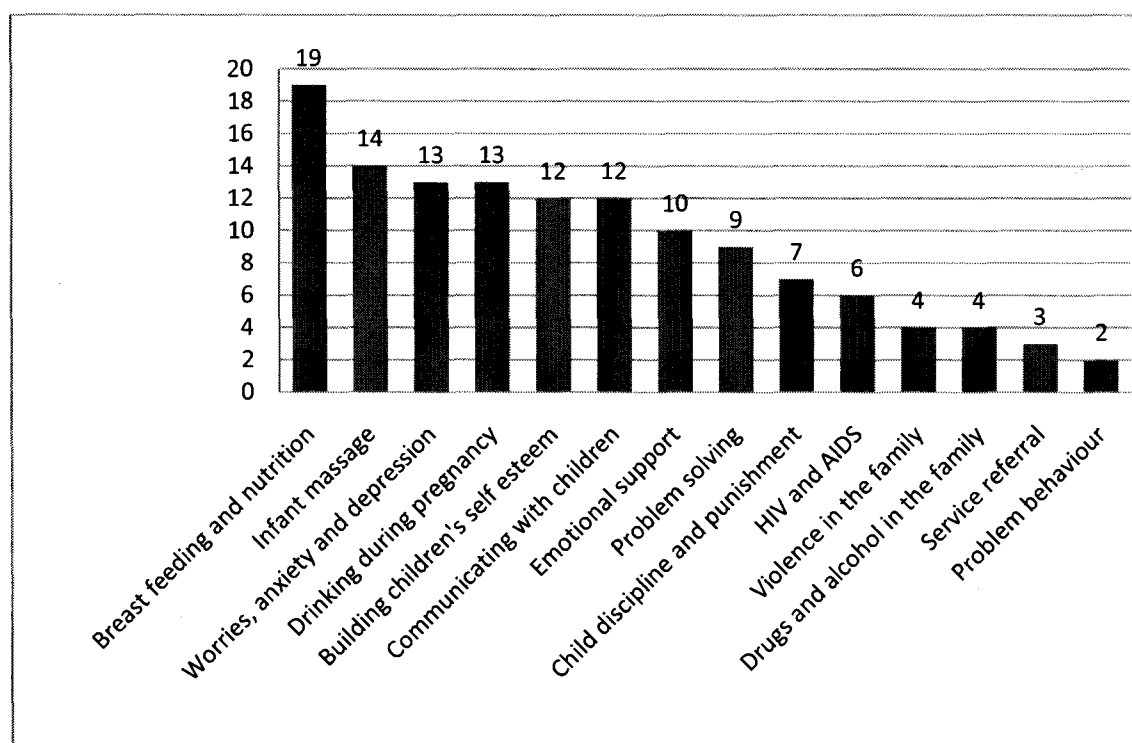


Figure 12. Number of times an area of assistance was rated in the top five.

The number of times that areas of assistance were ranked in the top five cannot however adequately reveal which areas were perceived to be most useful. Rather, the percentage of recipients who received assistance in an area who also rated that assistance in

the top five should be calculated for this purpose. This demonstrates which areas were perceived as most useful overall. For example, of the 24 recipients who received assistance with breast feeding and nutrition, 19 (72%) rated this support area as one of the top five most useful. A table detailing the percentages of recipients who rated in the top five the areas in which they were assisted is available in Table 11 below.

Table 11

Percentages of recipients ranking areas of assistance in the top five most useful

Support Area	<i>n</i> who received assistance	<i>n</i> who rated top five most useful	% Who received assistance who rated it in top five
Breast feeding and nutrition	24	19	79.2
Worries, anxiety and depression	20	13	65
Building self esteem in children	20	12	60
Drinking during pregnancy	21	12	57.1
Infant massage	25	14	56
Emotional support	24	13	54.2
Problem solving	18	9	50
Communicating with children	21	10	47.6
Drugs and alcohol in the family	9	4	44.4
Discipline	18	7	38.9
Violence in the family	11	4	36.4
HIV and AIDS	17	6	35.3
Service referral	9	3	33.3
Problem behaviour	18	2	11.1

Note. Where a small sample of recipients received service (such as service referral and drugs and alcohol in the family), the percentages of those rating this area in the top five are meaningless.

If the majority (i.e. 50% or more) of recipients who received assistance in a particular area ranked that assistance in the top five, then it can be said that that service was perceived as being considerably useful. Given this standard, the following support areas were perceived to be considerably useful by recipients:

1. Breast feeding and nutrition
2. Worries, anxiety and depression
3. Building self esteem in children
4. Drinking during pregnancy
5. Infant massage
6. Emotional support

Why each of these areas emerged as considerably useful warrants consideration. Breastfeeding and nutrition are highly relevant concerns to all new mothers. In South Africa, exclusive breastfeeding (EBF) has been found to be rare, with only 7% of children being exclusively breastfed (UNICEF, 2007). However, the World Health Organisation recommends EBF for the first six months of an infant's life (World Health Organisation, 2003). Even in circumstances where a mother is HIV positive, WHO still recommends that mothers exclusively breastfeed for the first few months of life if access to "acceptable, feasible, affordable, sustainable, and safe" breast milk substitutes are not available (World Health Organisation, 2001, p. 12). Furthermore, EBF may reduce the risk of mother-to-child transmission (MTCT) compared with mixed feeding (Coutsoudis *et al.*, 2001; Coovadia *et al.*, 2007). Given the fact that EBF is uncommon, and choosing EBF is not always a clear-cut decision for mothers, it is easy to see why information on breastfeeding and nutrition would be perceived as considerably useful by programme recipients.

As already noted, approximately one in three new mothers living in South African peri-urban settlements suffer from postnatal depression (Cooper *et al.*, 1999). Given this result, it is not surprising that programme recipients perceived help with their worries, anxiety and depression and the provision of emotional support to be considerably useful. However, it must be noted that the mean Edinburgh Postnatal Depression Scale scores for programme recipients was 9.19 during their second antenatal visit (AN2), 7.44 during their third postnatal visit (P3), and 7.67 during their thirteenth postnatal visit (P13). The Parent Centre considers scores of higher than 13 to indicate postnatal depression. No recipient had a score of higher than 13 at all three times (AN2, P3 and P13). This demonstrates that, overall, recipients were not suffering from postnatal depression. Although the recipients were not suffering from postnatal depression, being a new mother is an emotionally challenging period, especially for the vulnerable women targeted by the PIHVP. It is therefore not difficult to see why the provision of emotional support would be perceived to be considerably useful, even if recipients were not suffering from postnatal depression.

Due to the aforementioned high incidence of Foetal Alcohol Spectrum Disorders in the some areas of the Western Cape, it is clear that educating pregnant women on the harms of drinking during pregnancy is important. Such education was well-received by the recipients of the programme, who perceived information regarding drinking during pregnancy to be considerably useful. The extent of these harms is often not understood by women in at risk-communities and this is highlighted by some of the comments made by home visitors on their training questionnaires:

“Before I knew that alcohol was not good [but] I didn’t know why because [when] I grew up, pregnant women drink alcohol.”

“After training I know that to drink alcohol while you are pregnant is dangerous because everything you drink, you eat, the baby drink and eat.”

“I never knew before how does alcohol affect a foetus.”

Infant massage has been linked to a range of benefits for infants, such as improved neuropsychological development (Rice, 1977), improved sleeping patterns (Field *et al.*, 1996; Scafidi *et al.*, 1986) and weight gain (Scafidi *et al.*, 1986). Infant massage classes have also been found to help mothers relate better to their babies (Glover, Onozawa, & Hodgkinson, 2002). This is probably due to the fact that mothers are encouraged to look at and understand their babies and interact with their babies in a pleasurable way (Glover *et al.*, 2002). Since mothers suffering from postnatal depression often have difficulty relating to their babies (Murray, Fiori-Cowley, Hooper, & Cooper, 1996), infant massage is a useful tool for combating postnatal depression. Due to the range of benefits associated with infant massage, it is not surprising that programme recipients perceive it as being a considerably useful service.

It is interesting that building children’s self esteem was perceived by recipients to be one of the most useful services that recipients received. This was the only support area that is not highly relevant to new mothers that recipients perceived to be considerably useful. A chi-square analysis showed that recipients with older children were not significantly more likely than those who did not have older children to perceive the service as considerably useful ($\chi^2 = .086; p = .77$). The presence of older children was therefore not a predictor of perceived considerable usefulness. It is possible that the service was rated highly as recipients perceived it to be useful for the future. This however cannot be stated with certainty.

The services that were not perceived to be considerably useful (i.e. those areas for which less than 50% of recipients who were assisted in the area ranked it in the top five) are also important to consider. These included the following:

1. Problem solving
2. Communicating better with children
3. Drugs and alcohol in the family
4. Discipline
5. Violence in the family

6. HIV and AIDS
7. Service referral
8. Problem behaviour

It is probably the case that these areas were not perceived to be considerably useful as they are not highly relevant to new mothers. In particular, communicating better with children, discipline and problem behaviour would not be relevant to a new mother who does not have older children. Problem solving, drugs and alcohol in the family, violence in the family, HIV and AIDs and service referral are not perceived to be considerably useful by the recipients, probably because none of these services are directly related to pregnancy or childrearing.

Help with problem behaviour and discipline was not perceived to be useful, in all likelihood because they were not relevant to the recipients at the time. However, a large proportion of recipients received help in both these areas (66%); this suggests that the home visitor thought that the recipients were in need of this assistance, but clearly for recipients this was not as salient. There may be a particular as to why recipients did not perceive assistance with child discipline to be considerably useful. In South Africa, corporal punishment is frequently used by parents in disciplining their children and is considered to be a deeply entrenched practice (Dawes, Kafaar, Kropiwnicki, Pather, & Richter, 2004; Wood & Jewkes, 2001). Home visitors encourage recipients to use manage children's negative behaviour using the guidelines suggested by the World Health Organisation International Child Development Programme, which strongly advises against the use of physical punishment. It may be the case that the recipients are hesitant to change their disciplinary practises and for this reason did not perceive assistance with disciplining children and dealing with problem behaviour to be considerably useful. However, this is merely conjecture and it is also likely that recipients did not perceive these support areas to be useful because they were not relevant to the age of their child, as already discussed.

Recipients were also asked if there were any additional areas in which they desired assistance, but did not receive this. Eleven of the recipients identified at least one additional area that they in which they would have liked the home visitor to have assisted them, including:

1. Information on disability screening
2. For the programme to continue for longer
3. Information on where to find food hampers and clothes

4. Emotional support for an older child
5. Food for children
6. More help with poverty
7. More information on postnatal depression
8. For the visitor to buy groceries

It should be noted that these desired additional support areas did not receive more than one mention, with the exception of the desire for the programme to continue for longer ($n = 4$) and for the home visitor to buy groceries ($n = 2$). Of course, for the home visitor to provide assistance in some of these areas would not be feasible (such as buying groceries) and other areas are not the focus of the PIHVP (such as helping with poverty, providing food for children, and providing emotional support for older children). The provision of information on disability screening is feasible, however, and information on and assistance with postnatal depression is a desired programme outcome. The fact that 11 out of 27 recipients (40.7%) identified additional areas in which they would like to have been assisted may indicate that these recipients did not feel that the programme completely met their needs.

A small proportion of recipients ($n = 4$) indicated that they wished that the programme had lasted longer. The programme usually ends when the recipient's baby is six months old. Compared to other home visitation programmes, this is a young age at which to terminate a home visiting programme, with some programmes continuing until the child is two years old (e.g. Olds, 2002). The programme manager stated that the home visitors assess whether the recipient is ready to exit the programme when their baby is six months old. If it is determined that the recipient is not ready, then the programme will continue if funding allows for this.

It is possible that these recipients desired the programme to be longer because they were more vulnerable than other recipients. Programme records could not be located by the Parent Centre for one of these recipients so descriptive data could only be collected for three of the four. Overall, those who desired a longer programme may be considered as vulnerable, as they were all unemployed and had unplanned pregnancies. However, the majority of recipients fall into these categories, as most of them are unemployed ($n = 17$) and had unplanned pregnancies ($n = 16$), and many of them fall into both of these categories ($n = 12$). It is therefore not clear that those who wished for the programme to continue for longer were more vulnerable than the other recipients. However, many variables that indicate vulnerability were not clearly indicated in the programme records (such as those who have

experienced domestic violence or who have a history of depression), so this cannot be stated with certainty. Of course, it is possible that they expressed an interest in continuing the programme simply because they enjoyed the programme and the relationship that they had formed with their home visitor. Nonetheless, it is possible that those who desired a prolonged programme were genuinely in need of this.

It is worth noting that none of the recipients who desired a longer programme indicated that their home visitor referred them to services that they may need. This may be problematic because if recipients are not ready to exit the programme and funding does not allow for extra visits, then they need to be referred to other services that will meet their needs.

The answer to the evaluation question “Do recipients find the skills and knowledge that are applied by the visitors to be useful?” therefore seems to be: it depends on how relevant the assistance is to the recipient. In general, services that were directly related to helping with the infant and pregnancy were perceived to be considerably useful, but those services that were not immediately relevant, such as those related to discipline and communicating with children, were not. For some recipients, it appears that the programme did not fully meet their needs.

Evaluation Question Four

To answer the evaluation question “From the perspective of home visitors, does supervision adequately prepare them for home visits?” home visitors were asked to rate their experiences of group supervision (GS) and individual supervision (IS) on a questionnaire.

Overall, the results indicate that the home visitors perceived GS to prepare them for home visits. For all items measuring GS, item scores were equal to or higher than 8 and the mean overall score for the GS portion of the questionnaire was 9.37. A detailed table of the descriptive statistics for GS item scores is presented in Table 12 below.

Table 12

Descriptive statistics for group supervision questionnaire

Item	Content	Min	Max	<i>M</i>	<i>SD</i>
2	Emotional support	3	10	8.75	2.53
4	Acquisition of knowledge and skills	8	10	9.83	.58
5	Opportunity to talk about difficult cases	1	10	8.00	3.7
7	Informed on workshops and events	8	10	9.83	.58
10	Sufficient number of sessions per month	10	10	10.00	.00
11	Prepared for visits ahead	8	10	9.83	.58

The following comments on the GS questionnaire demonstrate how recipients believe that GS fulfils its supportive function:

“Sometimes I got a question or a case whereby I do not know how to handle it so in the supervision I can report it the group help me.”

“I unload the cases that worries me.”

“She always give us a chance to talk about your work load that you have during the week.”

“We support each other.”

“We all share our problems and we supporting each other by all means.”

However, a few home visitors did point out that in GS there is often not enough time to talk about their own challenging cases, but that more urgent cases are given priority:

“Time can be a factor as there is so much to share- challenging cases do however receive priority time slots.”

“Too little time, depending on the needs of other cases- more urgent ones”

The following comments demonstrate how the home visitors believe that GS fulfils the administrative function:

“[My supervisor informs us on upcoming workshops and events] so that we can remind each other and so we do not miss anything.”

“She will ask us to write in our diaries and before she will again inform us by phone or sms so that we may not forget.”

However, one home visitor did point out that her supervisor was not always certain about the details of the workshops they had to attend:

“[My supervisor is] most of the time, uncertain about dates and times” of events and workshops.

The following comment illustrates how GS fulfils the educative function:

“Here it’s everyone’s cases that we can learn from, e.g. referral or just how to handle a particular situation should it come your way or give input if you have a similar case.”

Home visitors also perceived that IS adequately prepared them for home visits. The mean overall score for the IS portion of the questionnaire was 7.96. The highest rated item was Item 1, which stated “During individual supervision, I feel emotionally supported” ($M = 9.25$), indicating that home visitors strongly agree that they feel emotionally supported during IS. This is to be expected, as during individual supervision all the supervisor’s attention is focussed on the individual, which would enhance home visitor perceptions of being supported. The item with the lowest mean score was the Item 9, which stated “I have an insufficient number of individual supervisions per month,” which had a mean of 4.00, but was reverse-scored due to the negative wording to produce a mean of 6.00. This indicates that some respondents do not think that they have a sufficient number of IS sessions per month. See Table 13 below for the descriptive statistics for the IS item scores.

Table 13

Descriptive statistics for individual supervision questionnaire

Item	Content	Min	Max	M	SD
1	Emotional support	5	10	9.25	1.49
3	Acquisition of knowledge and skills	4	10	8.75	2.14
6	Opportunity to talk about difficult cases	1	10	8.50	3.12
8	Informed on workshops and events	1	10	7.58	3.23
9	Sufficient number of sessions per month	1	10	6.00	4.31
12	Prepared for visits ahead	1	10	7.67	3.58

Whilst all item means (other than Item 12) were very high, it should be noted that there was variation within these scores. This indicates that while home visitors feel that IS adequately prepares them for home visits, that some home visitors viewed some aspects of IS less positively. The exceptions are clear in some of the comments given below.

The following comments illustrate how home visitors feel that IS fulfils its supportive function:

“I feel support because my supervisor always there for me.”

“Yes I feel emotional support cause even if we one on one we can talk about anything, cause sometimes you don’t want to share with a group.”

“If I am coming with a problem I know that she is going to give me an answer.”

One home visitor noted that she felt more prepared for visits in the week ahead after GS than after IS, emphasising the value that home visitors place on GS:

“ [During individual supervision, there is] no other input of the team, which could’ve had similar cases, only the supervisor gives me valid information, but it would’ve been a better week having other input too.”

The following comments illustrate how home visitors feel that IS fulfils its educative function:

“Our supervisor always have to tell us about new things that we supposed to know.”

“I get some new knowledge and skills.”

However, this view was not shared by all, as one home visitor stated:

“[For individual supervision] one person can give you the knowledge but not much,”

The following comment illustrates how home visitors felt that IS provides administrative support:

“[My supervisor informs me on upcoming workshops and events] so that I can be able to attend it and schedule my appointments on time.”

In order to determine whether there was a significant difference in the perceptions of home visitors towards GS and IS, a Wilcoxin test was performed on the data. The test revealed that there was a significant difference between GS and IS scores, with IS scores ($M = 7.96$) being significantly lower than GS scores ($M = 9.37$) ($z = -2.675$; $p = .007$).

It can therefore be stated that home visitors perceive GS to prepare them better for home visits than IS. However, it must be noted that the mean score for IS items is still very high. Therefore, while the difference in perceptions of group and IS is *statistically* significant, the difference is probably not *practically* significant, as the high mean overall score for IS (7.96 out of 10) demonstrates that, in general, home visitors view IS very positively.

In order to determine where the differences in perceptions of GS and IS lie, the mean scores for corresponding questions were compared. See Figure 13 below for a comparative chart of the IS and GS means for corresponding questions.

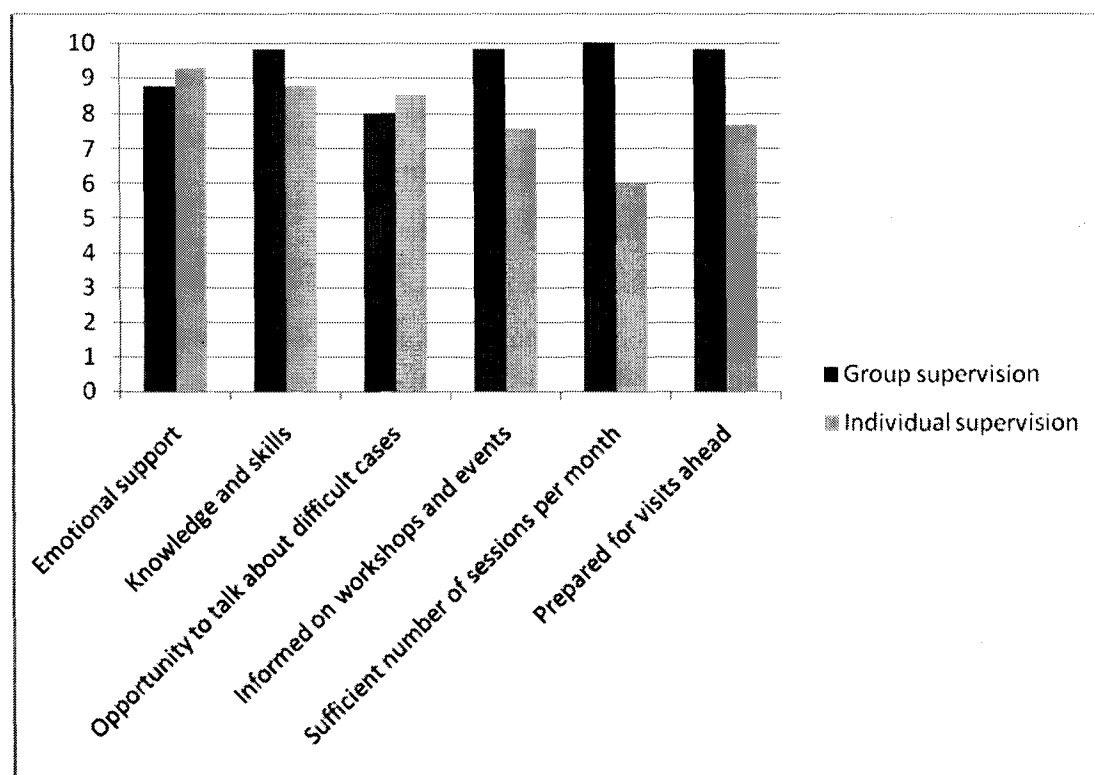


Figure 13. Comparison of GS and IS item scores.

Wilcoxin tests were performed on corresponding IS and GS item scores to determine whether there is a significant difference between perceptions of the extent to which the supervision types fulfil their functions. This was performed to determine whether there were specific functions that the home visitors perceived to be fulfilled better by one supervision

type than by the other. A list of the z and p -values for each comparison is available in Table 14 below.

Table 14

Paired Wilcoxin test results for comparison of GS and IS item scores

Items	Content	z	p
1 and 2	Emotional support	-.744	.457
3 and 4	Acquisition of knowledge and skills	-1.490	.136
5 and 6	Opportunity to talk about difficult cases	1.365	.715
7 and 8	Informed on workshops and events	-2.032	.042
9 and 10	Sufficient number of sessions per month	-2.232	.026
11 and 12	Prepared for visits ahead	-1.753	.080

Note: Bold p -values are significant at the .05 level.

There was a significant difference between the scores of GS and IS items measuring whether respondents were informed about workshops and events during supervision (i.e. Items 7 and 8), with GS item scores ($M = 9.83$) being significantly higher than IS item scores ($M = 7.58$) ($z = -2.032$; $p = .042$). This indicates that home visitors felt that GS fulfilled the administrative function better than IS. However, the mean IS score is still high, so this difference is probably not practically significant. It must also be remembered that Item 7 is an unreliable item, as outlined in Chapter Two of this dissertation.

There was also a significant difference between the GS and IS items measuring the sufficiency of the number of monthly supervisions (i.e. Items 9 and 10 respectively), with GS scores ($M = 10.00$) being significantly higher than IS scores ($M = 6.00$) ($z = -2.232$; $p = .026$). This demonstrates that respondents were significantly less satisfied with the number of IS monthly sessions than they were with the number of monthly GS sessions. This difference appears to be practically significant, as many respondents tended to agree that they have an insufficient number of IS sessions per month.

In general, with regard to the overall IS and GS means, the fourth evaluation question can therefore be answered in the affirmative. The results suggest that, while home visitors have more favourable perceptions of GS than of IS, overall they still have highly positive perceptions of both supervision types. However, there is a significant difference between perceptions of the sufficiency of monthly GS and IS sessions. The home visitors have one individual supervision session per month, and the results suggest that this may be too infrequent. This is probably due to the fact that home visitors receive individual attention during IS and some may not feel comfortable voicing certain concerns in front of a group.

Important Additional Findings

In the evaluator's examination of the programme records, two additional findings were made. These were not results that the evaluator sought to determine at the outset of the evaluation, but are worth mentioning nonetheless.

Missing data.

In attempting to obtain descriptive data on programme recipients, the evaluator found that data on many of the home visiting information sheets were missing. In addition, three recipient files could not be located by the Parent Centre. Home visitors are trained to administer the Edinburgh Postnatal Depression Scale to their clients three times during the programme: during the second antenatal visit (AN2), during the third postnatal visit (P3), and during the thirteenth postnatal visit (P13). However, in those files that could be located this data was missing for 12.5 % of recipients at AN2 ($n = 3$), 33.3% of recipients at P3 ($n = 8$) and 40% of recipients at P13 ($n = 9$). A list of the other missing data is available in Table 15 below.

Table 15

Frequencies and percentages of home visiting information sheet missing data

Data	<i>n</i> missing	% missing
Relationship status	5	20.8%
Number of people living in dwelling	4	16.6%
Infant birth weight	4	16.6%

It must be noted that the evaluator did not capture all the information from home visiting information sheets, as only those variables that could account for recipient vulnerability were captured. The evaluator observed that other information on these sheets was frequently missing, however.

Missing programme record data is problematic. Programme staff cannot confidently state that a programme is delivered as intended if data on the implementation is not available. In the case of the missing EPDS data, it is either the case the home visitors did not administer the scale, or they did administer the scale but failed to record the results in the programme records. The former is concerning as it would suggest that home visitors are not delivering the programme as intended, and the latter is problematic as programme records need to be

kept up to date so as to allow for monitoring of programme implementation and outcomes. This is also problematic as one of the aims of the PIHVP is to improve maternal well-being and the current state of the programme records cannot give evidence of this.

Inadequate recipient data.

Another limitation of the programme records is that some the factors which deem recipients “at risk” (according to the criteria used by the Parent Centre) are not recorded. While home visitors are required to record recipient age, EPDS scores, employment status and a description of the recipient’s dwelling, other criteria such as experiences of domestic violence, recipients’ relationships with their mothers and experiences of domestic violence, maltreatment and rape are not recorded explicitly. The fact that recorded descriptions of the recipients do not capture the extent to which recipients are “at risk” is problematic. This makes it impossible to determine from records either a) the vulnerability of recipients or b) whether the programme is delivered to the intended targets. This is problematic for the programme staff, as they will not know whether the programme is delivered to the target population.

Chapter Four: Conclusion and Recommendations

Answering the Evaluation Questions

Summaries of the answers to the evaluation question are presented below. It must be noted that the results are not linked to literature, as to the best knowledge of the evaluator no similar evaluations have been published. Rather, the results are linked back to the PIHVP programme theory where applicable.

The results suggest that training was perceived by home visitors to provide them with the knowledge and skills to deliver the programme as intended. Even when home visitors were in possession of the relevant skills and knowledge prior to training, training was still perceived to significantly contribute to their skills and knowledge in these areas. Furthermore training provided home visitors with a valuable experience for improving their own parenting practices and lives in general. The Parent Centre's training programme theory states that a short-term outcome of training is that home visitors will acquire the necessary skills and knowledge, and a long-term outcome is that the home visitors' family lives will be improved. This evaluation therefore offers support to this theory.

From the information provided by programme recipients, it appears that home visitors have applied what they learnt in training during home visitation. Three findings demonstrate this. Firstly, there is variation in the number of areas in which recipients were helped, with all recipients receiving help in at least seven and at most in all of the areas that home visitors were trained in. Secondly, the most common areas in which recipients were helped were highly relevant to new mothers. Thirdly, seven of the mothers identified additional areas in which they were helped. The latter two findings provide support to the claim that the programme is individualised to serve the needs of the client. Considering that home visitors are trained to individualise the programme in this way, it can be said that the home visitors successfully applied this aspect of their training to home visitation. The training programme theory states that a medium-term outcome of the programme is that the home visitors will apply their training skills and knowledge to their visits and this evaluation provides support to that claim. The PIHVP theory states that parents will be supported and provided with skills and knowledge during the programme. The fact that recipients identified at least seven areas each in which they were supported and given information offers support to this claim.

Whether recipients find the assistance provided by home visitors to be useful seems to depend on how relevant the area of assistance is to the recipient. In general, assistance that is directly related to infants and pregnancy was perceived to be considerably useful and

assistance that was not immediately relevant was not perceived as such. Some recipients indicated a desire for the programme to be prolonged and some listed additional areas in which they would like to have been helped, suggesting that they might feel that their needs were not fully met by the programme.

Home visitor ratings of both individual and group supervision were high, suggesting that they felt that both supervision types prepare them adequately for home visits. While both supervision types were highly valued, the results suggest that some home visitors desired more individual sessions per month. This may be because individual supervision offers more attention from the supervisor than group supervision and some home visitors may feel more comfortable voicing certain issues in individual supervision than in group supervision. Overall, however, individuals felt that both types supervision prepared them for home visits. The supervision programme theory is therefore supported by this evaluation, as it states that supervision will provide home visitors with support and hence prepare them for home visits.

Contributions to the Field

This evaluation contributes to the literature on home visitor training and supervision evaluations. Such evaluations are necessary if the outcomes of home visiting programmes are to be truly understood. It also offers support to the claim that paraprofessional home visitors can be trained to deliver a service as intended and that supervision is an invaluable service to such home visitors. Furthermore, this evaluation demonstrates that paraprofessional home visitors can deliver a service that is perceived to be useful by programme recipients. The evaluation also describes a programme that has been successfully adapted to the South African context, according to the criteria set by Lee *et al.* (2008).

Limitations

Small recipient sample.

Although much care was taken to randomly select a sample of recipients who completed the programme in 2008, the final 27 recipients who were interviewed are unlikely to be a representative sample of the 2008 programme recipients. Since 434 mother-infant dyads completed the programme in this year, only 6% of the programme recipients from 2008 were sampled for recipient interviews. This small sample was due to funding restrictions and the availability of home visitors for interviewing. For populations of this size, it would be desirable to utilise a sample approximately 30% the size of the population. A

future evaluation utilising programme recipients should therefore consider using a larger sample in order to ensure representativeness.

Self-report data.

For this evaluation, home visitors and recipients were asked about their perceptions of the PIHVP. The use of self-report data such as perceptions is however problematic. Cook and Campbell (1979) note that when respondents fill out self report questionnaires, they tend to either report what they think the researcher expects to see, or they answer in such a way as to positively portray their knowledge, skills or beliefs. It must therefore be noted that the positive perceptions by home visitors and recipients may be the result of these phenomena. Of course, it is likely that home visitors genuinely do positively perceive the training and supervision and that recipients did genuinely find the programme to be useful.

Another issue around the use of self-report data concerns the accuracy of memories. For the training questionnaire, home visitors had to think back to before training and to immediately after training when rating their home visiting skills and knowledge. Some home visitors had completed training six years prior to the evaluation and the evaluation required serious retrospection on their behalf. Such retrospective data collection may not be reliable as it cannot be assumed that their memories are reliable ratings of their prior skills and knowledge.

Future evaluations should therefore consider utilising additional methods to measure training, supervision and programme delivery which do not rely solely on self-report data. In particular, independent assessments of home visitor skills and knowledge should be conducted. These may include observations of home visitors' skills in the field, or written tests of home visitor knowledge. Such tests of skills and knowledge could be administered before and immediately after training. A method to adequately measure programme delivery may also include field observations or an examination of the programme records. These will ensure that programme implementation is evaluated more reliably.

Recommendations

Given the results of the evaluation, recommendations for refining the implementation of PIHVP and for better understanding of the vulnerability of programme recipients are proposed:

1. Overall, the training was perceived by home visitors to adequately prepare them for visits. However, it is clear that some home visitors already had extensive knowledge in some

of areas covered in training, due to prior training in areas such as breastfeeding and nutrition. It is therefore recommended that such trainees be allowed to contribute towards the training of other trainees in their areas of expertise, thereby acting as peer educators. Peer education in home visiting training has been recommended in the literature as a method of maximising home visitor learning (Wasik *et al.*, 1990), thus making it a desirable addition to the home visitor training programme.

2. In general, the assistance perceived to be most useful by programme recipients was that which was highly relevant to mothers with infants (such as assistance with breast feeding and nutrition, infant massage, depression and drinking during pregnancy). Training should therefore focus more on issues that are highly relevant to new mothers, and less on issues that are only relevant to them at a later stage in their child's life.

3. If funding allows for it, more individual supervision sessions should be provided for those who feel that they need it. It is not recommended that the number of monthly group supervision sessions be decreased in order to increase the number of monthly individual supervision sessions, as home visitors expressed an appreciation for the opportunity to support each other during group supervision.

4. Given the incomplete state of home visit records, two recommendations can be made. Firstly, home visitors should be informed and constantly reminded by their supervisors of the importance of completing home visit records. This will allow for better future monitoring of the programme implementation and its outcomes. Secondly, home visiting information sheets should be expanded to include other information related to the Parent Centre's vulnerability criteria, such as experiences of domestic violence, recipients' relationships with their mothers and experiences of domestic violence, maltreatment and rape. This data should not be collected during the first home visit due to its sensitive nature. Rather, it is recommended that this information is collect during a later visit (whichever is deemed suitable by the Parent Centre) once rapport and trust have been established. The collection of such data should allow home visitors to better identify the priority needs of the recipients and will enable programme staff to determine whether the programme is being delivered to the intended targets.

5. Some recipients expressed a desire for the programme to continue for longer. As it is unlikely that funding will be available for an indefinite continuance of the programme, mothers who are not ready to exit the programme when their child is six months old should be referred to appropriate community services. It would also be desirable for home visitors to conduct follow-ups with such recipients.

Overall, the Parent Centre home visitors feel that training and supervision supports them and prepares them for home visits. They deliver a programme that recipients perceive to be beneficial and that is well-adapted to the South African context. The implementation of the programme may be strengthened, however, if the above recommendations are considered by programme staff.

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Appendices

Appendix A Programme records cover sheet

<p><u>MOTHER'S PERSONAL DETAILS</u></p> <p>Mother's name:.....</p> <p>Mother's age:.....</p> <p>Mother's address:.....</p> <p>Mother's tel no:.....</p> <p>Marital status: (m / sa / su / d / w) (circle)</p> <p>No of children (exclu this pregnancy).....</p> <p>Highest grade passed:.....</p> <p>Employed / Unemployed/ Scholar (circle)</p> <p>Source of income:.....</p> <p><u>FATHER'S PERSONAL DETAILS</u></p> <p>Father's name:.....</p> <p>Father's age:.....</p> <p>Father's address:.....</p> <p>Relationship to mother: (husband/ boyfriend) (circle)</p> <p>Response to this pregnancy:.....</p> <p>Highest grade passed:.....</p> <p>Employed/ Unemployed/ Scholar (circle)</p> <p>Source of income:.....</p>	<p><u>THE PREGNANCY & BIRTH</u></p> <p>Baby planned: (yes / no) (circle)</p> <p>Pregnancy no: (this pregnancy).....</p> <p>Date of first visit from the PICC:.....</p> <p>Stage of pregnancy at first visit:..... (weeks)</p> <p>Mother booked at:.....</p> <p>Place of birth:.....</p> <p>Birth story: (positive / negative) (circle)</p> <p>Nature of birth: (NVD / C-section) (circle)</p> <p>Baby's birthdate:..... Sex:.....</p> <p>Head circumference:.....</p> <p>Apgar score: (see clinic card):.....</p> <p><u>FEEDING (breast feeding/bottle feeding)</u></p> <p>What does pregnant mother plan to do?</p> <p>What does mother decide after birth? (note changes in feeding as they took place)</p> <p><u>REFERAL TO THE PROGRAMME</u></p> <p>How was mother referred?</p>
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AN1	AN2	AN3	AN4	AN5
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EPDS 1.....
EPDS 2.....
EPDS 3.....

RFS:.....

H

P1	P2	P3	P4	P5	P6	P7	P8	P9	P10	P11	P12	P13	P14	P15
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<p>MOTHER'S OTHER CHILDREN</p> <p>Name Age Sex With whom do they live</p> <p>1.....</p> <p>2.....</p> <p>3.....</p> <p>4.....</p> <p>5.....</p> <p>6.....</p> <p>7.....</p> <p>Comments:</p>	<p>MOTHER'S ACCOMMODATION</p> <p>Does mother live in her own home? Yes / No (circle)</p> <p>If no, whose home does she live in? Give relationship to mother e.g. aunt</p> <p>Where does the mother live? Inside the house / in a shack / in a wendy house ? (circle)</p> <p>No of bedrooms.....</p> <p>How many people living on the property?.....</p> <p>Is there electricity in the house? Yes/ No (circle)</p> <p>Is there running water in the home? Yes/ No (circle)</p>
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OTHER PEOPLE LIVING WITH MOTHER (Excluding partner and biological children)			
Relation to mother	Age	Highest grade passed	Occupation
1.....	.....	.....	.....
2.....	.....	.....	.....
3.....	.....	.....	.....
4.....	.....	.....	.....
5.....	.....	.....	.....
6.....	.....	.....	.....
7.....	.....	.....	.....
8.....	.....	.....	.....
9.....	.....	.....	.....
Estimated household income:.....			

Appendix B Training questionnaire

Name: _____

Age: _____ Highest qualification: _____

Community work experience: _____

Number of years working as a home visitor for the Parent Centre: _____

Please rate your level of competency in the given areas before and after training. Do this by ticking the appropriate box (**1 = Very Incompetent and 10 = Very Competent**). If you would like to leave a comment, please do so.

1. My competency in helping parents to *understand their children's behaviour*:

Before training:	1	2	3	4	5	6	7	8	9	10
After training:	1	2	3	4	5	6	7	8	9	10

Comment: _____

2. My competency in teaching parents to *listen to their children*:

Before training:	1	2	3	4	5	6	7	8	9	10
After training:	1	2	3	4	5	6	7	8	9	10

Comment: _____

3. My competency in helping parents to *build their children's self esteem*:

Before training:	1	2	3	4	5	6	7	8	9	10
After training:	1	2	3	4	5	6	7	8	9	10

Comment: _____

4. My competency in teaching parents about *setting limits for their children*:

Before training:	1	2	3	4	5	6	7	8	9	10
After training:	1	2	3	4	5	6	7	8	9	10

Comment: _____

5. My competency in teaching parents about *appropriate discipline*:

Before training:	1	2	3	4	5	6	7	8	9	10
After training:	1	2	3	4	5	6	7	8	9	10

Comment:

6. My competency in teaching parents *how to use problem-solving techniques*:

Before training:	1	2	3	4	5	6	7	8	9	10
After training:	1	2	3	4	5	6	7	8	9	10

Comment:

7. My competency in *using problem-solving when counselling parents*:

Before training:	1	2	3	4	5	6	7	8	9	10
After training:	1	2	3	4	5	6	7	8	9	10

Comment:

8. My competency in *performing a behavioural assessment of an infant and parent*:

Before training:	1	2	3	4	5	6	7	8	9	10
After training:	1	2	3	4	5	6	7	8	9	10

Comment:

9. My competency in teaching parents how to *massage their infant*:

Before training:	1	2	3	4	5	6	7	8	9	10
After training:	1	2	3	4	5	6	7	8	9	10

Comment:

10. My competency in *detecting postnatal depression in mothers*:

Before training:	1	2	3	4	5	6	7	8	9	10
After training:	1	2	3	4	5	6	7	8	9	10

Comment:

11. My competency in recognising *when a child is being abused*:

Before training:	1	2	3	4	5	6	7	8	9	10
After training:	1	2	3	4	5	6	7	8	9	10

Comment:

12. My competency in teaching mothers about *breast feeding and infant nutrition*:

Before training:	1	2	3	4	5	6	7	8	9	10
After training:	1	2	3	4	5	6	7	8	9	10

Comment:

13. My competency in teaching parents about *HIV and AIDs*.

Before training:	1	2	3	4	5	6	7	8	9	10
After training:	1	2	3	4	5	6	7	8	9	10

Comment:

14. My competency in teaching parents about *Foetal Alcohol Spectrum Disorder*:

Before training:	1	2	3	4	5	6	7	8	9	10
After training:	1	2	3	4	5	6	7	8	9	10

Comment:

Appendix C
Supervision questionnaire

Name _____

Please tick the appropriate answer (**1 = Very Strongly Disagree, 10 = Very Strongly Agree**). If you would like, please leave a comment relating to the question.

1. During individual supervision, I feel emotionally supported.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

Comment: _____

2. During group supervision, I do not feel emotionally supported.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

Comment: _____

3. During individual supervision, I do not gain new knowledge and skills.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

Comment: _____

4. During group supervision, I gain new knowledge and skills.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

Comment: _____

5. During group supervision, I often don't get a chance to talk about cases that are challenging for me.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

Comment: _____

6. During individual supervision, I get a chance to talk about cases that are challenging for me.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

Comment: _____

7. During group supervision, my supervisor informs us on upcoming workshops and events that we can attend.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

Comment:

8. During individual supervision, my supervisor informs me on upcoming workshops and events that I can attend.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

Comment:

9. I have insufficient number of individual supervisions per month.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

Comment:

10. I have sufficient number of group supervisions per month.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

Comment:

11. After group supervision, I feel prepared for the home visits in the week ahead.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

Comment:

12. After individual supervision, I do not feel prepared for the home visits in the week ahead.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

Comment:

Appendix D
Recipient interview schedule

When our home visitor, _____, visited you, which of the following did she help you with? Please tick all that apply.

- Problems with my child's behaviour
- Child discipline and punishment
- Communicating better with my children
- Building self esteem in my children
- Infant massage
- My worries, anxiety and depression
- Breast feeding and nutrition
- HIV and AIDS
- Drinking during pregnancy
- Drugs and alcohol in the family
- Violence in the family
- How to solve problems
- Referral to services that my children and family need
- Providing me with emotional support

Is there anything else that she helped you with?

Now I want to ask about how helpful the home visitor was. From the list that we just discussed, I want you to tell me which were the most and least useful. I'm going to write them on cards and ask you to put them in order from most to least helpful (Instruction to interviewer: Write 1 on the back of the card she ranks first and the subsequent numbers on the back of the other cards. Write down the rank order below. Please make sure you return the cards!

1. (most helpful) _____
2. _____
3. _____
4. _____
5. _____

Is there anything you can think of which you would have liked the home visitor to do which she did not do? Is there anything else you would like to have been taught?

Appendix E
Home visitor consent form

Hello, my name is Robin Pocock

I am from the University of Cape Town. I am conducting research for my masters' degree. I would like you to fill out questionnaires on your experiences in the Parent Infant Home Visitation Programme. Specifically, I want to know about your experiences of training, supervision and home visiting. I am most grateful for your participation. Your participation may help improve the Parent Infant Home Visitation Programme. I will ask you to fill out 2 questionnaires today. The first questionnaire is on your perceptions of training. The second questionnaire is on your perceptions of supervision. There is a third questionnaire which I may give to you on another day containing questions about your home visiting experience with particular families. Filling in the questionnaires will last approximately 45 minutes.

Please understand that **your participation is voluntary** and you are not being forced to take part. The choice of whether to participate or not, is yours alone.

However, we would really appreciate it if you do share your thoughts with me. If you choose not to take part in answering these questions, you will not be affected in any way whatsoever. If you agree to participate, you may stop at any time and tell me that you don't want to go on with the questionnaires. If you do this there will also be no penalties.

Should you have any queries about the study please contact one of the following persons:

Ms Robin Pocock, ph: 021-6712047 or 082 598 8892

My supervisor: Professor Andy Dawes, ph: 082 422 9940

CONSENT

I hereby agree to participate in research regarding the Parent Infant Home Visitation Programme. I understand that I am participating freely and without being forced in any way to do so. I also understand that I can stop filling in the questionnaires at any point should I not want to continue and that this decision will not in any way affect me negatively.

I understand that all the information from these questionnaires will be combined in one report to the University of Cape Town. My name will not appear in that report. All the information gathered will be kept securely so that only the researcher and her supervisor have access to it.

I understand that this is a research project, which will not necessarily benefit me personally.

I have received the telephone number and name of a person to contact should I need to speak about any issues which may arise related to this research.

I understand that I will not receive feedback about my fellow home visitors as the findings are confidential

.....
Signature of participant

Date:.....

Appendix F
Programme recipient consent form

Hello, I am _____

I am from the Parent Centre. Our employee, _____, visited you as a part of the Parent Infant Home Visitation programme. We are conducting research on the programme with the assistance of Ms Robin Pocock, a post-graduate student at the University of Cape Town. I am most grateful for your participation. Your participation may help improve the Parent Infant Home Visitation Programme.

This interview will help me understand your experiences of the home visiting programme. In this interview I will ask you some questions about the time when you were visited. This interview should not take more than half an hour.

Please understand that **your participation is voluntary** and you are not being forced to take part. The choice of whether to participate or not, is yours alone.

However, I would really appreciate it if you do share your thoughts with me. If you choose not take part in answering these questions, you will not be affected in any way whatsoever. If you agree to participate, you may stop at any time and tell me that you don't want to go on with the interview. If you do this there will also be no penalties.

Should you have any queries about this research please contact one of the following persons:

The Parent Centre, ph: 021-7620116

Ms Robin Pocock, ph: 021-6712047 or 0825988892

Andy Dawes, ph: 082 422 9940

CONSENT

I hereby agree to participate in research regarding the Parent Infant Home Visitation Programme. I understand that I am participating freely and without being forced in any way to do so. I also understand that I can stop the interview at any point should I not want to continue and that this decision will not in any way affect me negatively.

I understand that all the information from this interview will be combined in one report to the University of Cape Town. My name will not appear in that report. All the information gathered will be kept securely so that only the researcher and her supervisor have access to it.

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

I have received the telephone number and name of a person to contact should I need to speak about any issues which may arise related to this research.

.....
Signature of participant

Date:.....