

A Process Evaluation of a Capacity-Building Project for Comprehensive HIV/AIDS Management in Nkonkobe Local Municipality, Eastern Cape Province, South Africa

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ABSTRACT South Africa has put in place policies to curb the HIV and AIDS pandemic and adopted the multi-sectoral approach to effectively implement the policies and manage the scourge in terms of prevention, treatment, care and support. However, the implementation of the policies has been hampered by lack of human capacity. This article focuses on the results of a process or implementation evaluation of a capacity-building project in the management of HIV and AIDS in one of South Africa's local municipalities. The intention of the researchers were twofold: (1) to provide a picture of important observations about the project in terms of delivery in line with the original plan, reaching targeted population, as well as frequency and adequacy of project activities (2) to draw up lessons that can be used to improve HIV and AIDS policy implementation through projects. Using interviews and corroborating them with, observations and documents, the process evaluation exercise focused on two levels of analysis, that is, the programme staff and their provincial partners, and the project's intended beneficiaries. The results of the evaluation showed a high level of fidelity implementation, reach and dose. The study highlights the lessons learnt in contributing to a co-ordinated and, participatory and vibrant response to HIV and AIDS management. It draws a number of recommendations for future policy and practices based on the project's experience.

INTRODUCTION

The devastating effects of HIV and AIDS cannot be overemphasised at this stage in the history of the pandemic's evolution. The effects are felt across all nations, developed and underdeveloped. According to UNAIDS (2011), the burden of the pandemic is, or has been felt more on the African continent, especially the Sub-Saharan Africa. In South Africa, for example, the pandemic has resulted in people's social, political and economic lives shifting to reflect a new order, compared to the period before the disease confronted humankind. As a result, civic organisations, international bodies and the South African government have resorted to adopting and supporting several strategies to reduce and slow down the impact of the pandemic on people.

Doing so has been fraught with challenges such as lack of human capacity to implement the strategies (UNAIDS 2009).

The Concept of Process Evaluation

This article reports on the findings of a process evaluation of a capacity-building project on HIV and AIDS management in the Nkonkobe Local Municipality in the Eastern Cape Province of South Africa. Process evaluation examines the extent to which a programme is operating as intended by assessing ongoing programme operations and determining whether the target population is being served (Casey Foundation 2002). Such an evaluation helps programme staff members identify needed interventions and change programme components to improve service delivery. A process evaluation often collects information, such as details of program operation, intensity and quality of services provided, context in which a program is delivered, collaborative partnerships, and staffing and training. The evaluation can be done during the early piloting stages of a programme or on an ongoing basis

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(Allen and Bronte-Tinkew 2008). For evaluation practitioners, the main advantages of carrying out a process evaluation exercise include, among others, knowing how and whether the programme is delivered, opportunity to examine the theory underlying the programme, specifically, how the program is administered and – ultimately – whether the program is unfolding “on the ground” as intended or designed (implementation fidelity), determine whether the programme is reaching targeted populations (reach), and whether both the number and frequency of programme activities are adequate (dosage) (Mihalic 2002).

Capacity-building in Health Delivery Programme Implementation

Capacity-building, participation and empowerment of local people and communities have moved to the centre stage of initiatives aimed at improving health in developing countries (Crosely 2000). Capacity-building refers to efforts to develop the ability of people, organisations, or groups, resulting in enhanced potential to manage their own needs (Potter and Brough 2004). Within the context of health delivery and management of health programmes, capacity-building has been shown to be central in improving the governance of health institutions and local communities in developing countries (Brinkerhoff 2007). It has also been related to participation and empowering of local communities in which a programme is operating, under the belief that enhancing capacity of local communities enables better management of their own health affairs (Craig 2007). Some critics argue that capacity-building is mere training (Potter and Brough 2004). In the context of HIV/AIDS management, the concept of capacity-building usually involves using external training partners brought into the community to raise the levels of available skills, knowledge and practices. Thus, UNAIDS (2005) reiterate that capacity-building is a pillar of HIV/AIDS management.

Some authors argue that if the concept takes a developmental approach, emphasis is placed on allowing individuals, community-based organisations and health institutions to participate more fully in the management of HIV/AIDS in order to further development (Fukuda-Parr et al. 2002). Doing so has ramifications for communities', institutions' and individuals' levels of per-

ceived self-efficacy and mastery of skills and knowledge about how to fight, and, or deal with the HIV/AIDS scourge (LaFond and Brown 2003).

The idea of capacitating role players and stakeholders for effective HIV/AIDS management is not new (Takahashi et al. 2007). In the US, Mayberry et al. (2009) showed the importance of building the capacity of local community-based organisations in the fight against HIV/AIDS. In their study, Mayberry and others found that providing skills, knowledge to community-based organisations improved their ability to deliver HIV/AIDS education. In Uganda, Okware et al. (2001) reported significant funding provision to health and human agencies to partner in enhancing health education, improve health care quality, and prevent diseases in communities at risk for HIV/AIDS. In South Africa, there are reports of increased effort and growth in health programme activities and budgetary allocations for capacity-building, from both civil society organisations and government for comprehensive responses to HIV/AIDS (SANAC 2006). However, the increase in the number of actors at both country and local levels resulted in vertical and piecemeal interventions that are unsustainable. The efforts require greater co-ordination among partners to ensure that enough resources are mobilised to wastage and duplication (South African National Plan of Health 2007).

Based on the above observations, the researchers report on a process evaluation of a project seeking to capacitate different stakeholders involved in HIV/AIDS fight in order to facilitate grassroots responses to HIV/AIDS in a rural local community in South Africa. The evaluation is guided by the concept of capacity-building for marginalised communities to create health enabling environments and to ensure delivery of quality health services in South Africa (Tawil et al. 1995). The body of research talks about multi-stakeholder partnership (Campbell 2003) in health services delivery in South Africa, emphasising the importance of skills, knowledge and local ownership of projects by local communities (El Ansari and Phillips 2001).

HIV and AIDS in South Africa

In South Africa, an estimated 5.7 million people are living with HIV and AIDS and the country is regarded as one of the worst case

scenarios in terms of the pandemic (UNAIDS Report 2008). According to the report, although the pandemic in the country is showing a steady decline, in terms of infection rates, South Africa follows behind India. According to the National Department of Health Report (2007), South Africa experienced an infection decline in 2007. The current recorded infection rate of 11.8% of the population and 18% of the adults between 15-49 (UNAIDS 2009) in the country means that most spheres of development are facing huge challenges. For example, the pandemic has destroyed the social fabric and social capital needed for development, has caused huge losses in terms of human resources for organisations and, government spending on health has increased (UNAIDS 2011). In response to these devastating effects, the South African government, through its National Strategic Plan (NSP) on HIV and AIDS covering the period 2007 to 2011 adopted the multi-sectoral approach in the implementation of its policies pertaining to HIV/AIDS. The NSP is guided by the South African National Aids Council (SANAC), an organisation comprising of several government departments, civil society groups and other relevant stakeholders. SANAC operates on certain principles that guide its members. The organisation whose programme was evaluated in this study is a civil society organisation under SANAC and therefore was guided by the principle of *'leadership for technical development and effective partnerships in HIV and AIDS prevention, care and support'* (SANAC 2007).

Context of the Project

Before any project or programme is evaluated, it is important to understand its operating environment. The project that was evaluated for the purpose of this study is being implemented in the Eastern Cape which is one of South Africa's nine provinces. Key characteristic features of the province are extreme poverty, mostly confined in the former homelands areas where 65% of the inhabitants live and mostly rely on subsistence agriculture (<http://www.info.gov.za>). There are high levels of under-development, high unemployment (27.9% by end of September 2009), low income base, inadequate social infrastructure and huge service backlogs (Eastern Cape Socio-Economic

Consultative Council (ECSECC 2009). The negative impact of HIV and AIDS is exacerbated by such characteristics, resulting in strain on household incomes, social cohesion and families; increasing numbers of orphans and child headed households, and increasing burden on older persons. According to the Eastern Cape's Department of Social Development Strategic Plan (2007-2009), there is a continued high rate of morbidity and mortality, coupled with high rates of infections. Moreover, evidence from the National Department of Health (DoH) (2008) shows that HIV prevalence in the province is little lower than the national average. The responsibility for HIV and AIDS management in the province is placed upon the Premier's Office. This mandate given to the Premier's Office resulted in the creation of the Eastern Cape AIDS Council (ECAC). This Council represents SANAC at the provincial level and is comprised of civic societies, religious groupings and government departments, together representing a multi-sectoral group responding to the HIV and AIDS pandemic. In 2010, ECAC developed a plan to tackle HIV and AIDS in the province. The plan, labelled 'Provincial Strategic Plan on HIV and AIDS 2010-2014', represents a multi-sectoral approach to HIV and AIDS management in the province. The civic organisation whose programme was evaluated in this report, is part of ECAC.

At the time of setting up the project, the Provincial Strategic Plan on HIV and AIDS as alluded to above had clearly indicated a focus from social welfare to social development, community empowerment using community-based organisations (CBOs) and service delivery using project approach (www.ecprov.gov.za 2007). The plan stipulated that any planned interventions for HIV and AIDS should be based on the establishment of efficient and effective management systems and processes. It further stipulated that the interventions should include community-based care, focusing on orphans and vulnerable children (OVC), prevention programmes, facility-based AIDS treatment, decentralisation of Anti-retroviral Treatment (ART) services to health care facilities manned by a doctor or a nurse, home and community-based care (HCBC), and support for support groups for people living with HIV and AIDS (PLHA).

Before the project was initiated, there was only 32% of PLHA in the province on ART (Provincial Strategic Plan on HIV and AIDS 2010-2014). In addition, the concentration of the ART services in one or two hospitals in each sub-district in the province, coupled with few primary health care (PHC) facilities that were able to provide refills of ART prescriptions were worrisome. This entailed long distance travelling for PLHA as well as caregivers, using expensive private transport to access clinical care and treatment. Another challenge to the decentralisation of ART services in the province was the lack of human resources and the unwillingness by health workers such as doctors, nurses, and pharmacists to work in the poor rural areas and support PHC. According to an Eastern Cape Socio-Economic Consultative Council Report (2009), there was a shortage of pharmacists in the province and the DoH struggled to recruit, train and deploy pharmacy assistants to PHC facilities. The report notes that, most health workers needed clinical skills' enhancement, on-the-job skills transference, coaching, job aids and effective supportive supervision. Within the province, the relationship between the care of HIV positive pregnant women and paediatric treatment was weak, with HIV/AIDS testing and counselling (HCT) services and care inadequately covering men as compared to women (Eastern Cape Health Department HIV and AIDS Team 2009). The Department of Social Development Strategic Plan (2007/2009) also notes that there had been failure by the DoH to scale up support and have sufficient number of peer PLHA support groups at most health facilities. The South African National AIDS Council (2006) reported that, because evidence for reduced HIV transmission was weaker in the province, there was need to move away from prevention activities and start addressing the hidden determinants of risky behaviour.

Against such a backdrop, the project under evaluation was therefore set up to provide technical assistance that focuses on systems strengthening, skills building and skills application to support the decentralisation of services to the PHC level and community, including mobilising and building the capacity of its existing and new CBOs, to empower them to provide sustainable HCBC services, and effective prevention of further HIV infection. A description of the project and methodologies/implementation strategies is given below.

Project Description

The project's strategies are human and institutional capacity building and systems strengthening in three closely linked project areas: (1) decentralisation of quality, clinical AIDS treatment services (2) expansion and strengthening of community-based care and support, OVC and prevention services, and (3) increased use of strategic information for service improvement and sustainability by district health teams and CBOs. The project commenced in January 2010 and is expected to end after three years, in 2012/13, latest.

The proposed purpose in the first project area is to ensure strengthened institutional and individual health worker capacity for decentralised provision of comprehensive HIV/AIDS clinical services by PHC facilities that refer to the project supported hospitals. The project staff provides technical leadership and transfer of clinical skills to both district and facility level staff. The clinical skills transfer involves specific training with regular on-the-job coaching and supportive supervision, and provision of job aids tailored to the needs of PHC workers. Mobile teams with experts are also used to close the gap caused due to the reluctance of physicians to be deployed in the rural areas. They support the delivery of PHC AIDS treatment services including diagnosis and treatment of advanced HIV disease, provision of adult and paediatric ART, prevention of mother-to-child transmission (PMTCT), early infant diagnosis (EID) services, treatment of TB/HIV co-infection and other opportunistic infections, prevention of new infections and encouraging living positively. Emphasis is also placed on the improvement of health and well being of PLHA, reduction of HIV and AIDS related stigma through promotion of living positively. The project staff is also having regular meetings with the Provincial DoH, advocating for the decentralisation of quality HIV and AIDS laboratory services to the PHC level.

In the second project area, the purpose is to mobilise communities and building capacity for HCBC, including the provision for OVC, and for effective prevention interventions. Activities involved include funding and skills training for CBOs so that they are able to undertake HCBC activities, manage volunteers,

undertake assessment needs. Peer support groups are being established for children on ART, and for OVC care givers, particularly those with HIV positive children. Facilitation of community gardens that provide nutritious additions to the diets of children and adults on ART as well as income generation for the gardeners in collaborating with the Department of Agriculture is also taking place. In addition, technical support is being provided by the project's staff to Voluntary Counselling and Testing (VCT) PMTCT and pediatric AIDS as a way of bridging the facility-based and community-based services.

The project's third area is making use of strategic information to improve facility and home and community-based services. Activities under this area include, among others, creating an electronic records system, development of tools for data collection that strengthens the link between facility and community based care. Other activities include providing of skills training and supportive supervision required for collection of reliable data, coaching clinicians to use information from available systems to better manage patients, and developing and supporting community monitoring and evaluation of prevention care and support.

The implementation of the programme is driven by the civic organisation providing both financial and technical resources, monitored by the Provincial DoH and DSD. The

technical team from the civic organisation consists of medical officers, nursing officers, nutritionists, prevention specialist, VCT specialist, OVC specialist. At the PHC and community levels, the other participants include the child care officers (CCFs), the peer groups, and other CBOs. A diagrammatic representation of the parties involved in the implementation is illustrated in Figure 1.

Figure 1 illustrates that the levels of analysis for the evaluation were those directly involved in the implementation of the project and their partners, as well as the targeted group(s). These were the civic organisation's staff at the sub-district level and its DoH and DSD partners as well as staff and the health care workers at the PHC, CBOs, support groups and community leaders.

Articulation of Theory behind the Project

A programme's or project's theory is a conceptualisation of what must be done before the intended social benefits are realised. According to Rossi et al. (2004), 'a programme theory forms the basis upon which the programme rests' (p.14). A programme theory helps the evaluator to prioritise evaluation questions, design evaluation research and interpret evaluation findings (Rossi et al. 2004).

The project the researchers evaluated in this study used two basic related models. The first one is the Asset Based Community Development

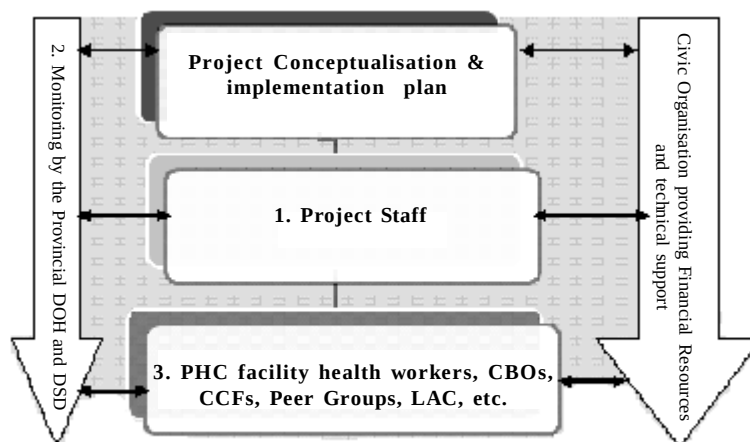


Fig. 1. Parties to the project implementation

Model (McKnight and Ktetzman 1993, 2001) which states that communities or people have 'assets' they can use towards the improvement of their own lives. The assets can be in the form of qualities, and skills that can be improved or provided and used to their own advantage. The second model the project used was the Primary Health Care Model (Harris et al. 2008). This model emphasises empowerment of community members to provide good HIV and AIDS related services. The underlying premise for the two models is that health workers and communities are better positioned to influence behaviour change within the community and to deliver quality community health services, if given proper training, support and assistance. The assumption taken by project funders in executing the project under evaluation was that: if quality health delivery service is to be achieved, capacitating and strengthening target groups such as project staff and community members so that they are able to influence change in the targeted areas of HIV and AIDS prevention, care and support in the province is critical. The idea was to improve systems, capacitate targeted groups and individuals through skills training, constant supervision, coaching, mentoring, and on-the job training to provide the required services.

Based on the above, and in line with the dictates of process evaluation, the theory of the project is articulated as follows:

- ♦ **IF** certain socio-economic conditions and conducive policy environment for provision of HIV and AIDS care, treatment and support exist, **THEN** space is provided partnerships targeting certain population groups and institutions to support the management of HIV and AIDS.
- ♦ **IF** the target population groups and institutions (health workers, support groups, PLHA, community leaders, health centres) are identified and given the best and latest knowledge and skills regarding the management of HIV/AIDS (community empowerment), **THEN** they will have relevant and useful tools and competencies.
- ♦ **IF** the target population groups and institutions are empowered, **THEN** they are able to provide quality sustainable and comprehensive HIV and AIDS services.
- ♦ **IF** there is improved quality sustainable comprehensive HIV and AIDS services provision, **THEN** people are going to live healthy lives and a broader impact on the province or country as a whole may be achieved.

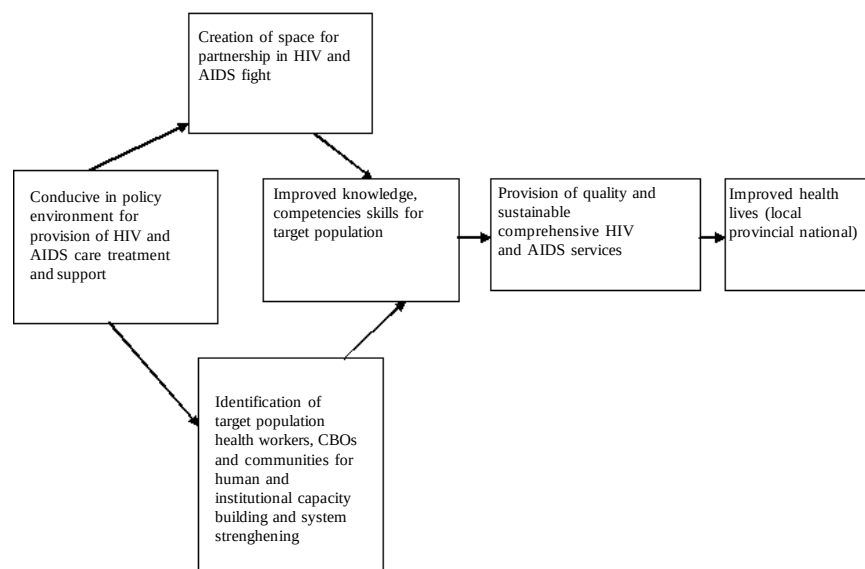


Fig. 2. Project theory

A diagrammatic representation of the programme theory is presented in Figure 2.

Objectives of the Evaluation

The main objectives of the evaluation were: (1) to determine whether the project was being implemented as originally intended (fidelity implementation) (2) to establish whether the project reached the targeted group or population (3) to determine whether the number and frequency of project activities were adequate to effect the needed changes, and (4) identify any challenges encountered in implementing the project activities.

EVALUATION METHODOLOGY

The methodology for the process evaluation was premised on Fetterman's empowerment evaluation and 'self determination', premised on the participation of key stakeholders in programme design and evaluation (Fetterman 2004). In this evaluation, the use of empowerment evaluation was an attempt to get an understanding of how the capacity building project was being implemented and whether such implementation was in line with the initially proposed project design. Therefore, a qualitative evaluation methodology was adopted. The use of qualitative methods in project evaluation is not unique as it is well documented in literature (Patton 2003; Denzin and Lincoln 2000). The advantages are that qualitative research methods tell the "project's story" mainly through the capturing of the narratives and experiences of the projects' participants and staff, are usually "naturalistic" and they do not tend to manipulate the setting of the project (Patton 2003). The researchers had to interact with both project staff and participants in their own natural setting. This was done for the purpose of giving the evaluators an "emic perspective" or "insider's viewpoint" (Babbie and Mouton 2001) on all the activities of the project and its implementation.

Data Collection

A qualitative research approach was adopted and qualitative methods of collecting process information were utilised. Specifically, documents, observations and interviews were used (Rubin and Rubin 1995). Patton (1990:244) argues

that "multiple sources of information are sought and used because no single source of information can be trusted to provide a comprehensive perspective on the programme. By using a combination of observations, interviewing, and document analysis, the fieldworker is able to use different data sources to validate and cross-check findings".

The researchers initial target group was the technical staff from the civic organisation undertaking the project, DoH and DSD staff, health staff and CBOs operating in various PHC facilities. The researchers attended meetings, to clarify the evaluation purpose to the project staff in order to get access to project documents. The researchers also attended quarterly progress and review meetings between the technical staff from the civic organisation running the project and DoH and DSD members as observers, taking notes that would help us in our evaluation. Information obtained was used to develop categories for the evaluation questions. The categories of questions focused on project implementation and design, resources adequacy, project beneficiaries and problems encountered. Semi-structured interview questions (Saunders et al. 2003) were developed and used to interview the relevant people. The interviews were secured with the following 10 people: Project Staff: Project Manager (respondent 1), Professional Nurse (respondent 2), Prevention Officer (respondent 3), Nutritionist (respondent 4), VCT specialist (respondent 5), one DoH Staff member (respondent 6). Project Beneficiaries: Peer Group person (respondent 7), LAC person (respondent 8), Monitoring and Evaluation specialist (respondent 9), and a health worker (nurse)(respondent 10).

Analysis of the Interviews

The data collected through interviews was analysed through content analysis ((Kumar 2011; Dawson 2006). This form of analysis focuses on identifying phrases or narratives that summarise ideas conveyed by a respondent and creating themes thereof. In the present evaluation, narratives from interviews were summarised for each category of the questions in the semi-structured interview guide. The idea was to find a common idea/theme as well as determining the number of respondents sharing the observed themes or idea for each question or category. The themes were not imposed by the evaluators but simply

emerged from the data collected. Thematic analysis also enabled the evaluators to identify various anomalies or differences emerging from the different data sources. The thematic content analysis was manually performed by the evaluators. All data collected were synthesised and used to make inferences or conclusions about the implementation of the capacity building project.

EVALUATION RESULTS

In this section, the researchers highlight and report on key findings which emanated from our fieldwork. The findings are based on the research objectives of the process evaluation which focused on: fidelity of implementation, coverage and dose, as well as challenges and constraints. The narratives and perceptions of all the levels of analysis were used to illustrate and assess whether or not the process aspects of the programme were being implemented.

Perceptions of Implementation Fidelity

The concept of implementation fidelity refers to how well the programme has been implemented in comparison with the intended or initial plan. Thus, implementation fidelity looks at issues around adherence, quality of programme delivery, the frequency of sessions or services delivered and the unique benefit of the programme as it is perceived by the beneficiaries (Dane and Schneider 1998). Fidelity of implementation is measured by gathering the views of programme participants, staff and other key stakeholders. It involves judgments by programme participants or beneficiaries about the implementation, relevance and outcomes of a programme (Carroll et al. 2007). Our findings revealed that the programme we evaluated satisfied all the various dimensions of implementation fidelity.

Information that the researchers collected showed that both project participants and staff were satisfied with the way the project was functioning and also the way the various activities were being implemented, despite some constraints here and there. The results showed high levels of implementation fidelity mainly because 75% of the respondents revealed that the project was being implemented in accordance with all the activities which had been planned for the year. When respondent 1 was asked to indicate how the project was being run, respondent had this to say:

“so far the project is running well and I have confidence that the project is well organised. We try by all means to attend all the required meetings for our peer education sessions...at the end of the day, one feels better off than before...”

Respondent 2 reiterated the same sentiments when he stated that, despite problems such as budget outweighing costs in some instances, they were happy because the project implementation was in line with their plan. The respondent stated that,

“I am impressed with the commitment and enthusiasm showed by our partners in this project that is DoH and DSD...the help they have given us, especially in terms of ensuring that we have access to the health facilities and staff, has managed to steer the project in the direction as planned.”

Capacity Building Activities: Fidelity, Reach and Dose

The success of any process evaluation rests on how the implementation is carried out in tandem with the project design. Evaluators involved in process evaluation have to ascertain whether or not the activities undertaken are geared towards the achievement of the project objectives. The project the researchers evaluated had three objectives. Although all the three objectives relate to the issue of capacity building, their areas of focus are somewhat different. Objective one related to capacity building in the areas of TB/HIV prevention, treatment and care, PMTCT and EID and decentralisation of the laboratory facilities. Some of the activities outputs for this objective included identification of PHC staff to be trained, development of training materials, training of PHC staff, provision of on the job and coaching for PHC staff, and lobbying for the decentralisation of NHLS.

The second objective focused on the establishment and capacity building of CBOs such as CCFs, peer groups, OVC caregivers and SCV with outputs as same as in first objective, but at community level. The last objective had outputs focusing more on the establishment of a functional HMIS and the training of the health staff to use it.

When the project staff were interviewed, 80% of them indicated that different groups to be trained have been identified, though there were a number of problems being experienced. For example, respondent 5 notes that:

"Yes we have management to locate those people who are critical in the project as we have planned. Our different staff members are working with different groups... what we see is only in some area the establishment of the groups has been slow, sometimes and I blame our mobilisation of community."

The identification of teams to work with was also echoed by the respondent 4, who indicated that:

"We have our people looking after PLHA already in place and we are moving according to schedule."

Respondent 2 said:

"Our visit to PHC facilities to identify and establish target teams to capacitate has gone on smoothly."

The project manager had this to say also, regarding project implementation fidelity:

"As the Project Manager, I can say to you that we are moving on as planned. Since the beginning of the year, we have managed to identify out target groups in almost all areas of our project."

The capacity building project was meant to provide skills and knowledge to the different health and community based workers in an effort to promote the delivery of quality HIV/AIDS care, treatment and support. A significant number of the project staff (60%) indicated that they had provided training on HIV and AIDS to both health staff and community members. They were also confident that adequate knowledge and skills had been imparted in line with the project's aim. Respondent 2 had this to say:

"From my side, I will tell you that we have trained nurses in the management of PMTCT, EID, diagnosis and management of HIV/TB. Remember, this is ongoing and we are still training in the project. The trainings we have done for different teams target health workers at the PHC level to provide them with information on how to achieve quality counselling of people diagnosed with HIV."

Evidence we collected showed that the project reached the intended beneficiaries as planned. The results indicated that beneficiaries had access to the knowledge, information and skills in some areas of HIV and AIDS management. For example, respondent 10 noted that:

"I have been involved with this project since it was put in our village. What they have done to me is that they teach me as a peer group facil-

itator to help PLHA to live a life what is normal like us". I am now able to do it with no fear or favour.

This view from a project beneficiary was consistent with what evaluators observed during fieldwork. In some cases, we attended record keeping training sessions and later found that beneficiaries were able to use electronic record keeping a week after training. Respondent 9 testified and said:

"Before this organisation came, we were not sure of the way we were keeping our records. In fact, we were using papers and some of the records got lost and stolen when thieves came to steal at night. My team at this hospital was very happy when the project organisers said they were teaching us how to store the information using a computer. Now we are able to record using a computer the information about patients...."

Further observations revealed that 65% of the project activity sessions on capacity building initiatives were conducted and attended by about 76% of all beneficiaries participating in the project. Such observation was supported by attendance registers and logs. Thus, the overall implementation fidelity of the project was relatively good as measured by the semi-structured interviews with the project's technical staff and beneficiaries, in addition to the direct observations of the researchers.

Project Relevance and Acceptability

The capacity building project under evaluation had both short and long term outcomes. The short outcomes included, among others, the capacitating, through knowledge provision and skills of training on different aspects of HIV/AIDS. The long term goals were the expanded health provision and delivery of comprehensive HIV/AIDS care, treatment and support. The present process evaluation tracked some of the changes that had been brought about by the introduction of the capacity building project, for both the target group and other relevant beneficiaries.

The majority (75%) of the interviewed project participants and staff expressed satisfaction regarding the relevance and significance of the project. Evidence collected indicated that the capacity building project was perceived as very relevant to people affected and infected with HIV

and AIDS in the local municipal area. One DoH facilitator (respondent 6) involved in the project pointed out that:

"The benefits are enormous, we have now moved quite very well in terms of seeing improvements in the delivery of health services in the district. There has been a marked increase in people involved and having an interest in supporting HIV/AIDS issues in the area."

Quite a number (68%) of the beneficiaries interviewed highlighted that they were satisfied with the project's activities as they were able to deal with HIV and AIDS well equipped with the necessary skills and knowledge. Respondent 10 was of the view that:

"What I can say is that the project has helped me a lot...I have seen a marked improvement in the way I diagnose different diseases associated with HIV and AIDS, there has also been improvements in the way we are keeping records, drugs and carrying out prevention activities in the area".

Further evidence of programme relevance came from the Local Aids Council (LAC) member who stated that:

"I can say the project is relevant because I have gained a lot when it comes to mobilising the community in terms of understanding the HIV/AIDS issues. I have dealt with schools, and youth in the community"

However, some project participants felt that there were some project activities that should have been considered as more important and relevant than others, especially those that involved the youth. One beneficiary indicated that:

"My worry is that the youth should be capacitated more than health care workers because that is where we are trying to prevent HIV and AIDS. For example, why spending more

resources on training doctors and nurses and not deal with behavioural issues of HIV and AIDS among our youth...especially those going to school?"

The above response shows that some project participants viewed certain project activities as more important than others. This indicates the presence of such a segment of participants in the target population. Despite this, our evidence indicated that the majority (75%) of the project participants saw some relevance and significance in the activities of the capacity building project.

Achieving Project Objectives

Project beneficiaries and staff were interviewed by the evaluators to give their opinion on whether the project was meeting its intended objectives. The respondents were asked to single out an objective which they considered to have been successfully met. Table 1 illustrates the views of the participants.

As revealed in Table 1, the most successful aspect of the project was thought to be the capacitation of PHC facility staff. Out of those interviewed, 50% considered the objective of capacitating PHC facility staff as having been achieved. They were satisfied that the project activities had managed to give the requisite skills to health care staff at different health facilities. Table 1 also shows that 40% of all the evaluation participants viewed the project as meeting its objectives of establishing and strengthening Community-Based Organisations in the management of HIV and AIDS in the municipal area. The results indicated the extent of community involvement in HIV and AIDS management in the area. Project participants viewed the record keeping objective as not adequately met, despite testimonies by other members that they were now

Table 1: Respondents views on project objectives

Objective	Number of respondents considering the objective being met
1. To capacitate PHC facility staff so that they delivery quality, facility-based HIV/AIDS prevention, care and treatment services.	5
2. To establish and capacitate CBO, and support them together with LACs in the delivery of quality community –based OVC and HIV/AIDS prevention, care and support services	4
3. To establish HMIS and support sub-district health teams and CBOs is the use of Strategic Information for service improvement and sustainability	1

able to electronically keep records since the inception of the capacity building project. Observational evidence showed that the reason for such view was lack of proper functioning computer equipment to deal with data on HIV and AIDS in the area.

Challenges in Project Implementation

Process data from the different sources highlighted several challenges that were being perceived as affecting the implementation of the various activities of the project. From interviews and observations, following challenges were noted:

Logistical and resource problems were mentioned by 75% of the evaluation participants. One project participant expressed concern on these challenges and said:

"I can say that, yes we have had a good start in terms of providing supervision in the form of coaching on the job for most our health staff. My worry is that we have been hit by shortage of transport. For those areas where we have succeeded in providing continuous coaching, sometimes the PHCs do not have the necessary tools and resources to use".

Besides logistical problems, project participants also highlighted that human resources needs were sufficient at the project staff level, but not adequate at the PHC levels. One of the facilitators clearly stated that:

"I wish the government could give us more staff to be trained so that our objectives are fully realised because these people are doing a good job for the province". This assertion was supported by one beneficiary who indicated that, *"We had thought that this capacity building project would make staff stay at some of our PHC facilities...."*

Challenges to do with budget have also been mentioned by 45% of the participants. At times budgets were outweighed by rising costs and some training had to be rescheduled. One interviewed participant indicated that:

"We had budgeted different amounts from what we are experiencing now... You know money that is donated requires you to do by the book and not deviate. I am told the establishment of the electronic data bases was also postponed in one area because of costs related issues."

On a smaller magnitude, 20% of the respondents interviewed revealed that there were sometimes conflicts between project staff and local traditional leaders who always demanded that they be accorded the respect they deserved. Traditional leaders also demanded money and food from project staff after attending the project meetings. The project manager pointed out that:

"It is sometimes difficult to put peer educators, or youth together because you also need to seek permission of traditional leaders who themselves want to be fed and assume that project is meant to financially benefit them..."

DISCUSSION

The process evaluation conducted by the researchers as an external team has been useful in assessing some reported success, constraints and complexities of project implementation in rural South Africa. The data gathered in this evaluation suggest that the programme was being implemented with high fidelity. Literature on process evaluation highlights that the major purpose of conducting a process evaluation is that of seeking to establish the degree of implementation fidelity (Backer 2002; Dubois et al. 2002; Elliot and Milahic 2003). In summary, implementation fidelity can be viewed as the degree of fit between the various elements of a prevention or treatment programme, and its actual implementation in a given setting (CSAP 2001). Against this backdrop, there seem to be a general agreement among programme participants and staff that the overall implementation and delivery of the programme is satisfying and encouraging. Evidence gathered in this study suggests that the project was considered as reaching the intended beneficiaries, especially in the capacitating of PHC facility staff and CBOs. Study participants highlighted that the trainings and workshops carried out as planned seemed to be a solution to the needs of empowerment and capacity-building among PHC and CBOs. Establishing whether a social programme is being delivered or carried as intended remains the overall goal of process evaluation (Backer 2002). Literature on process evaluation contends that any evaluation to be conducted under the ambit of 'process evaluation' need to establish whether the intended programme recipients are benefiting from the activities of the programme (Forgatch et al. 2005; McGew and Griss 2005; Carroll et al. 2007). In this

evaluation exercise, project beneficiaries reported having acquired skills, knowledge and exposure/practice in dealing with HIV and AIDS in the local municipal area. This finding confirms earlier findings by Campbell and Murray (2004) who argue that training in HIV and AIDS management tends to shift responsibilities of addressing the pandemic onto the shoulders of the local community. The researchers findings confirm or endorse previous work (Richter et al. 2007) which demonstrated the effectiveness of a capacity-building educational programme for CBOs. Such positive reports from project beneficiaries in the current evaluation indicate that the project is so far successful in achieving its major goal of providing:

“technical assistance that focuses on systems strengthening, skills building and skills application to support the decentralisation of services to the PHC level and community, including mobilising and building the capacity of its existing and new CBOs, to empower them to provide sustainable HIV and AIDS services, and effective prevention of further infection”.

The evaluation findings have also shown that the programme is working towards achieving all its core objectives with the exception of one objective which focuses on the establishment of an efficient and running health management system to manage HIV and AIDS data. While the process of capacity-building may be regarded as a panacea to knowledge and skill improvement, lack of supporting tools or equipment for the use of acquired skills and knowledge arguably, renders the capacity-building process useless.

The researchers evaluation was also centred on establishing the degree to which all the intended beneficiaries are participating and benefiting from the programme as initially intended. Such a degree is often referred to as “reach” or “coverage” in evaluation literature (Dane and Schneider 1998; Forgatch et al. 2005; Carroll et al. 2007). Study findings suggest that reach or coverage was very high for a significant number of activities for the project. There was a significant percentage (76%) report in terms of beneficiaries’ attendance of the activities of the project. In other words, the degree to which all the intended beneficiaries of the programme were benefiting is assumed to be around 76%. This might also be taken to mean that the project was rele-

vant and acceptable as perceived by the beneficiaries. However, observational evidence and attendance logs tend to show that reach was very high for PHC and CBOs capacity building sessions while reach was also lower for peer education and youth activities.

As evidenced by the process data, the project intervention objectives are being met, though there are various challenges that are affecting the effective implementation of the project. These challenges include logistical and human resources, budgetary and conflicts with traditional leaders.

CONCLUSION

Process evaluation is an important part of any intervention directed at ameliorating social challenges. It assists evaluators and programme planners to assess on whether implementation fidelity is being achieved in the various programmes they are involved with. The overall goal of process evaluation is that of ascertaining whether a programme or project is being implemented as planned. Frequent and useful process evaluations are useful in informing all relevant stakeholders about the progress made as well making the necessary adjustments possible at an early stage. As the case with the programme evaluated, process evaluation provided useful insights on how the programme was running and the major challenges that need attention. It is critical and mandatory therefore, that project or programme staff understand how the project delivery is going on and the difficulties associated with it. Richness and in-depth understanding of such implementation issues is integral for funding agencies and other key stakeholders implementing the project. It provides a platform to revise some project objectives, re-allocate financial and human resources, refine or maintain some activities. Results from this process evaluation have also highlighted the need to understand the context in which projects are carried out so that project beneficiaries do not feel that their social fabric and space have been invaded.

RECOMMENDATIONS

Basing on the researchers experience in evaluating the ‘Capacity Building Project on HIV/AIDS Management’, there are two major recommendations that can be proposed. Firstly, the

over-reliance on a single method of data collection particularly interviews with programme staff and participants might in some cases not yield sufficient and credible process data. The major threat to validity in such cases is that both programme staff and participants are likely to give socially desirable responses to all interview questions. This remains a methodological concern as process evaluation largely relies on the judgments of those involved and benefitting from the programme being evaluated. In this study, the researchers had to use multiple data sources as indicated earlier as a way of addressing this methodological challenge. The researchers propose that future research explore issues related to validity and credibility in gathering process data. Secondly, the researchers propose that there is a need for process evaluators to be involved in the initial phases of programme design (conceptualisation) till the launch of the programme. The assumption is that this applies to both internal and external evaluators. The challenge the researchers faced in this study is that they got involved to evaluate the programme when it was already operational. This implied that the researchers had to start learning about the design of the programme, its logic model and underlying theory of social change. The researchers recommend that evaluators be involved with the programmes which they will evaluate in future in their initial stages particularly the stage of conceptualisation.

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