THE VALUE OF PARTICIPATORY AND NON-PARTICIPATORY IMPLEMENTATION AND EVALUATION METHODOLOGIES OF HIV/AIDS COMMUNICATION-BASED INTERVENTIONS IN SOUTHERN AFRICA

by

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DECLARATION

I hereby declare that the whole thesis, unless specifically indicated to the contrary in the text, is my own original work and has not been submitted for a degree at any other university.

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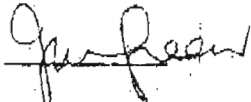
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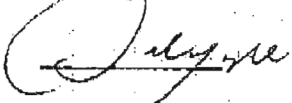Supervisor:

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DEDICATION

This work is dedicated to God Almighty; who, by His grace and love, stood as my rock and fortress

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ABSTRACT

HIV/AIDS is an epidemic that is in one way or another affecting humankind and particularly the African continent. Due to its devastating nature, many strategies and interventions are being employed at different levels and by different groups of people to fight it. Evaluation has been a component of these projects, but few have been subjected to systematic monitoring and evaluation that provides a foundation for the development and implementation of further projects. This is partly due to the fact that project implementation and evaluation can be rendered complex by several factors, such as the choice of methodologies, donor satisfaction and the very nature of interventions and evaluations themselves. Taking a situation where the aim of a project and its evaluation is to bring about social change, as is the case with many HIV/AIDS interventions, this study sought to investigate approaches that could be considered meaningful, useful and valuable.

In order to carry out the investigation of this study, the approach taken was an in-depth analysis of a few cases (in anticipation of greater achievement of insight), rather than broader survey types of perspectives. The study also concentrated on a review of the literature and on validation of documentary and interview evidence provided by beneficiaries, managerial staff and evaluators of communication-based HIV/AIDS.

Results of the study highlighted the fact that community-based factors, such as education, poverty, culture, beliefs, gender, crime and age, influenced social change (with respect to HIV/AIDS) in varying ways and depending on the communities concerned. The different ways in which these factors influenced social change within specific communities were noted to have implications on interventions dealing with them. As such, an in-depth assessment of these different ways with respect to specific groups of people was encouraged in order to have a meaningful, useful and valuable HIV/AIDS intervention. The theory of active participation of targeted communities was also propagated in an HIV/AIDS intervention. It was noted that when active participation is encouraged in a

project at both implementation and evaluation, taking the example of an HIV/AIDS project that intended achieving group knowledge acquisition, awareness, attitude change, skills acquisition, effective functioning and sustainability, such participation would contribute to:

- Override to a great extent, limitations arising from socio-demographic differences (project locations and gender, language, age and race of implementers, evaluators and beneficiaries), in the attainment of project objectives.

- Override to a great extent, limitations arising from differences in forms of evaluation (internal versus external evaluators), in the assessment of project objectives.

- Create an enabling environment for higher attainment of project objectives in comparison to a situation where active participation is encouraged only at implementation (and not at evaluation).

It was further discovered from this study that when beneficiaries are excluded from participating in the planning, action-planning and result-feedback stages of a project and its evaluation, dissatisfaction is experienced on the part of these beneficiaries as well as *missed opportunities* for useful contributions. The degree and quality of beneficiary involvement in project implementation and evaluation was seen to generate beneficiary excitement and a general sense of project acceptance: all of which was noted to create an enabling environment for the making of proper choices and decisions.

Finally, difficulty in accessing traditional evaluations and people's feeling of shame and ineffectiveness was noted in the work (in the area of collecting data pertaining to traditional evaluation). This pointed to possible compromise of meaningfulness, usefulness and value of traditional evaluations.

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CHAPTER 1: INTRODUCTION

1.1 Background to the study

HIV/AIDS is an epidemic that is in one way or another affecting humankind and particularly the African continent. The impacts of HIV/AIDS are being felt at all levels of society. These are more prominent in the developing world, which has more than 90 per cent of the 40 million people who have HIV or AIDS (Arnold 2002). Taking the impoverished southern African countries, life expectancies have dropped alarmingly and are expected to fall from 61 to 41 years by 2005 (Walsh 1998). Southern Africa, as reported by AIDS and Africa (2004), "is home to about 30% of people living with HIV/AIDS worldwide, yet this region has less than 2% of the world's population". The South African population was expected, without AIDS, to reach 52 million by 2015, a prediction which has been reduced to 43 million because of the many deaths attributed to HIV/AIDS related illnesses (Walsh 1998). Looking at the devastating effect of the HIV/AIDS epidemic in Southern Africa, UNICEF (2003) made the following pronouncement:

> With the highest levels of HIV/AIDS prevalence in the world, southern Africa has been hit with a destructive force that is devastating people's lives and potentially fuelling widespread social and economic breakdown. Not only is HIV/AIDS killing millions of people prematurely, it is also wiping out the most productive members of society - farmers, teachers, health workers - leaving millions of orphans, widows, widowers and elderly. As a result, decades of development gains have been lost and efforts to reduce poverty and improve living standards have been severely undermined (UNICEF 2003:1).

These statements indicate that health-enhancing interventions are required to limit the spread of HIV/AIDS.

1. 2 THE PROBLEM AND ITS SETTING

1.2.1 The importance of the study

In this section, the problem to be investigated is briefly described, followed by the need for the research and the contribution it could make to knowledge acquisition and the solving of relevant societal problems.

As put forward by Parker *et al.* (1998:10), "Every activity needs to have some way of evaluating its success or failure and of exposing the lessons learned" Also, individuals and other bodies often question the quality of projects, necessitating their evaluation. An assessment, therefore, of a project's objectives, effectiveness, impact, efficiency and sustainability is of importance in answering the different questions raised about projects and in furthering their value. Evaluation, which is seen by Rubin (1995: 13) as an assessment of the worth or value of something, thus helps us to understand what a piece of work has achieved. An understanding of this, in turn, contributes to better planning of future strategies.

It can be argued that health-enhancing interventions (with social implications) form a process. Evaluation is then seen as an organic part of that process, whereby project objectives are continually negotiated (Marsden and Oakley 1990:4). The gathering of experience from evaluation, is on the other hand, considered a learning process: a process and an experience that, in turn, lead to the empowerment of individuals, interventions and communities at large (particularly through awareness, knowledge and skills acquisition). The entire process can be graphically represented thus:

Needs identification   Goals/Objectives

strategy

mplementation

Improvement   Evaluation
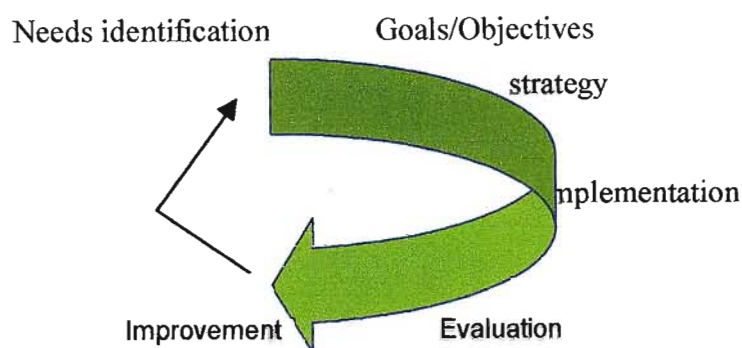
Figure 1.1. Social/community development as a learning process (after Rubin 1995:13)

Looking at Figure 1.1, a project may constitute the initiation of research, for example on the need for counselling HIV/AIDS infected patients. An intervention in that light may be instituted with set goals/objectives. Strategies to meet these set goals/objectives are put in place. Evaluation of the entire project is carried out. Lessons learnt from it are either rejected or implemented, leading to further research and project improvement. One contention is that evaluation should be an integral part of project implementation, rather than being depicted as the final stage of project implementation (Parker *et al.*, 1998)

Bearing in mind the notion of evaluation and the methods/methodologies used, one notices that evaluation has, with special reference to HIV/AIDS interventions, undergone a challenging evolution. As Caceres *et al.* (1994) put it; the evolution is partly influenced by funding considerations whereby donors are increasingly demanding more formalised data on problems to be addressed before they will allocate funds for interventions. These demands can be seen to have led to the over-reliance on quantitative (traditional) research. The former gives evidence of program success; but at the same time neglects the vital hidden elements (positive and negative) of the different processes that could benefit those concerned. It also makes the 'workers' in projects insecure and does not generally provide suggestions for improvement of projects.

More light is shed on the differences via the illustration by Robert Stake in Babbie and Mouton (2001:338); regarding the difference between a cook and a guest tasting a soup. The former tests a soup to improve on its quality and the latter does so mainly to give a

critique of it. This refers to the fact that qualitative/participatory evaluation is considered a vital indicator for programme improvement and implementation. As such, qualitative/participatory evaluation should not be undervalued due to the desires of donors to determine the success of a programme: a situation identified by Obashoro (2002) to be a challenge in Nigeria. Obashoro (2002:1) described programme evaluation to be

> Usually viewed from two sided-evaluation by the programme sponsors [to assess the progress of programme and final achievement] and the personal self-assessment [by the individual community of their own progress]. Most evaluation activities in Nigeria emphasise only the first, caused by the need to justify to the sponsor of the programme that money has been well spent (Obashoro 2002:1).

Furthermore, there is a shift in interventions from all the emphasis being on individually oriented approaches to more participatory ones that encourage group discussions, community participation and more widespread involvement; this coupled with the need for societal structural changes. The move, however, has not been fully backed by the introduction of methods of evaluation that reflect social and community changes. Also, from observation, just a few cases of projects have been subjected to systematic monitoring and evaluation that provides a foundation for the development and implementation of further projects. This is partly due to the fact that project evaluations can be rendered complex by several factors such as the choice of methodologies, donor satisfaction and the very nature of interventions and evaluations themselves (should the focus be on individuals or on societal structures). Evaluation encompasses a varied number of methods, audiences, funding sources, dimension, paradigms and solutions to problems, which, as Tyler (1997: 230) puts it, must be consistent with the purposes and essential conditions under operation.

In light of the above, the views of MacPhail and Campbell (1999: 160) and Patton (1982: 300) were considered vital in the identification of the core problem of this study. The former hold that a better understanding of what makes up a health-enhancing intervention (with social implications) would allow for improved project implementation. The latter draws the conclusion that "finding useful and feasible solutions to complex and situation specific problems is the epitome of the evaluation challenge ". The challenge then becomes the identification of meaningful, useful and implementable solutions to complex situations.

It should be noted that from an literature review (Grace 1992; Frierson *et al.,* 2002), it is rare to find only one optimal way to conduct and evaluate a project. Nonetheless, there are ways which, when adapted, would shed more light on the field of HIV/AIDS project implementation and evaluation. Taking a situation where the aim of a project and its evaluation is to bring about social change (society's change of attitude), as is the case with many HIV/AIDS interventions, the question that follows is: which approaches can be considered vital? Do more people need to be involved when impacting social changes on HIV/AIDS (*Community Action* 2001)?

The following should benefit from this study: project evaluators, donors, stakeholders/project managers, HIV/AIDS researchers/related others, and beneficiaries. They will all be able to acquire more knowledge/experience with respect to what contributes to HIV/AIDS infections, participatory and non-participatory evaluation methodologies with respect to HIV/AIDS projects.

It can be stated that, with the urgent call for effective information transfer, the types of social changes occurring and limited resources with which to handle them, the need for effective evaluation and accountability in the holistic healthcare service is of increasing importance. Ineffective evaluation may lead to serious consequences (in extreme cases). For example, poor usage of evaluation methodologies can result in poor diagnoses, inappropriate responses/solutions and eventually limited attitude change with regards to high-risk behaviours. This can, on the other hand, result in further complications or even loss of life. Effective evaluation of interventions (HIV/AIDS included) therefore may be as important as the recognition of symptoms and the cure of related diseases.

Due to the many different methodologies and the changes in strategies for the fight against sexually transmissible diseases, making the right choice with respect to the most appropriate evaluation methodology then becomes an issue to be considered. Bell (1999) makes this clearer, by stating that quantitative, qualitative, ethnographic, survey and action research, and a host of others, do not limit one to a particular method. Each has its strengths and weaknesses and an understanding of them is likely to help the researcher select the most appropriate methodology for the task at hand.

1.2.2 Broad problems and issues investigated

The present study, in the main, investigated the assumption that a detailed understanding of what contributes to an appropriate evaluation methodology could bring about effective social change. Given, however, the difficulty in separating interventions from evaluations as the latter starts when the former starts, this study incorporated communication-based projects (such as peer-education projects dealing with beneficiary empowerment) to investigate appropriate evaluation methodologies of such projects. In fact, MacPhail and Campbell (1999: 160) assert that more understanding of what contributes to a health-enhancing intervention would not only allow for improved project implementation, but would encourage more rigorous participatory evaluation. Frierson *et al.* (2002), on the other hand, share the view that if implementers were able to develop their own understanding of marginal issues, cultures, and contexts, it would add to their awareness of both the external and internal factors that impact on the goals of a project and in return, contribute towards a valid assessment.

1.3 Research Questions

The research questions in the present study are discussed in the following sections.

1.3.1 Main Question

Does participatory methodology contribute towards the implementation and evaluation of a meaningful, useful and valuable HIV/AIDS project?

1.3.2 Sub-questions

i)   What major factors influence social change and contribute towards a valuable HIV/AIDS health-enhancing intervention?

Factors representing social change models involving time period, action, target and context of interventions were broadly examined. Other factors influencing social change, such as culture, gender, language/communication, age, education and poverty, were identified. An analysis of how an understanding of these factors and the approach used in dealing with

them could contribute to enhancing HIV/AIDS behaviour related-change interventions, were carried out.

What major factors influence the evaluation of projects and contribute towards a valuable evaluation of HIV/AIDS intervention?

The meaning of an evaluation was given alongside the different methodologies used in the evaluation of HIV/AIDS communication-based interventions. The complexities of a meaningful, useful and valuable evaluation of projects were analysed in relation to participation. This was done in view of the importance of such evaluation when applied to HIV/AIDS interventions.

iii)   Does participatory methodology contribute towards the implementation and evaluation of a meaningful, useful and valuable HIV/AIDS project?

An analysis was carried out of the contribution of participation towards a meaningful, useful and valuable HIV/AIDS health-enhancing project and its evaluation. The project objectives were examined, alongside the participatory methodology used in meeting the objectives (to find out if the objectives were met), using both internal and external evaluators. From the HIV/AIDS project objectives, indicator variables, such as participation, awareness, knowledge, attitude, empowerment, effective functioning and sustainability, were tested.

What is the impact of participatory and non-participatory methodological frameworks on the meeting of a project's objectives (at both the implementation and evaluation phases)?

HIV/AIDS projects, implemented and evaluated through the use of participatory methodology, were compared with those implemented by participatory methodology, but evaluated using non-participatory/individually orientated methodologies. In order to answer the questions of this research, a research process was implemented, the details of which are given below.

1.4 Research process

As reported in Table 1.3, the research process had multiple facets in view of the variety of sources of data and methods of their collection. Data had to be collected from different sources (primary and secondary), using methods such as online searches, semi-structured interviews and evaluation report examinations, all supporting the concept of triangulation and validity. These notwithstanding, the study could only operate within certain parameters, given the constraints of time and budget.

Table1.1: Research questions, sources of data and methods of data collection

Question	Source of data	Method of data collection
What major factors influence social change and contribute towards a valuable HIV/AIDS health-enhancing intervention?	Literature review (primary and secondary sources), and observational data	Data most relevant to the study was collected via information search (Online using the Internet, library literature 'LL' OPAC, SABINET; contact with different organisations).
What major factors influence the evaluation of projects and contribute towards a valuable evaluation of HIV/AIDS intervention?	Literature review (primary and secondary sources), and observational data	Data most relevant to the study was collected via information search (Online using the Internet, library literature 'LL' OPAC, SABINET; contact with different organisations).
Does participatory methodology contribute towards the implementation and evaluation of a meaningful, useful and valuable HIV/AIDS project?	Observational data, report data and interviews/group discussions	Interviews: semi-structured interviews with project managers and evaluators. Focus group discussion with beneficiaries. Project and evaluation report examination
What is the impact of participatory and non-participatory methodological frameworks in the meeting of a project's objectives (at implementation and evaluation phases)?	Observational data, report data and interviews	Interview: semi-structured interview with project manager Project and evaluation report examination

1.5 Operational definitions of key concepts used in the study

With respect to the key concepts explored in the study, the following definitions were advanced:

i) The concepts of HIV/AIDS intervention, project and programme

An HIV/AIDS intervention (similar to an HIV/AIDS project) can be viewed as a precise activity (or set of related activities) that intends to bring about social/behavioural change in a particular target population through the use of a common strategy. An HIV/AIDS intervention has distinct process and outcome objectives and a set of rules outlining the steps for implementation. On the other hand, a programme is an interrelated set of interventions serving a particular population (California Prevention Services 2003). In this study, however, the concepts of intervention and project were used interchangeably to signify an HIV/AIDS scheme or plan of action in curbing the spread of HIV/AIDS in a given community.

ii) The concepts of meaningfulness, usefulness and value

While acknowledging the uniqueness of each of the concepts of meaningfulness (sense-making), usefulness (utility) and value (worth), they were used interchangeably in this study to assess varying perspectives. Stufflebeam (in Patton 1982: 297), for example explores the meaningfulness, usefulness and value of an evaluation in the perspective of an intended audience or beneficiary (which to him comes prior to matters of technical adequacy). The dominant concept, however, in this study was value: depicting the worth of a project's implementation and evaluation methodology in meeting its objectives. Figure 1.2 gives a summary of how meaningfulness, usefulness and value were viewed.

Meaningfulness   How were they assessed?

Usefulness   By whom: beneficiaries, evaluators, and implementers?

Valuableness   Why did they assess it the way they did?

                    What was the effect of the responses on the project?
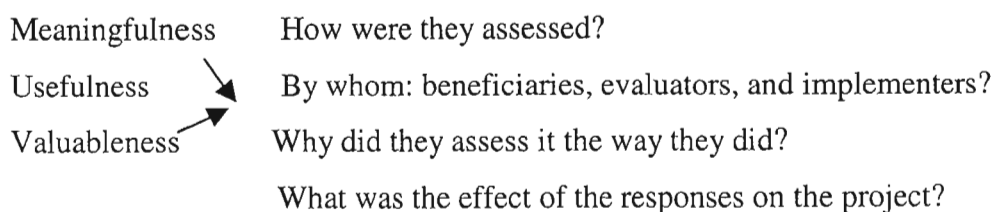
Figure 1.2: Concept of meaningfulness, usefulness and value

iii) The concept of methodology and method

- When dealing with evaluations, one realises that the methodologies and methods of handling them are almost inseparable. Leedy (1989: 88) defines methodology as an operational framework within which factors are placed so that their meanings may be seen more clearly. According to Bailey (1982: 33), methods do suggest certain methodological perspectives, ranging from qualitative (report of observations in natural languages with rare use of numbers) to quantitative (assigning numbers to observations). Kaplan (1973 cited by Cohen and Manion 1989), sheds more light on the definition by referring to methods as techniques and procedures used in the process of data gathering. In connection with this, he holds that the aim of a methodology (used in this study) is to describe and analyse the methods, throwing light on their limitations and resources, clarifying their presuppositions and consequences, and relating their potentialities to the twilight zone at the frontiers of knowledge. It is also to venture generalisations from successes of particular techniques, suggesting new applications and unfolding logical principles on concrete problems, while suggesting new formulations.

In this study, a methodology/method was used therefore to suggest different approaches in dealing with problems. Approaches that ranges from qualitative/ participatory to quantitative/non-participatory. The aim being to describe and analyse them, highlight their limitations and consequences and relate their potentialities to the empowerment of beneficiaries in communication-based interventions.

iv) The concept of participation

In the traditional approach, it was noted that poor people were marginalised and excluded from direct involvement (active participation) in development or change initiatives. During the late 1970s and 1980s, such marginalisation was noted to be some of the causes of people's poverty, thus suggesting new project designs (UNDP 1999).

> In the traditional approach to development it is well known that the administrators of development projects and the beneficiaries do not sit on the same side of the table. In fact they sit at different levels, the former being always at a higher level. What follows, therefore, is quite inevitable. Each look at each other with suspicion. To the official, the villager is lazy, ignorant, unresourceful and irresponsible. To the villager, the official is conceited, unsympathetic, unconcerned and corrupt. Each does not take the other into his confidence. Instead of getting together they continue to stay apart (Talagune in UNDP 1999).

In seeking for solutions to the traditional approach to development strategies, which would involve fundamental shifts in attitudes and in methodology (shifts from top-down non-participatory practices) were developed. This gave rise to participatory practices involving dialogues/discussions among various actors particularly the beneficiaries of a project. Such participatory practices, which formed the basis of this study, were intended to be realised at different levels and stages, for example, at the planning, decision-making, implementation, result-feedback and benefit sharing stages. In this way, participation (involving group activities such as group discussions, plays enactments, dances) as used in this study stands as a goal (intended to achieve in a project). It does not imply the mere presence of people on board but their active involvement. Also, participation implies that plays, dances etc are significant – but on their own, they are not. The essential therefore is an understanding of people collectively taking control, developing plans of action and responding to feedback in relation to future action.

This goal can be expressed as the empowering of people in terms of their acquiring the skills, knowledge and experience to take greater responsibility for their development. Participation is an instrument of change and it can help to break that exclusion and to provide poor people with the basis for their more direct and active involvement in development initiatives (Human Development Report 2003).

1.6 Study parameters

Many factors either impede or foster the implementation and evaluation of projects, in general, and in the field of HIV/AIDS, in particular. This study concentrated, in the main, on issues surrounding implementation and evaluation methodologies: methodologies that could be valuable in HIV/AIDS projects (participatory methodology being the main focus). In terms of the HIV/AIDS projects, the study focused mainly on communication-based projects (projects with social implications: projects that dealt with issues, such as group awareness and knowledge of HIV/AIDS, attitude change, empowerment and structural transformation of beneficiaries). It also concentrated on the validation of documentary and interview evidence provided by beneficiaries, managerial staff and evaluators in the determination of such potentially valuable methodologies.

While acknowledging the importance of aspects, such as the medical treatment of HIV/AIDS and individual level interventions (individual counseling, telephone help-lines and home-based care) in the field of HIV/AIDS in general, these were not investigated as they were outside the ambit of the study. Likewise, major aspects of general project management (planning and objective setting, control of implementation and leadership), techniques of report writing, project/evaluation budgeting, dissemination of evaluation reports and cost-effective assessments, were not investigated. Pertinent aspects relating specifically to the spread of HIV/AIDS such as sexual economy and systemic interventions (interventions that focus on institutional influences, for example the educational system highlighted by Arusha 2001 in relation to how HIV/AIDS affects it and what it is doing to fight it) were not dealt with in-depth given the methodological focus of the study.

The case studies of this research were limited to southern Africa, taking South Africa in particular as the main area of focus. The approach taken was to concentrate on immediate results via in-depth analysis of a few cases, rather than on a broader survey of types of perspectives. This approach was used in anticipation that greater insight would be achieved even if not necessarily generalisable to a wider group.

1.7 Summary

Chapter 1 served as an introduction, outlining the background of the work, and the problems, research questions, research parameters, and operational definition of key concepts used. As a background to the study, the gravity of HIV/AIDS epidemic was projected; this in spite of much effort made to curb its spread. That was seen as an indication for the need for more effective HIV/AIDS project implementation and evaluation. The question of whether methodologies that incorporate elements of participation could make a difference in HIV/AIDS project implementation and evaluation was asked. This was in order to carry out valid judgments that would contribute to the building of useful project and evaluation methodologies, for example those that could bring about positive change in the world of HIV/AIDS. The approach taken in the study was to concentrate on in-depth analysis of a few cases, rather than on a broader survey of perspectives. As a result of the study, project evaluators, donors, stakeholders/project managers, HIV/AIDS and other related researchers and individuals were expected to benefit.

CHAPTER 2: MAJOR FACTORS INFLUENCING SOCIAL CHANGE AND THEIR CONTRIBUTIONS TOWARDS A VALUABLE HIV/AIDS HEALTH-ENHANCING INTERVENTION

2.1 Introduction

This chapter seeks to answer the research question "What major factors influence social change and contribute towards a valuable HIV/AIDS health-enhancing intervention?" In order to answer the question, this chapter focused on broadly examining theories deemed vital to investigate social change patterns, taking cognisance of participatory strategies. It also concentrated on drawing together some major community factors that influence the adoption of social change and project selections that could lead to valuable interventions. A strong focus was on using an integrative approach (rather than a single in-depth approach) that helped in bringing together, in a broader sense, many different strands of thoughts. An analysis was carried out of how an understanding of these factors and the approach used in dealing with them in interventions could contribute to enhance HIV/AIDS interventions and healthy lifestyles. As a background to the study, a brief description is presented of HIV/AIDS, how it spreads medically and the strategies used by interventions to deal with it.

2.2 Reason for the study

The rationale behind this section of the study is given, followed by the parameters governing the selection of the different theories, influential factors and interventions. The present researcher devised the criteria for the selection of the theories, influential factors and interventions. The selection was based on the aim of this section of the study, which was to use an integrative approach (an approach that put together or assimilated different thoughts) to broadly assess theories and major factors influencing social change and project selections. Such an assessment was expected to contribute towards a valuable HIV/AIDS health-enhancing intervention. Factors, observed to be commonly reflected in the literature in the social behavioural area of the spread of HIV/AIDS were also selected. These were pre-existing and situational factors such as, culture/beliefs (Ellis 1999), language (Ellis

1999), religion (Thomas 2000), gender (Fofana 1999), age (Ciantia 2003), poverty/education (Awusabo-Asare 2002) and crime (Leclerc-Madlala 1999). The criterion for selection of the theories/factors was on the basis that they were integrative and had social implications so that differences in their social practices could be traced and analysed in line with the aim of this section of the study.

In-depth systemic interventions, in relation to HIV/AIDS, were also recognised in the selection process though not dealt with in-depth as they were outside the ambit of this section of the study. Their recognition was more in line with the observed phenomena that the reason why people do what they do is often not a matter of individual volition but of the systems in place - taking the example of Arusha (2001) regarding educational institutions. Within such institutions, the focus was noted to be on finding out how HIV/AIDS affects them, what they are doing to confront it and if what they are doing is working, and how? Section 2.3 gives details of the actual methodological framework.

2.3. Methodology used for this section of the study

A review of primary and secondary literature, with occasional insights from the researcher's observations of projects analysed, formed this section of the study. Figure 2.1 gives a breakdown of the methodological framework.
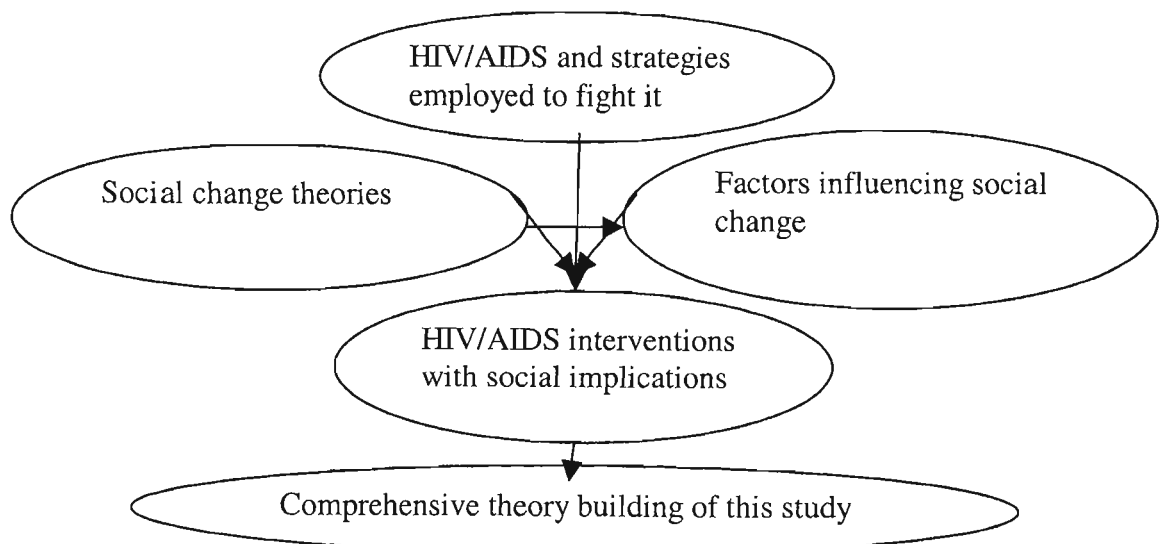
Figure 2.1: Methodological framework

From Figure 2.1 and section 2.2, relevant factors influencing social change (poverty/education, culture/beliefs, crime/violence, language, religion, gender and age) were linked to interventions dealing with them, all of which together (theories inclusive) culminated in the building of a comprehensive theory of this study.

2.4 What is HIV/AIDS?

Many controversial issues, especially in relation to its cause, prevention and cure, cloud the *Acquired ImmunoDeficiency Syndrome,* otherwise known as AIDS. It can, however, be argued that it is primarily a sexually transmitted disease caused by a *Human ImmunoDeficiency Virus* (HIV) which destroys the immune system, thus rendering the victim vulnerable to serious attacks from any form of ailment, no matter how mild.

A virus is a kind of microorganism that is exceedingly small, to the extent that it cannot be seen with human eyes. The human body is made up of small living building blocks, known as cells. The human immunodeficiency virus is known to successfully attack the T cells (also known as "T4," "helper-T," or "CD4" cells in the bloodstream that are specialised in fighting off invading microbes in order to keep the body healthy). A doctor diagnoses someone as having AIDS when that person, with an HIV-weakened immune system, succumbs to one or more opportunistic infections (cause illnesses due to weakened immune systems), or has a T cell count below 200, or 14% (HIVCO 2003).

At present, AIDS is known to have no medical cure even though, as a form of medical treatment (NIAID 2003), *AZT* combination therapy and prophylactic medicines are being used. Unfortunately, it is observed that *AZT* lasts for just a while and later may become poisonous to the body. Prophylactic medicines (different kinds of medicines used to prevent common AIDS infections), though useful, are expensive, as they must be used for a long period of time.

In terms of the different ways in which people can become infected with HIV, one would say that the commonly identified ones are through blood and blood products, semen and vaginal fluids (ASHA 2003). Infection takes place via unprotected sexual intercourse with someone already infected with the virus, infected blood or blood products, sharing contaminated needles and from infected mothers to babies before birth, during delivery and during breast-feeding (UNAIDS 2001).

With regards to vulnerability and HIV/AIDS, some people are more vulnerable to being infected than others. This is substantiated by the allegation that HIV can infect anyone who practises risky behaviour (NIAID 2003). Some examples are: prostitutes, due to their exposure to many partners; those who inject themselves with drugs, as the virus easily spreads through the shared use of needles and syringes contaminated with HIV-infected blood; men practising sex with other men, because AIDS virus is present in sexual secretions and is more likely to pass from an infected person to another during anal sex than during vaginal sex. Moreover, anal sex can result in injuries or tears of the delicate lining of the anus and rectum and any bleeding from these areas can allow virus transmission (UNAIDS 2001). Sexually transmitted infections (STIs) are also known to accelerate the change from HIV to AIDS. Many partners and unprotected sex (if one of the partners is already infected) can result in reinfection that, in turn, can speed up the change process from HIV to AIDS.

HIV is not transmitted through normal, daily living or through casual contact, where there is an absence of blood or body fluids. This means that people are *infected* with HIV and they do not *catch* it (HIVCO 2003). HIV cannot, for example, be transmitted through mosquito bites, sneezing, coughing, spitting, sweating and shedding of tears. People can play sport with infected persons, work together, shake hands, hug or kiss (on the cheeks and hands) and share the same room, toilets, swimming pools, utensils and towels. If, however, in any of these cases (except with the mosquito bite), there is an exchange of blood, such as from bleeding gums and ulcers of the two parties in contact, then the risk of getting infected will be higher. HIV/AIDS is incurable (AIDS Channel 2002) and is, at present, one of the leading causes of death in Africa. As a point of emphasis, Green (1994:1) holds that "AIDS is about sex and death together and is loaded with the combined

weight of their significance for us". There is no age distinction to it, as it attacks adults, children, teenagers and elderly people alike. A person can be infected with the virus and feel and look healthy. One cannot tell that someone is infected from the appearance of that person (Health Services 2002).

When infected with HIV/AIDS, the victims, over time, experience nervous and immune system damage and become sick with different illnesses, such as infections or cancers, which can kill them (The Funeral Directory 2000). Besides the physical ailments, the victim undergoes other forms of trauma. Psychologically, an infected individual suffers the perceived shame of it, the fear of his/her condition being known, how loved ones and the community will treat him/her, coupled with the fear of recurrent illness, job loss and, above all, death. Not disclosing one's infected status brings psychological self-torture and, when disclosed, some suffer from rejection, while loved ones or others share in the misery. Stigmatisation of HIV/AIDS, according to the Sunday Times Supplement (2002: 9), can bring about social rejection and alienation and can lead to the compromise of responsibilities such as employment, housing and schooling.

Taking the case of South Africa, Ellis (2001) feels that handling the HIV/AIDS issue " has been made more problematic than necessary because of a number of policy choices by the South African government that complicate the issue enormously". Ellis advances a number of arguments responsible for the complication: firstly, pressure from AIDS activists, who consider AIDS not a 'notifiable' disease and within the present policy it is even illegal for medical personnel to inform people that their patients are infected; secondly, the internal politics of the Health Departments, which have been made even more complicated by President Mbeki, in his questioning the origins of AIDS through the HIV virus. All in all, handling HIV/AIDS involves many complexities at different levels, be they medical, social or political.

2.5. Repercussions of HIV/AIDS

The following section broadly highlights repercussions of HIV/AIDS. It also highlights different strategies employed in the fight against the spread of HIV/AIDS.

Looking at a chain reaction, the effects of HIV/AIDS stretch from individuals, to families, to communities and nations and to the world at large. The illness and death of an individual follows the same trend: "In Africa, AIDS and famine now go hand in hand. Across southern Africa, some 7 million farmers have died from AIDS, according to official estimates, leaving many families with neither the means nor the experience to farm" (Thurow 2003). In 2001 alone, there were 3 million AIDS-related deaths, 5 million new HIV infections and the number of people living with HIV/AIDS worldwide rose to 40 million (UNAIDS 2001). Of the 5 million new infections, 3.4 million were from Sub-Saharan Africa (Avert 2001). Four southern African countries (Botswana, Lesotho, Swaziland, and Zimbabwe), for example, were identified to have national adult HIV prevalence rates exceeding 30% (Baylor 2004).

Socially we see that AIDS is, at the moment, not only incurable and fatal, but is also a social phenomenon which has, in one way or another, touched the life of every human being on earth (AIDS Channel 2002). The rate of spread of the epidemic is seen to be that where families cannot single-handedly manage the crisis, thus warranting society to step in. Not enough, unfortunately, is known about what is happening and those who are involved are observed to be overstretching themselves trying to contain the escalating number of cases. This situation if not well handled, can lead to a sick (stressed) community taking care of a sick (stressed) and dying people. Stress and depression "can compromise function and wellbeing in all areas of family life, including school and work performance, family relationships, and capacity for child-care" (Sunday Times Supplement 2001: 9). Responses to stress can stretch to alcohol and drug abuse, violence and unsafe sexual behaviours needing strategic intervention.

Economically, "there is clear evidence from several countries that staff ...are indeed dying, and that this influences the ability of institutions to perform" (Mullins 2001:9). Seeing that the working age group can be argued to be one of the most affected by this epidemic, the workforce suffers from the death of potential employers/employees and expertise. The district officer of agriculture in Rakai, Uganda, reported in 1995 that 20 to 50% of working time was being lost as a result of HIV/AIDS (FAO 1995:73).

In South Africa, HIV/AIDS is resulting in a rising cost of employment benefits and the "cost of an average set of risk benefits is expected to double over the next 5 to10 years, unless they are restructured" (Sunday Times 2001 Supplemnt: 13). This is illustrated in Table 2.1.

Table 2.1: Projected costs of risk benefits as a percentage of salary in South Africa (Sunday Times Supplement 2001)*

	1997	2002	2007
Lump sum death or disability benefit	1.5	2.9	4.5
Spouse's pension	4.0	5.9	7.5
Disability pension	1.5	2.1	2.6

* Metropolitan Life

Judging from the Table, should there be no checks, risk benefits such as those of spouses' pensions will rise from 4.0% to 7.5% by 2007. Increases of this nature could take a toll on total expenditures of companies and households, limiting progress and further employment. Moreover, in the case of a breadwinner, not being able to work any further, the entire family is likely to face a crisis.

Gordon (2003) made the following pronouncement with respect to the impacts of HIV/AIDS, drawing from the Sub-Saharan situation:

> The HIV/AIDS epidemic is profoundly altering the demographic picture of Sub-Saharan Africa in ways that are likely to undermine societal and economic structures at the household and community levels. It is attacking economically productive age groups, producing large numbers of orphans, undermining the family structure and the social fabric of local communities, and driving many into poverty. The most affected countries will be threatened by the loss of skilled professionals, the erosion of civil society, the decay in the state's ability to implement policies, and reduced economic growth; thereby rendering relatively fragile states even weaker. The deterioration in the quality of life could also undermine state legitimacy and contribute to civil violence and political disorder. Development, democratic institution building, and security are likely to be negatively impacted, especially in those states that lack the political will to respond to the crisis (Gordon 2003).

Looking at the huge implications of HIV/AIDS, and how it cuts across almost every aspect of society, it is difficult to stay silent. Due to its devastating nature, many strategies are being employed at different levels, and by different groups of people, to fight it.

2.6 Different strategies employed in the fight against the social implications of HIV/AIDS

Many individuals, organisations (both governmental and non-governmental) and support groups are providing strategies to contend with HIV/AIDS. These are provided in a variety of ways and through the provision of information, peer and community education/participation, home-based care, analysis of basic needs, gender and cultural and other methods. From this variety, four major categories of strategies can be identified: prevention strategies, support strategies, dialogue-oriented strategies and participatory strategies (Parker *et al.,* 1998:10). In all of these, evaluation stands out as an important component.

- *Prevention Strategies*

Education, coupled with the promotion of HIV/AIDS awareness, plays an important role in prevention strategies. High-risk groups, such as sex workers, youths and truck drivers are often the main targets. To achieve the desired goals, use is made of conventional and small media (television, radio, print, theatre, drama, leaflets and booklets). The use of condoms is promoted through free distribution in hospitals and clinics and life skills education is imparted to the youth (Parker *et al.,* 1998:10). References to interventions focussing on prevention strategies include among others: an educational programme on HIV/AIDS with junior high school students (Alteneder 1994); a behavioural change programme involving health education and condom promotion among street youths in Accra (Anarfi 1999); and an AIDS awareness campaign involving AIDS education, leaflets and radio messages in the peri-urban areas of Blantyre (Bacon *et al.,* 1996).

- *Support strategies*

Support strategies endeavour to provide a direct practical framework to the infected and affected persons. They do this through strategies such as the creation of networks, sourcing

of funds; provision of treatment facilities for HIV/AIDS connected diseases and setting up of home-based care units. References to interventions focussing on support strategies include: the Red Cross and Red Crescent AIDS Network for Youth, West-Africa (RANY-WA), that provide support in youth peer education through a system for effective management and co-ordination of intervention activities (Aryee 2000); and a Tanzania-based programme (TANESA) that assisted 22 communities to develop a gender sensitive response to an HIV/AIDS epidemic (Schapink and Nyonyo (2000).

- *Dialogue-oriented strategies*

Dialogue-oriented strategies provide forums, whereby searching questions about HIV/AIDS can be dealt with through question-and-answer sessions. Setting up counselling units, telephone help lines, and a host of other similar strategies does this. References to interventions focussing on dialogue-oriented strategies include: a voluntary counselling and testing (VCT) project that was conducted for the Africa Centre for Reproductive Health and Population studies in Mtubatuba, northern KwaZulu Natal (HIVCoRE 2003); an HIV/AIDS project that provided, among other things, counselling doctors to whom HIV/AIDS patients are referred (Foster 1990); and Centres for Disease Control and Prevention (CDC) and a national AIDS hotline that handles calls from people with questions about prevention, risk, testing, treatment and other HIV/AIDS-related concerns (ASHA 2003). Information specialists are available 24 hours a day, seven days a week and can answer questions, provide referrals and send free publications through e-mail and postal mail.

Participatory strategies

Participatory strategies are empowerment strategies that enable ample exploration of people's needs, as well as a reflection of their unique perspectives. Targeted audiences are highly represented and encouraged to participate at different levels of problem and solution identification. Participatory theatre, songs, poetry, marches and parades, at group and community levels, are some of the strategies used in participatory interventions (Parker *et al.,* 1998). References to interventions focussing on participatory strategies include: a project on the response of gay communities to the HIV/AIDS epidemic (Carr 1991); a rural community health programme focussing on gender, risk perception and protective practices

in relation to STIs (Harrison 1998); and an empowerment project aimed at reducing HIV infection and disease among women in Kinoni community (Luboobi *et al.*, 2000).

With the application of the different intervention strategies, key issues, such as culture/beliefs, crime, religion, gender, language and age, which are linked to social/behavioural theories, stand out as major concerns. Shuy (1979:18), for example, says that healthcare workers' poor knowledge and/or usage of communicative skills with which they will have to probe for information from respondents, as well as their poor knowledge of the socio-cultural background of the respondents, can block their understanding of the "non-medical" problems that affect the patients (the community).

Further investigation will concentrate on participatory strategy. This is because participation forms the methodological focus of this study.

2.7 Social change

The importance of focusing on social/behaviour change in the struggle against HIV/AIDS is becoming widely accepted. As put forward by Campbell and Mzaidume (2002), "HIV and AIDS prevention programmes often have little impact because such programmes have traditionally had a biomedical focus and an emphasis on individual behaviour. Yet social and community level factors influence the rate and method of HIV transmission and can affect the success and failure of prevention programmes". According to Harrison *et al.* (2000), there are limited possibilities of discovering a cure for HIV/AIDS. Social/behaviour change, they hold, therefore remains the most viable means of limiting the further spread of the HIV infection. The National Institute of Health (NIH 1997) proclaimed "Behavioral interventions to reduce risk for HIV/AIDS are effective and should be disseminated widely". This calls for the development of theories that would be of immense help to interventions dealing with social/behaviour changes. Fishbein (2000: 277) sheds more light on such an argument by stating that " What we do need, …is for investigators and interventionists to better understand and correctly utilise existing, empirically supported behavioural theories in developing and evaluating behaviour change interventions".

With respect therefore to theories governing social change and the fight against the spread of HIV/AIDS, the following were noted:

Bhana (1999: 230) considers participatory approaches, for example Participatory Action Research (PAR) to be an approach that enables mediation between individual and collective needs and that addresses the tension between the researcher and the researched. This, to Bhana, is done by, trying "to know with others, rather than about them, and to reconceptualise and foster knowledge as something that exists among people, rather than some sort of barrier between them". The implementer in a participatory project is playing the collaborative and supportive role of a facilitator, rather than a detached and dominating one as in traditional processes. Bhana (1999: 230) explains that while the traditional researcher would frame a question from a management point of view (" How can productivity be increased by eliminating time-wasting on the shop floor"), a participatory researcher, for example, a PAR researcher would frame it in collaboration with workers ("How can we make our work more meaningful so that we don't feel we're wasting our time on the shop floor?").

Campbell (2003) in her work *Letting them die* maintained, "the forces shaping sexual behaviour and sexual health are far more complex than individual rational decisions based on simple factual knowledge about health risks, and the availability of medical services." Some of the complexities according to Campbell (2003) arise from the dynamics of power-bases (in the search for solutions regarding HIV/AIDS) that are inherent in the visible/invisible structures found within impoverished communities. Remley (1999) on the other hand perceives the point of departure in HIV/AIDS programmes, to be that traced in Dickie's HIV theory:

> When examining a new disease like AIDS, it is very easy to ask: "What is wrong with these patients?" But if that is your starting point, then you might easily find yourself looking for flaws in the patient that are not there... What if there is NOTHING wrong with the patient? What if the patient's immune system is properly responding to an improper signal (or NOT responding to a LACK of a proper signal)..? It threw a different light on the issue, and suggested different avenues to investigate (Remley 1999: 2).

Looking at different avenues in investigating HIV/AIDS matters as suggested by Remley (1999), the integrative model of Fishbein (2000:275) provides some glue. The model states that any given behaviour is likely to occur "if one has a strong intention to perform the behaviour, if one has the necessary skills and abilities required to perform the behaviour, and if there are no environmental constraints preventing behavior performance". In some communities, people may be engaging in premarital sex because they have not yet formed the intention of abstaining. In others, the intention of abstaining might have been formed, but due to other environmental constraints, such as peer pressure, violence and poverty, they are hindered from practising abstinence. Leclerc-Madlala (1999) found out that children are raped due to the assumption that sex with children is safer, as the children are likely to be virgins. In this case, violence, through acts of rape can hinder victims from abstaining even if they have the intention to do so.

As communities and issues affecting social change (with respect to the fight against the spread of HIV/AIDS) differ, so do intervention approaches, for example, a particular determinant, such as attitude towards condom usage, may be thriving in one culture and not in another, thus needing different approaches in dealing with the issues.

> Although an investigator can sit in her or his office and develop measures of attitudes, perceived norms and self-efficacy, she or he cannot tell you what a given population (or a given person) believes about performing a given behaviour. Thus one must go to the members of that population to identify salient outcome, normative and efficacy beliefs. One must understand the behaviour from the perspective of the population one is considering (Fishbein 2000: 276).

In making use of the different approaches, it was considered vital to visit the communities concerned and sample their views/beliefs, in order to work within the confines of the people's perspectives. The major influences and the different ways in which they impact on peoples' behaviour and the fight against HIV/AIDS would need to be carefully studied. This is because an understanding of sexual behaviours can be seen to be of help in enabling interventions to be more focused and productive. According to Aggleton (1997:6), "appropriate and effective communication is central to the success of interventions to

reduce the risk of HIV infection". Dearing (1996) pointed to the importance of audience analysis in designing any health promotion initiative. This he held is due to the fact that "HIV prevention programs for unique populations can be culturally sensitive through the combined use of strategies based on the concepts of homophily, audience segmentation, and the sub-concept of compatibility".

Much is being done to curb the spread of HIV, but it is noticeable that, in spite of all the efforts HIV infection rates are escalating, especially in Sub Saharan Africa (see statistics in Table 1.1). A call for more profound social changes (an in-depth appreciation of the realities of life) is therefore essential, to halt the epidemic. This means having firm grasps of issues of gender, of poverty and of power relationships in everyday life (Dalrymple and Botha 2000). It also means having an in-depth appreciation of the realities of life (reflecting on unique perspectives of targeted communities), effective exploration of community needs such as pre-existing/environmental and situational factors and ensuring high audience representation, participation/peer education (songs, drama, group discussions) at different levels and stages of problem and solution finding.

2.8 Major community and social factors influencing the fight against HIV/AIDS

Sexual behaviour is perceived to be a complex and multi-causal phenomenon that is determined or influenced by intra-individual, inter-individual, community, social and economic factors. There are inadequate conceptual tools available to effectively understand or measure the interacting effects of them (Campbell and Williams 1998) as such, an analysis of these factors was considered vital in broadening people's view of the complex world of sexual behaviour, thus providing a clearer sense of direction. While one would admit the existence of a large number of influential and complex behaviour-change components, only those that met the criteria for this section of the study were chosen: factors that were integrative and had social implications so that differences in their social practices could be traced and analysed. These factors were commonly reflected in the literature in the social behavioural area of the spread of HIV/AIDS, for example, culture/beliefs (Ellis 1999), language (Ellis 1999), religion (Thomas 2000), gender (Fofana 1999), age (Ciantia 2003), poverty/education (Awusabo-Asare 2002) and crime (Leclerc-

Madlala 1999). For better understanding, the factors were viewed within two categories. The first category deals with pre-existing or background factors (environmental factors influencing community behaviours either directly or indirectly). Within this category are issues of culture/belief, language, religion, gender and age. The second category deals with situational factors (factors which influence what it takes for people to change), for example, poverty, education and crime.

2.8.1 Pre-existing or background factors

i) Culture/beliefs

In referring to culture/beliefs, Samovar *et al.* (1981:24-25) asserted that

> Culture manifests itself in patterns of language and in forms of activity and behaviour that act as models for both the common adaptive acts and styles of communication that enable us to live in a society within a given geographic environment at a given state of technical development at a particular moment in time. It also specifies and is defined by the nature of material things that play an essential role in common life.

In the communication process, participants bring with them differing backgrounds, which have been instilled in them by the different cultures to which they belong. In a multi-cultural society like South Africa, these backgrounds can be vastly different, especially because, within a culture, there are subcultures (economic, racial, ethnic, social and regional) that manifest certain peculiar patterns of behaviour that can be distinguished from others within a macro-culture. Values held by individuals are seen as relative to their societies. Individuals, however, of the same culture do not necessarily think and act in the same way. The standards often differ as a result of factors such as age, gender, attitudes, education, occupation and social status.

Corlien (1991) described the health system as "a set of cultural beliefs about health and illness that form the basis for health seeking and health promoting behaviour". Ellis (1999) took it further by stating that any illness or accident could be ascribed to supernatural forces, however trivial they may seem. He also stated that beliefs might vary remarkably from group to group and from individual to individual, even concerning specific causal theories. Looking at universal health beliefs, Ellis (1999) pointed out that Western patients

might believe in hormonal imbalances, clean air and even in the doctor. People with traditional beliefs might not only be interested in their illnesses, but also in who made them ill. This is due to the association of certain illnesses with spiritual forces and ancestors.

In some African communities, for example, the people believe that HIV/AIDS is a form of bewitchment or a curse and needs the consultation of the spirits. Mcetywa (2001) carried out research on the AmaMpondo people in South Africa. In her research, she discovered that the AmaMpondos view sexually transmitted infections as caused by what is known as 'amabekelo'. According to them, traditional healers can diagnose and heal these diseases. The things that may be new to them are the expressions HIV and AIDS, but the symptoms are known. Others believe that the condom is of the West and the campaign for its usage another form of imposition of Western culture. According to Mcetywa (2001), the AmaMpondo women believe in their traditional method of control and therefore do not appreciate the use of condoms. The AmaMpondo also consider condom usage as going against the laws of nature.

In Bafut and other villages or areas in Cameroon, issues related to sex are considered sacred and therefore open and free discussions about them are seen as taboo. Nkya (2003) reported a case where, in Tanzania, one Antonia went public regarding her HIV/AIDS status and many were appalled, including her stepfather, who said: "My daughter, I saw you on the television saying you are HIV positive. Oh! You have become such a bad woman ". According to Nkya (2003:1), "AIDS is not openly discussed in this East African country of over 34 million people, where the first AIDS case was discovered 20 years ago but communities still call it *slims*."

The culture of silence is observed to have a close link with denial and stigmatisation. Seen in the perspective of GAIA (2003), "When you work in Africa you become aware that the culture of silence surrounding HIV is nourished by the stigmatization of people living with HIV". GAIA (2003) reported a case of a Malawian cabinet minister who "stunned his staff by openly announcing that he had lost three children to AIDS and condemning the taboos and stigmas surrounding the disease".

In research carried out by Marcus (1999), on L*iving and dying with AIDS* in South Africa, she found that most participants, for example in the focus group organised for the research, "observed that AIDS is generally surrounded by secrecy and stigma"(Marcus 1999: 10). People would not speak openly about it but would say, when infected, that they have *idliso* (poisoning), pneumonia or *amagobhongo umeqo* (being bewitched by evil spirits). On the other hand, the culture of silence is surprisingly different among the AmaMpondos in South Africa. As revealed by Mcetywa's research, in the AmaMpondo communities, sex is discussed freely in approved sexual gatherings, supervised by elderly people. This is partly because they consider the safety of the community as every person's responsibility. Figure 2.2 gives a breakdown of factors influencing sexual practices and attitudes in relation to culture/beliefs and HIV/AIDS. An example of an intervention that focused on these specific factors is also given.
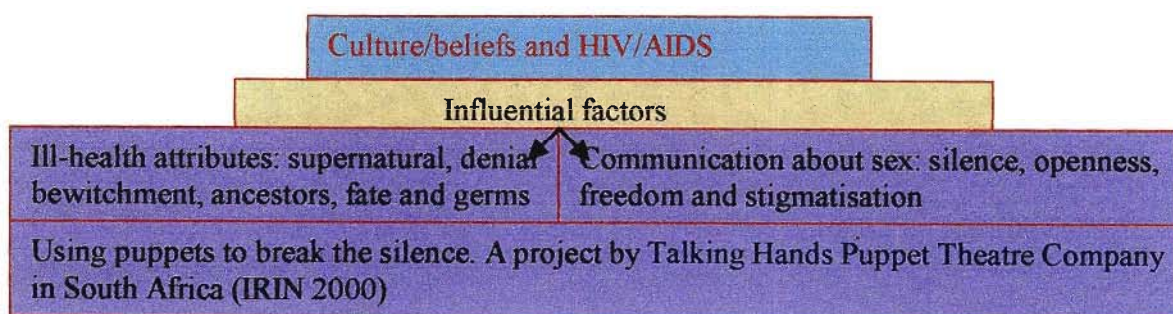
Figure 2.2: Proposed influential factors in relation to culture/beliefs and HIV/AIDS and examples of interventions.

As an example of a project or an intervention dealing with issues of silence (shown in Figure 2.2), a *Talking Hands Puppet Theatre* company is using short plays to teach children and teenagers life skills that are essential in the breaking of the wall of silence encompassing HIV/AIDS (IRIN 2000). Thus successfully targeting via participation media, the specific culturally linked HIV/AIDS issue 'the culture of silence'.

With all the different beliefs (bewitchment, fate, ancestors and germs), interventions like the one cited above need to take into consideration, via a participative study, of the values/influences of each community or group of people, so as to effectively pass on messages. This is because, if condoms, for example, are considered Western (foreign), or 'a

whiteman's scary story', then no matter how much is being done or effort expended about its usage, it will not be personalised until such a belief is altered.

ii) **Language**

Samovar *et al.* (1981:49) view language as

> An organised, generally agreed upon, learned symbol-system used to represent the experiences within geographic or cultural community. Each culture places its own personal and individualistic imprint on a word symbol. Objects, events, experiences, and feelings have a particular label or name solely because a community of people have arbitrarily decided to name it. Thus, because language is an inexact system of symbolically representing reality, the meanings for words are subject to a wide variety of interpretations. In fact, it is often stated that meanings are in people rather than in words (Samovar *et al.,* 1981: 49).

From the given definition, one could argue that things that are symbolic require some form of affiliation (interpreting material relative to a broader theoretical, historical, cultural or political framework) for them to be understood. One needs to give thought to the context in which the images and texts are created and to their history (Kelly 1999: 410). Kelly highlighted the fact that linguistic images need to be looked upon as reflecting a particular historical, socio-cultural and political context, as well as acquiring something in the context of speaking. The different contexts allow possible meanings to unfold.

Note was taken of the language of respect, fear and evasion, to directness, which can even cause a story to be told differently depending on who it is being told to (Ellis 1999), all portraying language as a complex issue of which recognising its different components was perceived in this work to be vital in dealing with HIV/AIDS interventions. This is because complaints relating to medical issues arise, not only from unavailability of treatment, but also because of a lack of inter-intelligibility between healthcare workers and clients (Niba 2000).

Given the heterogeneous state of most African communities, the occurrence of communication problems is likely. In isiMpondo, Mcetywa (2001) pointed out that there is no equivalent term for virgin, which may be due to the fact that the word carries a different meaning in isiMpondo. A virgin, she asserted, means in isiMpondo a girl who has not given

birth to a child and is in her fullness 'intombi'. Non-penetrative sex, which leads to the avoidance of teenage pregnancy, then becomes the norm.

Figure 2.3 portrays, in relation to HIV/AIDS, the various aspects of language that were handled in this section of the study and examples of interventions that specifically dealt with them.
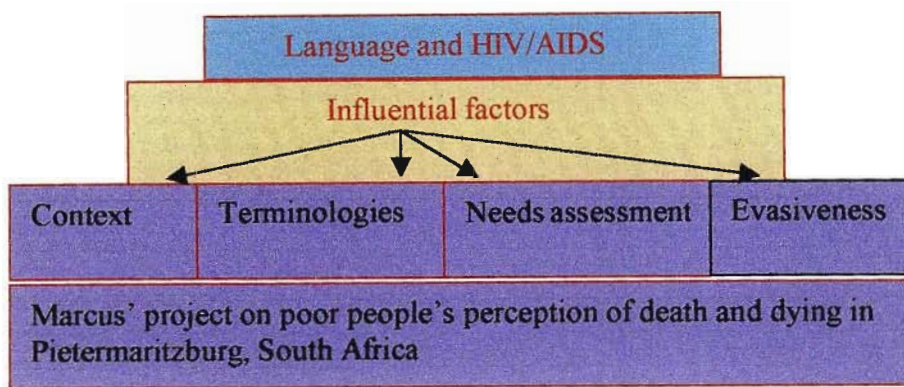
Figure 2.3: Proposed influential factors in relation to language and HIV/AIDS and examples of interventions

Marcus (1999), in her project on poor people's perception of death and dying in Pietermaritzburg, South Africa, identified the need for putting HIV/AIDS within a social context. She based her project (similar to that ideology of Kalish 1980) on the fact that every society has a built-in meaning system to manage and explain death. This system shapes the way death is interpreted. She successfully sought via focus group discussions, the experiences and perceptions (the meaning of death in relation to HIV/AIDS) of the poor in and around Pietermaritzburg. She concentrated specifically on the contextual interpretation of death; death that goes beyond biophysical changes. HIV/AIDS tended to result in "bad death".

Poor or inadequate knowledge of the intricacies embedded in language (context, terminology and evasiveness), can result in poor assessment or analysis of the actual information needs of the people. Wrong words or concepts used can also have serious

consequences in extreme cases. Boadi (1987:5) made it clear that, even when the language, for instance English, is appropriate for use, other codes such as those relating to scientific or technical terms, as well as format considerations, form barriers. This thus calls for interventions (like the one cited above) that will specifically, as opposed to generally, address the identified issues within the specific communities concerned.

iii)   **Religion**

Looking at the different factors affecting sexual behaviour, so much has been attributed to religion. Perceptions and attitudes of sexuality are often considered within certain religious frameworks. Today's society is different from that of the 1930s. It is shaped by modernity, individualism, ideologies and even the rejection of Christian morality (Roiphe 1997; Zani 1991). Historically, the rejection of religious morality started around the World War II era and reached its climax in 1960s and 1970s. The 1950s were known for 'double gender standards', where premarital sex was acceptable for men but not for women (Roiphe 1997).

Since 1980, much has changed and 'sexual abstinence' for women is being replaced by 'permissiveness' (Zani 1991). Besides the many ills attributed to moral decadence, the younger generation and those who look up to leaders as models stand to lose, especially in cases where such leaders (be they Church ministers, government officials, and parents) do not set 'good' examples. Moreover, as Roiphe (1997: 163) indicated, though certain sexual behaviours such as casual sex or cohabiting prior to marriage, have now been accepted as normal, they are not so acceptable that parents and teachers can teach them comfortably particularly to teenagers.

Without God, therefore, and without rigid social rules and regulations, Nsengiyumva (2000) lamented that today's generation was left with little to use to form new values. She added that this generation was left with the general feeling that someone has to teach them (children and teenagers inclusive) what to do about sex, but no clear sense of what exactly it is that should be taught. With, for example, respect to HIV/AIDS and moral values, should abstinence be the only source of prevention or should the use of condoms be condoned? If the former, what about those who do not adhere to morality? If the condom is introduced, what value is being promoted via the condom, promiscuity or sexual purity?

Religious bodies and leaders deal closely with the community and have a strong influence on the people, as the latter look up to the former for guidance. Due to the Church's acceptance, its role as guardian of the traditional code of morality and values, Berger (1994:1511) sees the Church as a common and culturally accepted healthcare provider in Africa. The Church's stance either promotes or inhibits high-risk HIV/AIDS practices. Abstinence, for example, is often preached in religious circles, but suggestions on how to control sex drives seem to be ignored.

Thomas (2000) reported that a gay priest felt that "Priests and others have to disguise and hide their sexuality in all sorts of ways". This is a situation which could be attributed to an unhealthy sexual practice, given that, when in hiding or pretence, the chances of being helped are slimmer compared to cases where one cries out for help.

Looking at the different aspects pertaining to religion and HIV/AIDS, Figure 2.4 gives a summary of them, as well as an example of an intervention, which deals with some of the aspects.
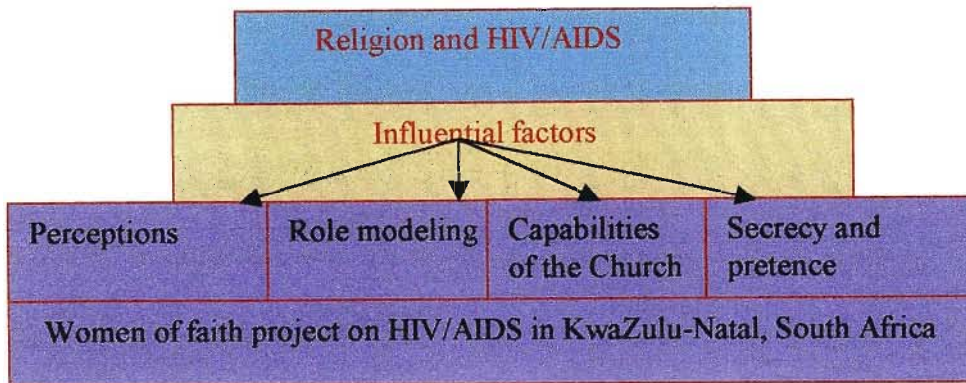
Figure 2.4: Proposed influential factors in relation to religion and HIV/AIDS and an example of intervention

A Christian-based group known as *Women of Faith* decided to take up the HIV/AIDS challenge, after discovering that, even though HIV/AIDS was a 'hidden' issue within the Christian circle, Christians (young, old, men, women) were getting more and more exposed to the risk of becoming infected. Men, for example, due to risky sex practices, such as marital unfaithfulness, get infected and in, turn, infect their wives and *vice versa*. Youths, out of disobedience to God's precepts and to their parents, or out of lack of discipline on the part of the parents, get involved in risky sex practices, such as premarital sex, and become infected with HIV/AIDS. Also, it was noted that infected persons kept their status a secret, for fear of being stigmatised. An awareness programme, therefore, that aimed at breaking the silence (secrecy and pretence) and dealing with perceptions (why people become infected with HIV/AIDS), through open and free discussion about HIV/AIDS and risky practices, was carried out with the *Women of Faith*. Given, however, the difficulty of initiating the programme without the participation of their male counterparts (as males were seen to be part of the problem), the *Women of Faith* decided to extend their programme to involve the participation of their spouses (Nyamboli 2003). With such a degree of participation, much in terms of secrecy and pretence was successfully dealt with, as both spouses were able to openly voice out their hidden challenges regarding HIV/AIDS, declare their status and those they have lost as a result of the infection.

iv)   **Age**

Age cuts across the previous factors, but also needs to have special mention, as one observes that it provides influential sources of data relating to risky behaviours and HIV/AIDS. The study of Mwalongo (2001) on youths in Dar es Salaam, Tanzania, partly unveiled this reality. In his research, it was discovered that about 60 percent of youths, from over 12 secondary schools and post-school boys and girls, aged 15-19, who screened their blood in Dar es Salaam, were HIV positive. Over 50 percent of primary school pupils, mainly grade seven and eight, in the Morogoro region of eastern Tanzania were already sexually active. Tanzania is an epitome of the all-African HIV/AIDS crisis. As statistics show, more than one million young people are being infected with HIV/AIDS every year in Africa (UNAIDS 1998: 4).

In Kenya, as far back as 1994, studies revealed that 75% of girls first had sexual intercourse before the age of 16. Fifteen percent had become sexually active before the age of 12 (Williams *et al.,* 1997). In South Africa, the South African Medical Research Council estimates that, if policies are not amended, deaths from AIDS could rise to 7 million by 2010 (BBC News 2002). According to The Economist (2003), with the prevalent rate of infection, approximately half the country's teenagers (below 15) can expect to be infected with HIV/AIDS.

Several reasons have been advanced for the HIV/AIDS youth crisis varying from the non-usage of condoms, inadequate information provision, peer pressure, maternal distancing and poverty to decaying morals. The president of South Africa, Thabo Mbeki, told South Africans: "You can't be going around having hugely promiscuous sex all over the place and hope that you won't be affected by something or other" (BBC News 2002). In the case of Tanzania, pupils were calling for the establishment of HIV related clubs in schools, where the dangers of the disease could be pointed out to them and discussed through simple games. They blamed decaying morals in the society as the major reason for the spread. In the Tanga region (northern Tanzania), teenagers as young as 12 years asked stakeholders to manufacture condoms in their sizes, as those in the market were too large for them. The uncontrolled spread of the 'new culture', partly ascribed to programmes aired on television

and the degree of poverty, were blamed for the decaying morals. To aggravate matters, research on the nature of sexuality has been restricted as a result of social, legal, political and religious norms and constraints (Nicolas 1994; Al-Gasser 1997).

Figure 2.5 gives a summary of the issues discussed in this section regarding age and HIV/AIDS. An example is given of an intervention dealing specifically with the identified issues.
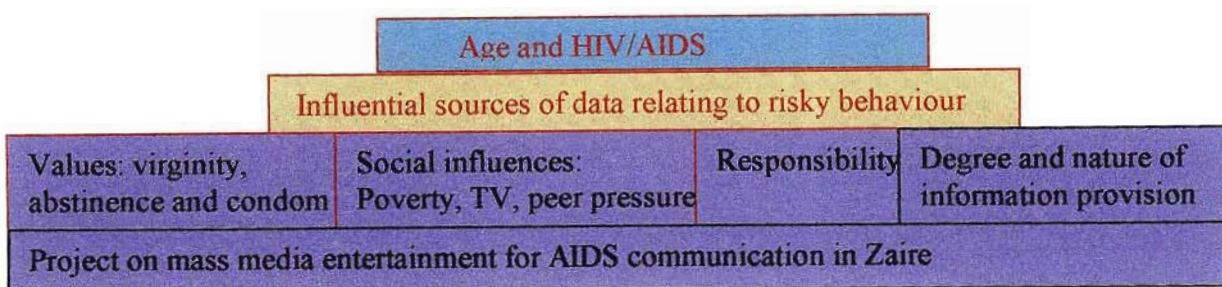
Figure 2.5: Proposed influential sources of data in relation to age and HIV/AIDS and an example of intervention

Looking at Figure 2.5, the organisation (Population Services International) identified HIV/AIDS in Zaire to be prevalent among youths (where most AIDS sufferers were infected as teenagers). The organisation noted that urban youths in Zaire had access to television and that they took part in high-risk sexual behaviour. The organisation, in collaboration with the government of Zaire's national AIDS programme, successfully designed an *AIDS Mass Media* project, aimed at using mass media entertainment to communicate AIDS messages to urban youths (Convisser 1992). By using the mass media, open viewership was encouraged from which parents and healthcare providers could also benefit by participating in open discussions.

In 1992, at the World AIDS Congress, President Museveni of Uganda said: "I believe that the best response to the threat posed by AIDS is to reaffirm the reverence and respect and responsibility every person owes to his or her neighbour. Young people must be taught the virtues of abstinence, self-control and postponement of pleasure and sometimes sacrifice" (Ciantia 2003). Ciantia (2003) also mentioned Janet Museveni (wife of Museveni) insisting on the education of the young in areas of responsibilities: responsibilities that start with true

understanding and the building of "a culture, based on family values, discipline as respect and love for others". The issue then is for religious communities, parents and health promoters, to specifically and in a participatory manner, encourage and advocate values such as abstinence as projected in figure 2.3 with the *project on mass media entertainment for AIDS communication in Zaire.*

2.8.2 Situational factors

i) Gender

Biological and physiological factors were considered to explain, only in part, the gender differences with respect to HIV/AIDS. This was attributed to the fact that "people, and specifically individual and collective human behaviour, constitute the key dimension in the HIV equation" (Mann *et al.,* 1992). Gender relations were defined by Schoepf (1993) as "the processes, structures and institutions by means of which societies order sex differences and invest them with cultural meanings for the people who act them out in daily life". A comprehensive understanding of gender differences must therefore go beyond biological factors in analysing male and female behaviours (Daniel *et al.,* 1996: 215).

Daniel *et al.* (1996: 216) pointed out that most programmes concentrate on abstinence; mutual monogamy; correct and consistent use of condoms; and appropriate treatment for STIs. These researchers lament such emphases, because the underlying assumption in them is that people are able to exercise control over the conduct of their sexual relations. In most cases, the reverse situation is true, especially when one examines the socio-cultural and economic determinants of sexual behaviour.

In a survey, for example, conducted by the Tanzania Media Women's Association (TAMWA), 442 house maids out of 737 (60 per cent) admitted to having had sex with male members of the families who employed them, after being promised gifts or threatened to have their jobs terminated (Irin 2003). From the survey, some of the housemaids explained why they had no alternative to the sex offers: "I had to accept the offer because I haven't been paid my salary for four months now." Another explained, "Baba said if I refused, he was going to terminate my employment without even giving me my salary, which was

already three months over-due. My mother is dead, I do not know my father, and I was afraid of going back to the village where life is more difficult due to poverty" This maid told her brother-in-law about the sex offer. To her surprise, he responded: "You are grown up now, aren't you? You matured last year, then what are you afraid of?" He also threatened that if she quit the job, he would not accept her in his home, as she would be an extra burden to the household.

Wars have left millions of people displaced, ill and helpless. Women and children are often the worst affected and are regularly among the population of refugees and internally displaced, making up 70 to 80 percent of an estimated 40 to 50 million uprooted cases. This can be due to the fact that the men are in exile, dead or are involved in the wars. Fofana (1999) presented a report on violence against women as a cofactor of HIV/AIDS. Her illustrations were drawn from two African countries, Rwanda and Sierra Leone. More men, she stated, die in battle than women; but women and girls are deliberately targeted for rape, torture, sexual slavery, trafficking, forced marriages and pregnancy. Women have no power to resist when their livelihoods are dependent upon compliant behaviour.

Fofana directed an HIV/AIDS prevention programme in Ngara, Tanzania, from 1994 until 1996, for 200 000 Rwandan refugees. She noticed that more than 50 percent of the Rwandan women, on both sides of the conflict, were beaten, raped and tortured. The violence continued when the women arrived at the refugee camps. Rapes in and around the refugee camps were frequent, particularly against women without adult men in their households. The unmarried mothers reported that men walked into their huts at will and raped them. The situation described by Fofana (1999) was aggravated by the location of latrines and water taps in the camps. They were situated some distance from their dwellings. As the women and girls visited the latrines or fetched water, they were raped. Self-appointed guards at the water taps demanded sexual favours from women seeking water.

In the declaration of commitment on HIV/AIDS, in the United Nation's General Assembly Special Session (UNGASS), stress was laid on identifying and targeting populations with high rates of HIV due to poverty, livelihood, location and sexual practices, of which mobile

workers were identified to be particularly vulnerable (Warmington and O'Connor 2002). When a husband is working and living in one area and his wife in another, they are both exposed to the temptation of having sex with those close by, thus running the risk of becoming infected and infecting others. The children are also observed to be at risk in such situations. They tend to be brought up by single parents, or by grandparents who are likely to be too tired to administer adequate follow-up and discipline. A number of cases of families living in such separate circumstances are widely noticed between domestic and mineworkers in South Africa and other African countries.

According to IRIN (2003), whenever a gold rush occurs, prospecting miners in Tanzania tend to seek their fortunes, and only return to their homes when the excitement dies down and gold becomes too difficult to find. Unfortunately, IRIN (2003) projects that it is during these times that sexual interaction between the miners and the surrounding community, for example high risk women in bars and hotels, occurs, with a corresponding increase in HIV infection.

Due to the separation of migrant workers from their families and familiar surroundings, they end up suffering from boredom. In order to deal with boredom, these workers tend to spend most of their time in bars (where the associated sex workers who are HIV-positive are likely to be found). "Migrant workers who practise unprotected sex with these prostitutes may get infected, and when they return home, will carry the diseases" (Medilink 2001). During a *Special Assignment* programme of 24th September 2002, on the South African Broadcasting Corporation (SABC 3), the story of a mineworker was televised. This worker had been on the mine for several years, separated from his family, only to come home to tell his wife he was HIV/AIDS positive.

Figure 2.6 projects factors relating to gender and HIV/AIDS and give an example of an intervention that took cognisance of them.
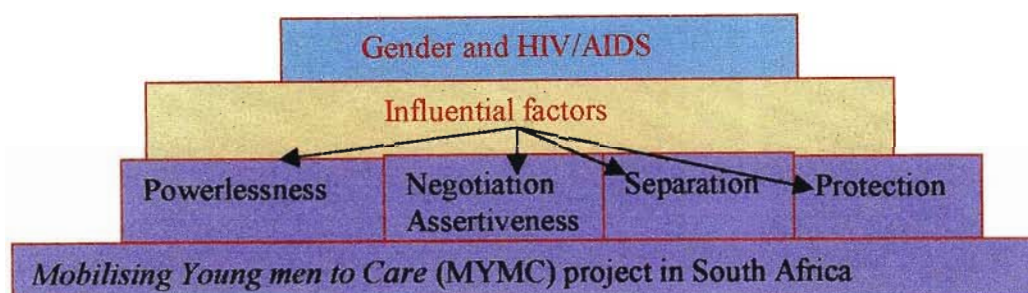
Figure 2.6: Proposed influential factors in relation to gender and HIV/AIDS and examples of interventions

The *MYMC* project, identified violence, gender inequality and high rates of HIV transmission as the three key problems at all levels of South African education (id21 education 2003). It noted that gender inequalities were manifesting in different types of violence: girls being raped by boys and boys being the main perpetrators of sexual assault (but also being the victims of assault by other boys). In all these, *MYMC* saw many interventions, basing their negotiation power on the perception that boys are the perpetrators and girls the victims. This left out the unanswered question of how the gap could be addressed between rhetoric and practice in addressing the vulnerability of both boys and girls. Based on this specific issue, and as seen within the South African educational institutions, a joint intervention between Dramaide (a South African NGO) and the University of Natal was carried out in two Durban schools. The aim was to use a mixed gender approach (single-sex and mixed gender interactions), via participatory/peer education methodology, to build a strong rapport with learners and, in turn, pave the way for the challenging of entrenched ideas about gender inequality. The project, successfully enabled girls to come to the understanding that it is not obligatory to have sex with an assertive boy and for boys to come to the stage at which they can take responsibility for their actions, express their emotions in a more dignified way and develop an understanding of 'doing masculinity' differently (id21 education 2003).

All in all, the question of gender was, however, seen to differ with the communities and individuals concerned. Not all communities, for example, are patriarchal, with the men

dominating sexually, politically, economically and otherwise. Gutmann (1993) sees post-parental women becoming more assertive (as post–parental men are becoming milder, the women are becoming more domineering and independent and are able to assert their own desires as the men choose to be softer in their approach). Mcetywa (2001), in her study of the AmaMpondo women in South Africa, presented a picture of women with relatively more power. According to her findings, the AmaMpondo community does not favour male domination and the imposition on females of matters relating to sexuality. The men are known to be the ones that propose sex in this community. The females, however, are entitled to their opinion (they can either reject or accept the proposal). In cases of physical violence, the man can be fined, depending on the magnitude of the violence. This refers to the fact that as a community or a people vary, so does their behavioural patterns. HIV/AIDS projects such as the one above therefore need, in a participatory manner, to take cognisance of the different socio-cultural factors affecting vulnerability to HIV when dealing with gender.

ii)   Poverty, education and HIV/AIDS

To better illustrate the issue of poverty, the stratification of African societies, with South Africa as an example, was deemed worth mentioning. Brundtland (1999) pointed out that the poor, such as South African blacks (see Figures 2.3 and 2.4), are the most exposed to the dangers of an unsafe environment and the least informed about threats to health. It is the poor, she thought, who bear the yoke of crude structural adjustment policies and unregulated globalisation and of epidemics of HIV/AIDS, malaria and tuberculosis. Marcus (1996) in a case study conducted in the trucking industry in South Africa revealed a situation of high-risk sex practices, where marginalised local women, driven by poverty, engage in the sex trade with truck-drivers, with the rare refusal of unsafe sex. According to a research finding by the University of South Africa (UNISA), "Six years after the official end of apartheid, its legacy lives on in a huge disparity in wealth between black and white South Africans" (BBC News 2000). The South African poverty gap is illustrated in Figure 2.7 below.
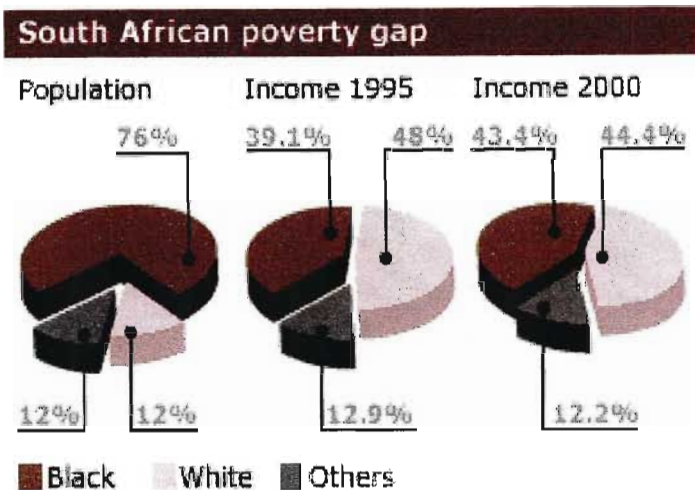
Figure 2.7: South African poverty gap (BBC News 2000)

Figure 2.7 shows that, even though black South Africans constitute the majority (76%) of the population, the 2000 proportional income (44.4%) of the white population (12%) surpassed theirs (43.4%). This is not to say that there are no poor whites and that all blacks are poor. The issue is that South African blacks fall, to a great extent, under the category of the poor, marginalised or underserved. The pictures below show some of their struggles for survival.

The poorest blacks
are not better off

The black-white gap remains wide,
despite having shrunk slightly

Figure 2.8: The struggle for survival among South African blacks (BBC News 2000)

From issues linked to poverty, one would argue that in terms of accessibility to concrete HIV/AIDS information, profitable jobs and affordable goods and services and less exposure

to high-risk sex practices, educated people would suffer less from HIV/AIDS. If general levels of literacy are taken as an indication of educational levels in a country, Brundtland (in WHO 1998) asserted that it might be expected that countries with high levels of literacy have low levels of HIV. If literacy and HIV are compared for the 161 countries in the world for which there are data on both HIV and literacy, a statistically noteworthy pattern of just this kind emerges. When, however, a closer look is taken at the 44 countries in sub-Saharan Africa (the worst affected), the relationship between HIV and literacy is reversed. In this region, the countries with the highest levels of HIV/AIDS infections are those with the higher levels of literacy.

In the sub-Saharan region, as in all others, the more educated populace is likely to be the more knowledgeable with regards to the dangers of HIV. They are also likely to be those with more disposable income than the illiterate populace. The question that then surfaces is why are they also those more likely to be HIV-infected? Many possible explanations could be advanced for the differences. The social changes that go with more schooling as suggested by Brundtland (in WHO, 1998), could be linked with behaviours that add to the risk of HIV infection. Similarly, this could be argued in the case of women who, 'without education', are likely to have less social mobility and a more reduced chance of exposure to a wide array of social and sexual relationships.

Another explanation could be that educated people with more social power make use of those powers to still engage in high-risk practices that expose them and others to HIV/AIDS and other infections. Research by Anarfi and Awusabo-Asare (2002) on HIV/AIDS in tertiary institutions in Ghana revealed such concerns regarding risky sex practices. The research indicated that one of the principals from the polytechnic commented: "I am getting concerned about the reports I receive about the behaviour of some of our students, especially the females". According to Anarfi and Awusabo-Asare (2002: 14), the comment was provoked by the allegation that female students were going out with older men who could finance their education.

Otaala (2000), in his study of the impact of HIV/AIDS at the university of Namibia, mentioned of a research carried out by a group of six students from the University of Namibia Students' Welfare Society. These students examined the views, beliefs and attitudes of fellow students at the University of Namibia (Windhoek main campus and Northern campus of Oshakati), regarding sexual behaviour. It was reported that female students sexual practices were perceived not just to be for the sharing of love and for reproduction, but also for economic gain, where one had to "sell" her body for money. The male students, on the other hand, saw sex in a more traditional way: "If a man hasn't had sex, he is not a real man, and is likely to be mentally disturbed" (Otaala 2000: 30).

According to the WHO (1998), countries often have very diverse epidemics, even within a single country; HIV can affect different populations in different ways, which may change with time. An analysis of the relationship between education and HIV can illustrate pitfalls in drawing deceptively simple conclusions about the determinants of an HIV/AIDS epidemic. Relationships that may seem clear at the global level may look very different at the regional level and even more complex over time in a single setting (Brundtland in WHO 1998). Thus, at the heart of sex and sex-related issues, Marcus (1996:2) felt that there "is a complex set of sexual practices and attitudes". If, for example, at the educational institutions described in this section, the influential factors are poverty, the desire for luxuries and the need to secure a pass mark, then interventions have to be designed in ways that can address these identified needs, which invariably contribute to the spread of HIV/AIDS.

Figure 2.9 gives a breakdown of factors influencing sexual practices and attitudes in relation to poverty/education and HIV/AIDS. Examples of interventions that have focused on these specific factors to determine how they can be addressed, in order to curb the spread of HIV/AIDS, are also given.
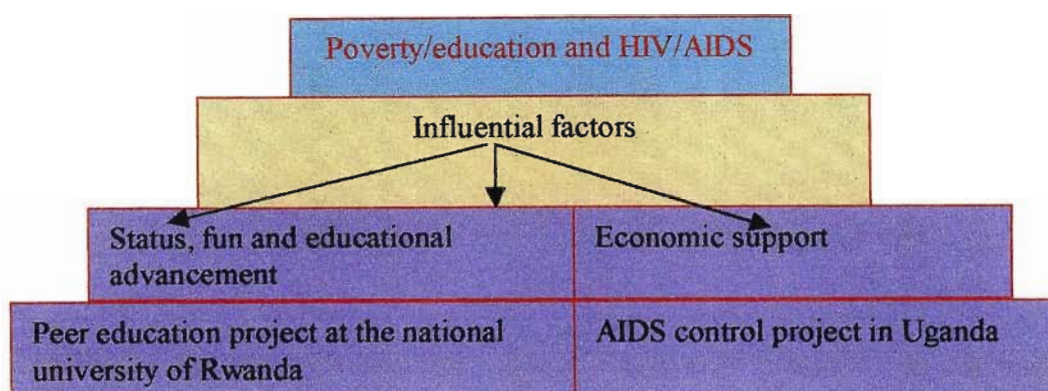
Figure 2.9: Proposed influential factors in relation to poverty/education and HIV/AIDS and examples of interventions

Figure 2.9 shows that status, economic support, fun and educational advancement (the need to progress academically), could be identified as sub-components of poverty and education influencing sexual practices and attitudes in relation to HIV/AIDS. Looking at status, fun and educational advancement, a body known as Support and Promote Health Organisation (SUPHO) identified a specific issue: the fact that students at the National University of Rwanda did not have mechanisms in place for social change, even though they knew about AIDS and how it was spread. They therefore designed a peer education/participatory programme to address that specific need. The programme, via participation, successfully dealt with delaying and negotiating sex (Muhereza *et al.*, 2000). For economic support, The AIDS Support Organisation (TASO) designed an AIDS control programme in Uganda, which aimed at promoting income-generating efforts (Magezi 1991).

Summarily, status, fun, educational advancement and economic support are some of the key factors (with respect to poverty/education and HIV/AIDS), identified in this section of the study to have an influence on high-risk behaviours within specified communities (and not communities in general). These needing participatory interventions such as those given above to specifically address them within the specified communities.

iii) Crime and HIV/AIDS

Looking at crime and HIV/AIDS, rape was seen to be dominant. Children, teenagers, adults and the old are reportedly being raped in sub-Saharan Africa, with some rapists doing so

under the guise that they will be cured of HIV/AIDS should they have sex with virgins ((afrol News 2003; PhRMA 2003; Health Action AIDS 2003). Leclerc-Madlala (1999) recounted the story of seven-year-old Sibongile and her 62-year-old neighbour. Sibongile, in good faith, admitted her 62-year-old neighbour, 'baba', when he came to her home. She knew 'baba' and used to play with his grandchildren. She sat on a table in her one-room house drawing figures, when 'baba' called her to the wobbly single bed she shared with her mother and informed her he was going to show her his 'toy'. Unfortunately, Sibongile (a grade 2 pupil) was raped before she could even react. She was then told by 'baba' not to tell anyone of 'their game'. When her mother returned from work, Sibongile complained of being 'sore'. The mother took her to the doctor where, in tears, she recounted what had happened to her. From the onset, 'baba' refused the allegation, but later confessed to the mother of Sibogile that he was HIV positive and wanted to 'cleanse' himself through having sex with a virgin.

In a study of responses of Zulu youth to the AIDS epidemic, Leclerc-Madlala (1999) found out that children are raped due to the assumption that sex with children is safer, as the children are likely to be virgins. She reported the case of a 23-year-old male who explained to her "everybody over 12 years old in the township might already have the virus. So your chances of not getting it are better if you go for the six- or eight-year-olds. Not 10-year-olds - some are already pretty experienced by that time." According to a report delivered by Govender (1999), a South African court prosecutor, Ayesha Bissessar, said that within a month they deal with about 50 to 80 rape cases. Most of the alleged rapists attest that sex with virgins helps in curing AIDS. Others said "they wanted to avoid contracting AIDS and felt safer having sex with young children" (Health Action AIDS 2003).

> While it is fairly well understood that prostitution and trafficking are significant contributors to the growth of the AIDS pandemic, it is less well understood that the AIDS pandemic is apparently a factor in the crime of sex trafficking, particularly the traffic in young girls. Men seek ever-younger partners or virgins to avoid becoming infected themselves, or in the mistaken belief that having sex with a virgin will cure a person of AIDS. In South Africa, these factors very likely have contributed to a dramatic rise in child rape (Health Action AIDS 2003:3).

They are other reported sex practices in South Africa, which include teenage boys having sex with goats for fear of being infected by teenage girls whom they consider already infected. An example was reported in Limpopo province (Mail & Guardian Online 2002). The teenage girls in this province reacted to the teenage boys having sex with goats by vowing not to get married to them. The people of this community became scared of eating goats, thus causing the owners to destroy their goats as no one wanted to buy or eat them. This decreased income and, consequently, increased poverty, together with the ills that went with it, could be seen as one of the consequences of such acts.

Whilst still on the subject of crime and HIV/AIDS, an infected person, out of an act of revenge or wickedness, can decide to deliberately infect others by wilfully practising unprotected sex and offering higher pay rates for it. Some people, stated CDS (2003), want to take revenge when they discover that they are HIV/AIDS positive. From personal observation this is quite common in Cameroon, where there is currently a popular slogan 'I no go die alone' (I will not die alone). According to the HIV/AIDS sufferers, somebody infected them (either knowingly or unknowingly) and, because of this, they want to do likewise.

An atmosphere of war often breeds criminal activities. These activities may promote high-risk behaviours in relation to HIV/AIDS. The war in Sierra Leone projects a vivid image of this allegation. Dr Andrew Kosia (1999), manager of the *National AIDS Control Programme,* made the following pronouncement:

> I believe the eight-year long civil war is mainly responsible for the upsurge in HIV/AIDS, and just among the military combatants alone, we are talking of 40 percent being infected...before the outbreak of the war in 1991, the figure was 0.5 percent. It has now increased to 7 percent. This means that from less than 500 victims in 1991, we now have more than 50,000.

During the war, cases of gang rape, intravenous drugs and homosexuality were frequently reported in the media. Medical and other care-giving activities were suspended during the war. Kosia (1999) stated, "The January invasion of the capital by rebels put on hold community-based counselling, free distribution of condoms and school and college-based awareness programmes". Figure 2.10 gives a summary of the different factors surrounding

crime and HIV/AIDS and examples of interventions that dealt specifically with the different factors, thus working with the target.
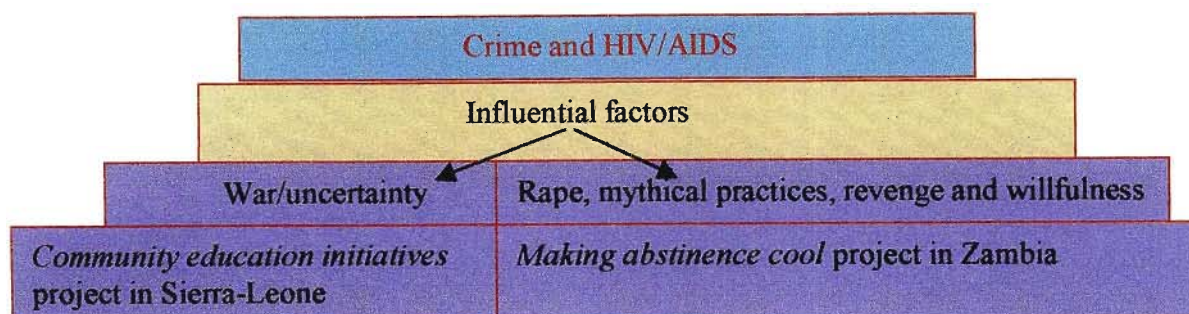
Figure 2.10: Proposed influential factors in relation to crime and HIV/AIDS and examples of interventions

Due to the war in Sierra-Leone that disrupted the educational system, leaving many hungry and uneducated and thus vulnerable to high-risk sex practices, the Ministry of Education, funded by USAID Food For Peace, successfully targeted the specific problem of poor education and hunger. This was done by the initiation of the project Community Education Initiatives, which aimed at communicating and/or maintaining quality formal and informal educational institutions and promoting, via food incentives, attendance at non-formal, primary education and vocational training (School Health 1999). Then school attendance meant lower HIV risk. The project *making abstinence cool*, reported in Global Health Council (2003), used a participatory approach, to successfully generate self-pride (in an attempt to control sex-drives), among the youths in Zambia by letting the youths explore the advantages or pride of abstaining from pre-marital sex.

The different scenarios of crime (war, rape, mythical practices and revenge) were seen to definitely impact on HIV/AIDS. The degree and nature of the impact also differs according to the groups, communities and individuals, as seen in the reasons for the rape of virgins in some communities with the thought of being cured of HIV/AIDS. Communication-based interventions like the ones cited above, will have to take into consideration aspects such as community participation in order to specifically locate and seek solutions to the spread of HIV/AIDS.

2.9 Comprehensive theory for this study

Putting together the factors (pre-existing, situational and sub-factors) influencing the spread of HIV/AIDS and the different ways in which HIV/AIDS projects/interventions dealt with them, one could develop broadly the following comprehensive theory for this study.

Reality   **Factors**

| Reflecting on unique perspectives of targeted communities | Participation | -Effective exploration of community needs
-Check pre-existing factors, for example, culture/beliefs, language, religion, gender and age.
-Situational factors, for example, poverty, education and crime |

Projects

Ensuring high audience representation, participation/peer education (songs, drama, group discussions) at different levels and stages of problem and solution finding

Figure 2.11: Comprehensive theory for this study

Figure 2.11 was developed after Bhana (1999: 230) and Campbell (2003)-participatory models (dynamics of power-bases and beneficiary participation), Darrow (1997)-theory of social marketing (social *factors* determining sexual risk), Fishbein (2000)-integrative model (integration of factors/models in effecting social change) and Rembey (1999)-Dickie's HIV theory (investigation of realities).

Looking at Figure 2.11, *reality* represents what is prevalent in a particular community as opposed to other communities: the unique perspective of a community. *Reality* goes hand in hand with *factors* (pre-existing and situational factors) promoting it. For example, poverty may be the prevailing factor in terms of vulnerability to high-risk practices in one community as opposed to people's educational status in another. Due to varied *realities* and *factors* (with respect to different communities) obviously unique solutions as *projects* or interventions are required. These interventions could effectively identify and seek solutions to factors and realities in those communities via creating an enabling environment, for example, audience participation.

Looking at the model represented in Figure 2.11, it is noted that the contributing models are interwoven/complex and so are the issues of *reality*, *factors* and *projects*. The researcher, nonetheless, developed the following guide for effective interventions with respect to social change:

- Realities: Careful assessment of the unique perspectives of targeted communities. Here, the interventionist is trying "to know with others, rather than about them, and to reconceptualise and foster knowledge as something that exists among people, rather than some sort of barrier between them" (Bhana 1999: 230).

- Factors: Incorporating the social factors could either directly or indirectly influence social change (Darrow 1997) and seek ways whereby these factors could be addressed relative to that community. Interventions could either seek ways to accommodate or change the factors. For example, in terms of language as a factor (pre-existing), interventions could accommodate it by speaking the language of the people. Another example relating to poverty (a situational factor), interventionists could mediate in order to change the situation by collectively seeking ways to improve the economic environment of that particular community.

Factors should also be integrated with each other rather than following a reductionist approach in order to effect social change (Fishbein 2000-integrative model). For example, crime or violent acts such as rape of virgins could be perpetuated by beliefs that people could be cured of HIV/AIDS if they have sex with a virgin. The impact of this means that in order to deal with crime (rape) the belief system of the people needs to be addressed.

- Participation: An approach that enables mediation between individual and collective needs and that addresses the tension between the community members and the project implementer. This, to Bhana (1999), is done by trying "to know with others, rather than about them, and to reconceptualise and foster knowledge as something that exists among people, rather than some sort of barrier between them". The implementer in a participatory project is playing the collaborative and supportive role of a facilitator, rather than a detached and dominating one as in traditional processes. Ensuring high audience representation and participation (songs, drama, group discussions, decision making) at different levels and stages of the project leads to more appropriate problem and solution finding.

- Projects, in an attempt to identify and seek solutions to the different realities and factors influencing social change, different methodologies need to be applied. This is partly due to the need to avoid victim blaming (Rembley 1999-Dickie's HIV theory) which may jeopardise a well-intentioned project. It is also partly due to the need to assess the dynamics of power-bases (Campbell 2003). According to Campbell (2003), issues surrounding sexual health are very complex. Some of the complexities, she holds, arise from the dynamics of power-bases (in the search for solutions regarding HIV/AIDS) that are inherent in the visible/invisible structures found within impoverished communities.

On the whole, the impact of the identified factors: culture/beliefs, language, religion, age (pre-existing factors), gender, poverty, education and crime (situational factors) are part of

the comprehensive theory of this study through the integration of participatory methods into the implementation of social change projects (Figure 2.11). All these point to the need for in-depth understanding of the realities of life and more profound social changes to halt the HIV epidemic. They also point to the role of participation in addressing the aspects above (reality, factors and projects).

2.10 Summary

This chapter sought to answer the research question "What major factors influence social change and contribute towards an HIV/AIDS health-enhancing intervention?" In order to answer the question, the chapter focused on examining theories and major influential community/social factors that impact on social change and the spread of HIV/AIDS. The community/social factors were divided into two categories: pre-existing (culture, language, religion, gender and age) and situational factors (poverty, education and crime).

The nature of the impact of the above-identified factors: culture/beliefs, language, religion, gender, age (pre-existing factors), poverty, education and crime (situational factors) were incorporated into the comprehensive theory of this study. They were incorporated into areas dealing with the call for interventions to display an in-depth understanding of them within specific communities (the call for ample exploration of people's needs, as well as a reflection of their unique perspectives-*realities* and *factors*) in order to specifically handle them. They were also incorporated into areas (*projects*) necessitating the call for targeted audiences to be highly represented and encouraged to participate at different levels of problem and solution identification given that appropriate and effective communication was noted to be central to the success of interventions to reduce the risk of HIV infection. On a whole, the need for more profound social changes and in-depth understanding of the realities of life to halt the HIV epidemic was noted. Note was also taken of the role of participation in addressing the aspects of reality, factors and projects.

CHAPTER 3: MAJOR FACTORS INFLUENCING THE EVALUATION OF PROJECTS AND THEIR CONTRIBUTION TOWARDS A VALUABLE EVALUATION OF HIV/AIDS INTERVENTION

3.1 Introduction

Chapter 3 seeks to answer the question " What major factors influence the evaluation of projects and contribute towards a valuable evaluation of HIV/AIDS intervention?" These factors could have implications both for interventions and their evaluations. As pointed out by Nutbeam (1998), a significant attempt is being made to understand the complexity of health promotion activities and the related need for sophisticated measures and evaluation research designs. As Dervin stated,

> No human is capable of making absolute observations, and since it is humans that produce that thing call information, all information is itself constrained. The constraints are many. There is the constraint of the physical limitation of human perceptual equipment. There is the constraint of time-observations made one moment do not apply to the next. There is the constraint of space-observations made in one space do not apply to another. There is the constraint of constant change. (Dervin 1982: 293).

A careful understanding of issues embodying evaluations, particularly those related to the values and ideologies of two key forms of evaluation (traditional and participatory evaluation) could then be considered to be of vital importance.

3.2 Reason for the study

The rationale behind this section of the study is given here, followed by the parameters governing the selection of the key issues embodied in evaluation. The criteria for selection of the key issues were based on the aim of this section of the study. Given, however, the large number of works on participatory evaluation and participatory processes, only those closely linked to this section of the study were included. These included works dealing with group knowledge acquisition, awareness, attitude change, empowerment, effective functioning and sustainability. Other critical works such as those of Bruyn (1998); Cohen (1998); Musendo (2003) that handled developmental, organisational and regional/national

processes involving long term communication and multisectoral strategies (legal services, human rights, land policies and others), were not dealt with because they were outside the ambit of this study.

3.3. Methodology used for this section of the study

A review of primary and secondary literature, with occasional insights from the researcher's personal observations, formed this section of the study. Figure 3.1 gives a breakdown of the methodological framework.
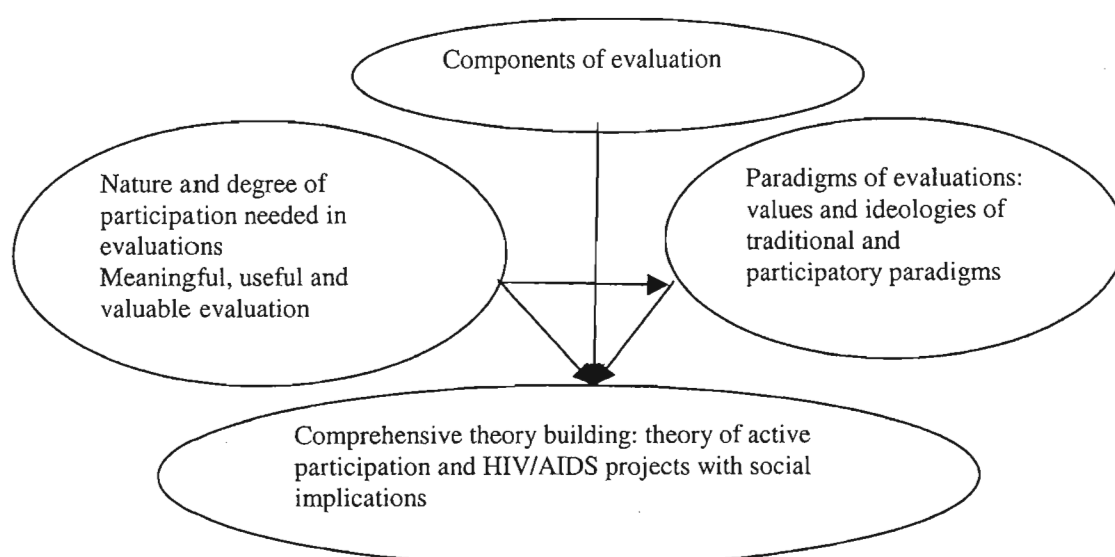
Figure 3.1: Methodological framework

Firstly, the components of evaluation, such as the multiple definitions, organisational structures, needs assessments, policy formulations and programme delivery were identified. The role of participation in the processes of evaluation, assessment of merit of worth, improvement of programmes and generation of knowledge were investigated. Paradigms, such as the positivist traditional paradigm, the interpretive paradigm and the hermeneutic paradigm were examined, alongside their roles in the evaluation of HIV/AIDS interventions. Examples of the different forms of evaluations were provided and linked to develop a basis for further research (see Figure 3.1).

3.4 Composition of evaluation

Patton (1990:11) asserted that human beings are engaged in all types of activities in order to make the world a better place. These efforts include, among others, the development of communities, management of people and resources, changing of organisational structures, needs assessments, policy formulations and programme delivery.

A clear-cut definition of evaluation is hard to come by, considering the complexities that evaluations entail. So much is embedded in evaluation that multiple definitions are required. Also, it is perceived that the era in which one lived or is living shapes the definitions. Rutman, for example, in 1984 stated " programme evaluation entails the use of scientific methods to measure the implementation and outcomes of programs for decision-making purposes" (Rutman 1984: 10). This definition is closely related to that of the 1930s era, where Babbie and Mouton (2001) felt that for programme evaluation to be accepted scientifically, it had to employ objective and systematic research methods and procedures.

Rossi and Freedman (1993:5) considered evaluation research to be " the systematic application of social research procedures for assessing the conceptualisation, design, implementation, and utility of social intervention programmes". The emphasis here is on evaluation being part of social sciences research. This means the utilisation of a number of social science methods in the evaluation of social intervention programmes. Rossi and Freedman's definitions tie in closely with the fifties and sixties eras, when social science methodology reached a reasonable level of sophistication, particularly in its measurement and statistical sampling techniques. All of these definitions stem from the scientific method of research or a traditional evaluation approach.

To sum up, evaluation research comprises an empirical and systematic collection of data and then analysis about the effectiveness of a programme. Evaluation relates to practice and the specific project or programme being evaluated. It is not analogous with research, but does incorporate many of the techniques of research (Anderson 1996: 166). Cohen and Manion (2000:38) elaborated on this, by identifying some of the areas of similarities. They held that research and evaluation both use methodologies and methods of social science

research, which include clarification of the purpose of an investigation. Evaluation also includes the formulation of a research design in relation to operational questions, appropriate methodology, instruments for data collection, a sample population and method of data analysis.

Concerning what makes up HIV/AIDS evaluation,

> It is clear that many sources of evidence have contributed to our grasp of what does and what does not work in HIV/AIDS education. Despite this, there has recently been a distinct move to narrow the evidence of success in this field to experimental and comparative work with randomised controlled trials positioned as the 'gold standard'. (Van de Ven and Aggleton (1999: 473)

The need for financial gain is gradually creeping into almost every sphere of life, including research and evaluation. Many research areas are now being identified by sponsors for fund allocation, which is likely to tilt the attention of the researcher and evaluator, more towards donor satisfaction and less towards the satisfaction of the participants. Rubin (1995: 20) supports this and said that evaluation could " be a highly-charged process politically, because of the relations of power and control that exist between *funder* and funded, between implementing agency and target population". He cited instances where evaluation had been linked to extension of funding decisions. In such circumstances, he felt that evaluation had tended to be more of a one-sided interrogation by *funders*.

MacDonald (1987) stated that an evaluator:

> Is faced with competing interest groups, with divergent definitions of the situation and conflicting informational needs...he has to decide which decision-makers he will serve, what information will be of most use, when it is needed and how it can be obtained.... No such commitment is required of the researcher. He stands outside the political process, and values his detachment from it. For him, the production of new knowledge and its social use are separated. The evaluator is embroiled in the action, built into a political process, which concerns the distribution of power, i.e. the allocation of resources and the determination of goals. The researcher is free to select his questions, and to seek answers for them. (MacDonald 1987:42)

Parker *et al.* (1998: 78) considered the difference between evaluations and research a matter of focus. The former helps to establish the value of a strategy and the latter the process of finding things out. In terms of HIV/AIDS evaluation, the value of, for example, an

implementation strategy could be assessed in the light of the worth of that strategy in bringing about the successful achievement of the goals or objectives of a project. With regard to HIV/AIDS interventions, and as highlighted in the introductory chapter of this study, such interventions could be argued to be a learning process, with evaluation being an organic part of that process, whereby objectives are continually negotiated (Marsden and Oakley 1990:4).

The continual negotiation of objectives refers to the fact that, all things being equal, the establishment of the value or worth of a strategy is not attributable to the implementation strategy only, but also to the evaluation strategy. An example could be the establishment of the value or worth of a methodology in the meeting of the objectives of a gender-related intervention: an intervention that aimed at empowering men, in a particularly patriarchal-dominated community, to act responsibly with respect to sexual practices. In establishing such a value, the question likely to be asked, based on the views of Marsden and Oakley (1990:4), would be not only about the contribution of the implementation methodology but also about the evaluation methodology. Also to be asked is how the evaluation methodology helped in negotiating or creating an enabling environment for the empowerment of the men of that patriarchal community.

Other researchers, such as Huizer (1983), Kronenburg (1986) and Potter (1999), have disapproved of the one-sided or top-down approach (noted not only amongst funders but also amongst evaluators of HIV/AIDS projects). Their disapproval is on the grounds of the narrow focus (outsider as apposed to insider perspective) of such an approach and of what it invariably propagates: that the generation of knowledge is the sole prerogative of an expert, thus the perceived need for a deeper understanding of what works and what does not work with respect to HIV/AIDS evaluations, particularly in situations where change is viewed in the light of social transformation.

3.5 Why are programmes evaluated?

A number of researchers, for example Patton (1997) and Rubin (1995), have given reasons for the evaluation of programmes. Table 3.1 gives a summary of the reasons and some references to HIV/AIDS evaluations.

Table 3.1: Three primary uses/purposes of evaluation studies*

Uses or purposes	Examples	Reference of such HIV/AIDS evaluation studies
Assessment of merit of worth	Summative evaluation Accountability Audits Quality control Cost-benefit decisions Deciding a programme's future Accreditation/licencing	Evaluation of the HIV/AIDS prevention project (aimed at preventing infection and pregnancy) among adolescents in rural KwaZulu-Natal. Using the *Stepping Stones* approach: Randomised controlled trial of 18 schools linked to six clinics (Harrison *et al.* 2000)
Improve programmes	Formative evaluation Identify strengths, problematic areas and their roots Quality enhancement Managing more effectively Adopting a model locally	Assessment of change in condom use and number of sex partners: whether people are changing, the reason for the change and the extent of it. Using epidemiological surveys, open in-depth interviews, semi-structured interviews, informal conversation and participant observations involving 196 respondents (within a three-year period) in rural SW Uganda (Poo and Kabunga 2000)
Generate knowledge	Acquisition of appropriate information about particular approaches (extrapolating principles about what works) Building new theories and models Informing policy Generalisations about effectiveness	Exploration of the use of participatory methods to help Ugandan communities fight HIV/AIDS, Using the Rakai AIDS Information Network (RAIN) that provides integrated HIV/AIDS prevention programmes within a community-based healthcare setup. Sampling exercises, carrying out interviews, community action plans and follow-up assessment were carried out (Coghlan 1995)

*After Patton (1997) and Rubin (1995)

Concerning HIV/AIDS evaluations, Patton (1997) summarised (Table 3.1) the general purposes of evaluation to be to build judgments of merit, to improve programmes and to generate knowledge. To build judgments of merits, questions relating to whether the programme achieves its goals and objectives and whether the programme is a success are central. Success in implementing a programme and the degree of its reception by all concerned is also central. To improve programmes, data are collected within a given time frame at the beginning of and/or within the implementation stage. Regular advice is provided to everybody concerned, for example programme managers, concerning the

strengths and challenges of the programme. The results are intended to serve as feedback and, consequently, a source of improvement.

In terms of knowledge-generation, Babbie and Mouton (2001) claimed that an evaluation similar to HIV/AIDS evaluation (see the reference in Table 3.1) could be carried out specifically to improve people's understanding of how programmes work. It could also be carried out to determine how people change their attitudes and behaviours as a result of the success of interventions. The driving force in this case is the generation of new knowledge, which includes the enlightenment of funders and stakeholders and the clarification of underlying theories. In this light, knowledge-oriented evaluations are seen to differ from judgment and improvement-oriented evaluations, which are concerned with use and application. Their end products require some decisions or actions, such as the cessation of funding or the fine-tuning of the programme.

In-as-much as there are several reasons for carrying out an evaluation (HIV/AIDS evaluation inclusive), it was stated that care should be taken not to confuse issues. An investigation of a culprit in the case of theft was seen to tie more with criminal investigations than evaluation. Resolving conflicts within a project or an organisation calls for a facilitator to deal with it, rather than an evaluator (Rubin 1995: 26). To get rid of a staff member, Rubin recommended a management review in order to avoid expensive and disruptive evaluation.

If evaluation is properly used, Rubin (1995) held that it could provide key information that when applied could encourage vital changes, even though it cannot provide answers to every problem and cannot be used as an alternative for good management.

3.6 Paradigms in evaluation

Evaluation involves varied models and traditions that are similar to all social science research. Mertens and Carael (1997) pointed out that evaluation involves multiple methods, audiences, funding sources, perspectives, paradigms and solutions to problems. To some people, evaluation calls for complex experimental-type studies and to others it means

pausing at the end of an activity to sort out what went well and what went badly. Due to the impossibility in exhausting the various paradigms, only those that were considered most relevant to this study (see section 3.2 for criteria for selection) were examined. These included: the traditional paradigm (positive and interpretive), the hermeneutic paradigm and the participatory paradigm, using the example of Participatory Action Research (PAR).

The traditional paradigm is based on the view that social science is virtually the same as natural science and is therefore concerned with the discovery of natural and universal laws that regulate and determine individual and social behaviour. The radical view of the traditional paradigm shares the rigour of natural science and traditional social science to describe and explain human behaviour, but stresses that people differ from inanimate natural phenomena and from each other (Cohen and Manion 1989). On the other hand, the hermeneutic theory makes it clear that mediation between different life forms is attainable. Participatory theory projects, the epistemological assumption that knowledge is constructed socially, therefore approaches that allow for social, group, or collective analysis of life experiences of power and knowledge, are most appropriate (Hall 1997).

3.6.1 The positivist, traditional paradigm

Experimental and quasi-experimental evaluation researches are rooted in the positivist traditional paradigm. Experimental evaluation shares, with evaluation research, the concern of group comparisons. Through it, knowledge, attitude, concept acquisition and aptitudes are evaluated. The limitation noted here is that it is not easy to arrange lives of people such that they conform to the essentials of an experimental design (Anderson 1996: 168). Quasi-experimental evaluation shares the concern that individuals are not randomly assigned to programmes, as is the case with the former, but often self-selected. Quasi-experimental evaluation is used to assess what different types of individuals learned in different circumstances. In this, generalisations can be made. As a limitation, the risk of mixed or irrelevant findings is high, considering the varied nature of individuals and circumstances.

Scientific paradigms as a whole (embedded in the positivist traditional paradigm) have a warrant to the deception that results are the final truth (Guba and Lincoln 1989), whilst science is a political act, open to manipulation, as controls for validity and reliability are

often not that effective. A quantitative researcher, for example, collects facts and studies their relationships. He/she uses techniques that are likely to produce quantified and, where necessary, generalisable conclusions. Examples of such techniques are questionnaires and the use of close-ended questions.

In relation to HIV/AIDS data collection for the assessment of behaviour change among truck-drivers, some of the close-ended questions could be:

- Tick the appropriate range regarding an estimation of the number of sex workers you visited per trip *before* the initiation of this prevention project 1-2, 3-4, 5-6.
- Tick the appropriate range regarding an estimation of the number of sex workers you visited per trip *after* the initiation of this prevention project 1-2, 3-4, 5-6.

The quantification of social behaviour, as seen from the questions asked has been a subject of much debate. According to Taylor (1971), a critique of positivistic science is that it regards meaning as hidden: a view which underestimates the importance of social dealings as "there is no such thing as the structure of meanings for him [man] independent of his interpretation of them" (Taylor 1971: 16). This is because it is not only important to know whether people are changing their behaviours, but also the rationale for the change (Poo and Kabunga 2000). An advantage, however, is that "measurement allows us to differentiate between objects on the basis of their relative standing on shared attributes" (Durheim 1999). To measure, for example, level of participation in a programme, one can have a rating scale of low, medium and high. Quantitative evaluation also facilitates comparison and statistical aggregation of data and makes it possible for the reactions of many people to be measured with a limited set of questions.

When dealing with interventions such as HIV/AIDS communication-based interventions, Marsden and Oakley (1990) emphasised that new methods and techniques need to be devised, as one is dealing with strategies that are different from those that uphold production. One is also dealing with changing scientific and social environments, where the old orthodoxies linked to Northern liberal scientific ideologies of economic growth and backed by objectivity no longer holds.

3.6.2 The interpretive, traditional paradigm

Naturalistic or qualitative evaluation research is embedded in this paradigm. Qualitative evaluation is seen by a number of evaluation theorists as an answer to dominant experimental evaluation. A number of alternative approaches to traditional methods of evaluation have been advanced. Although the approaches can make use of some of the tools used in traditional evaluations, they aim basically at making them more appropriate to measuring social changes/development (Rubin 1995: 22). Unlike experimental evaluation that focuses on comparisons, qualitative evaluation focuses on the acquisition of an in-depth understanding of a programme and its planned and unplanned effects. It helps to unmask the hidden mysteries surrounding the empirical, social world.

Qualitative evaluation has the advantage of permitting the combination of the strengths of quantitative and qualitative methods. It shares much in common with a case-study methodology. A case study is seen as an umbrella word for a family of research methods having in common the decision to focus on inquiry around an occurrence (Adelman *et al.,* 1976). Techniques used in qualitative research are mostly interviews, observations, role-plays and group discussions. Open-ended questions are commonly used, for example, with respect to HIV/AIDS and high-risk behaviours among African men, questions such as "why do you think African men hate using condoms during sexual intercourse?" The advantage of such a qualitative evaluation is that it could permit more detailed and in-depth studies of situations to be carried out: this due to the absence of predetermined categories. As a whole, taking HIV/AIDS qualitative evaluations as a point of contact, Belot (2003) explained:

> Qualitative methods help the HIV/AIDS evaluator understand participants' experience in greater depth than typical paper-and-pencil tests. The qualitative prevention programme evaluator usually wants to know about the meaning participants place on their experience in the programme The qualitative evaluator uses words, observations, pictures, photos, or behaviours, rather than numbers, to reflect participants' experiences. Participants' perceptions are important because their perceived reality is reality for them. A qualitative evaluator attempts to capture these perceptions through such methods as in-depth interviews, case studies, focus group discussion, or other participatory activities in order to understand the impact of the programme. At their worst, both quantitative and qualitative evaluation can be trivial, tedious, and boring (Belot 2003:1).

A critique of this paradigm is that it concentrates on in-depth analysis of a few cases, rather than on a broader survey of types of perspectives, thus not necessarily generalisable to a wider group.

3.6.3 The hermeneutic paradigm

Hermeneutics have over time, been expanded to accommodate other philosophical viewpoints, viewpoints that, for example, regard understanding and interpretation to be endemic to, and definitive of, human existence and social life (Odman and Kerdeman 1997:185). Hermeneutics is a theory that enables the study of people in a social context, a system of interpretation "used by people to reach the meaning behind myths, symbols, and actions" (Palmer 1969). Guba and Lincoln (1989), in their description of fourth generation evaluation, saw evaluations of like manner to be operating within socio-cultural/political factors, within a joint collaborative, teaching and learning process and within a process that creates reality. Hermeneutics, however, is different from other traditions of thought, even though, like other philosophies, it lays emphasis on the understanding and interpretation of social life. According to Odman and Kerdeman (1997), the uniqueness of hermeneutics is highlighted in the following areas:

i) Critical theory

Critical theory and hermeneutics consider understanding and meaning to constitute social life. Critical theory focuses on situating understanding within a wider universal explanatory framework, this, in order to make transparent the different ways in which ideologies inform and condition understanding, interest and relationships that make up social life. Hermeneutics promote the grounding of understanding in a theoretical framework and focuses on interpreting cultures within given situations and contexts. An example could be the understanding and interpretation of rape within a behavioural theoretical framework that is linked to the spread of HIV/AIDS, taking into consideration particular communities or contexts.

ii) Wittgenstein's later theory

The later philosophy of Wittgenstein (1988-1951) and that of hermeneutics have commonality in terms of meaning residing in conventions and practices of ordinary social

life (meaning is not rigidly determined by rules of ideal grammar; but is negotiable and is practicable). Wittgenstein, nonetheless, believes that no structure is common to all 'language games', where philosophical analysts can unfold to reconcile the different life forms. On the contrary, hermeneutics claim that mediation between different life forms is possible. In addition, it looks at language to be the mode by which being is revealed (Odman and Kerdeman 1997: 186). Hermeneutics aims at achieving mutual understanding of other cultures, individuals and groups, conditions and lifestyles. An example could be the understanding of the concept of HIV/AIDS death as perceived by different groups of individuals.

From the literature, it was, however, noted that not all researchers, particularly of old, agreed with the standpoint of hermeneutics, as advanced by Taylor (1971). Researchers such as Rorty (1979) and Gadamer (1975) felt that there was no fundamental difference between hermeneutics and science, given that all knowledge is interpretive. More modern thinking has, however, expanded the hermeneutic paradigm to emerge as a participatory paradigm.

3.6.4 Participatory paradigm

Participatory paradigm shares much with Participatory Action Research (PAR) particularly in providing opportunities for people develop themselves. It is associated with third world evaluation projects. Brunner and Guzman (1989) commented:

> During the last two decades, evaluation of non-formal educational development projects in the Third World has come under attack for its insensitivity to their true achievements and real problems. Local project directors, facilitators and beneficiaries have felt victimised by evaluators who were sent out by sponsoring agencies to assess either the viability of proposed projects or the results of ongoing ones. Typically these evaluators focused on cost-benefit or cost efficiency analysis, compared goals and objectives with results. They presented the evaluation results in technical reports that were often confidential and not accessible to the people who had been questioned and observed. In short, these evaluations reflected the world-view and priorities of the sponsoring agencies and denied any meaningful input from the main actors in the development projects (1989:9).

Based on the above comment of Brunner and Guzman (1989), Potter (1999) pointed out that criticisms started advancing during the 1960s and 1970s of the objective and measurement-based forms of evaluation. The criticisms by Potter (1999), stemmed from the fact that such forms of evaluation implied the conducting of an evaluation from an outsider to an insider perspective. In response to the criticisms of the 'imperialistic' approach to evaluation, alternatives were sought that would lead to the development of participatory evaluation.

According to Babbie and Mouton (2001: 358), three key principles govern participatory forms of evaluations. These are:

- The role of an evaluator being that of a methodological consultant and facilitator in the evaluation process. The participants and the evaluator jointly decide when the evaluation should take place, what should be evaluated, how, and what should be done with the final results. The evaluator is seen as a change agent responsible for building relationships with the participants on the basis of shared trust. Just like the participant, he/she is a learner and a non-imperialistic teacher. He/she actively participates in the evaluation, while at the same time helping in initiating necessary discussions for the sharing of ideas.

- Participatory evaluation should be seen as an educational process through which social groups come up with knowledge about their realities. This knowledge is action-oriented.

- Participatory evaluation is a learning process. Other members of the evaluation team may have to be coached in the beginning by facilitators and professional evaluators, but as the project grows the local evaluation team becomes increasingly knowledgeable, proficient and autonomous.

PAR shares most of the qualities of participatory evaluation and therefore is used as an appreciable example to make vivid the values of participatory evaluation. Participatory evaluation (similar to PAR), lays emphasis on rigour and relevance (Rapaport 1970). PAR is an approach, which is embedded, in the practical concerns of people in immediate problematic situations and to the larger goals of social science. According to Hoshmand and Obryrne (1996), PAR researchers argue that reliable knowledge of the human and social world can only be achieved in the process of attempting to change that world, and that genuine change can only occur when it is accompanied by shifts in the knowledge base of those concerned.

Bhana (1999:230) considered PAR to be an approach that enables mediation between individual and collective needs and that addresses the tension between the researcher and the researched. PAR achieves this by trying "to know with others, rather than about them, and to reconceptualise and foster knowledge as something that exists among people, rather than as some sort of barrier between them". He held that, while a traditional researcher would frame a question from a management point of view ("How can productivity be increased by eliminating time-wasting on the shop floor"), the PAR researcher would frame it in collaboration with workers ("How can we make our work more meaningful so that we don't feel we're wasting our time on the shop floor?"). The evaluator in this case is playing a collaborative and supportive role, rather than a detached and dominating one; this in order to give the people concerned the opportunity to develop themselves, a situation propagated by Nyerere (1973: 60) to be reflective of true development as, "people cannot be developed; they can only develop themselves" by full participation and as equals.

In PAR, full involvement of the participants (members of the community under examination and/or those to be affected by the intended changes) is encouraged in every aspect of a project. This gives participatory evaluation an advantage in that a variety of perspectives, including those from the benefactors of the project, are likely to be examined. It provides the concerned with an opportunity to examine their own operation, understand what is going on, identify the problems and their roots and help to provide a way forward. This notwithstanding, much time may be taken for organisational purposes.

Table 3.2 makes vivid the projection of the values and ideologies of traditional and participatory evaluation, taking PAR research as a case in point.

Judging from Table 3.2, PAR places more emphasis on collaborative relationship between the researcher and the researched and on community change. PAR, in this regard, aims to go beyond resolving singular problems such as prostitution, to transforming structures and the lives of all involved. A successful project empowers people. As put by Freire (1970), people become powerless when they play the role of an object that is acted upon, rather than a subject that is acting in and on the world. Bhana (1999:235) gave an example of powerlessness by citing the case of a community activist who said that it would never have occurred to her to express an opinion on anything. To her, it was inconceivable that her opinion had any value. Empowerment, therefore, is seen, not just as a way to better grasp a problem and the solution to it, but that, which raises awareness in people of their abilities and assets to muster for social action. This differs to some degree from traditional research, where more value is placed on individuals, but neglecting, as shown in Table 3.2, to promote the sense of balance between self-determination and distributive justice (justice that could be perceived to be inclusive, giving voice even to the marginalised or project beneficiaries in an intervention). Should, however, PAR researchers see themselves as rescuers of communities, then they would be invariably engaging themselves in the patronising method of evaluation that they seek to redress.

Table 3.2: Values and ideologies in traditional and participatory evaluations*

	Traditional approaches	Participatory approaches
Motive	People need to be helped -charity	People are able to help themselves – Empowerment
Assumptions	Based on scientific or interpretive assumptions about knowledge. Good life and good society are based on value-free liberalism, individualism and meritocracy -People are helpless and lack the ability and resources to develop themselves	Promotes grounded knowledge through collaborative relationships, which emphasise mutuality, obligations and the removal of oppression. -People have the ability to develop themselves and these can be mobilised
Attitude: To problems To participation	 Problem-solving Means to achieve needs	 Problem-posing A continues and endless process
Benefits	Preserves values of individuality and freedom.	Promotes sense of community and emancipation of every member of society.
Objectives of researchers	Implementation of project objectives	Striving for a common vision and an understanding of self-development
Values	Promotes self-determination of individuals, but neglects distributive justice. Helps individuals, not communities.	Promotes balance between self-determination and distributive justice. High degree of concern for well being of individuals and communities.
Relationship	Teacher-student-paternalistic Know-all versus know nothing	Everybody is teacher-student; at the same time and has something of interest to share: empathetic
Practices	Problems defined in asocial and deficit-oriented terms. Interactions are reactive.	Problems defined in terms of interpersonal and social oppression. Interventions seek to change individuals as well as social systems.
Risks	Victim-blaming and tacit support for unjust social structures. Solutions may have little relation to real-world experience.	Denial of individuality and sacrifice of personal uniqueness for good of the community. Solutions may not generalise beyond immediate contexts.
Actors: Change agents People seen as	 Policy-makers or researchers Targets, objects	 People themselves Subjects, actors
Policy/planning: Design criteria Approach to work Communication	 Productivity and economic growth Executing tasks Monologue, consultation, top-down	 Needs and criteria for well-being formulated by people themselves Listening to people and facilitating Dialogue, bottom-up
Planning format	Blueprint, project approach	Open-ended, process approach
Change seen as	Progress	Transformation
Effect of absence of leader	Project activities slow down	Development process continues
Type of solution	Symptom curing Evolutionary change	Aimed at eliminating root causes Structural change

*After Bhana (1999:229) and Servaes (1989:76)

With respect to HIV/AIDS empowerment evaluations (similar to those of PAR), Bourdon (1999) states:

Variations of empowerment evaluation have been extremely successful in measuring outcomes within public health programs, especially those that focus on HIV and...prevention, because these programs rely so much on rich qualitative findings about changes in participant behavior and attitude. The empowerment evaluation approach is key with these programs, because it reflects the true needs of a given community, thereby allowing them to establish sensitive goals and identify the steps and resources necessary to meet them. Traditional evaluations, in which evaluators are perceived as outsiders who may not be sensitive to the given goals of the program, are often too external and objective to capture a rich enough set of data. Rather, empowerment evaluation shifts the focus from external to an internal, community-based focus inherent in the program participants themselves (Bourdon 1999:1).

Thus, with HIV/AIDS interventions (interventions with social implications), one would expect a situation where every player in the evaluation process is a teacher-student having something of importance to share (see Table 3.2).

3.7 Taking the case of PAR, what nature and degree of participation is needed in an evaluation?

Participation can generally be referred to as a situation where assorted participants collectively work on a common problem or problems. In a more specific sense, participation, according to Babbie and Mouton (2001), implies "members of the subject of study are integrated in the research by participating fully and actively in the research process, from its outset and throughout most, or all, of its phases". The nature of the participation, therefore, must be authentic, in that it is " rooted in cultural traditions of common people ...resplendent with feelings and attitudes of an altruistic, co-operative and communal nature and which are genuinely democratic" (Fals-Borda and Rahman 1991: 5).

Even though participation in all the phases of an evaluation is seen to be critical, many intervening factors could hinder this reality due, for example, to the uniqueness of each

situation. In some situations, the issue of complete member attendance at meetings (for various reasons including tied schedules) could prevent full participation and, in others, it could be financial constraints. The nature and degree of participation needed for meaningful, useful and valuable evaluations, including those of HIV/AIDS interventions,

are thus perceived to be a dream that could rarely be realised. Borrowing, nonetheless, from PAR, there is always the possibility of improving on participation even when circumstances prove otherwise. Should there be the possibility of improving on participation, then the question of what makes for a meaningful, useful and valuable evaluation of interventions, with social implications, could be worth considering.

3.8 What is a meaningful, useful and valuable project evaluation?

The way one perceives an evaluation can be argued to determine its meaning, usefulness and value. Is it about the dignity of people, selecting issues that best describe a programme, or about finances? A practical evaluation is perceived to be do-able when the design is feasible and can be implemented within the time, financial and political constraints of a particular situation. Applicable is when the findings can be used appropriately and relevantly applied by information-users and decision-makers (Patton 1982: 296). In an *Evaluation Standards Committee* deliberations, Patton (1982) made mention of the opinion of Stufflebeam (1982):

> An evaluation should not be done at all if there is no prospect for it being useful to some audience. Second, it should not be done if it is not feasible to conduct it in political terms, or practical terms, or cost-effectiveness terms. Third, they do not think it should be done if we cannot demonstrate that it will be conducted fairly and ethically. Finally, if we can demonstrate that an evaluation will have utility, will be feasible and will be proper in its conduct, then ...we could turn to the difficult matters of technical adequacy of the evaluation (Stufflebeam in Patton 1982: 297).

From the above quote, issues such as utility and feasibility are reasoned to be paramount in evaluations. Technical quality follows less importantly. A successful evaluation or an evaluation that is meaningful, useful and valuable can be said to be that which is derived from a combination of factors (i.e. people, needs, constraints, politics and values), in particular situations. The meaningfulness, usefulness and value an evaluation is, to a great degree, considered relative. What may be meaningful, useful or valuable to an evaluator or a beneficiary may not necessarily be meaningful, useful or valuable to a donor, thus making the evaluation more complex.

When meaningfulness, usefulness and value are, however, examined alongside the different perspectives of those involved (i.e. beneficiaries, evaluators and donors), a more vivid picture can be projected. This is due to the fact that meaningfulness, usefulness and value can then be deduced through the recognition that different groups of participants have different perceptions that are important. Thus the need for negotiation during the evaluation process (in order to reach a consensus) becomes critical. Synchronising the different perspectives (which is one of the aims of hermeneutics) is seen to be a difficult task, yet

> When the recipient is required to participate in forming the message, even if it is only to fill in implicit premises, the chances of perceiving the message as important and the chances of remembering it would seem to be greatly improved (Knapp *et al.,* 1981:32).

Seen in the above quotation, beneficiaries are perceived to be the focal point where, through an ongoing evaluation, effective synchronisation of ideas and differences can take place, this especially where beneficiaries are considered to be the members of the community under examination and/or those to be affected by the intended changes. In summary, from a review of the literature, a meaningful, useful and valuable project evaluation (including HIV/AIDS projects) could be perceived to have the following indicators:
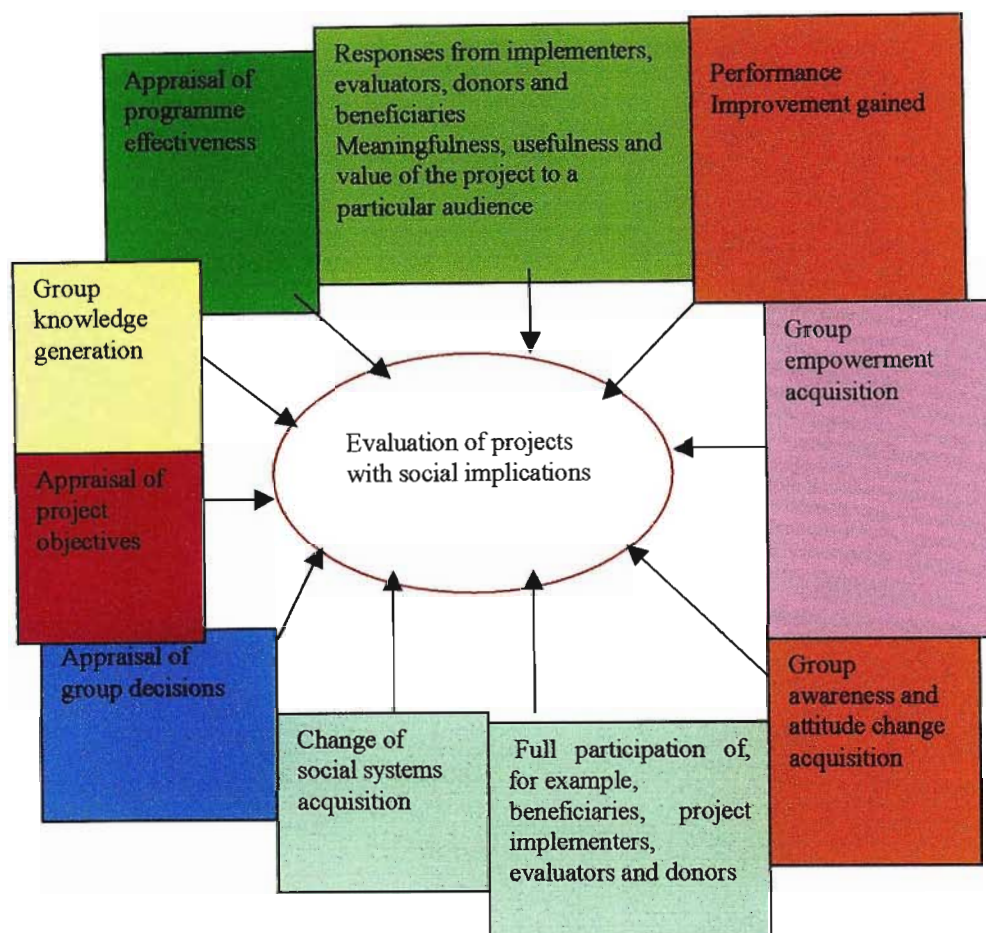
Figure 3.2: Identified indicators in the evaluation of projects developed from the literature

The different indicators shown in the boxes in Figure 3.2 are all observed to be important in their own right and they add up to meaningful, useful and valuable components in the evaluation of communication-based projects. This observation is reiterated in a citation from Evalnet (2000):

We promote the idea that the best results from an evaluation can often be obtained not from an outcomes-based evaluation (as is normally required by funding agencies), but from an early or mid-term evaluation of programme implementation activities, institutional processes and management systems. We also believe that evaluation, especially in developing countries, should be empowering to all participants. It should build their confidence in their own abilities. It should encourage them to reflect and find ways through which to improve their performance continuously. In a development context this will greatly enhance sustainability after donors or government withdraw their support. This is, in fact, what we mean by 'evaluation for sustainable development' (Evalnet 2000:1)

AfrEA (2002:1) developed a checklist that could be of importance in ensuring meaningful, useful and valuable evaluation of communication-based projects, particularly within the African context (for which it was designed). In addition to the importance of an ongoing evaluation and it being an integral part of an intervention, the checklist, known to be "The African evaluation guidelines", elaborated on the following:

o Persons and organisations involved in, or affected by, an evaluation (with special attention to beneficiaries at community level) should be identified and included in the evaluation process, so that their needs can be addressed and so that the evaluation findings are utilisable and owned by stakeholders, to the extent that this is useful, feasible and allowed.

o Comments and feedback of intended users on interim findings should be taken into consideration, prior to the production of the final report.

o The evaluation should be planned and conducted with anticipation of the different positions of various interest groups, so that their co-operation may be obtained, and so that possible attempts by any of these groups to curtail evaluation operations, or to bias or misapply the results, can be averted or counteracted to the extent that this is feasible in the given institutional and national situation.

o The evaluation should be efficient and produce information of sufficient value, so that the resources expended can be justified. It should keep within its budget and account for its own expenditures.

o Obligations of the formal parties to an evaluation (what is to be done, how, by whom, when) should be agreed to, through dialogue and in writing, to the extent that this is feasible and appropriate, so that these parties have a common understanding of all the conditions of the agreement and hence are in a position to formally renegotiate it if necessary. Specific attention should be paid to informal and implicit aspects of expectations of all parties to the contract.

o Evaluators should respect human dignity and worth in their interactions with other persons associated with an evaluation, so that participants are not threatened or harmed, or their cultural or religious values compromised.

o Conflict of interest should be dealt with openly and honestly, so that it does not compromise the evaluation processes and results.

o The programme being evaluated should be described clearly and accurately, so that the programme is clearly identified, with attention paid to personal and verbal communications, as well as written records.

o The context in which the programme exists should be examined in enough detail, including political, social, cultural and environmental aspects, so that its likely influences on the programme can be identified and assessed.

o The sources of information used in a programme evaluation should be described in enough detail, so that the adequacy of the information can be assessed, without compromising any necessary anonymity or cultural or individual sensitivities of respondents (AfrEA 2002:1).

All in all, seeing that evaluation similar to interventions with social implications have, in the main, been projected in this section to be concentrating on people within particular communities or setups and not individuals (treated as objects), one thinks that an extension of the assessment of meaningfulness, usefulness and value that focus basically on the perspective of the beneficiaries would be vital. This is due to the fact that it could provide another dimension of the understanding of the three concepts (meaningfulness, usefulness and value).

3.8.1 What is the meaning, use and value of an evaluation to beneficiaries?

There is a great possibility of the world of an evaluator being substantially different from those of the beneficiaries, particularly in situations where the evaluator is an outsider. If a project and its evaluation are geared towards social change, then it is obvious that the

meaning, use, and value of it should be interpreted within the context of those targeted (a characteristic which is deemed crucial in participatory evaluation). In other words, it is essential that the "recognition of essential or core values among the people in each region" is paramount (Fals-Borda and Rahman 1991:8). The beneficiary, just like any other player (project implementer, evaluator or donor), is then seen to be an active participant in constructing her/his understanding of the situation. "Both physicians and patients contribute to the final decision regarding appropriate and efficacious ...treatment" (Felicia 1997: 4345).

Meaningful results can be scientifically and socially derived. For them to be socially derived, it is assumed that beneficiaries need to help in informing and monitoring the project. By so doing, there is the likelihood that their needs are being met in diverse ways, including their cultural aspirations, and that a "sense of immediacy and personal identification" (Maclure and Bassey 1991: 191) with the project is also created.

Active involvement therefore of those "...who are affected by a problem and who are to be the direct beneficiaries of the research [evaluation], is essential for meaningful problem posing and problem solving and for research [evaluation] to be more meaningful to participants" (Babbie and Mouton 2001: 319). These researchers regard freedom from professional control to be essential in ensuring community control of a project. A case in point is an Ethiopian-based HIV/AIDS Participatory Learning and Action (PLA) project and evaluation among young and adult stakeholders. The project implementation and

evaluation was aimed at indicating how a participatory process with youths can help shape national policy (YouthNet 2003). The participatory-led project and assessment involved, among other things, youth-led workshops and in-depth group work, which resulted in the achievement of trust of one another and openness in the discussion of sexual matters. " Now I understand how important it is to take this information seriously and share with others..." said a 20-year-old male participant (YouthNet 2003).

If usefulness of findings is to be seen from the perspective of the beneficiaries, then it can be argued that the evaluator, like the donor, is not to impose or persuade the beneficiary of

is deemed to be useful, except the beneficiary regards it so within his or her own context. This is because beneficiaries are, in economic terms, the 'clients' or 'consumers' of a product and should therefore be given the privilege of choice and decision-making.

One thinks, however, that giving beneficiaries the privilege in choice and decision-making does not imply a neglect of the choices and decision-makings of other players, such as project implementers and donors. It does not imply a neglect of vital concerns, such as time and financial accountability and efficiency, that warrant inclusion in an evaluation. The issue here could be seen in the light of avoidance of persuasion, which can be perceived to be the norm in a 'capitalist' system and rather, a poor approach in the field of evaluation. From experience (including the field of HIV/AIDS) people would rather appreciate, own and make an effort to implement what they have, together with the change agents reasoned to be appropriate for them. Participation is a vital channel through which such reasoning could take place. In such a participatory forum, asymmetrical relationships (top-down) are converted to "symmetrical, horizontal or non-exploitative patterns" (Fals-Borda and Rahman 1991: 25).

Taking the example of PAR, as raised by Babbie and Mouton (2001: 320), research (just like evaluation) is conducted in the collective interest and perception of the beneficiaries. Problems are dealt with within the confines of the beneficiaries; data analysed in relation to their language and values (while not undermining those of the project agents and donors); the internal commitment and ownership of results generated; a critical self-awareness of

their environment promoted by enabling them to carry out social investigation and analysis of their own; and research (evaluation) 'demythologised' (no more considered magical, difficult and an exclusive monopoly of 'experts'). In fact, "the merging of this knowledge and academic knowledge into a common field of knowledge permits the acquisition of a much more accurate picture, as well as a more profound understanding of a situation" (Babbie and Mouton 2001: 320). Moreover, the knowledge or perspective of the beneficiary that is labelled by Elden and Chisholm (1993: 133) as "valid scientific sense-making", is appreciated and integrated in the evaluation process.

3.8.2 Approaches used in prevention interventions and their impact on the evaluation methodologies of HIV/AIDS

A shift of focus on individuals to communities or groups of people is now noticed in interventions with social implications. Approaches to prevention, according to MacPhail and Campbell (1999:160) have evolved from an early emphasis on informed-based HIV-awareness (concentrating on individual levels of awareness), towards more community-based ones that use participatory strategies. This can be partly attributed to the fact that most factors that influence behaviour change go beyond individual barriers. An example is the case of the AmaMpondo women who believe in their traditional method of controls and therefore do not approve of the use of condoms (Mcetywa 2001). The consequences of practising such beliefs are bound to affect not just the individuals concerned, but entire communities as explained below.

HIV, for example, can infect an individual, because he or she did not use a condom when having sex with an infected person. That infected person can, in turn, infect another, in unprotected sex. The illness of individuals can have side effects on households and communities in many ways, such as a drop in the workforce and increase in dependency ratio. These different factors that influence behaviour change also invariably influence evaluation. This is because the very nature of many projects with social implications makes it hard to come up with "intelligent statements about efficiency, effectiveness, viability and impact, unless the specific cultural and socio-political environmental conditions of a particular place are given central attention" (Marsden and Oakley 1990: 8).

Evaluation of projects such as HIV/AIDS projects have, as a whole, been identified by a number of researchers to reflect (via participation) the views of the community or groups of people involved. The people's views may be different from those of the evaluators, but the question is "how far can we go in articulating what should essentially be prerogative of people themselves to articulate?" (Rahman 1990:44). It is to a great extent probable that results are more likely to be used if those concerned participate in the activities of the project, as well as in the evaluation. Rubin (1995:22) supports this view. According to him, "if the people carrying out project activities are more involved in evaluating them, they are much more likely to use the results of that evaluation in present or future work". An

example is that of an Ndwedwe HIV//AIDS project/evaluation that aimed, via focus group discussions, to empower high school youths to live responsibly and to have an impact on the life of their peers. This programme led to the youths gaining, among other things, freedom to open discussion about HIV/AIDS matter and communication skills. All these culminated in the personalisation of the lessons learnt. Evident was the subsequent creation of a youth-led club, from which the youths worked creatively and visited neighbouring schools, where they shared the lessons learnt (June 2002).

In terms of HIV/AIDS evaluation, one can conclude this section by saying that whatever community is affected and whatever activity is risky, the theory of active participation by those affected in identifying risks, finding their own solutions and evaluating them remains basically the same. When more than 10% of the sexually active population is infected, it is noticed that approaches (not only in project implementation but also in evaluation) have to be broader and have to reach even more people. With limited resources, this means making hard choices about how to identify the most effective approaches (*Community Action* 2001).

3.9 Comprehensive evaluation theory building

Looking at evaluation theories such as those linked to HIV/AIDS, many complicated issues emerged. These are partly due to the point raised by Airhihenbuwa and Obregon (2000:218) that, most theories and models used to develop HIV/AIDS communication is based on social psychology that stresses individualism. As such, researchers, including communication and health scholars, are now questioning the supposed global implications of these models and thus the need to develop innovative theories and models that take into account regional contexts. Also, as new problems and contexts arise, so do evaluation models and approaches. Some of the theoretical issues even originate from the outcome of direct practical problems. The borders and elements, therefore, of particular models in evaluation pose problems, especially in cases of multiple theories, for example between 1967 and 1987, over 50 different evaluation models were developed (Worthen and Sanders 1987). To further justify these complications, Stake (1991:71) says, "What we have in the evaluation literature are not models but approaches or persuasions. Evaluation theorists

promote their concerns, advocate particular commitments, and emphasize particular purviews".

Nevertheless, in the present study, certain theories needed in-depth investigation, for example the participatory and positivistic theories, coupled with quantitative and qualitative methodological frameworks. In these theories, one found two main arguable views: the traditional view, which expresses the fact that social science is virtually the same as natural science and is therefore concerned with the discovery of natural and universal laws that regulate and determine individual and social behaviour; the radical view of the traditional paradigm, which shares the rigour of natural science to describe and explain human behaviour, but stresses that people differ from inanimate natural phenomena and from each other (Cohen and Manion 1989). In connection with the radical view in the traditional paradigm, is the participatory theory that holds the epistemological assumption that knowledge is constructed socially and therefore approaches that allows for social, group, or collective analysis of life experiences of power and knowledge are most appropriate (Hall 1997).

In dealing with quantitative and qualitative methodological frameworks, the assertion put forward by Marsden and Oakley (1990:8) was worth noting:

> The dichotomy between quantitative and qualitative data [is seen] as a false one, something that can [inhibit] rather than [enhance] progress in thinking about evaluation. Numbers can become ends in themselves rather than means to an end, and it is possible to put numbers to things, which one might not have thought possible. The crucial issue is what importance is attached to the numbers and knowing how they might be used and abused (Marsden and Oakley 1990:8)

Bearing in mind the falsehood of the notion of numbers and the fact that one did admit to the existence of different conceptualisations of questions that were of significance in understanding the empirical world, the existence of models that could make a difference were not undermined in the present study. The researcher recognised the standpoint of Smith (1997: 218), that it is in reconciling the contrast among the competing models, in substantiating selections among study alternatives and in developing designs that are

conceptually reasonable, technically feasible and situationally appropriate, that competing models serve to ameliorate professional judgments.

A theoretical argument in favour of a shift away from the individual to the social and community levels of analysis, where rigorous participatory/qualitative evaluation methodology is given enough weight in HIV/AIDS evaluation, therefore informed this study. In this, participants at all necessary levels (departmental, community, national) are given sufficient contributive opportunity. This was in connection with the assertion of Kreuter (1997:8) that:

Health promotion interventions and tactics will be effective to the extent that the target community has organisational entities and systems that are supportive of the enterprise and that these entities and systems are activated. The activation of relevant community entities and systems depends in part on the extent to which community members are aware of, value and trust the proposed intervention.

3.10 Summary

A careful understanding of certain key issues embodying evaluation was explored in this Chapter. These issues included: what evaluation entails, the reasons for evaluations, paradigms governing them and the recommended degree and understanding of meaningful, useful and valuable evaluations. The values and ideologies of two key forms of evaluations (traditional and participatory evaluations) were highlighted and differences in their social practices traced and analysed. With regards to traditional evaluation, its values and ideologies were seen to be based on scientific or interpretive assumptions about knowledge, individualistic, paternalistic (teacher-student orientated), victim-blaming, problem-solving and having the assumption that people are helpless and lack the ability and resources to develop themselves.

The values and ideologies of participatory evaluation were, on the other hand, seen to be grounded knowledge through collaborative relationships, problem-posing, dialogue-orientated (everyone a teacher and a student at the time) and mobilising for transformation (listening and facilitating discussions) as people are considered to be capable of developing

themselves. It was demonstrated from a review of the literature that when participation is reflected, not just in a project but also in its evaluation, participants tend to personalise the project and are therefore eager to put it into action. In the process of all these, participants are empowered with skills to communicate the lessons learned. It was argued that, to go beyond awareness, there was the need to make it possible for communities to change, meaning that communities have to assess their own vulnerabilities and ways of combating them. This was seen to take place more often in situations where there was an acknowledgement of the social drive of an epidemic such as HIV/AIDS and a communal approach to redress it (Community Action 2001).

In all these, note was taken of the fact that giving beneficiaries the privilege in choice and decision-making did not imply a neglect of the choices and decision-makings of other players, such as project implementers and donors. It did not imply a neglect of vital concerns, such as time and financial accountability and efficiency that warranted inclusion in an evaluation. The issue was seen to be the avoidance of persuasion, which was perceived to be the norm in a 'capitalist' system and rather, a poor approach in the field of evaluation.

CHAPTER 4: THE CONTRIBUTION OF PARTICIPATORY METHODOLOGY TOWARDS THE IMPLEMENTATION AND EVALUATION OF A MEANINGFUL, USEFUL AND VALUABLE HIV/AIDS PROJECT

4.1 Introduction

This Chapter sought to answer the research question: Does participatory methodology contribute towards the implementation and evaluation of a meaningful, useful and valuable HIV/AIDS project? An analysis of the contribution of participation towards a meaningful, useful and valuable HIV/AIDS health-enhancing project and its evaluation by internal and external evaluators is provided. As shown in Chapter1, the essential of participation is people collectively taking control, developing plans of action and responding to feedback in relation to future action (commonly indicated here as presence of people, particularly beneficiaries in change initiatives or interventions). Examining five case studies of preventative HIV/AIDS projects and their evaluations does this. These projects (of which for convenience and confidentiality are named P1, P2, P3, P4 and P5) handled HIV/AIDS social/awareness issues related to peer education, gender, culture and other socio-economic imperatives. They were also participatory, both in their actions and in their evaluations.

Table 4.1 gives a brief description of each of the projects and their evaluations, i.e. their objectives, target groups and the methodology used in implementing them (for a full description of each of the projects and their evaluations, see Appendix A). The projects and their evaluations were observed to be similar in many respects, so that differences in participatory practices could be highlighted. Judging from the evaluation reports, personal observations and interviews with project managers, evaluators and beneficiaries, Table, 4.1 outlines the main agreed objectives. It portrays many similarities in terms of the objectives of the projects and their evaluations and also in terms of the methodology used. Certain differences worth noting, were, however, observed in the target groups, actual implementation of the projects and their evaluations.

Table 4.1: Objectives and methodologies of the HIV/AIDS projects and their evaluations

Issues	Projects and their evaluations				
Area	P1: Durban SA*	P2: Ndwedwe SA	P3: Zululand SA	P4: Mzinoni SA	P5: Kriel SA
Project Objective	Reduce stigma, adopt healthy sex practices, empowerment, structural transformation, skills acquisition, create self-reliant opportunities, expansion	Reduce stigma, adopt healthy sex practices, empowerment, structural transformation, skills acquisition, create self-reliant opportunities, expansion, promote hygiene	Reduce stigma, adopt healthy sex practices, empowerment, structural transformation, skills acquisition, create self-reliant, opportunities, expansion, promote hygiene	Adopt healthy sex practices, empowerment, structural transformation, skills acquisition, create self-employment opportunities, expansion, curb prostitution, counselling	Adopt healthy sex practices, empowerment, structural transformation, skills acquisition, create self-employment opportunities, expansion, curb prostitution, counselling
Evaluation Objective	Impact and objective assessment, relevance, sustainability, improve service delivery of project staff, empowerment, structural transformation, skills acquisition	Impact and objective assessment, relevance, improve service delivery of project staff, sustainability, empowerment, structural transformation, skills acquisition	Impact and objective assessment, relevance, improve service delivery of project staff, sustainability, empowerment, structural transformation, skills acquisition	Improve service delivery of peer educators, empowerment, structural transformation	Improve service delivery of peer educators, empowerment, structural transformation
Project Target	Technikon students Tertiary institutions	Secondary school students	Primary school pupils	In and out of school youths, hotspots with sex workers and truck drivers	In and out of school youths, hotspots with sex and mineworkers
Evaluation Target	Technikon peer educators	Secondary school peer educators	Primary school peer educators	Peer educators	Peer educators
Project method	Participatory: Interactive peer education (dramas, songs, dances, poetry, enactments, discussion forums, videos, 'Felicia show')	Participatory: Interactive peer education (dramas, songs, dances, poetry, discussion, AIDS memorial quilt)	Participatory: Interactive peer education (dramas, songs, dances, poetry, discussion, beadwork)	Participatory: Interactive peer education (dramas, songs, dances, discussion)	Participatory: Interactive peer education (drama, songs, dances, discussion)
Evaluation Method	Participatory and qualitative: focus group. Quantitative: Pre-/post-test. Internally evaluated	Participatory and qualitative: focus group, semi-structured interviews and background documentation; Quantitative (use of control) Externally evaluated	Participatory and qualitative: focus group, semi-structured interviews. Quantitative: self-administered questionnaires Externally evaluated	Participatory and qualitative: quality checklist, self-evaluation. Internally evaluated	Participatory and qualitative: quality checklist, self-evaluation. Internally evaluated

SA means South Africa

Projects 1, 2 and 3 had as main targets both male and female Black South Africans (in-school youths in rural areas with the exception of project 1 that had its schools in an urban area in Durban). Prior to visiting the *mother* schools, such as those in the areas shown in Table 4.1, some out of school youths were temporarily employed by the project (for the period of their training and performance), trained and encouraged to perform drama and other activities in the schools. After that, a youth club was launched in these schools. The youth club members were then trained (by the project implementers) as peer educators to visit other schools (starting with the neighbouring ones), perform there and launch other youth clubs. They were encouraged to organise other activities such as *AIDS festivals* within their premises. During these festivals, students, parents and other useful government and non-governmental bodies were invited for networking. The youths were not on any *stipend* (formal or informal payroll*)*; but were provided with refreshments after every performance. They were encouraged to come up with ideas and means of generating their own sources of finance, such as the making of AIDS Memorial quilts and beadwork.

Projects 4 and 5 had, as their main targets, in and out-of-school Black South African female youths (mostly those exposed to the practice of prostitution) in urban areas. The in and out-of-school youths were divided into different groups, depending on their functions. A group of out-of-school youths implemented awareness campaigns (visits to hotspots such as 'shebeens', power stations, highways and plantations, where prostitutes, truck drivers or mineworkers met). The in-school youths organised awareness campaigns and counselling sessions within the schools. The project managerial staff (otherwise known as co-ordinators) trained the different groups of youths as peer educators. After the training, the out-of-school peer educators (those chosen for this study) carried out visitations to hotspots, where the peer educators engaged the people in discussions around HIV/AIDS, through drama, songs and dances. All the different groups of youths were on a *stipend* (informal payroll*)* and whenever they received any other form of employment, they were relieved of their duties as peer educators. They were also encouraged to come up with ideas and means of generating their own sources of finance, such as joint initiatives, for which the project provided loans.

For purposes of easier analysis and comprehension and considering that the HIV/AIDS projects chosen for this study were similar in many respects, their objectives were grouped

in this study and treated as a whole. Mention was, however, made in instances of any registered differences. The evaluations were known to be part of the HIV/AIDS projects and treated as an integral part of the HIV/AIDS projects. They were separated only when deemed necessary to do so. Table 4.1 shows that the grouped HIV/AIDS project objectives, and their evaluations, could be summarily presented thus:

- ❖ HIV/AIDS combined project objective 1: To understand and take successful actions to solve particular problems such as how to deal with the loss of a loved one due to HIV/AIDS, handle HIV/AIDS patients, reduce stigma over HIV/AIDS (project 1, 2 and 3). To curb prostitution and the spread of HIV/AIDS (project 4 and 5). To lead youths and other community members to adopt sexual practices that would avoid transmission of HIV (all 5 projects). All these boil down to the search for practical and workable solutions and the change of attitude to meet the identified needs.

- ❖ HIV/AIDS combined project objective 2: To go beyond understanding and solving particular problems to empowering people (raising awareness in them of their capabilities and resources to muster for social action). To, for example, let people review their worth (as being able to make a difference). To let them know that they are capable of voicing their own opinions and that those opinions are worth something. To make it possible for those whose ideas were previously not valued to be consulted regularly. To create enabling environment for skill acquisition.

- ❖ HIV/AIDS combined project objective 3: To bring about structural transformation: To encourage collaborative relationship (at all levels possible) between project managers or facilitators, evaluators and beneficiaries. To share knowledge. To actively engage people in a creative and interactive way both at personal and community levels (go beyond dealing with just individuals in a society to groups of individuals). To treat beneficiaries not as objects acted upon (top-down approach) but as respected human beings with a world of knowledge (bottom-up approach).

- ❖ HIV/AIDS combined project objective 4: In the area of economics, to provide self-employment opportunities, loans and jobs, to maintain sustainability.

With respect to the evaluation of the HIV/AIDS projects, their theoretical foundation was grounded in the social diffusion theory. This theory asserts " people evaluate changes, not by scientific evidence or authoritative testimony, but by subjective judgements of close, trusted peers who adopted changes and provide persuasive role models for change" (pointed out in Module 1 overview of project 4: see Appendix E).

The given objectives of the HIV/AIDS projects (including their evaluations) and the methodologies used in meeting them were analysed in this study vis-à-vis their final outcomes. This was to find out if, given the methodology they used in implementing the projects and in evaluating them, their objectives were met and had an impact on the targeted communities. In the following sections, a description is presented of why the HIV/AIDS projects and their evaluations were studied. This is followed by the methodologies used in studying them. With regards to the presentation of the study results, those pertaining to the findings from the projects are listed first. This is followed by results relating to the findings from the evaluations of the different projects. Lastly, a discussion is advanced concerning the identified outcomes of the projects and their evaluations. Such a discussion is advanced bearing in mind the following compounding variables which might have invariably impacted (either positively or negatively) on the outcome results of the projects studied and their evaluations:

> ➤ Socio-demographic differences (gender, race, language and age) of project implementers, evaluators and beneficiaries of the HIV/AIDS projects studied (and their evaluations);

> ➤ Rural-urban differences of the HIV/AIDS projects studied (and their evaluations);

> ➤ Differences in the choices of evaluators (some projects having external evaluators and others internal evaluators) in the HIV/AIDS projects studied (and their evaluations).

Other compounding variables, for example, styles of project management and development which would have invariably impacted (either positively or negatively) on the outcome results of the projects studied and their evaluations, were, nonetheless, not dealt with in-

depth. This was due to the fact that this section of the study was limited to the use of participation in broadly assessing a meaningful, useful and valuable HIV/AIDS project.

4.2 Reason for studying the HIV/AIDS projects (of this research) and their evaluations

In this section, the rationale behind studying the HIV/AIDS projects of this research and their evaluations is given, followed by the parameters governing the choice of their selections. The present author devised the criteria for the selection of the projects studied based on the aim of the study, which was to investigate the value of participation in implementing and evaluating HIV/AIDS projects. HIV/AIDS projects with elements of participation and social implications were selected, so that differences in their participatory and social practices could be traced and analysed. To trace the differences, the researcher needed not just projects that had been implemented; but those that had been evaluated with access to beneficiaries, project managers and evaluators and the original evaluation reports.

In summary, the projects were selected based on the following criteria:

- The project dealt with HIV/AIDS awareness and had attitude-changing and empowering goals
- The project had been evaluated (either internally or externally)
- The project and its evaluation methodologies both had elements of participation
- The project had community or social implications (gender and/or culturally related and could be dealing with issues of community transformation and empowerment)
- Access to the original evaluation report was possible
- Access to the evaluators, project managers and the beneficiaries was possible.
- The project took place within South Africa.

4.3 Methodology used in this research to study the HIV/AIDS projects and their evaluations (methodology of the present study)

The purpose of this section is to systematically describe the methodology of the present research, the method of analysis and tools used and the reasons for choosing them. For purposes of clarity, a table reflecting a timeline of the different aspects of the research and how they were pursued is presented.

As mentioned by Polkinghorne (1983: ix), it is worthwhile understanding the "why" of one's design and the "how" to carry it out. According to Bailey (1982: 33), methods do suggest certain methodological perspectives, ranging from qualitative (report of observations in natural languages, seldom using numbers) to quantitative (assigning numbers to observations). Looking at the possible approaches for studies of this nature, Trow stated that,

> ...The most widely accepted view among social scientists is that different kinds of information about man and society are best gathered in different ways, and that the research problem under investigation properly dictates the methods of investigation (in Bulmer, 1977: 15).

Given the nature of the present study, a combination of methodologies was adopted. For the study of the projects, an in-depth case study methodology was used, whereby a few cases were identified and studied in-depth. The purpose of undertaking such in-depth study of identified cases was to investigate the value of participation within the context of HIV/AIDS projects and their evaluations. In doing so, the researcher intended to acquire a comprehensive understanding of the intricacies embedded in project implementation and evaluation. Such a purpose is confirmed by Mouton (2001: 149), who stated that case studies are appropriate for research that intends carrying out in-depth descriptions of a small number of cases. They are studies of particular individuals, which could also be extended to single families or to a social course of action (Lindegger 1999:255).

In carrying out a pre-investigation into potential cases for in-depth follow-up, a survey methodology was applied. Different HIV/AIDS related organisations were surveyed telephonically and through digital communication. Once that was done, a pilot was

conducted using a pre-test with the use of semi-structured interviews, in order to identify and resolve any ambiguity in the research questions and procedure. Table 4.2 gives a clearer picture of the timeline of research activities and the methodologies used.

As shown on Table 4.2, the different research activities were pursued following a particular timeline and methodologies (all culminating in the final findings of the research), which are examined below.

Table 4.2: Timeline of research activity and methodology used

Research Activity	Methodology used
Survey into potential cases	Survey of institutions with potentially suitable projects
Sampling of HIV/AIDS projects	Non-probability sampling to meet criteria in section 4.2
Sampling of respondents	Convenience sample of people available in the projects in specified categories
Pre-test with an HIV/AIDS non-governmental (NGOs) project	Semi-structured interviews with a beneficiary managerial staff member and an evaluator
Data collection technique	Qualitative and participatory: Focus group discussion with beneficiaries Semi-structured interview with managers and evaluators
Analysis of documentation	Structured inspection of projects and evaluation reports
Analysis of collected data	SPSS and by inspection

4.3.1   Survey into potential cases

A survey research method was adopted in order to carry out a pre-investigation into potentially suitable projects. The researcher reviewed approximately 52 project organisations within Africa (approximately 75% of them outside South Africa). These

organisations were sourced through personal contact with university authorities and friends, searching the Internet and contacting specialist HIV/AIDS organisations (see list of 52 organisations in Appendix A). All the 52 (100%) used qualitative and participatory methodologies (with drama, songs, focus group discussions dominating) in implementing their projects.

Unfortunately, when it came to evaluating the above projects, the majority, 40 (77%) used purely quantitative approaches for evaluations (control and baseline studies via questionnaires), some of which were selected for a different purpose in the present (see Chapter 5). Only 12 (23%) had elements of qualitative and participatory methodologies in their evaluations. Out of the 12, the majority 7 (58%) used a combination of approaches, qualitative, participatory and quantitative, and the minority 5 (42%) used purely qualitative and participatory methodologies (focus group interviews, quality checklist and a user-focused approach of watching the peers practically facilitate a training course). It was from within the 12 organisations that the five that met all the conditions for this section of the study (see section 4.2) were finally chosen.

A survey method, as defined by Warwick & Lininger (1975: 1-2), is "a method of collecting information about a human population in which direct contact is made with the units of study through systematic means as questionnaires and interview schedules". Mouton and Marais (1988: 42) referred to a "research goal" as that which "provides a broad indication of what researchers wish to attain in their research." The present study can be seen as both exploratory (exploring a comparatively little-known field) and descriptive (in-depth description given of an individual, group or organisation). Looking at the descriptive purpose of the study, using a survey method as a pre-investigation into sourcing suitable projects clearly fits in. This is made clear by Babbie's opinion that " Survey research is probably the best method available to the social scientist interested in collecting original data for purpose of describing population too large to observe directly... Surveys are also excellent vehicles for the measurement of attitudes and orientations prevalent within a large population" (Babbie 1979: 316). They are used to obtain a broad array of information and to describe the characteristics of a population under study, estimate their proportions, make scientific predictions and test their relationships (Powell 1985).

Criticisms have been made about the survey research method. Marsh (1982: 3) felt that the criticisms are "usually reactions to poorly designed, inadequately conceptualised and theorised, unpiloted or just ill-managed surveys..." De Vaus (1986: 220-225) concluded by saying that, while surveys do have setbacks, "they are not as serious as many of the critics would have us believe." Therefore the initial projects were surveyed in order to determine their suitability for inclusion in this study. The directors or main project managers were contacted, where possible, via telephone, e-mail and personally.

4.3.2   Sampling within HIV/AIDS projects

Non-probability sampling method was used to sample the HIV/AIDS projects for this study, according to the criteria selected above. Permission to be included in the study was obtained and arrangements made to conduct focus group discussions and interviews. All these were done using an accompanying covering letter from the University (specifically endorsed by the Head of the Discipline of Community Resources). The covering letter stated the objective of the fieldwork for example, why the information collected was needed (see Appendix B) and the method to be used in collecting the information. The letter had a firm statement on the confidentiality of the information obtained. Names of interviewees were not required. Specific names of the organisations or projects were not to be released unless given permission to do so by those concerned. The researcher kept a copy of the letter (to be read and handed to the different interviewees prior to the interviews).

With the accompanying cover letter for the interviews and focus group discussions went the request for project and evaluation reports to be made available. The motive for requesting them and the kind of information needed (the objectives of the projects and their evaluation, how the projects and their evaluations were conducted and the results of the evaluations) was spelt out. Where appropriate, the researcher personally collected the reports from the organisations concerned (the case with projects 2, 4 and 5).

With respect to the actual sampling procedure, Table 4.3 provides approximations of the number of people (beneficiaries, managerial staff and evaluators) in each project and the

number participating in the research. It also provides a socio-demographic record of the people in each of projects and those participating the research.

Table 4.3: Approximation of project composition and number interviewed

Projects	Project composition					
	Beneficiaries		Managerial staff		Evaluators	
Projects	No. in project	No. interviewed	No. in project	No. interviewed	No. in Project	No. interviewed
Project 1:Grand total Gender: F*/ M* Ethnicity: Black /White/Coloured Age 17-48 Language**: IsiZulu/English/Afrikaans	27 18/9 27/-/- 27 27/-/-	5 (19%) 3/2 5/-/- 5 5/-/-	4 2/2 2/1/1 4 2/2/-	1 (25%) -/1 1/ -/ - 1 1/-/-	1 -/1(Internal) -/-/1 1 -/1/-	1 (100%) -/1 (internal) -/-/1 1 -/1/-
Project 2:Grand total Gender: F/M Ethnicity: Black /White/Coloured Age range: 10-25/ 26+ Language**: IsiZulu/English/Afrikaans	36 25/11 36/ -/ - 36/- 36/-/-	7 (19%) 5/2 7/-/- 7/ - 7/-/-	8 5/3 7/1/- -/8 7/1/ -	1 (12.5%) -/1 1/ -/ - -/ 1 1/-/-	1*** 1 (external)/- -/1/- -/1 -/1/-	1 (100%) 1 (external)/- -/1/- -/1 -/1/-
Project 3:Grand total Gender: F/M Ethnicity: Black /White/Coloured Age range: 10-25/ 26+ Language**: IsiZulu/English/Afrikaans	32 20/12 32/-/- 32/- 32/-/-	6 (19%) 4/2 6/-/- 6/- 6/-/-	4 2/2 2/2/- -/ 4 2/2/-	1 (25%) 1/- 1/-/- -/1 1/-/-	1 1 (external)/- -/1/- -/1 -/1/-	1 (100%) 1 (external)/- -/1/- -/1 -/1/-
Project 4: Grand total Gender: F/M Ethnicity: Black /White/Coloured Age range: 19-39/ 40+ Language**: IsiZulu/English/Afrikaans	30 30/- 30/-/- 30/- 30/-/-	6 (20%) 6/- 6/-/- 6/- 6/-/-	7 6/1 5/2/- 4/ 3 5/-/2	1 (14%) 1/- 1/-/- 1/- 1/-/-	4**** 4 (internal)/- 3/1/- 1/2 3/-/1	1 (25%) 1 (internal)/- 1/-/- -/1 1/-/-
Project 5:Grand total Gender: F/M Ethnicity: Black /White/Coloured Age range: 19-39/ 40+ Language**: IsiZulu/English/Afrikaans	24 24/- 24/-/- 24/ - 24/-/-	6 (25%) 6/- 6/-/- 6/- 6/-/-	6 4/2 4/2/- 3/3 4/-/2	1 (17%) 1/- 1/-/- -/1 1/- /-	3**** 3 (internal)/- 2/1/- 1/2 3/-/1	1 (33%) 1 (internal)/- -/1/- -/1 -/-/1

F* =Females. M* =males ** Most proficient language ***One in terms of a single organisation represented by a female evaluator invited to do the evaluation. The organisation was, however, made up of five members (Appendix A) **** Projects 4 and 5 used self-evaluation with one managerial staff in each of the groups of peer educators facilitating it and the discussions thereafter.

Judging from Table 4.3, out of an estimated number of beneficiaries, managerial staff and evaluators (188), in all the HIV/AIDS projects of the study, 40 were chosen, giving a sample percentage of 21%. This small sample size was due to budget limitation and unavailability of project members. A clearer sampling percentage is given in Table 4.4.

Table 4.4: Sampling percentage within the HIV/AIDS projects under study

Sampling percentages			
HIV/AIDS projects	**Beneficiaries (%)**	**Managerial staff (%)**	**Evaluators (%)**
Project 1	19	25	100
Project 2	19	12.5	100
Project 3	19	25	100
Project 4	20	14	25
Project 5	25	17	33
Percentage total	20	17	50
Grand percentage total	21		

For the data collection relating to the HIV/AIDS projects and their evaluations, a total of 30 beneficiaries out of 149 (from all projects) were chosen for focus group discussions. As shown on Table 4.4, this gave a sampling percentage total of 20%. For each focus group, a maximum of seven beneficiaries and a minimum of five were needed from each of the HIV/AIDS projects. Seven was seen to fall within the optimal size (eight) considered by Barbour and Kitzinger (1999) for focus group research. In project 1, out of approximately 27 beneficiaries (see Table 4.3 and 4.4 above), 19% of them were chosen. In Project 2, 19% were chosen out of 36 and in project 3, 19% out of 32 beneficiaries. In project 4 and 5, out of an average of 30 and 24 beneficiaries, 20 and 25% of them were chosen. Due to difficulties in locating the beneficiaries, given that they lived in areas where addresses were unknown, the project managers selected the beneficiaries.

From all the projects, a total of five managerial staff members out of 29 (percentage sample 17%) were selected for individual interviewing. In Project 1, out of four managerial staff members, 25% of them were selected; in project 2, out of eight, 12.5 % were selected;

Project 3, 25% out of four; project 4, 14% out of seven and project 5, 17% out of the six managerial staff members. A managerial staff member recommended by either the director of the organisation or by the project head manager, and who was directly involved with the day-to-day running of the project, was the one selected for interviewing.

As shown in Table 4.3 and 4.4, from all five HIV/AIDS projects, a total of five evaluators were chosen for this present study. This gave a percentage sample of 50% (five evaluators out of a total of 10). In project 1, the lone head managerial staff that did the evaluation was interviewed. In projects 2 and 3, the two respective external evaluators were interviewed. In projects 4 and 5, out of four and three managerial staff members who respectively supervised and facilitated the self-evaluations of the projects, one from each of the projects was selected. The head of the project managerial staff provided a list of the evaluation supervisors, from which the researcher selected an evaluator to interview.

Powell (1985: 67) considered sampling as one of the most crucial steps in survey research. When doing research among 'Africans', Simon (1985: 115) recognised the difficulty in attempting to construct an adequate sampling frame. Bulmer (1977) felt that a sampling frame with adequate coverage is an exception rather than a rule. In the present study one was faced with a situation where, as highlighted by Rose (1982: 59), there was a working universe, but it was not possible to construct a sampling frame. Rose suggests that in such cases, "... Accidental, snowball, or judgement sampling may be used." Such sampling procedures are categorised as non-probability sampling methods, which, according to Kalton (1983: 7), cover "a variety of procedures, including the use of volunteers and a purposive choice of elements for the sample, on the grounds that they are 'representative' of the population." Purposive sampling, which is considered by Fraenkel and Wallen (1993) as judgmental, was therefore used in sampling the informants in the present research.

Burgess (1984: 55) says "In judgment sampling, informants may be selected according to a number of criteria established by the researcher such as their status (age, gender and occupation) or previous experience that endows them with special knowledge." In the selection of such a sample, care is taken to ensure that the sample is reflective of the

general make-up of the project organisation and of the intended objective of the researcher (as demonstrated in this section).

Looking at the disadvantages of the non-probability sampling, Bailey (1982: 97) states that "the obvious disadvantage ... is that, since the probability that a person will be chosen is not known, the investigator generally cannot claim that his or her sample is representative of the larger population" thus the lack of external validity that comes from findings that cannot be generalised to a broader population (Golden 1976: 15).

Taking into account the identified weakness of non-probability sampling, it is clear that the sample in this study was limited in the area of representation and, consequently, in external validity. However, as Phillips (1976: 295) stated, external validity is influenced by sample size, where the greater the sample size, the lesser the opportunity to deal with problems of internal validity. Phillip therefore felt that a smaller sample size, which is the case in the present study, is likely to enable the investigator to concentrate more on internal validity (applying in-depth findings to the particular research situation under investigation).

4.3.3   Pre-test

The data collection instruments of this study were pre-tested by choosing one beneficiary, a managerial staff member and an evaluator of an HIV/AIDS project not included in the study. In choosing the project and interviewees for the pretest, care was taken to maintain some degree of similarity with the projects to be studied. The kind of project chosen was an HIV/AIDS project that aimed at empowering youths within a village community in KwaZulu-Natal, South Africa.

Certain weaknesses were noticed during the pre-test. The weaknesses confirmed the opinions of Fraenkel and Wallen (1993: 352) that, "A pre-test of a questionnaire or interview schedule can reveal ambiguities, poorly worded questions, questions that are misunderstood, and unclear choices and can also indicate whether the instructions to the respondents are clear".

The listing of the weaknesses are stated below:

- ❖ The present author noticed that interviewees were not able to differentiate between questions linked to the project and those linked to its evaluation. It was then decided that emphasis would be placed from the beginning of each interview or focus group section, on these different divisions. Resolving such inadequacy was considered crucial, given that valid and reliable data, pointed out by Blanche and Durrheim (1999), are embedded in their accuracy and consistency.

- ❖ Interviewees complained that the interview session was too long. Each pretest interview session took approximately two and a half hours. The researcher reduced it to approximately one hour for the actual field interviews.

- ❖ During the interview sessions, the researcher found it difficult to take notes and conduct the interviews at the same time, so it was decided that permission would be sought from the concerned authorities and interviewees to tape the discussions. In order to keep the interviewees at ease with this, reasons for doing so were to be clearly explained.

4.3.4 Data collection technique

A qualitative (in-depth case study) and participatory methodology, via focus group discussions with the beneficiaries and semi-structured interviews with managerial staff members and evaluators, was applied in the collection of data for this research. The questions asked of the interviewees (beneficiaries, managerial staff and evaluators) were divided into 4 sections (see Appendix C for details).

The first section dealt with questions related to the socio-demographic data of the 3 categories of interviewees (beneficiaries, managerial staff and evaluators). This data was needed in order to give and analyse the background composition of the people in the HIV/AIDS projects and those interviewed for this study. Questions regarding age, gender, race and language groupings were asked.

The second section dealt with questions of general interest. This was in order to get the views of the interviewees and situate them in context with actual projects and evaluations in which they were involved. Questions involved, for example, values held by interviewees regarding implementation and evaluation of HIV/AIDS projects. Prompts were given, for example: target people as individuals or as a group; derive the meaning of a project and its evaluation from donors, project implementers, beneficiaries and others. Other questions of general interest related to perceived challenges in meeting identified values and a way forward. Prompts, such as the question of time, meeting attendance, finance and synchronisation of ideas, were provided.

The third and fourth sections dealt with questions directly related to the HIV/AIDS projects and their evaluations. Questions such as the average knowledge and involvement level of interviewee, with regards to their different HIV/AIDS projects and their evaluations, were asked. With the average knowledge level, questions were asked, such as why the projects and the evaluations were carried out, who asked for them, the methodology used in implementing the projects, when and for how long the projects and their evaluations were carried out

.

With involvement levels, questions were asked, such as the different stages (with prompts of planning, action-planning, execution and result-feedback stages) in which interviewees were present in the project and the evaluations. The interviewees were asked to comment on their responses (their level of participation), the impact of the project and its evaluation on their work, and what they liked and did not like about the way the projects and their evaluations were implemented. All this was to discover the contribution or value of participation in HIV/AIDS projects and evaluations with social implications.

Stone (1984: 12) defines a semi-structured interview as one "in which some questions are structured ['closed'] and some are open-ended." A point of caution with respect to this technique used in the collection of data is that the interviewer must be well prepared before the beginning of the questioning process. She/he should know not just the questions to be asked, but also the sequence the questions will be posed and the method by which the data will be effectively recorded. This is because "well-planned interviews and carefully

worded questions usually produce the most useful information, as well as supplementary, insightful observations and opinions from respondents" (Busha and Harter 1980:78). In the present study, the researcher conducted all the interviews and so was well prepared.

The themes selected for focus group discussions and personal interviews were done in relation to the issues the researcher, the different projects and their evaluations sought to address. The themes selected dealt with methodologies used in implementing and evaluating HIV/AIDS projects, the need and extent of participation in such projects and their evaluations and the outcomes of the projects' objectives (stigmatisation, empowerment, gender divide, prostitution, skills acquisition, participation).

4.3.5 Analysis of documentation

Documentation of the present study was analysed using structured inspection of evaluation reports. Table 4.5 gives a summary of the format taken for the inspection process.

Table 4.5: Inspection of evaluation reports

Sections	Sub-sections	Evaluation report
Objective	Origin of project Origin of evaluation	Project rationale, proprietor(s), initiation date and duration Evaluation rationale, proprietor(s), initiation date and duration
Procedure	Project procedure Evaluation procedure	Project methodology Evaluation methodology
Composition	Project and evaluation composition:	Category: Beneficiaries, managerial staff, evaluators and donors Socio-demographics: Number, gender, ethnicity and language component Condition for recruitment and nature of service-provision
Target area	Project target area Evaluation target area	Project location and area of implementation Evaluation location and area of implementation
Calibre of participation	Participatory activities during project implementation Participatory activities during evaluation implementation	Interaction with beneficiaries: Dramas, songs, dances, discussions, poetry Interaction with management: Project planning, action-planning, execution and result feedback Interaction with beneficiaries: Focus group discussions Interaction with management: Evaluation planning, action-planning, execution and result feedback
Outcomes	Objectives met and process transformation	Degree of meeting objectives, relevance of project method, wider impacts identified, benefits accruing from project

In order for the researcher to resolve any ambiguities and for her to have a firm understanding of the projects and their evaluations, she cross-checked similar data from the field (through the interviews conducted) and from the reports, for example field data cross-examined with evaluation report data and *vice versa*.

In accordance with the partitions on Table 4.5, the following information was looked at:

> ➤ Objectives and procedures: In each of the evaluation reports of the projects, there were sections providing a brief description of the projects and their evaluations. Descriptions such as why the projects were carried out and evaluated, who asked for the projects and their evaluations, the methodology used in the projects and their evaluations, when and for how long the projects and the evaluations were conducted.

> ➤ Composition and target areas: The evaluation reports also had sections describing the composition of the projects and their evaluations (shown in Table 4.5). It had, for example, sections pointing to the projects and their evaluation locations and areas visited; the condition for recruitment (job requirements) and the nature of service provision (volunteering, educating, visitations).

> ➤ Calibre of participation: In the evaluation reports, the researcher was able to determine the calibre of participation and the extent of it from sections that dealt with the way the projects and the evaluations were conducted; where, for example, the different project and evaluation activities were listed. For the projects, the researcher checked for the number of participatory activities, activities such as drama, songs, and dances and, for the evaluations, activities such as focus group discussions. Where the researcher could not directly get the needed information from the evaluation reports she relied heavily on information from the interviewees. This happened particularly when she was investigating the comments of the interviewees regarding the way the evaluations were conducted.

> ➤ Outcome measures: Comment on the calibre of participation in the project and in the evaluation. What was the outcome of the project and the evaluation? What

made the recipients particularly happy about the way the project and the evaluation was conducted and why? What made them particularly unhappy and why? Outcomes of the different projects were spelt out in the evaluation reports in sections dealing with, for example, the assessment of the objectives and impacts of the projects. The researcher was then able to inspect the outcomes of the projects from these sections of the reports. She had the objectives of each of the projects outlined and cross-checked them by giving a tick in instances where a particular objective was met and writing down any testimony or evidence provided by it.

Some information on the reports was provided in patches and others in ways not very direct, needing some degree of assumption on the part of the researcher. As such, the researcher, had to go through the whole report before and after the fieldwork in order to get the trend of thought and, where not clear, she sought clarification from those concerned (heads of the projects, beneficiaries, managerial staff or evaluators) via telephone, e-mail or personal contact. A case in point is project 3. Here the specified roles of the evaluator and the managerial staff assisting her, and also the specified capacity in which the donors were operating, were not clearly spelt out. The researcher had to contact the project's head manager for clarification.

4.3.6 Analysis of collected data

The data of the present study (quantitative data) was analysed using the Statistical Package for Social Sciences (SPSS) and by inspection, the latter demanding a systematic inspection of the composition of the object of the study (Gay 1976: 137). For better analysis and comprehension, the interviewees (both in the focus group and individual interviews) were partitioned into three categories of beneficiaries, managerial staff and evaluators.

Scales for participation criteria were developed using different variables, such as 'low' and 'high', 'present' and 'absent', for the classification of interviewees' responses. Table 4.6 elucidates this form of classification.

Table 4.6: Classification into scales

Answers offered	Criteria for classification*	
	Focus groups with beneficiaries	Interviews with managerial staff and evaluators
Classification high	**Adequate answer from at least three beneficiaries in a focus group of about five to six beneficiaries and from at least four members in a focus group of seven members	Adequate answer from the respondent
Classification low	***Inadequate answers from three or more beneficiaries in a group of five or six and inadequate answers from four in a focus group of seven.	Inadequate answer from the respondent
Classification zero	****Negative response from each beneficiary in focus group	Negative response from the respondent

*The absence of extensive ratings, including modes was due to the small sample size and the need to simplify data

** Adequate answers meant the answers were given in great details and similar to those in evaluation reports, or were confirmed by authentic sources such as other project members and organisers

***Inadequate answers meant the answers were not given in great details and had some variations, either to those in evaluation reports or as presented by authentic sources such as other project members and organisers

**** Negative response meant respondent indicated not present

In-as-much as the scale ratings (shown in Table 4.6) were done the number of responses in mind, notice should be taken of the limited use of numbers/percentages attached to the findings. This is in line with the viewpoint of Bailey (1982: 33), *viz* that methods do suggest certain methodological perspectives ranging, from qualitative (report of observations in natural language, seldom with the use of numbers) to quantitative (assigning numbers to observations).

4.4 General overview of the HIV/AIDS projects and their evaluations

In this section, some general guidelines are provided concerning the application of concepts (in the result presentation), followed by the socio-demographic data of those interviewed by the researcher, *viz* the beneficiaries, for focus group discussions, and the managerial staff and evaluators, for individual interviews.

4.4.1 General guidelines in the application of concepts (in result presentation)

It is acknowledged in this study that evaluation is an integral part of a project and therefore need not to be treated in isolation. The HIV/AIDS projects in the present study were, when deemed vital (for purposes of clarification and convenience), separated from their evaluations. For the same purpose, the terminologies 'projects' 'programmes' and 'interventions' were used interchangeably to refer to an HIV/AIDS scheme or plan of action in curbing the spread of HIV/AIDS in a given community. 'Interviewees' or 'respondents' were used to refer to all the parties of the study (beneficiaries, managerial staff and evaluators). Where necessary, details of their differences were provided: details such as beneficiaries falling in the category of those for focus group discussions and managerial staff and evaluators in the category of those for individual interviews. The terminology 'participants' and 'beneficiaries' were used to refer to recipients of a particular project.

In this research, the benefactors were limited to the peer educators. This was because of the number of benefactors that stretched right to the wider community. To narrow the list, for easy access and analysis, the peer educators were chosen to represent that whole range of benefactors. Given the sensitivity of the issues raised in the study and the researcher's promise to maintain confidentiality of information disclosed, details such as names of donor organisations and projects were omitted. Projects and their evaluations were referred to as a project or an evaluation 1, 2, 3, 4 and 5.

4.4.2 Socio-demographic data of interviewees of the HIV/AIDS projects and their evaluations

In Table 4.7, a summary of the socio-demographic data of those interviewed (as a focus group and individually) about the HIV/AIDS projects of this study, and their evaluations, is presented.

Table 4.7: Socio-demographic data of interviewees from all five HIV/AIDS projects

Socio-demographics	Category of interviewees N=40		
	Beneficiaries N= 30	**Managerial Staff N= 5**	**Evaluators N= 5**
Gender:			
Females	22	3	4 (2 Internal, 2 external)
Males	8	2	1 (Internal)
Ethnic group:			
Blacks	30	5	1
Whites	–	–	3
Coloureds	–	–	1
Age range:			
12-18	18	–	–
19-29	12	2	–
30-39	–	1	2
40+	–	2	3
Main languages:			
isiZulu	30	5	1
English	–	–	3
Afrikaans	–	–	1

Five focus groups (of beneficiaries of the HIV/AIDS projects and their evaluations) were organised, one for each project. This means that Project 1 had a focus group of five beneficiaries, projects 2 of seven and projects 3, 4 and 5 of six each. All these give a total of 30 beneficiaries, as reflected on Table 4.7. The beneficiaries were all black South Africans (100%), who could communicate most effectively in isiZulu. They were of varying gender and age groupings. The focus group of project 1 was made up of three (60%) females and two (20%) males, project 2, five (71%) females and two (29%) males and project 3, four (67%) females and two (33%) males, all within the age range of 12 to 18. Projects 4 and 5 were made up solely of females (100%), within the age range of 19 to 29. In total, all the HIV/AIDS focus groups were made up mostly of females (73%). The majority of the focus group members (60%) were within the age range of 12-18 and the minority (40%) within the age range of 19 - 29.

For each of the HIV/AIDS projects of this study, one managerial staff member and one evaluator were interviewed. Table 4.7 paints a vivid picture of their socio-demographic composition. A composition, that reflects to a great extent the set up of all the HIV/AIDS projects (including the evaluations) of this research (see Table 4.3). Table 4.7 reveals that three female and two male managerial staff members above the age of 19 were interviewed. All of them (100%) were black South Africans who could communicate most effectively in isiZulu. In terms of the five evaluators that were interviewed, three were internal (projects 1, 4 and 5) and two external (projects 2 and 3). Most of them (80%) were females of whom (60%) were of the white race and fluent in English (40%) and Afrikaans (20%). The other female evaluator was a black South African isiZulu-speaker and the lone male a Coloured English-speaker.

There is no doubt that when one examines the cultural and linguistic dynamics of the different parties in the five HIV/AIDS projects (beneficiaries, evaluators and managerial staff), questions of uncertainties are raised, questions such as how the linguistic and cultural gaps between evaluators, for example, and beneficiaries are taken care of. This is especially important where 80% of the project evaluators cannot communicate effectively in isiZulu. The opposite is true with the beneficiaries that they evaluate; they are all black South Africans who can communicate most effectively in isiZulu.

From the researcher's findings, such linguistic and cultural problems were taken care of in varying ways. The way the HIV/AIDS projects were structured helped to minimise cultural and linguistic barriers. Most of the managers, as seen in those interviewed in this study, were black South Africans who could communicate effectively in isiZulu and in English. The internal evaluators of project 1 (Coloured English-speaker) and project 5 (white Afrikaans-speaker) could communicate in isiZulu, though not proficiently. In project 2, the external white English-speaker worked with trained black isiZulu-speakers as field assistants. In project 3, the external evaluator (white English-speaker), worked closely with one of the black South African managers of the project. This manager, though she communicated most effectively in isiZulu, was also versed in English, so she was the one who did most of the actual fieldwork.

The above section provided a general overview of the different projects and their evaluations and the socio-demographic data of the different categories of those interviewed in the study. Disparities in the socio-demographic set-up of the parties involved in the projects and their evaluations were noticed, these particularly so in areas of ethnicity and language. The different ways in which the disparities were addressed, for example the deployment of managerial staff and field assistants that were commensurate to the beneficiaries, apparently helped to minimise their impact on the projects and their evaluations.

The section following, presents the results pertaining to the findings from both the projects and their evaluations. As mentioned in the introductory section, the HIV/AIDS projects and their evaluations were treated as a whole, given that evaluation was an integral of a project, but for purposes of clarity, results of the projects are presented first, followed by those of their evaluations.

4.5. General interest results presented in relation to both projects and their evaluations

To maximise the chances of tapping out information necessary to answer the key question of this research (see Introduction in 4.1), questions of general interest about the projects and their evaluations were asked to the interviewees and their responses are presented in this section.

It was considered vital to get the values of interviewees, the challenges in meeting those values and a way forward vis-à-vis running a project and evaluating it. These values can be argued to have been essential in shaping the general outlook and expectations of the targeted parties in the different projects and their evaluations studied in this research. This is because, when a project of this nature (with social implications), is approached in view of the different expectations of the parties concerned, the outcome is likely to be better understood and appreciated.

i) Values held by interviewees in the running and evaluating of HIV/AIDS projects
Table 4.8 presents the different values held by interviewees in the implementation and

evaluation of projects. Considering that the values provided by the interviewees for the implementation and evaluation of projects were identical, only one table was provided for the results. The researcher considered the values to be vital in shedding more light on the targets and expectations of projects and evaluations, such as they ones in this research. To get the values, open-ended questions were asked of the interviewees, with prompts attached to them. The prompts were considered vital in keeping the interviewees within the research perspective. To widen the scope of the interviewees, and to maintain their freedom to reason what they perceived was proper; they were given the opportunity to either choose from the prompts or make their own propositions.

Table 4.8: Perceived values held by interviewees regarding the HIV/AIDS projects and their evaluations

*Values	Groups of interviewees' responses**		
	Beneficiaries*** N=5 focus groups	Managerial staff N=5	Evaluators N=5
Target recipients on individual basis	0 (0%)	0 (0%)	0 (0%)
Target recipients as a group	5 (100%)	5 (100%)	5 (100%)
Derive meaning of project and its evaluation from recipients	4 (80%)	5 (100%)	4 (80%)
Derive meaning of project and its evaluation from donors	1 (20%)	0 (0%)	1 (20%)
Derive meaning of project and its evaluation from project implementers	0 (0%)	0 (0%)	0 (0%)

*Values obtained by asking open-ended questions with prompts
**Only positive responses (the 'yes' responses) were reflected
***Score was given only when there was a unanimous 'yes' response in the group

A unanimous response (100%) was obtained from all the different categories of interviewees (beneficiaries, managerial staff and evaluators), with respect to projects and their evaluations targeting recipients in a group or community form, as apposed to doing so

on an individual basis. Different reasons were advanced for such a preference. These reasons were put together to reflect thus:

"In implementing and evaluating community projects, the implementers should work together, not just with the individuals, but also with the target groups or communities to seek for solutions to the social crisis" *(comment from a beneficiary, project 2).*
"The spread and impact of HIV/AIDS is linked to the behavioural pattern of the society concerned, meaning it is not just an individual matter, but also that of the community, needing groups of individuals to come together and reason out ways of dealing with it" *(Comment from a managerial staff member, project 3).*

Approximately 87% (average response rate) of the different categories of interviewees valued the fact that the meaningfulness of a project and its evaluation should be derived from the views of the recipients, as opposed to those of the donors and project implementers. In summary, what was unanimously pointed out, as rationale for favouring recipients, was the fact that recipients are the main targets and benefactors of a project and its evaluation initiatives and as such should be given preference in deciding what is considered meaningful (to them).

The issue of going beyond individuals to targeting communities falls in line with some of the objectives of the HIV/AIDS projects of this study and their evaluations. In the HIV/AIDS projects and, by extension, their evaluations, the project implementers intended to empower both individuals and communities. They intended to empower the beneficiaries (peer educators) to seek solutions for identified problems. They also intended to expose their recipients to the different opportunities available for them to fully participate in discussing issues that they considered meaningful in addressing the HIV/AIDS crisis. Such objectives were those assessed, whether they were met by the projects and their evaluations, or not.

Interviewees supported group participation and preference was given to recipients. They did, however, acknowledge certain challenges to that effect, as discussed below.

ii) Perceived challenges in maintaining the values of projects and their evaluations

Table 4.9 shows some of the challenges perceived by interviewees in maintaining the values of projects and their evaluations. Similar to the way responses to the perceived values were sought, open-ended questions with prompts were asked of the respondents. Their freedom to reason in a wider dimension was maintained, as they were also given the option to either select from the prompts or give their own propositions regarding the challenges.

Table 4.9: Interviewee's perceived challenges in maintaining project and evaluation values

Challenges	Groups of interviewees' responses*		
	Beneficiaries N=5 focus **	Managerial staff N=5	Evaluators N=5
Time constraint	3 (60%)	4 (80%)	4 (80%)
Poor meeting attendance	4 (80%)	4 (80%)	4 (80%)
Budget constraint	5(100%)	5 (100%)	5 (100%)
Dilemma with regard to the right role-player to please	5 (100%)	5 (100%)	5 (100%)
Synchronising ideas (Striking a compromise)	5 (100%)	5 (100%)	5 (100%)

*Only positive responses (the 'yes' responses) were reflected
**Score was given only when there was a unanimous 'yes' response in the group

According to the results shown in Table 4.9, all three categories of interviewees (100%) unanimously cited budget constraints, dilemmas as to which role-player to please and synchronising (selecting from the bulk and putting together) the different ideas of the role-players as major challenges. A beneficiary in project 1 said, " If project implementers and evaluators listen to the donors to our disadvantage, then we will not be part of the project or evaluation". Another beneficiary of project 1 added that "If, on the other, project implementers and evaluators listen to us, to the disadvantage of the donors, the donors may not release money for the project to function".

Eighty percent of interviewees identified poor meeting attendance as a challenge. This was followed by time constraints (73% = average response rate). In summary, the respondents

felt that the availability of enough money to budget for broad-based meetings (including all parties), and to do so regularly in order to secure full participation of all parties, was an issue. Even though they agreed on giving preference to the views of the recipients of the projects and their evaluations, they did, nonetheless, admit that the ideas of the other party members (donors, evaluators and project implementers) were equally important, posing the challenge of how to synchronise these ideas without undermining the priority group (recipients). Most of the time, interviewees held that, from experience, when broad-based meetings are called, only a handful of people respond and the rest complain of not being able to find time to attend.

For a way forward, most of the interviewees (on average 95% of the three categories of interviewees) insisted on broad-based committees that would ensure full participation of all the parties in the project and its evaluation. They felt that thus should be encouraged, irrespective of whatever it would take to achieve it.

Judging from the general perceptions of interviewees regarding values to be encouraged in projects and their evaluations, one noticed that so much was unravelled relating to this study. The perceived values, the challenges in meeting them and the way forward were seen to paint a clearer picture of issues examined in this study. This was more noticeable in the area of the objectives of the HVI/AIDS projects and their evaluations, as they handled similar issues of empowerment by maximum participation. With this in mind, it was worth seeing how these issues and others were dealt with in the HIV/AIDS projects and their evaluations under study.

4.6 Responses directly related to factors affecting the meeting of the objectives of the projects under study

Certain factors that possibly contributed (either positively or negatively) towards the projects meeting their objectives (see Table 4.1) or impacting their targeted communities by way of the participatory methodology, were investigated; factors such as the degree to which the interviewees were informed about the projects, the stages in which they were

involved in the projects and the different activities that they were exposed to. The results of the investigations are presented below.

4.6.1 Average knowledge level of interviewees regarding all HIV/AIDS projects

In order to determine the degree to which beneficiaries, implementers and evaluators participated in their different projects; questions relating to their knowledge about the projects were asked. These included the purposes of the projects, those who asked for them, which methodologies were used, when the projects were carried out and their duration. Knowledge levels were judged according to the quality of responses and the levels stretched from low to high (see Table 4.6 for details in classification). Shown in Table 4.6, the absence of extensive ratings, including modes, was due to the small sample size and the need to simplify data.

Table 4.10: Average knowledge level of interviewees regarding all HIV/AIDS projects

Knowledge	Knowledge Level		
	Beneficiaries N= 5 focus groups	**Managerial staff N= 5**	**Evaluators N= 5**
Purpose of project High Low	Low *- 5	High 5 -	High 3 2
Who asked for the project High Low	Low - 5	High 5 -	High 3 2
Methodology used High Low	Low - 5	High 5 -	High 3 2
When project started High Low	Low - 5	High 5 -	High 3 2
Duration of project High Low	Low - 5	High 5 -	High 3 2

*- Means in accordance with the classification rate of Table 4.6; none reflected that scale rating

The knowledge level was considered low from the focus group interviews with beneficiaries of all the HIV/AIDS projects. In all the five focus groups, none of the beneficiaries could adequately and precisely provide information regarding the purpose of the project, who asked for it and when it was carried out. In project 1, for example, one of the focus group members, in order to defend her ignorance, claimed she got involved

through the invitation of friends who did not brief her sufficiently about the project. Judging from the shallow responses of the beneficiaries, it can be argued that they were not adequately and precisely informed (by project implementers) of the necessary details of the projects. It can also be argued that the project implementers had not precisely informed the beneficiaries because they underestimated the value or contribution of such information to meeting the objectives of the projects. Objectives such as skill acquisition and empowering of the beneficiaries could be attained by the provision of adequate information. This is so because adequate information could be seen to expose recipients to a deeper and wider understanding of a project, a situation which is likely to give recipients an opportunity to master the intricacies embedded in a project and thus offer more useful contributions.

The beneficiaries could provide some sketchy but precise information, regarding the duration of the project. In projects 1, 2 and 3, a unanimous response was given concerning the date that had been fixed for a school festival of plays and other performances for the coming academic year (meaning the project was likely going to be extended for the coming year). In projects 4 and 5, the beneficiaries had not been informed of any termination of their activities, meaning they were sure of going ahead with their programmes, some of which involved the visiting of 'shebeens' (drinking places), to act plays, sing songs and engage the drinkers in HIV/AIDS discussions.

Where the focus group respondents came out the strongest was in the way each of the projects was run. In each of the 5 focus groups most of the members (approximately 80% of the members, i.e. 4 out of 5 members) could tell with excitement that their project was run through a series of workshops involving role plays, games, discussions and even the 'Felicia show' (similar to the 'Oprah show', where there is a main speaker, an audience and time slots of projected recordings). The beneficiaries selected for this study were peer educators. Therefore they constituted the training workshops and youth clubs, where all the necessary activities took place. They also formed part of the acting team that went out to the communities and to other schools to influence them, thus indicating the necessity for them to be adequately informed about the way their projects were carried out.

Of the five different project managers that were interviewed, all of them (100%) were adequately and precisely informed of the necessary details of their projects. The HIV/AIDS projects were managerially driven. The managerial staff members oversaw the overall planning and day-to-day running of the projects and, therefore, were very much abreast with what went on.

From the overall performance of the five evaluators, their knowledge level was comparatively high, considering that, out of the five of them, three (60%) were able to adequately and precisely provide the required information. These three were the internal evaluators, who were handling managerial positions. The two (20%) who could not adequately and precisely provide the required information were the external evaluators. They were not present from the outset of the projects.

4.6.2 Stage of participation of interviewees in project

The degree to which beneficiaries, managerial staff, evaluators and donors participated in their projects was examined in terms of their presence (active present) at the different stages of the projects. Questions required interviewees to indicate if they were present in one or more of the following stages: planning, action-planning, execution and result-feedback stages of the project. The stages of involvement were judged according to the respondent's presence in any of the discussion forums or stages. The levels stretched from zero to low and to high (see Table 4.6 for details in classification).

To facilitate understanding of the different stages, the researcher considered the planning stage of a project to be a stage of discussion and/or fine-tuning ways of addressing identified problems and the action planning stage, that of conducting a project. The execution stage was that of the actual fieldwork and/or co-ordinating it. The final stage (result-feedback) was that of discussing and/or fine-tuning conclusions, making recommendations and deciding future plans.

Table 4.11: Beneficiaries, managerial staff, evaluators and donors' stages of involvement in all HIV/AIDS projects

Stage	Beneficiaries' involvement N=5 focus groups	Managers' involvement N=5	Evaluators' involvement N=5	*Donors' involvement N=10*
Planning stage Present Absent	Zero **- 5	High 5 -	High 3 2	Low 4 1
Action-planning stage Present Absent	Zero - 5	High 5 -	High 3 2	Low 4 1
Execution stage Present Absent	High 5 -	High 5 -	High 3 2	Low 4 1
Result-feedback stage Present Absent	Zero - 5	High 5 -	High 3 2	Low 4 1

*Donors were not contacted. The five managerial staff and the five evaluators of the study reported on their participation
**- Means in accordance with the classification rate of Table 4.6; none reflected that scale rating.

Except at the execution stage, none of the beneficiaries (0%) indicated being present in any of the stages of the projects. On the contrary, all the managerial staff (100%) noted their own presence at different stages of their projects. The HIV/AIDS projects of this study are managerial-driven, with peer educators (beneficiaries) surfacing mainly at the execution stage of the projects; the stage where they are needed for training and for expanding their activities.

The presence of the evaluators in the different stages of their projects was noted to be relatively high. Three (60%) of the five evaluators interviewed were present at all the different stages. The three were the internal evaluators, who formed part of the management team of the HIV/AIDS projects. The two (20%) external evaluators were involved only in the evaluation of the HIV/AIDS projects.

The presence of donors in the different stages of the HIV/AIDS projects was low. It was only in project 3 that the donors were present at all the stages of the project. In this project,

one of the managerial staff specified the existence of a working committee. This committee was made up of members from their project, the donor organisation and from the community healthcare workers (employed by the donor organisation). Beneficiaries of the project were absent from the committee. The committee was involved in the actual planning and execution of the project's activities. The other four projects did not have such a broad-based committee; rather they had *ad hoc* committees such as managerial staff or co-ordinators' meetings. In project 1, for example, *ad hoc* meetings such as those involving management and the director of the project to brief one another of happenings and progress in project implementation took place, on average, quarterly.

In project 2, additional biannual meetings involving management, the director of the project and donors took place to resolve ambiguities. In projects 4 and 5, quarterly managerial staff (co-ordinators) meetings took place with head managers to relax, exchange new ideas, resolve ambiguities, build and strengthen group relationships and distribute materials such as condoms, teaching tools (flip charts) and peer educators' uniforms. Pairing up of managerial staff (more experienced staff with less experienced staff) for mentoring purposes also took place in these managerial staff meetings of projects 4 and 5. Weekly *ad hoc* meetings involving peer educators for the exchange of ideas took place as well, in all the HIV/AIDS projects. In projects 4 and 5, in some of such meetings, the peer educators 'bring and share their supper' and plan visits to the homes of their colleagues and those not well who were amongst them. All these were implemented for the purpose of strengthening ties and demonstrating group love, which, in turn, is considered to filter down to the larger community in which they live.

As expected, in comparison to all the other stages, results from the findings of this study revealed that the execution stage was that with the most activities. All the managerial staff and beneficiaries interviewed, indicated their presence at this stage. Many different group activities, such as drama, songs and dances, were noted at this stage. The different activities were an indication of how far the beneficiaries were involved in the different projects (the more the activities, the more their involvement in the activities).

Table 4.12: Magnitude of group involvement at execution stage of project (judged according to the number of group activities in each of the HIV/AIDS projects)*

Case studies	Group activities							
Project N=5	Drama	Song	Dance	Discussion	Poetry	Enactment	Video	'Felicia show'
1	1	1	1	1	1	1	1	1
2	1	1	1	1	1	_	_	_
3	1	1	1	1	1	_	_	_
4	1	1	1	1	_	_	_	_
5	1	1	1	1	_	_	_	_

* In the Table, '1' stands for a group activity that was carried in each of the projects and '_' for the 'absence' of it.

Project 1 had the highest number of group interactive activities (eight), showing how far the project went to get its target community involved. This was followed by projects 2 and 3, with five different group interactive activities and projects 4 and 5, with four. These activities were performed with the participation of the targeted communities. In projects 1, 2 and 3, for example, the peer educators prepared themselves for opportune occasions such as 'open days' and 'club launchings'. During such occasions, different group activities such as those listed in Table 4.12 took place. To make the activities interactive, the community was brought into the performances. The peer educators, in their acting, unveiled intentional issues such as polygamy and premarital sex; these issues being those they sought to redress via participation. In one of the dramas, for example, a peer educator was dressed like an old traditional noble and approached a high school girl for another wife in order to uphold his culture. The high school girl, having very little control of her body by virtue of her gender status, reluctantly accepted the offer. Another peer educator dressed like a school boyfriend presented the girlfriend with a sex offer. She, having no power to say 'no', agreed to sex without protection and later became pregnant and infected with HIV. The audience was then given the opportunity to comment on such behaviours and some volunteers were asked

to come on stage and demonstrate what they thought was the right approach to solving the problems. In doing so, they repeated the acting, doing what they thought was correct.

Another example of how the audience participated in a project's activity was taken from projects 4 and 5. As aforementioned, the out-of-school peer educators in these projects targeted hotspots such as 'shebeens' (drinking clubs). After prior notice to the club owners of their mission and date of performance the peer educators gathered in the club. They sang a few songs relating to their topic of discussion for the day and a sketch acted out in that regard as well. For a discussion on truck-drivers and high-risk behaviours, they acted sketches thus: a truck driver hastily drives on with his conductor. He stops at a particular spot to 'ease himself' and, in the process, 'disappears' with a prostitute into a dark corner. After the acting, the audience was brought into a discussion pertaining to what took place. They were given the opportunity to ask and answer questions, paying attention to the danger of HIV/AIDS.

Respondents were asked to comment on the varying degrees to which they participated or got involved in their respective projects. In all five focus groups, the beneficiaries raised concern for more participation, for example for them to be involved in all the stages of the projects. According to them, that would give them more opportunities to make suggestions that might be useful for the better implementation of the project. It would also give them more opportunities to acquire skills, for example communication and organisational skills. It would enable them understand similar HIV/AIDS projects and their implementations. "Tomorrow we will be running the projects, so we need to learn everything" (comment from beneficiary: project 2).

The beneficiaries were excited with the degree and quality of their involvement at the execution stage. In the five focus groups, the beneficiaries spoke in chorus form of the different ways in which they participated (in drama, songs and discussions). One of the beneficiaries of project 1 said that the Felicia show was like bringing the TV live to them and they were able to discuss serious matters among themselves in a lively way. They listed a number of benefits that accrued from that. These benefits stood as additional evidence of

the impact of the different projects in the lives of those targeted (see section 4.8 for more of the benefits).

Most of the managerial staff (80%) and evaluators (60%) were particularly concerned with the absence of beneficiaries at the planning, action-planning and result feedback stages of their respective projects. Something they could have included in order to have more impact on the people. They thus advocated more involvement or participation of all the concerned parties in the different stages of the projects, particularly the beneficiaries who were the main targets of the different projects.

The (20%) managerial staff and (40%) evaluators that were not particularly concerned with the absence of beneficiaries at the planning, action-planning and result feedback stages of their respective projects, gave various reasons. The evaluator of project 3, for example, said HIV/AIDS project 3 was designed for primary school pupils and to her, what do primary school pupils know about project designing and what can they contribute to that effect?

From the findings of this study as a whole, one was made aware of the fact that the composition of all the HIV/AIDS projects was similar in many respects to their evaluations. In fact, as earlier stated, the evaluations were embedded in the projects (not to be treated separately), which, for purposes of clarity, were looked at separately in this part of the research. The same questions that were asked about the projects were, nonetheless, asked to the same categories of interviewees (beneficiaries, evaluators and managerial staff) about the evaluations. This was to get more in-depth responses deemed necessary for the complete analysis of findings of this research. The responses of the interviewees *a propos* the evaluations are provided in the section below.

4.7. Responses pertaining to questions directly related to HIV/AIDS evaluations under study

Similar to the implementation of the HIV/AIDS projects, factors were investigated that contributed (either positively or negatively) towards the evaluations meeting their objectives or impacting their targeted communities via the participatory methodology.

4.7.1 Average knowledge level of interviewees regarding the HIV/AIDS evaluations

In order to get the degree to which beneficiaries, implementers and evaluators participated in their different evaluations; questions relating to their knowledge about the evaluations were asked. These included the purposes of the evaluations, those who asked for them, which methodologies were used, when the evaluations were carried out and their duration.

The knowledge levels of the interviewees regarding the evaluations were judged according to the quality of responses. The average knowledge levels of interviewees ranged from low to high, following the criteria in section 4.3.7: Table 4.6.

Table 4.13: Average knowledge level of interviewees regarding all HIV/AIDS evaluations

Knowledge	Knowledge Level		
	Beneficiaries **N=5 focus group**	**Managerial staff** **N=5**	**Evaluators** **N=5**
Purpose of evaluation High Low	Low *- 5	High 5 -	High 5 -
Who asked for the evaluation High Low	Low - 5	High 5 -	High 5 -
Methodology used High Low	Low - 5	High 5 -	High 5 -
When evaluation started High Low	Low - 5	High 5 -	High 5 -
Duration of evaluation High Low	Low - 5	High 5 -	High 5 -

*- Means in accordance with the classification rate of Table 4.6; none reflected that scale rating

Similar to the analysis of the projects, the knowledge level of the beneficiaries in the HIV/AIDS evaluations was considered low (see Table 4.13). In all the five focus groups, none of the beneficiaries could adequately and precisely provide information regarding why

evaluations were carried out, who asked for them, when they were carried out and their duration. Judging from the shallow responses of the beneficiaries, it can be argued that beneficiaries were not adequately and precisely informed (by concerned managerial staff or evaluators), of the necessary details of the evaluations, as in Table 4.1. It can also be argued that the managerial staff and the evaluators concerned with the evaluations had not precisely informed the beneficiaries, underestimating the value or contribution of such information in enhancing the objectives of the evaluations. Objectives were skill acquisition and empowering of the beneficiaries (via the evaluation process) whereby they are adequately informed of the evaluation in order that they can master the intricacies of it and thus offer more useful contributions. This view was otherwise expressed in "The African evaluation guideline" (AfrEA 2002): that an evaluation should be efficient and produce information of sufficient value.

Where the beneficiaries came out strongest was in the way each of the evaluations was conducted. In project 1, all the members could in one way or another, explain how one of the project implementers (most probably the internal evaluator) asked them questions after each performance session. The members talked of questions (asked to them), such as their impressions about the way the sessions were conducted, what it did or did not do for them and how performances could be improved. In projects 2 and 3 approximately 54% (four members out of seven and three out of six, respectively) could explain in one-way or another that somebody came from outside (the external evaluator), assembled them in a group and asked them questions pertaining to their projects. In projects 4 and 5, most of the members (approximately 67% of the members, i.e. four out of six members) could tell that the evaluation was done by the use of quality self-administered checklists, with the supervision of internal evaluators (see Appendix A).

Of the five different project managerial staff members that were interviewed, all of them were adequately informed of the necessary details of the evaluations. They could adequately and precisely state why the evaluations were carried out, who asked for them, the methodology used, when the evaluations started and the duration. Considering that the managerial staff members were at the helm of the affairs of the projects and by extension, their evaluations, they were very much in tune with what had occurred.

As can be seen from Table 4.13, there was no difference in the calibre of the three internal and two external evaluators concerning information about the necessary details of the evaluations. These evaluators were, in the main, the implementers of the evaluations and thus knew much.

4.7.2 Stage of participation of interviewee in evaluation

The degree to which beneficiaries, managerial staff, evaluators and donors participated in the evaluations was examined in terms of their presence at the different stages of the evaluations. To know in which of the stages the respondents participated, a set of questions which required respondents to indicate if they were present in one or more of the following stages: planning, action-planning, execution and result-feedback stages of the evaluations. The stages of involvement were judged according to the respondent's presence in any of the discussion forums or stages. The levels stretched from zero to low and to high (see Table 4.6 for details in classification).

To facilitate understanding of the different stages, the present researcher considered the planning stage of an evaluation to be a stage of discussing and/or fine-tuning ways of addressing identified evaluation problems. The action planning stage was that of discussing and/or fine-tuning ways of conducting an evaluation. The execution stage was that of the actual fieldwork and/or co-ordinating it. The final stage (result-feedback) was that of discussing and/or fine-tuning conclusions, making recommendations and deciding future plans.

A slightly different portrait was noted when compared to interviewees' involvement at the different stages of the projects. Similar to the HIV/AIDS projects, all the beneficiaries were absent in all the stages of the evaluations with the exception of the execution stage. However, unlike in the HIV/AIDS projects where all the five managerial staff noted their presence in the different stages of the projects, in the evaluations (see Table 4.14), only one managerial staff (20%) indicated her presence in all the stages of the evaluations. This managerial staff (from project 3), unlike the rest of the managerial staff, assisted the external evaluator in the evaluation of project 3 thus was present with her in the different stages of the evaluation. As expected, all the evaluators (100%) specified that they were

present at all the different stages of the evaluations. Meanwhile in the projects it was 60% of them (those that formed part of the management team the exception being the two external evaluators) that indicated their presence in all the stages of the projects. None of the donors (0%) were present at any of the stages of the evaluations, unlike in the HIV/AIDS projects were some of them (in project 3) were present as part of the project's committee.

Table 4.14: Beneficiaries, managerial staff, evaluators and donors' stages of involvement in all HIV/AIDS evaluations

Stage	Beneficiaries' involvement N=5 focus groups	Managers' involvement N=5	Evaluators' involvement N=5	*Donors' involvement N=10*
Planning stage Present Absent	Zero **- 5	Low 1 4	High 5 -	Zero - 5
Action-planning stage Present Absent	Zero - 5	Low 1 4	High 5 -	Zero - 5
Execution stage Present Absent	High 5 -	Low 1 4	High 5 -	Zero - 5
Result-feedback stage Present Absent	Zero - 5	Low 1 4	High 5 -	Zero - 5

*Donors were not contacted. The five managerial staff and the five evaluators of the study reported on their participation
**- Means in accordance with the classification rate of Table 4.6, none reflected that scale rating.

In view of the portrait of respondents' (interviewees') involvement in the different stages of the evaluations under study, it can be deduced that the evaluators (both internal and external) were in the main, fully responsible for the entire planning and running of their respective evaluations. The project implementers (including the managerial staff) and donors apparently agreed on the necessity of evaluating their projects including when and how they would be carried out. When that was settled, the task of planning, implementing and producing of the final evaluation report was then left into the hands of the evaluators.

As expected, participation was greatest at the execution stage (similar to the project). All the beneficiaries and evaluators interviewed (100% respectively), indicated their presence at this stage. Eighty percent of the managerial staff, except in project 3 (managerial staff assisted the external evaluator in the evaluation) and all the donors were absent.

Besides the evaluation methodologies such as the conducting of individual interviews and the use of questionnaires (see Table 4.1), activities such as focus group discussions (similar to those in HIV/AIDS projects) were organised by the evaluators for their HIV/AIDS evaluations. In the focus groups, the evaluators of the HIV/AIDS projects gave the beneficiaries the opportunity and liberty to air their views about the projects. The approach used in all the HIV/AIDS projects (where project implementers acted as facilitators and not as 'bosses') was the same approach that the evaluators used in evaluating all the HIV/AIDS projects.

With regard to the different degrees to which interviewees participated or got involved in their respective evaluations, they were asked to air their views. The responses were similar in many respects to those given about the HIV/AIDS projects. In all the 5 focus groups, the beneficiaries respectively said they would have loved to be involved in all the stages of the evaluations without any exception. According to them, that would give them an opportunity to make suggestions that may be useful for the better running of the evaluations. It would give them an opportunity as well to acquire more skills, for example, communication and organisational skills. It would enable them understand evaluation and its implementation better.

In the different evaluations, the beneficiaries, however, expressed their satisfaction with the degree of their involvement at the execution stage. Beneficiaries in project 1, similar to those in the other projects listed a number of benefits that accrued from that. Benefits such as: the evaluation via focus group discussion being a continuation of a learning, empowering and skill acquisition process from that in the project implementation where ideas are freely expressed and shared. In project 4, a beneficiary said "with the checklist and the discussion that follows, we are able to see where we fall short, for example in maintaining quietness and how we can improve that for the next performance".

Most of the managerial staff (80%) and evaluators (60%) were concerned as well with the absence of parties such as beneficiaries at the planning, action-planning and result feedback stages of the evaluations. Something they could have done in order to better impact the people. They thus, advocated for more involvement or participation of all the concerned parties particularly the beneficiaries who are in the main, the recipients of the fruits of the evaluations. The evaluator of project 1 stressed the importance of getting beneficiaries as involved as possible in order to empower them; but expressed the difficulty in doing so due to the question of time and other constraints.

On the other hand, the minority (20%) of managerial staff and evaluators (40%) were not particularly concerned with the absence of beneficiaries at the planning, action-planning and result feedback stages of the evaluations, as they did not perceive it very necessary. As in the project, the evaluator of project 3 said she was evaluating primary school pupils and to her, what do primary school pupils know about evaluation and what can they contribute to that effect? The evaluator of project 4 talked of a prepared checklist ready for use at any time by the peer educators thus a preparatory meeting not very vital.

All in all, the quality outcomes of the HIV/AIDS projects of this portion of the study and their evaluations are presented below. The quality outcomes are presented according to the respective variables tested. The variables were tested in this research against the background of certain variability in the HIV/AIDS projects (and their evaluations). Variations, which are identified in section 4.1 to be:

➢ Socio-demographic variations (gender, race, language and age) of project implementers, evaluators and beneficiaries of the HIV/AIDS projects studied (and their evaluations);

➢ Rural-urban variation of the HIV/AIDS projects studied (and their evaluations);

➢ Variation in the choices of evaluators (some projects having external evaluators and others internal evaluators) in the HIV/AIDS projects studied (and their evaluations).

4.8: Overall quality outcomes of the HIV/AIDS projects studied and their evaluations

The outcomes of the HIV/AIDS projects as a whole (the projects right through to their evaluations) are discussed in this section in line with answering the key question: Does participatory methodology contribute towards the implementation and evaluation of a meaningful, useful and valuable HIV/AIDS project?

Meaningfulness, usefulness and value have been identified in this work to denote that which recipients of a project or an evaluation perceive to be important, helpful, practical or functional to them. For easy comprehension, the overall quality outcome results were summarily presented in a table. The table portrayed the variables tested vis-à-vis the published overall positive and negative quality outcome results of the HIV/AIDS project and their evaluations. Looking at the HIV/AIDS projects, the following indicator variables were tested by the researcher: Group participation, awareness, knowledge, attitude, empowerment, effective functioning and sustainability.

Table 4.15 gives a vivid summary of the different variables (variables drawn from the HIV/AIDS project objectives of this study) that were tested in this part of the study. The variables were tested in relation to the extent to which each of them was met using the participatory methodology at both the implementation and evaluation phases of the projects. The extent to which the background (gender, age, language, location, race, internal/external evaluator variations of the beneficiaries, managers and evaluators) of each of the HIV/AIDS projects impacted on the variables was also tested.

4.15 Overall indicator variables and quality outcome results

Variation categories	Condensed project variations*					
	Project 1	Project 2	Project 3	Project 4	Project 5	
Gender (beneficiaries, managers and eval)	Mixed	Mixed	Mixed	Females	Females	
Race (beneficiaries, managers and eval)	**Eval Coloured	Eval White	Eval White	All Black	Eval White	
Language (beneficiaries, managers and eval)	Eval English	Eval English	Eval English	All isiZulu	Eval Afrikaans	
Age (beneficiaries, managers and eval)	***Wide	Wider	Widest	Narrow	Narrow	
Rural-urban	Urban	Rural	Rural	Urban	Urban	
Internal/External eval.	Internal	External	External	Internal	Internal	
Variables tested	****Project variable ratings					
						Average per variable
Awareness	5	4	5	5	5	4.8
Knowledge	5	4	5	5	5	4.8
Attitude	5	4	5	5	5	4.8
Empowerment	5	4	5	5	5	4.8
Effective functioning	4	4	5	4	4	4.2
Sustainability	3	3	4	5	4	3.8
Average rating per project	4.5	3.8	4.8	4.8	4.7	
Overall project average	4.5 (very high)					

* Variations assigned on basis of Tables 4.1, 4.3 and 4.7 content. **Eval=Evaluator
**Classification levels is from the narrow age gap differences between implementers (including evaluators) and beneficiaries to the widest
****Rating values assigned on basis of Tables 7.1 to 7.5 content in Appendix D evaluation reports findings and interview responses. Rating scale was from 1-6.
1=Very   low   (VL),   2=   Low   (L),   3=Average   (A),   4=High   (H),   5=Very   high   (VH),   6=Excellent   (E).

Judging from Table 4.15, it is noticed that irrespective of the different background situations projected in all the HIV/AIDS projects, the overall performance in terms of the variables tested was very high (5). This referring to the fact the background situation of the projects had minimal negative impact on the projects. It should, however, be noted here that certain conscious efforts were made by the implementers of the different projects to minimise the effect of these background situations on the projects. Examples of such efforts include: the selection of managerial staff to be concomitant to the beneficiaries. A projection of this is seen in section 4.4.2 where most of the managerial staff (similar to those interviewed in the study) of the different projects, were of the same race and language group as the beneficiaries. The managerial staff members were, in the main, Black South Africans who besides their capability of communicating in English, could effectively communicate in isiZulu as did the beneficiaries.

In cases of mixed races different, alternative arrangements were made. The internal evaluators of projects 1 and 5, though of different race and language groupings (Coloured English and White Afrikaans respective speakers) could also communicate in the language of the beneficiaries (isiZulu). In project 2 the external White English-speaker who could not communicate in the language of the beneficiaries (isiZulu), worked with trained Black isiZulu-speakers as field assistants. In project 3, the external evaluator (White English-speaker) did likewise by working closely with one of the Black South African managerial staff of the project.

In spite the fact that Table 4.15 portrays on the overall, very high performance, some of the HIV/AIDS projects, nonetheless, performed better than others. Project 3 and 4 are some of those that performed better with them registering the most commonly occurring score (4.8). Project 2 though high; registered least of the five projects (3.8). In the main, project 2's position can be argued among other things to have been partly due to the fact that they had a less more helpful support system: a system, which affected to an extent, the smooth implementation of the project. The donors of the project, alongside the sponsored implementers were on the field but with little communication and collaboration (see Table 7.2): the one blaming the other for things not properly done (an issue which was resolved

but at the evaluative phase of the project via a discussion forum including the parties concerned).

Project 3 (one of the projects with the highest rating) on the other hand, had a committee made up of project implementers, community health care workers and donors of the project who worked collaboratively in the day to day running of the project (see Table 7.3). A forum: though not highly representative (beneficiaries not present) had the added advantage of enabling ambiguities to be resolved even at the early stages of implementation. One of such ambiguities was the issue of the project expanding its activities to include school hygiene such as cleaning of toilets (something which could have brought division or taken a while to resolve). The donors felt that was not part of the agreement as it was not an HIV/AIDS related matter. The managerial staff interviewed by the researcher said in that committee, the issue was raised and resolved amicably with them explaining to the donors the link between hygiene and HIV/AIDS.

Project 4 (of the same overall rating as project 3: the highest), had among other things an added advantage of a much more reliable support system for sustainability. The project (see Appendix A), took place in Mzinoni: head quarters of the project organisation where most of the provincial, divisional, zonal and area training meetings of coordinators took place. In all these meetings, project 4 beneficiaries had the added advantage of hosting, getting to exchange ideas and build up partners for expansion and joint project initiatives (projects that can be funded for the generation of income).

All in all, looking at the very high performance of all the HIV/AIDS projects put together (Table 4.15), the rationale for that is discussed below in relation to each of the variables tested. Identified inadequacies, which served as impediments to excellence, are, as well made mentioned of. In doing so, cognisance is taken of the researcher's reliance on the social diffusion theory (a theory which stood as the basis for the operation of the HIV/AIDS projects of this section of the study). The theory stipulates " people evaluate changes not by scientific evidence or authoritative testimony, but by subjective judgments of close, trusted peers who adopted changes and provide persuasive role models for change" (pointed out in Module 1 overview of project 4: See Appendix E).

4.8.1. Rationale of very high project performance (per variable tested)

Awareness and knowledge: From evaluation reports and as shown in Tables 7.1 to 7.5 (Appendix D), one gathered that irrespective of some differences, there was strong evidence to suggest that beneficiaries of all the HIV/AIDS projects had become critically aware of health matters due to their participation in the club activities. Activities, which they felt gave them the opportunity to share their experiences and rehearse 'real life situations' (dramatised the reality of HIV/AIDS) thus enabling them to be more serious in measuring and assessing their behaviours.

In all the evaluation reports (see appendix D) it was spelt out that the beneficiaries used correct terminologies to speak knowledgeably of the 'facts' about HIV/AIDS and could link discussions to issues of STIs, prevention of HIV/AIDS transmission, ways in which the virus can be 'slowed down' and many other health issues. In projects 1, 2 and 3, the evaluation reports revealed that beneficiaries were able, to a great extent, contextualise discussions about HIV/AIDS and show sensitivity on ways to treat People Living with AIDS (PLA's). They were aware of stigmatisation and, meaningfully, spoke of the essence to minimise it and rather show respect, love and support to HIV/AIDS sufferers.

In Project 3, the evaluation report, for example, revealed that one of the beneficiaries, prior to the workshops, thought HIV/AIDS was similar to influenza with infected persons avoided. In the same report, it was held that beneficiaries had internalised the message of rights. Beneficiaries "spoke with conviction and sincerity about 'rights'- the rights of PLA's and the rights of girls to say 'no'. One of the pupils referred to it as "… the constitution". To show the hunger in the hearts of the pupils to acquire as much as they could, project 3 report (similar to the other reports), highlighted the fact that in the group discussions, many relevant questions were asked. Also that group discussions ended naturally without any deliberate attempts on the part of the facilitators to do so. Babbie and Mouton (2001: 320) crowned the sharing of knowledge with the assertion that "the merging of this [local] knowledge and academic knowledge into a common field of knowledge permits the acquisition of a much more accurate picture, as well as a more profound understanding of a situation".

Attitudes: Similar to the extent of awareness and knowledge gained, attitude change is projected in Table 4.15 to be relatively high in all five projects. One of the ways in which project 1 dealt with the problem of stigmatisation was to network with people living with HIV/AIDS (Table 7.1: Appendix D). These people lived among the peer educators, interacted with them and facilitated their activities. Project 2 and 3 boosted the level of participation at the execution stage of the project by bringing people living with HIV/AIDS to participate in the focus group discussions of the projects and their evaluations (see Appendix A for details).

In response to the above interactions, the evaluation report of project 1 revealed that of every focus group with 13 to 15 members, at least four disclosed their status to the facilitators. They (those who disclosed their status) felt they were coping with HIV/AIDS as such, promised to publicly disclose their status in the coming year. There is no doubt that the number of those who disclosed their status is questionable in terms of reflecting the success of the project. When, however, one considers the background situation whereby prior to the HIV/AIDS projects, the beneficiaries indicated that they were unbending about disclosing their status, the number of those who did disclose, cannot be undervalued. In project 2, one of the beneficiaries declared that HIV/AIDS was no longer 'abstract' to him. In projects 4 and 5, the newly acquired value of the peer educators stands as an indication of the positive outcome of the projects. The reports of project 4 and 5 revealed that the beneficiaries were in the main former prostitutes and some living with HIV that were conscripted from the communities (on a stipend) and trained to serve as peer educators (see Table 7.4 and 7.5: Appendix D). Hoshmand and Obryne (1996) alleged that reliable knowledge of the human and social world could only be achieved in the process of attempting to change that world. Also that genuine change can only occur when it is accompanied by shifts in the knowledge base of those concerned.

Empowerment: It was stated in all the evaluation reports that beneficiaries were empowered as a consequence of the way the projects were conducted (using elements of participation). They were empowered in varying ways. Project 1 evaluation report talked of personal and group empowerment with beneficiaries making mention of self-efficacy and

group efficacy. As beneficiaries (of project 1) put their individual efforts together to acquire and practice ways of fighting, for example, discrimination against those with HIV/AIDS, they reported gaining individual and group confidence to act. The evaluation reports of project 2, 3, 4 and 5 also made mention of beneficiaries having been empowered to work as a team due to their acquisition of group and self-confidence. In addition, Project 3 report, spelt out that the boys reported being empowered to act responsibly within relationships, for example, to be patient sex wise, respect the views of the other partner, 'condomise', be open and be faithful. Girls reported to have been empowered to uphold their rights in sexual relationships. Both genders indicated being empowered to make proper choices and decisions relating to sex as well as taking responsibility for their health.

Effective functioning: Effective functioning in the area of strengthening collaborative relationships at all levels possible or having full participation of all concerned parties, the different evaluation reports as a whole, revealed that it was achieved to a relatively high extent. The implementers of all the HIV/AIDS projects were noted to be acting as facilitators: willing to give as well as to receive. It was, for example, highlighted in the evaluation report of project 3 that one of the beneficiaries commended the facilitator to be a good role model for them in terms of the way she conducted herself. Babbie and Mouton (2001: 358) commends such behaviour. According to them, the role of an implementer (project implementer/evaluator) should be "that of a methodological consultant and facilitator …responsible for building relationships with the participants on the basis of shared trust. Just like the participant, he/she is a learner and a non-imperialistic teacher".

Effective functioning via networking was also noted to be relatively high. In project 1, 2 and 3, there was networking with stakeholders such as the teaching staff who participated in the workshops (see Appendix A). During the launching of the youth clubs, the continued participation and collaboration of the principals of the schools, students and pupils, teaching staff, governing body members, representatives from Welfare Services and teachers from the other schools of the area was registered. In project 4 and 5 the peer educators networked with hotspot owners and with similar peer educators in other areas. They met regularly and those more experienced placed with those that of a lesser experience in order to build up one another. The authenticity of such an approach is held

by Fals-Borda and Rahman (1991: 5) to be deeply " rooted in cultural traditions of common people ...resplendent with feelings and attitudes of an altruistic, co-operative and communal nature and which are genuinely democratic".

Sustainability: In terms of financial sustainability, it was seen to be quite challenging. Nonetheless, in projects 1, 2 and 3, the evaluation reports revealed that the beneficiaries were said to be orientated towards self-employment by the making of HIV/AID memorial Quilt and beadwork. Projects 4 and 5 evaluation reports revealed that the beneficiaries were prostitutes that were employed on voluntary bases for a 'stipend'. When they as a group came up with a project to earn a living, they were provided with a loan. They (beneficiaries) also contributed money on a regular basis to lend out. One of the roles of employment, stated by the project director (Project 4), was that if in due course someone got a job, she had to give up her position so that another prostitute out there in the 'blue' could be given an opportunity as well for change.

In all the HIV/AIDS projects, there were indications of their activities having been expanded. Reports of projects 1, 2 and 3 revealed expansion of their activities through club launchings, visitations to neigbouring schools and the 'open day' in mind for the coming year. For projects 4 and 5, the reports mentioned the peer educators expanding their territories to include hotspot owners, mineworkers and prostitutes with them making regular visits to act, sing and dance.

The above evaluation report comments (per variable) were further reinforced from the results of the focus group discussions conducted by the researcher with the beneficiaries. Due to excitement, beneficiaries spoke in chorus form of the different ways in which they participated in their projects, for example, in songs, drama and discussions (see 4.6.2). Knapp *et al.* (1981) reveals that "When the recipient is required to participate in forming the message, even if it is only to fill in implicit premises, the chances of perceiving the message as important---would seem to be greatly improved" (Knapp *et al.*, 1981:32). Taking the example of the 'Felicia' show (see Table 4.12), one of the beneficiaries of project 1 said that the show was like bringing the TV live to them and they were able to discuss serious matters among themselves in a lively way. When acting, said another

beneficiary, "I could feel like I was truly HIV/AIDS positive". Two (40%) of the focus group members (still in project 1) confirmed the reflective technique of songs, drama and discussions to have deepened their understanding of the essence of HIV/AIDS testing to the extent that they went for it. One (20%) said he used to distance himself from his HIV/AIDS positive friends but stopped as a result of the impact of the project on him. A beneficiary in project 2 who would not eat with a spoon used by an HIV/AIDS patient (for fear of getting infected) admitted doing so after the HIV/AIDS project.

In project 3, 100% of the peer educators promised abstention of pre-marital sex. When the researcher asked why, one of the beneficiaries said because there were no condoms of their sizes. The researcher then tried to find out whether if condoms were made of their sizes they would go in for premarital sex. The rest of the group said no because from the project, they had come to know the dangers of HIV/AIDS too well to venture into any risky practice. All (100%) of the beneficiaries of project 4 and 5 admitted that the projects had changed their lifestyles: once they were prostitutes but now peer educators and know better.

Interviewees, during the interview sessions, confirmed likewise the expansion of the different project activities (drama, songs dances, discussions) as reported in the evaluation reports. The beneficiaries talked of taking the lessons learnt to the communities and to their families and friends. One talked of constantly briefing the mother of their discussions, the other of being a 'student nursing aid assistant' and helping in many ways to assist the students by making sure they took their medications when ill. In projects 2 and 3, the members talked of their youth clubs expanding their activities to include cleaning campaign projects. Toilets kept cleaned, toilet rolls supplied and littering of the environment checked. They even talked of going to companies to solicit for supply of toilet rolls. These activities, according to what they learnt, were linked to HIV/AIDS given that cleanliness, for example, helps prevent diseases. In Project 4 and 5, the peer educators talked of accompanying some of the patients to the clinic besides counseling and providing condoms to them.

With respect to the evaluations, a collaborative relationship and the sharing of experiences were also reiterated (Table 4.14). Beneficiaries of all the focus groups in the different

evaluations were, on the whole, satisfied with the degree of their involvement at the execution stage (see 4.7.2). They unanimously acclaimed that the participatory method (focus group discussion) of the evaluation served as a learning process to them. A process that enabled them to pick up vital issues of the project that they had forgotten or overlooked but were brought to light by other members of the group. In fact, one of the interviewees of the focus group of project 1 (similar to the others) told the researcher that the focus group evaluation made her "to see where others were at": a discovery that made her to re-evaluate her stand on HIV/AIDS prevention. Guba and Lincoln (1989), in their description of fourth generation evaluation, applauded such method of learning as they according to them it operates within socio-cultural/political factors, within a joint collaborative, teaching and learning process and within a process that creates reality.

The evaluations were also said to have helped in enhancing the self-employment strategies and expansion of the projects' activities. During the focus group discussions, ideas on how to strengthen sustainability were shared. In addition, peer educators of project 4 and 5 held that after each performance session as earlier mentioned they returned to discuss as a group, their strengths and challenges, and ways of improving. Once improvement strategies are put in place, they then went out to implement them through visitations to hotspots, thus guaranteeing service quality and continuation.

4.8.2 Indicated inadequacies from variables tested:

Certain setbacks (Table 7.1 to 7.5: Appendix D) were, however, noted in the testing of the indicator variables. In as much as the HIV/AIDS projects and their evaluations aimed at achieving full participation (collaborative relationship at all levels possible), evaluation reports and interview results showed some gaps. Taking a close view at the different stages of interviewees' participation in the projects and their evaluations, a gap was noticed in terms of an all encompassing collaboration and sharing of knowledge. In the different stages of the HIV/AIDS projects, all the beneficiaries and external evaluators were absent, except at the execution stage where the beneficiaries were present (Table 4.11). For the evaluations, all the beneficiaries and managerial staff (exclusion of the managerial staff of project 3 who assisted the external evaluator) were also absent at the different stages,

except at the execution stage where the former was present (Table 4:14). A situation, which as pointed out by Fishbein (2000), is a matter of concerned. Fishbein holds that:

> Although an investigator can sit in her or his office and develop measures of attitudes, perceived norms and self-efficacy, she or he cannot tell you what a given population (or a given person) believes about performing a given behaviour. Thus one must go to the members of that population to identify salient outcome, normative and efficacy beliefs. One must understand the behaviour from the perspective of the population one is considering (Fishbein 2000:276).

The average knowledge level of beneficiaries was further observed to show some loopholes especially knowledge regarding the overall setup of the projects and their evaluations (see Table 4.10 and 4.13).

In project 1, the evaluation was seen to have a limitation in terms of measuring emerging 'positive living' trends on campuses. Inadequate communication among project implementers was made mentioned of in project 2 and the problem of stigmatisation not having been fully dealt with. Beneficiaries were reported to be still not fully confident in revealing HIV/AIDS sufferers that they know of in their families. In project 3 there were also some reluctance among beneficiaries in discussing openly about sex (likely due to their ages as they were primary school pupils). The parents in these rural areas were said to be resistant as well to open discussions about sex.

Babbie and Mouton (2001: 320) see the need for full participation and knowledge sharing to be that which "members of the subject of study are integrated in the research by participating fully and actively in the research process, from its outset and throughout most, or all, of its phases". This situation, due to the above-identified inadequacies was not the case. As far as making an effort to encourage as much participation as possible of all the stakeholders is, however concerned, evidence has been cited of opportunities given to recipients to air their views. In the projects, opportunities via different activities such as interactive drama, songs, and discussion forums were given and in the evaluations opportunities were given via focus group discussions.

Beneficiaries were satisfied and excited in response to the way the HIV/AIDS projects and their evaluations were conducted. This can be argued to be indicative of the interventions' value, usefulness and meaningfulness to the beneficiaries. In an *Evaluation Standards Committee* deliberations, Stufflebeam reported "An evaluation should not be done at all if there is no prospect for it being useful to some audience" (Stufflebeam in Patton 1982: 297). On the other hand, when recipients are able to relate the value, meaningfulness and usefulness of something to their situation, the likelihood of change is seen to be greater. The different areas where beneficiaries acquired skills both in the project implementation and evaluation (with the exception of acting talent that was acquired at project implementation) can be summarised, to include the following:

- o Acting talent
- o Communication skills: debating, discussions, acknowledgement and persuasive techniques
- o Leadership skills
- o Organisational skills
- o Problem solving, negotiational and decision-making abilities
- o Learning via activities
- o Co-operation and sharing of resources abilities
- o Life skills and ways of teaching learners about it
- o Showing of sympathy
- o Listening, observational and assertive skills

Fishbein (2000:275) held that any given behaviour is likely to occur "if one has a strong intention to perform the behaviour, if one has the necessary skills and abilities required to perform the behaviour, and if there are no environmental constraints preventing behavior performance". From the identified skills and the overall minimal environmental or background impact of the projects on the recipients, change (see Table 7.1. to 7.5: Appendix D) was on the whole, noticed; the summary of which is:

- o Acceptance of social responsibility;
- o Awareness of the necessity to challenge stereotypes and can now do so;
- o Accept, care and love HIV positive people;

- o "HIV/AIDS became more simpler than being abstract because of our facilitators organised people already living with virus" (project 3);
- o Can talk freely about sexuality and HIV/AIDS;
- o Can say 'no' to unwanted or unprotected sex offer;
- o Can muster strength and courage to abstain from sex until marriage, be faithful and 'condomise' if need be;
- o Seen the necessity to reach families, friends and the community with lessons learnt.

This evidence can thus be argued to override to a great extent, the criticism of non-formal educational development project implementation and evaluation in the Third world. A criticism, which has been advanced by Brunner and Guzman (1989: 9) to be project implementation and evaluations reflecting "...the world-view and priorities of the sponsoring agencies and denied any meaningful input from the main actors in the ...projects". In the HIV/AIDS projects and evaluations studied, beneficiaries have, in this part of the work, identified the different areas where they had been empowered: made aware of their abilities to muster for social action and where they had acquired skills. The situation of powerlessness which Freire (1970) described as that which people play the of role of an object that is acted upon rather than a subject that is acting in and on the world was therefore counteracted by the use of the participatory methodology. On the whole, instead of beneficiaries citing situations where they or others undervalued their opinions, they rather cited instances where they were empowered and equipped for social action and where the community looked up to them for help.

All in all, judging from the validity of the outcomes, methodology and wider social impacts, one can say that the degree and quality of beneficiary involvement in project implementation and evaluation generates beneficiary excitement and a general sense of project acceptance: all of which was noted to create an enabling environment for the making of proper choices and decisions. When beneficiaries are excluded from participating in the planning, action-planning and result-feedback stages of a project and its evaluation, dissatisfaction is experienced on the part of these beneficiaries as well as *missed opportunities* for useful contributions. On the other hand, when group participation is

encouraged in projects (like those examined in this study), it contributes to override to a great extent, limitations arising from socio-demographic differences (project locations and gender, language, age and race of implementers, evaluators and beneficiaries), in the attainment of project objectives. It would also override to a great extent, limitations arising from differences in forms of evaluation (internal versus external evaluators), in the assessment of project objectives.

4.9 Summary

An analysis of the contribution of participation towards a meaningful, useful and valuable HIV/AIDS health-enhancing project and its evaluation by both internal and external evaluators informed Chapter 4. Factors that could contribute towards a project meeting its objectives or impacting its targeted community were investigated. These factors at both implementation and evaluation stages, included:

- the degree to which interviewees were informed about a project,
- the stages at which they were involved,
- the different group activities that they were exposed to and
- the role of internal versus external evaluators.

HIV/AIDS projects that had elements of participation both at implementation and evaluation phases were selected for the study. Focus group discussions were conducted with the beneficiaries and individual interviews with the managerial staff and evaluators. As was expected, results of this study revealed that the execution stage was that with the highest participatory activities. Many different group activities, such as group discussions (at both implementation and evaluation) drama, songs and dances (at implementation), were noted at this stage. The different activities were seen to be an indication of how far the beneficiaries were involved in the different projects.

Dissatisfaction was, however, noted on the part of the beneficiaries about their lack of participation in the planning, action-planning and result-feedback stages of the projects and their evaluations. Also, the beneficiaries (unlike the managerial staff and evaluators) were

poorly informed concerning details of the projects and their evaluation; such as why the projects/evaluation were carried out, who asked for them, and their duration. Nonetheless, in spite of socio-demographic differences within the projects, the beneficiaries (at implementation and evaluation) were excited with the degree and quality of their involvement. The degree and quality of participation was shown in the study to override the influence of socio-demographic differences (gender, age, race and language) as well as internal versus external evaluator differences.

As a whole, the beneficiaries, showed signs of change and of being role models, impacting positively the lives of others in their communities. They indicated being empowered to make proper choices and decisions relating to sex as well as taking responsibility for their health. They were aware of the consequences of stigmatisation and ways of counteracting it. This revealed the positive value of the participatory HIV/AIDS projects and their evaluation to the beneficiaries.

CHAPTER 5: THE IMPACT OF PARTICIPATORY AND NON-PARTICIPATORY METHODOLOGICAL FRAMEWORKS IN THE MEETING OF A PROJECT'S OBJECTIVES

5.1 Introduction

As highlighted in the introductory chapter of this study, health-enhancing interventions could be argued to be a learning process, with evaluation being an organic part of that process, whereby objectives are continually negotiated (Marsden and Oakley 1990:4). This refers to the fact that, all thing beings equal, the meeting of the objectives of projects are not only attributable to their implementation strategies, but also to their evaluation strategies. Projects, like the ones selected for this study, could intend empowering beneficiaries by increasing their knowledge, awareness and abilities. To achieve this, such projects (seen in the light of those selected for this study) could intend creating an enabling environment for the beneficiaries to experience true leadership. Put forward by Nyerere (1974: 27), such an environment would be that which the beneficiaries would develop themselves, by joining in "free discussion of a new venture, and participating in the subsequent decision", at all possible levels or phases of the projects, rather than being herded like animals into the new venture. With this in mind, the value of participation (people collectively taking control, developing plans of action and responding to feedback in relation to future action- commonly indicated here as presence of people, particularly beneficiaries in interventions), with respect to HIV/AIDS projects was investigated in this chapter.

In Chapter 5, the value of participation was investigated by comparing the impact of participatory and non-participatory methodological evaluation frameworks in the meeting of a project's objectives. By using HIV/AIDS projects that shared, in the main, similarities in terms of project objectives and implementation strategies, but differed in their evaluation strategies, it was intended to highlight differences in the impact of the projects. The researcher looked, for example, for projects that were implemented and evaluated using a participatory methodology and compared their impact with those that were implemented using similar participatory methodology, but evaluated using a non-participatory methodology.

For convenience and confidentiality, projects that were evaluated using participatory methodologies were referred to as participatory evaluated projects (P2, P3 and P6) and those that used the non-participatory methodologies: non-participatory evaluated projects (NP1, NP2 and NP3).

Similar to the participatory evaluated projects (of which P2 and P3 were the externally evaluated projects in Chapter 4), the non-participatory projects handled HIV/AIDS social/awareness issues related to education, gender, culture and other socio-economic imperatives (see Table 4.1). Table 5.2 provides a brief description of each of the projects, for example their objectives, target groups and the methodology used in implementing and evaluating them, followed by their outcomes and the eventual comparison of results (comparison of overall outcome results of P and NP projects). Prior to this, the rationale for the study and the methodology used by the researcher are presented.

5.2 Reasons for studying the participatory and non-participatory evaluated projects

In this section the rationale behind studying the participatory and non-participatory evaluations of projects is given, followed by the parameters governing project selections. The present researcher based the criteria for the selection of the projects on the aim of this section of the study, which was to investigate further the value of participation in HIV/AIDS projects with social implications. To trace the differences between the participatory and non-participatory evaluated projects, and keep as many other aspects of the projects as similar as possible, the researcher devised the project criteria shown in Table 5.1.

Table 5.1 Criteria for project selection

Criteria A: Participatory evaluated projects	Criteria B: Non-participatory evaluated projects
Implementation participatory Evaluation participatory (The project and its evaluation methodologies both had elements of participation)	Implementation participatory Evaluation non-participatory (The implementation phase of the project had elements of participation and the evaluation phase did not)
The project dealt with HIV/AIDS awareness and had attitude changing and empowering goals	The project dealt with HIV/AIDS awareness and had attitude changing and empowering goals
The project had been evaluated (either internally or externally)	The project had been evaluated (either internally or externally)
The project had community or social implications (gender and/or culturally related and could be dealing with issues of community transformation and empowerment)	The project had community or social implications (gender and/or culturally related and could be dealing with issues of community transformation and empowerment)
Access to the original evaluation report was possible	Access to the original evaluation report was possible
Access to the evaluators, project managers and the beneficiaries was possible	Access to the evaluators, project managers and the beneficiaries was possible
The project was within southern Africa	The project was within southern Africa

In attempting to minimise extraneous variation between the projects that would present competing hypotheses, as many of the criteria as possible shown in table 5.1 were sought as characteristics of the selected projects. This was very difficult to achieve, especially in the area of having access to the evaluators, project managers and beneficiaries of all the projects for interviewing. This situation was partly attributed to the stigma attached to evaluations (evaluations seen as judgmental or finger-pointing), particularly in cases of highly quantified data reports. For the non-participatory evaluated projects, for example, after having made a search of approximately 52 project organisations and selected a few (about 11, of which three were finally chosen), the researcher contacted some of the implementers and evaluators for interviewing and these were some of their responses:

"We are still at the learning phase of our evaluations". "Even though we are through with the first phase of our evaluation, we do not think it is proper yet". "There is a lot of protocol involved and. for the beneficiaries, I do not think you will ever get to meet them". One implementer asked the researcher to contact the external evaluators themselves and when

she did they said, "Tell us exactly what you want". When the researcher explained that she was interested in the methodology used in the evaluation, the communication stopped. In desperation, the researcher sought the advice of her supervisor who, besides admitting the difficulty and sensitivity of the matter, suggested a change in tone and terminology, something which the researcher did, to no avail. This reflects a possible negative aftermath of non-participatory evaluation.

Due to the above difficulties, the researcher decided to focus on getting published evaluation reports via the Internet, or via journal articles where it was not possible to get the original evaluation reports. She focused on interviewing only those that availed themselves and that procedurally it was possible to do. In addition, the possibility of matching projects 'perfectly' posed an obstacle, leading the researcher to keep variability amongst minor characteristics to a minimum.

5.3 Methodology used to study the participatory and non-participatory evaluated projects

In view of the complexities involved in the nature of the HIV/AIDS projects to be examined, a combination of methodologies (shown in Figure 5.1) was adopted.

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┌──────────────────────────┐        ┌──────────────────────────┐
│ Participatory evaluation │        │ Non-participatory        │
│ (Externally done)        │        │ evaluation               │
│                          │        │ (Externally done)        │
└──────────────────────────┘        └──────────────────────────┘
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Project locations

Southern Africa

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┌──────────────────────────┐        ┌──────────────────────────┐
│ Two from South Africa    │        │ Two from South Africa    │
│ One within southern      │        │ One within southern      │
│ Africa                   │        │ Africa                   │
└──────────────────────────┘        └──────────────────────────┘
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Method of analysis

Documentary analysis of evaluation report
Occasional insights from interviews

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┌──────────────────────────┐        ┌──────────────────────────┐
│ Interviews with          │        │ Interview with           │
│ beneficiaries,           │        │ beneficiaries, project   │
│ project managers and     │        │ managers and evaluators  │
│ evaluators               │        │ (where possible)         │
│ ( where possible)        │        │                          │
└──────────────────────────┘        └──────────────────────────┘
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┌─────────────────────────────────────────────┐
│            Brief description                 │
│ Project                    Evaluation        │
│              Location                         │
│ Composition              Composition          │
│ Objective                Objective            │
│ Target group             Target group         │
│ Methodology              Methodology          │
│ Practicalities           Practicalities       │
│           Outcome results                     │
│           Concerns raised                     │
└─────────────────────────────────────────────┘
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Overall outcome results

Comparison of overall outcome results

Figure 5.1: Methodological framework

As shown in Figure 5.1, a documentary analysis of evaluation reports and occasional insights from interviews stood as the main methods of carrying out this portion of the study. Depending on information from the evaluation reports and interviews, indicator

variables such as group knowledge acquisition, awareness, skills acquisition, attitude change, effective functioning and sustainability (representing the objectives of all the projects) were assessed across the two project categories (participatory and non-participatory evaluated projects). The assessment was done in terms of the extent to which the two project categories, via the different methodologies they used, were able to address those variables (at both the implementation and evaluation phases), following which a comparative analysis was carried out with respect to the overall outcome results of the participatory and non-participatory evaluated projects. Such a comparative analysis was conducted in order to give a proper perspective to the findings of the study. Examples of such a comparison relate to the following questions:

If the project intended empowering beneficiaries as a group, then:
Were beneficiaries empowered as a group at the implementation stage, thanks to the implementation methodology?

Were beneficiaries empowered as a group at the evaluative stage, thanks to the evaluation methodology that helped in negotiating or enhancing group empowerment?

Judging from the responses given to the above questions, to what extent can one say the project as a whole successfully met its objective of group empowerment, at both implementation and evaluation phases and thanks to the methodological frameworks?

5.4 Project descriptions

In order to get a vivid picture of each of the studied HIV/AIDS projects and their evaluations, a brief description of each of the projects was provided (for details of each see Appendix 1). The first part of the project description consist of the participatory evaluated projects (P1, P2 and P6) and the second, the non-participatory evaluated ones (NP1, NP2 and NP3).

5.4.1 Descriptions of participatory evaluated projects
Table 5.2 gives us a brief description of each of the participatory evaluated projects.

Table 5.2: Brief description of the participatory evaluated projects

Issues	Brief descriptions*		
	P2	P3	P6
Area	**Ndwedwe** **SA****	**Zululand** **SA**	**Kinshasa** **Zaire (DRC)*****
Project Objectives	Reduce stigma Adopt healthy sex practices Empowerment: skills acquisition Structural transformation Create self-reliant opportunities Expansion and promote hygiene	Reduce stigma Adopt healthy sex practices Empowerment: skills acquisition Structural transformation Create self-reliant opportunities Expansion and promote hygiene	Adopt healthy sex practices Empowerment: skills acquisition Structural transformation Create self-reliant opportunities Expansion and promote hygiene Integrate HIV/AIDS prevention into programmes of community development: trade union and market women's associations
Evaluation Objectives	Impact and objective assessment Relevance Improve staff service delivery Empowerment	Impact and objective assessment Relevance Improve staff service delivery Empowerment	Impact and objective assessment Relevance Improve staff service delivery Empowerment
Project Target	Secondary school students: Male and females	Primary school pupils: Male and females	Female sex workers with little or no literacy in problem-solving approaches to risk reduction
Evaluation Target	Secondary school peer educators	Primary school peer educators	Female sex workers as peer educators
Project method	Participatory: Interactive peer education: Focus group discussions Drama, songs, dances AIDS memorial quilt	Participatory: Interactive peer education: Focus group discussions Drama, songs, dances Beadwork	Participatory: Experiential training: Focus group discussions Role plays, simple posters Structured group 'processing'
Evaluation Method	Participatory and qualitative: Focus group discussions Semi-structured interviews Background documentation Quantitative: Questionnaire with use of control Externally evaluated	Participatory and qualitative: Focus group discussions Semi-structured interviews Background documentation Quantitative: Questionnaire Externally evaluated	Participatory and qualitative: User-focused evaluation: Re-enactment of training by the sex workers to friends under external supervision Externally evaluated

Source of information: from evaluation report of P2, P3 and P6 ** South Africa ***Democratic Republic of Congo

Table 5.2 portrays many similarities in terms of the objectives of the projects and their evaluations and also in terms of the methodology used. Certain background and practical implementation variations were evident.

P2 and P3 had as main targets both male and female black South African in-school youths in rural areas meanwhile P6 had black female sex workers (with little or no literacy) in problem-solving approaches to risk reduction in the suburban neighbourhood of Kinshasa, Democratic Republic of Congo.

Prior to visiting the original schools of P2 and P3, some out-of-school youths were temporarily employed by the project (for the period of their training and performance), trained and encouraged to perform drama and other activities in the schools. After that, a youth club was launched in these schools. The youth club members were then trained (by the project implementers) as peer educators to visit other schools (starting with the neighbouring ones), perform there and launch other youth clubs. They were encouraged to organise other activities such as AIDS festivals within their premises. In these festivals, students, parents and other potentially helpful government and non-governmental bodies were invited for networking. The youths were not on any stipend (formal or informal payroll), but were provided with refreshments after every performance. They were encouraged to come up with ideas and means of generating their own sources of finance, such as the making of AIDS Memorial Quilts and beadwork.

The third participatory project (P6) was carried out by invitation: invitation from the leader of a sex worker's network. From the network, the female sex workers were chosen to act as peer educators. These sex workers came from a background of poverty, with exclusive reliance on sex with multiple partners for a livelihood. Due to stigmatisation, the sex workers requested that the project be carried out away from their area. As a result, the project was carried out in a walled garden, 500 yards from their area. Their training took the form of icebreaking via role-plays, discussion forums, simple posters and structured group 'processing'. Networking took place with some churchwomen's groups that were invited to participate in the training sessions. The sex workers were not on any formal payroll and income-generating activities were later identified in the discussion sessions of the training as one of the topmost priorities for the bringing about of change.

5.4.2 Evaluation of the participatory evaluated projects

In the practical evaluation of P2 and P3, the evaluators used other methodologies, besides participation, and they focused mainly on group discussions (see Table 5.2). P2 evaluation took place with the peer educators at the different secondary schools. An independent body externally conducted the evaluation. This body was made up of five official members, in the capacity of evaluators, and a core of Zulu-speaking research assistants, who were experienced in conducting focus group discussions, interviews and preliminary data analysis. One of the official members, assisted by the Zulu-speaking assistants, carried out the evaluation. The evaluation focused mainly on assessing the impact of the project and finding out if the objectives of the project were met. It also focused on empowering the people, via for example, bringing about structural transformation and skills acquisition.

Use was made of similar methodology (participatory methodology) in the evaluation, as in the project. Focus group discussions (made up of both male and female peers) were held at the schools where the projects had been implemented. In discussion forums the research assistants acted as facilitators. Questionnaires were issued to key informants such as the trained teaching staff. The evaluation was done after the completion of the initial set of workshops and other follow-up activities. Critical issues for discussion in the evaluation included the question whether or not peer educators were sufficiently well trained, what they valued most about belonging to the club, what new things had been learned, how learners looked after themselves before and after the project, impact of life skills, any change in attitude towards people living with HIV/AIDS, any translation of knowledge into actual changes in behaviour, how members would feel about themselves if infected, whether members had disseminated the lessons learned, whether they had challenges and way forward.

P3 evaluation took place with the peer educators at the different primary schools targeted by the project. An external evaluator conducted the evaluation. She did the evaluation in close collaboration with one of the Zulu-speaking managerial staff members of the project. This staff member was well versed in conducting focus group discussions, interviews and preliminary data analysis.

The evaluation focused mainly on assessing the impact of the project, its relevance and finding out if the objectives of the project were met. It also focused on empowering the peer educators. Use was also made of similar methodology (participatory methodology) in the evaluation as in the project. Focus group discussions (made up of both male and female peers) were held at the schools where the projects had been implemented, with a managerial staff member acting as facilitator. Semi-structured interviews and questionnaires were issued to key informants such as the trained teaching staff. Direct observations were made of learners participating in the activities, such as launching new clubs. Critical issues for discussion in the evaluation included the question whether or not critical awareness among peers had been facilitated, societal prejudices confronted, peers had been empowered, participatory teaching methodologies had been used, any expansion of activities, opportunities to network created, any benefits from the project, change of attitudes towards sex, people living with HIV/AIDS, development of appropriate skills and how?

P6 evaluation took place with the female sex workers in the suburban neighbourhood of Kinshasa, Democratic Republic of Congo. An independent body externally conducted the evaluation. This body was made up of international team members for a site visit. The evaluation focused mainly on assessing the impact of the project, finding out the relevance of the project to the beneficiaries and if the objectives of the project had been met. It also focused on bringing about improved service delivery of project staff and on empowering the beneficiaries.

Use was made of similar methodology (participatory methodology) in the evaluation, as in the project. The participatory methodology was in the form of a user-focused evaluative response to the project " Teach us to do what you do so that we can inform our colleagues" (Evaluation Report of P6: 1406). In a practical session, the trained sex workers demonstrated the method used by the managerial staff in training them. This was done for friends in the presence of the international team members. Role-plays, discussion forums, simple posters and structured group 'processing' were re-enacted in the practical demonstration sessions. The icebreaker via role-play was re-enacted in a similar way as in the implementation.

Other practical sessions re-enacted involved the dramatisation of mother-to-infant transmission of HIV/AIDS, with mother and grandmother taking a sick baby to the hospital, only to discover that the baby was infected.

Similar to Table 5.2, Table 5.3 portrays many similarities in terms of the objectives of the NP projects and their evaluations and also in terms of the methodology used. Certain background and practical implementation variations were noted, as discussed here.

NP1 and NP2 had as their main targets black South Africans and NP3 black Zimbabweans. NP1 handled male and female high school youths in an urban African township in Cape Town; NP2 project support staff and influential/high-risk groups (male soccer players) in both urban and rural townships; and NP3 vulnerable groups of male and female sex workers in an urban area in Bulawayo, Zimbabwe.

5.4.3. Descriptions of non-participatory evaluated projects

Table 5.3 provides a concise, but brief, description of the non-participatory projects.

Table 5.3: Brief description of the non-participatory evaluated projects

Issues	Brief descriptions		
	NP1	**NP2**	**NP3**
Area	**Cape Town SA****	**Durban, Pietermaritzburg SA**	**Bulawayo Zimbabwe**
Project Objective	Reduce number of sex partners Adopt other healthy sex practices Empowerment: skills acquisition Structural transformation Create self-reliant opportunities Expansion and sustainability Address personal issues concerning AIDS for young people	Adopt healthy sex practices Empowerment: Skill acquisition Structural transformation Create self-reliant opportunities Expansion and sustainability Provide human and financial support to projects that handle epidemiological issues	Reduce number of sex partners Adopt other healthy sex practices Empowerment: skills acquisition Structural transformation Create self-reliant opportunities Expansion and sustainability
Evaluation Objective	Impact and objective assessment Empowerment	Impact and objective assessment Empowerment Relevance Improve staff service delivery	Impact and objective assessment, Empowerment
Project Target	High school youths Males and females	Project support staff Influential/high-risk groups for example, male soccer players as peer educators	Female and male sex workers
Evaluation Target	High school youths Males and females	Project staff and male peer educators	Female and male sex workers
Project method	Participatory: Interactive education: Focus group discussion, role plays, games, structured group work and videos	Participatory: Interactive peer education: Focus group discussions, dramas, songs and dances	Participatory: Interactive peer education: Focus group discussion, songs and dances
Evaluation Method	Non-participatory: Pre and post self-report questionnaires and control	Non-participatory: Pre-test-post-test non-equivalent Comparison, group design, Questionnaires and individual interview	Non-participatory: Questionnaires, baseline survey and individual interviews
	Externally evaluated	Externally evaluated	Externally evaluated

Source of information: from evaluation report of NP1, NP2 and NP3
** South Africa

For the practical implementation of NP1, the primary responsibility was in the hands of the teaching staff (co-ordinated by the project managerial staff) in the school, as the programme was integrated into the school structure, with use being made of the existing

resources (classrooms, stationery, school clinics and others). Prior to initiating the project, permission was obtained from the education authorities together with the consent and support of the parents of the students. A parent's association meeting was called for, with the school nurses providing detailed information on the dangers/seriousness of HIV/AIDS and the need for AIDS education. A series of planning meetings for the brainstorming of ideas, assigning tasks and responsibilities regarding the programme then took place. These meetings were held with interested staff members, the students' representative council, and random groups of students and staff. The project's managerial staff then trained the teaching staff members (those who were to act as facilitators). Before the full launch of the programme, an HIV/AIDS infected person was invited to give an address on HIV/AIDS.

The AIDS awareness programme of NP1 covered all the classes in the school. The classroom activities included, among others, structured information sessions on HIV/AIDS, open discussions about HIV/AIDS and the integration of the HIV/AIDS content into the language curriculum. Language exercises having HIV/AIDS themes were carried out. Exercises included crosswords, incomplete sentences and responsive dialogues. School nurses helped in assisting the facilitators in the provision of consultation during the programme. Slogan competitions were organised during the programme and HIV/AIDS information leaflets (meant as well for competition) prepared. The students were to take some of the leaflets to their parents and get them registered for the competitions. HIV/AIDS posters and banners were made, facilitated by the trained art teacher. These posters and banners served as art exhibitions in the schools, as well as a means of generating income.

NP2 had a programme committee and an advisory board through which they functioned. The advisory board was said to have seven local experts, who met twice a year to share their experiences in gender, religion and research related matters. They provided support to the management of the project. The project had a broad target group, within which the necessary manpower, skill and financial support were provided. Some of the target groups included selected male soccer players who acted as peer educators. Among the soccer player peer educators, HIV/AIDS awareness issues were dealt with through interactive drama, songs, role-playing and discussions. The HIV/AIDS messages were centred on the

encouragement of the soccer players to maintain healthy lifestyles and to serve as role models for the rest of the community.

To initiate NP3, a rapid formative assessment (involving informal discussions and observations), with 149 female sex workers and 74 clients, was carried out. Bars, homes and streets linked to sex work were mapped and potential programme beneficiaries identified. An interview survey of sex workers' organisations, condom use, sexual and work pattern, health service use and STD history was done as well. From these activities, trust with the sex workers was built and then informal leaders were recruited on a stipend and trained as peer educators. The peer educators were divided into seven zones (each zone functioning cohesively), with a senior peer educator heading it. The senior peer educator worked closely with the co-ordinator of that zone. All the senior peer educators met regularly with different co-ordinators, to plan the activities of the groups and to prepare for weekly training meetings with the peer educators.

Through activities such as drama, songs and dances, the peer educators in their different zones held community meetings and distributed condoms every week, in their social networks (bars, selected workplaces and health units). In addition, each peer educator received private and free STI treatment cards for themselves and for other sex workers.

5.4.4   Evaluation of non-participatory projects

With regards to the evaluations, NP1 and NP2 used experimental and control groups and NP3, a baseline and follow-up survey. The evaluation of NP1 took place with the targeted high school students in Cape Town. An independent body externally conducted the evaluation. This body was made up of approximately three official members in the capacity of evaluators. The evaluation helped in assessing the impact of the project, finding out if the objectives of the project were reached. The evaluation also intended empowering the high school students via, for example, bringing about structural transformation within the project and skills acquisition by the students.

Unlike the implementation methodology of the project, which was participatory, the evaluation methodology was non-participatory (pre and post non-equivalent comparison

group design with the use of self-report questionnaires). Before the programme, 231 students were given self-report questionnaires to complete and after the programme 206 did complete the self-report questionnaires. Two classes from each standard were selected from the programme school and compared with those from a neigbouring school in the same community (having similar students and teaching profile but with no specific HIV/AIDS education programme). In the comparison school, 336 and 276 students completed the self-report questionnaires at the equivalent time intervals. The questionnaires were translated into the mother tongue of the students (Xhosa). Among other things, questions were asked relating to the following:

- ➤ Knowledge-based: How HIV is transmitted, how it is not transmitted, how it can be prevented, whether there is a cure for it.
- ➤ Attitude-based: Whether they can accept someone with HIV/AIDS into their class.
- ➤ Beliefs about personal susceptibility: What are their concerns about AJDS, whether AIDS to them is a problem and whom they think is affected by it.
- ➤ Intentions and communications: What are their responses to AIDS, what makes up their communication plans with peers, parents, sexual partners and nurses, relating to HIV/AIDS.

The evaluation of NP2 took place with the targeted group of male and female project support staff and with the soccer player peer educators. An independent body, made up of two main evaluators, externally evaluated NP2. The external evaluators were answerable to a programme committee (made up of project secretariat and donor members who were responsible for the monitoring of the project and reporting back to the donors. The donors (one main donor body and four minor ones) were those requesting the evaluations.

The evaluation helped in assessing the impact of the project and finding out if the objectives of the project were reached. The evaluation intended assessing the relevance of the project, improving service delivery of project staff and empowering the people.

The evaluation was non-participatory and individually orientated and used individual interviews and questionnaires (to the staff members) and pre-test-post-test non-equivalent

comparison group design to the soccer peer educators. The soccer peer educators were made up of two groups, the experimental and the control groups. The former, sharing many similarities with the latter, participated in the peer education activities and the latter did not. Both of them completed the pre-test and post-test questionnaires within a two-month observance period.

With regards to the calibre of questions asked in the evaluation, the following were noted: For the project staff: The extent to which the institutional arrangements contributed or presented a barrier to achieving its expected results, the effective management of its finances and the strength and weaknesses of its implementation, network and advocacy strategies.

For the soccer peer educators: Their information sources (of HIV/AIDS), number of sexual partners, knowledge and attitude of STI treatment, frequency and reason for using condoms and the educators' demographic records.

NP3 evaluation took place with the targeted group of male and female sex workers in Bulawayo, Zimbabwe. NP3 was externally evaluated by an NGO in Nairobi, Kenya, made up of about five member evaluators. The evaluation helped in assessing the impact of the project and finding out if the objectives of the project were reached. The evaluation also intended empowering the people.

The evaluation was non-participatory and individually orientated (pre-test-post-test one group design with the use of individual interviews and questionnaires), a method contrary, as well, to that used in implementing it. The external evaluators carried out a baseline and a follow-up survey (after two years), to assess the impact of the project. Part of the survey was to determine the number of sex workers and their clients in Bulawayo. A team of 100 members, assisted by some groups of trained students, did the counting of the sex workers. The counting was done in 56 bars (from opening to closing time of the bars). In fact, one of the national surveys conducted in Bulawayo showed that bars were the major places of solicitation: 80% of sex workers and 82% of their clients sought commercial partners in bars (Ngugi 1996).

With regards to the calibre of questions asked via the questionnaires and the individual interviews, questions were asked such as those pertaining to condom usage, visits to health units for STIs and number of clients before and after the project.

5.5: Overall evaluation outcomes of the participatory and non-participatory evaluated projects

Prior to making a comparison of the participatory and non-participatory evaluated projects, the overall outcomes of the two types of HIV/AIDS projects as a whole (the projects right through to their evaluation) were examined in this section. This was in order to provide a solid base for the classification and eventual comparison of the impact of the two methodological frameworks (participatory and non-participatory) in the evaluation of the given HIV/AIDS projects. The variables (group participation, awareness, knowledge, attitude, skills acquisition, effective functioning and sustainability) made up the parameters used to assess the HIV/AIDS projects (in their respective categories: participatory and non-participatory). These variables were taken from the common objectives of all the HIV/AIDS projects.

In order to control for intervening factors, background variations of gender, race, age, language and location were checked (the extent to which each of them impacted on the project/evaluation methodology). Other compounding variables, for example, styles of project management and development which would have invariably impacted (either positively or negatively) on the outcome results of the projects studied and their evaluations, were, nonetheless, not dealt with in-depth. This was due to the fact that this section of the study was limited to the use of *participation* (commonly referred to here as people's presence) *or no participation* in broadly assessing a meaningful, useful and valuable HIV/AIDS project/evaluation. Also that it was impossible to separate these aspects when dealing with finalised projects.

For easy comprehension, the overall evaluation outcome results were rated. Extensive ratings, including modes, were avoided due to the small sample size and the further need to simplify data.

The ratings were given according to the researcher's judgment of the performances of each of the projects, based on information provided from the evaluation reports and occasional insights from interviews (in Appendix D Tables 7.2,7.3,7.6,7,8 and 9). Given the difficulty in getting interviewees, others (besides) the researcher, did not do the ratings.

Ratings were assigned according to the following scales: 1=Did not occur or was very low (VL), 2= Low (L), 3=Average (A), 4=High (H), 5=Very high (VH), 6=Excellent (E), based on the performances of each of the projects. Ratings were used as such and not combined in the following discussion.

The overall evaluation outcome results of the participatory evaluated projects are presented first, followed by the non-participatory ones.

5.5.1 Overall outcomes of the participatory evaluated projects

From the evaluation reports of the participatory evaluated projects (P2, P3 and P6), and occasional insights from interviews (see Appendix D: Tables 7.2, 7.3 and 7.6 for details), one gathered the following data in response to the variables (objectives) tested:

i) Objective 1: Group awareness and knowledge acquisition

❖ **Was Objective 1 achieved at the implementation phase of the 'P' projects, thanks to the implementation methodology?**

Irrespective of some limitations, for example beneficiaries were not involved in the planning phase of the projects (see Appendix D), there was strong evidence to suggest that beneficiaries of all the HIV/AIDS projects had become critically aware of health matters due to their participation in the different project activities. They felt that activities (focus group discussions, drama, songs, dances) gave them the opportunity to share their experiences and rehearse 'real life situations' (dramatised the reality of HIV/AIDS), thus enabling them to be more serious in measuring and assessing their behaviours.

At the implementation phases of the projects, all the evaluation reports spelt out that the beneficiaries used correct terminologies to speak knowledgeably of the 'facts' about HIV/AIDS and could link discussions to issues of STIs, prevention of HIV/AIDS transmission, ways in which the virus can be 'slowed down' and many other health issues. In P2 and P3, the evaluation reports revealed that beneficiaries were able, to a great extent, to contextualise discussions about HIV/AIDS and show sensitivity on ways of treating people living with AIDS (PLAs). They were aware of stigmatisation and, meaningfully, spoke of the essence to minimise it and rather show respect, love and support to HIV/AIDS sufferers.

In P3, the evaluation report revealed that one of the beneficiaries, prior to the workshops, thought HIV/AIDS was similar to influenza, with infected persons being avoided. In the same report, it was held that beneficiaries had internalised the message of rights. Beneficiaries "spoke with conviction and sincerity about 'rights'- the rights of people living with AIDS (PLAs) and the rights of girls to say 'no'. One of the pupils referred to it as "… the constitution". To show the hunger in the hearts of the pupils to acquire as much as they could, the P3 report (similar to the other reports) highlighted the fact that in the group discussions, many relevant questions were asked and also that group discussions ended naturally without any deliberate attempts on the part of the facilitators to end the discussions.

Beneficiaries in P6 were reported to have commended the dialogue approach, which enabled the breaking down of complex concepts for easy understanding. With the role-plays they saw it as eliciting strong emotional impact, enabling retention. For example, in the role-play of mother-infant transmission, a beneficiary exclaimed, "Oh, the poor thing hasn't even begun to live and now he's dying of AIDS"

- ❖ **Was Objective 1 achieved at the evaluative stage, thanks to the evaluation methodology that helped in negotiating or enhancing objective 1?**

With respect to the participatory methodology used in evaluating P2, P3 and P6, beneficiaries attested to it having created an enabling environment for them to become

more aware and knowledgeable in HIV/AIDS related matters; this given the fact that the way the evaluations were conducted was, to the beneficiaries, a learning process. According to beneficiaries of P2 and P3 (interviewed by the researcher), the focus group discussions (used for evaluation purposes) created an environment for the sharing of their experiences. They could (as said in the interviews), pick up vital issues of the project that they had forgotten or overlooked and were brought to light by the other members of the group, thus furthering their knowledge and awareness.

With P6, the user-focused evaluation was indicated in the evaluation report to have provided beneficiaries with opportunities for new-shared experiences and valid generalisations that were applied creatively. The role-plays, discussions, simple posters and structured group 'processing' that were re-enacted for evaluation purposes were indicated to have led to considerable new knowledge being retained and some misinformation dispelled. Eight months after the intervention, a decline in regular use of condoms was reported, the reason for which was a rumour about the low quality and ineffectiveness of condoms. Thanks to the group discussions (for evaluation purposes), this misinformation was dispelled, thus improving, once more, the awareness and knowledge levels of the beneficiaries.

❖ **Judging from the responses given to the above questions, to what extent can one say the 'P' projects successfully met Objective 1 (at both implementation and evaluation phases and thanks to the methodological frameworks)?**

Combining the implementation and evaluation phases of P2, P3 and P6 and evidence given of the extent to which their methodological frameworks (participatory in both phases) contributed in successfully meeting their objective (Objective 1), one would assign the mode 5.

Group awareness and knowledge values at implementation phase   P2=5   P3=6   P6=6

Group awareness and knowledge values at evaluation phase   P2=3   P3=4   P6=6

Total average value per project=   8/2=4   10\2=5 12/2=6

Total average value of the projects combined= 4+5+6/3= **5**

Five, according to the rating scale (1-6) mentioned earlier in section 5.5, indicates a very high average performance or extent to which P2, P3 and P6 beneficiaries became aware and acquired knowledge on HIV/AIDS related matters, at both the implementation and evaluation phases, thanks to the participatory methodology used.

ii) Objective 2: Attitude change and group skills acquisition

❖ **Was Objective 2 achieved at the implementation phase of the 'P' projects, thanks to the implementation methodology?**

Attitude change and group skills acquisition by beneficiaries were noted in all the evaluation reports to have taken place at the implementation stage of the projects, thanks to the participatory methodology. In P2, beneficiaries were said in the evaluation report to have had 'physical contact' via group participation with those infected with HIV/AIDS and were reaching out to them without fear (unlike before). Skills, such as communication, for example knowing how to tactfully answer questions about HIV/AIDS and initiate personal precautions without causing offence, were indicated in the report to have been acquired. In P3, beneficiaries were reported as being willing to abstain from pre-marital sex and to stay faithful to one partner when married. Beneficiaries were reported to have been empowered to act responsibly within relationships, for example the boys talked of empowerment to be patient, sex-wise, respect the views of the other partner, 'condomise', be open and be faithful and girls of upholding their rights in sexual relationships. Skills such as problem-solving, negotiation, decision-making, debating, persuasive and acting were mentioned. After three months of the programme, all but one client were reported in P6 to be regularly using condoms, with skills such as acting talent, group communication, leadership, organisation and negotiation having been gained via participation.

❖ **Was Objective 2 achieved at the evaluative stage, thanks to the evaluation methodology that helped in negotiating or enhancing Objective 2?**

Information from evaluation reports and occasional insights from interviews gave indications of beneficiaries attesting to change of attitudes and skills acquisition due to their

continued participation in the group discussions organised for the purposes of evaluations. In P2, beneficiaries talked (during group interviews) of emphasis being laid (during the evaluation group discussions) on the challenging of stereotypes, which further strengthened their desire to avoid stereotyping.

In P3, beneficiaries talked of emphasis being laid on abstinence, which made them more determined to abstain from pre-marital sex. Participation in the evaluation group discussions further empowered them (beneficiaries of P2 and P3) to talk freely about sexuality and HIV/AIDS, furthering their group communication skills such as problem solving, negotiation, decision-making, debating and persuasion.

With P6, the emotions of beneficiaries were, as stipulated in the evaluation report, further strengthened, leading to new levels of empowerment (boldness) and attitude change. With the re-enactment of the drama of the sickly infant (infected with HIV/AIDS) strong emotions were aroused to the extent that two of the beneficiaries, who had, within their own families, experienced similar situations, openly and boldly talked about it.

❖ **Judging from the responses given to the above questions, to what extent can one say the 'P' projects successfully met Objective 2 (at both implementation and evaluation phases and thanks to the methodological frameworks)?**

Combining the implementation and evaluation phases of P2, P3 and P6 and evidence given of the extent to which their methodological frameworks (participatory in both phases) contributed in the successful meeting of their objective (objective 2), one would assign an average value of 5:

Attitude change and group skill values at implementation phase   P2=4 P3=6 P6=6

Group attitude change and group skill values at evaluation phase   P2=4 P3=4 P6=6

Total average value per project=   8/2=4 10\2=5 12/2=6

Total average value of the projects combined=   4+ 5+6/3= <u>5</u>

Five indicates a very high average performance, or extent to which P2, P3 and P6 achieved attitude change and group skills acquisition, at both the implementation and evaluative phases, thanks to the participatory methodology used.

iii) Objective 3: Effective functioning and sustainability

❖ **Was Objective 3 achieved at the implementation phase of the 'P' projects, thanks to the implementation methodology?**

Effective functioning and sustainability were revealed in all the evaluation reports (P2, P3 and P6) to have taken place. The implementers of all the HIV/AIDS projects were noted to have, via participation, acted as facilitators, willing to give as well as to receive. It was highlighted in the evaluation report of P3 that one of the beneficiaries commended the facilitator as a good role model for them in terms of the way she conducted herself. Effective functioning via networking was also noted.

In P2 and P3, there was networking with stakeholders such as the teaching staff who participated in the workshops (see Appendix A). During the launching of the youth clubs, the continued participation and collaboration of the principals of the schools, students and pupils, teaching staff, governing body members, representatives from Welfare Services and teachers from the other schools in the area were registered. In P6, networking was noted with women in church organisations.

Financial sustainability was seen to be quite challenging in all three participatory projects. In P2 and P3 the evaluation reports revealed that the beneficiaries were said to be orientated towards self-employment by the making, as a group, of an HIV/AIDS Memorial Quilt and beadwork and, in P6, the making of HIV/AIDS posters. Expansion of the projects' activities were indicated, with P2 and P3 via collective club launchings and visitations to neigbouring schools, and P6 sex workers informing their clients of the value of condoms and spreading the lessons learnt in their neigbourhood and to other sex workers.

❖ **Was Objective 3 achieved at the evaluative stage, thanks to the evaluation methodology that helped in negotiating or enhancing objective 3?**

With respect to the participatory methodology used in evaluating P2, P3 and P6, the evaluation reports and occasional insights from interviews showed that effective functioning and sustainability was achieved. It was with much reservation that the latter was achieved (reservation in terms of financial sustainability due to limited income and ways or creative ideas in achieving that). According to beneficiaries of P2 and P3 (from group interviews), they experienced a collaborative relationship and the sharing of experiences via focus group discussions, where the evaluators, similar to the project implementers, acted as facilitators. By acting as facilitators, they promoted effective functioning in the sense of true democracy, which, according to Servaes (1983), is not merely government "of the people for the people", but more deeply, "by the people". In fact, when interviewed by the present researcher, beneficiaries of P2 and P3 revealed that they were satisfied in terms of the degree of their involvement at the execution stage of their evaluations (showing how effective the methodology was to them).

In the same sense of true democracy, a similar situation, was projected in the evaluation report of P6, where the beneficiaries, in the re-enactment of their training, acted as facilitators in the re-enactment of the focus group discussions, thus promoting effective functioning. While the focus group discussion in the evaluative phase of P6 led to the discovery that some beneficiaries (two, as indicated in the evaluation report) had, due to the impact of the project, turned down men who refused the use of condoms, the others talked of the difficulty of doing so, especially when extra money was offered. Thus, for effective expansion, suggestions were made for the inclusion of men of all social milieus in HIV/AIDS educational projects of like nature. Moreover, according to the sex workers reported in the evaluation, the "user-focused evaluation assessment" surpassed the conventional health centre education in terms of its functioning abilities".

❖ **Judging from the responses given to the above questions, to what extent can one say the 'P' projects successfully met Objective 3 (at both implementation and evaluation phases and thanks to the methodological frameworks)?**

Combining the implementation and evaluation phases of P2, P3 and P6, and evidence given of the extent to which their methodological frameworks (participatory in both phases) helped in successful meeting their objective (Objective 3), one would assign an average value of 5 in terms of effective functioning and 3.7 in terms of sustainability.

Effective functioning value at implementation phase	P2=4	P3=5	P6=6
Effective functioning value at evaluation phase	P2=4	P3=5	P6=6
Total average value per project=	8/2=4	10\2=5	12/2=6
Total average value of the projects combined = 4+ 5+6/3= **5**			

Sustainability value at implementation phase	P2=4	P3=5	P6=2
Sustainability value at evaluation phase	P2=2	P3=3	P6=2
Total average value per project=	6/2=3	8\2= 4	4/2=2
Total average value of the projects combined= 6+ 4+2/3= **3.7**			

Five indicates a very high average performance, or extent to which P2, P3 and P6 achieved effective functioning at both the implementation and evaluative phases, thanks to the participatory methodology used. Three point seven indicates a lower (though, on the whole, high) average performance or extent to which P2, P3 and P6 achieved sustainability at both the implementation and evaluative phases, thanks to the participatory methodology used.

Looking at the different objectives (variables) tested so far, Table 5.4 reflects the overall performances or extents to which P2, P3 and P6 achieved their objectives at both the implementation and evaluative phases, thanks to the methodology they used. Intervening variables, such as background variables of gender, age, language, location, race and internal/external evaluators of each of the HIV/AIDS projects (indicated in section 5.5), were assessed in order to determine their impact on the variables or objectives tested.

Table 5.4 Indicator variables and overall performance of the "P" projects*

Objective or variation categories	Participatory projects		
	P2	P3	P6
Gender (between beneficiaries, managers and **eval)	Mixed	Mixed	Beneficiaries: females
Race (between beneficiaries, managers and eval)	Eval White	Eval White	_***
Language (between beneficiaries, managers and eval)	Eval English	Eval English	_***
****Age (between beneficiaries, managers and eval)	Wider	Widest	Narrow
Rural-urban	Rural	Rural	Suburban
Internal/External eval.	External	External	External
Variables tested	*****Project variable ratings		
			Average per variable
Awareness	4	5	6	5
Knowledge	4	5	6	5
Attitude	4	5	6	5
Skills	4	5	6	5
Effective functioning	4	5	6	5
Sustainability	3	4	4	3.7
Average rating per project	3.8	4.8	5.7	
Overall project average	4.8 (very high)		

*Background variables assigned in the main, on the basis of Table 5.2. Rating values assigned on the basis of evaluation reports findings and interview responses (in Tables 7.2, 7.3 and 7.6 content in Appendix D) and rating scale was from 1-6. 1=Did not occur or was very low (VL), 2= Low (L), 3=Average (A), 4=High (H), 5=Very high (VH), 6=Excellent (E) **Eval=Evaluator ***- Not indicated in evaluation report ****Age classification levels comes from the narrow age gap differences between implementers (including evaluators) and beneficiaries, to the widest

From Table 5.4 it is noticed that, irrespective of the differences in background variables projected in all the participatory evaluated projects, the overall performance in terms of all the variables tested was very high (4.8). This referred to the fact that the background variables of the projects had minimal negative impact on the projects. Certain conscious efforts were made by the implementers of P2 and P3 to minimise the effect of the background variables on the projects. Examples of such efforts included the project implementers (evaluators inclusive), either being of the same race and language grouping as the beneficiaries, or making a conscious effort to identify with the people by speaking

their language, even if not fluently. Another alternative was working closely with those who could speak the language of the beneficiaries (see section 4.4.2). The exception is P6, where information was not provided in the evaluation report.

5.5.2 Overall outcomes of the non-participatory evaluated projects

Information from the evaluation reports of the non-participatory evaluated projects (NP1 NP2 and NP3), and occasional insights from interviews (see Appendix D: Tables 7.7, 7.8 and 7.9 for details), provided a base for the testing of the objectives of the NP projects. The NP projects had similar objectives to the P projects: empowerment of beneficiaries by increasing their knowledge, awareness and abilities through the creating of an enabling environment for the beneficiaries to experience true leadership (free discussion of the new undertakings). Due to the similarities in the objectives of the NP and P projects, the questions that were asked relating to the testing of the P projects were reiterated for the NP projects. The rating process for the NP projects and their evaluations was similar to those described for the P projects.

From the evaluation reports of the non-participatory evaluated projects (NP1, NP2 and NP3), and occasional insights from interviews (see Appendix D: Tables 7.7, 7.8 and 7.9 for details), one gathers the following in response to the variables (objectives) tested:

i)   **NP Objective 1: Group awareness and knowledge acquisition**

❖ **Was NP Objective 1 achieved at the implementation phase, thanks to the implementation methodology?**

In terms of the participatory methodology used in implementing the NP projects, all the beneficiaries (of NP1, NP2, and NP3) commended the methodology of implementation in their evaluation reports. The report of NP1 stated that beneficiaries considered the focus group discussions as having necessitated debates on the acceptance of people living with AIDS and the challenge of deep-seated fears and prejudices. In fact, 78% of students were reported to have approved of their active involvement and 80% rated the programme implementation strategy as excellent. Beneficiaries were said to have become aware of the

need to accept someone with HIV/AIDS "so that he can feel wanted among people, and get love like everybody". Their knowledge on HIV/AIDS prevention, transmission and course of illness, indicated a significant improvement. The Pearson chi-square tests on mode of transmission (HIV cannot be passed by drinking from unwashed cup) showed p=.001, with general knowledge level having risen from 35.6 % before the programme to 67.8% after it and, for the control group, 34.1% to 37.1%.

The evaluation report indicated that the soccer players of NP2 had the realities of STI/HIV and AIDS revealed to them via participation and thus the need to seek early treatment for STIs. There was a significant difference between the programme and control group (Kruskal-Wallis test p=.0009), because before the programme 14 had had an STI and, in the previous two months, none, whereas in the control group18 had had an STI and, in the previous two months, five. Knowledge level about sores, glands and discharges were significantly higher amongst programme youths (Kruskal-Wallis test p=.0009, .0003 and .0002). The support staff members were able to think as a pool, rather than as individuals, leading to their becoming aware of the need to develop a clear strategic direction. Their interaction with the advisory board (seven local experts) led to the gaining of experience and knowledge, such as in gender-related matters.

Sex workers, as reported in the evaluation report of NP3, talked of the participatory methodology to have enabled them to share ideas and learn from one another and become aware, as well as knowledgeable of the dangers of unprotected sex and untreated STIs.

❖ **Was NP Objective 1 achieved at the evaluative phase, thanks to the evaluation methodology that helped in negotiating or enhancing NP Objective 1?**

Unlike the implementation methodology of the NP projects, which was group participatory, the evaluation methodology was individually orientated and non-participatory (individual interviews, self-report questionnaires, with pre-test-post-test non-equivalent comparison group design). This reflects an absence of an enabling environment such as focus group activities or re-enactments in the evaluations, where ideas could be shared, leading to the negotiation or enforcement of NP Objective1.

With NP1 an unresolved rumour that the reason for the initiation of the AIDS programme was because the students and teachers had AIDS brought distress among students and staff: "we have now become a laughing stock of other schools" (reported in the NP1 evaluation report).

With NP2, the evaluation report talked of the soccer players expressing the need for opportunities to ask and seek answers to questions, during the evaluation process. This was something that did not occur. Some support staff of NP2 were either not aware, or incorrectly perceived, the intention of the evaluation. The support staff (unlike the donors and evaluators) saw themselves to be more of a support organisation than an implementation body and did not need an evaluation that focused more on implementation issues. Such a misunderstanding, with the lack of an enabling environment (at the evaluative phase of the project), meant that it was not discussed and the misunderstanding remained. The missed opportunity of correcting or developing new knowledge led to the support staff resenting findings of the evaluation. One member of the staff vented her anger when interviewed by the researcher long after the evaluation "I do not want to see that evaluation report". She felt that the organisation was being judged on incorrect criteria.

It was noticed in the evaluation report of NP3 that mechanisms to sustain long-term behaviour change were lacking, as well as regular evaluation to motivate programme participants and to monitor the progress of the project. These were issues that one perceives could have been discussed and measures taken to resolve them, particularly by those concerned (the beneficiaries) during the evaluation, had such an opportunity been provided.

> ❖ **Judging from the responses given to the above questions, to what extent could one say the 'NP' projects successfully met NP Objective 1 (at both implementation and evaluation phases and thanks to the methodological frameworks)?**

Combining the implementation and evaluation phases of NP1, NP2 and NP3 and evidence given of the extent to which their methodological frameworks (participatory at

implementation and non-participatory at evaluation) helped in successfully meeting NP Objective1, one would assign an performance average value of 2.8:

Group awareness and knowledge values at implementation phase NP1=5 NP2=4 NP3=5
Group awareness and knowledge values at evaluation phase   NP1=1 NP2=1 NP3=1
Total average value per project=   6/2=3   5\2=2.5   6/2=3
Total average value of the projects combined= 3+2.5+3/3=**2.8**

According to the rating scale (1-6) mentioned earlier in section 5.5, 2.8 indicates a low to average total performance, or extent to which NP1, NP2 and NP3 beneficiaries became aware and acquired knowledge of HIV/AIDS related matters. This includes both the implementation and evaluation phases and is based on their combined methodological frameworks, as reflected in the evaluation reports.

ii) NP Objective 2: Attitude change and group skills acquisition

❖ **Was NP Objective 2 achieved at the implementation phase, thanks to the implementation methodology?**

Attitude change and group skills acquisition were noted at the implementation phase of all the HIV/AIDS NP projects. NP1, for example, talked of beneficiaries' significant acceptance of someone with AIDS in the class (Pearson chi-square tests p=.0001). This is because 16.6 % level of acceptance was noted before the programme and 41.2% afterwards and, for the control group, 9.5% before and 10.8% afterwards. The beneficiaries were empowered with skills such as acting talent, group communication, leadership, organisation and negotiation. They were significantly empowered to discuss AIDS with their parents, friends, sexual partners, nurses and teachers. With parents (Pearson chi-square tests p=.0001) before the programme 15.6 % did discuss and after the programme 69.2% and, in the control group, 18% before and 34.5% afterwards. One of the beneficiaries said, in relation to confronting HIV/AIDS, "I know the rules of this disease so it's no problem. You won't get AIDS by just being in the same room" (NP1 evaluation report: 165).

With the soccer players of NP2, a significant change was noted in the use of condoms after the programme (Kruskal-Wallis test p =.0000). Before the programme none of the soccer players used condoms always and after the programme18 did. In the control group: none before and only 1 after. For the support staff, an attitude of enthusiasm was built up. The soccer players and the support staff gained group communication skills and leadership, organisational and negotiation skills.

As indicated in the evaluation report of NP3, condom use rose from 18% (start of the programme) to 66% within two years. This portrayed a strong linear relationship between programme exposure and reported condom use. The sex workers gained acting talents, group communication skills and leadership, organisational and negotiation skills. Sex workers were empowered to protect themselves against STIs and HIV/AIDS infections, with a remarkable drop in visits to health units (average quarterly attendance for the five quarters before the commencement of the programme was 4 960 visits and after the commencement of the programme it dropped to 3 368 visits (t test, P=.0001). This was reported (in spite the many confounding factors that might have affected clinic attendance) as due the empowerment of the sex workers to protect themselves. They consequently suffered fewer health problems.

❖ **Was NP Objective 2 achieved at the evaluative phase, thanks to the evaluation methodology that helped in negotiating or enhancing NP Objective2**

There were no group activities in the evaluations of NP1, NP2 and NP3, given that their evaluations were carried out in a non-participatory manner (see section 5.4.4). This refers to the absence of an enabling environment, where beneficiaries could have participated to their own development or change. Development as stated by Servaes (1995), is inextricably linked to participation. Participation entails full and active integration of beneficiaries throughout most or all of the phases of a project (Babbie and Mouton 2001). By learning from one another, for example in a focus group discussion, listening to others talk, venting frustrations and contributing ideas for growth, the evaluation methodology of the NP projects could invariably have led to the negotiation or furtherance of NP Objective2. In the reports there was no evidence of these types of activities as part of the evaluation process.

❖ **Judging from the responses given to the above questions, to what extent could one say the 'NP' projects successfully met Objective 2 (at both implementation and evaluation phases and thanks to the methodological frameworks)?**

Combining the implementation and evaluation phases of NP1, NP2 and NP3 and evidence given of the extent to which their methodological frameworks (participatory at implementation and non-participatory at evaluation), helped in successful meeting their objective (NP Objective 2), one would assign an average value of 2.8:

Group awareness and knowledge values at implementation phase NP1=5   NP2=4   NP3=5

Group awareness and knowledge values at evaluation phase   NP1=1   NP2=1   NP3=1

Total average value per project=   6/2=3   5\2=2.5   6/2=3

Total average value of the projects combined= 3+2.5+3/3= **2.8**

According to the rating scale (1-6), 2.8 indicates a low to average total performance, or extent to which NP1, NP2 and NP3 beneficiaries were empowered as a group to change their attitude and the extent to which they were empowered via group skills acquisitions (at both the implementation and evaluative phases of the projects). Looking at the low to average performance of the NP projects (stemming mainly from the non-participatory cost-benefit or cost-efficiency form of their evaluations), Brunner and Guzman (1989) comment that such evaluations tend to reflect the world-view and priorities of the sponsoring agencies, while denying any meaningful input (input which could further necessitate group skill empowerment and change) from the main actors in the development projects.

iii) Effective functioning and sustainability

❖ **Was NP Objective 3 achieved at the implementation phase of the 'NP' projects, thanks to the implementation methodology?**

Effective functioning and sustainability was noted at the implementation phase of all the NP projects, but with some limitations worth noting (in areas such as financial sustainability, where it was seen to be an issue in all the NP projects). The project

implementers all acted as facilitators. In NP1, planning meetings were held with staff members and the students' representative council and *ad hoc* groups of students and staff members, where ideas were brainstormed and tasks and responsibilities assigned. Networking took place with people living with HIV/AIDS, *viz.* parents, school authorities and nurses. As an income-generation exercise, and as a means of spreading HIV/AIDS messages, art exhibitions were held in the school and students indicated discussing HIV/AIDS with their friends, parents and sexual partners.

No planning meetings were indicated in NP2 and NP3, but the support staff of NP2 were said to have networked with stakeholders (similar to their own stakeholders) in SA. They spoke of having had a budget increase, with an increase in the number of donors (from one main body, to three additional minor bodies), all indicating some degree of effective functioning, and of the increasing financial sustainability of the project. Unfortunately, limited priority settings within the programme support systems, and rather too broad-based advocacy and the problem of different donors having different targets and empowerment strategies, were noted to hinder cohesiveness. NP3 networked with bar owners and male clients for effective functioning. The NP3 beneficiaries had some form of financial sustainability, through private and free STI treatment cards given to them and their counterparts by the NP3 project supporters. The beneficiaries carried out weekly distribution of condoms to bars and selected workplaces.

❖ **Was NP Objective 3 achieved at the evaluative phase, thanks to the evaluation methodology that helped in negotiating or enhancing NP Objective 3?**

In the non-participatory evaluation of the NP projects, given the absence of group participatory activities, the evaluators did not act as group facilitators, interchanging, as explained by McQuail (1983: 97), the "sender-receiver roles" in a free discussion forum. Such an exchange of roles is considered vital in challenging the act of leaders (implementers and evaluators inclusive) usurping the role of the people (Nyerere 1974). It is also considered vital in empowering the beneficiaries by giving them a voice, building pride and self-confidence in them as human beings thus promoting effective functioning.

Considering that the issue of financial sustainability was an identified problem in all the NP projects, beneficiaries were not empowered as a group by, for example, evaluation group discussions to collectively seek ways of redressing the problem. This includes the negotiating or furthering of networking and expansion of the project's activities, of which beneficiaries were not empowered, as well as a group to redress them.

> ❖ **Judging from the responses given to the above questions, to what extent could one say the 'NP' projects successfully met Objective 3 (at both implementation and evaluation phases and thanks to the methodological frameworks)?**

Combining the implementation and evaluation phases of NP1, NP2 and NP3, and the evidence given of the extent to which their methodological frameworks (participatory at implementation and non-participatory at evaluation) helped in successful meeting their objective (NP Objective 2), one would assign an average value of 2.7 in terms of effective functioning and 2.1 in terms of sustainability:

Effective functioning value at implementation phase NP1=5 NP2=3 NP3=5

Effective functioning value at evaluation phase   NP1=1   NP2=1 NP3=1

    Total average value per project=   6/2=3   4\2=2   6/2=3

    Total average value of the projects combined= 3+ 2+3/3=**2.7**

Sustainability value at implementation phase NP1=4 NP2=3 NP3=3

Sustainability value at evaluation phase   NP1=1   NP2=1 NP3=1

    Total average value per project=   5/2=2.5   4\2= 2 4/2=2

    Total average value of the projects combined= 2.5+ 2+2/3=**2.1**

According to the rating scale (1-6), 2.7 indicates a low to average performance or extent to which NP1, NP2 and NP3 achieved effective functioning at both the implementation and evaluative phases: judging from the different methodological frameworks used. Two point one indicates a lower average performance or extent to which NP1, NP2 and NP3 achieved sustainability at both the implementation and evaluative phases, judging from the different methodological frameworks used.

Table 5.5 gives the overall performance of the non-participatory evaluated projects: overall performances or extents to which NP1, NP2 and NP3 achieved their objectives at both the implementation and evaluative phases (judging from the methodology they used). For all to be equal, intervening variables, similar to those in the participatory projects (gender, age, language, location, race, internal/external evaluators of each of the HIV/AIDS projects), were assessed in order to determine their impact on the variables or objectives tested.

Table 5.5: Indicator variables and overall performance of the non-participatory evaluated projects*

Variation categories	Non-participatory evaluated projects		
	NP1	NP2**	NP3
Gender (between beneficiaries, managers and eval***)	Mixed	Soccer players males Support staff mixed	Mixed
Race (between beneficiaries, managers and eval)	_****	Support staff eval English Soccer players Zulu	Eval. Kenya Beneficiaries and managers Zimbabweans
Language (beneficiaries, managers and eval)	_	English, Zulu	Kenya and Zimbabwe
*****Age gap (between beneficiaries, managers and eval)	Wide	Narrow (between project staff and eval) Wide (between eval, soccer players)	Narrow
Rural-urban	Urban	Rural-Urban	Urban
Inter/ext evaluators	External	External	External

Variables tested	Project variable ratings		
			Total average rating per variable
Awareness	3	2.5	3	2.8
Knowledge	3	2.5	3	2.8
Attitude	3	2.5	3	2.8
Skills	3	2.5	3	2.8
Effective functioning	3	2	3	2.7
Sustainability	2.5	2	2	2.1
Average rating per project	2.9	2.3	2.8	
Overall project average	2.7=Average			

*Background variations assigned, in the main, on the basis of Table 5.3. Rating values assigned on a basis of Tables 7.7, 7.8 and 7.9 content in Appendix D, evaluation reports findings and interview responses. Rating scale was from 1-6. 1= Did not occur or was Very low (VL), 2= Low (L), 3=Average (A), 4=High (H), 5=Very high (VH), 6=Excellent (E) **NP2 project evaluation was in two parts: implementation with soccer players and organisation with project staff ***Eval=Evaluator ***- Not indicated in evaluation report ****Age classification levels comes from the narrow age gap differences between implementers (including evaluators) and beneficiaries to the widest

Table 5.5, shows that, irrespective of the different background variations projected in all the non-participatory HIV/AIDS projects, the overall performance in terms of the variables tested was low to average (2.7). The background variation of the projects was noticed to

have had a minimal impact on the projects. This was due to the relatively narrow gap differential between the implementers and the beneficiaries in the three projects.

The overall performances of the participatory and non-participatory evaluated projects have been examined in this section. The examination was done in order to provide a solid base for the comparison of the two methodological frameworks (participatory and non-participatory) in the evaluation of the HIV/AIDS projects. This base provided information that was used to classify the performances of the two types of projects (at both the implementation and evaluative phases), for in-depth comparison. The objectives or variables (group participation, awareness, knowledge, attitude, skills acquisition, effective functioning and sustainability) made up the parameters from which projects (in their respective categories, participatory and non-participatory) were examined.

5.6 Comparison of the overall outcome results of the participatory and non-participatory evaluated projects

In order to facilitate the comparison of the two project categories (participatory and non-participatory evaluated projects), the researcher used the total average rating per variable as the parameter for comparison. This meant that the total average rating per variable of the three participatory evaluated projects (shown in Table 5.4) compared with the total average rating per variable of the three non-participatory evaluated projects (shown in Table 5.5). The reason for such a comparison was to determine the value of participation in both the implementation and evaluation of HIV/AIDS projects. This value was investigated in Chapter 5 by appraising the participatory and non-participatory methodological frameworks with respect to the extent to which they contributed the meeting the objectives (from implementation, right through to evaluation) of the projects studied.

Table 5.6: Comparison of overall performance of the participatory non-participatory evaluated projects*

Variables tested	Participatory evaluated projects	Non-participatory evaluated projects
	Average ratings per variable of all three participatory evaluated projects (combined)	Average ratings per variable of all three non-participatory evaluated projects (combined)
Awareness	5	2.8
Knowledge	5	2.8
Attitude change	5	2.8
Skills	5	2.8
Effective functioning	5	2.7
Sustainability	3.7	2.1
Overall project performance	4.8 (high to very high)	2.7 (low to average)

*Ratings results from Tables 5.4 and 5.5

Looking at the overall performance of the two project categories (Table 5.6), the participatory evaluated projects displayed a very high performance (4.8), as opposed to the average performance (2.7) of the non-participatory projects. With the participatory evaluated projects, the overall evidence regarding the very high attainment of the variables tested came not merely from the methodology used in implementing the projects, but also from that used in evaluating them. As shown in section 5.5.1 and Tables 7.2, 7.3 and 7.6 (Appendix D), awareness, knowledge, attitude, skill acquisition, effective functioning and sustainability were experienced both at the implementation and evaluation phases of the projects by the use of participatory methodology.

With respect to the participatory methodology used in evaluating P2, P3 and P6 beneficiaries commended it. According to them, a collaborative relationship and the sharing of experiences were gained through focus group discussions: focus group discussions (and user focussed re-enactments in P6) served as a learning process. This process enabled them to identify vital issues of the project that they had forgotten, or overlooked, but which, were brought to light by other members of the group. In fact, according to them, the focus group

discussions organised during the evaluations helped to renegotiate the projects' objectives (awareness, knowledge, attitude change, empowerment, effective functioning and sustainability).

Occasional insight from interviews with beneficiaries of P2 and P3 revealed that the beneficiaries were satisfied in terms of the degree of their involvement at the execution stage of their evaluations. With the user-focused evaluation of P6 in correcting the drop- off in condom use through misunderstanding about the poor quality of condoms, knowledge and awareness were reinforced and corrected.

Looking at attitude change and skills acquisition, the following were noted: beneficiaries having 'physical contact' and reaching out to those infected without fear (unlike before) with communicational skills (how to tactfully answer questions about HIV/AIDS and instigate personal precautions without causing offense) renegotiated at the evaluative phase (P2) and beneficiaries willing to abstain from pre-marital sex and stay faithful to one partner when married, with skills such as problem solving, negotiation, decision-making, debating and persuasion renegotiated (P3). The emotions and attitudes of beneficiaries that were stirred at implementation via the different dramas were further strengthened during the evaluation process, leading to new levels of empowerment (boldness) and attitude change (P6). Acting talent, group communication skills and leadership, organisational and negotiation skills were renegotiated with the sex workers empowered to make their own situational risk assessment and deliberate upon appropriate individual and collective actions to take.

In the same sense of true democracy, P6 beneficiaries, in the re-enactment of the training, acted as facilitators, as did P2 and P3 evaluators, thus promoting effective functioning. For effective expansion, suggestions, for example in (P6 user-focused evaluation) were made for the inclusion of men of all social milieus in HIV/AIDS educational projects of like nature. Moreover the "user-focused evaluation assessment", according to the sex workers, surpassed the conventional health centre education in terms of its functioning abilities.

In spite of indications of achievement and renegotiation of objectives of the "P" projects, sustainability was noted in the evaluation reports to be not so good. This was due to factors such as time limitation preventing many outreaches (P2) inadequate resources for travelling (P3) and insufficient income-generating activities (P2, P3 and P6).

Taking the case of the non-participatory evaluated projects, a different scenario was experienced. Statistical and qualitative evidence regarding changes, as a result of beneficiaries' participation in the different group activities (drama, songs, videos), at the implementation phases (and not at the evaluation phases) of the projects, were cited in the different evaluation reports (see section 5.5.2 and Tables 7.7, 7.8 and 7.9 of Appendix D). The evidence was related to group knowledge acquisition, awareness, skill acquisition and attitude change, effective functioning and sustainability. Evidence, for example, 78% of students approving of their active involvement at the implementation phase and gaining knowledge on the vice of stigmatisation (NPI); the participatory methodology at the implementation phase enabling the unfolding of the depth of STI/HIV and AIDS to the soccer players (NP2) and to the sex workers (NP3).

In terms of attitude change and skills acquisition, evidence was noted of a significant level of beneficiaries' acceptance of someone with AIDS (NP1), significant change in condom usage (soccer players of NP2 and sex workers of NP3) and empowerment for open discussions about sex matters (NPI, NP2 and NP3).

Evidence similar to that of the participatory projects, where implementers of NP1, NP2 and NP3 acted as facilitators in the participatory activities, thus fostering effective functioning at the implementation stage was also provided. Sustainability, as in the participatory projects, was again noted to be an issue (due mainly to financial constraints) and to a greater degree compared to the participatory projects (see Table 5.6).

In assessing the evaluative phases of the non-participatory evaluated projects, a contrast was observed when compared to the participatory projects. In the evaluative phases of the "NP" projects (unlike the "P" projects), there were no group participatory activities, for example focus group discussions and re-enactment exercises from which similar evidence

(indicated at the implementation phases of the projects) were identified. This referred to the fact that, unlike the "P" projects, the objectives of the "NP" projects (group knowledge acquisition, awareness, skill acquisition and attitude change, effective functioning and sustainability) were not renegotiated at the evaluative phases via non-participatory methodology. Thus the partial meeting (at the implementation, but not at the evaluative phases) of the objectives of the "NP" projects: a relatively lower performance rate (overall average performance rate of 2.7) compared to the "P" projects (a very high overall performance rate of 4.8).

At the evaluative phases, with respect to group knowledge acquisition and awareness, no evidence was provided in the evaluation reports (NP1, NP2 and NP3) as to these having been renegotiated, due to the absence of an enabling environment (evaluation was non-participatory). This situation was similar to group attitude change and skills acquisition, where no evidence was provided in the evaluation reports (NP1, NP2 and NP3) for them having been renegotiated for similar reasons. None of the evaluators of NP1, NP2 and NP3 acted as group facilitators (posing as learners and teachers and at the same time for the fostering of effective functioning), as there were no group activities to facilitate or to exchange ideas.

In fact, instances were noted of unresolved misinformation (a situation unlike that of the 'P' projects, taking the cited case of P6, where the rumour on poor quality of condoms was resolved at the evaluative phase due to an enabling environment). With NP1, one noted misinformation stemming from the rumour that the AIDS programme was initiated because the students and teachers had AIDS. With this misinformation, and it not being resolved at the evaluation phase, inaccessibility to correct or new knowledge was noted bringing about distress among the students and staff and, consequently, 'cold feet' with regard to the continuation of the programme.

With NP2, it was the misinformation regarding the rationale for the evaluation where, according to the support staff members, they saw themselves more as a support to an implementation body (a body that provided the necessary financial and staff support to project implementers). This refers to the fact that an evaluation of their organisation had to

handle issues concerning support strategies, for example skills in providing support to HIV/AIDS project implementers. The evaluation, as perceived by the support staff, dealt with issues concerning actual HIV/AIDS project implementation strategies. Such a misunderstanding was unfortunate, with the lack of an enabling environment (at the evaluative phase of the project) for it to be discussed and resolved. This led to inaccessibility of correct or new knowledge that led to the resentment of the findings of the evaluation by the support staff.

Other reported areas of issues that went undiscussed right through to the evaluative phase of NP2 (not reported in NP3) included, confusion as to who made the ultimate decision in the functioning of the advisory board and programme committee of NP2. Confusion in views regarding targets and strategies of NP2 stemming from 'mix partners' (different donors) with different targets and empowerment strategies made a coherent strategy difficult to come by. Moreover, with the evaluation of the actual implementation project of NP2, the HIV/AIDS soccer player project, the evaluation report talked of the soccer players expressing the need for opportunities to ask and seek answers to burning questions during the evaluation process (something which did not take place). According to the AfrEA (2002) developed checklist that could be of importance in the evaluation of projects with social implications, particularly within the African context (for which it was designed), conflict of interest is to be dealt with openly and honestly, so that it does not compromise the evaluation processes and results (as seen with the "NP" projects). When comparing the "P" and "NP" projects, one can conclude (judging from the evidence provided) as follows:

Table 5.7: General evidence provided with respect to "P" and "NP" projects

General evidence				
Variable	"P" Projects		"NP" Projects	
	Implementation	Evaluation	Implementation	Evaluation
Group awareness,	Evident	Evident	Evident	Not Evident
Group knowledge	Evident	Evident	Evident	Not Evident
Group attitude change	Evident	Evident	Evident	Not Evident
Group skills	Evident	Evident	Evident	Not Evident
Group effective functioning	Evident	Evident	Evident	Not Evident
Group sustainability	Evident	Evident	Evident	Not Evident

Looking at Table 5.6, Caceres *et al.* (1994) held that evaluation had, over the past years undergone an evolution partly due to funding considerations whereby donors were increasingly demanding more formalised data before they could allocate funds for interventions. This approach fails to promote long-term community development processes (like the ones in this study) and to capture the "community level processes that state-of-the-art HIV prevention interventions seek to promote" (MacPhail and Campbell 1999:149).

Unlike in the non-participatory evaluations, the present researcher, in spite of internal/external differences and limitations of full participation, found strong evidence of group empowerment, awareness, knowledge acquisition, effective functioning, sustainability and, above all, attitude change, being effected at the implementation and evaluation phases of the projects, this with the use of the participatory methodology at project implementation and evaluation; a situation which can be said to share some commonalities with that highlighted by Hall (1997). Knowledge is socially constructed. Therefore approaches that allow for social, group, or collective analysis of life experiences of power and knowledge are most appropriate (Hall 1997).

5.7 Summary

The value of participation was further investigated in Chapter 5 by comparing the overall outcome results of participatory evaluated projects with non-participatory ones. Both types of projects handled HIV/AIDS social/awareness issues related to education, gender, culture and other socio-economic imperatives. They also had similar objectives: creating, via participation, an enabling environment for group knowledge acquisition, awareness, skill acquisition, attitude change, effective functioning and sustainability. All these were done in order to achieve attitude change with respect to HIV/AIDS matters.

The results of the comparison showed that, in spite of socio-demographic differences, the participatory evaluated projects performed better that the non-participatory evaluated ones. The non-participatory projects failed to carry forward their objectives right through into the evaluation.

With the participatory evaluated projects, the overall evidence regarding the very high attainment of the variables tested (creating an enabling environment for group awareness, knowledge acquisition, effective functioning and sustainability) came not merely from the methodology used in implementing the projects, but also from that used in evaluating them. Beneficiaries commended the participatory methodology used in evaluation. According to them, a collaborative relationship and the sharing of experiences were gained through focus group discussions and re-enactments. These processes enabled them to identify vital issues of the project that they had forgotten, overlooked, or were brought to light by other members of the group.

In the participatory evaluated projects, skills, such as communication, leadership, organisation, problem-solving, negotiation, ways of teaching learners and showing sympathy were acquired at implementation and renegotiated at evaluation. Effective functioning, through the challenging of the "top-down" approach, was also highlighted at the implementation and evaluation phases of the participatory evaluated projects.

In the non-participatory evaluated projects, a different scenario was experienced. Statistical and qualitative evidence of beneficiaries' participation at the implementation phases (and not at the evaluation phases) of the projects, were cited. Evidence, similar to that in the participatory evaluated projects, for example, of beneficiaries approving of their active involvement at the implementation phase and gaining knowledge, was cited.

In assessing the evaluative phases of the non-participatory evaluated projects, a contrast was observed. In the evaluative phases, there were no group participatory activities. Thus the objectives of the non-participatory evaluated projects were only partially met - at the implementation, but not at the evaluation phase. In fact, it was difficult even to have access to the evaluators, project managers and beneficiaries for interviewing. This situation was partly attributed to the stigma attached to evaluation (evaluation seen as judgmental or .finger-pointing) particularly in cases of highly quantified reports. They responded negatively with some claiming to still be at the learning phase of evaluation and others of not being ready for the complexity of procedures.

CHAPTER 6: SUMMARY, CONCLUSION, LIMITATIONS AND RECOMMENDATION

6.1 Introduction

This study concentrated, in the main, on issues surrounding implementation and evaluation methodologies: methodologies that could be valuable in HIV/AIDS projects (participatory methodology being the main focus). In terms of the HIV/AIDS projects, the study focused mainly on projects with social implications: projects that dealt with issues such as group awareness, knowledge, attitude change, empowerment and structural transformation. It also concentrated on the validation of documentary and interview evidence provided by beneficiaries, managerial staff and evaluators in the determination of such potentially valuable methodologies.

In Chapter 6, a brief summary of the study is given, followed by comprehensive theory building, study limitations and suggestions for further research.

6.2 Summary

The present study has been an attempt to examine approaches that could be considered vital in the implementation and evaluation of projects that aim at bringing about social change: taking the case of HIV/AIDS communication-based projects/evaluations.

In Chapter 1, the introductory chapter, the background of the work, the research problems, questions and parameters, along with the different concepts used in the study, were defined and discussed. As a background to the study, the gravity of the HIV/AIDS epidemic was projected, in spite of much effort to curb its spread. This was seen as an indication for the need for more effective HIV/AIDS project implementation and evaluation. The question of whether methodologies that incorporate elements of participation could make a difference in HIV/AIDS project implementation (with social implications) and evaluation was asked. This was in order to carry out valid judgments that would contribute to the building of useful project and evaluation methodologies.

The case studies of this research were limited to southern Africa, taking South Africa in particular as the main area of focus. The approach taken was to concentrate on immediate results via in-depth analysis of a few cases, rather than on a broader survey of types of perspectives. This approach was used with the anticipation that greater insight would be achieved even if not necessarily generalisable to a wider group. The dominant concepts in the study were:

- Value: depicting the worth of a project's implementation and evaluation methodology in meeting its objectives.

- HIV/AIDS intervention: Depicting a precise activity (or set of related activities) that intended to bring about social/behavioural changes in a particular target population through the use of a common strategy. The focus was on communication-based interventions with a peer education element.

- Methodology: Suggesting different approaches in dealing with problems. Approaches that ranged from qualitative (report of observations in natural languages with rare use of numbers) to participatory (active involvement of beneficiaries) and to quantitative (assigning numbers to observations). The aim being to describe and analyse them, highlight their limitations and consequences and relate their potentialities to the empowerment of beneficiaries in communication-based interventions.

- Participation: Direct involvement or active presence of people in change initiatives: this, involving various stakeholders particularly the beneficiaries of a project. Such participatory practices, which formed the basis of this study, were noted to be realised at different levels and stages, for example, at the planning, decision-making, implementation and result-feedback. In this way, participation (involving group activities such as group discussions, plays enactments, dances) was used in this study as an assesement mechanism.

Chapter 2 consisted of discussions (mainly based on a review of the literature) around various issues related to theories and major influential community/social factors that could impact on social change and the spread of HIV/AIDS. The chapter sought to answer the research question "What major factors influence social change and contribute towards a valuable HIV/AIDS health-enhancing intervention?" In order to answer the question, the chapter focused on broadly examining theories deemed vital to investigate social change patterns, taking cognisance of participatory strategies. It also concentrated on drawing together some major community factors that influence the adoption of social change and project selections that could lead to valuable interventions. A strong focus was on using an integrative approach (rather than a single in-depth approach) that helped in bringing together, in a broader sense, many different strands of thoughts. An analysis was carried out of how an understanding of these factors and the approach used in dealing with them in interventions could contribute to enhance HIV/AIDS interventions and healthy lifestyles. Such an analysis was expected to contribute towards a valuable HIV/AIDS health-enhancing intervention.

Factors, observed to be commonly reflected in the literature in the social behavioural area of the spread of HIV/AIDS were selected. These were pre-existing and situational factors such as, culture/beliefs (Ellis 1999), language (Ellis 1999), religion (Thomas 2000), gender (Fofana 1999), age (Ciantia 2003), poverty/education (Awusabo-Asare 2002) and crime (Leclerc-Madlala 1999). The criterion for selection of the theories/factors was on the basis that they were integrative and had social implications so that differences in their social practices could be traced and analysed in line with the aim of the section of the study.

In-depth systemic interventions, in relation to HIV/AIDS, were also recognised in the selection process though not dealt with in-depth as they were outside the ambit of the study.

Putting together the factors (pre-existing, situational and sub-factors) influencing the spread of HIV/AIDS and the different ways in which HIV/AIDS projects/interventions dealt with them, a comprehensive theory for the study was thus developed.

- Realities: Careful assessment of the unique perspectives of targeted communities. Here, the interventionist was seen as trying "to know with others, rather than about them, and to reconceptualise and foster knowledge as something that exists among people, rather than some sort of barrier between them" (Bhana 1999: 230).

- Factors: Incorporating the social factors could either directly or indirectly influence social change (Darrow 1997) and seek ways whereby these factors could be addressed relative to that community. Interventions could either seek ways to accommodate or change the factors. For example, in terms of language as a factor (pre-existing), interventions could accommodate it by speaking the language of the people. Another example relating to poverty (a situational factor), interventionists could mediate in order to change the situation by collectively seeking ways to improve the economic environment of that particular community.

Factors should also be integrated with each other rather than following a reductionism approach in order to effect social change (Fishbein 2000-integrative model). For example, crime or violent acts such as rape of virgins could be perpetuated by beliefs that people could be cured of HIV/AIDS if they have sex with a virgin. The impact of this means that in order to deal with crime (rape) the belief system of the people needs to be addressed.

- Participation: An approach that enables mediation between individual and collective needs and that addresses the tension between the community members and the project implementer. Ensuring high audience representation and participation (songs, drama, group discussions, decision making) at different levels and stages of the project leads to more appropriate problem and solution finding.

- Projects, in an attempt to identify and seek solutions to the different realities and factors influencing social change, different methodologies need to be applied.

This is partly due to the need to avoid victim blaming (Rembley 1999-Dickie's HIV theory) which may jeopardise a well-intentioned project. It is also partly due to the need to assess the dynamics of power-bases (Campbell 2003).

On the whole, the impact of the identified factors: culture/beliefs, language, religion, age (pre-existing factors), gender, poverty, education and crime (situational factors) were seen to be part of the comprehensive theory of this study through the integration of participatory methods into the implementation of social change projects (Figure 2.11). All these pointed to the need for in-depth understanding of the realities of life and more profound social changes to halt the HIV epidemic. They also pointed to the role of participation in addressing the aspects above (reality, factors and projects).

A careful understanding of certain key issues embodying evaluation was explored in Chapter 3. These issues included: what evaluation entails, the reasons for evaluations, paradigms governing them and the recommended degree and understanding of meaningful, useful and valuable evaluations. The values and ideologies of two key forms of evaluations (traditional and participatory evaluations) were highlighted and differences in their social practices traced and analysed.

With regards to traditional evaluation, its values and ideologies were noted (after Bhana 1999:229 and Servaes 1989:76) to be based on problem-solving, scientific or interpretive assumptions about knowledge, for example good life and good society are based on value-free liberalism, individualism and meritocracy with little relation to real-world experience.

The values and ideologies of participatory evaluations were, on the other hand, noted to be problem posing, promoting collaborative relationships, eradicating oppression and mobilising people to develop themselves with the assumption that people have the capabilities to do so.

It was demonstrated from a review of the literature that when participation is reflected, not just in a project but also in its evaluation, participants tend to personalise the project and are therefore eager to put it into action. In the process, participants are empowered with skills

to communicate the lessons learned. It was argued that, to go beyond awareness, communities had to change by assessing their own vulnerabilities and ways of combating them. This was seen to take place more often in situations where there was an acknowledgement of the social drive of an epidemic such as HIV/AIDS and a communal approach to address it.

Note was taken of the fact that giving beneficiaries the privilege in choice and decision-making did not imply a neglect of the choices and decision-makings of other players, such as project implementers and donors. It did not imply a neglect of vital concerns, such as time and financial accountability and efficiency that warranted inclusion in an evaluation. The issue was seen to be the avoidance of persuasion, which was perceived to be the norm in a 'capitalist' system and rather, a poor approach in the field of evaluation.

An analysis of the contribution of participation towards a meaningful, useful and valuable HIV/AIDS health-enhancing project and its evaluation by both internal and external evaluators informed Chapter 4. Factors that could contribute towards a project meeting its objectives or impacting its targeted community were investigated. These factors at both implementation and evaluation stages, included

- the degree to which interviewees were informed about a project,
- the stages at which they were involved,
- the different group activities that they were exposed to and
- the role of internal versus external evaluators.

HIV/AIDS projects that had elements of participation both at implementation and evaluation phases were selected for the study. Focus group discussions were conducted with the beneficiaries and individual interviews with the managerial staff and evaluators. As was expected, results of this study revealed that the execution stage was that with the participatoriest activities. Many different group activities, such as group discussions (at both implementation and evaluation) drama, songs and dances (at implementation), were noted at this stage. The different activities were seen to be an indication of how far the beneficiaries were involved in the different projects.

Dissatisfaction was, however, noted on the part of the beneficiaries about their lack of participation in the planning, action planning and result-feedback stages of the projects. Also, the beneficiaries (unlike the managerial staff and evaluators) were poorly informed concerning details of the projects and their evaluation; such as why the projects/evaluation were carried out, who asked for them, and their duration.

In spite of socio-demographic differences within the projects, the beneficiaries (at implementation and evaluation) were excited with the degree and quality of their involvement.

Beneficiary participation was seen in the study to override the influence of socio-demographic differences (gender, age, race and language) as well as internal versus external evaluator differences.

On the whole, the beneficiaries, attested to change and of being role models, impacting positively the lives of others in their communities. They indicated being empowered to make proper choices and decisions relating to sex as well as taking responsibility for their health. They were aware of the consequences of stigmatisation and ways of counteracting it. This revealed the positive value of the participatory HIV/AIDS projects and their evaluation to the beneficiaries.

The value of participation was further investigated in Chapter 5 by comparing the overall outcome results of participatory evaluated projects with non-participatory ones (of projects that were participatory in nature). Both types of projects handled HIV/AIDS social/awareness issues related to education, gender, culture and other socio-economic imperatives. They also had similar objectives: creating, via participation, an enabling environment for group knowledge acquisition, awareness, skill acquisition, attitude change, effective functioning and sustainability. All these were done in order to achieve attitude change with respect to HIV/AIDS matters.

The results of the comparison showed that, in spite of socio-demographic differences, the participatory evaluated projects performed better that the non-participatory evaluated projects. The non-participatory projects failed to carry forward their objectives right through into the evaluation in terms of creating an enabling environment for group knowledge acquisition, awareness, attitude change, empowerment, effective functioning and sustainability.

With the participatory evaluated projects, the overall evidence regarding the very high attainment of the variables tested (creating an enabling environment for group awareness, knowledge acquisition, effective functioning and sustainability) came not merely from the methodology used in implementing the projects, but also from that used in evaluating them. Beneficiaries commended the participatory methodology used in evaluation. According to them, a collaborative relationship and the sharing of experiences were gained through focus group discussions and re-enactments. These processes enabled them to identify vital issues of the project that they had forgotten, overlooked, or were brought to light by other members of the group.

In the participatory evaluated projects, skills, such as communication, leadership, organisation, problem-solving, negotiation and decision-making abilities, learning and ways of teaching learners, and showing sympathy were acquired at implementation and renegotiated at evaluation. Effective functioning, through the challenging of the "top-down" approach, was also highlighted at the implementation and evaluation phases of the participatory evaluated projects.

In the non-participatory evaluated projects, a different scenario was experienced. Statistical and qualitative evidence of beneficiaries' participation at the implementation phases (and not at the evaluation phases) of the projects, were cited. Evidence, similar to that in the participatory evaluated projects, for example, of beneficiaries approving of their active involvement at the implementation phase and gaining knowledge, was cited.

In assessing the evaluative phases of the non-participatory evaluated projects, a contrast was observed. In the evaluative phases, there were no group participatory activities. Thus

the objectives of the non-participatory evaluated projects were only partially met - at the implementation, but not at the evaluation phase. In fact, it was difficult even to have access to the evaluators, project managers and beneficiaries for interviewing. This situation was partly attributed to the stigma attached to evaluation (evaluation seen as judgmental or finger-pointing) particularly in cases of highly quantified reports. They responded negatively with some claiming to still be at the learning phase of evaluation and others of not being ready for the complexity of procedures.

6.3 Comprehensive theory building of findings of the study

Communication-based projects like the ones selected for this study, could enable beneficiaries to collectively experience knowledge acquisition, awareness, attitude change, empowerment, effective functioning and sustainability. To achieve this, such projects intend creating an enabling environment. Such an environment would be that which the beneficiaries would develop themselves, by joining in "free discussion of a new venture, and participating in the subsequent decision" at all levels or phases of the projects, rather than being herded like animals into the new venture (Nyerere 1974: 27).

Evaluation has been emphasised in this work as being an organic part of a project implementation process, whereby objectives are continually negotiated (Marsden and Oakley 1990: 4) and that all understand the focus of the projects. Therefore at the evaluative phases of projects like those studied in this work, one would expect a continual reassessment or further strengthening of set objectives. Continual negotiation through the creation of an enabling environment, such as that which provides free discussion, would have the result of empowering beneficiaries by increasing their knowledge, awareness levels and abilities (see Figure 6.1).

Project

HIV/AIDS communication-based projects, such as those having elements of poverty/education, culture, crime, language, religion, gender and age relative to specific communities and peer education (Chapter 2)

General project objectives

That have objectives of group knowledge acquisition, awareness, attitude change, empowerment, effective functioning and sustainability (Chapter 3)

Nature of Participation

When initiated at project implementation and renegotiated at evaluation via participatory activities, such as focus group discussions and re-enactments (Chapters 4 and 5)

Outcomes

Would experience:
Participation overriding to a great extent, limitations arising from socio-demographic differences (project locations and gender, language, age and race of implementers, evaluators and beneficiaries) in the meeting of project objectives

Participation overriding to a great extent, the limitations arising from differences in forms of evaluation (internal versus external evaluators) in the assessment of project objectives

Participation creating an enabling environment for higher attainment of project objectives in comparison to a situation where active participation is encouraged only at implementation (and not at evaluation): the objectives of group knowledge acquisition, awareness, attitude change, empowerment, effective functioning and sustainability where beneficiaries would in turn, be role models, exhibiting the desirable HIV/AIDS behaviour/social changes and impacting positively and creatively, the lives of others in the community

Recommendations

Therefore:
Communication-based projects that have objectives of group knowledge acquisition, awareness, attitude change, empowerment, effective functioning and sustainability need to create an enabling environment for a higher attainment of such objectives by:
 Ensuring participation (contribute in decision-making) of all stakeholders particularly beneficiaries at **all stages of implementation and evaluation** (planning, action-planning, execution, result-feedback etc.)
Ensuring participation of all stakeholders particularly beneficiaries in **as many levels as possible** both at implementation and evaluation (decision making in group discussions, plays, enactments, dances, songs etc.)

Figure 6.1: Comprehensive theory building of findings of the study

Knowledge, on the whole, is socially constructed. Therefore approaches that allow for social, group or collective analysis of life experiences of power and knowledge are most appropriate (Hall 1997). In addition, such approaches, especially in the area of evaluation (evaluation having varied methods, audiences and funding sources), must be consistent with the purposes and essential conditions under which the approaches operate (Tyler 1997: 230). Seeing, therefore, the varied opportunities offered by active participation of all players particularly the beneficiaries for projects to highly attain their objectives participatory methodology (both at implementation and evaluation) has much to offer, especially so when compared with the limitations of non-participatory and individually orientated methodologies.

6.4 Conclusions based on the types of projects investigated in this study

6.4.1 Overall research question

- **Does participatory methodology contribute towards the implementation and evaluation of a meaningful, useful and valuable HIV/AIDS project?**

As demonstrated in the findings of this study, a participatory methodology adds meaning, use and value to the implementation and evaluation of HIV/AIDS projects. This is witnessed more in the area of participation creating an enabling environment for a high attainment of group awareness, knowledge, attitude, empowerment, effective functioning and sustainability in a project. In the participatory evaluated projects of this study, skills, such as group communication, leadership, organisation, problem-solving, negotiation and decision-making abilities, learning and ways of teaching learners, and showing sympathy were acquired at implementation and renegotiated at evaluation. Effective functioning, through the challenging of the "top-down" approach, was also highlighted at the implementation and evaluation phases of the projects.

It was further discovered from this study that when beneficiaries are excluded from participating in the pre-planning, action-planning and result-feedback stages of a project

and its evaluation, dissatisfaction is experienced on the part of these beneficiaries as well as *missed opportunities* for useful contributions.

The degree and quality of beneficiary involvement in project implementation and evaluation generate beneficiary excitement and a general sense of project acceptance: all of which create an enabling environment for the making of proper choices and decisions.

Participatory methodology contributes in the overriding, to a great extent, of limitations arising from socio-demographic differences (project locations and gender, language, age and race of implementers, evaluators and beneficiaries) in the meeting of project objectives.

Participatory methodology contributes in the overriding, to a great extent, of limitations arising from differences in forms of evaluation (internal versus external evaluators) in the assessment of project objectives.

Difficulty in accessing traditional evaluations and people's feeling of shame and ineffectiveness was noted in the work (in the area of collecting data pertaining to traditional evaluation). This pointed to possible compromise of meaningfulness, usefulness and value of traditional evaluations.

6.4.2 Sub-research questions

- **What major factors influence social change and contribute towards a valuable HIV/AIDS health-enhancing intervention?**

From literature, community/social factors such as: pre-existing (culture, language, religion, gender and age) and situational factors (poverty, education and crime) do influence social change and contribute in varied ways towards a valuable HIV/AIDS health-enhancing intervention. This is especially so when they are incorporated into different theories of social/behavioural predictions and strategies. From the findings, if pre-existing and situational factors are incorporated into social theories like those of participation and social marketing, valuable intervention processes do emerge. Processes that depict realities

(reflecting of unique perspectives of targeted communities), factors (effective exploration of community needs and the identification of pre-existing and situational factors) and projects (ensuring high audience representation, participation/peer education via songs, drama, group discussions etc. at different levels and stages of problem and solution finding.

- **What major factors influence the evaluation of projects and contribute towards a valuable evaluation of HIV/AIDS intervention?**

From the findings of this study, evaluation of projects is influenced by many factors including the stage and degree of participation of all stakeholders involved. Full participation at all stages (planning, action-planning, execution and result-feedback stages), with special reference to the execution stage, and the involvement of all stakeholders particularly beneficiaries in many different group activities so that they can develop themselves, add value to the evaluation of HIV/AIDS projects.

The extent to which all stakeholders, particularly beneficiaries, are informed about an evaluation, influences project evaluation. Providing beneficiaries, for example, with adequate information about an evaluation so that they can make more informed decisions, adds value to the evaluation of HIV/AIDS projects (indicated by the beneficiaries interviewed for this study).

- **What is the impact of participatory and non-participatory methodological frameworks on the meeting of a project's objectives (at the evaluation phase)?**

The consistent use of a participatory methodology creates an enabling environment for the objectives of a communication-based project to be greatly realised. It creates, for example, an enabling environment at implementation for the meeting of a project's objectives (group awareness, knowledge, attitude, empowerment, effective functioning and sustainability) and at evaluation, for the internalisation of those objectives through activities, such as focus group discussions and re-enactments.

Due to the absence of group activities through which an enabling environment can be created, a non-participatory evaluation, on the other hand, limits the widespread attainment of a project's objectives.

6.5 Limitations of the study

- In order to improve the calibre of the study conducted, interviews and focus group discussions pertaining to the meaningfulness, usefulness and value of participatory and non-participatory methodological frameworks should have been conducted with all the stakeholders (beneficiaries, managerial staff, evaluators and donors) and not just with those accessible as did in this study.

- More than the nine used case studies of HIV/AIDS communication-based projects should have been investigated in order that differences in their social practices could be better traced and analysed in line with the aim of the study (meaningfulness, usefulness and value of participatory and non-participatory methodological frameworks).

- Multiple individuals should have been involved in using the rating scales presented by the researcher in the study for the analysing of meaningfulness, usefulness and value of participatory and non-participatory methodological frameworks. This should have been done in order as well to improve the calibre of the study conducted.

6.6 Suggestions for further research

6.6.1 Other forms of participatory studies

➢ A detailed study on systemic interventions could be done via comparing the strengths and weaknesses of systemic interventions, for example, HIV/AIDS interventions that focus on institutional influences in the educational, agricultural and health sectors with formalised interventions that encourage direct working with the ultimate beneficiaries (as handled by this study).

➢ Other participatory processes, not dealt with in this research such as development and management styles of HIV/AIDS communication-based projects should be researched particularly in the light of their determining influences on project outcomes. These could be aspects of development and management styles that relate to planning and objective setting, control of implementation and leadership, techniques of report writing, project/evaluation budgeting, dissemination of evaluation reports and cost-effective assessments.

➢ A detailed study on social capital and sexual economy pertaining to aspects such as why people get involved in prostitution (needs assessment) and whether participatory project implementation and evaluation could provide a way forward should be carried out as these were rather broadly examined in this study.

➢ Experimental research comparing different evaluation methodologies of identical communication–based projects in the same or very similar communities could be carried out. Experimental research of, for example, participatory and non-participatory evaluations of communication-based projects could be carried out in Pietermaritzburg, South Africa and the results compared in order to determine their values.

➢ A detailed study on how to achieve longer-term outcomes of participatory/non-participatory methodologies could be done. Immediate assessment of

participatory/non-participatory HIV/AIDS communication-based project evaluations could be carried out and the process repeated after a year or two.

➢ Wider impacts on participatory and non-participatory evaluation of HIV/AIDS communication-based projects could be traced and analysed by not just interviewing beneficiaries of identified projects but also non-project participants within project communities.

6.6.2 Geography of projects

➢ Given that the HIV/AIDS projects selected for in-depth study in this work were limited to southern Africa, a comparative study could be carried out using HIV/AIDS projects from other areas such as West and East Africa and urban-rural areas. A comparative study could be carried out on the implementation and evaluation of HIV/AID projects in the 'developed' nations compared with those in the 'developing' nations.

6.6.3 Methodology of analysis

➢ A more detailed study on the intricacies of donor-driven forms of evaluations of projects could be done in order to highlight their implications in HIV/AIDS interventions and the role of participation. Studies on, for example, the purpose of donor-driven forms of evaluation, who gets the benefit, how are such results sustained and what is the way forward?

6.6.4 Methodology of complete evaluations

➢ With greater funding, more interviews with stakeholders and a wider selection of case studies could be carried out in order to undertake a more in-depth study on beneficiaries' involvement at the often omitted planning stages of an evaluation. The same applies to other individual stages, such as result-feedback stages.

6.6.5 Methodology of complete projects

➢ A survey with participatory aspects (debates, interviewing all participants) could be carried out with all the participants of the selected projects evaluating the impact of

participatory and non-participatory methodological frameworks in the meeting of a project's objectives.

6.6.6 Methodology of outcomes

➢ A study could be carried out on the difficulty in accessing traditional evaluations and implementers' feeling of embarrassment and inadequacy (as noted in this work). The study could investigate people's feelings regarding traditional evaluation, the impact of the emotional response on the projects and the cause of the inadequacy if noted. This could be done in anticipation of overcoming this for future evaluations.

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APPENDIX A: SAMPLED ORGANISATIONS AND PROJECT DESCRIPTIONS

i)   ORGANISATIONS CHECKED FOR PROJECT SELECTION* (N=52)

Country Subjects	Type of intervention	Method of evaluation	Analysis
Kenya Sex workers	Free primary health care (mainly STD); individual and group health education; encourage clients to use condoms; condom distribution.	Questionnaire completed frequently; estimates of impact on HIV through modelling; numbers of condoms handed out; numbers of STDs compared to another area.	Quantitative
Nigeria Sex workers, clients and non-commercial partners	Peer education; condom promotion; STD clinic; educational videos; leaflet distribution.	Baseline survey and follow up KAPB; record of condoms distributed and individuals reached.	Quantitative
Rwanda Female Outpatients and male partners	Videos; HIV testing and counselling; free condoms and spermicides; focus group discussions.	Baseline and follow up KAPB; HIV and gonorrhoea testing; diaries of sex acts to determine protection used.	Quantitative
Zimbabwe teachers	Lecture; question session; condom demonstration; role plays; psychodrama; video about well known PWA	Pre- and post-test with two different intervention groups; KAPB; number of partners; measurement of sex without condoms	Quantitative
Zimbabwe workers	Committee formed; cards to healthy sex workers; sex workers with HIV or STDs prevented from working; monthly examinations for STDs; STD lectures.	Looked at STD rates at a local clinic.	Quantitative

Zaire	Community	Small group dynamics; role plays; case studies; condom demonstrations; adjusted AIDS message for individuals; work shops.	User-focused evaluation; meeting held to see what changes were being maintained.	Qualitative/ Participatory
Honduras	Sex workers	Weekly talks on STDs and HIV; free condom distribution.	Pre- and post-intervention KAP survey; condom diaries.	Quantitative
Singapore	Brothel based sex workers	3 hour intervention session with educational lectures; video presentations; role playing.	Pre- and post-test case-control study; KAPB and gonorrhoea rates.	Quantitative
Thailand	Sex workers and clients	Free condom distribution; identification of brothels without 10096 condom use; mass advertising.	Ongoing STD monitoring; evaluation of numbers of clients; numbers using condoms; statistics on number of sex establishments.	Quantitative
Ghana	Sex workers	Peer education; role plays; condom distribution.	Pre- and post-test KAPB and measurement of impact of contact with project staff.	Quantitative
Peru	Secondary school students	Educational sessions within school hours by trained teachers.	Pre- and post-test case-control study; KAPB; intervention evaluated with questionnaire.	Quantitative and qualitative

Tanzania	Primary school students	Factual information; poster creation; performing songs and poetry; peer leaders; group discussions; role plays; panel discussions with community and meetings with parents.	Pre- and post-test case-control; KAPB.	Quantitative
Thailand	Rural community	Mass media intervention by central government.	Questionnaires on changes in sexual behaviour and places where people get AIDS information. Participant observation.	Quantitative and qualitative
South Africa	Students	Structured information sessions; open discussions; role-plays; games; group work; language exercises with AIDS theme; videos; poster creation and exhibition; slogan competition; graffiti wall; stickers; condom distribution; leaflets.	Pre- and post-test case-control; KAPB; student evaluation of intervention.	Quantitative and qualitative
Zaire	Sex workers	Monthly interviews and STD diagnosis; 3 monthly HIV screening; free STD treatment among HIV negative women; individual health education; free condoms.	Condom use and numbers of clients evaluated in monthly interviews; intervention exposure estimated from attendance at appointments; STD and HIV tests performed.	Quantitative

India	Sex workers	Group discussions; counselling of madams, pimps, sex workers; posters; pamphlets and Hindi video; peer education.	Pre- and post-intervention KAPB surveys with HIV testing.	Quantitative
India	Sex workers and madams	Group discussions; educational videos; condom demonstrations.	Pre- and post-test case-control with HIV, Hep B and syphilis testing; questionnaire on demographics, clients, STDs and KAPB.	Quantitative
Malawi	STD patients	Trained counsellors discussed the seriousness of STDs; condom demonstrations.	Pre- and post-test case-control study; risk behaviour; STD occurrence and behaviour.	Quantitative
Uganda	Adult rural community	Condom distribution; AIDS pamphlets; meetings at village level.	Pre- and post-intervention KAPB questionnaire; investigated how well intervention had reached community.	Quantitative
Thailand	Sex workers, clients and brothel owners	Peer educators; educational lectures; condom demonstrations; games and small group training sessions.	Volunteer clients requested sex without condoms and offered to pay 3 times the usual price at baseline and 2 follow ups.	Quantitative
Philippines	High school students	Role playing; condom promotion; games; didactic lectures; group discussions; exercises; focus groups.	Pre- and post-test case-control KAPB. Actual intervention also evaluated by external review committee.	Quantitative

Community	STD syndromic management; staff training; supervisory visits; regular supply of drugs; group health education.	Pre- and post-test case-control questionnaire on sexual practices; testing for HIV, syphilis, gonorrhoea and chlamydia.	Quantitative
Students	No information given except that education was provided by student nurses in a structured manner. 14 classes. Presume group education.	Pre- and post-test case-control knowledge questionnaire on AIDS, STDs and alcohol and drug abuse. Also questionnaire on performance of student nurses.	Quantitative
Sex workers, clients and pimps	Interactive lectures; informal advice and condom distribution; formal training sessions; client media in brothels (posters and pamphlets).	Pre- and post-test case-control with sex workers and clients; KAPB.	Quantitative
Adult Community	Informal presentation; condom demonstration; stickers; posters; free condoms; HIV leaflets.	Pre- and post-test case-control KAPB.	Quantitative
sex workers and general community	Peer educators; condom and information distribution; co-operation with people connected to the industry; posters; pamphlets; meetings; dances and films.	Attempt to make full and effective use of community participation; used simulated clients; some qualitative interviews.	Qualitative
Community	Radio drama broadcasting local language.	Pre-and post-intervention KAPB survey with case-control. Control group selected from area unlikely to have heard drama.	Quantitative

Kenya and Zimbabwe	Sex workers	Peer education and improved STD management in Kenya.	Pre- and post-intervention surveys; Kenya was 1 year with consideration of STD rates in and Zimbabwe Kenya. Rapid formative assessment initially and then in-depth interviews in Zimbabwe. Also questioned on programme exposure.	Quantitative
Mozambique	Prisoners	Pamphlets and cartoons about HIV and STDs; peer education; theatre group.	Pre- and post-intervention KAPB surveys.	Quantitative
India	Students	School-based education programme.	Pre- and post-test with questionnaire on transmission and prevention of HIV/AIDS.	Quantitative
Kenya	Trucking company Sex workers	HIV serological testing; counseling; condom individual promotion; STD diagnosis and management.	Baseline with regular follow-up interviews and STD and HIV testing.	Quantitative
Tanzania	Women and at truck-drivers' stops	Already had peer education and condom distribution in place, now provided improved STD treatment. Comparison of different methods.	Pre- and post-intervention questionnaire on demographics and acceptance of STD services. 3 case groups and one control group.	Quantitative
Uganda	Community	Government intervention - posters; condom distribution; availability of information through a number of mass media sources.	Baseline survey with a number of follow-up surveys using KAPB. HIV testing at one early survey.	Quantitative
Brazil	Students	Group discussions; training for teachers; peer support; public events; condom demonstrations;	Baseline surveys using KAPB at case and control schools. Follow-up questionnaires at end of intervention.	Quantitative and qualitative

Mexico	Homosexual men	Intervention designed by participants to empower community by enhancing collective action, skills development and resource creation.	KAPB survey. No control group and not known if pre- and post-testing completed.	Quantitative and qualitative
Zimbabwe	Students	Unknown (presumed to be group education)	Pre- and post-test case-control KAPB questionnaires.	Quantitative
Uganda	Muslim Community	Education provided by imams and family AIDS workers to increase HIV knowledge and condom use; to encourage support from the community towards those infected.	Pre- and post-intervention questionnaires as well as focus groups and in-depth interviews.	Quantitative and qualitative
Thailand	Youth in factories	Education through videos, cartoons and other unknown methods.	Pre- and post-test case-control study with KAPB questionnaire, in-depth interviews and focus groups	Unknown
Nepal	Pharmacists	Syndromic management training	Pre- and post-intervention interviews using simulated patients	Quantitative
Singapore	Sex workers	Development of negotiation skills, educating clients and mobilizing support from peers and health staff for condom use	Pre- and post-test case-control study using KAPB and gonorrhoea testing.	Quantitative
Uganda	Community	Single oral dose of STD treatment; HIV prevention education and counseling; condoms and free healthcare	Randomized controlled trial with baseline and post-testing using KAPB, HIV and STD testing.	Quantitative
South Africa	Technikon students	Dramas, songs, dances, poetry, enactments, discussion forums, videos, 'Felicia show')	Focus group discussions, pre and post test	Qualitative/ participatory and quantitative
South Africa	Secondary school students	Dramas, songs, dances, poetry, discussion, AIDS memorial quilt	Focus group, semi-structured interviews. self-administered	Qualitative/par ticipatory and quantitative
South Africa	Primary school students	Dramas, songs, dances, poetry, discussion, beadwork	Focus group, Self-administered questionnaires	Participatory/ qualitative: Quantitative: self-administered
South Africa	Female sex workers	Drama, songs, dances, discussion	Quality checklist, Self-evaluation.	Participatory and qualitative
South Africa	Female sex workers	Dramas, songs, dances, discussion	Quality checklist, Self-evaluation	Participatory and qualitative

South Africa	High school youths	Focus group discussion, role plays, games, structured group work and videos	Pre and post self-report questionnaires and control	Quantitative
South Africa	Project support staff Influential/high-risk groups for example, male soccer players as peer educators	Focus group discussions, dramas, songs and dances	Pre-test-post-test non-equivalent Comparison, group design, Questionnaires and individual interview	Quantitative
Zimbabwe	Female and male sex workers	Focus group discussion, songs and dances	Questionnaires, baseline survey and individual interviews	Quantitative

* (After Macphail and Campbell 1999)

ii)   HIV/AIDS PROJECTS (PARTICIPATORY AND NON-PARTICIPATORY EVALUATED PROJECTS)

Each HIV/AIDS project is described in terms of the location, objective, target group, methodology used and practical ways of its implementation. The evaluation of each of the projects is described following the same pattern. The first part consists of participatory evaluated projects followed by the non-participatory evaluated ones.

1.1 Participatory evaluated Project 1(P1)

1.1.1 Location

The HIV/AIDS project took place in Durban, South Africa, at two tertiary technikon colleges.

1.1.2 Project composition

In the two tertiary colleges, there were approximately 27 trained peer educators (13-14) in each of the technikons), four managerial staff members (two in each of the technikons) and two health workers (one in each of the technikons).

1.1.3 Objectives

The project intended achieving the following objectives:

i)   Reduce stigma on HIV/AIDS

ii)   Give the recipients the opportunity to adopt healthy sex practices

iii)   Provide opportunities for individual and group empowerment

iv)   Provide opportunities for structural transformation of the project itself

v)   Provide opportunities for individual and group skills acquisition

vi)   Create opportunities for building self-reliance of the peer educators

vii)   Increasing of the programmes for expansion

viii)   Increase opportunities of interaction between people living openly with HIV/AIDS and students

ix)   Develop support groups for students

x)   Provide education and support between these groups

1.1.4 Target group

Technikon students and tertiary institutions in Durban were the target groups of the HIV/AIDS projects.

1.1.5 Methodology used in implementation of P1

Participatory methodology was used via interactive peer education, which was dialogue-based. The peer educators were both males and females. Use was made of entertainment based activities such as role-plays, songs, enactments, games, discussion forums, video projections and Tele-broadcast ('Felicia' show). Focus group discussions were used to obtain feedback from the audiences.

1.1.6 Practical ways of implementing P1

A youth health promoter was employed by the project implementers on a yearly contract basis to live and interact with the peer educators and technikon students. The health promoter employed in this project was someone with HIV/AIDS who was willing to disclose his status openly, was fluent in English and Zulu, having matriculated and within the age range of 26 and 30. He displayed signs of being a 'normal' person and living a 'normal' life (not shy of his status, not living in seclusion. going about his daily chores when able to). He worked closely with the managerial staff in, for example, facilitating the peer workshops. He offered information resources to students on matters relating to gender sensitivity and advocacy of positive living.

The entire project centered on 'action reflection' praxis with two parts: a preparatory training and implementation phase. Prior to launching the peer education programme, some out-of-school youths were temporarily employed (just for the preparatory and performance period) and trained in singing and acting. Arrangements were made with the college school authorities for the creation of youth clubs and for the out-of-school youths to come into the school premises and perform. After this performance, a youth club was established. The club was made up of peer educators. Membership was limited to an average group size of 13-14 for effective management and follow-up. The youths then underwent preparatory training as peer educators. The training was facilitated by the HIV/AIDS project managerial

staff and the health promoter. After the training, the implementation stage included the official launching of the youth club. The launching, just like any other opportune occasions such as 'open days' was well publicised and used as a cascading and networking forum. School authorities (lecturers and administrative staff), governmental and non-governmental organisational members (healthcare workers), students and parents were invited.

The performances of the peers were seen to be highly HIV/AIDS related, unpacking in a critical manner political, social, cultural and economic forces that influence the realities of living with HIV/AIDS. In the drama performance, for example, one of the characters would be someone living with HIV/AIDS who has been abandoned by his friends and relatives for fear of being infected. The audience would be asked to comment on such behaviour and some of them asked to come and re-enact the scene in such a way that the behaviour they consider appropriate is portrayed.

The peer educators were not given a stipend; but were encouraged to look for means of generating their own sources of income, for example, through craftwork and others. The reason for doing was to empower them to be independent and self-reliant. After training and launching, the peer educators were given the opportunity to run the clubs (without the project implementers; but with the help of the health promoter), to initiate other performing occasions, visit neighbouring schools and launch other youth clubs, practice what they have learnt, share their knowledge and experience with their friends, neighbours, families and other community members.

1.1.7 Evaluation of P1

The evaluation took place with the peer educators of the two targeted technikon schools. The main project managerial staff did the evaluation in an ongoing manner (after every training process and at the end of the academic year). The evaluation helped in assessing the impact of the project, finding out if the objectives of the project were reached, if the project was relevant to the recipients and how services could be improved. It explored the perceptions of students regarding emergent trends and social development in the HIV/AIDS world. The evaluation also intended empowering the people, bringing about structural transformation within the project and skills acquisition.

Use was made of participatory methodology in the evaluation. The main project managerial staff used a focus group discussion (made up of both male and female peers) for the evaluation. In the discussion forums the evaluator acted like a facilitator. Pre- and post-tests with open-ended questionnaires were also administered to peer educators. Interviews were conducted with key informants. After the completion of each part of the project (preparation training and implementation), reflection time, which was a feedback session, was conducted as part of the evaluation. Critical issues for discussion in the evaluation included: the question as to whether positive living, gender issues, supportive environments, interaction between people living with HIV/AIDS had been achieved and how? Critical issues for discussion also included the training experiences of the peer educators and the value of the methodology used in the project. What, for example, made them (peer educators) happy or unhappy about the process of the project (if it was complex, simple, enjoyable, boring, creative and entertaining) and why?

1.2 Participatory evaluated Project 2(P2)

1.2.1 Location

The HIV/AIDS project took place in four rural secondary schools at Ndwedwe, South Africa.

1.2.2 Project composition

In the four rural secondary schools, the peer educators were approximately 36 (nine in each group) excluding out-of school trained peer educators (16 in total). The managerial staff members were approximately eight in number (two per school) and the trained teaching staff 15 (3 per school).

1.2.3 Objectives

The project intended achieving the following objectives:
- i) Reduce stigma on HIV/AIDS
- ii) Give the recipients the opportunity to adopt healthy sex practices
- iii) Provide opportunities for individual and group empowerment
- iv) Provide opportunities for structural transformation of the project

v)   Provide opportunities for individual and group skills acquisition

vi)   Create self-reliant opportunities for the peer educators

vii)   Increasing of the programmes for expansion

viii)   Promote personal hygiene

ix)   Create a support network to promote and sustain healthy lifestyle

x)   Broaden project's scope to include basic home care of pediatric AIDS patients and AIDS orphans

1.2.4 Target group

High school students in the wider community, in rural Ndwedwe region were the target groups of the HIV/AIDS project.

1.2.5 Methodology used in implementation P2

Participatory methodology was used via interactive peer education. The educational method went beyond the provision of information to actively engage people in an inspiring and interactive experience of the impact of HIV/AIDS both at individual and at community levels through the use of drama, songs, dances, poetry, discussion forums and the making of an AIDS memorial quilt. Both males and females made up the peer educators.

1.2.6 Practical ways of implementing P2

Certain practical implementation strategies were employed in the project some of which are listed below.

i)   Introduction of project to educational authorities in the community

ii)   Training of Ndwedwe teaching staff in the schools

iii)   Training of out-of-school youth to introduce the workshops

iv)   Operating youth club workshops

v)   Organising school festivals of plays and other performances

vi)   Increasing of the programmes for expansion

vii)   Creation of a forum for health educators

viii)   Monitoring and follow-up

The project was introduced to educational authorities in the community of Ndwedwe. In order to do so, meetings were held with the governing bodies, school principals, school circuit inspectors and the clinic staff. The presentation by the project managerial staff focused on the value of the project, the concept of schools promoting health and the making of an AIDS Memorial quilt (regarded as a tool for healing and learning).

When educational inspectors approved the project, they helped in selecting the secondary schools for the interventions. Phase one of the project took place with the four rural secondary schools. Phase two was supposed to be with the four 'deep' rural secondary schools. Unfortunately, due to poor access it was not possible for that to take place. As such, only the four rural schools were reached and dealt with in Project 2 and by the researcher of this study.

Prior to launching the peer education programme, some out-of-school youths were temporarily employed (just for the preparatory and performance period) and trained. They were trained in youth drama skills, introduction of the AIDS Memorial quilt; knowledge and understanding about prevention of HIV infection, value of general hygiene, home care and support. After the training, the out-of-school youths went and performed an educational play in the targeted schools, following which they established youth clubs of approximately nine members of both genders. The club members then underwent preparatory training as peer educators. The HIV/AIDS project managerial staff facilitated the training. After the training, the peers were given the opportunity implement what they had learnt. Some of the opportunities included: the launching of a youth club, organising school festivals, plays and other activities; visiting neighbouring schools and launching other youth clubs, practicing what they had learnt, sharing their knowledge and experience with their friends, neighbours, families and other community members. Interested teaching staff of the different schools was trained to help facilitate the activities of the club when the project implementers had left.

The clubs' activities and performances were seen to be highly HIV/AIDS related; unpacking in a critical manner the political, social, cultural and economic forces that influence the realities of living with HIV/AIDS. In one of their festivals, for example, focus

was on celebrating life, addressing key matters relating to health and HIV/AIDS and demonstrating creative talents of youths.

The peer educators were also not given a stipend; but were encouraged to look for means of generating their own sources of income, for example, through craftwork such as the making of AIDS Memorial quilt and others.

1.2.7 Evaluation of P2

The evaluation took place with the peer educators at the different secondary schools. An independent body externally conducted the evaluation. This body was made up of five official members in the capacity of evaluators and a core of Zulu-speaking research assistants who were experienced in conducting focus group discussions, interviews and preliminary data analysis. One of the official members, assisted by the Zulu-speaking assistants did the evaluation.

The evaluation focused mainly on assessing the impact of the project and finding out if the objectives of the project were met. It also focused on bringing empowering the people, bringing about structural transformation and skills acquisition.

Use was made of similar methodology (participatory methodology) in the evaluation as in the project. Focus group discussions (made up of both male and female peers) were held at the schools where the projects had been implemented. In discussion forums the research assistants acted as facilitators. Questionnaires were issued to key informants like the trained teaching staff. The evaluation was done after the completion of the initial set of workshops and other follow-up activities. Critical issues for discussion in the evaluation included: the question as to whether peer educators were sufficiently well trained; what they valued most about belonging to the club; what new things had been learned; how learners looked after themselves before and after the project; impact of life skills; any change in attitude towards people living with HIV/AIDS; any translation of knowledge into actual changes in behaviour; how members would feel about themselves if infected; had members disseminated the lessons learned and how; any challenges and way forward.

1.3 Participatory evaluated Project 3(P3)

1.3.1 Location

The HIV/AIDS project took place in four primary schools in three areas in Zululand, South Africa.

1.3.2 Project composition

There were about eight-trained peer educators in each of the four primary schools, giving an estimated total of 32 peer educators (excluding about 15 trained out-of-school peer educators). In all four primary schools, a committee of approximately four managerial staff, two donor staff members and two community healthcare workers jointly implemented project 3. Each school also had on average four trained teaching staff (16 in total).

1.3.3 Objectives

The project intended achieving the following objectives:

i)   Reduce stigma on HIV/AIDS

ii)   Give the recipients the opportunity to adopt healthy sex practices

iii)   Provide opportunities for individual and group empowerment

iv)   Provide opportunities for structural transformation of the project

v)   Provide opportunities for individual and group skills acquisition

vi)   Create self-reliant opportunities for the peer educators

vii)   Increasing of the programmes for expansion

viii) Promote personal, home and school hygiene

ix)   Offer life skills education that challenges youths; their
       teachers, parents and peers to take responsibility in shaping their environment, lives
       and community

x)   To challenge stereotypes in society (particularly gender- related stereotypes)

xi)   How to deal with the loss of loved ones

1.3.4 Target group

Primary school pupils in the rural Zululand region were the target groups of the HIV/AIDS projects.

1.3.5 Methodology used in implementation of P3

Creative and participatory methodology was used. The educational methods also went beyond the provision of information to actively engage people in an inspiring and interactive experience of the impact of HIV/AIDS both at individual and at community levels through drama-in-action, songs, dances, poetry, discussion forums and the making of beads. Both males and females made up the peers.

1.3.6 Practical ways of implementing P3

The implementation strategies and organisational structures were observed to be similar to those in Project 2 (section 1.2.6). The exceptions were that the project implementers, unlike in the rest of the projects, worked together with members of the donor organisation and with community healthcare workers employed by the latter. These groups of people formed a working committee that went to the schools together to implement the projects. They trained the peer educators and the teaching staff that had to help in facilitating the activities of the peer educators. They also provided classroom lectures to the pupils besides club activities.

Selection of the target schools was done in collaboration with the donors. In fact the target schools were noted to be those constructed by the donors in Zululand.

The peer educators were not given a stipend; but were encouraged to look for means of generating their own sources of income, for example, through beats making.

1.3.7 Evaluation of P3

The evaluation of the HIV/AIDS project took place with the peer educators at the different project targeted primary schools. An external evaluator conducted the evaluation. She did the evaluation in close collaboration with one of the Zulu-speaking managerial staff of the

project. This staff member was well versed in conducting focus group discussions, interviews and preliminary data analysis.

The evaluation focused mainly on assessing the impact of the project, its relevance and finding out if the objectives of the project were met. It also focused on empowering the peer educators, bringing about structural transformation and skills acquisition. Use was made of similar methodology (participatory methodology) in the evaluation as in the project. Focus group discussions (made up of both male and female peers) were held at the schools where the projects had been implemented with a managerial staff member acting as facilitator. Semi- structured interviews and questionnaires were issued to key informants like the trained teaching staff. Direct observations were made of learners participating in the activities such as launching new clubs. Critical issues for discussion in the evaluation included: the question as to whether critical awareness among peers had been facilitated; societal prejudices confronted; peers having been empowered, participatory teaching methodologies had been used; any cascading of activities; opportunities to network created; any benefits from the project, change of attitudes towards sex, people living with HIV/AIDS, development of appropriate skills and how?

1.4 Participatory evaluated Project 4(P4)

1.4.1 Location

Unlike projects 1, 2 and 3 that took place in the rural areas, project four took place in an urban area of Mzinoni, South Africa. This is an area with highways, power stations and plantations where truck drivers and prostitutes can easily be located. The project was made up of approximately two secondary schools in Mzinoni (with in-school peer educators) and one group of out-of-school youths (as target for this study).

1.4.2 Project composition

Mzinoni project is one of the many projects run by a non-profit support association in South Africa. This large association has 54 HIV/AIDS prevention projects and many youth-related ones, including 35 HIV/AIDS care (mitigation) units. The association has one head manager and an assistant besides the directress. It also has approximately eighty

coordinators who act as managerial staff (junior to the head manager) and 2000 peer educators (both in and out of schools and performing varied functions such as awareness campaigns, counselling and home-based care). Other stakeholders (of the association's committee and not of project 4 in particular) include: district, municipal, corporate and community representatives.

Project 4, had approximately 30 peer educators (an average of 10 per group). It also had seven managerial staff: on average two in each group of peer educators, with one person acting as a supervisory evaluator. The directress, head manager and assistant head were responsible for the overall management of project 4.

1.4.3 Objectives

The project intended achieving the following objectives:

     i)   Curb prostitution

     ii)   Enable peer educators, truck drivers, plantation workers and prostitutes in the wider community adopt healthy sex practices

     iii)   Empowerment of peer educators

     iv)   Structural transformation of the project

     v)   Create self-reliant opportunities for the peer educators

     vi)   Increasing of activities for expansion

     vii)   Create awareness amongst community members to take responsibility in making well informed choices regarding their health

     viii)   Support and train family members to care for their sick ones

1.4.4 Target group

For this study, the out-of-school females who had been prostitutes and some living with HIV/AIDS; and truck drivers, prostitutes and plantation workers from the wider community of Mzinoni (head quarters of the project organisation) were the target groups of the HIV/AIDS projects.

1.4.5 Methodology used in implementation of P4

Participatory methodology was used via interactive peer education. The peer educators were all females. Entertainment-based activities such as: drama, songs, dances and focus group discussions were used to obtain feedback from the audiences. The peer educators, for example, dressed in colourful costumes, would visit a power station. After obtaining permission from the station manager, would start singing to attract attention. When the people are gathered, they would stop and explain who they are and what they intend doing. After that, they would either sing more songs or act a drama (all relating to HIV/AIDS). They would then engage the viewers into a discussion session (facilitated by them) by asking them to respond to the song or drama. Those who need further help, counselling or condoms are attended to after the session or on appointments.

1.4.6 Practical ways of implementing P4

Peer educators were responsible for an awareness campaign (the one studied in this project) that concentrated on visiting the "hot spots" where at-risk people were to be found. The head manager and her assistant trained the coordinators (those who acted as junior managers for each of the peer groups) and the coordinators in-turn, trained the peer educators. The trained peer educators, under the supervision of the coordinators apportioned to them (approximately two coordinators per group), did the practical implementation of the lessons learned. The in-school peer educators conducted awareness campaigns and counseling within the school. The out-of-school peer educators, for example, were responsible for awareness campaigns (those chosen for this study), did visitations to the hotspots where they engaged the people in discussions around HIV/AIDS through songs, drama and dances. Approximately five hotspots were targeted: highways, 'shabeens' power stations, plantations and other prostitutes' and truck drivers' hotspots.

All peer educators were given a stipend, and should they get a paid job, they were encouraged to resign and for new recruits to take their place. They were also provided with loan facilities to help them when creating an independent self-sustaining project.

1.4.7 Evaluation of P4

The evaluation was conducted with the different groups of peer educators, supervised by their coordinators. It was self-evaluation with the use of a quality checklist. The directress of the project drew up the checklist (see sample below in 1.5.8). One of the co-ordinators (managerial staff) of each of the group of peer educators helped in supervising the evaluation and in facilitating discussions resulting from the evaluation. After every visit to the hotspots, an evaluation was conducted. The evaluation helped mainly in improving service delivery, empowering the peer educators and enhancing structural improvement of the project.

1.5 Participatory evaluated Project 5(P5)

Project 5 operated in similar manner as project 4 with slight variations. These variations were in the locations and targeted audience.

1.5.1 Location

Project 5 took place in the urban community of Kriel, South Africa. This is an area with a mining industry, dominated by mineworkers and 'illegal' settlers (including sex workers) who have moved into it because of the attraction of the mining company. The project took place in one secondary school (with in-school peer educators) and two groups of out-of-school youths within the vicinity of Kriel.

1.5.2 Project composition

The project had approximately 24 peer educators (average eight in each group). There was one in-school group and two out-of-school groups. Six managerial staff conducted the project: two in each group of peer educators with one acting as a supervisory evaluator.

1.5.3 Objectives

The objectives were similar to those of project 4 but for the fact that more attention was paid to the mine and sex workers compared to general community members. The project intended achieving the following objectives:

i)   Curb prostitution

ii)   Enable peer educators, mineworkers, prostitutes and truck drivers in the wider community adopt healthy sex practices

iii)   Empowerment of peer educators

iv)   Structural transformation of the project

v)   Create self-reliant opportunities for the peer educators

vi)   Increasing of activities for expansion

vii)   Create awareness amongst community members to take responsibility in making well informed choices regarding their health

viii)   Support and train family members to care for their sick ones

1.5.4 Target group

For this study, the out-of-school female youths, the mine and sex workers in the wider community of Kriel were targets of HIV/AIDS project 5. However, the in-school groups were also tasked with combating the attractions of the migrant mineworkers.

1.5.5 Methodology used in implementation P5

Participatory methodology was used with dialogue-orientated drama, songs and dances. The peer educators, for example, made contacts with 'shabeen' owners. A drama is acted, followed by a session of questions and answers relating to the drama. The peer educators facilitate the question and answer session at the end of which condoms are distributed and unanswered questions kept for next visit. They do this by allowing the clients to seek their own solutions or answers to the questions asked. In one of the 'shabeen' sessions observed by the researcher, a drama about an unfaithful partner was acted. Questions relating to the consequences of such act and ways of redressing them were deliberated upon. Some of the questions asked by the clients were, for example, "why in times past people were unfaithful yet they did not contract HIV/AIDS?" "Where has HIV/AIDS suddenly come from?" "What we are doing today was what we did in the past yet we did not have HIV/AIDS; our lifestyle has not changed yet we are dying, why?" "Why is it that we keep going to the clinic for treatment and we do not get better; we still die?"

1.5.6 Practical ways of implementing P5

It was observed that most of the mineworkers came from other regions and lived in Kriel area without their families. They were attracted mainly by the mining industry. Other outsiders particularly females in need and willing to exchange their bodies to meet their needs, were on the other hand, attracted to the mineworkers. Others took advantage of the situation to open 'shabeens' (noticed to be comfortable meeting spots for rendezvous). Contacts were made in order to explain their intentions of frequently visiting their 'shabeens'. The purpose of their visits (to create HIV/AIDS awareness) and time location (not more than 30 minutes) were clearly outlined. They also spelt out that they did not intend to spy on illegal settlers to report them to the authorities (as some were scared of that) and send away their clients. Prior to each visit, the peer educators notified the 'shabeen' owners. On arrival, the owners introduce the peer educators to their clients and usher them into a bigger part of the 'shabeen' or a more convenient spot. The peer educators, in order to attract attention and maintain some calm, get into where the people are gathered by singing and dancing. After that, one of the peer educators welcomes them. The drama programme is presented and question-and-answer session is conducted.

Female students of the different schools were also seen to be victims of this exchange practice. As such, the training of peer educators was geared mostly towards redressing the needs of women to earn money, which were considered to a great extent, to be responsible for the spread of HIV/AIDS.

Peer educators were divided into two categories. Category one was made up of in-school peer educators that were in-charge of awareness campaigns and counselling. Category two (those targeted for this study) was made up of out-of-school youths in-charge of community awareness campaigns (visits to approximately 3 hotspots: highways, 'shabeens' and power stations).

1.5.7 Evaluation of P5

The evaluation was conducted in a similar manner as project 4 with the different groups of peer educators, supervised by their coordinators. It was self-evaluation with the use of a quality checklist (see sample in 1.5.8 below). One of the coordinators (managerial staff)

helped in supervising evaluations and in facilitating discussions resulting from the evaluation. After every visit to the hotspots, the evaluation was conducted. The evaluation helped mainly in improving service delivery and empowering the peer educators.

1.5.8 Sample of quality checklist

Please tick either YES or NO for each questions

No	Question	Yes	No
1	Was the meeting place as cool and airy as possible?		
2	Were the audience sitting comfortably on seats or mats, for indoor meetings, or sitting or standing under shade, for outdoor meeting?		
3	Were the audience in a horseshoe, within 5 metres of the presenter(s) for lectures or discussion and 7 metres for drama or role-plays?		
4	Were there at least 10 people in the audience, excluding the presenter(s)?		
5	Did the presenter(s) talk loudly enough for the audience to hear?		
6	Did the audience listen quietly, silencing any disruptive or drunk people, when the presenter(s) spoke?		
7	If there was a lecture, was it no loner than 8 minutes?		
8	Was there at least 1 participatory exercise (picture code, 1-minute role-play, 10-minute drama or game), followed by a discussion?		
9	Did the audience show visible enthusiasm during the participatory exercise?		
10	Was all the factual information presented in the lecture, participatory exercise or discussion in agreement with the information checklist?		
11	Did the lecture and/ or participatory exercise avoid blaming women for the spread of STD/AIDS?		
12	Was there at least 20 minutes, preferably 30 minutes, for discussions?		
13	Did at least 3, preferably 10, members of the audience join in the discussions?		
14	Was the number of women contributing to the discussion proportionate to the number of women in the audience?		
15	During the discussion, did the presenter(s) listen to each comment without showing facial disapproval or interrupting (except where the speaker was drunk or deliberately disruptive)?		
16	Did the presenter(s) respond very briefly to each comment, asking the audience to comment further, without answering the comment personally?		
17	Did the presenter(s) lead the discussion away from basic facts about AIDS, to attitudes, values and personal concerns?		
18	When women and STD/AIDS were discussed, did the presenter(s) guide the audience to focus on men's responsibility for STD/AIDS?		
19	Did the presenter(s) offer condoms at the end of the meeting?		
20	Did the presenter(s) end by telling the audience where and when the could contact the project for further information?		

Score Below 10 Years Weak 10-15 Years Fair 16-20 Years Good

1.6 Participatory evaluated Project 6(P6)

1.6.1 Location

The HIV/AIDS project took place in a suburban neighbourhood in Kinshsa, Democratic Republic of Congo.

1.6.2 Project composition

In the suburban neighbourhood in Kinshasa, a network of 15 sex workers made up the project's experimental group with approximately three managerial staff members.

1.6.3 Objectives

The project intended achieving the following objectives:

    i)   Give the recipients the opportunity to adopt healthy sex practices

    ii)   Provide opportunities for individual and group empowerment

    iii)   Provide opportunities for structural transformation of the project

    iv)   Provide opportunities for individual and group skills acquisition

    v)   Create self-reliant opportunities for the peer educators

    vi)   Increasing of the programmes for expansion

    vii)   Integrate HIV/AIDS prevention into programmes of community development: trade unions, market women's associations

1.6.4 Target group

Female sex workers (with little or no literacy in problem-solving approaches to risk reduction) in the suburban neighbourhood of Kinshasa, Zaire were the target groups of the HIV/AIDS project.

1.6.5 Methodology used in implementation of P6

Participatory methodology via experiential training (discussion forums, role plays, simple posters, and structured group 'processing') was used in implementing P6.

1.6.6 Practical ways of implementing P6

The participatory project (P6) was carried out on invitation: invitation from the leader of the sex worker's network. From the network, 15 female sex workers were chosen to act as peer educators. These sex workers came from a background of poverty with exclusive reliance on sex with multiple partners for a livelihood. Due to stigmatisation, the sex workers requested that the project be carried out away from their yard. As such, the project was carried out in a walled garden: 500 yards from their vicinity. An example of some of the practical ways of running the educational workshops with the selected group of sex workers included the following:

Icebreaker via role-play: A male visitor is welcomed into a village by a female chief whose position, as a chief remains unknown to the visitor. The women, who know what exactly is going on, laugh at the visitor's display of ignorance. Later, the women are asked to describe what they saw, heard and felt with the underlying meaning of the sketch being the unrecognised responsibility of women in the society. The sketch is then applied to the issue of HIV/AIDS of which different interpretations are given, for example, AIDS is fatal to oneself and to others as such care must be taken to avoid being infected.

Other practical sessions involved the dramatisation of mother-to-infant transmission of HIV/AIDS with mother and grandmother taking a sick baby to the hospital only to discover that the baby is infected: This arousing sympathy from the women.

Different groups of women such as churchwomen's groups were invited to participate in the training session as a networking strategy. Income generating activities were later identified in the discussion sessions of the training as one of the topmost priorities for the effecting of change.

1.6.7 Evaluation of P6

The evaluation took place with the female sex workers in the suburban neighbourhood of Kinshasa, Democratic Republic of Congo. An independent body externally conducted the evaluation. This body was made up of an international site visit team members.

The evaluation focused mainly on assessing the impact of the project, finding out the relevance of the project to the beneficiaries and if the objectives of the project were met. It also focused on bringing about improve service delivery of project staff, empowering of the people, bringing about structural transformation and skills acquisition.

Use was made of similar methodology (participatory methodology) in the evaluation as in the project. The participatory methodology was in the form of a user-focused evaluation assessed response to the project " Teach us to do what you do so that we can inform our colleagues" (Evaluation report of P6: 1406). In a practical session, the trained sex workers demonstrated the method used by the managerial staff in training them. This was done to friends in the presence of the international site visit team members. Role-plays discussion forums, simple posters, and structured group 'processing' were re-enacted in the practical demonstration sessions.

1.1 Non-participatory evaluated Project 1(NP1)

1.1.1 Location
NP1 took place in a high school in Cape Town, South Africa within a socio-economically disadvantaged, urban, African township.

1.1.2 Project composition
In the high school, there were approximately 1000 students, 50 teaching staff and four managerial staff.

1.1.3 Objectives
The project intended achieving the following objectives:

    i)   Reduce number of sex partners

    ii)   Give the recipients the opportunity to adopt healthy sex practices

    iii)   Provide opportunities for individual and group empowerment

    iv)   Provide opportunities for structural transformation of the project itself

    v)   Provide opportunities for individual and group skills acquisition

vi) Increasing of the programmes for expansion

vii) Address personal issues concerning AIDS for young people

viii) Create opportunities for networking

ix) Create and make use of opportunities within the social fabric of the school for HIV/AIDS awareness

x) Create opportunities for building self-reliance of the students

1.1.4 Target group

High school youths (male and female) in a socio-economically disadvantaged, urban, African township in Cape Town were the target group of the HIV/AIDS projects.

1.1.5 Methodology used in implementation of NP1

Participatory methodology was used via entertainment-based activities such as group discussions, role-plays, games, structured group work and video projection.

1.1.6 Practical ways of implementing NP1

The primary responsibility of the project was in the hands of the teaching staff (coordinated by the project managerial staff) in the school as the programme was integrated into the school structure with use being made of the existing resources. Prior to initiating the project, permission was obtained from the education authorities alongside the consent and support of the parents of the students. A parent's association meeting was called for with the school nurses providing detail information on the dangers/seriousness of HIV/AIDS and the need for AIDS education. A series of planning meetings for the brainstorming of ideas, assigning of tasks and responsibilities regarding the programme then took place. These meetings were held with interested staff members, student representative council, and ad hoc groups of students and staff. The project managerial staff then trained the teaching staff members (those who were to act as facilitators). Before the full take off of the programme, an HIV/AIDS infected person was invited to give an address on HIV/AIDS.

The AIDS awareness programme covered all the classes in the school. The programme was intense, of a high-profile focus on HIV/AIDS and for a two-week period. The classroom activities included among others structured information sessions on HIV/AIDSS, open

discussions about HIV/AIDS and the integration of the HIV/AIDS content into the language curriculum. Language exercises having HIV/AIDS themes were carried out: exercises such as, crosswords, incomplete sentences and dialogues. HIV/AIDS posters and banners were also made; facilitated by the trained art teacher. These posters and banners served as art exhibitions in the schools as well as means of income generation. Slogan competitions, and leaflets organised including those of parents. The students were to take the leaflets for competition to their parents. School nurses helped in assisting the facilitators in the provision of consultation during the programme.

1.1.7 Evaluation of NP1

The evaluation of NP1 took place with the targeted high school students in Cape Town. An independent body externally conducted the evaluation. This body was made up of approximately three official members in the capacity of evaluators. The evaluation helped in assessing the impact of the project, finding out if the objectives of the project were reached The evaluation also intended empowering the people, bringing about structural transformation within the project and skills acquisition.

Unlike the implementation methodology of the project, which was participatory, the evaluation methodology was non-participatory (pre and post self-report questionnaires and control). Before the programme, 231 students were given self-report questionnaires to complete and after the programme, 206 did complete the self-report questionnaires. Two classes from each standard were also selected from the school and compared with those from a neigbouring school in the same community (having similar students and teaching profile but with no specific HIV/AIDS education programme). In the comparison school, 336 and 276 students completed the self-report questionnaires at the equivalent time intervals. The questionnaires were translated into the mother tongue of the students (Xhosa). Among other things, questions were asked relating to the following:

- ➢ Knowledge-based: How HIV is transmitted, how it is not transmitted, how it can be prevented, whether there is a cure for it.
- ➢ Attitude-based: Whether they can accept someone with HIV/AIDS into their class.

- ➢ Beliefs about personal susceptibility: What are their concerns about AJDS, whether AIDS to them is a problem and whom they think is affected by it.
- ➢ Intentions and communications: What are their responses to AIDS, what makes up their communication plans with peers, parents, sexual partners and nurses relating to HIV/AIDS.

1.2 Non-participatory evaluated Project 2(NP2)

1.2.1 Location

NP2 took place in Durban and in the rural area (Mafakathini) and urban area (Ashdown) of Pietermaritzburg.

1.2.2 Project composition

In the peer-mediated HIV/AIDS educational programme of Mafakathini and Ashdown, a sample of 42 male soccer players (21 from each of the areas) made up the programme. For the project support staff, they were approximately nine.

1.2.3 Objective

NP2 intended achieving the following objectives:

i) Reduce number of sex partners

ii) Give the recipients the opportunity to adopt healthy sex practices

iii) Provide opportunities for individual and group empowerment

iv) Provide opportunities for structural transformation of the project itself

v) Provide opportunities for individual and group skills acquisition

vi) Increasing of the programmes for expansion

vii) Create opportunities for building self-reliance of the sex workers

viii) Provide human and financial support to projects that handle epidemiological issues

1.2.4 Target group

Male and female support staff members and young male soccer players of the rural and urban areas of Mafakathini and Ashdown were the target groups of the HIV/AIDS projects.

1.2.5 Methodology used in implementation of NP2

Participatory methodology was used via entertainment-based activities such as dramas, discussion forums, songs and dances.

1.2.6 Practical ways of implementing NP2

As aforementioned, NP2 project basically aimed at working through participation (sharing of ideas and skills) in its respond to the HIV/AIDS context of South Africa. It had a programme committee and an advisory board. The advisory board was said to have seven local experts who met twice a year to share their experiences in gender, research and religious related matters. They provided support to the management of the project. The project had a broad target group within which it provided the necessary manpower, skill and financial support. Some of the target groups included selected male soccer players who acted as peer educators. Among the soccer player peer educators (as was the case of those in Mafakathini and Ashdown), HIV/AIDS awareness issues were dealt with. In such awareness campaigns, participatory methodologies (interactive drama, songs, role-play and discussions) were used to pass across HIV/AIDS messages. The HIV/AIDS messages were centered on the encouragement of the soccer players to maintain healthy lifestyles and to serve as role models for the rest of the community.

1.2.7 Evaluation of NP2

The evaluation of NP2 took place with the targeted group of male and female project support staff and with the soccer player peer educators. An independent body made up of two main evaluators externally evaluated NP2. The external evaluators were answerable to a programme committee (made up of project secretariat and donor members who were responsible for the monitoring of the project and reporting back to the donors. The donors (one main donor body and four minor ones) were those requesting the evaluations.

The evaluation helped in assessing the impact of the project and finding out if the objectives of the project was reached. The evaluation also intended assessing the relevance of the project, improve service delivery of project staff, empower the people, bring about structural transformation within the project and enable skills acquisition.

The evaluation was non-participatory and individually orientated with the use of individual interviews and questionnaires (to the staff members) and pre-test-post-test non-equivalent comparison group design to the soccer peer educators. The soccer peer educators were made up of two groups: the experimental and control groups. The former, sharing many similarities as the latter received the peer education and the latter did not. Both of them completed the pre-test and post-test questionnaires within a two-month observance period.

With regards to the caliber of questions asked in the evaluation, the following were noted:
For the project staff: The extent to which the institutional arrangements have contributed or presented a barrier to achieving its expected results, the effective management of its finances and the strength and weaknesses of its implementation, network and advocacy strategies.

For the soccer peer educators: Their information sources (of HIV/AIDS), number of sexual partners, knowledge and attitude of STI treatment, frequency and reason for using condoms and their demographic records.

1.3 Non-participatory evaluated Project 3(NP3)

1.3.1 Location

NP3 took place in Bulawayo, Zimbabwe.

1.3.2 Project composition

In the Bulawayo peer-mediated HIV/AIDS educational programme, there were approximately 80 informal peer educator leaders within a seven-zone division. Each zone had a senior peer educator heading it. Approximately, four project managerial staff members facilitated the entire project.

1.3.4 Objective

NP3 intended achieving the following objectives:

  i)   Reduce, in a sustainable manner, STIs and HIV transmission primarily among the listed vulnerable groups of individuals in Bulawayo Zimbabwe.

  ii)   Reduce number of sex partners

  iii)   Give the recipients the opportunity to adopt healthy sex practices

  iv)   Provide opportunities for individual and group empowerment

  v)   Provide opportunities for structural transformation of the project itself

  vi)   Provide opportunities for individual and group skills acquisition

  vii)   Increasing of the programmes for expansion

  viii)   Create opportunities for building self-reliance of the sex workers

1.3.4 Target group

Vulnerable groups of male and female sex workers in the urban area of Bulawayo, Zimbabwe were the target groups of the HIV/AIDS projects.

1.3.5 Methodology used in implementation of NP1

Participatory methodology was used via entertainment-based activities such as dramas, discussion forums, songs and dances.

1.3.6 Practical ways of implementing NP3

Sex workers in Zimbabwe (a situation commonly witnessed in sub-Saharan Africa) were also engaged in the sex trade due to poverty and lack of opportunities for alternative employment: sex trade seen as a means of subsistence to them and their families.

In attempting to provide a way out to the given problem of vulnerability the HIV/AIDS peer-mediated educational programme was instituted with participatory methodology used in implementing it. The clients of the female sex workers were also included in the programme (male bar patrons and men in highly mobile jobs such as truck driving, the military and migrant work). To initiate the programme, a rapid formative assessment (involving informant discussions and observations) with 149 female sex workers and 74 clients was carried out. Mapping of bars, homes and streets linked to sex work were mapped potential programme beneficiaries identified. A scrutiny of sex workers' organisations, condom use, sexual and work pattern, health service use and STD history was done as well. From these activities, trust with the sex workers was build and at the end 80 informal leaders were recruited on a stipend and trained as peer educators. In a 3-hour

meeting held weekly, peer educators were trained in matters relating to STI and HIV/AIDS (community mobilisation, condom promotion, education and counselling). The peer educators were divided into seven zones (each zone functioning cohesively) with a senior peer educator heading it. The senior peer educator worked hand in glove with the zonal coordinator of that area. All the senior peer educators met regularly with different coordinators to plan the activities of the groups and to prepare for weekly training meetings with the peer educators.

Through activities such as drama, songs and dances, the peer educators in their different zones held community meetings and distribute condoms every week in their social networks (bars, selected workplaces and health units). In addition, each peer educator received private and free STIs treatment cards for themselves and for other sex workers.

1.3.7 Evaluation of NP3

The evaluation of NP3 took place with the targeted group of male and female sex workers in Bulawayo, Zimbabwe. NP3 was externally evaluated by an NGO in Nairobi Kenya made up of about five member evaluators. The evaluation helped in assessing the impact of the project and finding out if the objectives of the project was reached. The evaluation also intended empowering the people, bringing about structural transformation within the project and skills acquisition.

The evaluation was non-participatory and individually orientated with the use of individual interviews and questionnaires (a method contrary as well to that used in implementing it). The external evaluators carried a baseline and a follow-up survey (after two year) to assess the impact of the project. Part of the survey was to determine the average number of sex workers and their clients in Bulawayo. Taking the counting of the female sex workers, a team of 100 of them, assisted by some group of students was trained to do the counting. The counting was done in 56 bars (from opening to closing time of the bars). In fact one of the national surveys conducted still in Bulawayo showed that 80% of sex workers and 82% of their clients sought commercial partners in bars with 56 of the bars associated with such commercial sex (Ngugi 1996). In total, sex workers ((almost 12000) noted an average of

4.5 weekly clients suggesting an average of >2.8 million commercial sex work occurring yearly in Bulawayo.

With regards to the calibre of questions asked via the questionnaires and the individual interviews, questions such as those pertaining to condom usage, visits to health units for STIs and number of clients before and after the project were asked.

APPENDIX B: LETTER OF NOTIFICATION TO INTERVIEWEES

HIV/AIDS BEHAVIOURAL INTERVENTIONS IN SOUTHERN AFRICA: THE VALUE OF IMPLEMENTATION AND EVALUATION METHODOLOGIES OF PROJECTS WITH SOCIAL IMPLICATIONS

Dear interviewee,

The purpose of this interview is to collect information on methodologies used for the implementation and evaluation of HIV/AIDS interventions with social implications. The information collected will help in identifying methodological problems experienced in the implementation and evaluation of HIV/AIDS related projects. It is hoped that the result of the interview will inform healthcare workers in general, project implementers, evaluators, information managers and other concerned authorities, in the better management of implementation and evaluation processes for effective realisation and use of findings. A situation that can in turn, add value to the fight against HIV/AIDS.

All information acquired through this interview will be treated in **strictest confidence** and used in the preparation of a thesis in fulfilment of a Ph.D. degree in the Discipline of Community Resources, Faculty of Science and Agriculture, University of Natal.

Sincerely,

Niba MB, Discipline of Community Resources
School of Agricultural Sciences and Agribusiness,
Faculty of Science and Agriculture,
University of Natal, Private Bag X01
Pietermaritzburg 3209

Oct. 2002

APPENDIX C: INTERVIEW SCHEDULE

HIV/AIDS BEHAVIOURAL INTERVENTIONS IN SOUTHERN AFRICA: THE VALUE OF IMPLEMENTATION AND EVALUATION METHODOLOGIES OF PROJECTS WITH SOCIAL IMPLICATIONS

i)   BENEFICIARIES' INTERVIEW SCHEDULE

- ➢ **Please answer the questions as honestly as possible**
- ➢ **Please also remember that there are no right or wrong answers**

The interview questions are grouped into 2 main categories: category A is for questions pertaining to projects and category B to project evaluations.

Thank you for your co-operation

Category A (projects)
Part 1: socio-demographic data

1.   can you please state your role in the organisation and for how long you have played that role?....

2.   Gender: 1.1. Male ☐
                                               1.2. Female ☐

3.   Ethnic group: 2.1. Indian   ☐
                                               2.2. White   ☐
                                               2.3. African   ☐
                                               2.4. Coloured   ☐
                                               3.5. Other?.........

4.   Age range: 3.1. 18-29   ☐

                                           3.2. 30-39   ☐

                                           2.3. 40 and above ☐

5. Given the following languages, please indicate the ones you can most effectively communicate in

                                           5.1. English   ☐

                                           4.2. Afrikaans ☐

                                           4.3. Zulu   ☐

                                           4.4 Others? ....

What I want to do now is give you a list of factors, which could possibly have an effect an HIV/AIDS project that aimed at social change like the one who are involved in. I also want to question you about your experiences.

In the HIV/AIDS prevention project that you are involved in:

6. Briefly, describe the project:

                              Prompts:

                              6.1. Why it was done

                              6.2. Who asked for the project

                              6.3. Which methodology was used

                              6.4. When the project was carried out

                              6.5. For how long

7. Were you involved in:

7.1. The planning of the project?

7.1.1. What do you have to say about that?

7.2. The execution and managing of the project?

7.2.1. What do you have to say about that?

7.3. The using of the results?

7.3.1. What do you have to say about that?

8. Can you comment generally on the calibre of participation in the project?

                8.1. Was satisfactory

                8.2. Could have been more

8.3. Why do you say so?

9. What was the outcome of the project?

      Prompts: What made you particularly happy about it and why?

      What made you particularly unhappy and why?

10. From your experience, what do you think an HIV/AIDS prevention project (like the one you were involved) should concentrate on in order to make a major contribution to its implementation?

        Solely on individuals

        The target group as a whole

        What we the beneficiaries say is useful and

        meaningful to us

        What the donors say is useful and

        meaningful to them

        Others

10.1. Can you rank them in order of importance?

10.2. Why do you say so?

Category B: Virtually the same questions will be asked: but this time with respect to how the project was evaluated

11. Briefly, describe the evaluation:

        Prompts:

        11.1. Why it was done

11.2.Who asked for the evaluation

11.3.Who did it

11.4.Which methodology was used

11.5.When the project was carried out

11.6. For how long

12. Were you involved in:

12.1. The planning of the evaluation?

12.1.1. What do you have to say about that?

Prompts: any example of what you suggested

and that was reflected in the planning?

12.2. The execution and managing of the evaluation?

12.2.1. What do you have to say about that?

12.3. The using of the evaluation results?

12.3.1. What do you have to say about that?

13. Can you comment generally on the calibre of participation in the evaluation?

13.1. Was satisfactory

13.2. Could have been more

13.2. Why do you say so?

13.3. What was the outcome of the evaluation?

What has happened since after the evaluation?

If nothing why?

Any steps or evidence of it taken by you the beneficiaries in implementing evaluation results?

14. What made you particularly happy about the way the evaluation was carried out and why?

14. What made you particularly unhappy about the way it was carried out and why?

15. **From your experiences and as time has progressed, what do you think HIV/AIDS evaluation (like the one you were involved in) is to presently concentrate on in order to make a major contribution?**

> Solely on individuals
>
> The target group as a whole
>
> What the we the beneficiaries say is useful and
>
> meaningful to us
>
> What the donors say is useful and
>
> meaningful to them
>
> Full contribution by all involved in the project evaluation
>
> Others

15.1. Can you rank them in order of importance?

15.2. Why do you say so?

15.3. From your experiences over time, what do you think have been the main challenges in effectively implementing the things you have just identified above (in question 15)?

15.3. Why do you say so?

15.4. What do you suggest be done to remedy the situation?

16. Any concluding remarks about the way evaluations should be carried out?

Many Thanks

**ii)   PROJECT IMPLEMENTERS AND EVALUATORS' INTERVIEW
        SCHEDULE**

**HIV/AIDS BEHAVIOURAL INTERVENTIONS IN SOUTHERN AFRICA: THE
VALUE OF IMPLEMENTATION AND EVALUATION METHODOLOGIES OF
PROJECTS WITH SOCIAL IMPLICATIONS**

- **Please answer the questions as honestly as possible**
- **Please also remember that there are no right or wrong answers**

The interview questions are grouped into 2 main categories: category A is for questions pertaining to projects and category B to project evaluations.

Thank you for your co-operation

Category A (projects)

Part 1: socio-demographic data

1.   Your position in the organisation and for how long you have handled it?….

2.   Gender: 1.1. Male ☐

                                      1.2. Female ☐

3.   Ethnic group: 2.1. Indian   ☐

                                      2.2. White   ☐

                                      2.3. African   ☐

                                      2.4. Coloured   ☐

                                      3.5. Other?………

4.   Age range: 3.1. 18-29 ☐

                                      3.2. 30-39 ☐

                                      2.3. 40 and above ☐

5. Given the following languages, please indicate the ones you can most effectively communicate in

                        5.1. English   ☐

                        4.2. Afrikaans ☐

                        4.3. Zulu   ☐

                        4.4 Others? ....

What I want to do now is give you a list of factors, which could possibly have an effect on your project that aimed at social change. I also want to question you about your experiences.

In your HIV/AIDS prevention project that aimed at bringing about change in behaviour:

6. Briefly, describe the project:

                        Prompts:

                    6.1. Why it was done

                    6.2. Who asked for the project

                    6.5. Which methodology was used

                    6.6. When the project was carried out

                    6.5. For how long

7. Who was involved in:

7.1. The planning of the project?

7.1.1. What do you have to say about that?

7.2. The execution and managing of the project?

7.2.1. What do you have to say about that?

7.3. The using of the results?

7.3.1. What do you have to say about that?

Planning	Participants	Managing & executing	Parti.	Result usage	Parti.
Purpose	Donor Beneficiaries Implementers	Decide result usage	Donor Bene. Imple.	Decide result feedback	Donor Bene. Imple.
Method	Donor Beneficiaries Implementers	Concluding & recommending	Donor Bene. Imple.	Decide way of sharing lesson learnt	Donor Bene. Imple.
		Ways of communicating results	Donor Bene. Imple.	Decide future plan	Donor Bene. Imple.

8. Can you comment generally on the calibre of participation in the project?

            8.1. Was satisfactory

            8.2. Could have been more

8.3. Why do you say so?

9.What was the outcome of the project?

      Prompts: What made you particularly happy about it and why?

      What made you particularly unhappy and why?

10. From your experience, what do you think an HIV/AIDS prevention project (like the one you were involved) should concentrate on in order to make a major contribution to its implementation?

          Solely on individuals

          The target group as a whole

          What the beneficiaries say is useful and meaningful

          to them

What the donors say is useful and meaningful to them

Others

10.1. Can you rank them in order of importance?

10.2. Why do you say so?

Category B: Virtually the same questions will be asked: but this time with respect to how the project was evaluated

11. Briefly, describe the evaluation:

Prompts:

11.1. Why it was done

11.6.Who asked for the evaluation

11.7.Who did it

11.8.Which methodology was used

11.9.When the project was carried out

11.6. For how long

12. Who was involved in:

12.1. The planning of the evaluation?

12.1.1. What do you have to say about that?

Prompts: any example of what i.e. beneficiaries suggested and that was reflected in the planning?

12.2. The execution and managing of the evaluation?

12.2.1. What do you have to say about that?

12.3. The using of the evaluation results?

12.3.1. What do you have to say about that?

Planning	Participants	Managing & executing	Parti.	Result usage	Parti.
Purpose	Donor Beneficiaries Implementers	Decide result usage	Donor Bene. Imple.	Decide result feedback	Donor Bene. Imple.
Method	Donor Beneficiaries Implementers	Concluding & recommending	Donor Bene. Imple.	Decide way of sharing lesson learnt	Donor Bene. Imple.
		Ways of communicating results	Donor Bene. Imple.	Decide future plan	Donor Bene. Imple.

13. Can you comment generally on the calibre of participation in the evaluation?

            13.1. Was satisfactory

            13.2. Could have been more

13.2. Why do you say so?

13.3. What was the outcome of the evaluation?

      What has happened since after the evaluation?

      If nothing why?

      Any steps or evidence of it taken by the concerned in implementing

      Evaluation results?

14. What made you (project implementer) particularly happy about the way the evaluation was carried out and why?

14. What made you particularly unhappy about the way it was carried out and why?

15. What made the beneficiaries particularly happy about the way it was carried out and why?

16. What made the donors particularly happy about the way it was carried out and why?

17. What made the donors particularly unhappy about the way it was carried out and why?

18. From your experiences and as time has progressed, what do you think HIV/AIDS evaluations (like the ones you were involved in) are to presently concentrate on in order to make a major contribution its implementation?

> Solely on individuals
> The target group as a whole
> What the beneficiaries say is useful and
> meaningful to them
> What the donors say is useful and
> meaningful to them
> Full contribution by all involved in the project evaluation
> Others

18.1. Can you rank them in order of importance?

18.2. Why do you say so?

18.3. From your experiences over time, what do you think have been the main challenges in effectively implementing the things you have just identified above (in question 18)?

18.3. Why do you say so?

19.4. What do you suggest be done to remedy the situation?

20. Any concluding remarks about the way evaluations should be carried out?

Many Thanks

APPENDIX D: OUTCOME RESULTS OF PARTICIPATORY AND NON-PARTICIPATORY EVALUATED PROJECTS (FROM EVALUATION REPORTS AND INTERVIEWS)

Table 7.1: P1 indicator variables and quality outcome results*

HIV/AIDS project 1		
Variables tested	**Outcome result**	
	Positive outcome	**Negative outcome**
Project **PP Method	PP method commended. Beneficiaries talked of interactive training sessions having boosted their confidence and self-esteem i.e. they could confidently talk 'AIDS' to tertiary students	Representation not fully achieved i.e. see Table 4.11 and 4.14
Awareness	Critical awareness of health matters noted i.e. beneficiaries aware of stigmatisation	***_
Knowledge	Acquisition of knowledge noted i.e. beneficiaries using correct terminologies to speak of 'facts' about HIV/AIDS	Knowledge of project and evaluation limited i.e. see Table 4.10 and 4.13 Changing dynamics of knowing one's status not effectively covered
Attitude	Attitude change noted i.e. beneficiaries willing to change such as being prepared to show love to HIV/AIDS sufferers	_
Empowerment (Skills gained)	Acting talent, group communication skills, leadership and organisational skills	-
Effective functioning -Role modeling -Networking	Project implementers acting as facilitators Networking noted with people living with HIV/AIDS, teaching staff, students, welfare workers and principals	Not enough student support groups
Sustainability -Self-employment -Expansion	The making of AIDS memorial quilt noted Club launching, 'open day' festivals, visitation to neighbouring schools	- Not enough networking with peer educators of other campuses
Evaluation PP Method	Commended: focus group discussions seen as a learning process with the furtherance of awareness, knowledge, attitude change, empowerment, effective functioning and sustainability i.e. could pick vital points raised by others in discussions, could share visions and opinions	Emerging 'positive living' trends on campuses not effectively covered

* Results from evaluation reports and interviews **PP=Participatory methodology ***- =None indicated

Table 7.2: P2 indicator variables and quality outcome results*

HIV/AIDS project 2		
Variables tested	**Outcome result**	
	Positive outcome	Negative outcome
Project **PP Method	PP method commended i.e. beneficiaries saw it as a learning process	Representation not fully achieved i.e. see Table 4.11
Awareness	Critical awareness of health matters noted i.e. HIV/AIDS declared no longer 'abstract'. Beneficiaries also gained awareness of their rights. One said "I now know I have a right to say no"	*** _
Knowledge	Acquisition of knowledge noted. Beneficiaries able to tell the different ways of contracting HIV i.e. that HIV cannot be contracted from a spoon used by an infected person Knowledge gained regarding polygamy "polygamy is a matter of the past"	Inadequate communication amongst implementers regarding project goals Knowledge of project and evaluation limited i.e. see Table 4.10 and 4.13
Attitude	Attitude change noted i.e. beneficiaries having 'physical contact' and reaching out to those infected without fear (unlike before)	Disclosure of status still a problem
Empowerment (Skills gained)	Communicational skills i.e. how to tactfully answer questions about HIV/AIDS and instigate personal precautions without causing offense	_
Effective function -Role modeling -Networking	Beneficiaries engaging in health related projects such as to reduce litter at school, improve toilet hygiene, tending gardens Networking noted with teaching staff, students, welfare workers, people living with HIV/AIDS and principals all sharing their opinions	Challenge of being given names i.e. "They say I think I am clever ..." Not enough active support from educational authorities
Sustainability -Self-employment -Expansion	AIDS memorial quilt noted Club launching, 'open day' festivals, visitation to neighbouring schools	Still not sufficient income-generating activities Time limitation preventing many outreaches
Evaluation PP Method	Commended: focus group discussions seen as a learning process with the furtherance of awareness, knowledge, attitude change, empowerment, effective functioning and sustainability i.e. could pick vital points raised by others in discussions, could share visions and opinions	Representation not fully achieved i.e. see Table 4.14

* Results from evaluation reports and interviews **PP=Participatory methodology ***- =None indicated

Table 7.3: P3 indicator variables and quality outcome results*

HIV/AIDS project 3		
Variables tested	**Outcome result**	
	Positive outcome	**Negative outcome**
Project **PP Method	Commended i.e. beneficiaries asked questions on HIV/AIDS related matters and discussions ended without deliberate attempt by facilitator to do so	Parents of learners in rural areas resistant to open talks about sex i.e. a beneficiary said the parents regard it as 'naughty'
Awareness	Critical awareness of health matters noted i.e. Awareness of the dangers of getting infected via risky sex practices such as blood to blood contacts and unprotected sex	***_
Knowledge	Acquisition of knowledge noted i.e. beneficiaries could link issues of HIV/AIDS to STIs and the need for blood test in a new relationship	Knowledge of project and evaluation limited i.e. see Table 4.10 and 4.13
Attitude	Attitude change noted i.e. beneficiaries willing to abstain from pre-marital sex and stay faithful to one partner when married	Still some reluctance to talk about sex due to cultural norms and expectations
Empowerment (Skills gained)	Problem-solving, negotiation, decision-making, debating, persuasive and acting skills	_
Effective function -Role modeling	Project implementers acting as facilitators Beneficiaries engaging in health related projects such as improve toilet hygiene	_
-Networking	Networking noted i.e. a committee including community healthcare workers, and donors of the project. Networking also with teaching staff and students	Inadequate interaction with other youths involved in similar projects
Sustainability -Self-employment -Expansion	Beadwork noted. Teachers forming a support quorum to ensure project continuity. Club launching, 'open day' festivals, visitation to neighbouring schools	_ Inadequate resources for travelling
Evaluation PP Method	Commended: focus group discussions seen as a learning process with the furtherance of awareness, knowledge, attitude change, empowerment, effective functioning and sustainability i.e. could pick vital points raised by others in discussions, could share visions and opinions	Representation not fully achieved i.e. see Table 4.14

* Results from evaluation reports and interviews **PP=Participatory methodology ***- =None indicated

Table 7.4: P4 indicator variables and quality outcome results*

HIV/AIDS project 4		
Variables tested	**Outcome result**	
	Positive outcome	**Negative outcome**
Project **PP Method	Commended PP method i.e. working as a group help build some sense of security (that you are not alone in the HIV/AIDS battle)	Beneficiaries see PP method challenging i.e. Much practice and performances
Awareness	Critical awareness of health matters noted i.e beneficiaries aware of the dangers of prostitution	***_
Knowledge	Acquisition of knowledge noted i.e. beneficiaries could link HIV/AIDS, poverty and risky sex practices such as prostitution	Knowledge of project and evaluation limited i.e. see Table 4.10 and 4.13
Attitude	Attitude change noted i.e. beneficiaries were once prostitutes rejected by society, but changed to role models; loved and relied on by their communities	_
Empowerment (Skills gained)	Counseling, leadership, acting, co-operation, resource sharing and showing of sympathy	"People think we are qualified nurses and expect so much from us"
Effective function -Role modeling -Networking	Valued by the community i.e. "the people now trust us even more than the nurses" Network with 'hotspot' owners and members of the same project in different areas	- -
Sustainability -Self-employment -Expansion	Have joint initiative projects, loan provisions Regular visit to community 'hotspots'	"We see many helpless cases needing financial assistant yet we cannot meet them all" Challenge of being innovative "we need to come up with new things to avoid boredom"
Evaluation PP Method	Checklist commended i.e. seen as ways of improving performance (service quality). Focus group discussion commended: seen as a learning process with the furtherance of awareness, knowledge, attitude change, empowerment, effective functioning and sustainability i.e. could pick vital points raised by others in discussions, could share visions and opinions	Checklist method limited mainly to peer educators (not extended to 'shabeens' participants)

* Results from evaluation reports and interviews **PP=Participatory methodology ***- =None indicated

Table 7.5: P5 indicator variables and quality outcome results*

HIV/AIDS project 5		
Variables tested	**Outcome result**	
	Positive outcome	Negative outcome
Project **PP Method	Beneficiaries commended PP method: thought-provoking and adding realism to HIV i.e. a community member asked, "we are still doing what we used to do in the past; yet in the past we did not have AIDS and now we do so where has the HIV come from?"	PP method quite demanding in terms of time and effort to be put in
Awareness	Critical awareness of health matters noted i.e beneficiaries aware of dangers of much alcohol and prostitution	***_
Knowledge	Acquisition of knowledge noted i.e. beneficiaries could link HIV/AIDS to the influence of alcohol and prostitution	Still knowledge of project and evaluation limited i.e. see Table 4.10 and 4.14
Attitude	Attitude change noted i.e. once prostitutes rejected by society, but changed to role models loved and relied on by their communities	_
Empowerment (Skills gained)	Learning through activities, discussion, acknowledgement, leadership, acting, co-operation, resource sharing and showing of sympathy	Challenge of managing many HIV/AIDS crisis cases
Effective function -Role modeling -Networking	Valued by the community i.e. "when we started the people used to jeer at us but now they come to us for advice, help, condoms..." Network with prostitutes, mineworkers, 'hotspot' owners and members of the same project in different areas	_ _
Sustainability -Self-employment -Expansion	Have joint initiative projects, loan provisions Regular visit to community 'hotspots'	Inadequate funding Few workers " the cases needing help are too many for us to handle"
Evaluation PP Method	Checklist commended i.e. seen as ways of improving performance (service quality). Focus group discussion commended: seen as a learning process with the furtherance of awareness, knowledge, attitude change, empowerment, effective functioning and sustainability i.e. could pick vital points raised by others in discussions, could share visions and opinions	Opinion of the community such as the hotspot participants that we visit not sought for with the use of the checklist system

* Results from evaluation reports and interviews **PP=Participatory methodology ***- =None indicated

Table 7.6: Project 6 indicator variables and quality outcome results*

Variables tested	Outcome result		Negative outcome
	Positive outcome		
Project **PP Method	From the evaluation report, PP method was commended: dialogue approach enabled the breaking down of complex concepts for easy understanding as beneficiaries were made to start with what they already know; the role-plays elicited strong emotional impact enabling retention. In a role-play of mother-infant transmission, a beneficiary exclaimed, "Oh, the poor thing hasn't even begun to live and now he's dying of AIDS"		***_
Awareness	Critical awareness of health matters noted i.e. beneficiaries became aware of stigmatisation and guilt linked to HIV/AIDS		_
Knowledge	Knowledge on HIV/AIDS gained and in turn, raised the status of the sex workers among rival networks and among their clients i.e. Clients reported being surprised that the sex workers now knew the value of condoms		_
Attitude	Attitude change noted i.e. after three months of programme, all but one client reported regular condom use. The one that did not use condom complained of genital ulcer of which she was taken for treatment		_
Empowerment (Skills gained)	Acting talent, group communication skills, leadership, organisational, and negotiation skills were gained. The women empowered to make their own situational risk assessment and deliberate upon appropriate individual and collective actions to take.		_
Effective functioning -Role modeling -Networking	Project implementers acting as facilitators and the sex workers in the evaluation demonstration exercise, did likewise to their trainees. Networking noted with women in church organisations		_
Sustainability -Self-employment -Expansion	The making of HIV/AIDS posters noted. Sex workers informing their clients of the value of condoms, spreading the lessons learnt in their neigbourhood and to other sex workers		Self-sustenance indicated by beneficiaries to be a major issue
Evaluation PP Method	The user-focused evaluation indicated in the evaluation report provided opportunities for new shared-experiences and valid generalisations that were applied creatively i.e. eight months after intervention a declined in regular use of condoms was reported which in the evaluation discussion, reason was given to be a rumour propagated by some university students and a medicine shop clerk of the low quality and ineffectiveness of condom; a situation which was later rectified. The evaluation also as such, helped in the furtherance of awareness, knowledge, attitude change, empowerment, effective functioning and sustainability.		_

* Results from evaluation reports and interviews **PP=Participatory methodology ***- =None indicated

Table 7.7: Project NP1 indicator variables and quality outcome results*

HIV/AIDS project NP1		
Variables tested	**Outcome result**	
	Positive outcome	**Negative outcome**
Project **PP Method	From the evaluation report, PP method was commended, for example, the focus group initiated debates on the acceptance of people living with AIDS and also enabled the challenging of deep-seated fears and prejudices. 78% of students approved of the active involvement and 80% rated the programme as excellent	PP method seen as slow
Awareness	Critical awareness of health matters noted: beneficiaries became aware of the need to accept someone with HIV/AIDS "so that he can feel wanted among people, and get love like everybody"	***_
Knowledge	Knowledge on HIV/AIDS prevention, transmission and course of illness improved significantly: Pearson chi-square tests on mode of transmission i.e. (HIV cannot be passed by drinking from unwashed cup) p=.0001 (knowledge level rose from 35.6 % before programme to 67.8% after and for the control group 34.1% to 37.1%)	_
Attitude	Attitude change noted i.e. acceptance of someone with AIDS into the class: p=.0001 (16.6 % level of acceptance before programme and 41.2% after and for the control group 9.5% before and 10.8 after)	Rumour stemming from the programme (that the reason for the initiation of the AIDS programme was because the students and teachers had AIDS) brought distress among students and staff ' we have now become a laughing stock of other schools"
Empowerment (Skills gained)	Acting talent, group communication skills, leadership, organisational, and negotiation skills were gained. The students empowered to discuss AIDS with their parents, friends, sexual partners, nurses and teachers i.e with parents p=.0001 (before programme 15.6 % did discuss and after programme 69.2% and in the control group 18 before and 34.5 after). Empowered to confront the disease "I know the rules of this disease so its no problem"	-
Effective functioning -Role modeling -Networking	Project implementers including the trained teaching staff acting as facilitators. Planning meetings held with staff members and student representative council and ad hoc groups of students and staff members. Ideas brainstormed in the meetings and tasks and responsibilities assigned. Network with people living with HIV/AIDS, parents, school authorities and nurses.	_
Sustainability -Self-employment -Expansion	Arts exhibitions in the school and AIDS information leaflets containing competitions of which students took to their parents Students discussed HIV/AIDS with their friends, parents and sexual partners	_
Evaluation PP Method	_	_

Results from evaluation reports **PP=Participatory methodology ***- =None indicated

Table 7.8: Project NP2 indicator variables and quality outcome results*

HIV/AIDS Project	HIV/AIDS project NP2	
Variables tested	Outcome result	
	Positive outcome	Negative outcome
Project **PP Method	From the evaluation report, PP method was commended: for soccer players, it unraveled the realities of STI/HIV and AIDS to them and support staff, it enabled them to think as a pool leading to the development of a clear strategic direction	Evaluation report revealed inadequate informatio sharing such as between donors and programm committee, which the evaluator felt was a due t overload of work on the part of the donors rathe than unwillingness to share
Awareness	Critical awareness of health matters noted: soccer players became aware of the dangers of STIs and the need to seek early treatment (before the programme 14 had had STI and in the past two months, none whereas in the control 18 and within the past two months five giving a significant p value of .0009). Support staff became aware of trust and openness	***
Knowledge	Improvement of knowledge noted. Soccer players p value regarding knowledge about discharge was .0002, about sores .009 and about glands .0003. Support staff, interaction with the advisory board (seven local experts) led to the gaining of experience such as in gender related matters	Confusion as to who makes the ultimate decisio was reported in the functioning of the advisor board and programme committee
Attitude	Attitude change noted. Soccer players, a significant change of p value .0000 was noted in the use of condoms i.e. before programme, none used condoms always and after 18 did and in the control group, none before and only 1 after. For the support staff, an attitude of enthusiasm was built	_
Empowerment (Skills gained)	Soccer players and support staff gained group communication skills, leadership, organisational, and negotiation skills. Soccer players empowered to protect themselves against infections such as HIV and STIs. Support staff empowered to be more committed	_
Effective functioning -Role modeling -Networking	Project implementers acting as facilitators. Support staff networked with other stakeholders in SA	Limited clear priority settings within the programm(support systems (project work largely broad-base(advocacy rather than specific). Problem of 'mi: partners' with different targets and empowermen strategies all making a coherent strategy difficult
Sustainability -Self-employment -Expansion	Budget increase noted with increase number of donors (from one main body to three additional minor bodies).	_
Evaluation PP Method	_	With the soccer player evaluation, the evaluatior report noted the deprivation of opportunities for the players to ask and seek answers to questions they had during the evaluation. Some support staff on the other hand questioned their evaluation by doubting the perceived relevance of the evaluatior programme committee given that their organisatior was more support to implementation-based Occasional insight from interview with one of the support staff revealed that the evaluation as a whole was questionable and she vented her frustration about it by saying, "I do not want to see that evaluation report"

* Results from evaluation reports and occasional insights from interview with support staff
PP=Participatory methodology *- =None indicated

Table 7.9: Project NP3 indicator variables and quality outcome results*

HIV/AIDS project NP3		
Variables tested	**Outcome result**	
	Positive outcome	**Negative outcome**
Project **PP Method	From the evaluation report, PP method was commended. It enabling the sex workers to share ideas and learn from one another.	*** –
Awareness	Critical awareness of health matters noted: Awareness of the dangers of unprotected sex and untreated STIs	–
Knowledge	Improvement of knowledge noted: knowledge regarding risky sex practices, STIs, HIV and AIDS.	Evaluation report indicating the need for more up-to-date information on community training, activities and participation
Attitude	Attitude change noted. As indicated in the evaluation report, condom use rose from 18% (outset of programme) to 66% within two years portraying a strong linear relationship between programme exposure and reported condom use	–
Empowerment (Skills gained)	The sex workers gained acting talents, group communication skills, leadership, organisational, and negotiation skills. Sex workers empowered to protect themselves against STIs and HIV/AIDS infections: In spite many confounding factors that might have affected clinic attendance, a remarkable drop of visits to health units (average quarterly attendance for the five quarters before the commencement of the programme was 4960 and after the commencement of the programme it dropped to 3368: t=4.8. by t test, P=.0001) was noted as a result of the empowerment of the sex workers to protect themselves.	–
Effective functioning -Role modeling -Networking	Project implementers acting as facilitators. Networking with bar owners and male clients noted	Still insufficient social networking: Health and community workers were not sufficiently included in the project.
Sustainability -Self-employment -Expansion	Private and free STI treatment cards for the sex workers and their counterparts Weekly distribution of condoms to bars and selected workplaces	It was noticed in the evaluation report that mechanisms to sustain long-term behaviour change were lacking. Some of the mechanisms included financial support.
Evaluation PP Method	–	Lack of regular evaluation to motivate programme participants and to monitor the progress of the project

* Results from evaluation reports **PP=Participatory methodology ***- =None indicated

APPENDIX E: EXCERPTS OF BOTH THE PARTICIPATORY AND NON-PARTICIPATORY EVALUATED PROJECTS

I) PARTICIPATORY EVALUATED PROJECT 1(P1)

A contextual orientated and theory based approach to training PWHA's. Key elements of social learning theory (Bandura, 1977 cited in UNAIDS, 1999) were used to develop health and peer educators to be able to mobilise advocacy as positive role models. The training for the health pro peer educators was designed for the specific needs of the participants. It was important for young people in able to demonstrate that they were able to cope positively with the responsibility incumbent in knowing ones This would help to provide leaderships for the diffusion of innovation of ideas around positive living for peer and students on campus (Rogers, 1983 cited in UNAIDS, 1999). Central to fulfilling this role is the belief that living positively and have control over the way in which they choose to deal with situations which HIV/AIDS f confront.

Personal empowerment has to do with psychological processes and parallels self-esteem and self-efficacy (cited in UNAIDS, 1999). Self-efficacy and group efficacy is integrally related and individual contributions are defining boundaries. Their common struggle to acquire and practice skills to combat discrimination against t status provides the necessary confidence for the group to act (Werner, 1977 cited in UNAIDS, 1999).

At the third peer educators training at DIT out of the group of 13-15 ... students revealed their status to the facilitator. In response to the previous workshop (Peer educator t they had gone for testing and found that their status was positive. They felt that they were coping with ... that they would reveal their status more publicly at the beginning of the new academic term. Strong efficacy in regard to coping with the positive result was seen as a result of a supportive environment and a p outlook.

Commenting on the PWHA's as peer educators many students felt that the method of using opinion widely accepted. In response to the project most felt that using workshops facilitated by health prom encourages healthy and positive life-styles.

In response to the training the participants indicated that the training boosted their *confidence* and *self-esteem*. The training helped them to talk to tertiary institution students with confidence. Key to this was their understanding of student issues and i campus contexts which prepared them for their role as Health promoters. It equipped participants on a personal level to c impacting negatively on health.

Though I get ill sometimes, I am very healthy because of the positive mindset and the fact that 1 am helping others to cop challenge.

The training and experiences in the implementation impacted significantly on self-efficacy, self- esteem and confidence of participants. The majority of the students listen to me and treat me as a normal person and not as an HIV positive person... 1 can listen to other people's problems and 1 can handle pressure and constructive criticism ... This comment seems to indicate that the respondent's belief in self is developed enough to not feel 'oversensitive' to *critics*. Implications on the deferral nature of his treatment by students as normal indicates acceptance of his HIV status.

The value of the methodology was that it was a clear, simple and enjoyable approach to follow and implement. In addition the methodology was really an energiser because it assisted with providing different opinions i.e. the methodologies on how to creatively run or through entertainment ...thru the training we shared a vision together.

The development of perceptions of self, consistent with respect and integrity seems to indicate growths in confidence and these may be attributed in part to the action reflection nature of the training which does not limit learning to the parameters workshop, but extends it to the experiential process of implementing new skills. These new skills are embedded in activities that are valued as platforms to share intense emotions, information and ideas. As entertaining and engaging entry points they develop place for the dialogue of change.

It also challenges me into becoming the Best person I have ever dreamt to be. Commenting on the role of the health promoters, students and HIV/AIDS managers felt: the role of the

openly positive health promoter and peer educator provides a dramatic context in which affective response by young people. It is therefore crucial that disclosure and 'coming out' be carefully explored so the implications and incumbent responsibilities are realised on a deeply personal level by participants.

II) PARTICIPATORY EVALUATED PROJECT 2(P2)

What members enjoyed most about the play-making and life skills training they had experienced.

The group valued the experience greatly, both for the information on HIV/AIDS they had gained and the opportunity to help others learn about the virus. They found much ignorance in the rural schools they visited about the virus, and had been able to dispel some myths by the 'explicit message in their drama'.

New things learned about HIV/AIDS prevention from the course they attended.

Facts and skills learned included:

* protection against transmission when nursing a sufferer by using a barrier to avoid contact with body fluids.

* correct sexual behaviour if both partners are HIV positive

* correct method of condom use

* quality of life possible with the virus

* advisable to have a blood check for the virus before starting a family *Communication.*

They learned how to deal with questions about the virus in a tactful manner, and to instigate their own precautions without causing offence (something Club learners had difficulty achieving).

Appropriate sexual behaviour to avoid transmission of the virus: the impact of the course on choices and behaviour regarding this.

This group was unanimous in the view that it was better never to 'trust' a sexual partner and to always practice safe sex, using a condom. Whilst not all learner respondents appeared sexually active, all members of this group were. No one mentioned abstention as an alternative to safe sex. Those that were faithful to one partner still used a condom, 'to be

safe'. Both genders were firm in espousing the practice of safe sex, unlike the schools groups where females tended to be less assertive about this.

Attendance at the course had influenced choices and behaviour about sexual practice by highlighting the prevalence and fatality of HIV/AIDS. While sexual activity continued for all group members the focus had moved from preventing pregnancy through contraception, to preventing transmission of the virus through condom usage. The failure of any member to select abstention as an alternative recalls the point made in the schools focus group analysis that learners who were already sexually active were less inclined to abstain than those who had not yet begun.

Comment: Responses to this topic suggest scope for further exploration on the possibility of meaningful relationships that do not necessarily involve intercourse.

Attitudes to HIV/AIDS
a. What happens to someone with HIV/AIDS?
Most members were aware of the range of physical symptoms displayed by the sufferer and the emotional effects of the virus (social withdrawal). A good understanding of declining immunity due to the virus was shown.
b. Attitudes towards an infected person - had the course in influenced attitudes?
The group felt `bad' about those with the virus. Certain groups were seen as `victims' contracting the virus against their will. These were wives whose husbands refused to wear condoms and were unfaithful; children who had contracted it from mothers; those orphaned by the virus. Many in the community said that the condition was due to witchcraft, and no support given to sufferer in this situation. The group expressed less sympathy for youth who engaged in unsafe sex: "they should know better". This latter comment approaches the moralistic condemnation by elders, as revealed by responses in the schools focus groups.

The course influenced this group's attitude towards those with the disease through facts gained about transmission. They were unafraid now to have physical contact, and felt empowered by their knowledge to reach out to those with the virus. While some members

reiterated disapproval at those 'who were careless', all still expressed pity for any sufferers and the need not to discriminate against anyone with the virus.

Comment: Future workshops with older youth may need to uncover and counteract a tendency to judge younger people as careless or immoral

c. What did families of the group say about infected persons?
Parents of this group were more open to discussing the virus than many of the learners' parents. Parents had changed in this, from an attitude that: " any topic on sex was not discussed in front of children in our culture". This might be due to the course providing the young adults with tools to clearly inform their parents about the virus, for which the latter were appreciative. Perhaps the younger, Club members lacked the status and the communication skills to be taken as seriously by their parents. The general feeling in families of the group was concern about the spread of the virus and support for those who were infected.

d. How would a group member feel is he/she had the virus? Would the course help in this situation?
Responses suggested the course had given members tools to cope better in this event, particularly the realisation that one could live for a long time and have good quality of life.. None spoke of suicide, but about taking the correct care of oneself, physically and emotionally. Several would disclose to close friends and family, and later to the community. Many would tell others about the virus, using themselves as an example. The group felt that as a team they would help each other in this situation, by advising parents of the infected person and offering practical support.
Comment: These comments offer excellent support for the assistance the 'Act-Alive' project is offering to older youth.

Making healthy choices
This topic explored whether the group had discussed safe sex with their partner, or said 'no' to sex. The entire group had done this and some were prepared to terminate a relationship should their partner refuse (males and females).

Comment: A few of the boys and all the girls felt there was no need `to have sex all the time', and that a relationship is not just sex. This healthy attitude could be developed even more in workshops.

Caring for those with AIDS

Positive responses from the entire group indicated an awareness of the practical and psychological issues involved in caring for those with full-blown AIDS. The group found the course offered valuable advice on this topic. One expressed concern was how to deal with those who were stubborn, `refusing to be washed', or cooperate in other ways. This issue could have been better explored in the course, with role-play a useful technique to do so. Insight into why the sufferer is 'stubborn' would be useful.

Responses regarding emotional support referred to: being positive; not discriminating; giving love; taking them out; and helping them have a normal life. What seemed lacking in these responses is awareness that a sufferer may need to take time to talk about and come to terms with, what has happened. In a way the `jolly' tone of the help proposed by the group may be a form of denial of the depth of pain the infected person is feeling.

Networking

By nature of their outreach through performing the initial AIDS play at each school, this group communicated the message to many learners. Responses also indicated the importance of speaking to younger (primary) children about the virus, particularly in relation to sexual abuse by older men of young virgins (myth referred to earlier). The group found it harder to communicate the messages to peers, for the same reasons expressed by learner groups.

Various communities and local clinics to take the play to them had approached the group. They wished to do this but funding was the problem.

Comment: The last comment raises the issue of entrepreneurship linked to training in dramatic skills for this group. Some understanding of fund raising and of self-marketing

might allow them to generate some income themselves from schools or communities requiring their services. They might even be able to obtain a small sponsorship from a local business.

Personal growth through play-making training

All felt this had occurred. Acting talent and communication skills and self confidence had been enhanced. They had also learned to work as part of a team. They had found the positive response from learners at all schools fulfilling and motivating. Self-esteem had grown.

The way ahead

Issues generated by the out-of-school group are:

Viability of taking the plays to other schools in a future phase of the project. The group is keen to do this and the need exists.

Some form of certification to enhance the group's credibility in the community.

Evaluative Conclusions Based on Focus Group Analysis

This group of older youth demonstrated a more sophisticated understanding of all AIDS issues. They appeared to have had a sound grasp of the basic facts of the disease before the intervention, but gained in various knowledge areas as a result of the course and their performances at schools. This related to precautions in caring for an AIDS patient, correct condom use and blood checks, amongst other facts. This group already practiced safe sex and the course served to strengthen this resolve. Growth in this group from the course, centred on, acquisition of the techniques to counsel those with the virus, as well as skills (drama) to communicate AIDS messages to others. Self-esteem and direction were further gains from the course.

Workshop material led to the intended outcomes in this group, in terms of objectives. Aspects of satisfying relationships other than those centred on sex is one area workshops could explore in more depth. The group had successfully taken the message to people other than school learners, such as their parents. They have been approached by community

groups to broaden their outreach. This is an area to consider in follow-up phases to the intervention.

III) PARTICIPATORY EVALUATED PROJECT 3(P3)

The project recognises the importance of continuing to collaborate with the community after the initial start-up phase, during which the community members are consulted with regard to the work and the establishment of the Youth Clubs. The most immediate 'community' is the teaching staff in the various schools. In some of the schools, close collaboration with the teachers was more visually obvious than at others, although at all the schools, which took part in the focus group discussions, there was evidence of some support from the teaching staff. At two of the four schools I visited, I was introduced to the Principals, who then actively voiced their support for the programme.

There is strong evidence to suggest that learners had become critically aware of health issues as a result of the work done by the Youth Clubs. In the various focus group discussions, it was evident that the learners were aware of both the broad and the narrow issues relating to health promotion. They spoke knowledgeably of the 'facts' about HIV / AIDS and could link the discussion to issues of sexually Transmitted Diseases (STD's), prevention of AIDS transmission, ways in which the virus can be 'slowed down' and other health issues. They used the correct terminology and were able to contextualise the discussions about HIV/AIDS. They were also able to talk knowledgeably about medically related issues like the need for a blood test when embarking on a 'new' relationship, and the transmission of the virus to unborn or newly born children. Learners in one focus group in particular, requested additional medical information that they felt would be best supplied by a medical practitioner, either a doctor or a nurse.

In addition, learners who had participated in the workshops showed sensitivity to issues like how to treat People Living with AIDS (PLR's). They spoke meaningfully about the need to respect, love and support PLR's as human beings "just like ourselves". They were aware of the societal reasons why PLR's are stigmatised and shunned, and acknowledged that this was something that needed to be changed. The learners spoke with both conviction

and sincerity about 'rights' - the rights of PLR's and the rights of girls to say "no". There was clear evidence to suggest that they had internalised the message of rights: one pupil said, "It's the constitution".

In most cases, the focus group discussions with learners ended, without any deliberate attempts to do so on the part of the evaluator, with learners asking questions related to HIV /AIDS and related health matters. This provides strong evidence of the 'hunger' that young people, who start to open their minds to health promoting information, start to experience. In general, the learners appeared to be fully aware of current HIV /AIDS related issues that are emerging both nationally and internationally. For example, most of the learners interviewed were aware of the national current debate relating to theories regarding the link between HIV and AIDS, which commenced last year and which emanated from the President of South Africa's Office.

The creation of Charters for Health Promotion at some of the schools is further evidence of the critical awareness developed by the learners in the Youth Clubs. The facilitators assisted the Youth Club in drawing up the Charter. These health-promoting Charters has great significance for the importance of the Club in terms of the following:

- giving the Youth Club status in the wider community
- providing continuity for the Club so that if individual members leave the Club, the basis and foundation of the Club remains
- public affirmation of the members' commitment to the Club •
- establishing good relationships between facilitators and the school as well as between the school and the surrounding area
- encouraging and promoting other health related areas: for example, pupils who participate in the Clubs are also encouraged to keep their schools clean and tidy and to help fight crime.

The use of personal testimony by speakers from People Living with AIDS (PLR's) helped to establish a sense of realism about the pandemic. In all three areas, it was local people who provided personal testimony about Living with AIDS and this brought the reality home to many of the participants at the training workshops. One participant said that AIDS

was no longer "abstract" for him - it had become a reality through the disclosure of various speakers' AIDS status.

Confronting societal prejudices

Learners spoke freely about the cultural issues relating to the transmission of HIV / AIDS. They spoke about the need to break the practices of polygamy, and a number of learners said things like, "Things have changed - it might have been okay for them in the old days but it is no longer the case". Another pupil said that adults find it "difficult to believe us because we are young". However, they showed a willingness to confront societal misconceptions and practices that led to the transmission of AIDS. Unanimously, they said that it was necessary to be faithful to one partner.

A number of the participants spoke of what they perceived as cultural barriers with regard to talking openly about sex, particularly with school going youth. One participant said that the parents regarded it as "naughty" and not within the boundaries of 'formal' education.

...Participant said that she had been of the belief that it was easy to identify (and by implication avoid) someone with AIDS, but the personal testimony of a PLA had dispelled this idea: "When you see a person confessing to having the disease, you expect to see someone having signs of sickness. It makes you aware that there are lots of people with AIDS that you don't know about because it is not visible.

The learners were also aware of the reasons why some people do not believe them when they talk about AIDS and the danger that this holds for them: they said that this was partly because, in the early stages of the virus, it is not visibly evident that someone is HIV positive. However, once the person develops full-blown AIDS, they are often kept out of the public eye for fear of the societal prejudices that exist.

The messages contained in the various items presented at the Youth Club launches are important in illustrating the extent to which societal prejudices are being confronted. In one of the dramas or plays, children showed the understanding of the link between 'societal' problems, like alcohol abuse and incest, and their relationship to HIV / AIDS issues. It also

showed an understanding of what "breaking the silence" means and how important it is to achieve this. It spoke of the importance of talking out against child abuse and rope. It also showed that the children who participated have realised the importance of speaking out about HIV in order to prevent the spread of the virus.

Implicit in the dramas was an understanding of the following:

- the magnitude of the pandemic
- the potential danger of HIV
- societal reactions to People Living with AIDS (PLR's)
- the social stigmas associated with AIDS
- the benefits of abstinence at a young age
- the right to say "no" to sex
- the trend in society to deny the evidence of rape
- the importance of reporting rape.

Another important form of enactment was the use of individual speakers coming forward to make statements relating to health promotion. These were punctuated by singing and rhythmic movement. The messages showed that the pupils were aware of, inter alia.

- the need to condomise
- how to treat People Living with AIDS (PLR's)
- people's rights associated with HIV / AIDS
- the importance of being faithful to one partner
- avoiding sexual promiscuity
- the importance of abstinence and virginity.

It is difficult to gauge the reaction of the different groups in the diverse audience to these messages. The older members of the audience appeared to be 'shocked' at some points as can be expected. The pupils in the audience, some of whom were very young (in lower grades) appeared to be interested and were keen to see the 'outcome' of the drama as it unfolded.

Empowerment

There are very clear indicators that the learners who participated in the workshops and joined the Youth Clubs were empowered in different ways. Boys were empowered to act in

responsible ways within relationships, while girls were made to realise that they have rights in terms of sexual relationships. In addition, there is clear evidence that learners are empowered to make appropriate choices and decisions about sex. Learners also showed that they were prepared and ready to take responsibility for their health.

At a group level, where the boys were in the majority, the girls often took a 'backseat' and were led by the boys. However, in one of the focus group discussion, where the girls were in the majority, the reserve occurred. While it is widely accepted that it is important to train young men to care as well as young women to be assertive, there is nevertheless a cautionary note that needs to be raised when one particular group dominates the discussions.

Using participatory teaching methods

There is strong evidence to suggest that the facilitators have made use of participatory educational methods. The learners who attended the focus groups spoke of having taken part in the following kinds of activities:

- Discussions
- Role-plays
- Enactments
- Musical participation
- Performing sketches
- Role-playing
- Launching the Club • Games

It was also quite apparent that the learners had taken an active role in devising the programmes for the launches of the various clubs. They were encouraged to assume responsibility and partake in active rather than passive ways. It was also abundantly clear that the facilitators have a very good [relationship] with the learners and the learners at one of the schools said that the facilitator was a good role model for the learners in terms of the way in which he conducted himself.

Participants at the teacher training workshops indicated that they were prepared to take the advocacy campaign to all parts of their community, including to friends, relatives, teenagers, church members, neighbouring schools, other teachers in their own and other schools,

Creating a forum for youth

The establishment of such Youth Clubs has created a forum in which teenagers can discuss issues related to sexual health in a positive and constructive manner. Not only is it possible to discuss such issues among themselves, but they then also have the means to discuss these matters with other teenagers and members of the community.

Opportunities to network

There have been attempts made to allow learners in Clubs the opportunities to interact with other youth involved in similar projects. Learners at one school in particular expressed the desire to visit' other schools in order to perform the plays they had developed but were unable to do so due to transport costs, and, indirectly, financial constraints related to travelling. There was a strong feeling at one of the schools that learners wanted to feel part of a larger advocacy campaign but were experiencing feelings of restraint and isolation.

The Youth Club at the schools indicated that they had been visited by a number of other stakeholders in the region with the intention of providing networking opportunities. These 'visitors' included the following:

- Parents
- Friends
- Other schools
- A neighbouring primary school • Nurses
- Policemen
- People Living with AIDS (PLR's)
- Local councillor

Benefits

Development of appropriate knowledge

There is no doubt that the teachers and learners who took part in the workshops benefited enormously from their participation. In order for any development to be integrated and holistic in nature, the development of knowledge, skills and attitudes simultaneously, needs to take place in an integrated manner. There is evidence to suggest that learners and teachers who attended the workshops were able to acquire appropriate knowledge, skills and attitudes.

- "How to take care of people with the disease [HIV]"
- Knowledge about HIV / AIDS
- Knowledge about civil responsibilities
- Opportunity to clear up misconceptions and myths about HIV / AIDS
- "how to prevent being infected"
- "HIV is different from AIDS"
- "STD's [sexually transmitted diseases] may cause another disease"
- "I now have [the] right information of how HIV is transmitted sexually"
- learning about 'sexuality' (including the physical, emotional and intellectual) aspects of sexual matters) as opposed to 'sex'
- "We were also given contact numbers should we require counsellors"

Development of appropriate skills

Teachers and learners also showed evidence of having acquired the following skills:
- Leadership skills
- Organisational skills
- Debating techniques
- Life skills ("I gained more facts and experience in life skills") •

Techniques
- Skills of how to care for themselves sexually
- Discussion techniques
- Persuasive techniques
- Problem solving ability
- Decision-making ability

- Verbal communication skills
- Learning through activities
- "how to teach learners about life skills"
- Co-operation and sharing of resources

• Acknowledgement
- Using group work effectively
- Significance of using games to learn
- The need to be exemplary role models for the pupils
- How to conduct participatory activities (in order for the pupils to become involved and gain)
- How to identify children with different / diverse needs
- "We will make the content very interesting through dramatisation"
- Get to know the pupils through the use of games • "dramatisation"
- "The games as methodology are highly recommended as it refreshes and shows [the] inner person of the young people."
- Negotiation skills
- Decision-making skills Listening skills
- Observation skills
- Assertiveness
- "develop love for the people [with] AIDS"
- "How to handle yourself and others especially teenagers"
- "I've developed the skill of being proud to teach people about the disease because I have been taught almost everything"
- Show sympathy
- Using group work effectively
- Significance of using games to learn
- To be exemplary role models for the pupils

IV) PARTICIPATORY EVALUATED PROJECT 4(P4)

Excerpt representing the implementation and evaluation theory (MODULE 4) used

[Evaluation theory for P4]....theoretical foundation in social diffusion theory, which asserts that people evaluate changes not by scientific evidence or authoritative testimony, but by subjective judgements of close, trusted peers who have adopted changes and provide persuasive role models for change. Numerous reviews of health promotion campaigns affirm the importance of normative influence in promoting behaviour change. Community peer education programmes can effectively harness social normative influence to successfully promote behavioural change at community level

...Peer education programme [harnessed] the skills and energies [of the peer educators]

Through [the] peer education, programme [the] hidden, marginal or under-served communities [were reached]

The involvement of community peer educators [increased] community participation in [the] AIDS prevention activities

Involving volunteers [peer educators] [compelled the organisation to] become better organised, effective and rigorous in their management

V) PARTICIPATORY EVALUATED PROJECT 5(P5)

Excerpt of the training programme

D   Day one - Monday 231! August 1999

09h00 - 09h 15 - Prayer

09h 15 - 11h00 - Session one Practical skills workshop Infection control

D   Universal precautions

D   Preparing sterilizing solutions.

D   General cleaning and correct disposal of soiled linen, sharps

        etc. Speaker

11h00 11h30 - Morning tea

-

11h30 13h00 - Social security

-

Help organize applications for person/disability grant or other grants and facilitates collection of grants. Bathing patient in bed.

Speaker

13h00 -Lunch

D   Day two - Tuesday 24^1h August 1999 09h00 - 09h 15 - Prayer

09h15 - 11h00 - Session Two

D   Common Problems of patients at home - what to do and when to refer. 1. Pain

2.   Respiratory - cough/ difficulty breathing. 3. Fever

4. Diarrhea/vomiting 5.Oral/ vaginal thrush 11h00 - 11h30 - Morning tea

11h30 - 13h00 - Practical skills workshop.

D   Bathing patient in bed - changing linen, patient's clothes, etc.

D   Analgesics - types of pain and remedies for these.

D   Oral re-hydration suspension (ORS).

D   Mouths care demonstration.

D   Vaginal persary demonstration

Speaker 13h00 - Lunch

D   Day three - Wednesday 25 August 1999 09h00 - 09h 15 - Prayer

09h15 - 11h00 - Session Three

D   Common problems of patient's at home (continued). 6.Skin condition - shingles, rashes (dry/itchy). 7.Management of wounds - skin lesion. 8.Nutrition

D   Weight loss/ decreased appetite.

D   Recommended foods/ danger foods. 11h00 - 11h30 - Morning tea.

11h30 - 13h00 - Practical skills workshop.

D   Pressure area care for bed bound - patients.

D   Skin care with creams and lotion.

D   Mixing foods supplements correctly.

D   Emphasis on cooking foods correctly.

Speaker 13h00 - Lunch

D   Day four - Thursday 26^{1}h August 1999 09h00 - 09h15 - Prayer

09h15 - 11h00 - Session four D   What is AIDS/HIV? D Feelings about HIV/AIDS - prejudices/beliefs/etc.

D   Listening skills - reactions to illness, loss or death.

D   Spiritual needs of patients at home. D Confidentiality

11h00 - 11h30 - Morning tea

11h30 - 13h00 - Dealing with physical disabilities, making applications for Wheelchairs, calipers, etc   Speaker 13h00 -Lunch

D   Day Five - Friday 27^{1}h August 1999 09h00 - 09h15 - Prayer

09h15 - 11h00 -Session Five

Dealing with psychiatric problems and referral

11h30 - Morning tea.

11h30 - 13h00 - counseling/ spiritual needs of terminally/ chronically ill patients.

Sneaker

13h00 –Lunch 14h00 - General information on: D   Record keeping

D   Weekly meeting for follow-up debriefing.

D   Monthly training workshops - suggestions

D   Code of conduct.

VI) PARTICIPATORY EVALUATED PROJECT 6(P6)

Provide a new exercise to help participants move forward. Trainers work in teams, with one person leading the activity and another designated as ob-server/recorder, Shared daily, trainers notes and recollections provide data for subsequent sessions.

Adapted to AIDS prevention, participants are empowered to make their own situational risk assessments and to decide upon appropriate actions to take as individuals and as a group. In

contrast to the directive methods of conventional public health education, workshop trainers do not give advice or transmit messages.

The training approach aims to enhance participants' experience of personal autonomy and power, thus increasing their capacity to control risky situations. Telling people who have experienced social stigma, powerlessness, and low self worth how they 'should' act is tantamount to blaming them for their predicament.

The approach rests on learning theories drawn from several sources. The learning-by-doing frame-work developed by John Dewey emphasizes that from a young age, humans have within them the capacity to reflect upon experience and to generalize morn it. Because it is remote and transmits precepts already distilled, traditional education often blunts rather than fosters this capacity. Learning abilities are enhanced more by shared experiences guided by teachers than by rote learning. People remember best what they discover for themselves. Moreover, social learning in an interactive group stimulates creative challenges to received wisdom.

Creation of a favorable learning climate is crucial. Perhaps even more than children and adolescents, adults require that education relate to their experience, challenge their powers of observation and reasoning, allow them to participate in shaping their curriculum, and foster rather than attack their sense of personal worth and dignity.

In July, a training-off-trainers workshop was held for the entire team plus six additional research assistants. Following training, the team was reconstituted. In September the author provided additional training on AIDS and sexuality. Role-plays, problem-posing picture 'codes' and other exercises based on the ethnography were designed for use in the field. Community-based workshops began in October 1987. They engaged women of a low-income community, with little or no literacy, in problem-solving approaches to risk-reduction. The four-session workshop design used active learning methods, including role-plays, simple posters, small group discussions and structured group 'processing'.

A few examples will illustrate the method. An initial role play served as an 'ice-breaker.' A male visitor fails to recognize that the woman who welcomed him to her village is a chief. The scene was adapted from a passage in Dr David Livingstone's diary relating his visit to a Lunda group in what is now south eastern Zaire, where women chiefs were common a century ago [67,68]. The women immediately saw the visitor's problem and laughed at him [69]. Participants were asked to describe what they had seen, heard and felt. The sketch provoked the insight that women's responsibilities often go unrecognised. Applied to AIDS, they concluded that they must take care not to become infected because AIDS is fatal and others, including children, siblings and elderly parents, depend upon them for support. Used to demonstrate the `experiential cycle' of psychosocial process-training, the initial exercise was followed by an exercise on expected workshop outcomes.

Exercises showed metaphorically how the HIV progressively attacks the body's defences against disease, and can be transmitted by healthy-looking carriers. A dramatization of mother-infant trans-mission, during which mother and grandmother take a sick baby to the health centre, elicited strong emotional reaction. One participant exclaimed: "Oh, the poor thing hasn't even begun to live and now he's dying of AIDS"

An entire session was devoted to familiarization with condoms, demystifying what was to most an unfamiliar, uncongenial, unnatural, foreign technology. The group consumed soft drinks together. A facilitator produced a box of condoms and displayed one, irreverently drawing it over her forearm. The condoms were passed around and each participant rolled one over her empty soft drink bottle. Some broke, giving rise to jokes which provided opportunities for further learning. In the ensuing role-play, a sex worker showed a reluctant client how to use a condom, summoning her powers of seduction to overcome his resistance. Played to the hilt, the scene caused great mirth. Participants took condoms to try out with clients, and shared their experiences in the next workshop.

The two series of workshops ran concurrently for four weeks in October-November 1987. An effort was made to remove some of the stigma and guilt associated with the link between sex and AIDS by enabling couples to speak of other possible transmission routes. The wider family health context was explored first. For example, malaria prevention was

included as one means to reduce the need for blood transfusions among anaemic mothers and children [68]. Sterilization of needles and syringes also was addressed, since poor people cannot afford to purchase disposables for each injection. Although, unsterilised instruments are probably not a major route of HIV transmission, this danger has been widely publicised. Following this role-play, women decided to check on hygiene standards in neighborhood dispensaries. The experience was empowering and will help to reduce risk off other infections in the course of health care [70].

Nevertheless, sexual transmission was uppermost in the women's minds. Participants devised a role-play to help wives persuade husbands to remain at horse instead of accompanying their friends to bars where they spend money on beer and sexual adventures. The drama showed how male peer group pressures work to prevent behaviour change. Participants decided that although married women are definitely subordinate within the household, the wife-and-mother role also provides some opportunities to cajole husbands into dialogue about the need for protecting parents and children.

The workshops provided a forum in which to practice communication skills and to develop confidence in parrying male resistance, denial and deception.

User-focused evaluation assessed response to the interventions. At the end of the fourth week, participants in both groups demanded: "Teach us to do what you do so that we can inform our colleagues." Following a practice session, the sex workers demonstrated the method to friends in the presence of an international site visit team. The performances made clear that considerable new knowledge had been retained and some misinformation dispelled. Condoms were made available on a continuing basis and workshop participants were encouraged to share their knowledge and supplies with others.

Role-plays were enacted with great success. As before, the drama of the sickly infant aroused strong emotion. Two women testified that they had experienced this situation in their own families. Participants suggested that this and other familiar scenarios would be appropriate for men's groups. Participants contrasted the active learning experience with conventional health centre education.

Additional meetings were held at 3 and 8 months following the workshops to determine what changes, if any, sustained. At the end of 3 months, all but one of the sex-workers reported using condoms regularly, he nonuser reported that a genital ulcer made condom use painful, so we assisted her to obtain hospital treatment. Even without laboratory tests, which would have necessitated two re-visits and doubled the cost, the fee was equivalent to 20 client encounters.

Client acceptance of condoms was reported high, despite wide publicity about a purported `cure'. Two women said that they had turned away men who refused condom protection. Others agreed that this was wise, but that sometimes they needed immediate cash and had no other clients waiting. One woman who solicited in a popular entertainment district reported that she found it difficult to refuse the extra money offered by clients for unprotected sex. The group urged that men in all social milieus be educated to the vale of condom protection, since their clients are extremely diverse and since, in the final analysis, men control the decision.

Participants perceived the training as valuable. Knowledge off AIDS apparently raised their status among clients and community residents. Clients were surprised to discover that the sex workers knew about the value of condoms for AIDS prevention. The women felt somewhat less threatened by neighbours. They also had gained in status among rival networks of sex workers to whom they spread the word. They mentioned these immediate social and psychological benefits.

VII) NON-PARTICIPATORY EVALUATED PROJECT 1(NP1)

The programme had "a dramatic impact on the extent to which students discussed AIDS with their parents, friends, teachers, nurses and sexual partners. The focus group ... initiated debate between students around the acceptance of people with AIDS, and challenged deep-seated fears and prejudice. Students expressed strongly hostile and fearful responses to a person with AIDS, but the knowledge that there was no risk of transmission from everyday contact, began to challenge this view.

Students' most immediate response to the programme was their concern about the AIDS rumour. They felt humiliated and insulted that people were' saying that the reason their school had an AIDS programme was because there were people in the school with AIDS, "We have now become a laughing stock of other schools." "This gives a bad name to our school."

Overall the students expressed positive opinions -about the programme. 'They felt that it had been a good idea to give out condoms in the school but were [afraid] having to ask a teacher for them. "Say it's Friday, he's going to think that I am going to have sex this weekend", explained one of the students. Students felt that they would have liked to have met someone with AIDS.

VIII) NON-PARTICIPATORY EVALUATED PROJECT 2(NP2)

- **Support staff**

Programme monitoring. ... in collaboration with the ....secretariat- holds overall responsibility for monitoring the progress and reporting to donors, in the form of the Programme Committee. Some participants questioned the extent to which these are specifically relevant to [the organisation] as a support programme (as opposed to an implementing programme). Combined, these factors make the collection of cumulative data and the tracking of progress challenging. Indeed, the Evaluators sensed that this is an area in need of improvement - particularly in the light of some back donors' expressing the need for a more formal, results-based framework.

The evaluation team was concerned that it did not formally involve partners or those beyond the immediate "family," such as government, donors and PLHA groups. In terms of its strategies, the evaluators were impressed by [the organisation's efforts to "fill a gap" and avoid replicating efforts.

In general, the participants in the Evaluation felt that strategic direction has been appropriate - in terms of its geographical focus, types of intervention, target groups and theoretical frameworks. However, they also identified some limitations. These included that

working in the Northern Province has proved logistically challenging and that much efforts have focused on broad-based advocacy work [see box]. They also included that selected target groups have been very broad which - although appropriate to a high prevalence context - limited clear priority. Also, while [the organisation] has successfully identified dedicated and enthusiastic groups, the mix of partners has presented some limitations.

However, participants felt that the Board has worked transparently and, as one of the members put it: "We leave *our organisational* hats at the door, and have been able to *work for* the broader interests of the programme *and* not *for* the individual projects we *work* with." It was also felt that the concerns were counter-balanced by the reality of having a relatively small pool of local expertise from which to draw.

In terms of representation, the Board has attempted to address its gaps, for example by recently involving someone who is both a representative of the youth sector and a man (helping, in a modest way, to address the gender imbalance).

- **Soccer players**

The experimental group: The number of participants with one partner increased from 1 to 7. Three of these participants lost someone close due to HIV/AIDS, which may be an intervening variable influencing the results. The number of participants that have 2-3 partners increased from 7 to 11 but there was a decrease in the number of participants with 4-5 partners - from 11 to 3 whilst that of participants with more than 5 partners was eliminated from 2. These two moved from having more than five partners to having between 2 and 3 partners. So, even if there was an increase in the 2 to 3 partners it means participants moved from having 4 to 5 partners to having 2-3 partners. This is a positive change because the fewer the number of sexual partners one has, the lesser the chances of contracting STI and HIV.

The control group: 1 participant has 1 partner whereas before none of the participants had 1 partner. The number of participants with 2-3 partners decreased from 10 to 8 but there was an increase in the number of participants with 4-5 partners - from 8 to 10. It may seem that

the two participants who had 2-3 partners increased their partners to 4-5. This is a negative change as two more participants have increased their risk chances to infection.

Statistically the two groups (experimental and control) show a highly significant difference in the number of sexual partners using the Kruskal-Wallis test(p = .0000). This means that the intervention was greatly successful in getting the soccer players to reduce the number of partners. This implies that the peer educators were successful in their education to raise awareness among their peers (soccer players) to reduce the number of partners.

Prior to the intervention the highest number of participants was concentrated in using the condoms "sometimes" for both groups. The groups were similar because the p value was .5. After the intervention the number of soccer players using condoms all the time increased to 18. The number of participants using the condoms "sometimes" dropped from 16 to 3 as most of them started using condoms all the time. Four participants that had never used the condoms before reported using them all the time and one started to use them sometimes.

IX) NON-PARTICIPATORY EVALUATED PROJECT 3(NP3)

In 1989, the Bulawayo City Council, supported by the University of Zimbabwe, initiated a peer-mediated education program for sexually vulnerable groups in Bulawayo, Zimbabwe's second largest city, with a population of - 1 million [4]. The program's major focus is female sex workers. In addition, however, male educators are recruited and trained from vulnerable groups of men, including clients of female sex workers. They attend 3-hours meetings held each week throughout the_year, at which time they are trained in STD and HIV information, educational and counseling techniques, condom promotion, and community mobilisation. Peer educators are divided into seven major zones, reflecting the geographic and demographic makeup of Bulawayo. Each zone functions as a cohesive unit and has a senior peer educator or group leader responsible for organizing, motivating, and supervising peer educators in her zone. The coordinator and senior peer educators meet frequently to review and plan activities and to prepare for the weekly training meetings with all peer educators.

Every week, peer educators each hold two or more community meetings in their social networks. Peer educators are also given large supplies of condoms, which they distribute in their social networks and at 'barsγ selected workplaces, and health facilities. In addition, peer educators receive free STD treatment cards for themselves, and for distribution to other sex workers. The most experienced peer educators receive extra training to serve as STD prevention and partner referral counselors at health facilities. Peer educators have diaries and monitoring

An evaluation was done in 1992 to assess the coverage and impact of the program. First, an attempt was made to estimate the number of female sex workers in Bulawayo. In a national survey of 815 female sex workers and 918 clients, 80% of sex workers and 82% of clients reported seeking commercial partners in, bars [21]. A team of 100 enumerators (sex workers, assisted by students) was trained to count all female sex workers in these 56 bars from opening to closing time on one payday Saturday. The dress of all sex workers was recorded and computer coded to identify and remove double counts. Excluding a -30% double count, 6873 sex workers were identified. Next, a sampling frame was developed and 15 bars were randomly selected, using selection criteria that conferred greater inclusion probabilities on larger bars. Random starting times were chosen and a random sample (weighted by the sex worker count in each bar) of 1381 sex workers was identified and interviewed on a Saturday night.

Condom use rose from 18% of all reported sensual contacts at the outset of the program to 66% within 2 years. The relationship between program exposure and reported condom use was also examined. A strong linear relationship is evident, suggesting the importance of repeated educational exposures.