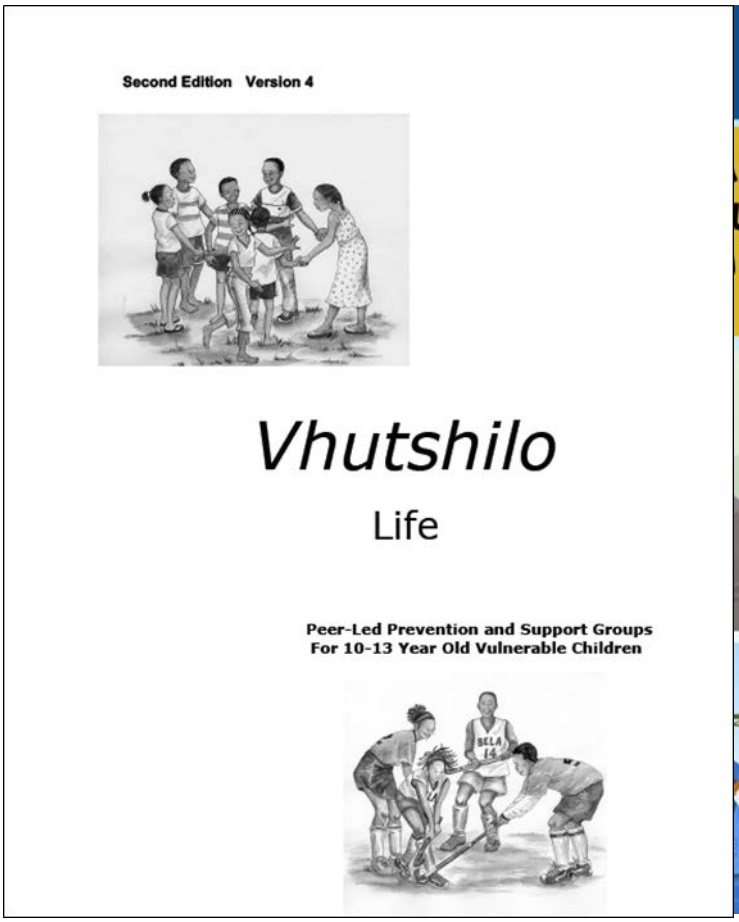


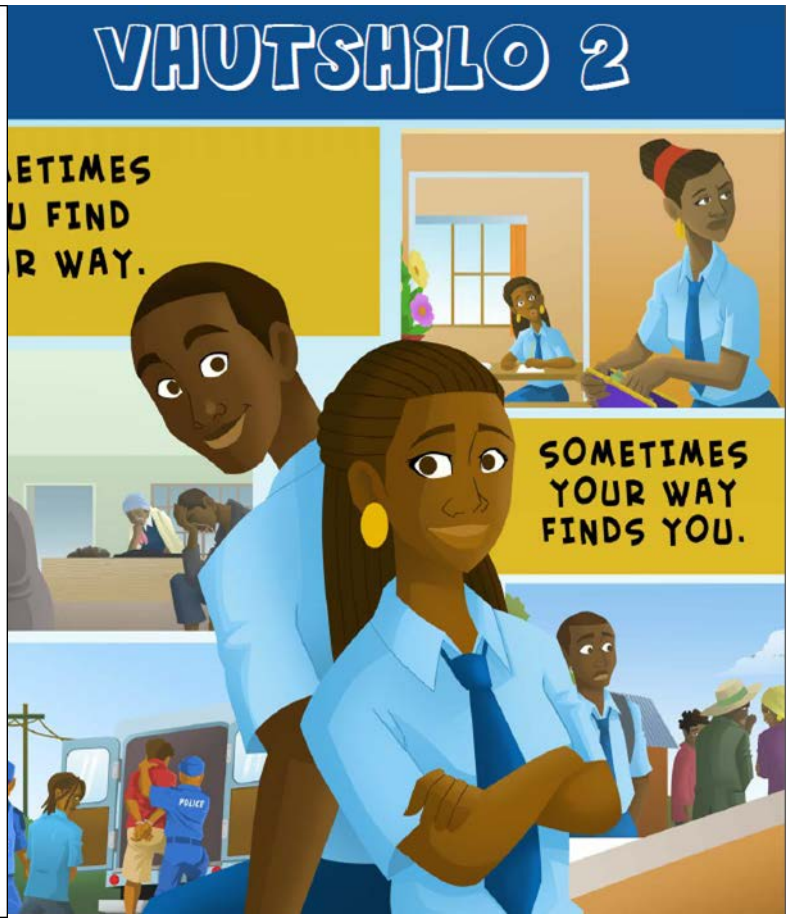


**Vhutshilo 2 is for 14 – 17 Year Old Vulnerable Children**

# Evaluation of *Vhutshilo 1* and 2 Curricula in South Africa

# Summary Report

**[August 2015]**

This publication was produced at the request of the United States Agency for International Development. It was prepared independently by Shamima Vawda, Dr. Femi Otulaja and Mpho Khasake from Systems Approach

# ACRONYMS

| | |
|---|---|
| **AIDS** | Acquired Immune Deficiency Syndrome |
| **CCF** | Child Care Forum |
| **CPC** | Centre for Positive Care |
| **CSPE** | Centre for the Support of Peer Education |
| **FF** | Future Families |
| **FHI360** | Family Health International 360 |
| **HIV** | Human Immunodeficiency Virus |
| **IP** | Implementing Partner |
| **OVC** | Orphaned and Vulnerable Children |
| **OVCY** | Orphaned and Vulnerable Children and Youth |
| **PEPFAR** | U.S. President's Emergency Plan for AIDS Relief |
| **USA or US** | United State of America |
| **USAID** | United States Agency for International Development |
| **V1 and V2** | *Vhutshilo 1 and 2* |
| **WVSA** | World Vision South Africa |
| **YF** | Youth Facilitators |

# EVALUATION SUMMARY REPORT

## EVALUATION PURPOSE & EVALUATION QUESTIONS

This implementation evaluation provides insights into the process of implementation of the first round of *Vhutshilo 1 (V1) and 2 (V2)* curricula by four implementing partners (IPs) who carried out their interventions in complex, but varying, contexts in South Africa. The objectives of the evaluation are to determine the facilitators and barriers to implementation, as well as the receptivity, readiness and value of V1 and V2 curricula from the perspectives of the IPs and other stakeholders interviewed. The receptivity focused the feasibility and acceptability of the *Vhutshilo* implementation by exploring the experiences, perceptions, and attitudes towards the implementation of the curriculum by the four IPs. Readiness was assessed based on the factors encountered by implementers within pre-implementation and implementation phases that positively or negatively impacted the rollout and uptake of the V1 and V2 curricula. Value was assessed through and understanding the aspects of the implementation that resonated most with the implementers and beneficiaries. In addition, the areas that the implementers felt were in need of strengthening were also considered.

The evaluation also considered the impact of delivering V1 and V2 on the IPs, the models for sustainable implementation, the identification of the most significant changes that took place, and the influence of gender-combined groups.

## PROJECT BACKGROUND

The United States Agency for International Development (USAID) identified a need for a modular curriculum that could be used to help children -- mostly orphans and vulnerable children and youth (OVCY) who were receiving support a drop-in centers -- with decision-making skills and improved HIV information.

The Centre for the Support of Peer Education (CSPE) produced V1 for 10 to 13 year old children, and V2 for 14 to 18 year old children and youth. The curricula served the following two purposes: 1) an education program on HIV prevention and risk reduction, and 2) a 'youth-friendly' mechanism for providing psychosocial support in establishing local networks of care. V1 and V2 curricula are comprised of 12 and 13 sessions, respectively. The curricula are packaged as a manual for peer educators to use in planning and facilitating sessions. Peer educators who are a few years older than the youth they work with are trained to work in groups of 2 or 3 to lead the structured activities with a group of 15 to 17 OVCY. Each team of peer educators is supervised by a more experienced adult who helps with the planning, referrals for OVCY to supportive services, and also debriefs peer educators after difficult sessions.

The first round of implementing V1 and V2 curricula began in 2009 with funding from the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) by Future Families (FF) and World Vision South Africa (WVSA), and later by the Centre for Positive Care (CPC) and Woz'obona. CSPE received the funding for training, monitoring, supporting, and providing technical assistance to

the IPs. IPs were required to adhere to the following minimum implementation norms by CPSE: 1) an adult supervision infrastructure must be in place to support peer educators; 2) the sequence of sessions must be followed; and 3) the groups must be closed to new participants after the second session.

## EVALUATION METHODS & LIMITATIONS

Recognising that V1 and V2 curricula were implemented by four different partners in varying contexts, a *qualitative case study* methodology was adopted in analyzing qualitative data collected from implementers. The methodology used one-on-one in-depth interviews and focus group discussions in addition to document analysis. Evaluators treated each IP's delivery method as a unique model. This provided opportunity for the evaluation to describe, define and analyse how and why different implementation approaches were more or less effective across contexts. Five (5) focus group discussions were conducted with peer educators/youth facilitators (YF) and adult supervisors. Sixteen (16) in-depth interviews were conducted with stakeholders from USAID, CSPE, CPC, FF, WVSA, and Woz'obona. These methods were triangulated with review of documents from each IP as well as a review of the international literature on peer education.

The evaluation was conducted from the 18th March 18 to May 8, 2015 with fieldwork occurring from April 2 to 29, 2015. All the in-depth interviews and focus group discussions were digitally-recorded and transcribed into English. The data collected were cleaned, after which data capturing was done manually. All transcripts were coded and captured into a table using MS Word. Thematic analysis was conducted on the data set through an iterative process which first focused on descriptive analysis, then moved into an analytical interpretation of the data.

The implementation evaluation faced two main challenges, namely: 1) program documentation was thin across all implementing partners; and 2) key informants from Woz'obona were unavailable during the fieldwork period.

## FINDINGS

### *Facilitators and Barriers to Implementing V1 and V2 Curricula*

Table A presents the facilitating and impeding factors to effective implementation of V1 and V2 curricula in South Africa.

*Table A: Facilitators and Barriers to Implementing V1 and V2 Curricula in South Africa*

| FACILITATORS | BARRIERS |
|---|---|
| 1. Demand for a structured HIV prevention education curriculum amongst IPs.<br>2. Need for HIV prevention and reproduction and sexual health education and psychosocial support.<br>3. Aligned to IP's organisational goals.<br>4. Matches IP's developmental approaches. | 1. Difficult to select, recruit and retain peer educators.<br>2. Resource intensive; requires:<br>a. Adult supervision infrastructure;<br>b. Responsive referral system; and<br>c. Operational budget for stipends/incentives, refreshments, |

| FACILITATORS | BARRIERS |
|---|---|
| 5. The curricula are portable and can be used in any context.<br>6. The curricula address the factors contributing to reckless behavior amongst youth.<br>7. Peer education coupled with the constructivist pedagogy allows children and young people to talk openly about their concerns.<br>8. The long duration of the curricula enables IPs to 'get to know' their OVCY; consequently to be responsive to their needs.<br>9. Curricula can be tailored to organizational systems<br>10. Avoids ad hoc discussions that are considered as prevention programs<br>11. Requires strong adult infrastructure to ensure quality | venue, travel, stationery and equipment.<br>3. Designed for out-of-school programs and cannot be easily integrated into formal school curriculum.<br>4. Attendance and drop-out rate is challenging due to many competing priorities for children and their families (chores, school work, etc.) |

### *Receptivity of V1 and V2 Curricula for Implementing Partners*

The evaluation showed a high level of receptivity of the V1 and V2 curricula by IPs. It met a demand within their organisational plan for the group of OVCY that they work with, particularly since the format suited the informal, after-school context in which they operated. This was true even for Woz'obona, which implemented an informal program within a formal school setting. The approach, content and outcomes of the curricula aligned well with IPs' own organisational goals and enactment of children and youth developmental strategies and practices. V1 and V2 were separately and readily integrated into IPs' existing programming and organisational infrastructure.

The integration of a psychosocial support system embedded in the format of the curricula and the duration of the curricula helped IPs to get to know the OVCY who they work with, and consequently helped implementers to be more responsive to individual children's and youth's needs.

### *Value of V1 and V2 Curricula for Implementing Partners*

The value of V1 and V2 curricula lie in the fact that it offered IPs a structured HIV prevention education intervention for OVCY that had been adapted suitably for the implementers' clientele, context, and peer education praxis. Implementing partners appreciated that the curricula were: 1) contextually relevant, 2) well structured, 3) had a sustained intervention period, 4) integrated HIV prevention and psychosocial support, 5) were peer led, 6) created group interactions, 7) included sexual and reproductive health issues, 8) promoted positive agency, 9) created awareness of local services, 10) fostered children and youth resilience, and 11) were fun and creative.

### *Readiness to Implement Vhutshilo 1 and 2 Curricula of Implementing Partners*

Evaluating readiness of IPs indicated that CPC and FF among all the four implementers had the necessary adult supervision infrastructure in place. The HIV prevention education became an integral part of the services they offered OVCY. This enabled these organisations to institutionalise V1 and V2 curricula, respectively.

Woz'obona piloted V2 curriculum as an informal intervention within the formal school program. The evolution of the pilot into an extra-curricular offering was not effectively documented in terms of what was learned from the sessions.

For WVSA, V1 and V2 was implemented as part of a study conducted by Tulane University. The Tulane University study and how it was designed appeared to affect how WVSA implemented V2 in Eastern Cape, which was different from the way they implemented V1 and V2 in Free State and Limpopo and faced several challenges. While ordinarily WVSA does not provide incentives to children, they did so to get children to attend the program in the Eastern Cape Province. This may have been done to overcome the various contextual limitations needed to implement Vhutshilo 1 in more rural communities. In addition, in the WVSA Eastern Cape sites, the distances YF had to travel to get from village to village reduced the contact time between the YF and the OVCY per session. There was also concern for the safety of YF who were travelling to distant sites without secure transport, as most of the YF were girls working alone without a co-facilitator.

## LESSONS LEARNED

Through this evaluation of the implementation of V1 and V2, several critical lessons learned emerged including the following:

1) Peer education is a very effective approach to integrating HIV prevention education and psychosocial support to OVCY;
2) There are demands for structured HIV prevention curricula from grassroots organisations who provide various forms of assistance to OVCY;
3) There is a need for a peer educator/youth facilitator support guide that will help them to respond to various implementation contexts;
4) There is a need to review and update the curricula both in terms of its content and cultural-relevance of the context in which it is implemented;
5) The V1 and V2 curricula are resource-intensive in terms of both peer educator and adult supervision infrastructure, and other resources for incentives, refreshments, transportation, stationery, and venues; and
6) Implementing in rural villages requires additional resources and community buy-in.

## CONCLUSION

V1 and V2 curricula offered IPs an educationally rigorous and structured HIV prevention education program that challenged them to use peer education as an effective tool to disseminate health information to OVCY in all communities where it was implemented. The topics are relevant to OVCY, and the peer-led YF approach delivered sexual reproductive

health knowledge, HIV prevention education, and psychosocial support in a "we-are-in-this-together" environment.

IPs with existing adult infrastructure and services specifically targeted to OVCY have integrated the V1 and V2 curricula into their programming. While the curricula are portable, it is resource-intensive and requires specific funding to be allocated for implementation.

## RECOMMENDATIONS

The recommendations emerging from the implementation evaluation of V1 and V2 curricula in South Africa are as follows:

### *For Vhutshilo Curricula:*

1. The curricula should be updated to align to contemporary issues facing OVCY. V1 curriculum should be finalised.
2. Develop a supporting peer educator/youth facilitator guide to enhance their planning, coping and knowledge to deliver topics that they may consider difficult.

### *For CSPE:*

1. CSPE should act as a 'clearing house' for peer education and the *Vhutshilo* approach. This would provide a resource center and contribute to a community of practice.
2. Provide training, technical assistance and mentorship to IPs as a way to maintain and support quality HIV prevention education, and to support expansion and further development based on contextual needs.
3. A toolkit should be designed and made available to IPs to facilitate effective delivery of the *Vhutshilo* approach.
4. A training program should be designed for IPs to use in their internal, on-going professional development initiatives.

### *For USAID:*

1. Adequate funding should be made available to IPs to promote quality results and impact for target groups with HIV prevention interventions using V1 and V2.
2. Strengthen the role of community, government and private sector stakeholders in the provision of required additional services and referrals for OVCY at site level (i.e. access to youth friendly clinical, social and educational services)
3. FF implementation model should be written up as a best practice model for the *Vhutshilo* approach.
4. Build in reflective learning workshops on the implementation and benefits as an annual learning platform for IPs.

***For IPs:***

1. Capture HIV prevention data that recognizes the repeated exposure prevention education approach and links to HIV-related outcomes.
2. Strengthen data storage and retrieval systems.
3. Strengthen adult infrastructure and a responsive referral system to improve the effectiveness of the *Vhutshilo* approach.
4. Ring-fence *Vhutshilo* operational budget.
5. Provide ongoing professional development of the adult supervisors in order to maintain standards and contribute to innovation.
6. Integrate *Vhutshilo* indicators into internal monitoring and evaluation systems.
7. Consider community contexts in planning and resource allocation.

# ANNEX A: EVALUATION TERMS OF REFERENCE

I. Background of the Program

South Africa has the highest number of citizens living with HIV in the world. Around 12.2% of the 15-49 population is HIV positive (Shisana et al., 2014). A consequence of such high adult prevalence is a high number of orphans and vulnerable children who live without adult protection, supervision and guidance. In order to address this particular consequence of HIV, the South African government has developed a comprehensive plan to mitigate the spread and effects of HIV. This has been supported by the President's Emergency Plan for AIDS Relief (PEPFAR) and the United States Agency for International Development (USAID).

It is estimated that there are 3.8 million children in South Africa who have lost one or both parents. Many millions more children are currently living with parents who have AIDS. While the national HIV prevalence of 12.2% (which is even higher in some regions of the country) places all South African adolescents at high risk for HIV, orphans and vulnerable children (OVC) are particularly exposed to the conditions that create additional vulnerability. Available research focusing on orphans indicates that OVC have greater exposure to established HIV risk factors and as a result have elevated levels of both sexual risk behavior and HIV infection.

Recent PEPFAR guidance for HIV prevention stresses the importance of specialized evidence-based HIV education and behavioral interventions for OVC and guidance for OVC programming also highlights this aim. Despite this emphasis, few OVC programs explicitly offer such services. Data from USAID indicates that only about one quarter of adolescent OVC served by current PEPFAR partners in South Africa received HIV prevention education. In addition, research by Tulane University in South Africa illustrates measurable deficits in HIV knowledge among the OVC population. Lack of HIV knowledge and skills necessary for practicing preventive behaviors among adolescents has been identified as an important determinant of risky behavior. According to the South African National HIV Prevalence, Incidence and Behavior Survey of 2012 close to 70% of young men and women between the ages of 15 and 24 lack sufficient knowledge about HIV/AIDS.

Vhutshilo 1 and 2

The Vhutshilo 1 program (2006) was developed by a Program of the Harvard School of Public Health (HSPH) through its Centre for Support of Peer Education (CSPE) in South Africa which was later integrated into the establishment of the South African non-profit organization Health and Education Training and Technical Assistance Services (HETTAS) in 2007. The model was developed by HSPH through a field generated consultative process involving representatives from selected NPOs and various expert stakeholders. The Vhutshilo program was designed specifically for adolescent OVC in South Africa; it generated two curricula aimed at two distinct age groups. Vhutshilo 1 (V1) was tailored to the 10 to 13 year old age group. Vhutshilo 2 (V2) was designed to reach 14 to 17 year olds. V2 (2008) was developed as an intervention designed to provide age appropriate prevention and risk reduction information to adolescent OVCs. Pilot implementations of both the curricula were administered through the Human Sciences Research Council (HSRC) and two reports were generated out of this pilot research. A revision of V2 was prompted by the recommendations out of the HSRC research that suggested that the youth did not find the original artwork appealing. An extensive review was conducted that included revision

of the illustrations and a need to ensure that pedagogical relevance and contextual appropriateness were attained for youth in the 14 to 17 age category. On recommendation and a request from Tulane and USAID some additional sessions on HIV; unplanned pregnancy and gender based violence were added to the V2. This was planned for use in the intervention of V2 with World Vision in the Eastern Cape and would be sites for an extensive comparative study by Tulane at the request of USAID. The resultant V2 curriculum corresponds to selected outcomes of the Department of Basic Education's Life Orientation Skills program and has both urban and rural relevance.

The Vhutshilo 2 program consists of 13 sessions implemented once a week in closed groups of 15 – 17 youth, covering topics that include receiving and giving emotional support, dealing with grief and loss, alcohol and substance abuse, gender issues and gender violence, HIV/AIDS, sexual health, safe sex and healthy relationships, and unplanned pregnancy. In addition to its knowledge component, the program tries to build skills necessary to act on this knowledge. The Vhutshilo program uses a participatory approach in reflective workshops to combine vulnerability risk reduction, grief support and assistance and guidance in peer network formation where parents are absent or deceased. The hope is that an active social support network would assist children and adolescents cope with social rigors of being vulnerable.

Vhutshilo is a well conceptualized and promising approach to reducing HIV risk. The formative assessment conducted by Swartz et al to learn about the acceptability of the curriculum, the feasibility of its delivery and how the intervention could be improved found that Vhutshilo was a feasible program to implement and acceptable for the OVC. While this initial evaluation of Vhutshilo provided promising results and the results of the Tulane study are yet to be finalized, further evaluation on the implementation of the intervention is still needed.

The table below provides a summary of Vhutshilo Program partners and the geographic areas they covered:

| Partner Organization | Vhutshilo Phase | Geographic Coverage |
|---|---|---|
| World Vision | V2 | Eastern Cape – Matatiele and Seymour (WV ADP office since closed but Tulane still doing post intervention follow up) |
| Future Families | V1 | Pretoria and environs |
| Centre for Positive Care | V2 | Thohoyandou |
| Woz'obona | V2 | Sekhukune |

## II. Evaluation Objective

Vhutshilo was designed at the request of USAID to develop a peer led curriculum to help bridge the gap of providing psycho-social support to youth and children in community based settings and structures through strengthening peer networks. This evaluation will assess the implementation of Vhutshilo curricula in South Africa and help to determine facilitators and barriers to effective, sustainable implementation of the curriculum (including pre-and post-implementation stages). The results of the evaluation may serve as guidance for implementing partners who are planning to introduce Vhutshilo 2 curriculum in their programs.

The objectives of the evaluation are to:

1. Determine the feasibility and acceptability of the Vhutshilo implementation from the perspective of implementing partners by exploring their experiences, perceptions, and attitudes towards the implementation of the curriculum

2. Determine the factors encountered by implementers within pre-implementation and implementation phases that influenced the rollout and uptake of the V1 and V2 curricula in either positive or a negative way

3. Determine the aspects of the curricula implementations that resonate most with the implementers and beneficiaries and the areas that they feel are in need of strengthening.

Findings and recommendations from this evaluation will describe approaches used to implement V1 and V2. The analysis of the "lessons learned" will help to distill implementation challenges and successes and serve as guidance to those who are considering implementation of the Vhutshilo program.

The audience of the evaluation will be CSPE as implementing partner, USAID as well as FHI 360 and the South African Government. The primary evaluation participants are implementing partner's staff, youth and peer facilitators as well as a sample of beneficiaries.

## III. Scope of Work

The focus of the evaluation will be to determine facilitators and barriers to effective, sustainable implementation of the curriculum (including pre- and post-implementation stages). They will look at pre implementation requirements, training and implementation of the program with specific focus on:

- The experiences of V1 and V2 implementers related to program management, coordination, logistics, and content delivery.
- Issues related to training and management of the peer educators and youth facilitators (including their training in facilitation techniques, supportive supervision, as well as retention of an adequate pool of trained youth facilitators/peer educators).

- Issues related to curriculum content, including youth facilitators/peer educators' experiences with delivering the sessions, what worked and what did not, their experiences with supportive supervision and linkages to other services.

## IV. Evaluation Questions

The evaluation questions are purposely divided into structural and activity questions to determine whether program functioned the way it was intended. Structural questions relate to resources and organization, whereas activity questions relate to staff and beneficiary behaviors.

The key evaluation questions to be addressed are:

Structural Questions

1. What structures and systems were in place during pre-implementation and implementation phase to support the delivery of V1 and V2 curricula, quality training for peer educators/youth facilitators; and desired behavioral outcomes?
2. What is the administrative structure which supports the V1 and V2 curricula training program (organizational chart, board of directors, personnel policy, hiring practices which are consistent with philosophy and program intent, etc.)? Does the physical setting of the Vhutshilo program conform to the program's intent or objectives?
3. How did implementing organizations deal with identification and selection of peer educators/youth facilitators' turnover?
4. What quality assurance mechanisms were in place to ensure quality information, guidance and support provided to and from peer educators? Were there mechanisms for accountability? How did the implementing organizations assess the effectiveness of peer-led sessions in achieving curricula objectives?

**Activity Questions**

5. What types of training were offered in V1 and V2? How were peer educators selected? How were peer educators supported in the implementation? What were the strengths and weaknesses of gender combined groups including issues faced by implementers regarding combined groups to what intensity and which specific sessions?
6. How were sites for implementation selected and agreed? How was the community prepared for the intervention? What types of stakeholders were included in the mobilizing of the community prior to intervention? At what times and in what settings were the services received? What challenges inhibited or negatively influenced the uptake of the curricula by implementing organizations?
7. How were the groups monitored? How were beneficiaries' attendance at sessions managed; and what was the follow up with youth that dropped out? What can be done to improve the rollout, implementation and uptake of the curricula and a peer led

intervention? Did any beneficiaries need referrals out of the sessions? How did this happen?

8. What are the successes of the implementation of the Vhutshilo intervention?

# ANNEX B: SOURCES OF INFORMATION

The sources for primary data are captured in the Evaluation Methods and Limitations section in the main report. The following documents were reviewed for the implementation evaluation of the *Vhutshilo 1 and 2* curricula in South Africa.


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